SOCIAL SERVICES FOR VIETNAM VETERANS AND THEIR FAMILIES: CURRENT PROGRAMS AND FUTURE DIRECTIONS

HEARING

BEFORE THE

SUBCOMMITTEE ON
OVERSIGHT AND INVESTIGATIONS

OF THE

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HOUSE OF REPRESENTATIVES

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SOCIAL SERVICES FOR VIETNAM VETERANS AND THEIR FAMILIES: CURRENT PROGRAMS AND FUTURE DIRECTIONS

WEDNESDAY, MAY 18, 1994

HOUSE OF REPRESENTATIVES,
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS,
COMMITTEE ON VETERANS AFFAIRS,
Washington, DC.

The subcommittee met, pursuant to call, at 8:30 a.m. in room 334, Cannon House Office Building, Hon. Lane Evans [chairman of the subcommittee,] presiding.

Present: Representatives Evans, Long, Ridge, and Quinn.

Also Present: Representatives Peterson and Velazquez.

OPENING STATEMENT OF CHAIRMAN EVANS

Mr. EVANS. Today, the subcommittee expects to receive some very important testimony on the provision of social services to Vietnam veterans and their families. We will hear from those who know best about this subject. We'll hear from those who provide these services, from those who support these services and from those who receive them. We expect to learn much about what is occurring today, what has already been accomplished and what remains to be done.

VA has traditionally viewed veterans as individuals and the care and services it has provided to veterans has generally been individual in nature. VA has treated veterans for their individual needs. As a result, VA has not always recognized that veterans can also be fathers or mothers, sons or daughters, sisters or brothers, aunts or uncles, husbands or wives, or workers or bosses. Veterans have been viewed generally as men and women who don't have significant personal relationships with other people.

Fortunately, this incomplete view of veterans has begun to change and much of this change has been brought about by veterans themselves. Veterans know they can both influence and be influenced by those with whom they have important relationships. Veterans are not one dimensional.

Many Vet Centers, for example, provide services to veterans and to other individuals with whom veterans have important relationships. These important services provided to spouses, significant others and the children of veterans also serve veterans.

Since its inception, the Agent Orange Class Assistance Program has been instrumental in focusing attention on the reality of the lives of Vietnam veterans and their families. By providing critically

needed support and encouragement to service providers, Agent Orange Class Assistance Program has made possible the delivery of services important to both veterans and their families.

The history of the Agent Orange Class Assistance Program is not yet complete; its legacy not yet written. But its positive impact on the provision of services to veterans and their families is already well established.

Today we want to learn about projects and programs that have been supported and encouraged to serve our veterans and their families. We want to identify some of these services and we want to hear from those who have received them. We hope to learn much from those who will testify today.

Most of those who will testify today have never appeared before a committee of the Congress. To each of you we extend an especially warm welcome. You are truly the most important people in this hearing room this morning. With you, there would be no congressional hearing. Today we are here to listen. If an occasional question is asked, its purpose will be to clarify statements or to gather more information.

If anyone should be nervous about testifying, please keep in mind that you're among friends. Every man and woman who serves on this subcommittee has chosen to do so because of their commitment to our Nation's veterans. We certainly appreciate the sacrifices you made when you put on the uniform of our country. We also recognize the sacrifices made by family members of those who wore the uniform.

The prepared statement of each witness will be included in its entirety in the written record, without objection. Each witness is again requested to observe the 5-minute rule and to limit their oral remarks to 5 minutes. The red light on the table will signal the end of the 5-minute period.

Before calling the members of our first witness panel, I would like to recognize the gentleman from Pennsylvania, the Ranking Minority Member, for any comments he would like to make.

OPENING STATEMENT OF HON. THOMAS J. RIDGE

Mr. RIDGE. Thank you, Mr. Chairman. I do have a brief statement.

Let me first of all thank you for scheduling today's hearing and thank the witnesses for their very important and valuable testimony.

In reading through your written testimony, I'm reminded of the phrase, and I must paraphrase it now, no man or woman is an island. A Vietnam veteran cannot separate problems he or she experiences because of the war from their relationship with their family.

We will have compelling testimony today as to how problems associated with service in Vietnam lingers and dramatically affects the soldier and the family. I believe that the members of this committee, Republicans and Democrats alike, recognize that when an individual puts on a uniform, when he or she returns home from faraway places having served their country, that individual and that experience is often carried into the family relationship and that individual's spouse and/or children sometimes have to endure

and live with that experience in a lot of different ways. That's why your testimony today is very important and very helpful to us.

I commend the Agent Orange Class Assistance Program, not only for their recognition of the necessity for family-centered services, but also for making available grants that place a special emphasis on service to families with children with developmental or other chronic disabilities. I also commend the recipients of these funds for their dedication in meeting the social service needs of Vietnam veterans and their families.

I look forward to hearing the oral testimony of our distinguished witnesses, Mr. Chairman, and I thank them for appearing here before us today.

Mr. EVANS. Thank you. We always appreciate the assistance of Congressman Ridge, who is a combat veteran of Vietnam.

I'd like to yield of the gentleman from New York for any remarks he might like to make.

Mr. QUINN. Thank you, Mr. Chairman. I have prepared remarks that I'll enter into the record, but want to welcome all of our panel members here today and thank you, Mr. Chairman and Mr. Ridge for opening remarks and for calling the hearing.

You said just a minute ago not to be nervous, that you're here with family members—you're here for family members. But we view our Committee as family members as well, and we look forward to all the testimony and appreciate the time they're spending here today.

Mr. EVANS. Thank you for being with us.

Members of our first witness panel this morning are Dennis Rhoades and Dr. Charles Figley. Please come forward to the witness table at this time.

Before formally introducing Dennis, I am pleased and honored to recognize a good friend and colleague, a former member of this committee and subcommittee, Congressman Pete Peterson to introduce Dr. Figley.

STATEMENT OF HON. PETE PETERSON, A REPRESENTATIVE IN CONGRESS FROM THE STATE OF FLORIDA

Mr. PETERSON. Thank you, Mr. Chairman. It is a real pleasure to be back here before my old subcommittee. I would like to say that having worked with this staff, I think they demonstrate the height of staff professionalism here, and I miss this committee very much.

But I'm here today to introduce a good friend and real pioneer in the issue of PTSD and the family relationships crucial to the readjustment of Vietnam veterans. I could actually testify here as well as perform the introduction of my good friend Charles Figley from FSU, which is in my district. I personally have suffered through some of the things that will be discussed today. My family very definitely has. What you're going to hear, I think, is that the family unit is the best source of rehabilitative services that we can provide and that we must help them help their members.

Dr. Figley is a renowned author and probably the first person to have identified the problems of PTSD. He and I talked several years ago when I first got involved in the study of this issue, and I was amazed at the depth of his knowledge. He's carried that

through his work on this important issue of how we deal with stress within the family element. I am more than pleased to introduce him to this panel who, I know will give him the privilege of presenting to you information that you'll be able to use and disseminate through the United States.

Thank you.

Mr. EVANS. I thank the gentleman from Florida for that introduction. For people who don't know, Pete Peterson served over 6 years in the Hanoi Hilton and is very helpful to this committee on a continuing basis as we explore issues such as this one, not only for the veterans themselves, but their families as well.

The other member of this panel is Dennis Rhoades who is Executive Director of the Agent Orange Class Assistance Program here in Washington, DC. Both Dennis and Michael Leaveck, who have assisted this subcommittee in its preparation for today's hearing, have served in Vietnam beyond the call of duty.

We recognize your contributions on behalf of all Vietnam era veterans and thank you for your compassionate and dedicated service.

We understand, Dennis, that you and Dr. Figley both have other commitments this morning. We thank you for your participation and you will not be detained any longer than is necessary this morning. As I said earlier, your entire statements will be made part of the record, without objection, and you may summarize your remarks.

STATEMENTS OF DENNIS K. RHOADES, EXECUTIVE DIRECTOR, AGENT ORANGE CLASS ASSISTANCE PROGRAM; AND DR. CHARLES R. FIGLEY, PROFESSOR AND DIRECTOR, PSYCHOSOCIAL STRESS RESEARCH PROGRAM AND FAMILY THERAPY CENTER, FLORIDA STATE UNIVERSITY

STATEMENT OF DENNIS K. RHOADES

Mr. RHOADES. Thank you, Mr. Chairman. I appreciate the subcommittee's invitation to appear today to discuss alternative models for providing needed social services to Vietnam veterans and their families.

As you are well aware, the Agent Orange Class Assistance Program is a network of 72 programs which operates nationwide, in all 50 States plus the District of Columbia and Puerto Rico. In the course of our 5½ years of operation, we have provided services to over 150,000 persons.

This week—and that is the commitment to which you referred, Mr. Chairman—we are conducting a national symposium which will permit us to assess and distill the experience of our network in providing services to Vietnam veterans and their families, as well as to assess the public policy implications. We're holding this event precisely because the problems of clients we serve necessitated the development of service methodologies which differ considerably from the traditional veteran program service models.

My written testimony outlines the course of the litigation and the development of the subsequent settlement and I'd like briefly to highlight a few points in that testimony.

First of all, we faced several constraints in developing the Agent Orange Program. The first constraint was that no program could

be funded which provided for large-scale research into the causal relationship between agent orange and any health effects. The reason that happened was that this was a lawsuit settlement between the chemical companies and the plaintiffs.

The second constraint we had, which is why we have been absent from visiting with you up on the Hill more than we otherwise would have wanted, is because the Second Circuit Court in affirming the settlement and the distribution plan prohibited us from political activity. So, we apologize. We've been strangers to the committee more than we wanted to be, but we're here at your invitation and we are happy to provide whatever information you need.

Our program's basic design was dictated by the nature of the plaintiff class. The plaintiff class not only consisted of Vietnam veterans, but also included their parents, their spouses and their children. Our great emphasis on children with health problems—developmental and other chronic disabilities—also stems from the fact that this was one of the most prominent problems that Judge Weinstein heard about in the fairness hearings following the settlement. It certainly dominated the phone calls and letters we received in the early days of the program. So, ultimately, the network that we did design had a number of characteristics, but chief among them was that it was family-centered. We were a settlement which had to deal with families. We had to be family-centered.

We learned a lot about families. For one thing, most human services in the United States over the last 5 to 10 years are recognizing that you have to heal the family before you can heal the individual. Dr. Figley will discuss this issue in detail shortly.

The second thing we had to do was we had to leverage services. We only had $52 million, which as you are well aware dealing with multi-billion dollar budgets every year, is not a lot of money. How could we stretch that $52 million to help the most people in the best ways? The key is service coordination. No, we couldn't pay for a lot of surgery or a lot of direct services. What we could do was employ service coordinators to help the families access the system.

I have said in my written testimony that dealing with Medicaid, for example, is a very frustrating experience for a lot of people. It's the most user-unfriendly law Congress ever passed. In one state the instent application is 42 pages long. For our families, a lot of them, they couldn't deal with it.

I think finally the last characteristic of our program is its community-based orientation. We're community-based because most human services outside of the Department of Veterans Affairs and Social Security are delivered at the State and community level. As you are well aware, that's been going on for 20 years. So, you need to know the other service providers who are operating in the local community, in order to get services for our families that very often manifest a variety of needs.

I'm not going to comment at any length about our specific programs because I'm being followed by service providers that can speak far more eloquently about the kinds of work they do than I ever could. But I would say that less than 2 weeks ago we marked the tenth anniversary of the settlement. Next month we're marking the 50th anniversary of the GI Bill. Though many have quarreled and will continue to quarrel about whether a settlement should

have been reached at all, I believe we've accomplished some important tasks with the limited settlement resources at our disposal. But our efforts are time limited and the settlement funds are finite and not renewable. We can't come back to Congress and ask you for another appropriation. Our program doesn't work that way. Ultimately the care of our veterans and their families is the responsibility of the government, and I know Jeff Lande made that observation at our session yesterday. Hopefully, the testimony to follow me will help illuminate what that responsibility is and how to approach that responsibility most effectively. I want to thank you once again for your investigation.

[The prepared statement of Mr. Rhoades appears on p. 65.]

Mr. EVANS. Dennis, thank you. We appreciate your testimony.

Dr. Figley.

STATEMENT OF DR. CHARLES R. FIGLEY

Dr. FIGLEY. Thank you, Mr. Chairman. You have my written comments.

I would first of all send greetings from our president, Sandy Dellenbert. Also, Coach Bowden would send his greetings, but he's a little preoccupied with a Sports Illustrated story that came out recently.

Among other things, what I do at FSU is direct the AOCAP Project, the Vietnam Veterans Families Project. It's within the context of FSU's Marriage and Family Therapy Center. The center treats generally inactive cases of about 200 at any one time.

First of all, before I go any further, I'd like to also acknowledge an important funding source for this project that recognized that it's important to focus on families and that is the National Veterans Foundation. In the audience is Mr. Shad Mishad and Patty Diamond. They came through for funding to provide us with important resources to further our research and to essentially develop a model, part of which I'm presenting today.

Mr. EVANS. Doctor, the Chair would ask Shad and Patty stand up and be applauded for their work.

Dr. FIGLEY. Thank you. It's interesting because Mr. Meshad also was an innovator. He essentially was the architect of what is now called the Vet Centers, the Readjustment Counseling Program. Part of my remarks identify that program, but there is a supplement that I hope will be part of the record and I'm not sure if you have this in front of you. It is an extract from the vet center's Direct Service Operations Manual.

(See p. 77.)

This is an example of what I am emphasizing this morning to suggest that the vet center program, even though it started out in an excellent way, is off the mark. They have not gone far enough. What I'm suggesting is that the vet center, the Veterans' Administration and the Federal Government have been anti-family with regard to the services to veterans. In this manual, they include a description of the services provided by the vet center. It says screening for PTSD, in all cases counseling and/or psychotherapy for PTSD when indicated, employment education and counseling, job finding assistance, and here's the kicker, family counseling when needed for readjustment of the veteran. So, if you're a wife or a

child who has been beaten up by a vet as a result partly of his or her substance abuse or PTSD directly related to the war, you cannot go, you will be turned away by any Federal Government services associated with veterans.

The other element, it says significant other. Significant others are seen if necessary to provide adequate readjustment counseling services to the veteran. This suggests, explicitly suggests that family members are not perceived as veterans of a war, that they are not perceived as being affected by the war and they clear are.

As Pete Peterson said, we have lots of examples and lots of research to show that trauma is infectious, that we bring home, whether it is from a war or from a rape or from a victimization, from a natural disaster, we bring these kinds of frightening experiences back to the family and they absorb that. They absorb it because they love the person who is affected, that they care about that person and also the person who is affected in this case by PTSD, war-related PTSD, is dysfunctional. They're ineffective as a father or as a mother or as a son.

It's interesting that the VA in the outreach program has been permitted to see family members. That's very much an important innovation and that happened only in 1992 as a result of the Gulf War. In my written testimony, I summarized a congressionally mandated study. It was—you required the VA to do a study of the Vietnam War era generation. In addition to finding 15 percent active PTSD among Vietnam veterans, they also looked at the family members. If I can identify very quickly among the findings that they found, they essentially found that—I'm sorry. I can't find it right now. I know it fairly well. They found that there is a higher divorce rate among Vietnam veterans. They tend to be married for a shorter length of time. There is the higher incidence of—compared to non-combat veterans or non-Vietnam theater veterans, a higher incidence of marital discord, a higher incidence of family conflict, a higher incidence of wife and child abuse, a higher incidence of demoralization among the spouses and the children, a higher incidence of behavioral difficulties among the children. What this suggests is that we have to look beyond the veteran. We have to say that the families are the last remnants of war and that we have a responsibility to them.

If we have a family-centered program, whether it is mental health or physical medical health, it's cost effective because they live with that veteran everyday, 24 hours a day frequently. They know when he's troubled or when she is troubled.

I want to thank the subcommittee for inviting me. As you might guess, I have a lot more to say. I have the written statement and I'll be happy to answer any questions you have.

[The prepared statement of Dr. Figley appears on p. 71.]

Mr. EVANS. Doctor, thank you very much.

Several witnesses today refer to secondary traumatic stress. This is what you're referring to.

Dr. FIGLEY. Yes.

Mr. EVANS. In the VA studies which report on the research done at centers on PTSD, is this term used in any of the literature?

Dr. FIGLEY. No, it is not.

Mr. EVANS. It's not? Who originated the term?

Dr. FIGLEY. I did.

Mr. EVANS. You did?

Dr. FIGLEY. Yes.

Mr. EVANS. Have you been in contact with VA professionals involved in the research?

Dr. FIGLEY. Absolutely. As a matter of fact, the Center for PTSD, their director, Dr. Matt Friedman, who has a Ph.D. and M.D., he will be—he is well aware of the research that has emerged not only in this country but in Israel, quite aware of the secondary affects of trauma on families and on relationships and children. They are very interested in initiating research in that area. As a matter of fact, he will be with me as a member of the faculty of a worldwide teleconference on the 23rd of June which focuses on—we're calling it compassion fatigue. It not only affects those husbands and wives and children of Vietnam veterans and other veterans, but also those who research them, those who treat them. They also are affected by the difficulties, the manifestations of PTSD.

Mr. EVANS. I know you have another commitment so I'll yield to my other colleagues for questions.

Mr. RIDGE. Mr. Rhoades, could you tell us how many veterans and their survivors have received payments from the Agent Orange Class Assistance Program since its inception?

Mr. RHOADES. Well, as far as the Assistance Program is concerned, we don't do direct payments. We provide services. I am prepared, however, to tell you about the payment program——

Mr. RIDGE. Please.

Mr. RHOADES [continuing]. Which is the other part of the settlement.

Mr. RIDGE. Please.

Mr. RHOADES. To date, as of the 13th of May, 36,055 people have received payments from the payment program. That breaks down to 25,967 veterans and 10,088 survivors. The money involved for that comes to a total of $131.8 million for the veterans and $23.5 million for the survivors.

Mr. RIDGE. What does that break down to in terms of average payment?

Mr. RHOADES. The average payment for both is about $4,300.00. The maximum payment for survivors is about $3,500.00. Maximum for veterans is about $12,000.00.

Mr. RIDGE. What does a veteran or his survivor have to demonstrate in order to get that sum?

Mr. RHOADES. They have to demonstrate total disability of some sort or another by Social Security standards, and the fact that they were in Vietnam at a place where Agent Orange was sprayed. That determination is made by documentation submitted and evaluated by the Stellman's at Columbia University who did the Agent Orange study for The American Legion.

Mr. RIDGE. The second part of the settlement dealing with the assistance program and the foundation that you set up, have you been able to generate any financial assistance from other organizations in support of your effort? Have you just had to rely on those limited finite resources that you referred to in order to get the job done?

Mr. RHOADES. Well, I think a lot of our organizations are beginning to do that. They're beginning to generate funds. You'll hear very soon from Eileen Pencer of the Lower Eastside Service Center and they've been very successful in New York City in generating funds. But to be candid, a lot of our organizations are not actively going out after funds. The resources that we have made available to our programs are very hard to replace simply because of the size of the grants we've made in order to create effective programs.

Mr. RIDGE. Do you have any idea in terms of the outreach how many veterans and families you've been able to assist?

Mr. RHOADES. A little over 150,000. I hedge that figure a little bit because there is some duplication of—not duplication of services, but what might be otherwise be called double counting primarily because we have a National Information System which serves as a clearinghouse, as well as individual projects to whom the National Information System refers clients. So, it's around 150,000, probably about 50,000 of whom are children.

Mr. RIDGE. Thank you.

Dr. Figley, I applaud your work and thank you for appearing as well as Mr. Rhoades.

I think everybody on this committee probably deals in a very special way with Vietnam veterans when they come into their office looking for some kind of assistance. I know I do and I suspect just about everybody on the committee does as well. This whole notion of family-centered assistance is one that I think, had the VA talked to those of us who deal in many instances on a regular basis with soldiers affected by PTSD and who see the impact on the families, we would have been able to make the recommendation of family-centered assistance to them.

I've got a good vet center. I'm aware of some very good vet center operations throughout the Commonwealth of Pennsylvania. But obviously you and I believe that they should expand their outreach.

What specific recommendations would you make immediately to the VA and to these vet centers in recognition of the need for more family-centered, government supported help to Vietnam veterans?

Dr. FIGLEY. That's an excellent question and I don't know if I can answer it. Really, the answer really has to do with a paradigm shift. If you look at all of the regulations that the vet centers, for example, and the medical centers and the inpatient treatment centers for PTSD throughout the system, there is no mention of families. There is a discussion about significant others. It really does take a complete shift. I don't see how piecemeal it could be done.

If you look at your own vet center, if you go in and you ask them candidly and off the record, they'll tell you they see families.

Mr. RIDGE. You're right, they do.

Dr. FIGLEY. They see them illegally perhaps. They don't count them, but they do it because they know they have to, that that's the way to get the job done. So, maybe a short-term solution is to urge the VA and to provide them with the resources obviously to do it, to count the family members and children just as they would veterans. That would be a start, at least.

Mr. RIDGE. Thank you very much, gentlemen.

Mr. EVANS. The gentleman from New York.

Mr. QUINN. Thank you, Mr. Chairman.

Thank you for your testimony, all three of the panel members as well as our colleague, Pete.

Mr. Rhoades, you mentioned that this situation is one in which you can't come back to the Congress or the committee for more appropriations. It's not a budget situation which we understand. You also mentioned that later on, witnesses will make some suggestions about that because ultimately the government is responsible for our veterans. I support that concept, as well as does the committee.

Can you briefly give me a synopsis of what some of those suggestions might be in terms of how the government, who is responsible for our vets, might be able to address this funding situation?

Mr. RHOADES. Well, I think first and foremost, I think the Federal Government really needs to adopt a family-centered approach to dealing with many of the issues of veterans. I find it fairly ironic that the vet centers now have authority to deal with the families of Persian Gulf vets, but not any other generation of vets. I think that's something that needs to be remedied, for starters.

Above and beyond that, I suppose that the kind of work we do deals with child health issues. One of the concerns that is being debated out at the national symposium is the whole issue of health care reform. It is astonishing to observe when a family has a child with a severe disability. So, I think that needs to be taken in context as Congress considers the health care reform issue because children with long-term disabilities require a lot of care, it's often quite expensive and it bankrupts a lot of families.

Mr. QUINN. Thank you very much.

Mr. EVANS. Just one other question. The military during the Persian Gulf War learned a few things, I think, from the Vietnam experience in terms of developing family support groups before people were sent overseas and then sending people over in units so that they had a sense of identity with their fellow soldiers and so forth. Are those things useful, do you think, as preventative medicine?

Dr. FIGLEY. Absolutely. As a matter of fact, the VA, to their credit, was well prepared before these men and women returned and they had a family component. They went beyond just including the spouse and the children, they were concerned about the parents as well.

The thing that's so striking, all of us know that Lou Puller killed himself a week ago. We have a wall devoted to all those men and women who lost their lives. But there's no wall for families. There's no wall for the wives and the children who lost loved ones over there and are still losing them today. In many ways, the Gulf War provided a context for the way to do it correctly and that is to start before they come back, primary prevention.

Mr. EVANS. Thank you very much.

Congressman Peterson, good to have you on board again today and I look forward to working with you on these issues.

Dennis and Dr. Figley, thank you very much for your testimony. It's been very valuable to us.

Mr. RHOADES. Thank you, Mr. Chairman.

Mr. EVANS. The members of our second witness panel are Eileen Pencer, Thomas Schroeder, Tony Gonzalez and Raymond Swope.

Eileen is Vice President and Chief Program Officer and Director of Vietnam Veterans Family Services Center, Lower Eastside Service Center, Incorporated, New York City, NY.

Thomas is Executive Director, Rock Island County Council on Addictions, RICCA, located in East Moline, IL, my district I'm proud to say. He's accompanied by Vietnam vet Tony Gonzalez, Program Supervisor of Vietnam Veterans and Family Assistance Program.

Raymond is with the Universal Family Connection, Chicago, IL.

Each of your written statements will be made part of the record and we will ask you to summarize from them. Eileen, once you're situated, we'll start with you.

STATEMENT OF EILEEN PENCER, VICE PRESIDENT, CHIEF PROGRAM OFFICER, LOWER EASTSIDE SERVICE CENTER; THOMAS SCHROEDER, EXECUTIVE DIRECTOR, ROCK ISLAND COUNTY COUNCIL ON ADDICTIONS, ACCOMPANIED BY TONY GONZALEZ, PROGRAM SUPERVISOR, VIETNAM VETERANS AND FAMILIES ASSISTANCE PROGRAM; AND RAYMOND SWOPE, DEPUTY EXECUTIVE DIRECTOR, UNIVERSAL FAMILY CONNECTION, INC.

STATEMENT OF EILEEN PENCER

Ms. PENCER. Thank you, Chairman Evans.

Chairman Evans and members of the subcommittee, I would like to give you an overview of a very effective family service program called the Vietnam Veterans Family Services Center at Lower Eastside Service Center in New York City which provides treatment and other services to Vietnam veterans and their loved ones.

The VVFSC started up with funding from the Agent Orange Class Assistance Program in 1990 to fill a formerly unmet need with the guiding principle that veterans requiring assistance can be most effectively helped in the context of their families. Our services are provided through a geographically dispersed service delivery network that leverages off of the well organized veterans' community as well as existing social services available through the VA, State and city agencies.

Currently, VVFSC operates through an integrated service delivery model with VA vet centers where we have established satellite clinics and where our family therapists are outposted. The principal benefit of our partnership lies in the complementarity of services that bridge the gap in services to families, who, based upon VA eligibility requirements, are otherwise ineligible. As a result of this synergy, both the quality of services provided to Vietnam veterans by the VA and the effectiveness of family treatment provided by our Center are immeasurably enhanced. Neither the VA nor our Center can accomplish alone what we have been able to accomplish together.

Our Center utilizes a systems approach to treat the entire family constellation. We firmly believe that the entire family's participation in the resolution and restorative process is critical; responsibility for effecting and maintaining change cannot rest with the veteran alone. Our family therapists provide individual, couples and family therapy; group therapy for children, adolescents, adult chil-

dren of Vietnam veterans and women; PTSD, secondary PTSD counseling and education, as well as case management services.

VVFSC's greatest contribution to the veterans' community is in its service to our target population—veterans' children. Services provided to address veterans' children's physical, emotional, behavioral and developmental needs are not part of the mission of traditional veterans' services as furnished by the VA and are not provided by the mental health community at large for many reasons, including lack of awareness, lack of training and lack of funds. In our program, usually for the first time in their lives, children explore sensitive personal and family issues with the guidance of professionals trained to deal with the special difficulties that veterans' families must deal with.

There is a direct benefit to veterans as well through our collaborative team model. For example, the psychiatrically impaired veteran suffering from PTSD who may have previously refused to take his psychotropic medication often becomes more aware of the impact of his recalcitrance and becomes compliant out of concern for his family's safety; substance-abusing homeless veteran, motivated by reunification with his child, becomes drug free and economically self-sufficient; and the veteran newly-aware of the horrific effects of domestic violence on his family can be induced through effective modeling to break the cycle of destructive behavior he finds himself in.

These are all apparently small victories perhaps, but they improve the quality of life for entire families and reduce the probability that such veterans and their families will become burdens on their community.

I encourage you to consider the model we have established as a paradigm for the provision of services to veterans and their families. We respectfully submit that our experience has shown that such services can be an indispensable springboard to recovery for veterans and their families. As such, programs such as the VVFSC are simultaneously an investment in the futures of veterans and their families and an expression of appreciation by our society to those who have served to protect us.

I now look forward to answering your questions.

[The prepared statement of Ms. Pencer appears on p. 78.]

Mr. EVANS. Ms. Pencer, we've been joined by Congresswoman Velazquez, a strong advocate for veterans in her district and I'd like to recognize her for any remarks she'd like to make.

Ms. VELAZQUEZ. Thank you, Mr. Chairman. I want to welcome Ms. Eileen Pencer and publicly congratulate you for the extraordinary work that you are doing in New York, not only in the Lower Eastside, but in New York City.

Ms. Pencer, Mr. Chairman, joined the Lower Eastside Service Center in 1990 as supervisor and family therapist of the Vietnam Veterans Family Services Center and was responsible for the development of this program from its inception. She was promoted to Assistant Director of Treatment Programs in 1991 and was responsible for agency-wide outreach and client recruitment. As a result of her extensive outreach into the Vietnam veterans' services network, the program became a strong presence in the New York veterans' community. Her training and experience in special education

and marriage and family therapy contributed to the Vietnam Veterans Family Services Center's family and child focus.

Ms. Pencer's work on behalf of the veterans of New York City has been outstanding and I am most pleased to have her here to share her experience so that this committee could benefit in terms of the services that we must offer to the veteran community in this nation.

Thank you.

Mr. EVANS. Thank you. The Congresswoman and I know that people testifying today are front line soldiers. So, we appreciate your being with us for awhile today. We know you have many other important responsibilities, but we appreciate hearing from you and from your constituent.

Ms. VELAZQUEZ. Thank you, Mr. Chairman.

Ms. PENCER. Thank you.

Mr. EVANS. Now we'll hear from one of my constituents, Tom Schroeder.

STATEMENT OF TOM SCHROEDER

Mr. SCHROEDER. Thank you, Mr. Chairman, members of the subcommittee.

My name is Tom Schroeder and I'm the Executive Director of the Rock Island County Council on Addictions, which is a traditional substance abuse and family service agency in Congressman Evans' district in Illinois.

With me today is Tony Gonzalez. Antonio is our program supervisor with our Vietnam Veterans and Families Assistance Program funded by the Agent Orange Class Assistance Program. Tony is a two tour veteran of the Vietnam War and a 21 year Army career. He rose to the rank of command sergeant major. Tony and his staff, who are also Vietnam-era veterans, bring to this project a really unique not only service but passion for their work. The difference between this project and other projects that our Agency has been involved with has been mainly that sense of ownership, that sense of really compassion that these gentlemen and the people involved in the program, the advisors, bring to their work.

We have found in our experience that most traditional family service agencies like ours have viewed the Vietnam veteran in a very unique way. Basically they've not known how to deal with the Vietnam veteran, not known how to treat the Vietnam veteran and/or his family and have tried to take the Vietnam veteran and move the veteran in a way that they would try to create change in that veterans life that the veteran is not prepared to change and not willing or able to carry forth. Consequently, the family becomes a victim just as the veteran has.

In chemical dependency, we talk about how families of chemically dependent people become as affected or in many cases more affected than the chemically dependent person. Our experience in working with Vietnam veterans in this short time in our Vietnam Veterans Family Assistance Program has been that that is even more true with the Vietnam veteran and their family.

People that have been run through the traditional system have been turned away by many organizations because they can't be helped, have been misdiagnosed, gone through the process of trying

to be changed and molded into a pattern that doesn't fit that family and doesn't effectively help that family. These families become desperate, they become angry, they become in many cases unwilling to even trust us or work with us. We have found through our case management approach working with the entire family that these people that work in our program very doggedly go about working with each individual case, each individual situation. In many ways, it's unbelievable the amount of effort that it takes to work people through a system. Frankly, it's unbelievable the amount of effort it takes to work through the VA system and the Medicaid system to help a family to get payment, to get services.

What we've been able to prove, I think, in our short existence, which has been just since 1992, that vietnam veterans and their families have some very, very special needs, that the traditional family service system and family service networks have not been able to meet those needs. But it takes programs like this in order to effectively deal with Vietnam era veterans and their families.

We also have come to believe in working with this program that this program is an example for the rest of family service, that this effort, this system, the way that we case manage and work with families and individuals and doggedly go about pursuing outcomes for people is the way that we should look at treating all issues that families deal with. I especially believe it's the way we should begin to deal with and treat chemical dependency and that's something that this program has brought to our organization, a new approach to dealing with individuals and dealing with families.

Unfortunately, the Agent Orange Class Assistance Program has a very short life. In our case, in our community, we are going to work very, very hard to try to make certain that this program does not die because in my 15 years of experience in family service organizations, this program is a shining example for the country and it's a way that we need to go about beginning to treat all issues and all situations that affect families.

Thank you.

[The prepared statement of Mr. Schroeder appears on p. 87.]

Mr. EVANS. Thank you, Tom.

Mr. Swope.

STATEMENT OF RAYMOND SWOPE

Mr. SWOPE. Thank you, Chairman Evans and members of the House Veterans Affairs Subcommittee. Thanks for inviting me here this morning to present testimony on the topic of social services for Vietnam veterans.

My name is Raymond Swope. I am a Vietnam veteran. I was wounded twice in Vietnam. I'm currently Deputy Executive Director of Universal Family Connection, a non-profit community-based social service organization located in Chicago, which would serve the City of Chicago as well as the suburbs.

As the Deputy Executive Director, I've been in social work for 15 years and a licensed clinical social worker for 13 years. I'm a member of the Academy of Certified Social Workers and a Board certified diplomate. All these experiences would mean nothing without my experience in Vietnam. Being a deputy executive director, and

providing services for veterans in the veterans' community, without my experiences in Vietnam, wouldn't have been possible today.

I think because of our unique relationship with the Agent Orange Class Assistance Program and our prior experiences in dealing with families at the community-based level, we have been able to establish significant relationships with other veterans' organizations throughout the City of Chicago and suburbs, as well as community-based organizations, legal clinics and other social service providers. Through our linkages and through our agreements, we have been able to provide intensive on-going case management services. Although this is our bread and butter, this is something we've been doing even before we received a grant from the Agent Orange Class Assistance Program, AOCAP only added additional depth for the services for Vietnam Veterans Agent Orange Class Assistance Program.

In the past 3 years, with our relationships with the Class Assistance Program, we have seen over 600 families per year. When the families are referred to us, the veterans present problems, physical ailments, mental and emotional problems. They have been diagnosed with posttraumatic stress disorders, they have been diagnosed with major psychotic disorders. They have been diagnosed with major depression, bipolar disorders, substance abuse and generally a combination of all. The families seem to also suffer the same similar type of problems that the veterans also present.

I've also found time and time again that most of the veterans at this particular time when they are referred to us, they have really been disenfranchised from their families. The family linkages that now exist between the veteran and their family is really fragile, almost non-existent. I think the only thing that really keeps them together, when there is a family support system intact, is basically just hope and optimism.

The veterans complain that they have went to the VA repeatedly for assistance and no one has really done anything to help them or their families. When they heard about us, this seems to have been the something for them that said "Well, I'm going to try one more time." For some reason, we have been able to at least provide that positive impetus to—positive intervention. For some reason it's been working. I know, being a social worker, that the foundation is the family and it's the key to success because once the families start coming together, then the veterans seem to be making positive strides toward working on their problems.

I have outlined some unique things that I think could definitely help the Vietnam veterans and their families as well as their children because the children do seem to suffer the most. Children come to us with diagnoses of hyper or hypoactive disorders, with many physical ailments, which I know you've heard many of them. The school complains about the children's behavior in school. They describe the child as non-attentive in school, or having an attention deficit disorders. The teachers cannot control them or the child seems to be withdrawn or isolated from others.

When I have visited schools as part of the school staffings, some of the preschool teachers have asked me, "What could be possibly wrong with this child? We have medical records in front of us and the medical records seem to indicate that there is no specific prob-

lem that requires special education. Why is this child perhaps acting differently?" When we review the records and especially those of our Vietnam veterans, we know that there is a strong possibility or there is a strong linkage that this child is an offspring of a veteran who was exposed to Agent Orange. Once we make this impression upon the teachers and the staff, then they seem to modify at least their educational procedures toward the children.

I think in order for us to be effective, I'm talking about Universal Family Connection, we have to draw on various techniques of intervention. We use several models in order to be eclectic in approach. We use the psychodynamic approach. We use the humanistic approach, basic family counseling and intervention. But more importantly, we do case coordination and I think that's the key, case coordination with other veterans' services. We obtain prior records of the client from other agencies that provided services for the veterans. We go to the VA hospital and check out whether or not the veteran was provided direct services and what type of services. We try to reduce or prevent duplication of services.

I'm just going to summarize this quickly, I think the Department of Veterans Affairs should be reconfigurated to accommodate more comprehensive service strategies. I think there should be a concerted effort that should be developed to provide a positive relationship and linkages (agreements) with appropriate local, State and community resources, both public and private, to more effectively address the needs of the veterans. I also think the Department of Veterans Affairs, particularly in the areas of counseling, needs to look more directly at rehabilitation and vocational guidance as well as employment programs for the veterans and their family.

I think the Department of Veterans Affairs, as well as the Department of Labor for veterans, should adopt strategies to maximize their efforts to develope contracts for services with the appropriate community-based, not for profit social services agencies. I also think that those agencies that are charged with changing things, should really examine and look thoroughly at the intensive family-centered case coordination models for case management to ensure that the Vietnam veterans and their families receive the necessary services that they require.

I thank the members for listening to me this morning.

[The prepared statement of Mr. Swope appears on p. 91.]

Mr. EVANS. Thank you, Raymond. We appreciate your testimony.

Eileen, you indicated that about 85 percent of the children that you treat are suffering from the secondary effects of PTSD. Is that also the experience of the other members of the panel?

In Rock Island and Chicago do 85 percent of the children also suffer from secondary trauma?

Mr. SCHROEDER. That's a very high percentage. We can't come up with an exact percentage, but it would be at least that high, I would guess.

Mr. EVANS. Will each of you please describe the effects you've seen in children relating to education?

Mr. SWOPE. Well, I've definitely seen, because we are involved with similar programs throughout the City of Chicago in elementary schools and high schools. But being specifically involved in State pre-kindergarten programs and Head Start programs, we see

the little children before they go into the primary grades. We have seen them ranging from, as I say, physical ailments which we know that is easily recognizable, but more importantly the behavioral problems which somewhat disassociate them from the normal child development, which also is bared out by the Chicago Early Assessment, which is a screening instrument that the pre-schools do use to help assess the normal development of a child in contrast to their peers. We have seen significant impairments with them, especially in terms of attention deficits, being able to manipulate certain types of three or four pieces puzzles which normally three and four year olds should be able to do, following instructions, responding appropriately to authority figures. These type of symptoms we see as early as 3 and 4 years of age, that we know is an insidious process and is going to get worse as they get older.

As a family-oriented agency, we see families range—as long as there's a child in the family under the age of 18, we see them from birth through age 17. So, we're able to examine the whole spectrum of child development.

Mr. EVANS. Eileen?

Ms. PENCER. The symptoms of secondary PTSD that we see in our children are not dissimilar to the symptoms of PTSD that we confront with veterans. In many instances, as Mr. Swope has suggested, we deal with schools to provide secondary PTSD education because schools are not at all trained to deal with these children. We also educate the mental health community regarding the symptoms of secondary PTSD which can range from attention deficit hyperactivity disorder to learning difficulties which may result in special education placement and associated difficulties.

Mr. EVANS. Tom or Tony?

Mr. SCHROEDER. I think the only thing that I'd like to add is that in our case where we're working with children who are identified in school systems or diagnosed as learning disabled, attention deficit, behavior disorder, the school systems want to try to get a diagnosis here that works and they want to work with the family. I serve on the school board in my local community and we're finally getting our school counselors and social workers and psychologists to ask questions about whether or not there's a Vietnam veteran in that family. These people are very open to wanting to work with that family and try to learn more information, which I think is very positive.

Mr. EVANS. What will happen to each of your programs, which is helping us fill a critical gap as the VA confirms in its testimony, as Agent Orange Class Assistance Program money is phased out? What do you think will happen when that occurs?

Mr. SWOPE. Well, since 1984, Universal Family Connection has off and on been working with veterans, initially with readjustment counseling for any veteran. Of course, over the past 3 years, we've been involved more directly with Vietnam veterans.

Our program is going to diminish with our involvement with the veterans unless they're referred to us for other types of problems, for other family-related problems. They must live in our service areas that are covered by other governmental contracts, for example the Department of Children and Family Services, the Department of Human Services. If these individuals or veterans do not

live in our catchment area, then we have to send them to St. Elsewhere for services. But there is no other place to send them besides the vet centers which have not provided family services for the veteran. So then, of course, there's going to be a big void. These families are not going to be served.

Mr. EVANS. Eileen.

Ms. PENCER. Dennis Rhoades, in his testimony, referred to the fact that Lower Eastside Service Center is very strongly committed to continuation of this program. Herbert Barish, First Vice President, as well as Carolyn Rainer, Board Mmber and Poject Coordinator, who is here with us today, have worked very hard in this regard. For example, Lower Eastside Service Center was awarded a $25,000 development grant from New York City Memorial Fund, $20,000 from the Disabled American Veterans and $65,000 from the van Amerigan Foundation. But we all know that this will not maintain the program for years to come.

We're also currently working on-site at VA Vet Centers to provide family services. However, once we leave the Vet Centers, these services will no longer be available for our families.

Mr. EVANS. Tom.

Mr. SCHROEDER. In our case, it is my belief that a grant of this magnitude, in our case it's $150,000.00, is very difficult to find in a local community. Our United Way can't come up with one penny for any new services because they've been strapped and not able to meet their goal. Any of our local foundations also have a very difficult time funding more than $5,000.00 or $10,000.00 to a program. I believe money is going to drop from the sky on this one in that this is a nation-wide network that you won't find like this anywhere in human services and that somebody is going to find this to be very attractive and want to continue these services, especially if we can prove outcomes. If we can show people and hold up that we have affected positively families and individual veterans. But this is going to be something that someone will step forward and take responsibility for.

Mr. EVANS. The Chair yields to the gentleman from Pennsylvania.

Mr. RIDGE. How successful have you been in soliciting and getting the assistance of local social service agencies to assist you in meeting these families needs? I think, Ms. Pencer, you talked about educating them to the problem and that's very important, but I'm even more interested in how successful your three organizations have been to integrate your effort with existing social service agencies to help particularly with regard to the children. Could you each comment?

Mr. SWOPE. I can comment on that. I think we have been extremely successful at recruiting veterans. That has not been a problem for us because we have linkage agreements with the veterans hospitals, with many of the community social services centers throughout the City of Chicago, legal clinics, the Social Security Administration. That has not been the problem of recruiting. In order to elicit significant coordination of services with other mental health providers, it has been extremely difficult because based upon their contracts, they have limitation in the type of services that they can provide. However, I think that we've been successful

with our clientele for the most part, trying to provide that continuity of care through case coordination. However, there were not enough dollars to provide the type of linkages and the kind of case coordination that we would have liked to have seen from the community. One of the things they wanted us to do was to provide follow-up services. That's the thing, the follow-up on the clients, because things take time. Working with just the Department of Veterans Affairs takes time. Often times by the time we complete certain types of documentation is required by the Social Security Administration, the veterans can become lost. Many of them disappear. Many of them are homeless and we can't find them again.

But I think we have made an impact and we were able to do a positive job. Trying to assess the positive outcome, can be very difficult for us at this time, at least for our agency. But I think that was one of our unique things, the case coordination with other social service agencies and the case management concept that we were using and I think it was successful.

Ms. PENCER. Sadly, mental health service agencies do not consider it their responsibility to provide such services. Thus, part of what we have accomplished is to alert direct care and administrative staff to the fact that Vietnam veterans and their families require their help.

Mr. RIDGE. Sergeant Major?

Mr. GONZALEZ. Thank you.

Mr. RIDGE. Oh, listen, I was just a staff sergeant. I know who to defer to any time.

Mr. GONZALEZ. Thank you and good morning.

In our case, we have been very successful in using the human services agencies that are in our community. The fear from our clients is that once we are gone, that they are going to be treated again like numbers and not like persons. We are trying to emphasize that. It is going to be a pity if we have to go away. Our most powerful weapon that we have in our programs is the ability to be able to advocate for these people, to include going with them to the human services agencies if they want us to. We even go to their houses and pick them up and bring them back. I'm telling you, it makes a big difference to be treated like a person and not just like another number.

Mr. RIDGE. I think all of us on this committee feel that caring for veterans after they've taken the uniform off is a continuing cost of defense. We sometimes fail in recognizing that. I'm very interested in your professional experiences. Could you tell me whether or not the veterans themselves have been or are getting some disability from the VA based on PTSD. What percentage of the veterans you're dealing with, who have these psychological problems, have been recognized as being disabled by the VA? My thinking being, of course, that if we're to look to an expanded family-centered approach, that maybe we could enhance that approach by qualifying family members whose father or mother has been recognized by the VA as having that disability and maybe following up on it.

So, could you tell me the percentage of veterans that you're dealing with whose psychological problems have been identified and accepted by the VA, depending on what region of the country you're

in, and that in and of itself is a problem. It took a long time for the VA to recognize that PTSD even existed.

Mr. GONZALEZ. It's still a problem to try to process a claim through the complex and time-crippled claims' system of the Department of Veterans Affairs, especially trying to prove PTSD. Because we encounter problems, we have become strong advocates in helping veterans develop and process claims for PTSD, including assisting the veteran through the claims process from the beginning to the end. From our clientele, about 28 percent of the veterans suffer from PTSD, but only 8 percent are getting some kind of benefits for 10 percent, 30 percent, or 50 percent for PTSD. Although it is only a little bit of money, it comes in handy. You see, most veterans already come upon employment difficulties; not to mention, the problems they confront if they happen to be suffering from coping complications as the result of PTSD.

Mr. SWOPE. I would be hard pressed to come up with any significant numbers, but I can let you know we have been very successful at having diagnoses changed from preexisting diagnosis that were given through the veterans hospital to posttraumatic stress disorder. This allowed benefits to have been increased. Out of the veterans that we have seen, I can guarantee that's been a significant number. But to put an exact number, I would really be hesitant on indicating that now. It has been significant.

Ms. PENCER. It would be difficult to identify a precise number. But you raise an important issue, one that needs to be framed as a comprehensive problem since it is not only specific to the veteran. Part of our work, as all of us have stated, is to advocate for the veteran when the veteran applies for that benefit since we all know how difficult the process can be.

Mr. RIDGE. Thank you.

Mr. EVANS. We thank this panel very much for its important testimony and appreciate your participation.

We will now stand in recess for a period of about 5 minutes.

[Recess.]

Mr. EVANS. The members our next panel are Thomas James, Milton Reaves and Michael McKelroy. Thomas is managing director, Community Outreach to Vietnam Era Returnees in Charlottesville, VA. Milton is from Charlottesville, VA. Michael is project director of Veterans Assistance Project, Team of Advocates for Special Kids, Anaheim, CA.

Again, each of your statements will be included in the record in its entirety, without objection, so ordered. You are invited to summarize from your prepared remarks.

Mr. James, we'll begin with you.

STATEMENTS OF THOMAS JAMES, MANAGING DIRECTOR, COMMUNITY OUTREACH TO VIETNAM ERA RETURNEES; MILTON REAVES, VIETNAM VETERAN; AND MICHAEL McKELROY, PROJECT COORDINATOR, VETERANS ASSISTANCE PROJECT, TEAM OF ADVOCATES FOR SPECIAL KIDS

STATEMENT OF THOMAS JAMES

Mr. JAMES. Okay. Thank you, sir.

My name is Tom James. I'm a veteran and co-founder and managing director for a private non-profit community-based counseling agency for Vietnam veterans and their families. We service 37 jurisdictions in the mountain regions of Virginia and West Virginia. Our agency was founded in 1979 by my wife, with the sole purpose of offering services to veterans and their families.

Over the years we have served over 6,000 veterans and family members. Our clients represent a broad range of professions and experiences. All share a common denominator and that's concern for their families. The vet sees his family as his squad. These families have faced hardships, be it financial, emotional or dealing with the medical conditions of the children and/or the veteran. They have faced these hardships as a family unit. What affects one, affects all.

The veteran is the gatekeeper for services to himself and his family. An agency offering services to this population must have an understanding of the veteran's perception of his or her community in order to access the family. You must meet the veteran on his own terms. Most vets don't trust organizations or most government agencies. An agency must be able to develop the trust with the veteran in order to facilitate change. It is a great deal to ask a veteran to give up the tools he has developed to survive over the years. He learned the meaning of fear and helplessness while in combat and he has developed his own means of controlling his environment so as to never have to face such fear and helplessness again.

Our experience has shown that other conventional mental health agencies serving the general population consider veterans as uncooperative and difficult to engage in the counseling process. Many have rigid intake procedures and extended waiting lists for services. Most veterans are turned off by such a process and the agency is, in turn, turned off by the veteran. Many who do enter these types of services fall through the cracks.

It has been a difficult process to keep our doors open. We receive funding through the VA Readjustment Counseling Program, the VA Fee Service Program and through private donations or contracts with corporate EAPs. We are always juggling resources and evaluating our programs to maximize our cost effectiveness. Flexibility is our password and key to survival of our programs. During all this, our case load has continued to grow and is larger now than it's ever been.

For the purpose of this hearing, I will quickly highlight how much of the funding is available for families of Vietnam veterans. The contract program allows for reimbursement for spouses on certain occasions, but due to the limited monies available to the vet centers and contracts programs, little if any funding is available. It boils down to a choice between paying for the veteran or for his or her spouse.

The VA has attempted to try to figure out ways to do it. They had a formula once of one visit for the spouse per ten visits by the veteran. On some occasions they have reimbursed for spouse groups on a very specified period of time. And on occasions they have approved individual services for spouses facing extraordinary situations. Our primary means of servicing families over the 15 years is to offer it free or pick up donations to fill that need. We

have found that veteran families do not make good poster kids for finding money. It has always been an uphill battle to continue our family services.

Since 1989, with the AOCAP funding, our family program services were expanded to include monthly children's play groups, informational groups for children of veterans, support groups for teenagers, plus weekly spouse groups at each of our three offices. Individuals and couples counseling for spouses and children are also provided. We also do special workshops, debt management, financial management where we have bankers come in. We do stress management, communication skill workshops for the families. COVER staff also provides case management services to meet the social service needs of the entire family.

We were able to purchase three outreach vehicles to go the veterans' homes and deal directly with the family. These vehicles run weekly routes throughout our region. We drive family members to needed medical appointments. We developed a food bank to deliver to families during hard times. Staff members have assisted clients in repairing and maintaining necessary farm equipment. Our case managers negotiate with hospitals on forgiving sizeable medical bills faced by veterans' families with children with disabilities.

We are now part of a national network of local, State and national agencies interested in the special needs of veterans and their families and lend significant support to our clients. Imagine an agency having the capacity to call another agency in Georgia to assist in acquiring a computer for a disabled child, and simultaneously calling an agency in Connecticut to assist in working with hospitals and forgiving and decreasing medical bills. On the same day have the ability to call the Legal Center in Washington, DC on behalf of our client to assist in applying for Social Security benefits for children and to be able to offer all these services while supporting the individual family members through counseling.

Our 15 year passage and evolution has placed us in a position to offer extensive and encompassing service to the veterans' families. We offer such services in a region with limited resources for the veteran. COVER is an example of what the VA's readjustment counseling contract program was established to accomplish. It has taken patience and commitment. The extensive services that COVER provides cannot continue on good intentions or staff dedication alone. Without a stabilization of funding for VA's contract program and a commitment to the family services, these services will vanish and veterans and their families will have their hopes dashed once again. Agencies like ours will die a slow but certain death through a series of cuts here and cuts there, until all the good that's been done and created will just be so much history.

Thank you sir.

[The prepared statement of Mr. James appears on p. 95.]

Mr. EVANS. Thank you, Mr. James.

Mr. Reaves.

STATEMENT OF MILTON REAVES

Mr. REAVES. Good morning, Chairman Evans and members of the subcommittee.

In my testimony, I will not be reading word for word of everything. I will prefer through it because I feel I am a true example of my testimony which I want to give and which I have experience.

My name is Milton Reaves and I'm a Vietnam vet. Infantryman is where I served in Vietnam. I am the owner of, and proud owner I might add, of a Purple Heart. I had personally not heard of PTSD, didn't know what was going on with me upon my return from Vietnam. I do know one thing, that my behavior pattern from as a country boy living out in a rural area had changed somewhat. I saw some authority figures as being somehow not quite right with me. Coming from a killing field right back into society with no one telling me at any point, "Milton, you no longer need to steal a helmet. Milton, you no longer need to this weapon." I experienced all types of resentment, anger, rage, and not really thinking anything was abnormal with Milton. I was okay. It was everyone else who had the problem, not me.

To make a long story short, I have been divorced twice. I have four children. Two of those children have accompanied me here today, a nine year old and a ten year old. There's a daughter that's aged 20 and a son that is 25.

I went through all types of problems, encounter with the law, into the Virginia State Penitentiary at one point because of my irrational behavior. I also had a tendency to continue to repeat that pattern of behavior. I discovered from some friends of mine who were Vietnam vets as well who told me about an organization called COVER. I developed a drinking problem in which these individuals told you, "You need to go talk to these people. They're there in place to help you, Milton," and I just didn't see me having the problem. Finally I went to COVER and perhaps COVER was the best thing that could have ever happened to Milton Reaves because he, Milton Reaves, was headed down a road to destruction, disaster. COVER helped me—took a person like me who is an alcoholic, helped him find a program, committed me to that program, walked me through those stages or processes in which I had to deal with in getting into a recovery program. There was some counter of being a divorcee of trying to obtain custody of my children after I successfully completed the program within the alcohol problem in which I had. COVER helped me go through the program of an intake meeting where I was allowed to have the custody of my kids. COVER appointed me an attorney. This attorney was an ex-Vietnam vet himself who understood my behavior and was able to present to the courts my past behavior to help me obtain the custody of my children.

I feel, Mr. Chairman, organizations as COVER, from my personal experience, Mr. Evans, that they should be in place. I shouldn't have to feel as I have felt, sir, in situations where I have went to the VA and felt like they were doing me a favor. I was wounded. I earned this. I don't feel they are giving me anything, with all due respect to everyone. I earned it. It should be there, sir.

My children, my son, one son that's present here today who has a psychiatric problem at times with his behavior. My question is why is there not hair growing on my leg? Why is it that in the summer I can scratch and I will receive welts, water blisters on my arm. Whether Agent Orange did that or not, I feel, sir, in my end-

ing, that I need to say that these programs are well needed to be in place. If it's something that someone has a question about numbers as we play with, no, sir, not numbers, I earned it. It should be there.

I ask, please let these programs be existing for the vets because we need them, sir. And thank you in ending.

Mr. EVANS. Mr. Reaves, would you ask your kids to stand up?

Mr. REAVES. Yes. Evan and Milton, would you please stand for the committee?

Mr. EVANS. It takes a lot of courage for you to come forward before a congressional hearing and make that kind of personal statement, but it really gives us good ammo as we fight for programs on posttraumatic stress disorder to have that kind of human testimony. So, we appreciate it very much and salute you for your courage.

Mr. REAVES. Thank you, sir.

[The prepared statement of Mr. Reaves appears on p. 102.]

Mr. EVANS. Let me yield to the Congresswoman from Indiana for any remarks.

Ms. LONG. Thank you, Mr. Chairman. I simply want to commend you for holding this hearing and also the panelists. This is quite a group of panelists that we're going to have today and thank them for their testimony.

Mr. EVANS. I thank the Congresswoman for her attendance.

Mr. McKelroy.

STATEMENT OF MICHAEL McKELROY

Mr. MCKELROY. Thank you, Chairman Evans and members of the subcommittee. Thank you very much for allowing me to be here this morning and present some testimony.

My name is Mike McKelroy. I'm a Master Sergeant in the U.S. Marine Corps. I'm retired. I'm a combat vet with three combat tours in Nam. I'm presently employed by Team of Advocates for Special Kids, which is an Agent Orange Class Assistance Program. I'm the project coordinator for this program. Our mission at TASK is to help parents access through the special education services for these children we've been talking about this morning and also to get the support services for these children.

I am also a receiver from Agent Orange Class Assistance Program as well as now a provider of services. If it had not been for this program, I wouldn't be sitting here this morning and have the privilege of talking to everyone. As I said, I retired 23 years in the Corps. If you'd ask me 9 years ago did I have PTSD, did I have a drinking problem, I would have told you no. I didn't believe in PTSD and my drinking was fine.

I've got five children, my wife Anita and myself, three boys, two girls. Michael, Jr., Daniel, Robert, Anna and Kathleen. My wife Anita and my son Robert are here with me this morning. They're my backbone. My family is my backbone.

We retired in 1985 and moved to Riverside, CA. Then, my son, Mike, Jr., started attending school in the Alvord School District right there in Riverside. He began having some basic problems, learning, discipline problems, things of this nature there. We held meetings with counselors, principals. We had a teacher tell Michael

that, "You're going to fail in life. Just don't bother attending school." I can truthfully say I had a principal tell me to my face and my wife was sitting there, that all Michael needed was the hell beaten out of him and that would force him to learn.

Well, we didn't do any of the things they suggested, but were crying for help. My wife was constantly on the phone to the school, constantly being down there and nothing helped. Mike quit school at 15. Mike went into the juvenile justice system for taking his mother's car for a joyride. We figured, that's great, we've got some help now. The judge is going to order Mike to go to school. The judge did that. Mike still didn't go to school. At 17 years old, Michael served 15 days in juvenile hall for a violation he committed at 15.

Danny started having problems. Danny did make it through junior high school because the system put him on home teaching. If you're familiar with home study, that's one hour a day, one day a week. His first year in high school, he got in trouble and was expelled. If it had not been for TASK, my marriage would have been completely destroyed because we were already told, "You're bad parents. That's the reason your boys are acting this way." We would have not had a family.

We didn't have anywhere to turn to but TASK, through the Agent Orange Program. We turned to them. I finally realized, Congressman Evans, that Congress had passed a law, 94–142, that protects my kids. The system didn't tell me about this law. They didn't say my children had rights to free appropriate education because they have disabilities. No one in the system told me this.

Then what happened is—it's very complicated when you're dealing with these things. I deal with this everyday with parents. This is the last resort. These programs are the last resort that parents have. They hear about it, as Milton did, from someone else. This is not advertising such as the VA or United Way would do. This is word of mouth. "Hey, brother, go there. They can give you help." I had another Vietnam veteran tell me about this program and now I'm there.

You know, it's been 9 years. Mike, Jr. is married, three children. Danny is married, one child. He started his own business. He works 10 to 12 hours a day, 6 days a week. Anna and Kathleen are doing great. My son Robbie is doing wonderful. My wife and me have a very strong marriage. We have five grandchildren.

I've heard a lot this morning about questions on what should be done. The main thing that should be done is anything that has to deal with the entire family because you cannot treat the symptoms of disease, you must treat the disease.

In closing, I'd just like to read something. One of the parents found out that I was coming here this morning and wrote a letter. This child in 9th grade had been expelled from school, 9th grade. Another Vietnam veteran. "If it were not for TASK, my son would not be allowed to go to public school. I would have to pay for his education, which we cannot afford. My husband is an unemployed Vietnam veteran. We own our own home, pay our taxes on time. I have a part-time job which barely gets us by. Our son had an unfortunate incident at school and was suspended for 5 days. He was

not allowed to return to school, to the Los Angeles Unified School District."

Basically at the end, this mother says, "So, to sum it up, who cares about the kids? They don't get a second chance to correct something that is not even in their control. That's why the dropout rates are so high and the only place the kids can turn to is to streets, drugs and gangs," and I see this as now a care provider. I would have lost my family. I would have been out there on the streets, I'll tell you that right now. My children would have been in the adult correctional facilities and you, me as taxpayers would have been picking up the bill.

Thank you for allowing me to be here and please, we need it. Thank you.

[The prepared statement of Mr. McKelroy appears on p. 105.]

Mr. EVANS. Thank you, Mr. McKelroy, and I salute you for your personal statement.

Based on your testimony, if it had not been for the help of your respective agencies, you might still be in the wilderness, so to speak, in terms of grappling with these problems, maybe still in denial that they even existed. Is that essentially correct?

Mr. MCKELROY. I would have, sir. Yes, sir. I would have denied it. My wife would blame me. I would blame her. I wouldn't have a family and I'd be heavy into my old alcohol.

Mr. REAVES. Chairman Evans, I would say the same thing. I didn't see myself having a problem. The thing that I personally feel comfortable with COVER is that there are other Vietnam vets there who are counsel staff members that I can relate to, not some individual, with all due respect, that went to some ivy league college and read a book to tell me about what I experienced in the killing field. I can talk to an individual at COVER who walked the same trail I went down.

Had it not been for the organization COVER, I know I would have been headed down the road to either the graveyard or to the penitentiary. Just that simple. And I am grateful that they are there. I pray that they will always be there, because I have met many Milton Reaves out there that are still out there that haven't even come up to the table, as I finally have 20 some years later. But it's better late than never, sir.

Mr. EVANS. How old were you when you left the military?

Mr. REAVES. I was approximately 21 years old, 22, somewhere around there, sir, if I remember correctly. I discharged from Fort Meade.

My point is I have experienced, Chairman Evans, all the endures of hardship that one can go through and I'm a living example today, a man who came from an alcoholic, a man who had a less than honorable discharge, a man who went to the penitentiary, a man who served his country and almost died giving his life for this country now has his children and hopefully on the road to recovery due to the thanks of COVER. That's the only people who have helped me, not the VA. They feel—sometime I have been felt like that's my enemy, and it shouldn't be that way, sir. It shouldn't be that way at all. I earned this. The other Vietnam vets earned it and vets of America who served this country earned it, sir, and thank you for that.

Mr. EVANS. Mr. McKelroy, you had these problems while you were still in the Marine Corps, I take it?

Mr. MCKELROY. Yes, sir, but I didn't recognize the problems. I handled myself just outstanding on duty. I made——

Mr. EVANS. Submerged it, maybe?

Mr. MCKELROY. Sir?

Mr. EVANS. Submerged your problems into your work?

Mr. MCKELROY. Yes, sir. I made E–8 in less than 20 years. Like I said, I had a good wife that stood beside me no matter what happened. That's the one thing that really helped me was my wife, and then when Robert came along it has helped me, but I denied that there was anything wrong with me. It took me a long time to say, yes, I've got problems.

Mr. EVANS. We are grappling not only on this committee but also on the Armed Services Committee, on which I also serve, with trying to assist career people in terms of getting help, whether it be for PTSD or most recently those who may be having problems with the Persian Gulf Syndrome, as it's been called.

What can we do to give people more assurances who are making the military a career that they're not going to be drummed out of the military for complaining about the problems that they have? What kind of protections can we give those folks?

Mr. MCKELROY. I would suggest, sir, that it needs to be an open forum. Right now I know for a fact some friends of mine that did have alcoholic problems, turned themselves in and they stayed the same. Rankin was forced out. They say it doesn't affect. It does. I think the counseling should be in effect there.

It's hard for you when you spend 20 odd years giving orders to get out here into society and realizing that you're a dime a dozen, and that is a big problem also on the PTSD is getting out and realizing that 20 years of your life is no longer. You can't get up in the morning for something you love to do. I feel that before a man retires there should be some counseling for him and his family, because the family is the unit. Without that family, we're going to continue having all kinds of problems.

Mr. EVANS. We thank you. We realize your service to our country didn't stop the day you left the military. To both of you, we appreciate your testimony.

Mr. James, you report in your prepared statement that your fear is that what has been created will some day disappear before it's completed its mission.

Mr. JAMES. Yes, sir.

Mr. EVANS. What will happen to vets such as these two or others who have not yet been reached if your organization and others like it disappear?

Mr. JAMES. Well, we've been around for 15 years and I think probably what will happen is what happened the way we lived prior to 1989. When my wife founded this agency, she envisioned the vet and the family member. Without the family, the vet has got no connection to anything.

We had to shoestring the family service program. I said in my statement that they don't make good poster kids. There's no money out there. I mean, we have been dealing with State conventional mental health agencies, community service boards and all those or-

ganizations, agencies, foundations, whatever. What we've had to do is go after contracts to pay to see the vets, and we keep our overhead down so we can keep seeing the spouses and the children.

The program that I described to you that exists right now will not exist at the end of the AOCAP grant. I can see no funding that is now available. I don't care what foundations say. I don't care what a lot of other folks say. The reality is this is going down. And it's taken a lot of time to develop. It's taken a lot of energy. And it will not stay.

Mr. EVANS. Thank you.

I want to thank you all very much.

Mr. JAMES. Thank you, sir.

Mr. EVANS. You've added to our knowledge.

Mr. EVANS. Peter La Count, accompanied by Leslie Felton, Peggy St. Clair, and Dr. Brian Smith are the members of our next witness panel.

Peter is Project Coordinator, Vietnam Veterans Family Support Project, Kennedy-Krieger Institute, Baltimore, MD. He's accompanied by Leslie Felton of Baltimore, MD.

Peggy is Service Coordinator, Project Access, University of Arkansas, University Affiliated Program, Little Rock, Arkansas.

Dr. Smith is Director, National Information System, Columbia, SC.

Again, your statements will be included in their entirety in the printed record of this proceeding, without objection, so ordered, and you are invited to summarize from your prepared remarks.

Peter, we'll start with you and in the order of introduction.

STATEMENT OF PETER LA COUNT, PROJECT COORDINATOR, VIETNAM VETERANS FAMILY SUPPORT PROJECT, KENNEDY-KRIEGER INSTITUTE, ACCOMPANIED BY LESLIE FELTON; PEGGY ST. CLAIR, SERVICE COORDINATOR, PROJECT ACCESS, UNIVERSITY OF ARKANSAS; AND BRYAN C. SMITH, DIRECTOR, NATIONAL INFORMATION SYSTEM, UNIVERSITY OF SOUTH CAROLINA

STATEMENT OF PETER LA COUNT

Mr. LA COUNT. Good morning, Mr. Chairman and Committee members.

My name is Peter La Count and I am the Project Coordinator for the Vietnam Veterans Family Support Project at the Kennedy Krieger Institute in Baltimore, MD.

Funded by AOCAP, the Project provides to families service coordination, home-based professional services, financial assistance to help families purchase needed services, educational workshops and support groups for parents.

Leslie Felton is the head of a household receiving such services from our project. She has two children: Melissa, age 10, and Devin, age 9, who are here today with us. The father, a Vietnam veteran, no longer lives with the family. Since 1991, the family has received from our project family counseling, occupational therapy, and financial assistance.

Given that, I'd like to introduce to you Leslie Felton.

STATEMENT OF LESLIE FELTON

Ms. FELTON. Good morning, Mr. Chairman and Committee members.

My name is Leslie Felton.

The services that VVFSP provides to families has made a great difference in my family's life. My father, all six of my brothers, and many uncles are in the military.

Veterans and their families do have unique social needs. Many family problems of Vietnam vets come from drugs and abuse. These are issues that other family members cannot always address or fight. If a vet doesn't trust anybody, how do you fight that as a family member? If the vet has PTSD, how do you fight that as a family member. Some issues the family cannot deal with on its own and the vet needs convincing that he or she needs help as well.

The vet, spouse and kids tend to stick together no matter the horrors. A non-vet family with drug and violence in the family split up to save the spouse and the children from harm, but my family always made excuses for my mate's abusive behavior because he was a vet. He was never at ease with anybody. He became abusive and neglectful to the family. He was also an alcoholic and drug abuser. He was always in the attack mode because of his training. If we try to wake him up, he may attack us thinking he was back in Vietnam. He was always ready to fight, even though there was no war. It came to a point when I thought my life was in danger. I kept saying this situation cannot go on forever.

Even in this day and time when everybody is confessing everything, the family of a Vietnam vet will not often talk about their troubles to others. There are so many avenues for the vet to get help, but the veteran's family has little recourse if the vet is not willing to have help for himself.

I don't know where else I could have gotten the assistance I've received had it not been for VVFSP. How would our family's life have been different if these services weren't available? I've asked myself this question many times.

It is easy to condemn an abusive parent, but I could easily have been one because I did not know how to deal with my children. We went through a great strain when my ex-husband became ill and left home. I believe that if I had not received support services for the kids, they would have ended up living with another family member for I would have been completely unable to handle the situation at home.

The support services have allowed the kids and I to listen to the feelings, emotions and outcries we all were having. Before receiving family therapy, we were used to being called the Bickersons. The kids and I had problems communicating because communication is not just two people talking back and forth but it is also listening. The therapy helped me to deal with some of my anger concerning their father, the kid's questions about their Dad, and the divisions between me, him, and the children. We were all in a great deal of pain and did not know how to deal with it.

The staff at VVFSP really listened to our needs and helped us through some very tough times. The services have helped us function better as a family.

Melissa is now doing great in school, as well as Devin. She used to struggle so hard until both of us got frustrated. Educators came to our home and taught me how to get the services at the school that my daughter had the right to receive.

The support services have helped me to graduate from college with my AA degree in education.

Our family is one of the fortunate ones. We were able to be linked with services that helped us to become a healthy, productive, viable and loving family, whereas we could have been the exact opposite. I have gained a lot of confidence in myself and my ability to raise my children.

I thank you for the opportunity to speak before your Panel and I hope my testimony is helpful in your endeavors.

[The prepared statement of Ms. Felton appears on p. 110.]

Mr. EVANS. It certainly is very helpful, Ms. Felton, and we appreciate your appearing before us today.

Peggy, will you place that microphone directly in front of you, please?

STATEMENT OF PEGGY ST. CLAIR

Ms. ST. CLAIR. Chairman Evans, members of the House Veterans Affairs Subcommittee, thank you for the opportunity to address you today concerning the social service needs of Vietnam veterans and their families.

My name is Peggy St. Clair and I'm the wife of a Vietnam vet. My husband, Lance, served a tour of duty in 1970. Upon his return home, his wife gave birth to a stillborn child and a child with a disability. I've given birth to stillborn twins and two children with disabilities. My family lives in Mountain Home, a small community of 9,000 in the mountain and lake country of north central Arkansas. For the past year, I've been employed as a service coordinator for a program funded by the Agent Orange Class Assistance Program at the University of Arkansas, University Affiliated Programs.

Today I will address many of the points listed in your hearing invitation within the context of my overall testimony. I will relate to stories of my families and the stories of several families with whom I work. I hope this will illustrate the complexity of the social service needs we are experiencing over 20 years after the Vietnam war. The results of an informal survey of Vietnam vets in norther Arkansas will also be discussed.

The birth of our daughter, Grace, in 1975 was the beginning of our journey through the maze of social services. Grace was born with spina bifida and has been diagnosed as having severe mental retardation and 11q-chromosome deletion, Bernard's syndrome, and leukodystrophy. We were bewildered and overwhelmed by all these problems. We didn't have any idea of where to go for help. When she was 8 months old we were told to institutionalize her and go on with our lives. They weren't sure if she would live or, if she did live, what quality of life she would have.

For 2 years in a rural county in California we received no services. By moving 15 miles over the county line, within 60 days we had a health nurse and a service coordinator at our door asking what they could do to help. They didn't even know where to start.

It took them several days to assist me in setting up a plan of therapy and appointments to help Grace.

Hank, our service coordinator, accompanied me to appointments and coached me on how to get the information I wanted and needed from these professionals. These people became our friends, showing a genuine concern for Grace and our family. As I gained the skills to advocate for our child, Hank relinquished his role to me. When crises arose, though, he was always there. These professionals helped us through a maze of agencies and services for providing us with good useful information. They looked at all our family needs, not just Grace's. Thus, they allowed us to become independent, not dependent.

Grace has graduated from high school and lives in her own apartment with the help of a live-in caregiver. She attends a day service center for training and in her free time is in the community with her friends. She comes home for brief times and celebrations, but this kid prizes her new independence. The help Hank and other professionals gave us 17 years ago allowed us to choose a much more professional and easier life for this child.

Many referrals that I get come as a result of crisis situations that have developed because problems have gone unaddressed over the years. One such case is the family of a vet who is 100 percent disabled and has been receiving help from the VA for over 10 years. They called me when their 13 and 9 year old children had threatened suicide and they were told it would take 3 months to get them help. We talked that day and the next morning they called again. The 13 year old had taken an overdose of medication and they were told again they had to wait the 3 months for their appointment. By that afternoon I had the children evaluated and admitted to the hospital for treatment. Within a week, even though they were 100 miles away, I had all the emergency services that this family needed set up. Their big concern, why did it take so long to get help?

Two other cases that I work with resemble each other. These young men needed training. They were told by their school counselors that they were able to only do manual labor due to their special education. After a phone call to Rehab. Services, these boys will be entering college under a special program in the fall.

As you can see, my work sometimes only takes a phone call or packet of information to get services. Other cases require hours of coordination between agencies and professionals. With a history and philosophy of family-friendly community-based service coordination in the University Affiliated Program, I have been able to successfully address the needs of families of Vietnam vets. These veterans are independent, proud, and generally distrustful of systems.

In the last 12 months in my 12 county area I've received 57 referrals concerning Vietnam vets and their children with disabilities. As you'll look at the breakdown of these referrals, you'll see that these vets still have major needs today.

Last year Lance and I traveled 156 miles to Little Rock to get his Agent Orange physical. During this physical we gave them a detailed family history including the disabilities of our children and Lance's health problems. Not one family referral was made. I

thought this was unusual and asked my clients that I work with. They said they'd never been asked if they needed family services either. Asking Vietnam vets in the local area, I got the same conclusion.

I made an informal survey and these conclusions come from my experience. These were some of the suggestions that they have made.

They would like to see better communication between the client and the VA, individualized care by the VA, more accessible services, family intervention by the VA, referrals for service coordination when the family member has a child with a disability, and a directory of systems available for them. You'll find these in an expanded version in the last 2 pages of my testimony.

These suggestions fortify my convictions which are holistic, family-friendly and community-based services are what vets want today.

Thank you.

[The prepared statement of Ms. St. Clair appears on p. 115.]

Mr. EVANS. Thank you, Peggy. We appreciate your testimony.

Dr. Smith.

STATEMENT OF BRYAN C. SMITH

Dr. SMITH. Thank you very much, Chairman Evans, for inviting me for this testimony.

I have been personally moved by the statements that I've heard before my testimony and I'd like to depart from my prepared text and say a couple things.

I'm not here to bash the vet centers. We work well with vet centers. The vet centers are not well prepared to deal with children with disabilities. One vet center said to a veteran that they were not issued a child when they enlisted.

The family centered approach is essential for families that have children with disabilities. We talk about PTSD and I heard the question raised about disability payments. And while the disability payment goes to the veteran, that doesn't mean it goes to the family.

The other question dealing with what happens after AOCAP, we are part of a network and we are a national program that serves that network. If that network doesn't exist, sir, we will not exist. Our service, the service we have provided has helped 15,000 veterans, family members, and 8,000 of those have been children.

What I'd like to do is go back to my text now and say some things that I feel are designed to get your attention.

The veteran or family member who calls us is often in a family constellation that is struggling with the debilitating consequences of PTSD, conditions that despite their destructive power are still largely under-recognized and inadequately treated. Therapists in the network have described working with many children, most of whom are now approaching adulthood, who have grown up in an atmosphere where parents' untreated PTSD demands that they walk on eggshells to maintain some kind of tranquility at home. Many of them have been exposed for years to substance abuse, angry outbursts and domestic violence. The effects of this are being manifested today in the children of Vietnam veterans as secondary

PTSD. In fact, it truly marks a second generation of individuals affected by a disorder that requires a level of awareness to diagnose and a commitment of time and resources to treat.

Compounding this issue is the common characteristic of families that affects their ability to obtain services and presents implications for organizations that work with them. Many demonstrate a reluctance to initiate involvement with the organizations that could potentially assist them. They exhibit a peculiar distrust of and failure to pursue assistance from agencies that give even the slightest appearance of government affiliation.

Individual grantees working in various parts of the country were recently asked to provide their perspectives on several broad questions about Vietnam veterans that they have helped. There has been an almost unanimous identification of the prerequisite need to develop trust. These issues are playing a role in how these families interact or fail to interact with the service delivery system.

The reluctance of Vietnam veteran families to follow-through with referrals to organizations that potentially could address some of their unmet needs was a phenomenon that we investigated 2 years ago. It was perplexing to find that the lack of self-advocating behaviors is present even in situations where families appeared to be in desperate need of services and the usual obstacles such as cost or availability of services were not issues. Quite simply, for a variety of reasons, the veteran family itself presents one of the largest single barriers to accessing those services.

Some obstacles facing these families can be overcome. Noteworthy evidence of this has been seen in the fact that families were more likely to follow through with referrals when a local grantee was involved in a service coordinating capacity.

It is the belief of the Class Assistance Program that veterans and their families can benefit greatly from quality case management and information referral services to ensure quality and equal access to services and benefits that are already available. This operational policy has amplified the effect of the settlement funds, fostered development of clients' skills in using community programs and services, and represents a more holistic and integrated approach to serving people.

Service coordination is based on a family-centered empowerment model in which services are oriented toward the family rather than toward an individual such as a veteran or a child with a disability. Because veteran families in need of services are characterized by a high incidence of family dysfunction, psychological problems and alienation, it is probably only marginally effective to offer single-faceted services such as counseling or rehabilitation.

The veterans' reluctance to self-advocate and their wide array of unique problems are the primary reasons why a specialized network of veteran family-focused services is needed. The service coordination to help the families connect with these services is critical. Service coordination not only provides an avenue for more effective service delivery through integrated family-focused approaches. It also facilitates the leveraging of services on behalf of veteran families.

We studied leveraging outcomes and its cost effectiveness to determine what impact these activities have made. Conducted at the

end of 1993, data were collected for members of the plaintiff class who had entered the network through our system. A benefit-cost ratio showed that for every class assistance program dollar spent on services and equipment there was a $27.58 return in outcomes leveraged through either financial assistance or services received. This occurred although no grantee had operated with a specific mission of leveraging monies. The greatest proportion of these leveraged funds and services were for veterans' children, primarily from education and SSI.

Veteran families are a unique group of people with a wide array of human service needs. The challenge they present for service providers lies in the fact that any family with such a diverse range of needs generally has difficulty obtaining help from the complex web of agencies and convoluted assortment of professionals that comprise the community-based service system. Veteran families are frequently unable to navigate this service system successfully on their own.

In conclusion, I would like to point out the undeniable fact that the traditional service delivery system, which demands effective family functioning to successfully use its services, rarely meets the needs of many of the veterans' children and families with whom we have dealt. Instead, it pressures the families to adapt to the service delivery system. Neither more of the same, nor organizational restructuring of the system alone are strategies that can meet the veteran families' diverse needs. We have seen compelling evidence that the family-focused approach and service integration offer promising avenues worthy of exploration for the future.

Thank you very much.

[The prepared statement of Dr. Smith appears on p. 121.]

Mr. EVANS. Thank you, Dr. Smith.

You made an important point in your off-the-cuff remarks concerning the network. I've asked several of the agencies if they're likely to succeed if funding isn't available. But I take it not only those agencies would suffer and their clients would suffer, but also those agencies that continue to exist wouldn't have the availability of resources and information that would exist through that network to the extent that it does now.

Dr. SMITH. That's correct. We're a national support service and without that service, if we didn't have the network, we would not provide that service.

Mr. EVANS. So a program could survive and maybe have the same level of funding, but not be resource-rich because of the deprivation of those resources?

Dr. SMITH. That's correct.

Mr. EVANS. How do the needs of Vietnam veterans and their families for case management and service coordination compare with others who need social services? Why are Vietnam veterans different?

Dr. SMITH. Vietnam veterans are different. They have different problems and possibly the most different aspect is the fact that the parents have disabilities themselves, usually PTSD. I think it's extremely difficult for a family with a child with a disability to access all the services and obtain services by themselves. But when the

family itself is dysfunctional and has difficulty surviving, it adds another level of difficulty to get services.

Mr. EVANS. And maybe because of the veterans' disdain for bureaucracies generally?

Dr. SMITH. It's a very difficult process. They need advocates and that's what the network has been providing.

The other aspect is that many veteran families have many children with disabilities. Many of the children have multiple disabilities, and I think all of those dimensions make it very difficult.

Mr. EVANS. Peggy, have you found the same to be true?

Ms. ST. CLAIR. Yes, sir, a lot of my families. It has to be the whole family, I've found, and it's going from generation to generation. Right now I'm treating a daughter of a vet and her children, all with ADHD and PTSD, and so it keeps going. You have generation to generation.

Mr. EVANS. In the case of Agency Orange screening, there are specific questions. I've never had one myself, to be honest with you, but there are specific questions about family history which in the instance that you cited basically should have caused a reaction by the VA to refer people who have these kinds of problems to other social service agencies?

Ms. ST. CLAIR. I would think so. We gave them all of Grace's 27 handicaps. We gave them our son's handicaps, my step-daughter's. He never once, and I didn't tell him what my position was, asked, do you need help? Do you need BDS contact or do you need social service contact or do you have a decent house to live in? Are all these child needs met? He wrote it down and went on and that was it.

Mr. EVANS. Leslie, when did you first contact the Vietnam Veterans Family Support Project and what prompted you to do so?

Ms. FELTON. It was back in 1991. What had happened is I had recognized as well as Melissa's teacher that she was having some difficulties in school. The school attributed it to she just wasn't applying herself. Even her pediatrician had attributed it to I was seeing things and she wasn't applying herself.

When we went to one of the Kennedy-Krieger offices called the Learning Center, it was a social worker there who referred us. When I was explaining about my family's problems, my husband's background, that he had been exposed to Agent Orange and his readiness all the time for combat even though he was no longer in a war situation, she referred us to VVFSP's family support program.

Mr. EVANS. Had you gone to any other social service agencies before that and not received——

Ms. FELTON. Only thing I had tried before was working through the pediatrician to see if he knew of any avenues of any types of situations, of any types of services that could help us to find out what is going on. But, like I said, he just kept thinking there wasn't any problem going on at all and that we just needed to go on with our lives instead of just trying to deal with the situation at hand. He felt there wasn't a problem other than to continue on with your life, everything will work out fine.

Mr. EVANS. We really want to thank you and Peggy for personalizing this. It helps convey the message in real human terms. We appreciate your honesty and courage in coming forward.

The Gentleman from Pennsylvania is now recognized.

Mr. RIDGE. I'm sorry, Mr. Chairman, that I was delayed and didn't hear all the testimony.

I have a couple of generic questions, though, that I think are very relevant and based on your experience you might be able to answer.

Ms. Felton, I did not read your entire testimony. I looked at it and I saw your children are 8 and 10. Mine are 6 and 8. I have to ask you some personal questions to get you to put on the record some of your observations that are relevant to, I think, this inquiry.

Was your husband a combat veteran?

Ms. FELTON. As far as I understood it, yes.

One of the situations that's not in the testimony is that my husband is almost 12 years my senior, so what I know I only know from his conversations. I don't know actual situations. I only know from dreams or shouts and dreams or things that he has said to me when I have approached him about different things that have gone on. But, yes, he said he was.

Mr. RIDGE. And how did your children relate to his experience as a soldier? I mean, my children knew I was a soldier. How do your children relate to the experience their dad had as a soldier? Is it a positive for them? Were they proud of it? The children really suffer most. Spouses, of course, also suffer. A couple of witnesses talked earlier about the real trouble and the trauma the children experience and I'm curious as to how your children related to their dad's experiences being a combat soldier.

Ms. FELTON. Well, my son, I guess this sounds biased, but he kind of glorified it. He wants to go into the military himself. In fact, he wants to just drop school now and then go into the military. But they really thought of it as a position of honor. And also because I have other family members, brothers, who are in the service, they thought it was a great thing to be in the military and they still do. That has not changed, but that's only through time and I believe our counseling because in the beginning my daughter did not share that opinion of it being wonderful. She thought of it as something that really just hurt people, that just churned people around. But now through counseling she has realized it is not really something that will do damage or, if it does do damage, there are avenues to get help. She doesn't see it as a bad thing anymore. But my son still thinks it's a wonderful institution and glorifies it, and he glorified their father for being in the military.

Mr. RIDGE. Your testimony doesn't reflect when your husband left. Would you be kind enough to say how long he's been absent from the home?

Ms. FELTON. Almost 8 years now. He left approximately when my son was 6 months old because he felt as though he didn't want to handle the situation with two children. And with my daughter having a problem now with learning disabilities and her epilepsy, he still doesn't address the problem. In fact, he's even neglectful. In a situation when they asked for him to come in to help her with

her psychological needs, he flew and it was almost a year before we heard from him again when I had asked him to attend to help us.

Mr. RIDGE. So he has not been readily available to be part of any kind of group counseling or anything like that?

Ms. FELTON. No, not at all. In fact, at one time he had even called the Veterans' Administration and—I mean, the VVFSP office and said he's not a vet, that he didn't want to have my children in any type of services whatsoever and he actually told them that I was lying. He really just made a big scene over the phone with one of the social workers there.

Mr. RIDGE. Anybody else care to comment?

I'm particularly concerned about the impact of all this on children because I have seen first-hand in my congressional district servicemen who've been diagnosed as having PTSD. VA has at least acknowledged the problem and yet the help is really limited, not only for the veteran but obviously for the family. It has affected the relationship with children. The children don't pick their parents. These are the children of Vietnam veterans who absorb and endure and live with part of that emotional trauma and have to adjust to it. Yet there's not a lot of outreach, there's not a lot of coordination. That's what you are doing and doing so well, and that's why I'm particularly pleased to have your testimony.

Anybody else care to share any other comments?

Ms. St. Clair?

Ms. ST. CLAIR. I can tell you this. We just went through it again. My husband is also a Desert Storm veteran, and so my youngest children—my son is severe ADHD and when he went to Desert Storm, since then we've had a terrible time with him. In fact, he'll be going down to Children's probably as an inpatient when I get back. He used to think let's play guns, let's play soldiers, and then when Dad went again this was a big thing. But it affects the children forever.

My step-daughter last Friday delivered our first grandchild and the whole 9 months she worried to death that her child was going to have disabilities, so it goes on and on forever. You look at the kids and the trauma, and we put up like pictures from Desert Storm, kids don't want them up there. They don't want to be reminded at all of anything that's going on. They asked how come Grace has what she has. We don't know. They tell us it's possibly caused by Agent Orange, but we don't know. And all of her cases are so rare that they can't tell us. We've had genetic testing that they can't find anything, no reason why these children have disabilities, so it carries on for a long time.

Mr. RIDGE. Dr. Smith?

Dr. SMITH. ADHD is Attention Deficit Hyperactive Disorder. What we see with a lot of children is the learning disability with violence and what we're describing here is kind of a condition. Compared to other groups that we've served there are a large number of children with Attention Deficit Disorder with violence, and that's unusual. The other groups have hyperactivity.

The divorce rate is high. The second marriage divorce rate is high. That doesn't mean that all veterans who have divorced have lost interest in the earlier families. We receive calls from veterans

who care about all their families, particularly when the children have disabilities, and they've heard about the program and they want to find out if they can provide some help for that family. So while the situations sometimes sound abandoning to the family, this is not always the case. There is a sense of responsibility and blame that still exists that the cause of the problem was brought home from their service and that they feel a responsibility for that problem still.

Mr. RIDGE. One final question, Ms. Felton. Did your husband ever seek help from the VA or disability assistance for PTSD, and what was the VA's response?

Ms. FELTON. One time when I was discussing with him Melissa's situation of depression she suffered, very deep depression, she at that time was maybe eight, about eight, and I had told him about it and I said, well, maybe since you won't come with us to seek help or to help Melissa, maybe you should go and seek some help yourself.

He went to the Veterans in Baltimore. They did a psychological on him and according to him they said that there was nothing wrong with him. The problem was our fault. We weren't adjusting to him. We were being neglectful to him. That is what he said that the VA had told him, that there was nothing wrong, and that they also told him that there was not enough evidence out that Agent Orange affected you in any way, because my husband also has cancer, and there was not enough evidence out there that Agent Orange affects you in any way. This is what he said that they had told him and that they gave him a pat on the back and some information and sent him home.

Mr. EVANS. I want to thank this panel for very good testimony. It's very helpful to us. Appreciate your time. Thank you very much.

The members of our next witness panel are Dr. Carl Calkins, Dr. John Reiss, and Frank McCarthy.

Dr. Calkins is President of the American Association of University-Affiliated Programs and a Professor at the University of Missouri at Kansas City.

Dr. Reiss is Associate Director, Institute for Child Health Policy in Gainesville, Florida.

Frank is a member of the Board of Advisors, Agent Orange Class Assistance Program and President of the Vietnam Veterans Agent Orange Victims, Incorporated.

Dr. Calkins, we will start with you.

STATEMENTS OF CARL CALKINS, PROFESSOR OF PSYCHOLOGY, UNIVERSITY OF MISSOURI AT KANSAS CITY; JOHN REISS, ASSOCIATE DIRECTOR, INSTITUTE FOR CHILD HEALTH POLICY, UNIVERSITY OF FLORIDA; AND FRANK McCARTHY, PRESIDENT, VIETNAM VETERANS AGENT ORANGE VICTIMS, INC.

STATEMENT OF DR. CARL CALKINS

Dr. CALKINS. Thank you for the introduction. I appreciate the opportunity to speak to you today, Chairman Evans and members of the subcommittee.

You have my written testimony and the topic is social services for Vietnam veterans and their families, current programs and future directions. I'm going to attempt to speak to you directly and not from my paper, which will probably be substantially more interesting, and I'll try and be very succinct and incorporate all major points.

What I would like to describe to you is the effect of the AOCAP programs and the systems that these programs interfaced with. In addition, I will describe why some changes were able to take place in those human and social services that made a difference. So, really, the issue that I want to address is systems change, the kind of change activities that were provided and how the AOCAP program precipitated some of these.

I am Professor of Psychology and Director of the Institute for Human Development, which is a university-affiliated program. We are also the recipient of an AOCAP project, as a grantee. The program is called MOVVERS, the Missouri Vietnam Veterans Education and Resource System. I will try and summarize for you some of the outcomes of working at both the national level and State level.

Three things happened in particular that may be of interest to you. One, there was a partnership formed between AOCAP, the American Association of University-Affiliated Programs, and the Administration on Developmental Disabilities under Health and Human Services. That partnership, I think, has been critical in implementing the overall kind of—or the intended outcomes of what AOCAP's goals were. Those goals were targeted on children with disabilities, on families of Vietnam veterans and also on building a national support network.

The American Association of University-Affiliated Programs is a network of some 58 programs across the country that are funded through the Administration on Development Disabilities. Their purpose is design programs, support change and improve system of services for people with disabilities and their families. This was a real appropriate kind of partnership. What happened, my first encounter with AOCAP was in about 1989 when it joined with the Administration on Developmental Disabilities and AAUAP. Several contracts were let to individual university-affiliated programs, 13 across the country, which our program was one, and then a larger contract was let to the American Association of University-Affiliated Programs to build a national support network. You've heard testimony about the national support network for families. That's one of the important national outcomes.

I think there are three levels that change took place as a result of this program. One at the systems level where people receive and manage human services, how does that all take place. The second is at the family level and it's at this level where lifestyles are really determined. You heard some of the previous testimony that stated, "I would not have made it if it was not for my family." Then at the individual level where choices are made and really the quality of life is determined for everybody.

I mentioned to you the partnership and the match. Out of that partnership, university-affiliated programs look in particular on how to change and build the capacity of systems. From our pro-

gram in Missouri, MOVVERS, the Missouri Vietnam Veterans Education and Resource System, we learned basically five things, that there were five needs and five appropriate kind of responses to those needs. Let me just summarize those real quickly for you.

The first was the need for sensitivity and respect. There was a lot of frustration, a lot of anger with the families that we dealt with and it all evolved around really getting an appropriate response from individuals at agencies and understanding how to work with that.

Dr. Jean Ann Summers in our program summarizes the appropriate response of an agency that attends to the issue of sensitivity and respect. She says that, "It implies total honesty and integrity, making no promises that one is unable to keep, following through without fail and taking some immediate action that responds to a family's expressed or perceived need rather than just a service provider's perception of a family's need." That's an important distinction when you respond to individual needs.

The second need is the need to be recognized as a family. You've heard a lot of testimony about this, in many cases these are facilities with multiple challenges. Now, what that ends up meaning is that you have a dad with PTSD, a mom with secondary affects from the PTSD. You have children with disabilities. The family is challenged at several levels and then the car breaks down. The appropriate intervention at that point is the car needs to be fixed and this is where our program was responsive. People won't attend to appointments, won't attend to counseling or other things until what they perceive is the most important need is attended to. That may well be the car.

So, in many cases, these families were encountering what we call stress pileup. It just gets worse and worse and worse and you have to attend to the most important thing, regardless of what your service guidelines say that you can do.

The third need is the need for social support in the community. Basically, this is the "sense that others that have had like experiences, and provide a great deal of support and encouragement for you to move ahead and interact with systems." That means other families of children that have disabilities were very helpful. Other Vietnam veteran families were very helpful in encouranging to even participate in the services.

The fourth need, and you really wouldn't think that this would be a need, but it's a need for information and training. That need relates to information on how to deal with various systems. The problem is it's not all put together and it is very confusing and frustrating for families.

The fifth need is the need for advocacy and the appropriate responses that you need is to match either with the AOCAP program staff that we have or with supports from peers for people to effectively make it through the maze of these human services. They've been described like a minefield where you can step on a mine at any point and kind of get knocked out of the game. Families of children with disabilities experience this and veterans' families experience this across both of those systems of services.

The real issue was that before AOCAP there wasn't an external force to bring these services together, to define the services and to

really be an assist in making it through the service delivery system. That's what needs to continue. Many times we had to train staff of existing human service agencies, veterans agencies on just how to deal with people. You wouldn't think that you would have to do that, but we do. That relates to the final need that I want to bring out to you and that's the need to move the system from a dependency model to an empowerment model. This is why in many cases the programs don't work or aren't effective or people won't participate in them.

You can think of the dependency model as this. If you're trying to convince an agency that you're 70 percent disabled or 100 percent disabled, you go to all that justification and they say, "We finally agree, you're a total wreck." The point of it is there's no future orientation. In an empowerment model in the services that we relate it to, one Vietnam veteran dad said, "The most positive experience that I had in my life was when you sat down with my son, who is disabled, and did a personal futures plan." It looked at the child and the family strengths and it offered a hope for the future and that's what many of the social services and veterans-related services don't offer and I think that's where we need to move the next step. I think you can accomplish this through training, through community-based support services and through moving toward an empowerment model.

Thank you.

[The prepared statement of Dr. Calkins appears on p. 129.]

Mr. EVANS. Thank you, doctor.

Dr. Reiss.

STATEMENT OF DR. JOHN REISS

Dr. REISS. Chairman Evans and members of the subcommittee, thank you for inviting me to present testimony here today on the topic of social services for Vietnam veterans and their families, current programs and future directions.

My name is John Reiss and I am the Associate Director of the Institute for Child Health Policy at the University of Florida. I'm also an Assistant Professor of Pediatrics and hold a doctoral degree in Counseling Psychology.

In my written testimony I describe in detail the system of care that children with special health care needs and their families need. Briefly, this system is family-centered, collaborative, community-based, culturally competent, care coordinated, comprehensive and accountable.

The development of such systems has been the focus of the U.S. Public Health Service's Maternal and Child Health Bureau and state Title V Children with Special Health Care Needs programs since 1987 when former Surgeon General Koop launched his national campaign to reform health care for America's special needs children and their families.

Since 1989, AOCAP has made a significant contribution to this effort, focusing on the development of consumer friendly and consumer responsive systems of care for Vietnam veteran families, including those with children with special needs.

From my perspective, because many of the staff are themselves Vietnam veterans, AOCAP projects have a special understanding of

Vietnam veteran families and the veterans themselves, and the care coordination and the advocacy services that AOCAP provides serves as glue that holds together the fragmented pieces of a service system.

In addition, AOCAP is founded on the philosophy that the family, rather than an individual family member, is the unit of care. This is especially important when working with children with special needs.

I also feel that Title V Children with Special Health Care Needs programs are also effective in serving Vietnam veterans who have children with special needs. Title V programs don't only pay for needed health care services, they also help to assure that providers work together in a coordinated fashion and work with families as partners in making decisions and providing care. However, Title V agencies, just like most Federal and State agencies, do not ask or gather information about the military service of parents. Therefore, these programs do not have specific data on the effectiveness of their services for Vietnam veteran families, nor do they have services that are typically focused specifically on this population.

In 1992, the Maternal and Child Health Bureau asked me to facilitate a work group comprised of AOCAP and Title V Children with Special Health Care Needs programs to promote collaboration between these programs and to assure optimal use of resources and to support the institutionalization of the lessons learned through AOCAP. The finding of this work group indicate that while these projects currently do do a good job, they could do a better job if they work more closely together to take advantage of each other's unique knowledge, experience and skills.

The work group has developed a detailed plan of action and the details are in my written testimony. Briefly, this plan involves working together to increase the awareness and understanding of the special health and social service needs of Vietnam veterans' families with children with special needs, ensuring that these families have access to all available health and social services, and also ensuring that services for these families and their children promotes independence, productivity and empowerment of the child and family.

It is now up to the staff of Title V programs and AOCAP projects to put into action that plan. However, in my opinion, these efforts could be enhanced through federal guidance. That is, for example, Vietnam veterans' families with children with special needs could be identified as a population in need of special attention and the various research, service and training grants that are currently administered through federal programs as administered through the Maternal and Child Health Bureau, the Administration on Children and Families, the Department of Education, Rehabilitative Services Administration and the Department of Veterans Affairs. This would help to target existing service, research and training resources on this population and this would help to document the number of Vietnam veteran families with children with special needs and would also describe the extent to which their needs are not appropriately addressed.

In addition, federal resources are also needed to support collaborative Title V, AOCAP, care coordination, health and social service

programs, the training of providers to increase their knowledge and skills to work effectively with Vietnam veterans' families with children with special needs, the training of families themselves about the availability of and how to access health care services, social services and support programs.

Also, from my perspective, the Department of Veterans Affairs also needs to modify its perspective and change its paradigm so that it's more in keeping with the principles of family-centered, community-based culturally competent care.

Thank you again for the opportunity of presenting testimony and I hope you find this useful.

[The prepared statement of Dr. Reiss appears on p. 135.]

Mr. EVANS. Doctor, thank you very much. Your testimony is appreciated..

Mr. McCarthy.

STATEMENT OF FRANK McCARTHY

Mr. MCCARTHY. Chairman Evans, members of the subcommittee, I thought coming here today it would be very easy for me to do this. I've done it so many times. I find it exceedingly difficult for me to speak here now at this time. My mouth is drying up. My heart is pounding. I've testified before the 96th Congress, the 97th Congress, the 98th Congress, the 99th Congress, the 100th Congress, the 101st Congress, the 102nd Congress and now we have the 103rd Congress. I feel like I should be testifying before the House Ethics Committee, the House Judiciary Committee.

I've been President of Vietnam Veterans Agent Orange Victims for 17 years. I've watched the organization that I represent initiate this lawsuit that created these programs that you have heard today, help these families that needed to be helped. I've watched my 68 chapters run by veterans who were dying of cancer, dying of neurological damage, immunological damage, have watched them all go down the tubes because they couldn't continue providing the services for the families suffering and dying because it was too expensive, it's too cost effective. They died and the chapters died with them.

We initiated this lawsuit not for an amount of money. There was never an amount of money involved. It was to create a foundation, an AOCAP that would go on forever, providing the services that you've heard today. That's not going to happen. It's not going to happen because the judicial system failed us, like all those other Congresses failed us, because they haven't been able to solve the dispute of whether Agent Orange causes any problems or not, even though we all know it does, like we know cigarettes cause cancer. The vets know that, the American public knows that. But all those Congresses have failed us, all those previous administrations have failed us. Otherwise, AOCAP wouldn't need to exist. These people wouldn't be providing those services they're providing now.

All those veterans who have died of all those cancers that could have been detected early if the VA would have provided that cancer information, like the testicular guide I put in my written statement. We put that guide out because veterans were dying of testicular cancer, the pure example of the kind of programs and services, aside from what you've heard here today. We put that guide out

because veterans needed to check themselves and those who got the guide and checked themselves and saw that lump and went to the hospital lived. They got operated on, they lived. Those who didn't get the guide, died.

The VA told me that that guide was an alarmist, it was inaccurate, not a proper interpretation of medical issues of Agent Orange. But all their hospitals, every single hospital bought that guide because they needed something to give the veteran that Central Office wouldn't give them. They bought them by the tens of thousands. We took the money that we got from those VA hospitals and made more guides and gave them out to veterans for free. They came to us and said, "Thank you. I had that guide, I saw that lump and my life was saved." I'll be haunted forever by those who told me, "It's too late for me. I didn't get the guide. I'm going to die. But thanks anyway."

That's what these people are doing every day. You've heard all this testimony. Lives are being saved everyday because of this litigation, because one judge said, "I'm not going to watch this suffering. I'm not going to listen to the Second Circuit Court of Appeals who took it from an Agent Orange suit and made into a Vietnam vet suit covering all the issues." He said, "I'm going to do something."

Dennis and Mike, the AOCAP Board and everybody got together and this is what you see. Kids lives are being saved everyday.

Now, that money is going to be gone soon and these people for the most part, you heard them say, they're not going to exist, some of them. I'm going to be here. What am I going to do, Mr. Chairman and members of the subcommittee, and I wish I could shake every door in this building and all the other buildings like it, what am I going to do when the money runs out for AOCAP in June of 1995? I know what I'm going to do. I'm going to be burying more veterans unnecessarily. I'm going to have to look into the eyes of more kids and say, "Sorry, kid. I know your birth defect isn't repaired, but I've got 10,000 other kids lined up behind you and you're going to have to wait." I'm not going to have any money.

My recommendations here are plain and simple. I'm not asking the VA to do anything. I'm not asking the Congress to do anything. I demand as a human being who has seen the catastrophe of Agent Orange and the way this government and this judicial system has treated them, I demand you force the VA to do what they're doing or fund them. There is no other moral imperative. You have to. I'm not asking, I'm demanding as a human being. You've got to do this. I'm going to be alone when this is gone and I don't know what the tell the veterans. I don't know what to say.

Mr. Ridge, I'm going to speak to him personally because he had some questions about the litigation. A lot of veterans think it's a sellout. If they could see the lives that these people have saved, they would never say that. If they could count the hundreds of millions of dollars that the Veterans Leadership Program has gotten them in compensation, they wouldn't say that. You can't put an amount of money on one life that one of these have saved and they've saved tens of thousands of lives.

It's going to be gone and what's the VA going to do? Nothing, not in my book. They have adhered to an unconscionable position

that—unprecedented in the VA system, "You prove to me that Agent Orange caused it," and they're doing the same thing to our kids, the Desert Storm veterans. They're our kids. They're us. It's the same thing. "Oh, it's in your head. Send them to the shrink. Oh, we don't know. We've got to study it," and start another study.

Well, we were supposed to stop that with the Vietnam War. Didn't we learn that from the Vietnam War? Didn't we learn from Agent Orange? Obviously we didn't because we're doing it to our kids. Where is it going to end? Where's the ugly face of war going to stop? We've got to do something now and the VA has the responsibility and Congress has the responsibility to force the VA because they won't do anything that Congress doesn't force them to do.

So, my plea is to end the controversy. The vets don't care whether Agent Orange caused it or not. The public don't care whether Agent Orange caused it or not. It's time that we took a moral position and do what AOCAP has done. We've shown the way. It's the VA's responsibility.

I said I'd never appear before the House again. I'm here because I know you care, Mr. Chairman. That's the only reason. I'm here for those people because they're trying their hearts out everyday and they're succeeding. They're doing it. We've got to help them to continue on because the money is going to go. It's as simple as that.

Thank you.

[The prepared statement of Mr. McCarthy appears on p. 145.]

Mr. EVANS. Thank you, Frank. That's very moving testimony. We appreciate your contributions today.

I think it's fair to point out that while these funds are drying up, the Agent Orange Class Assistance Program and even the compensation portion of the suit have helped far more many Vietnam veterans, the dependents and their families than the U.S. government has. I think the record is very clear that we wasted over $50 million on studies of this through the CDC, the Veterans' Administration and elsewhere and only find that many of those studies were rigged to fail and purposely flawed and that money could have been used directly for these kinds of programs.

We thank you for being in the trenches. Even before I got to Congress, I knew about your hard work. Unfortunately, it's going to have to continue and I have to count on you to come here again probably next year and fight as we phase out the settlement program and fight for the money we need.

So, we appreciate your testimony and your continued strong advocacy of Vietnam veterans and now Persian Gulf veterans, as you say. That's the next battle as well.

Dr. Calkins, you raised the issue of an empowerment approach and I think that's the real shift of paradigm that we need here in terms of looking at how we provide services. The five or so factors that you indicated, they start with empowerment, with sensitivity and respect, gaining information about the services available, the advocacy programs. They're all empowering kinds of things.

Could both of you tell us how the VA might try to adapt this kind of approach into its system?

Dr. CALKINS. I don't know that we have that long. No, not to be cryptic, but it really takes a substantial amount of shift in ideology

to put in place an empowerment model. When the entire eligibility of a system is based on deficits, you don't treat people toward their strengths and toward their capacities. You look at those deficits and that becomes the way that you interact with them. So, it would take massive amounts of retraining and this is not just true in veterans' organizations, but this is true also in human service organizations. We're finding that those deficit models don't lead people to wellness. They don't lead people, they become more debilitating. I think retraining, redirecting the funds away from structures that are heavily bureaucratic and heavily encumbered with their own procedures.

What community-based organizations do is they do whatever it takes. They also listen, I think finally, directly to what the people who are the consumers say the needs are. This is something that we as organizations don't often do. We have a set of, "This is what your needs probably are and we'll get you these services." But if you really listen to what people's needs are, they're willing and committed to work with you and that's how you make that shift too. So, they need to be part of the service delivery system.

Dr. REISS. I guess I'd like to build on two things that you said. One has to do with flexibility and the other has to do with involving consumers or parents. The flexibility of funds, I think, is critical. I think one of the reasons that AOCAP has been able to do what it can do is because it has a modest amount of resources that it can use to fill in the gaps when other existing resources aren't able to address the needs. But they're also able to work with all the available social health and support systems to say, "We're getting somebody to pay the electricity, we're getting somebody else to provide transportation." They're the glue. They're the ones that bring that together.

I know within bureaucracies, state and Federal Government, there are clear restrictions as to how many units of care you can provide to an individual, how many units of care you can provide to a spouse. Giving systems the flexibility to address the needs and do what's needed I think is critical.

The other thing that's happened with the family-centered care movement, especially with children with special needs, is many organizations now utilize parent advisory boards and, in fact, give them concrete, explicit power and responsibility that helps shape the service system and also to actively participate in the provision of services. AOCAP uses Vietnam vets and their families as care coordinators and care providers. I think institutionalizing, giving Vietnam vets and their families significant responsibility and power to provide advice and also have the opportunity of having oversight in terms of the allocation of resources, I think resource and money and power go together. If they're just an advisory board that says, "You ought to do this or you ought to do that," things aren't going to change. If an administrator needs to get the approval of an advisory board to allocate resources to a need program or to new services, I think that's the way you'll see change.

Mr. EVANS. I want to thank this panel very much for their important testimony. Thanks for your time and energy.

The members of our final witness panel represent the Department of Veterans Affairs. Dr. David Law is Acting Associate Dep-

uty Chief Medical Director for Clinical Programs. He is accompanied by Dr. Laurie Harkness, Chief Psychiatrist, Rehabilitation Section, Social Work Services at the VA Medical Center, West Haven, CT.

Doctor, we're ready when you are and your entire statement will be made part of the record.

STATEMENT OF DR. DAVID H. LAW, ACTING ASSOCIATE DEPUTY CHIEF MEDICAL DIRECTOR FOR CLINICAL PROGRAMS, DEPARTMENT OF VETERANS AFFAIRS; ACCOMPANIED BY DR. LAURIE HARKNESS, CHIEF OF THE PSYCHIATRIST REHABILITATION PROGRAM, SOCIAL WORK SERVICE, VA MEDICAL CENTER, WEST HAVEN, CT

STATEMENT OF DR. DAVID LAW

Dr. LAW. Certainly. Thank you.

I'm pleased to represent the Veterans Health Administration and to discuss what the Department of Veterans Affairs does to assist veterans and their families using social services.

Mr. Chairman, the terrible impact of war and military service on families has been recognized throughout our Nation's history. It's been experienced directly by millions of our citizens and has been a very personal experience for many present at this hearing.

An important VA mission is to provide for the military-related social service needs of our veterans. To meet those needs, the VA has implemented programs that deal with posttraumatic stress disorder, substance abuse and family violence. While VA only has authority to provide direct treatment to family members as a collateral treatment for the veteran in certain mental health, rehabilitation and long-term care programs, VA does respond to the other needs of veterans' families indirectly through well-established referral networks and community agency partnerships. Clinical staff assigned to VA medical centers, outpatient clinics, community-based veteran centers and veterans benefits counselors in our VA regional offices and hospitals provide such primary linkage and referral services to community agencies and other programs.

Also, among the social services most frequently provided directly for our veteran patients, are those impacting on the family. Namely, advanced discharge planning, information and referral, case management and family consultation. In the last 3 months alone, nearly one quarter of a million veterans received these specific services from our VA social workers.

In rural and smaller communities, finding appropriate agencies with the right services available for the veteran's family members becomes a challenge. Managing a case encompasses much more than just providing high quality health care to the veteran. It means getting the family the services it needs so that they can support the veteran during and following a course of VA hospitalization or outpatient care. Also, without effective coordinated case management services, some families at high social risk may not receive services at all.

Mr. Chairman, we in VA applaud the Agent Orange Class Assistance Program or AOCAP for its outstanding work with families and children of Vietnam veterans. As you have noticed and noted,

it's filled a critical gap in service delivery to a highly needful population of veteran families by providing a full range of these community social services which are so essential for the effective delivery of health care to veterans and the healthy functioning of their families.

We also appreciate the networking we've been able to establish with the community agencies funded by AOCAP. They are skilled in working with the families and disabled children of Vietnam veterans. We've collaborated with many of those agencies to meet the psychological and social needs of veterans, especially those whose children were undergoing concurrent medical care in the community.

With them, we have learned that programs which best meet the social service needs of veterans and their families share certain characteristics. First, they systematically address the biological, psychological, social and vocational needs of the veteran. Then, based on a family needs assessment, they incorporate a holistic approach and seek solutions through the use of the family itself, through VA programs and through community resources. The successful programs focus on healthy family relationships. They encourage independence and personal responsibility. They use volunteers and program graduates and they provide case management and coordinated services.

The full text of my testimony, Mr. Chairman, outlines several examples of locally developed VA programs designed to strengthen the family unit based on these principles.

Mr. Chairman, this concludes my testimony. However, my colleague, Dr. Harkness, has some comments to make and then we would be pleased to address your questions.

[The prepared statement of Dr. Law appears on p. 151.]

Mr. EVANS. Doctor.

STATEMENT OF DR. LAURIE HARKNESS

Dr. HARKNESS. Hi. I'm here to share my experience of the last 17 years working at the West Haven VA. I was head of the outpatient PTSD clinic for a number of years before I took over my present position.

There are a lot of caring, very concerned people who work at the VA. I'm there because I want to be there. I enjoy my job and I also feel like I not only serve the veterans that served this country, but I am teaching others how to provide services to them in a high quality way.

Now, the VA is only one of a group of people that have become real experts in understanding the multi-problems of Vietnam veterans who suffer from PTSD. We do acknowledge that PTSD not only affects the veteran, but it affects the entire family system. I myself spent 3½ years gathering data for the first study ever done to examine the impact of PTSD on the family system and specifically I looked at the impact of a father's PTSD on the children and a number of variables of children's development.

We do offer treatment for spouses and for families, but we cannot be experts in everything. One of the things that VA has, and I have to say only in recent years, begun to do is to collaborate and work with those people that do have the expertise, for example in the

treatment of children with multiple disabilities or other sorts of emotional problems. I think that is a direction that the VA does need to continue to develop in working with community agencies and facilities who have those expertise.

We also are very aware that the way to bring people home from Vietnam and to help them have the energy and the motivation and the strength to not only take responsibility for their symptoms and learn to manage their symptoms is to develop two things. One is meaningful family and social relationships and the other is meaningful activities to do with their days. If you don't have anything meaningful to look forward in your day, you're not going to feel very good about yourself and you're not going to be a very good parent or spouse.

Now, my own research did find that the group of children that I studied, and believe me it was a very, very painful 3½ years because I heard some of the most horrific stories and experienced some of the most painful children's day to day struggles, found that these children did have many problems, did resemble more a clinic-seeking sample than a normal sample, and that they already are identifiable at risk for later problems. What we at the VA are trying to do is work with these children and with their families, like I say, to link them to not only people in our agency but in the community that can help address these problems in a preventative way rather than later when they're fullblown.

Now, we also work very closely with other people in the community. We work very closely with veterans' service organizations to help teach them how to understand and to deliver the services that these families need. I myself do a lot of work with the schools in my community. I run workshops for teachers, for children, for families about the affects of PTSD and the affects of violence on the family system and on the learning process. I actually myself ran a group for children who were school bullies because we know that kids cannot learn in the classroom if there are kids there that are terrifying them.

We work very closely with getting grants for housing, but not just housing for individuals, which I think is historically what people have done. We're in the process of building a house with HUD money that is for Vietnam veterans and their families. In the process of planning this facility, what we did was we involved the veterans and their families in the process. One of the things they told me that I wouldn't have thought of was that they needed a common room, they needed washers and driers not in their apartments, but they needed it in a social room where they would have to go out of their apartments and interact with other people to help them overcome the social isolation and the tendency for social withdrawal.

I work very closely with AOCAP. I'm one of their family providers, as well as I run half day psycho-educational problem solving workshops with the Shriver Center out of Boston. I'm not the only one that does this, there are a lot of other VA employees that do this.

Yes, the VA has to work very hard to break down the negative stereotypes that have developed over the years and it did take us a long time to understand how to help—not only how to under-

stand PTSD, but how to help and work with the veterans and their families. But I also think at this point that is breaking down and that the collaborations and partnerships that are beginning are part of the answer to helping families get better treatment and get on with their lives.

Mr. EVANS. Doctor, thank you.

Doctor, we appreciate what you're doing at West Haven, but I'm not sure that's being duplicated throughout the other 171 VA medical centers.

Dr. HARKNESS. I do a lot of public talking with other VA medical centers and I do know that this is happening in a growing number of VA's throughout the country. I would be less than honest if I didn't say that not everywhere I go they totally agree with what I'm saying about the importance of working with the family system as well as with the veteran. Sometimes it is difficult the way the VA reimbursement system is set up for people to feel like they have the resources to serve the families directly in the VA medical centers, which is why what I say is don't give up at that point. I say look in your community and find what resources you can link with and then work with those resources to make sure that not only do they understand the multi-level needs of these families, but make sure that the families link up with these facilities.

Mr. EVANS. In these talks, do you actually identify the effects posttraumatic stress disorder on the kids as secondary PTSD or use terms of that nature?

Dr. HARKNESS. I actually don't use the term secondary PTSD because I actually think many of these children are primarily traumatized by living in these families and that they are having PTSD in and of itself that's a result of that interaction.

Let me just say one thing. In my study, I had originally thought it would be the severity of the father's PTSD that would be most highly correlated with problematic child behavior. In fact, the one variable that accounted for 60 percent of the variance was the presence or absence of violent behavior. So, in my talks and when I work with my veterans, what I say to them is that you can have PTSD, we can teach you how to struggle and how to manage these, but if you beat your children, you're destroying them as well. I think that that is a very important message that we need to get out to the community and is actually what I'm going to be talking about tomorrow at the AOCAP symposium.

Mr. EVANS. I appreciate your attendance. In a nutshell, as I won't be there, what might the VA be able to do that it isn't doing now particularly in terms of shifting to an empowerment kind of strategy with the family-oriented, community-based kinds of service?

Dr. HARKNESS. The first is the continuing ongoing education of people to ask the right questions. We happen to be part of the Yale system, so that we're always having training people come in. I'm always part of that orientation program.

The second is to make sure that the resources are available and to invite the veteran to bring their family in as part of the evaluation assessment period, not only part of the later treatment.

The third is to work with the agencies in the community that have the expertise in learning disabilities and other areas, make

sure that they know about PTSD, about how it affects the family system and about the problems that these families deal with.

Mr. EVANS. Dr. Law, in your statement you indicated, as I've quoted before, that AOCAP has filled a critical gap. As AOCAP phases out, what will the VA do to meet the needs to continue the filling of that gap?

Dr. LAW. That's a perplexing problem. VA is strongly supportive of any way that we can keep the AOCAP activities going. As you well know, VA is not permitted to do a number of the things that AOCAP does. I think some of the lessons that have been learned will be very useful. Now, already, I think there's ongoing training, continuous ongoing training for all of our 800 plus readjustment counseling service staff on a continuing basis dealing with family counseling. Our Social Work Service, all of its 4200 plus social workers throughout the country, get ongoing education and ongoing training in family counseling including national televised programs, as part of the social work leadership training programs. So, the recognition that these things have to play a much greater role in solving the problems is there.

I don't think that the VA has the capability or the support to do what AOCAP does. I think the VA is more and more discovering that it must be dependent on community facilities and must interact intimately with community facilities and must make the point that veterans and their families are not just the responsibility of the VA, but that they are active members of the community. I think our social workers and readjustment counseling people are actively trying to integrate the care of the veterans and their families into existing community agencies and organizations. And, of course, AOCAP has been a model for that.

Mr. EVANS. My time has expired and I have a number of other questions which I'll submit to you in writting for your responses. Those questions and your answers will also be made part of the record.

Thank you very much for your testimony.

That concludes our hearing. I want to thank everyone that has participated. It's been a very helpful hearing, not only for the Members of Congress who attended, but also for the Department of Veterans Affairs whose representatives were present for the entire hearing and we appreciate that. We think it's very helpful in terms of making an impact on the VA as well as this body to have the benefit of the testimony presented today.

I want to thank the Majority and the Minority staff for their hard work as well.

With that, this hearing is now adjourned..

[Whereupon, at 11:30 a.m., the hearing was adjourned.]

APPENDIX

Families of Vietnam Veterans With Post-Traumatic Stress Syndrome: Child Social Competence and Behavior

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Abstract

Aspects of combat-related post-traumatic stress disorder (PTSD) in Vietnam veterans may affect their children's development. In this study, researchers assessed the influence of the severity of the father's PTSD symptomatology, level of family functioning, and the presence or absence of violent behavior in the veteran father on the child's social competence and behavior patterns. Forty families involving eighty-six children ages six to sixteen were recruited for the study. Fathers were assessed through various instruments to determine combat exposure and severity of PTSD symptoms. Both veteran fathers and their wives independently completed family function assessments and child behavior questionnaires. The children's teachers also completed child behavior questionnaires.

Results indicate that many children demonstrated problematic behavior and were at risk for developing more severe psychiatric disorders. A child whose father is violent is more likely to have additional behavior problems, poorer school performance, and lower social competence than a child whose father is not violent. Violence is most strongly related to lower socioeconomic status, larger family size, and unemployment or underemployment. Violent behavior in the father has a great impact on general family functioning, which has significant influence on the child's functioning. Clinicians should identify high-risk families and children and treat children by emphasizing their separateness from their father and that they are not responsible for their father's behavior or pain. Longitudinal follow-up studies should be conducted to assess the risks in various age groups and examine the family outcome following treatment.

Families of Vietnam Veterans With Post-Traumatic Stress Syndrome: Child Social Competence and Behavior

The relationship of a father's war experiences and subsequent post-traumatic stress disorder (PTSD) to family life has generated growing concern. Flashbacks, nightmares, and startle responses, along with irritability, violence, depression, and substance abuse are among the most common and most disturbing symptoms of combat-related PTSD. These all have an impact on interpersonal and family relationships. Many of these families appear to have suffered from the well-known profound and prolonged psychological effects that many veterans experience. However, relatively little has been done to investigate the characteristics and problems of the children in the families that Vietnam War veterans formed in the post-war period. This study examines aspects of PTSD in Vietnam veterans that may affect their children's development. Investigation of these children is essential in order to comprehend the long-term implications of the experiences of veterans with combat-related PTSD.

Studies of children of Holocaust survivors and children of psychiatrically disturbed parents have clearly suggested that the psychological reverberations of traumatic events may persist into the next generation. An individual's PTSD becomes part of the entire family system and can affect other family members. The effects of trauma on the second generation can occur in many ways, both subtle and overt. Children can experience the impact of their parent's traumatic symptoms of anxiety, depression, withdrawal, or anger (Beardslee et al., 1983; Weissman et al., 1984; Krystal, 1968), hear repeatedly about their father's war experiences (Robinson and Winnik, 1978), observe how other people treat their father, be overprotected (Sonnenberg, 1974), adopt their parent's reactive attitudes of bitterness or suspicion, or feel pressure to compensate for their parent's deprivation and suffering (Levine, 1982). Deficits in the children have been documented in many areas, including cognitive-intellectual functioning (Rolf, 1972; Erlenmeyer-Kimling et al., 1981), social-interpersonal functioning (Beisser, Glasser, and Grant, 1967; Erlenmeyer-Kimling, 1975), and affective functioning (Weissman et al., 1984; Beardslee et al., 1983). However, some research with trauma survivors has shown that the consequences are not necessarily pathologic (Krell, 1982). Some children can shelter themselves from the negative impact of the environmental and familial sequelae of traumatic experience. They have the capacity to elicit positive responses from parents, friends, and teachers. The risks associated with parental PTSD can also be buffered by constitutional characteristics of the child.

Recently, several authors have reported their clinical impressions on the impact of combat-related PTSD on the children of Vietnam War veterans. Haley (1983) observed that child-rearing seems to emphasize the veteran's working through the transition from the "reflex" of combat aggressiveness to adaptive, nondestructive aggression in their current lives. Her emphasis is more on how to help the veteran father deal with the young child than on actual child developmental issues. Rosenheck (1985a), after encountering several troubled and symptomatic children whose fathers were being treated for PTSD, described a process he called "secondary traumatization" to characterize the relationship between the father's combat experiences and subsequent stress disorder and children's problems.

In cases of secondary traumatization, the child, exposed to the father's symptoms of PTSD, especially the flashbacks, nightmares, and vivid memories that the veteran father continuously relives and often even reenacts, identifies with the parent and experiences in fantasy the same kinds of events his or her parent actually lived through. This study investigates these impressionistic findings through empirical research.

To date, the only published empirical study to investigate the impact of PTSD on children has been the National Vietnam Veterans Readjustment Study (NVVRS) (Kulka et al., 1990). The NVVRS found that children of Vietnam veterans with PTSD do tend to have more behav-

ioral problems than do children of Vietnam veterans without PTSD and that they resembled a clinic-seeking sample of age mates rather than a normative sample. That study also found that these families reported more marital problems, more problems related to parenting, lower family adjustment, and more family violence than is found in families of those without PTSD. That study concluded that living with a veteran suffering with PTSD appears to have a significant negative impact on the psychological status and well-being of their spouses or coresident partners and their children (Kulka et al., 1990, p. 20). We examined which variables contributed to the variance in child behavior scores: the severity of specific PTSD symptoms or other associated problems. Results of this study are important in helping clinicians identify where to focus their clinical interventions: on PTSD, on the family, or on violence.

In an unpublished paper, Harkness and Giller (1992) reported the results of a study that examined spousal reports of their marital relationships in a group of forty Vietnam veterans with PTSD and their wives. Many of the couples reported problems in family functioning, including communication patterns, expressions of intimacy (cohesion), and problem-solving abilities (adaptability). A large number of couples described their family patterns of interaction as disengaged and rigid. Variables that most influence the level of family functioning were identified and discussed.

A major finding of the study was the powerful effect in the family of current violent behavior. Violent behavior was found to be even more influential than either the severity of a father's PTSD or the level of family functioning. The presence of violence not only makes the family system as a whole at risk for extreme dysfunction but the individual children in these families at risk for developing maladaptive behaviors and dysfunction (Harkness and Giller, 1992). This present study assessed the influence of the severity of the father's PTSD symptomatology, the level of family functioning, and the presence or absence of violent behavior in the veteran father on the child's social competence and behavior patterns. These independent variables (severity of PTSD, level of family functioning, and violence) have been proposed in the clinical literature to be important to a child's development.

Subjects and Procedure

After describing the study to the veteran father and obtaining his informed consent, he received the Structured Clinical Interview for DSM-III-R (SCID) (for PTSD) (Spitzer and Williams, 1985) and Schedule for Affective Disorders and Schizophrenia (SADS) (Endicott and Spitzer, 1978) diagnostic interviews. If the veteran was diagnosed as having PTSD by DSM-III-R criteria and did not meet research diagnostic criteria (Spitzer, Endicott, and Robbins, 1978) for schizophrenia or bipolar illness and gave written informed consent, he was further interviewed about his war experiences using the Jackson Interview (Keane et al., 1985), Figley's Structured Interview for PTSD (Figley, 1977), Horowitz, Wilner, and Alvarez's Impact of Events Scale (1979), and the VESI Stress Questionnaire (Wilson and Drauss, 1980). These instruments were used to assess combat exposure and severity of PTSD symptoms. He was also asked to complete a demographic questionnaire that included questions about psychosocial adjustment since the war.

A time was then scheduled to meet with the other members of his family, including all children above the age of six, pending the willingness of the wife and children to participate. These meetings occurred either at a local U.S. Department of Veteran Affairs Medical Center or at a Vietnam Veteran Outreach Center (Vet Center).

Of the forty-eight veterans recruited from Vietnam Veteran Outreach Centers, Vietnam Veterans of America chapters, and from the local VA Medical Center's Outpatient Mental Hygiene Clinic, forty-two met the inclusion criteria. Two wives refused to participate in the study. In the forty families who completed the study, all eighty-six children ages six to sixteen participated.

After explaining the purpose of the study to the family and obtaining informed consent, each member was asked to complete the Family Adaptability Cohesion (FACES II) (Olson et

al., 1982) and the Parent-Child Communication Scale (Olson et al., 1982) as the measures of family function. To assess child functioning, two variations of the same form were used: the Achenbach Child Behavior Checklist (CBCL) (Achenbach and Endlbrook, 1983) and the teacher's form of the Child Behavior Checklist, the TBCL (Achenbach and Endlbrook, 1983). Both self-administered questionnaires measure the social competencies and behavioral problems of children ages four to sixteen, as reported by their parents or teacher. The nine behavior scales derived from the 118 behavioral problem items are: schizoid or anxious, depressed, uncommunicative, obsessive-compulsive, somatic complaints, social withdrawal, hyperactive, aggressive, and delinquent. Derived from these are two more general factors called internalizing and externalizing behaviors.

With the parent's signed release of information, each child's teacher was asked to complete the TBCL. The TBCL behavior and competence scales that teachers score differ from those the parent scores. Behavior and competencies not evident to parents may be of great concern to teachers. Therefore, teachers are asked to provide competence information that focuses on the provision of special services, repetition of grades, ratings of academic performance, and on four general adaptive characteristics: how hard the child works, how appropriately the child behaves, how much the child is learning, and how happy the child is. Although the parents' and teachers' scores cannot be directly compared, together they give a better picture of child competence and behavior patterns. The higher the child's score for any scale, the more problematic the child's behavior.

Data are presented in two ways. Raw subscale scores are used to report on specific sex and age groups and to compare them with both a normative and clinic-seeking group of age mates. Second, to compare groups other than by age and sex, e.g., by severity of PTSD, T scores were used to allow comparison across age and sex groups.

Results

The children in this study resembled a clinic-seeking sample on many of the CBCL scales. For girls ages six to eleven, all but one behavior scale score was similar to those of a clinical sample. For girls ages twelve to sixteen, all the subscale mean scores were in the clinical range except the immature/hyperactive, schizoid, and delinquent scale scores, which were between the clinical and non-clinical values. For boys ages six to eleven, all the behavior scale scores were in the clinical range; and for boys ages twelve to sixteen, most of the behavior scale scores were in the clinical range. The only scales not in the clinical range in the male ages twelve to sixteen group were the immature behavior and obsessive/compulsive behavior subscales, which fell between the non-clinical and clinical scores. For all groups, internalizing and externalizing factor scores were in the clinical range (Table 1). On the total competence scale, this sample scored in the clinical range mainly due to their low activity subscale scores (Table 1). On both the social and school competence subscales, this sample scored between the clinical and non-clinical scores.

Effect of Severity of PTSD

To examine the effect of the severity of father's PTSD symptoms and level of family functioning on CBCL scores, several additional analyses were performed. Using T scores, a 2 x 3 ANOVA (severity x level of family functioning) showed a main effect of level of family functioning on both the Internalizing and Externalizing Behavior Scale scores (Table 2). Tukey post-hoc t-tests revealed that children from lower functioning families (as measured by the FACES II), regardless of the severity of the father's PTSD symptoms, scored significantly higher (more problematic) than children from higher functioning families on both the Internalizing and Externalizing Behavior Scales. No significant main effect of severity of PTSD or interaction between severity of PTSD and level of family functioning was found on any of the other scores. When family mean CBCL T scale scores, rather than individual child T scores, were used, a 2 x 3 ANOVA (severity of PTSD x level of family functioning) showed a main

Table 1. Child Behavior Checklist Scale T Scores for This Study and Other Normative and Clinical Samples (Values Are Mean ± SD)

	Current Study	Clinical Sample	Nonclinical Sample* (n = 300)
Girls 6–11(n=46)			
Internalizing	63.4 ± 9.7*	67.0 ± 9.1	51.3 ± 9.1
Externalizing	63.5 ± 11.1*	68.1 ± 9.5	51.0 ± 9.5
Social Competence	40.3 ± 1.51*	36.7 ± 10.0	51.1 ± 9.7
Girls 12–16 (n=34)			
Internalizing	60.0 ± 8.7*	64.3 ± 8.4	49.8 ± 8.0
Externalizing	57.4 ± 8.6*	64.0 ± 8.6	49.4 ± 7.5
Social Competence	44.7 ± 16.9*	36.9 ± 9.8	50.9 ± 10.0
Boys 6–11 (n=22)			
Internalizing	63.6 ± 9.7*	65.6 ± 8.9	51.2 ± 9.1
Externalizing	65.5 ± 9.9*	68.1 ± 8.7	51.0 ± 9.3
Social Competence	39.8 ± 13.4*	37.0 ± 9.0	51.0 ± 10.0
Boys 12–16 (n=22)			
Internalizing	62.0 ± 9.3 *	64.7 ± 8.2	51.3 ± 9.0
Externalizing	59.6 ± 10.1	66.2 ± 8.1	51.4 ± 8.9
Social Competence	40.8 ± 11.0*	35.5 ± 9.2	50.9 ± 10.1

* Ratings comparable to a clinical sample as reported by Achenbach and Endlbrook, 1983.

Table 2. CBCL Individual Children T Scores Compared by Severity of Father's PTSD Symptoms and Level of Family Functioning (Values Are Means ± SD)

	Low	Mild	High	F	P
Internalizing					
Mild PTSD	65.4 ± 10.2	59.2 ± 8.2	57.0 ± 7.8	7.26	.0001
Severe PTSD	66.7 ± 8.5	59.1 ± 7.1	58.3 ± 7.8		
Externalizing					
Mild PTSD	63.8 ± 12.2	60.3 ± 9.3	56.3 ± 8.8	4.22	.001
Severe PTSD	65.3 ± 9.0	60.1 ± 8.9	55.4 ± 8.0		
Social Competence					
Mild PTSD	39.4 ± 19.6	44.2 ± 14.8	42.9 ± 10.0	0.59	.711
Severe PTSD	39.6 ± 10.1	41.8 ± 12.8	41.9 ± 12.9		

effect of level of family functioning only on the internalizing behavior factor (Table 3). Tukey post-hoc t-tests revealed that children from lower functioning families, regardless of the severity of PTSD symptoms, scored significantly higher than children from higher functioning families on the internalizing behavior scale. No significant main effect of severity of PTSD or interaction between severity of PTSD and level of functioning was found on this scale. No significant difference was found among groups on the externalizing behavior or social competency scale T scores.

Table 3. CBCL Family T Scores Compared by Severity of Father's PTSD Symptoms and Level of Family Functioning (Values Are Means ± SD)

	Low	Mild	High	F	P
Internalizing					
Mild PTSD	61.5 ± 10.2	58.6 ± 5.2	57.9 ± 5.0	3.35	.015
Severe PTSD	67.9 ± 7.0	59.0 ± 4.0	58.3 ± 6.7		
Externalizing					
Mild PTSD	59.1 ± 10.2	60.0 ± 7.3	58.4 ± 6.5	1.43	.240
Severe PTSD	66.3 ± 6.9	58.5 ± 9.7	55.4 ± 4.8		
Social Competence					
Mild PTSD	43.9 ± 13.6	41.6 ± 9.2	44.7 ± 8.3	0.39	.851
Severe PTSD	38.9 ± 5.4	43.9 ± 12.2	41.9 ± 14.0		

Violence

Because of the effect of paternal violent behavior on family functioning found in the previous study (Harkness and Giller, 1992), children were grouped by presence or absence of current violent behavior in the father. Significant differences were found on the Internalizing and Externalizing Behavior Scale T scores (Table 4), the school performance scale T score, and total competency scale T score. Children ages six to eleven from families with a violent father were more aggressive and delinquent; girls this age were more socially withdrawn. These problems seem to increase for the older children. Not only were both boys' and girls' behavior scale scores in the clinic-seeking sample range, but the scores of boys ages twelve to sixteen were *higher* than the clinic-seeking sample.

Table 4. CBCL Scale T Scores for Children from Families with Violent vs Nonviolent Fathers as Reported by Fathers and Mothers (Values Are Mean + SD)

	Nonviolent (n=102)	Violent (n=70)	t	p
Behavior Scales				
Internalizing	59.2 ± 7.9	67.1 ± 9.5	5.73	.0001
Externalizing	58.7 ± 9.1	66.0 ± 10.5	4.76	.0001
Social Competence Scales				
Activity	41.5 ± 12.0	39.4 ± 10.2	1.28	.201
Social	44.6 ± 9.2	41.5 ± 14.0	1.59	.114
School	46.8 ± 12.7	42.2 ± 13.9	2.16	.032
Total Competency	43.3 ± 14.5	37.9 ± 12.7	2.59	.011

School

Of the eighty-six children who participated in the study, 64 percent of their teachers completed and returned the teacher's TBCL. In terms of their overall social competence and behavior mean scale scores, these fifty-five children were similar to the full sample of the eighty-six.

When teachers' and parents' internalizing and externalizing scores were compared, it was found that the teachers saw these fifty-five children as significantly less internalizing and externalizing than did either of their parents (Table 5), i.e., less anxious, less socially withdrawn, less nervous, less inattentive, and less aggressive. When compared with scale norms, the teachers' scores saw this group of children as falling between the non-clinic-seeking and

clinic-seeking sample. On the behavior subscale scores, when teacher's mean T scores for each behavior scale were compared first by severity of father's PTSD and then by level of family functioning, no significant differences were found between groups.

Table 5. Comparison Among Mother's, Father's and Teacher's Mean T Scores on CBCL Internalizing and Externalizing Behavior Scales (Mean + SD (n=55))

	Mother	Father	Teacher	F	P
Internalizing	62.6 + 9.6	60.3 + 9.2	54.0 + 9.0	12.60	.0001
Externalizing	61.2 + 10.9	60.1 + 10.6	52.8 + 11.9	9.39	.0001

Comparison: Mother=Father>Teacher

When teacher's mean scale T scores for each behavior scale were compared by presence or absence of violent behavior in the father, however, significant differences were found in many behavior scale scores (Table 6). Children from families with violence were significantly more anxious, unpopular, inattentive, and aggressive. There was also a strong tendency for them to be more socially withdrawn, immature, and self-destructive. In the area of social competence, teachers reported a tendency for the children of fathers with severe PTSD to perform less well academically than children of fathers with mild PTSD (p=.065). Teachers also reported that these children do not learn as much (p=.087). No difference was found between groups on comparison of hard working, appropriateness of behavior, or happiness. Teachers reported no significant differences in social competency scores among children from low-, middle-, or high-functioning families. A tendency (p=.085), however, was found for children from low-functioning families to be less happy than children from higher functioning families.

Table 6. Teacher's CBCL Behavior Scale T Scores for Children from Families with Nonviolent and Violent Fathers (Values Are Mean + SD)

	Nonviolent (n=33)	Violent (n=22)	t	p
Anxious	56.9 ± 3.3	59.9 ± 5.5	2.31	.025
Social Withdrawal	57.4 ± 4.2	60.9 ± 8.3	1.84	.072
Unpopular	57.4 ± 4.8	62.5 ± 8.9	2.47	.017
Obsessive/Compulsive	59.0 ± 6.8	62.8 ± 9.0	1.15	.262
Inattentive	56.9 ± 3.7	60.8 ± 7.8	2.17	.035
Immature	56.6 ± 2.7	62.7 ± 7.6	1.90	.070
Self-Destructive	59.3 ± 5.2	62.8 ± 7.1	1.97	.054
Aggressive	57.0 ± 4.4	62.5 ± 10.1	2.42	.019
Nervous	60.6 ± 10.2	61.6 ± 7.6	.31	.760

There were a number of significant differences between the violent and nonviolent groupings (Table 7). Children from families with violent fathers performed significantly more poorly academically, did not learn as much, and tended to be less happy. There was a tendency for them to behave less appropriately. Thus, as with the parents' reported scores, violence seems to be more of a discriminating variable in children's social competencies than severity of PTSD symptoms.

Table 7. Teacher's TBCL Social Competency Scale Scores for Children from Families with Nonviolent and Violent Fathers (Values Are Mean + SD)

	Nonviolent (n=33)	Violent (n=22)	t	p
Academic Performance	3.5 ± 0.8	2.7 ± 0.7	3.70	.0001
Externalizing	4.4 ± 1.7	3.7 ± 1.8	1.33	.190
Behaving Appropriately	4.5 ± 1.6	3.6 ± 1.6	1.88	.066
Learn Much	4.8 ± 1.4	3.8 ± 1.7	2.25	.029
Happy	4.6 ± 1.3	3.8 ± 1.6	1.98	.058

Discussion

This study of eighty-six children from forty families found that many children resemble a clinic-seeking sample of age mates on many problematic behavior scales, and are, therefore, identifiable as children "at risk" for developing more severe psychiatric disorders. In general, parents saw their children as depressed, anxious, somatizing, schizoid, uncommunicative, hyperactive, aggressive, and delinquent, with boys being perceived as having slightly more problems. Within this "high-risk" group, a lower level of family functioning and current violent behavior in the father were found to be significantly associated with the behavior problems of the children.

It is important to note that teachers saw a subgroup of fifty-five of these eighty-six children as significantly less behaviorally problematic than did the children's parents, rating them as more similar to the non-clinic seeking normative sample. This may reflect parental concerns and preoccupations that heavily weigh their observations. It may also be that when the child is in the family environment, he or she is triangulated into a dysfunctional family role, but outside the family, the same child, without role expectations, may behave differently.

Parental perceptions can influence children's behavior; if parents see their child as problematic, the likelihood of the child behaving that way is increased. In this study, very few differences were found between father's and mother's perceptions of child behaviors and social competencies. This was surprising because in the survivor literature, particularly in researching the Holocaust, several writers (Rakoff, Sigal, and Epstein, 1965; Sigal, Silver, and Rakoff, 1973) hypothesized that the survivor parent(s) tended to be either overly harsh and judgmental, to hold high expectations for their children, or to be overly lenient in their perceptions of them.

A major finding of this study, supported by both the parent and teacher ratings, was that children from families with a violent father were significantly more likely than children from families where the father was not violent to have more behavior problems, poorer school performance, and lower social competence. Girls ages six to eleven years with violent fathers were more frequently perceived as socially withdrawn and delinquent. All mean scores for girls ages twelve to sixteen from families with a violent father were in the clinical range, with externalizing behavior aggressive scale score and *all* internalizing behavior scores (anxious/obsessive, schizoid, depressed/withdrawn, and immature/hyperactive) significantly higher than for girls with nonviolent fathers. For younger boys with a violent father, all externalizing behavior scores were significantly higher than for boys ages six to eleven with a nonviolent father; boys ages twelve to sixteen with a violent father showed all behavior scale scores higher than even the clinic-seeking mean.

Teachers' scores corroborated this perception. They reported these children as demonstrating poorer academic performance, not learning as much, not behaving appropriately, and less happy than their peers. They also reported them as more anxious, socially withdrawn, unpopular, inattentive, immature, self-destructive, and aggressive. Violent behavior has a powerfully destructive effect on children, and this effect in these families appears to be more

influential than either the father's PTSD or the level of family functioning. In this study, violence was most strongly related to lower level of family functioning (families with lower cohesion and adaptability), lower socioeconomic status, larger family size, and unemployment or underemployment. In addition, a prominent symptom of PTSD, social isolation and alienation, is another social and family factor that often increases the likelihood of family violence (Steele, 1978). Violent behavior in the father was shown to have a great impact on general family functioning, which, in this study, has significant influence on the child's function. Research has shown that veterans with PTSD experience a high incidence of marital discord and domestic violence as well as higher unemployment, drug and alcohol abuse, and social isolation (Figley, 1977). The causal relationship among these variables is unclear. For example, does the unemployment lead to increased symptoms (substance abuse, violence, and social isolation) or does an increase in symptoms lead to unemployment and thus influence general family functioning and child behavior?

Clinical Implications

To date, the connections between violent behavior, PTSD, and child development has not been a focus of significant professional attention. This study represents the first work to examine the transgenerational effects of combat-related PTSD on the veteran's family system, especially on children's social competence and behavior patterns. The findings of this study raise questions about preventive programs not only for children of combat veterans with PTSD who are from lower functioning families or whose fathers are violent, but also raise questions about children in general from families where there is violence. Effective intervention and treatment begins with identifying these families and, therefore, the children in these families as "high risk" and identifying, through an early comprehensive assessment, specific problem areas. This assessment needs to focus on individual and family dynamics, including violence, which always has a negative effect on family stability and emotional tone. Individual, couple and family therapy may all be necessary, dependent upon the individual case and family circumstances. Clearly, treatment considerations will vary depending on who is the focus of treatment.

Many child behaviors reported by the parents resemble behaviors exhibited by the father, e.g., depression, anxiety, low frustration tolerance, and outbursts of anger. In working with these children, clinicians need to be sensitive to the presence of these behaviors in the father as they diagnose and treat the child. The strengthening of ego functions should be a major focus of treatment with these children with an emphasis on reality-testing, increasing frustration tolerance, and encouragement of verbalization as an alternative to reenactment. These children need to recognize their separateness from their fathers and be helped to discover that being different from their dad would be what would make him most proud. They need to become aware that they are not responsible for their parents' behavior and pain and do not need to feel guilty about it. They can thus gain needed distance from the intensity of family interactions and begin to address their own developmental concerns more appropriately.

The whole question of family and its role in the psychosocial generational transmission of trauma needs to be more clearly explored. During development, a child is subjected to an array of factors that affect him or her. These factors include the quality of the parents' interaction with each other and with the child, the mother's personality and her reactions to the father's PTSD, and the influence it has on the family life, the family dynamics, the child's constitution, and other life circumstances. These factors may aggravate or ameliorate particular potential problems.

From the studies of Holocaust survivors, children of psychiatrically disturbed parents, and this study, it is clearly important to continue to identify early those factors that make these children "high risk" and also continue to develop a knowledge base for the future that will guide clinicians toward more optimum interventions. Finally, longitudinal follow-up studies are needed that both assess further the risks in the different age groups and examine what happens to these families and children with treatment.

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STATEMENT
of

DENNIS K. RHOADES
EXECUTIVE DIRECTOR
AGENT ORANGE CLASS ASSISTANCE PROGRAM
before the

SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS
COMMITTEE ON VETERANS AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES

May 18, 1994

Mr. Chairman, I appreciate the Subcommittee's invitation to appear today to discuss alternative models for providing needed social services to Vietnam veterans and their families. My name is Dennis Rhoades and I serve as the executive director of the Agent Orange Class Assistance Program (AOCAP). In that capacity I have overseen the development of a network of 72 programs which provide broad based social services to Vietnam veterans and their families in all fifty states plus the District of Columbia and Puerto Rico. In the course of AOCAP's five and a half years of operation, this network has provided services to over 150,000 persons.

As you are aware, Mr. Chairman, this week AOCAP is conducting a National Symposium, which will permit us to assess and distill the experience of our network in providing services to Vietnam veterans and their families and to assess the public policy implications of our efforts. We are holding this event precisely because the problems of the clients we serve necessitated the development of service methodologies which differ considerably from traditional veterans program service models.

In order to understand why they differ, it may be useful to review AOCAP's development and the lawsuit settlement which created it.

The Agent Orange Product Liability Litigation began in 1978, when a Vietnam veteran filed a lawsuit against the United States government and numerous chemical companies that manufactured herbicides, including Agent Orange, used as defoliants in the Vietnam War. Many other veterans soon filed similar lawsuits. The plaintiffs claimed that exposure to Agent Orange and other dioxin-contaminated herbicides caused injuries and death to veterans as well as miscarriages for their spouses and birth defects among their children. The lawsuits were transferred by the Multi-District Litigation Panel to the United States District Court, Eastern District of New York. Ultimately, the case was certified as a class action and the plaintiff class was defined as all persons who served in the United States, New Zealand and Australian armed forces between 1961 and 1972 and who were injured by exposure to Agent Orange or other phenoxy herbicides while in or near Vietnam. The class also includes the parents, spouses, and children of the veterans.

On May 7, 1984, the day the trial was to have begun, the attorneys for the plaintiff class and the chemical companies agreed to settle the case for $180 million. After ruling that the settlement was fair and reasonable, the supervising judge, Jack B. Weinstein, worked with an advisory board of Vietnam veterans to design a distribution plan that made the best and fairest use of the limited settlement fund. The Court solicited and received advice from hundreds of individual veterans and veterans organizations.

Throughout, the Court was constrained by the relatively small size of the settlement fund in comparison with a plaintiff class that included not only the three million veterans who served in Vietnam, but also their families. The Court initially announced the distribution plan in an opinion issued on May 28, 1985. The plan had two major components.

The largest component, the Agent Orange Veteran Payment Program, is currently distributing cash payments to totally disabled Vietnam veterans and to the spouses or children of deceased Vietnam veterans. To be eligible for a payment, the applicant must show that the veteran meets a Court-approved test of exposure to Agent Orange and that the disability or death was not caused by traumatic, accidental or self-inflicted injury. The Court allocated $170 million of the settlement fund to the Payment Program.

The second, and more unusual component of the distribution plan was the creation of a foundation which would provide services to the class through grants to human service organizations. Although the United States Second Circuit Court of Appeals would later proscribe the use of an independent, private foundation, it upheld the concept of distribution of a portion of the settlement funds in the form of grants, as long as such funding was conducted under the supervision of the District Court. In June of 1988, the Supreme Court upheld the settlement and distribution plan, as revised by the Second Circuit Court. The District Court appointed me executive director in December of 1988, as well as an unpaid, ten member Board of Advisors, all but one of whom is a Vietnam veteran. The Agent Orange Class Assistance Program (AOCAP) began operation the following month.

In developing the Assistance Program as the distribution plan envisioned it, we faced several constraints. For example, no program could be funded which involved research into the causal relationship between Agent Orange exposure and health effects. This, in effect, removed us nearly entirely from the ongoing debate about agent orange. In addition, the ruling of the Second Circuit Court of Appeals explicitly prohibited any political activity. For this reason, our relationship with the Congress, as well as other policy making bodies in the Federal government, has necessarily been very limited.

In addition to these constraints, we also confronted a number of challenges. First, since the settlement was the result of a nationwide class action, we were required to develop a program which was truly national in scope. Second, such a program needed to serve the entire class, which included not only the 2.5 to 3 million veterans who served in Vietnam, but also their parents, spouses and children. Although the $52 million set aside by the court for AOCAP represented a substantial investment in Vietnam veterans and their families, the very size of the class and the diversity of needs presented a formidable challenge in equitable distribution of these non-renewable resources.

This latter question of need and program focus was central to our efforts from AOCAP's earliest days. While both the advisory board and the court recognized many worthy needs, they were at the same time concerned that by distribution of funds into too many service areas the settlement would not achieve a positive lasting impact on the class. Our choices were numerous, as reflected in the proposals submitted in response to an August 1988 Request for Proposal (RFP) issued by the Court-appointed Special Master for the Settlement, Kenneth R. Feinberg, shortly after the Supreme Court ruling. In addition to requesting funding for local memorials and research projects, the 147 proposals we received posed solutions to many problems, from homeless advocacy and employment and training programs, to a "cure" for agent orange poisoning (and Post Traumatic Stress Disorder) through massive injections of vitamin C.

The proposals we received were thus not, in their totality, an accurate barometer of need, but instead reflected institutional interests and issues which were not necessarily congruent with those needs. Working with our advisory board, we sought to discover those areas in which a demonstrable need was clearly unmet and in which, with AOCAP's limited resources, the funds could do the greatest good.

The need which was most apparent to us at the outset was for services for Vietnam veterans' children with health problems. As the subcommittee is well aware, throughout the course of the Agent Orange debate, veterans have expressed concern for the health of their children. Moreover, nearly sixty percent of all of the telephone calls and correspondence from the public as we began operation concerned child health issues, most particularly the financial burden in providing adequate health care. I remember talking on the telephone with numerous families, many of whom were so far into debt owing to hospital and doctor bills, they were being evicted from their homes. While it was not, and is not, appropriate for the Assistance Program to judge the cause of any given disability, we believed that it was AOCAP's responsibility to attempt to address the very real needs of these children and their families.

Understandably, after five years of court appeals, the expectations of Vietnam veterans and their families about our program's services were high. AOCAP thus began its grant making within three months of the program's startup, before we had even acquired a permanent office. Still wrestling with establishing long range goals, we developed a a set of criteria for our initial selections which has served us well for the past five years: (1) that the grants reflect a broad geographic distribution; (2) that grants be made to organizations with proven records of successful services in the community; (3) that AOCAP funding would neither duplicate existing services nor replace public monies; and (4) that initial grants would place a special emphasis on services to families with children with developmental or other chronic disabilities.

In consultation with our Advisory Board and the court, we carefully studied and monitored the progress of those organizations to which we had distributed funding. As the number of grants we developed and supervised grew, the more apparent it became that there was a real commonality in service approaches among our most effective programs. These approaches were guided by the following principles:

Family Centered Service. The very nature of the plaintiff class - consisting of the Vietnam veteran and his or her family as co-equal partners - seemed to dictate a family-oriented approach to the provision of services. In this, AOCAP was not alone: for the past several years, human service providers have acknowledged that empowering the family empowers the individuals in the family. Dr. Charles Figley, who is to follow me on this panel, discusses this issue in some detail. Moreover, our projects were finding that many veterans were accessible only though providing help to their families. After twenty years, many of the most disadvantaged Vietnam veterans had become mistrustful of agencies which purported to serve them as individuals. But while they might eschew seeking or receiving help for themselves, they would rarely, if ever, deny that assistance to their families, regardless of any institutional prejudices they might have. And since family centered services are holistic in their very nature, the veteran received the help that he or she might otherwise have spurned.

Service Coordination. Many of the Vietnam veterans and their families who visited our projects had multiple needs: income supplement for high doctor and hospitalization bills, basic preventative health care, mental

health, adaptive equipment, etc. Resources to meet these needs were available, but often difficult to access. Medicaid, for example, has been rightly characterized as the most user-unfriendly program ever adopted by Congress. In one particular state, the initial application for care is forty-two pages long. The need to maneuver through the welter of applications for service, changing eligibility requirements, and resistant bureaucracies is for many families an insurmountable barrier. Many have simply given up. The ability of a well trained service coordinator to guide a family through the maze necessary to meet multiple needs is therefore invaluable. In addition, given AOCAP's limited resources and the extent of the need for help, the ability of a project to leverage resources was clearly critical to its success. In this area, our projects have enjoyed considerable success. Dr. Bryan Smith will discuss later this morning the surprising extent to which the Vietnam Veterans Family Assistance Network has been able to find resources for its clients which far exceed AOCAP's funding investment.

Community-Based Service. Service coordination succeeds best when the services offered by an agency are a part of an integrated delivery system in the community. This, Mr. Chairman, is as true for veterans as it is for anyone else. Each community differs in its needs and systems designed to meet those needs. As members of this subcommittee are well aware, the trend toward decentralization of programs is now over a generation old. Large scale national categorical programs are becoming rarer as we approach the end of this century. Service coordinators need not only to have a basic generic understanding of available services, they also need a knowledge of eligibility requirements peculiar to a given program at the state or local level. Effective service coordinators constantly work to develop key agency contacts with whom they can establish a good working relationship.

Cultural Competence. Each veteran and family member is also as product of their community. Their needs and attitudes are shaped by that community. This is particularly the case with minority veterans. Developing the cultural competence which acknowledges differences between and within communities in order to tailor effective programs for Vietnam veterans and their families has been a vital element in our grant development efforts.

As we began to build these principles into our new grants and grant renewals, a coherent network of services, reaching from Fairbanks, Alaska to Brevard County, Florida began to emerge. Rather than operating in isolation, our projects started collaborating in serving individual clients, as well as working to resolve common problems. In the New England area, the AOCAP grantees formed a consortium and developed a common intake form. Similar collaborative systems were established in the midwest, the Rocky Mountain states and within state in both California and New York. These regional consortia were not the full extent of network collaboration. Later this morning you will hear from Tom James and Dr. Bryan Smith concerning agencies in widely different geographic areas coming together to support the needs of individual families.

Mr. Chairman, I do not mean to suggest that our network is homogeneous or that we have developed grants based on a rigid template. In fact, there is considerable diversity among the agencies which comprise our network. These organizations fall into four general categories: veterans organizations, disability service agencies, family service programs and national support projects.

Veterans organizations comprise about a third of current AOCAP grantees. In addition to the 15-state family assistance program of The American Legion, AOCAP provides funding to 23 community based veterans projects, whose primary mission is to meet the service needs of Vietnam veterans. AOCAP grants have expanded the service capabilities of these

organizations, which traditionally have provided help only to individual veterans. AOCAP funding has permitted these agencies to serve the broader needs of Vietnam veterans and their families, with particular emphasis upon services to children with disabilities.

Twenty-four AOCAP programs are operated by agencies serving persons with disabilities. They include University Affiliated Programs for Children with Developmental Disabilities (UAPs), national disability organizations, parent advocacy agencies, and local chapters of organizations such as United Cerebral Palsy and the Association for Retarded Citizens.

Twenty grantees are agencies whose primary mission is counseling, either general family therapy, or problem-specific services such as substance abuse recovery programs. Family assistance agencies (many of which, incidentally, began as service agencies for returning veterans of World War I and their families) have shown keen interest in participating in the Assistance Program since its beginning, and often specialize in service coordination, a critical need of Vietnam veterans and their families.

Five national support projects provide the core of the consultation, technical assistance, training and other support services to the network of AOCAP-funded community projects in order for those projects to access the tools, skills and expert advocacy necessary to serve individual clients. These projects range from the National Veterans Legal Services Project, with their expert knowledge of the veterans benefits system and veterans law to the Access Group project of the United Cerebral Palsy Association and their state of the art knowledge regarding assistive technology for persons with disabilities. Each of these projects provides a significant level of direct services to Agent Orange Class Members as well. Also included among the national support projects is the National Information System (NIS) at the University of South Carolina. The NIS is an advice and counseling system accessible through a toll-free telephone line which helps families develop strategies for serving the needs of their children and link up with appropriate resources in their communities or anywhere they may be available. NIS counselors are well trained and educated in the field of developmental disabilities, and they work from a nationwide database of over 100,000 service providers in seeking out sources of help for Vietnam veterans' children.

Tied together through AOCAP's electronic mail system, which we call VETnet, the Vietnam Veterans Family Assistance Network, is capable of providing services to Vietnam veterans and their families in need throughout the United States. The best example of that capability is found in our National Outreach Initiative. This initiative was designed to contact all of the original agent orange settlement claimants who submitted claims based upon the health problems of their children.

Following the May 1984 settlement agreement, but prior to the development of the distribution plan, approximately 250,000 claims were filed against the settlement. During the period of higher court appeals, these claims records languished in the basement of the Federal District Courthouse in Uniondale, New York. Once the settlement was finally approved, all claimants were notified of the provisions of the Payment Program. Yet, many of the claims were not made by veterans with various medical conditions, but were made by families on behalf of their children. Using students from a nearby law school, these claims were disaggregated from the larger group, and their addresses were sent to NIS. Serving as a clearinghouse, NIS began two years ago sending registered letters to the last known address of these families. Upon making contact with the family, the NIS screened that family's presenting needs and referred that family either to an AOCAP grantee or to another appropriate agency, depending upon what services were being sought. As of last week, Mr. Chairman, we will have finished our effort to

contact and provide services to all 76,000 families with claims filed on behalf of children.

Mr. Chairman, I am aware that many of the panelists who will follow me are either AOCAP service providers or Vietnam veterans and their families who have been helped by through their assistance. I have attempted here only to provide the subcommittee with a broad overview of the AOCAP system and its development, a context for understanding why the service models which have evolved from our five year effort really do present a meaningful alternative to more traditional methodologies.

Mr. Chairman, less than two weeks ago marked the tenth anniversary of the Agent Orange settlement. Though many have quarreled, and will continue to quarrel , about whether a settlement should have been reached at all, I believe we have accomplished some important tasks with the limited settlement resources at our disposal. But our efforts are time-limited, the settlement funds finite and not renewable. Ultimately the care our veterans and their families need, like the problems associated with Agent Orange, is the responsibility of government. I respectfully ask that you bear this in mind, as you hear from the service providers and their clients who follow.

Once again, thank you for inviting me to this hearing.

STATEMENT
of
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FLORIDA STATE UNIVERSITY--TALLAHASSEE, FLORIDA
before the
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS
COMMITTEE ON VETERANS AFFAIRS
UNITED STATES HOUSE OF REPRESENTATIVES

May 18, 1994

Mr. Chairman, I am honored to be invited by the Subcommittee to assist you in your critical work on behalf of Vietnam war veterans and other veterans to insure that they receive high quality, cost-effective social services. My name is Dr. Charles R. Figley. I am a professor at Florida State University. I am an elected Fellow in five professional associations including the American Psychological Association and the American Association for Marriage and Family Therapy. At FSU I direct a nationally recognized therapy center which includes a family therapy clinic and a stress reduction clinic, and a very special project, the Vietnam Veteran Families Project. The project has been funded in large part by the Agent Orange Class Assistance Program and by the National Veterans Foundation of Los Angeles. We have been active in developing a highly efficient antidote to PTSD.

I am here today, Mr. Chairman, to support Congressional efforts to make government more family-friendly. I hope to provide support for this effort by emphasizing the need for family-centered veteran services, especially medical and mental health services. My hope is that this Committee will be instrumental in insisting, as part of their oversight function, that such characteristics be part of any health and mental health services package, especially those that focus on the long-term needs of war veterans. For the bulk of my time I would like to identify five characteristics of family-centered services. First I would like to provide some rationale for adopting a family-centered approach.

Members of Congress and most Americans are members of families. All had parents, most have nurtured or are nurturing children. Our families are, most often, our lives; our most precious resource; the most sacred of treasures. When our children are happy, it makes us happy; when they are sad, we are sad. And our partner, our spouse, our friend--irrespective of our living arrangements--know us better than nearly anyone else, often knows us better than we know ourselves. Family members are precious. When they are ill it is extremely stressful for us.

Mr. Chairman, scholars like myself who study the family are impressed by its power to inspire, depress, protect, hide, influence, hurt, preoccupy, and obsess its members. The family is a system. As such, it functions well or not so well by virtue of those who are its members. With "good families" members can prosper; the opposite is true for "bad families." Unfortunately, mental health professionals mostly see the "bad families", or at least that is the way portrayed by many clients. Enough clients to convince psychotherapists that families do more harm than good. Yet, the great majority of households and families function well. More than 75% of Americans treasure their family and family life over all else. Most college students cite parents as the most consistent source of social support. We are born, we live, and we die in families and are better off for it, by and large.

As a traumatologist I know that when we are exposed to highly stressful situations, families play a vital role in the recovery process. As an intimate social support system, family members promote recovery in at least four separate and related ways: They are (1) detecting traumatic stress; (2) confronting the trauma; (3) urging the recapitulation of the catastrophe; and (4) facilitating resolution of the trauma-inducing conflicts. We are all, nearly always, trying to figure out and help other family members--even when they don't want it.

When a war veteran returns he (or she) is shaken up physically and mentally. This shaking is transmitted to the family in various ways. The recovery works in the same way, only in reverse. Family members are connected to each other. The family system is like a giant spider web, the connections linking family members vibrate with each shock to the system. The family is a very unique system. Think about your own family. Family members are connected to one another, at varying times and intensities in at least five ways emotionally, genetically, socially, economically, and physically. Thus shaking endured by the family affects all aspects of the family system. Research suggests that this systemic shaking, referred to by

scholars as secondary traumatic stress or compassion fatigue, a form of burnout, is frequently found among combatants traumatized in the line of duty in combat.

Mr. Chairman, as you know, the special study of the Vietnam war generation, mandated by Congress, illustrated this phenomenon. The study, conducted by the Research Triangle Institute of North Carolina, under the direction of Dr. Richard Kulka, has become one of the most important community mental health studies ever conducted.

Among other things, the research team found that **combat stress is "infectious."** The research team conducted interviews the spouses or partners living with the war veterans. Nearly everyone asked participated and answered all the questions. Among other things, the research team found that households with a war vet suffering from PTSD was significantly different from households with a war vet who was not suffering from PTSD.

Partners/Spouses with diagnosed with PTSD in contrast to those without, have the following characteristics: (1) Married More Often, (2) Fewer Years Married; (3) Higher Estimates of PTSD in Partner; (4) Higher Readjustment Problem Index Score; (5) Lower Life Functioning (6) Higher Marital Problems Index; (7) Higher Standard Family Violence Index ; (8) Alternate Family Violence Index; (9) Standard Family Violence Index for Partner/Spouse; (10) Alternate Family Violence Index for Partner/Spouse; (11) Higher Childhood Behavior Problems Index; (12) Higher Alternate Childhood Behavior Problems Index; (13) Lower Subjective Well-Being of the Partner/Spouse; (14) Higher PERI Demoralization Score of the S/P; and (15) Higher Incidence of S/P Felt Like Nervous Breakdown.

Those households with war vets with PTSD appear to be less happy and satisfied, to have more general distresses, including feelings as though they might have a nervous breakdown, have children with various behavioral problems, members who are more demoralized than households without PTSD. Also, they report more marital problems and more family violence than in families of those without PTSD.

Mr. Chairman, there is a human side to all of this. Examples abound where a war veteran has PTSD and, somehow, the family functions quite well.

Gail Davies, a colleague and friend, and her family is a good example. She served as a nurse in Vietnam between 1969-1970 in Quang Tri Province at the Medical Evacuation Hospital. She has noted recently that partly because of her Vietnam war experiences she treated her twin sons differently. Though they appear to not have suffered any from it, she notes the times within the family that the war played a negative part. She experienced periods during which she felt she behaved over-protective and fearful for them. At times she would withhold information, especially that information which related to her war experiences. Their high school years and their graduation from high school were also very stressful for the family. This she partly attributes to the parallels between their ages and the ages of the combat soldiers she cared for in Vietnam. The stress contributed to increased anger, distancing and arguing between all family members.

Gary May, long-time friend and veteran advocate is currently a fellow Social Work professor at another university (Southern Indiana University). He was one of the first to educate his fellow social workers to the plight of Vietnam veterans. He was a member of the faculty of the first national training conducted by the VA on the topic more than 15 years ago. Gary lost part of both legs in Vietnam. One day not long ago, after struggling for years to walk using his prosthetic legs, Gary made a decision. He decided that walking around in prosthetic legs takes too much energy. He saves energy these days by riding in a wheel chair. His family recognized the shift right away. Gary's children have seen him in many moods--the highs and lows--but they know what he did in the war and his life after it means something.

Michelle Mitchell is 24 from Tampa. She was five years old when her father, Michael, died in Vietnam near Tam Ky. Her mother claims she looks a lot like him. She said in an interview:

"When I turned eighteen, my mother gave me a hope chest filled with Dad's things. Every time we look into it, we both cry. There re letters Mom sent that he never received. One was postmarked on the day he died." (Santoli, A. "We Never Knew Our Fathers" Parade Magazine, May 27, 1990, page 21-22.)

A final example is a composite of numerous cases. **Doug Johnson** has two teenage girls and a younger son. He has been a contractor for three years and is doing very well with 5-8 employees. Doug was diagnosed with PTSD when he was 30, this was over 10 years after leaving Vietnam. His family knew about his problem long before that. His 12-year old son once found him huddling in a hallway closet looking frightened and confused. Although Doug regained consciousness quickly, his son was shocked by it. And this would not be an isolated incident over the years. Now with proper diagnosis, Doug is treated and fully recovered. His family is still recovering.

These families deserve programs that consider the circumstances and needs of all its members. In terms of medical care, for example, being family-centered means services performed first by a family physician. The family physician should know everybody in the family by name and disposition. Family-centered mental health means the same thing. The therapist looks for strengths and attempts to help the family identify and correct unwanted patterns or problems affecting everyone. Family stress increases in times of transition, such as the birth, death, or departure of a family member.

A family-centered approach adopts a systems perspective which is committed to improving the quality of human services. As a result practitioners are not only concerned about the client family's immediate environment, but also environments in which members work, play, are educated, and the community and nation within which they live.

Practitioners always attempt to increase the power and sense of control within the family by helping to realize and solve their own problems. Practitioners view their clients within a larger, community context and, with the family's permission collaborate with other professionals with some responsibility over the welfare of the family (e.g., physician, dentist, teachers). This also extends to sharing insights and important clinical methods and innovations with one's fellow professionals at conferences and through professional publications.

This family-centered paradigm can be applied to a program at the local or regional level, but it can also be applied at the national level. The only example of a national family-friendly or family-centered approach to the delivery of services is the AOCAP system. Because of the National Symposium schedule, many of those associated with the AOCAP system are here today. They will describe their own program and, collectively, provides a description of the architecture of this nation-wide system. Let me discuss a few of its characteristics that make it so important as a national model.

Veteran's services have traditionally been designed to meet the veteran's needs - the veteran has been the only recipient of the services. The families of these veterans, while being valued in our society, have been excluded as beneficiaries by these service providers. AOCAP recognized from the beginning the powerful role of the family in service delivery. They recognized the role of the family in the health of it's members is a concept which has emerged only within the past 40 years.

AOCAP's national program can serve as one model for a family-centered service delivery system. This grant-funded national network of independent programs was established to address the needs of Vietnam veteran families. In large measure, it's uniqueness lies in the fact that it was developed in response to needs of veterans rather than capitalizing on the capacities of the service delivery system. AOCAP has not been limited in it's responses by traditional bureaucratic structures, layers of hierarchical managers, standardized policies and procedures, and intimidation. It was not organized around the traditional central administrative office which mandated traditional methods of operation.

What AOCAP asked of the network of grantees was commitment to meeting the needs of veterans in their communities, in whatever way possible, drawing on their own professional and personal experiences within their communities. There was support for creating new, non-traditional programs, specialized programs, broad-based programs, and networking between programs. Administrative support for sharing information with other grantees has been demonstrated through the AOCAP national and regional conferences.

What has emerged from this novel approach of serving Vietnam veterans has been a national network of family and children focused programs. Just a glance at

the list of projects names from around the country reveals the family and child focus: Portland, Indiana's Community and Family Services; Green Bay, Wisconsin's Family Service Association of Brown Co.; Anaheim, California's Team of Advocates for Special Kids; Hawaii's Learning Disabilities Association; Tallahassee, Florida's Vietnam Veteran Families Project, and so many others.

AOCAP has been able to accomplish what traditional veteran service programs have been unable to. These individual projects have been designed in the communities where the veteran lives. The project's are staffed with individuals familiar with the community, with family values common in that community, with area resources, and how to access those resources for their clients. Additionally, they were linked to a national network of AOCAP providers which enabled these case managers to seek and find resources beyond their geographic boundaries. In a sense, AOCAP programs have been the link between resources in the community and beyond the community.

Some may question the wisdom of making government programs more *family friendly.* Adopting a family-centered approach to veteran services is (1) good social policy, (2) cost-effective, (3) humane, and (4) it helps pay our debt to war veterans.

* It is good health policy because the preponderance of evidence shows that treating the family as a system reduces costs, increases family morale, increases medical compliance, and increases the treatment effectiveness.

* It is cost-effective because families first go to a family-oriented health or mental health practitioner to insure that presenting problems can be remedied without a specialist or hospitalization. Much of family-centered care is preventive: good psychoeducation about parenting, sexual development, nutrition, exercise, and family communication. Research has confirmed the importance of this preventive approach in reducing health care utilization rates.

* It is humane because families suffer from war-related stressors too. They need the recognition of this.

* Perhaps as importantly as any other reason, it repays our Nation's debts.
Lincoln was not the first to remind the nation of these debts in his Second Inaugural Address on a chilly March 4 in 1865. In the body of this speech was a message. It urged the country to bind up the nation and take care of those who were our protectors in that great struggle. Because if we do not attend to those most hurt by our war, we will fight them again. It was one of the first and most powerful discussions of a veteran's family. In the middle of the address he stated,

"With malice toward none; with charity for all; with firmness in the right, as God gives us to see the right, let us strive on to finish the work we are in; to bind up the nation's wounds; to care for him who shall have borne the battle, and for his widow, and his orphan -- to do all which may achieve and cherish a just and lasting peace among ourselves, and with all nations."

Today I will suggest that we owe a debt. The debt is owed not just to those who bore the battle, but also to those who bore the battle of the battle: veterans families. These families who are left to grieve what the war has taken from them, like Michelle Mitchell and her mother. And even if veteran families are a healthy as Gary May's, they deserve services that take everyone into account.

In conclusion, Mr. Chairman, what is most important is our confirmation as a Nation that we collectively recognize:

that the wake of trauma is long-lasting and pervasive;

that war is a unique stressor but the effect is generally the same as other highly stressful events;

but that war is both highly stressful and profound;

and that war is frightening and long-lasting;

that one of the most affected is the war veteran family;

that adopting a family-centered approach to veteran services is cost effective, humane, and good public policy.

Therefore, any program for the veteran should focus on his family unit who are fellow war veterans, once removed.

Mr. Chairman, thank you for your attention and your invitation.

EXTRACTS FROM VET CENTERS' DIRECT SERVICE OPERATIONS MANUAL

Collectively these [social and psychological] services are designed to assist veterans resolve war-related psychological difficulties and attain a well adjusted post-war work and family life. Vet Center services include:

(1) Screening for PTSD (post-traumatic stress disorder) in all cases;

(2) Counseling and / or psychotherapy for PTSD when indicated;

(3) Employment and educational counseling;

(4) Job-finding assistance;

(5) Family counseling when needed for the readjustment of the veteran; and

(6) Multiple activities designed to broker services for veterans.

(Source: Vet Centers' DIRECT SERVICE OPERATIONS MANUAL, Page 3-1)

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c. Significant Others. Significant others are seen if necessary to provide adequate readjustment counseling services to the veteran.

(Source: Vet Centers' DIRECT SERVICE OPERATIONS MANUAL, Page 4-1)

Statement of

EILEEN PENCER

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Before the

Subcommittee on Oversight and Investigations
of the
House Veterans' Affairs Committee

May 18th, 1994

Chairman Evans and Members of the Sub-Committee, thank you for inviting me to testify before you today. I would like to give you an overview of a very effective family service model for the provision of treatment and other services to Vietnam Veterans and their loved ones that we have developed at Lower Eastside Service Center (LESC). It is considered by many in the New York veterans' community as an indispensable resource, and clearly, LESC's Vietnam Veterans Family Services Center (VVFSC) fills a formerly unmet need. LESC recognizes the value of helping veterans in the context of their families and, through Agent Orange Class Assistance funding, addresses their needs through the use of a geographically dispersed service delivery network.

I am currently Vice President, Chief Program Officer of LESC, a private, community-based, non-profit organization in New York City providing substance abuse, mental health, HIV and TB services. I am responsible for the supervision of all treatment programs. I joined LESC in 1990 and participated in the development of the VVFSC as Supervisor and Family Therapist. My educational background (post-graduate degrees in Special Education and Social Work) and experience in special education, marriage and family therapy were contributing factors to the development of a program with a family/child focus.

VVFSC, an Agent Orange Class Assistance Program grantee agency, was the first of its kind in the New York metropolitan area and at its inception was essentially the only family-centered Vietnam Veterans' resource in the metropolitan area. Currently, VVFSC has developed and implemented a collaborative, integrated service delivery model with the VA Veterans Outreach Centers, where we have established satellite clinics and where our family therapists provide services.

Our funding through the Agent Orange Class Assistance Program will be ending within the next two years, with the result that the families of veterans to whom we provide services may be deprived of such services permanently. It is imperative that funding be continued to enable community-based organizations such as ours to continue to provide family treatment for Vietnam veterans.

OVERVIEW OF LESC:

Throughout its thirty-five year history, LESC has remained loyal to its original mission of providing services for individuals and families with substance-abuse related problems such as addiction, mental illness, HIV and TB. Today, LESC is recognized as a pioneer in the field of substance abuse and is one of the largest non-hospital based substance abuse treatment centers in New York City.

Using a coordinated model of care, LESC provides comprehensive outpatient services through the VVFSC, as well as through its Mental Health Clinic, Methadone Treatment Program and HIV - Counseling, Testing, Referral, Partner Notification/Primary Care/Directly Observed Preventive Therapy Program. Residential services are provided through the Short Stay Methadone and Su Casa Methadone to Abstinence Programs.

LESC's ongoing determination to broaden its continuum of care to the community led counseling staff to recognize that Vietnam veterans presented a different profile and that their distinct needs required specialized services. In the process of networking and interfacing with a broad range of service providers, they became familiar with the veteran's specialized network of care and developed informal affiliations with veterans' service organizations. These same organizations would later support the establishment of the VVFSC.

GENESIS OF VVFSC:

Veterans' families are often significantly affected by the problems affecting veterans, including Post-Traumatic Stress Disorder (PTSD), secondary PTSD, substance abuse or other dysfunctional behaviors. United States District Court Judge Jack B. Weinstein, presiding judge in the settlement of the Agent Orange Class Action lawsuit, directed services to those associated with the veteran, primarily the children, spouses and parents. The Agent Orange Class Assistance Program was established in 1984 to distribute funds and services to programs throughout the United States, to reach out to these categories of the veteran population.

At the same time, LESC recognized in 1989 that Vietnam veterans and their families did not receive adequate services and decided to enter into a partnership with the Vietnam veterans community to provide such services. Through this partnership, the VVFSC was established in August 1990 to provide treatment for Vietnam veterans, their wives and significant others and most importantly, their children. From its inception, the VVFSC's goals have included veteran community collaboration, service coordination and family-centered, systems treatment.

Overview of VVFSC Services:

The VVFSC is a comprehensive family treatment and referral center based in lower Manhattan and is thus centrally located and easily accessible to all mass transportation systems. Program staff consist of three full-time certified clinical social workers, a part-time Administrative Assistant and a Security Guard. Taking into account the veteran's war experience as a major contributing factor to family dysfunction, VVFSC staff provide case management, counseling, referral assistance and advocacy services to Vietnam veterans' families. Counseling services include individual, couples and family therapy; group therapy for children, adolescents, adult children of Vietnam veterans and women; PTSD and secondary PTSD education/counseling. Special emphasis is placed on the secondary effects of PTSD in children, with referrals facilitated for those whose school performance, functioning and behavior may be indicative of psychological, developmental, and/or learning disabilities.

VVFSC utilizes a family-centered "systems" approach to treat the entire family constellation. Addressing members of the veteran's family as equal partners removes the veteran from the role of "identified patient" and source of pathology, and shifts the restorative responsibility onto the veteran's interpersonal network, the family. We firmly believe that the entire family's participation in the resolution and restorative process is critical; responsibility for effecting and maintaining change cannot rest with the veteran alone.

Our clients represent a broad cross-section of the New York metropolitan area veterans' population: the formerly homeless, those receiving public assistance, the working poor, the struggling middle-class. Primarily residing in the inner-city, with multiple levels of stress brought on by a prevalence of violence, crime and substance abuse, these families are 42% White, 36% African-American and 22% Hispanic.

In addition to the range of therapeutic services, children and their families are granted temporary reprieve from their daily stress to participate in family-oriented group experiences within this community-based environment. For example, each December, VVFSC staff hold a Christmas/Hanukkah party for children that begins with recreational activities, therapist-led carol singing and distribution of holiday stockings and gifts and ends with VVFSC's Security Guard acting as Santa Claus. The VVFSC represents a unique family resource with a distinctly human approach for this community.

VVFSC/VA VET CENTERS' COLLABORATIVE MODEL:

An overriding goal of the VVFSC has been that of integrating family services into the established resource network of veterans' community services. We have found that by establishing linkages with a broad range of veterans' service providers we are better able to coordinate case management services and facilitate effective service delivery. In keeping with this goal, VVFSC staff have successfully gained Vietnam veterans' community support by working on-site at VA Vet Centers, where VVFSC has established satellite clinics and where VVFSC family therapists are currently outposted. VVFSC family therapists function as an integral part of the VA Vet Center treatment team, share in case conferences, receive and make referrals and collaborate in shared cases. We also collaborate in accessing much-needed resources for our respective clients through a coordinated system of case management services. This partnership brings myriad benefits to our work with veterans and their families, including proximity to their home communities and services' networks and increased effectiveness in our advocacy on their behalf.

There is a direct benefit to veterans as well through our collaborative team model. Our program efforts often enhance veterans' self-esteem and functioning as responsible parents. For example, the psychiatrically-impaired veteran suffering from PTSD becomes compliant with his psychotropic medication out of concern for his family's safety; the substance abusing, homeless veteran, motivated by the prospect of reunification with his child, becomes drug-free and economically self-sufficient; the veteran newly-aware of the consequent effects of domestic violence on his family instead models positive, cooperative behavior and breaks the cycle of destructive behavior. An effective, coordinated team now provides the full range of treatment for veterans suffering from PTSD, and/or substance-abuse, reducing associated problems such as domestic violence and secondary PTSD.

For VVFSC and VA Vet Center staff, this partnership provides opportunities for collaborative learning, as well. For example, in 1991, we were invited to present on "Domestic Violence" at a VA Vet Center Clinical Conference; for three consecutive years, we have been invited to present at the veteran-sponsored Annual Conference of the "Still Hidden Client". Our participation is always well-received by a community that values our contributions and recognizes the importance of family services programs such as ours. The VVFSC is proud to have forged this collaborative vehicle, which is an innovative model of a productive relationship between a community-based organization and a federal agency.

Bridging the Gap in Veteran-Family Services Treatment:

The principal benefit of our partnership with the VA lies in the complementarity of services that bridge the gap in services to families, who, based upon VA eligibility requirements are otherwise ineligible for these services. Thus, while the VA Vet Center's focus is on the "veteran," with services developed in accordance with the veteran's needs; the VVFSC's focus is on the "family," with services tailored to meet client-family needs. The implications of this complementarity are far-reaching and a source of significant gain for families, who, were it not for the VVFSC, would be totally without services. The following outlines the VA Vet Centers' gap in services to veteran-families that the VVFSC has effectively bridged.

Currently, in VA Vet Centers, the veteran-family may receive services only as a direct adjunct to the veteran's treatment; family service eligibility is contingent upon the veteran being the primary client. Services may be provided for members of the immediate family - if such services are determined to be essential to the effective treatment and readjustment of the veteran. Consequently, the family is ineligible for services if the veteran is unwilling or unmotivated to seek treatment, or if the family lives apart from the veteran through separation, divorce or incarceration. The family may also become ineligible for continuation of services should the veteran withdraw

from treatment or should his/her marital situation change. Thus, the family will only remain eligible for service continuation if their participation is essential to the treatment of the veteran.

Veteran-family survivors are also ineligible for family services at the VA Vet Centers. For example, widows and children of veterans killed in action, prisoners of war, missing in action or whose deaths occurred following the war, are not entitled to grief therapy or grief-resolution. "Gold Star Mothers" who lost sons/daughters and paid the highest price for their country are also ineligible for services. Prior to the inception of the VVFSC, these categories of families requiring specialized veteran-related services were routinely referred for standard mental health services to traditional social service centers.

Without recourse to specialized family service programs such as the VVFSC, these families wounds will never heal. These in-need families would again be referred to traditional community mental health agencies lacking professionals specially-trained in second generation effects of PTSD, war trauma counseling and with limited knowledge of veterans' community resources.

OUR TARGET POPULATION: VETERANS' CHILDREN:

VVFSC's greatest contribution to the veterans' community is in its service to our target population - veterans' children. Our service menu is without parallel within either the traditional veterans' services system or the larger mental health community in addressing veterans' children's physical, emotional, behavioral and developmental needs. This includes facilitating referrals for diagnostic assessment, screening and specialized services. In accordance with our systems approach, we enter into collaborative relationships with all other systems involved in the child's care and develop an overall treatment plan that ensures service coordination and continuity of care. We believe that multi-faceted services, consisting of client-centered case-management and counseling are most effective in addressing these children's complex constellation of needs.

Since, approximately 85% of our children and adolescents have their initial therapy experience at the VVFSC, we exercise both skill and caring to engage the child's participation and cooperation in the treatment process. Thus, often for the first time, within either individual, family and/or group counseling, children and adolescents vent their feelings and explore longstanding, sensitive, family issues such as the veteran's PTSD, substance abuse or domestic violence.

The VVFSC provides a broad range of treatment options for children based upon their age, functioning, and their physical and emotional development. Approximately 20% of children receiving services are between the ages of three through eight. They freely communicate private, innermost thoughts using paint, collage or dollhouse play, while they engage in "play" therapy. Approximately 57% of children receiving services are between the ages of nine through nineteen and engage in behavioral or psychodynamic therapy. Many are referred due to acting out in school, brought on by stress from a dysfunctional home environment. VVFSC therapists work closely with school guidance counselors and teachers (e.g. PTSD education) to resolve ongoing behavioral and emotional problems. Whether treatment is behavioral or psychodynamic, the team effort between VVFSC therapists and school professionals is critical to accomplish treatment objectives.

Of the 173 children seen at the VVFSC since its inception, approximately 25% are learning disabled, (underachieving and hyperactive); 85% are emotionally disturbed (secondary effects of PTSD, substance abuse, domestic violence); approximately 20% are in special class and/or attend special schools. With the help of the VVFSC and its case management, treatment and referral services, these "special needs" children receive help regarding veteran-related issues, otherwise unavailable to them in their school or community.

CASE EXAMPLES:

In assessing and treating children at the VVFSC, we consider the multiple factors impacting upon them, especially their family relationships and home environment. We strengthen and empower the caretaking abilities of parents, and strive to improve relationships among family members as they struggle with the following issues.

Secondary Effects of PTSD:

~ Approximately 85% of the children we treat are suffering from the secondary effects of PTSD or "secondary traumatization" (suffering related to veteran's war experience) and are referred for treatment of this disorder. For example, a 12-year old whose over-identification with his veteran father exacerbated a severe cardiac problem, was referred by his cardiologist for treatment of secondary traumatization. The extent of the secondary effects became apparent, when in the course of a session, the fire alarm sounded, forcing all occupants to evacuate the building. Shortly afterwards, firemen arrived, determined it to be a false alarm and deemed the building safe for re-entry. While all other occupants returned, father and son did not. They stood, huddled together, in a highly agitated state near the fire-engines. This incident marked the beginning of treatment work in that father and son, for the first time, acknowledged the secondary transmission of PTSD.

~ Approximately 30% of VVFSC veterans have sought inpatient treatment for psychiatric disorders, PTSD and substance abuse. For example, one warm and committed father of 8 children, with a history of psychiatric medication non-compliance would, during these phases, gradually develop psychotic symptoms. In the course of one of these episodes, following his 18-year old daughter's reporting that she had been raped, he attempted to strangle her. In family sessions, his children were educated about their father's PTSD, specifically, about the risk of violent reactions brought on by flashbacks to the war, and provided assistance in identifying behavioral signs signaling relapse. With the cooperation of the veteran and his family, the VVFSC Family Therapist developed an exhaustive behavioral inventory checklist that demonstrated for them the subtle and more obvious signs of relapse. This checklist, posted on the refrigerator, provided family members with an assessment tool to determine if their father required immediate psychiatric intervention and, ultimately, provided the family with some sense of control.

Emotional Withdrawal:

~ One of the symptoms of PTSD, "emotional withdrawal," causes the veteran to distance himself from family members and avoid intimacy. Within family therapy, children who personalize the rejection and blame themselves are able to verbalize feelings and request clarification. For example, A., a 16-year old son of an emotionally withdrawn veteran reported in therapy having had an extremely distant relationship with his father and attributed his father's rejection to flaws in his appearance. With the help of the VVFSC therapist, A. summoned the courage to ask his father if his impressions were accurate and learned that his father's behavior was a function of his PTSD and longstanding difficulties tolerating intimacy ~ not his own inadequacies. This action dramatically increased A.'s self-esteem and was an impetus in his directly confronting relationship issues from that point on.

~ The VVFSC also provides group treatment for adolescents between the ages of 12 through 15 suffering from secondary traumatization. The focus of this group is upon the adolescents' unexpressed anger towards their emotionally withdrawn veteran fathers and their profound feelings of abandonment and loss. The following example will highlight the benefits of early intervention and its effectiveness in treating secondary traumatization: Following the departure of 15-year old group member, B., who elected to join an after-school tennis class rather than continue in group counseling, group members were encouraged to express through art (e.g. clay modeling, drawing, writing) their feelings about the loss. What followed was an outpouring of

emotion that corresponded to the deeply-felt feelings of rejection they experienced with their fathers. To begin, Adolescent C., drew the attention of the group when he masterfully shaped a clay model of B, with racket in hand, on a tennis court. At the suggestion of Adolescent D., C. shaped a clay model of B.'s opponent and, strategically, placed a clay machine gun aimed at Model A, in the opponent's hands. When the model of the opponent was completed, C., acting on this model's behalf, proceeded to violently smash, with his fist, Model B, until all that remained was a lump of clay. In a moving interchange, following the discussion, each member described the anger they felt towards B. in relation to the anger they felt towards their fathers. One by one, they also agreed that, similar to their fathers, they shared a fascination with machine guns. With each passing session, these adolescents articulated, more and more, the details of their shared experience and, with the support of the group, steadily worked towards their common goal of repairing their ruptured relationships with their veteran fathers.

Substance Abuse:

~ Approximately 80% of VVFSC's veterans have substance abuse problems, are in recovery or have died from substance-abuse related problems. For example, one veteran who became homeless and lost all contact with his family as a result of substance abuse began his rehabilitation at the Borden Avenue Veterans Shelter in New York City. He was referred to the VVFSC where, in weekly family meetings, we provided him the only opportunity to be with his 5-year old son. Week after week, in these supervised visits, they built the foundation of a relationship that would define the son's development from then on. This strong father-son bond was the catalyst in the veteran's eventual move to independent living, full time employment and regular unsupervised visits.

~ The VVFSC pre-schoolers' group for children, ages 4 through 6, focuses upon substance abuse and the effects this has had on family relationships. The group consists of a 4-year learning-disabled male, a 5-year old female with a suspected brain tumor, and two sisters, ages 4, and 6, whose mother was hospitalized with a substance-abuse related illness. These children all live in single-parent families; their veteran fathers have been absent for many years due to chronic substance-abuse. In a play session on the topic of family roles, the children were asked to select a preferred family role, in preparation for their favorite activity, "doll-house play." As the children settled into activity, it became clear that since all declined to play the father role, this role would be rotated. Doll-house play began with an animated physical fight between Father and Mother Doll, and ended with Father Doll lying, forgotten, on the kitchen floor and the children deliberating: "What to do with Daddy Doll"? The discussion that followed, demonstrated that the children's confusion in deciding upon "what to do with Daddy Doll" was based upon a lack of familiarity and positive experience with a father figure.

Domestic Violence:

~ Teenagers who witness repeated incidents of domestic violence often develop a skewed view of marital relationships in general and appropriate behavior between intimates in particular. Unless these teenagers learn differently, there is significant likelihood that they will model their parents' dysfunctional behavioral patterns. For example, following participation in family therapy at the VVFSC, a 19-year old female, who had grown up in a home with a high incidence of domestic violence (verbal and physical abuse) requested individual therapy services. In addition to working on increasing her self-esteem, she determined to break a pattern of negative programming which was affecting her relationship with her boyfriend. In therapy sessions with him, she discovered that she was modeling her father's behavior, that her boyfriend's behavior more closely resembled her mother's, and that their relationship was evolving into a modified version of her parents' relationship. This knowledge subsequently motivated her to alter her own behavior patterns and interrupt the destructive cycle of domestic violence.

CASE MANAGEMENT/SERVICE COORDINATION:

Central to our work with children is case management or service coordination to access-resources related to developmental disabilities, special health conditions, academic and emotional problems, including referrals to, and service coordination with, school-based educational psychologists or community-based service centers for diagnostic assessment, developmental screening and family support services. In addition, VVFSC staff have access to a national veterans' service network, the "National Information System" of the University of South Carolina, that provides on-going consultation services for disabled children of Vietnam veterans. Utilizing a client-centered "empowerment" model, we actively help and support these families' efforts to negotiate systems, model effective negotiation skills, and ensure that families and children receive their entitlements.

CASE EXAMPLES:

Learning Disabilities:

~ The Family Therapist meets with the family to assess family functioning, in addition to facilitating and following up a referral for their child's educational/psychological evaluation. These meetings provide relevant information about the impact of the child's disabilities upon the family in addition to providing information about the impact of the parental relationship upon the child. For example, Mr. and Mrs. F., (who share custody of their 12-year old learning disabled son) requested a referral for educational and psychological evaluations to determine whether their son continued to need special class placement. Recognizing that their conflicted relationship may be adversely affecting their son's school performance, they also agreed to attend short-term counseling to improve interpersonal communication. This intervention, focusing upon parent-parent and parent-child behavioral patterns, was a key factor in the subsequent improvement of their son's academic performance and resulted in his being mainstreamed into a regular class the following year.

Physical Disabilities/Emotional Disabilities:

~ It is not uncommon for a child with a physical disability to develop concurrent emotional difficulties. Such was the case, with H., a 12-year old with Tourette's Syndrome and attention deficit hyperactivity disorder, who according to all family members' reports was responsible for the chaotic home environment. While the presenting problem was that of locating a "special needs" residential school for him, it became clear that there were also many other case management needs requiring immediate attention. These included, but were not limited to, consultation with the special education class teacher, psychiatrist and neurologist as well as liaison work with a school placement social worker. In the final family session, before leaving for residential school, H. sincerely apologized for the pain and sorrow he had brought onto the family, which included having tortured and killed the family pet. This case management work, coupled with the behaviorally-focused family treatment, assisted greatly in normalizing family life.

School Case Management:

Children of Vietnam veterans often reflect their father's difficulties with large bureaucracies and find our large public schools insensitive to their needs. A particularly moving case was that of J., a sensitive 17-year old who sought treatment after he witnessed the drug-related murder of a neighborhood friend. In therapy, he described a childhood, punctuated by his alcoholic father's physical abuse and a history of academic difficulties, exacerbated by an inability to adjust to the large, impersonal school and indifferent personnel. J. worried that he, too, would be lost to drugs and violence and sought to actively prevent this. Realizing that this school could not meet J's academic and emotional needs, the Family Therapist and J., researched alternative public schools and succeeded in locating a small student-centered community school. The caring and concern of the staff so impressed the Family

Therapist that when another VVFSC client, a 15-year old female, was unjustly expelled from a parochial school, the Family Therapist accessed the same resource. These children flourished and thrived in the small, student-centered, school environment sensitive to their special needs.

RECOMMENDATIONS:

Based upon VVFSC experience over the nearly four years since Agent Orange Class Assistance Program began developing a functional model and speaking as an Administrator and Family Therapist who has witnessed first-hand the benefits and effectiveness of our service delivery model, I respectfully submit the following recommendations:

INTEGRATION OF FAMILY SERVICES:

It is important to recognize that integration of family-centered service delivery with overall veteran service delivery is key to providing comprehensive services. This critical goal can be achieved by formalizing and strengthening current affiliations, structurally integrating a family-centered focus into overall service delivery, and converting family-centered service delivery from short-term to long-term practice.

To provide family-centered services, programs must focus upon incorporating the needs of veterans in the context of their families and on accommodating the needs of families and family members where possible. The shift towards a balanced service delivery approach, with its consideration of veteran needs in the family context, would expand the treatment focus to include the family and elevate these services from auxiliary to primary status. Developing a partnership with the veterans' services network would enable family therapists to participate in service planning and program development and give a voice to those experienced in delivering comprehensive family/children's services. Thus, from the screening interview and development of the treatment plan through to delivery of treatment care, the needs of the veterans' family system (including the children) would be paramount, requisite and indisputably essential to the treatment and readjustment of the veteran.

We believe that the VVFSC's framework of service relationships represents a model of effective interfacing between a community-based organization, VA Vet centers and the veterans' services network and points to an important future direction in the social services field. Implementation of models such at this would maximize the results of effective cooperation, expand on the established framework of service relationships and best serve the special needs of this community.

Thank you once again for the opportunity to testify before your committee. I encourage you to consider the model we have established as a paradigm for the provision of services to veterans and their families. We respectfully submit that our experience has shown that such services can be an indispensable springboard to recovery and a safe haven for veterans and their families. As such, programs such as the VVFSC are simultaneously an investment in the futures of veterans and their families and an expression of appreciation by our society to those who have served to protect us.

STATEMENT OF

Thomas D. Schroeder
Executive Director, Rock Island County Council on Addictions (RICCA)
East Moline, Illinois

accompanied by:

Tony Gonzalez
Program Supervisor,
VIETNAM VETERANS AND FAMILIES ASSISTANCE PROGRAM
managed by RICCA

Before the
Subcommittee on Oversight and
Investigations of the House of the Veterans
Affairs Committee

May 18, 1994

Chairman Evans and Members of the Subcommittee, we feel privileged and grateful to be given this unique opportunity to present testimony concerning "Social Services for Vietnam Veterans and Families" and how our program is able to deliver those services to the veterans of Vietnam and their loved ones.

I'm Tom Schroeder, Executive Director of the Rock Island County Council on Addictions and with me is Tony Gonzalez, a two tour veteran of Vietnam and the Vietnam Veterans and Families Assistance Program Supervisor. Our testimony will address what our program accomplished, how we were able to provide services to the Agent Orange Class Members in our community, and the questions you have asked in the context of our program.

How did we get started and what have we accomplished?

The program started just as a vision. A vision that was made possible because of your support, Mr. Chairman, the support from RICCA, the Agent Orange Class Assistance Program (AOCAP), local Veteran Service Organizations, the Vietnam veterans - but most importantly, their children and family members.

The $150,000 grant our agency received from the AOCAP came as a blessing to our community. It came to our rescue at a time when resources in our community were scarce, agencies were closing because of lack of funding, and the ones that were still open were overcrowded or poorly operated.

The Vietnam Veterans and Families Assistance Program, serving five counties of Western Illinois and Eastern Iowa, opened in December 1992. During our first year, we established the goal of helping 150 Vietnam veterans and their family members. In actuality, by January 31, 1994, we served 234 veterans, 107 family members, and 65 children for a total of 406 visits of clients calling for our services. We found ourselves overwhelmed by the range of issues and problems these families face each day.

Motivated by the response of Vietnam veterans and families, and with the purpose of providing an outlay of relief for the many issues presented to us, keeping in mind that most of the problems are linked to the their service in support of the Vietnam War, we immediately implemented a client-centered problem resolution approach.

Our approach emphasizes crisis intervention, and starts providing assistance to best support Veterans and their family members by providing: Prompt identification of resources available within the community, help with the application process and accessibility to facilities; awareness and assistance in the applications for benefits from federal agencies and the Agent Orange Payment Program. Counseling is provided either in our facility or their residence, with emphasis on child-parent conflict resolution and how to improve communication with a Vietnam veteran parent suffering from Post Traumatic Stress Disorder.

Employment search assistance and guidance is provided, specifically concentrating on how to improve job seeking skills. In conjunction with employment counseling, assistance is given in locating suitable housing, in many cases even an overnight shelter for those that are homeless, or coordination of rent assistance through the various Veteran Assistance Commissions. Vietnam veterans or their family members needing immediate medical care for unattended illnesses are linked to health centers, along with continued coordination of other help for health problems, and for the full spectrum of diseases and disorders.

The program works to coordinate legal problems resolution, and guide veterans recently released from prison back into the community. For members in need of substance abuse intervention or treatment, linkage is made to RICCA's Alcoholism and Drug Dependence Counseling Center. Mental Health services are coordinated for individuals dealing with ongoing suicidal ideation and attempts.

Perhaps the most precious service provided to members is the advocacy in working through the sometimes disheartening paperwork and bureaucracy of the Department of Veterans Affairs (VA) and the Social Security Administration (SSA). Our strong advocacy with VA and SSA is extremely valuable in the coordination of services for our clients. We feel that if we leave it to the overcrowded agencies, the needs of our clients will not be met.

Except for VA, during the months of our program has been in place, we've found that even the agencies with good intake procedures neglect to address the issue of military service, let alone service in Vietnam. Not asking this pertinent information leads to mis-diagnosis of services needed, fails to consider alternative benefits available, and adds to an already troubled family.

Family Services

The families served by our program significantly differ from the issues and presenting needs of other families served by other agencies in that the ongoing trauma, stress, and physical and emotional wounds related to PTSD or their family members are rarely addressed or even discussed at medical or social services agencies where they have sought help. Consequently, the families are confused, angry, desperate and sometimes cynically hesitant to trust or believe in the ability of our program to provide assistance.

The lone exception to this systemic blowout that our families experience is the work of the local Moline, Illinois Veterans Center of the Department of Veterans Affairs. The Veterans Center is effective in addressing most of the needs of the Vietnam Era veteran through their services, but is limited by their hours of operation, caters mostly to veterans, and is handicapped in its ability to serve the family, especially as a wholistic unit.

Because of this weakness in the system, a strong linkage and relationship has been forged between the Vets Center and our program to meet the needs of the whole family. In collaboration, we work to share information, coordinate all members of the family are receiving, thus, cutting down or eliminating bureaucratic stonewalling.

We have come to believe, through our experiences, that the families, specially children, of Veterans of the Vietnam War need an empathetic harbor where they can relate their frustrations and pain, and enact a plan of assistance. Far too often, the families are tossed from one agency or program to another, perhaps receiving a fragment of assistance, but never feeling that their issues were addressed comprehensively and with dignity. Labels have been attached to their children, and multiple diagnosis rendered by professionals, without once the experiences of the Vietnam Veteran considered as a causal or contributing factor.

Our program is staffed by Veterans with service in Vietnam. We operate with a simple premise; "Walk through our doors and we will greet you and your family with kindness and empathy. Your issues will be treated with respect and seriousness. We will provide the assistance, or help you find it. We are here to serve at your convenience, not ours". If you need us to open at night or on weekends to accommodate your needs, we will. If coming to our facility causes hardship, we will come to your residence. Our brochure reminds our clients that our function is

"Helping Vietnam Veterans, especially families, cope with the aftermath of a conflict long gone by".

We need to understand that we serve a very unique group. This group served our country proudly, endured the hardship of an unpopular war, and came back to be ridiculed by the same citizens they served, supported, and fought for.

Prior to the formation of the Vietnam Veterans and Families Assistance Program, the families of Vietnam Veterans were serviced in multiple service settings on a "catch as catch can" basis with no consistency and services received in response to crisis.

Our program allows for Vietnam Veterans and their family members to enter the service system through one point, a triage assessment process that understands, case manages and plans based on the experiences and issues, physiologically and psychologically, of Vietnam Veterans and members of their families. The family is treated as a wholistic unit, with case management and planning coordinated around each family member with concern for the impact on the unit.

Our accomplishments are best illustrated by mentioning the following comments of appreciation from 3 of our clients:

" Your program saved me and my boy a lot of heartaches. It facilitated finding a source for adaptive equipment, help me process the paperwork, and stayed with us the whole way".
Disabled Vietnam veteran, single father, Rock Island, IL".

" Your case-management, personal touch, and excellent family counseling helped our family of three stay together".
Divorced mother of 2, Iowa.

" Your advocacy helped me tremendously when it came time to sort through numerous papers and forms needed to be identified and submitted to VA when my husband died".
Vietnam veteran's widow, Mercer County, IL

To provide some sort of recreational activity, our program, in coordination with Wilderness Inquiry from Minneapolis, Minnesota, the Easter Seals Foundation - Camp Sunnyside of Des Moines, Iowa, and Universal Family Connection of Chicago, put together a canoe/camping trip for children of all abilities and their parents at Camp Loudthunder Boy Scouts Reservation. This joint effort not only saved money, but also made it possible for us to set up a meaningful event that none of us would have been able to do alone. Although a little wet and wrinkled, all 21 campers loved the experience.

To help bring a smile to a few of our class members having problems making ends meet, in partnership with the Vietnam Veterans of America, Chapter 669, Moline, IL, we coordinated and delivered Christmas food baskets last December for six needy families. They were all very thankful that we cared enough to think of them.

Conclusion

As you can see Mr. Chairman, we have tried to be as innovative as possible, at the same time, operate a cost efficient and vitally needed service delivery program that is meeting the needs in the veteran community. It is going to be a tremendous loss when this program disappears in 1995. Subject to your questions, this concludes our testimony. Thank you for allowing us to share the story of our program with you.

TESTIMONY
of

RAYMOND SWOPE, LCSW, ACSW
Deputy Executive Director

Universal Family Connection, Inc.
Chicago, Illinois

Before the
Subcommittee on Oversight and Investigations
U.S. House of Representatives
Veterans Affairs Committee

May 18, 1994

Chairman Evans and members of the House Veterans Affairs Subcommittee, thank you for inviting me to present testimony here today on the topic of "Social Services For Vietnam Veterans and their Families: Current Programs and Future Directions".

My name is Raymond Swope. I am a combat Vietnam Veteran, and I am an accredited Licensed Clinical Social Worker presently on the staff of Universal Family Connection, Inc. (UFC), a not-for-profit community-based social service organization, serving the Chicago metropolitan area as well as the south suburbs. At UFC I hold the position of Deputy Executive Director, and believe me that in this position not one day goes by that I don't give thanks for my combat training and the skills that I acquired while serving in Vietnam. Because of our agency's magnificent partnership with the Agent Orange Class Assistance Program (AOCAP), I have had the privilege of building numerous essential networks with; 1. not-for-profit Vietnam Veterans community-based organizations (CBOs); 2. Vietnam Veterans and Developmental Disabilities Groups; 3. other veterans groups; 4. social service communities, as well as; 5. Veterans law centers, all of which through our links are able to provide the total and unique social services that Vietnam Veterans and their families need. As a Vietnam Veteran the experiences which I, UFC and many others have had with the Vietnam Veterans Community through the AOCAP Program are what I would like to speak about and share with you this morning.

Some selected issues, expected to be examined by the subcommittee and which are outlined in your hearing announcement, which I believe, through my experience with our project funded by AOCAP, represent significant areas of unmet needs among Vietnam Veterans and their families.

In the past three years UFC had the unique opportunity to provide comprehensive case management social services to a multifaceted group of Vietnam Veterans, their families and their children. Many veterans served were suffering from physical ailments associated with their exposure to the chemical defoliant Agent Orange. But they also suffered from mental and emotional disorders associated with their experience in Vietnam complex. Many had pre-existing diagnosis of Post Traumatic Stress Disorders. At the same time, their families suffered from similar problems associated with their experience with the veterans.

When the veteran was referred to us for family services, the veteran was disenfranchised from their family. They were either divorced or separated, or the boundaries that still existed were so fragile or traumatic that it was only hope that kept them together.

The children of the veteran seemed to suffer most. These young and little people present problems in mood disorder, behavioral disorders, physical limitations, and social intangibleness. They have been diagnosed with attention deficit disorders, hyper or hypo active disorders, learning disabilities, and children with special needs. Physically, they have been described as having soft bone tissue, underdeveloped bodies, or birth defects.

These children required and need ongoing intervention and assistance. Most coming from the mother and little if any from Veterans Associations.

In serving a client population with needs as diverse as those of the Agent Orange Plaintiff Class, it has always been apparent that Vietnam Veterans and their families have unique social service needs which are related to their military service and experiences. It is further apparent that in order for these unique human service needs to be met successfully, it is necessary for these services to be provided through partnerships with Comprehensive Community-Based Organizations which have historically had only minimal contact with Veterans at best. The goals of UFC's Vietnam Veteran's assistance program within the network is to ameliorate the severe problems encountered by the population as they attempt to readjust to civilian life. Our experience with veterans has taught us that many barriers confront the Vietnam War Veteran as he/she attempts to maintain a normal existence and family life. Naturally, the problems faced by the Veterans affect his family reunification and growth.

UFC has been very successful in meeting the veterans and their families unique social service needs by drawing on various therapeutic forms of treatment, such as psychodynamic, humanistic, family-centered case management, structural communication and behavioral therapy. Additionally, intensive case-coordination is utilized to insure that the Vietnam Veterans and their families needs are approached in a holistic manner, using an ecological perspective of servicing.

All of this leads me into another very important issue: Is the VA providing veterans and their families needed social services, and does the VA coordinate the delivery of social services to veterans and their families with other social service providers?

UFC has worked with veterans since 1984. Initially with veteran in the area of readjustment counseling. We found that few VA sponsored providers that delivered family centered counseling. We were told time again by the VA that we were the first to see them as a family unit. They have sought services from the VA on many fronts, but due to the lack of case coordination, nothing was done , and in most cases there was duplication of services. The VA Hospitals, the Vet Centers, and the local veterans organizations failed to tie together the family and social needs of the veteran.

When UFC provided readjustment counseling to the veterans family we were successful because we used the family case management approach. We have repeated this process with our Agent Orange service delivery program. We obtain records, documents, verifications, and statements from VA providers, the Social Security Administration, former employers and most importantly, from the veterans family. The fragmentation that currently exists with VA service providers makes them ineffective. A system must be designed to be flexible and progressive in its approach to service delivery. An effective delivery system should not be an impediment but rather a bridge that connects all service systems.

The following are a number of general Veteran public policy recommendations which, once again, are based on our experiences gained through the AOCAP network or program, but are not rooted in any specific legislative proposals.

The Department of Veterans Affairs should be re-configured to accommodate more comprehensive service strategies. Equally important, a concerted effort should be made to develop service relationships and even agency agreements with appropriate state, local

and community social service resources, both private and public, in order to more effectively address the needs of Veterans and their families.

Inclusion of Families in Service System
The Department of Veterans Affairs in particular, and especially in the aspects of counseling, rehabilitation and vocational guidance programs and employment services, should be charged with reorienting its program to consider the needs of the the Veterans in the context of his or her family, and to accommodate the needs of that family and family members where possible.

The Department of Veterans Affairs, as well as the Department of Labor Programs for Veterans should adopt strategies to maximize the interface and contract for services with appropriate community-based, not-for-profit social services agencies.

Intensive family-centered case-coordination/case management, should be utilized to insure that the Vietnam Veterans and their families needs will be approached in a holistic manner, using an ecological perspective of servicing.

Naturally, our service approach is based on preserving the family, stabilizing family conflicts which may break them up, and reunification of the family where possible.

The adoption of even parts of any of the preceding recommendations would necessitate the adoption of modern social service strategies and especially counseling models. Intensive training and some re-configuration of existing program would be imperative.

In closing veterans have told me over and over again how they wish they could give their family something else instead of heartaches. They want to leave something, a gift, a legacy, a positive remembrance. For many, this has been made possible through our case management family approach at the community level.

Thank you once again for the opportunity to present testimony before your committee.

TESTIMONY OF

THOMAS JAMES

MANAGING DIRECTOR

COMMUNITY OUTREACH TO VIETNAM ERA RETURNEES

(C.O.V.E.R.)

CHARLOTTESVILLE, VIRGINIA

BEFORE THE
HOUSE VETERANS AFFAIRS COMMITTEE
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS

MAY 18, 1994

GOOD MORNING CHAIRMAN EVANS AND MEMBERS OF THE SUBCOMMITTEE. MY NAME IS THOMAS JAMES. I AM A VIETNAM VETERAN AND THE CO-FOUNDER AND MANAGING DIRECTOR OF A PRIVATE, NON-PROFIT, COMMUNITY BASED COUNSELING AGENCY FOR VIETNAM VETERANS AND THEIR FAMILIES. I AM ALSO AN ATTORNEY PRACTICING IN CHARLOTTESVILLE, VIRGINIA.

MY AGENCY IS CALLED C.O.V.E.R., COMMUNITY OUTREACH TO VIETNAM ERA RETURNEES AND WE ARE BEGINNING OUR FIFTEENTH YEAR OF SERVICE TO VIETNAM VETERANS AND THEIR FAMILIES. WHAT BEGAN AS THE GRADUATE SCHOOL PRACTICUM OF MY WIFE, MARY COATES JAMES GREW TO A FULL-TIME VOLUNTEER EFFORT ON HER PART. SHE MAINTAINED THIS VOLUNTEER EFFORT FOR TWO YEARS. SHE WAS THE DRIVING FORCE IN CREATING THE SPIRIT AND MISSION OF OUR AGENCY. THE SPIRIT AND MISSION SHE INSTILLED HAS EVOLVED INTO AN AGENCY WHICH CURRENTLY HAS THREE OFFICES, THREE OUTREACH VEHICLES, A STAFF OF TWELVE SERVING THIRTY-SEVEN JURISDICTIONS IN CENTRAL, WESTERN, AND SOUTHWESTERN VIRGINIA AS WELL AS THE EASTERN MOUNTAINS OF WEST VIRGINIA.

I BELIEVE THE EXPERIENCE OF MY AGENCY AFFORDS ME THE QUALIFICATIONS TO SPEAK BEFORE THIS COMMITTEE ON THE TOPICS YOU HAVE OUTLINED FOR TODAY'S HEARING. MY HOPE IS TO TRANSLATE OUR FIFTEEN YEARS OF EXPERIENCE INTO INFORMATION YOU MAY FIND VALUABLE IN FUTURE POLICY DECISIONS.

OUR SERVICE REGION IS PRIMARILY RURAL. THE APPALACHIAN REGION OF VIRGINIA IS PART OF OUR CATCHMENT AREA. OUR CLIENTS ARE NOT WEALTHY, AND LIVE FROM PAY CHECK TO PAY CHECK. MANY HAVE AGRARIAN RELATED EMPLOYMENT WITH A FEW OWNING FARMS. THE FARMS ARE SMALL; FORTY TO FIFTY ACRES. MANY RAISE CATTLE OR DAIRY WITH SOME GROWING TOBACCO. MOST LIVE IN MOUNTAIN SETTINGS FAR FROM THE LARGER TOWNS IN OUR REGION. A PORTION OF OUR CLIENTS WORK IN FACTORIES OR SLAUGHTER HOUSES. OUR AREA IS KNOWN AS ONE OF THE POULTRY CAPITALS OF THE UNITED STATES AND CONSTRUCTION RELATED PROFESSIONS ENCOMPASS THE LARGEST SEGMENT OF EMPLOYMENT FOR OUR CLIENTS. MANY ARE SELF-EMPLOYED CONTRACTORS OR SUBCONTRACTORS, SKILLED LABOR AND ARTISANS. WE HAVE ALSO SEEN ATTORNEYS, BANK EXECUTIVES, CORPORATE EXECUTIVES AND AN OCCASIONAL MINISTER AS CLIENTS. MANY ARE EX-LAW ENFORCEMENT OFFICERS WHO CHOSE TO LEAVE THEIR RESPECTIVE DEPARTMENTS. ALL CLIENTS REGARDLESS OF THEIR PROFESSIONS SHARE ONE COMMON DENOMINATOR: CONCERN FOR THEIR FAMILIES.

I BELIEVE IT IS SAFE TO SAY THAT EIGHTY PERCENT OF OUR VETERAN CLIENTS ARE MARRIED AND HAVE CHILDREN. MANY ARE ON THEIR SECOND AND THIRD MARRIAGES WITH CHILDREN FROM EACH RELATIONSHIP. THESE FAMILIES HAVE FACED THEIR SHARE OF HARDSHIP; BE IT FINANCIAL, EMOTIONAL OR DEALING WITH MEDICAL CONDITIONS OF THEIR CHILDREN OR THE VETERAN. IT IS ALSO WORTH NOTING THAT A SIGNIFICANT PORTION OF THE VETERANS WHO ARE DIVORCED AND AS OF YET NOT REMARRIED HAVE CUSTODY OF THEIR CHILDREN. AS STATED EARLIER, MANY LIVE IN THE MOUNTAINS OF A RURAL COMMUNITY. WHEN I SAY RURAL, I DO NOT MEAN 'COUNTRY-SUBURBAN' RURAL AS IN COMMUNITIES WITHIN URBAN RINGS OF MAJOR CITIES. I AM SPEAKING OF AN EXISTENCE WHERE YOUR NEIGHBOR MAY BE ONE MILE AWAY. SOME VETERANS ARE THE ONLY RESIDENTS ON MOUNTAINS OR FOOTHILLS NEAR THE BLUERIDGE. THEY HEAT WITH WOOD STOVES AND MANY COOK WITH A WOOD STOVE. THEY KEEP ONE OR TWO PIGS FOR SLAUGHTER EACH YEAR AND THEY HUNT FOR MUCH OF THEIR FOOD. TV FOR MANY IS UNAVAILABLE AND IN SOME CASES AVOIDED. SUCH CLIENTS MAINTAIN A FULL-TIME JOB AND HAVE TO SPEND LONG HOURS AFTER WORK MAINTAINING THEIR HOMES AND PROPERTY. AGAIN, I WANT TO STRESS, SUCH WORK IS NOT LIKE MOWING LAWNS OR CUTTING SHRUBS; RATHER IT IS CHOPPING WOOD FOR THE STOVE, MENDING FENCE LINES, EARLY MORNING HUNTING OR FISHING, AND GENERAL REPAIRS ON THE HOUSE.

WE HAVE LEARNED MANY LESSONS OVER THE YEARS IN DEALING WITH THIS POPULATION. THE CARE OF VETERANS AND THEIR FAMILIES REST UPON THE FUNDAMENTAL FOUNDATIONS OF OBLIGATION AND

COMMITMENT. THE GOVERNMENT HAS THE OBLIGATION TO LEGISLATE AND INSURE CARE FOR THOSE WHO HAVE FOUGHT OUR WARS, AND THE ACTUAL CARE PROVIDER MUST HAVE THE COMMITMENT TO OFFER SERVICES UNDER DIFFICULT AND UNIQUE CONDITIONS. THE VETERAN POPULATION WE SERVE HAS NEEDS WHICH INCLUDE BOTH PSYCHOLOGICAL THERAPY TO HEAL THE EMOTIONAL WOUNDS OF COMBAT AND SOCIAL SERVICE ORIENTED CASE MANAGEMENT TO ADDRESS THE 'HERE AND NOW' LEGACY OF THOSE WOUNDS BOTH ON THE VETERAN AND THE FAMILY. THE DIFFICULTY IN MEETING THESE NEEDS STEM FROM THE UNIQUE CHARACTERISTICS AND QUALITIES OF THE VETERANS THEMSELVES.

THE VETERAN IS THE GATEKEEPER FOR SERVICES TO HIMSELF AND HIS FAMILY. AN AGENCY MUST HAVE THE UNDERSTANDING OF THE VETERAN'S PERCEPTION OF HIS COMMUNITY IN ORDER TO ACCESS THE FAMILY. THE VETERAN DOES NOT TRUST ORGANIZATIONS OR GOVERNMENT AGENCIES. HE OR SHE IS APPREHENSIVE ABOUT INTERACTING WITH ANYONE, LET ALONE A FORMALIZED AGENCY OR INSTITUTIONALIZED BUREAUCRACY. THE VETERAN WILL TEST THE SERVICE PROVIDER TO ASCERTAIN HOW THE AGENCY OPERATES. HE OR SHE WILL LOOK FOR AN ANSWER TO THE QUESTIONS OF: "HOW FAR WILL THESE PEOPLE GO AND HOW COMPETENT ARE THEY?", OR: "CAN I TRUST THESE PEOPLE WITH MYSELF AND MY FAMILY?". THE WORD 'TRUST' HAS A DEEPER AND MORE COMPREHENSIVE MEANING TO A VETERAN THAN TO A CIVILIAN. TRUST IS SYNONYMOUS WITH THE ABILITY TO SURVIVE.

THE DIFFICULTY IN ENGAGING WITH THE VETERAN CLIENT TAKES ON OTHER TRAITS. THE VETERAN HAS PROBLEMS MAKING SCHEDULED APPOINTMENTS. HE OR SHE,AS DESCRIBED EARLIER IS WORKING FULL-TIME AND BASICALLY WORKING A SECOND FULL-TIME JOB IN MAINTAINING HIS PROPERTY. HE LIVES AN ISOLATED LIFE-STYLE AND IN MOST CASES IS UNAWARE OF PROGRAMS AND BENEFITS. THE VETERAN LIVES IN GEOGRAPHICALLY ISOLATED AREAS AND HE LIVES THERE BY CHOICE AND NOT CHANCE. HE IS NOT ACCUSTOMED TO SHARING FEELINGS OR DISCUSSING EXPERIENCES WITH A STRANGER. HE IS SO INVOLVED WITH PROVIDING FOR HIS FAMILY AND DEALING WITH DAY TO DAY LIFE STRESSORS THAT HE DOES NOT EVEN CONSIDER EMOTIONAL ELEMENTS OF HIS LIFE OR HIS FAMILY. HE IS AMBIVALENT REGARDING SEEKING TREATMENT. IT IS A GREAT DEAL TO ASK A VETERAN TO GIVE UP THE TOOLS HE HAS DEVELOPED TO SURVIVE OVER THE YEARS AND TO ACCEPT A DIFFERENT AND POSSIBLY BETTER SYSTEM TO DEAL WITH HIS COMMUNITY, FAMILY AND SELF. HE LEARNED THE MEANING OF FEAR AND HELPLESSNESS WHILE IN COMBAT, AND HE HAS DEVELOPED HIS OWN MEANS OF CONTROLLING HIS ENVIRONMENT SO AS TO NEVER HAVE TO FACE SUCH FEAR AND HELPLESSNESS AGAIN.

THE VETERAN IN MANY CIRCUMSTANCES IS FINDING HIMSELF TOO OLD TO 'KEEP PUSHING THE WHEELBARROW AT WORK. HE SEES HIMSELF AS FACING A FUTURE WITH FEW JOB OPPORTUNITIES. THE VETERAN ADJUSTED HIS LIFESTYLE TO THE COMMUNITY HE FACED WHEN HE IMMEDIATELY RETURNED HOME FROM VIETNAM; A VERY INHOSPITABLE WELCOME HOME; A HOMECOMING WHICH OFFERED LITTLE VALIDATION FOR HIS SERVICE TO HIS COUNTRY OR TO THE PERSONAL COST ASSOCIATED WITH FIGHTING A WAR. HE HAS FOUND WAYS TO DISTANCE HIMSELF FROM HIS COMMUNITY. HE HAS LEARNED TO UTILIZE THESE METHODS EFFECTIVELY AND AS A CONSEQUENCE HAS THE ABILITY TO TURN OFF THE MAJORITY OF PEOPLE HE MAY COME IN CONTACT WITHIN A NON-SOCIAL SETTING. SIMPLY STATED, THE VETERAN IS NOT THE IDEAL CLIENT FOR A CONVENTIONAL, GENERAL MENTAL HEALTH SETTING OR FOR A FORMAL, INSTITUTIONALIZED, INFLEXIBLE, MEDICAL MODEL, BUREAUCRACY.

OUR EXPERIENCE HAS SHOWN THAT OTHER CONVENTIONAL MENTAL HEALTH AGENCIES SERVING THE GENERAL POPULATION CONSIDER VETERANS AS UNCOOPERATIVE AND UNWILLING TO ENGAGE IN THE COUNSELING PROCESS. THE AGENCIES HAVE DEVELOPED A RIGID INTAKE PROCESS AND IN MANY CASES HAVE EXTENDED WAITING LISTS FOR AN INITIAL MEETING. THEY HAVE ESTABLISHED A SYSTEM SUITED FOR THE SERVICE PROVIDER NEEDS AND NOT TO THE SPECIFIC NEEDS OF THE CLIENT. MANY VETERANS ARE TURNED OFF BY THE INTAKE PROCESS AND IN MANY CASES THE AGENCY WILL BE TURNED OFF BY THE VETERAN. VETERANS,OUR EXPERIENCE SHOWS, ONCE IN SUCH A SYSTEM FALL

THROUGH THE CRACKS, AND IN MANY CASES THE AGENCIES ARE NOT MOTIVATED TO SEARCH FOR DIFFICULT CLIENTS WHEN THEY HAVE AN ABUNDANCE OF A GENERAL POPULATION OF COMPLIANT CLIENTS. SOME PROVIDERS FROM SUCH AGENCIES HAVE ALSO VOICED THEIR FEAR OF VETERANS BASED ON WHAT THEY HAVE HEARD ON THE NEWS OR IN GENERAL DISCUSSIONS.

OUR AGENCY, AS MANY ACROSS THE NATION,UNDERSTANDS THE NECESSARY ISSUES TO ADDRESS WITH A VETERAN. THE PROBLEM IS THE EXTENT AND CONTINUITY OF PROGRAMS WE OFFER IS BASED ON FUNDING. OUR FUNDING IS PRIMARILY THROUGH GOVERNMENT CONTRACTS, GRANTS, AND DONATIONS. WE HAVE HELD CONTRACTS UNDER THE READJUSTMENT COUNSELING CONTRACT PROGRAM SINCE 1982. WE ALSO ARE REIMBURSED FOR BILLINGS UNDER THE VA'S FEE SERVICE PROGRAM. OUR AGENCY HAS RECEIVED YEARLY GRANTS FROM THE AGENT ORANGE CLASS ASSISTANCE PROGRAM SINCE 1989. WE HELD A CONTRACT FOR TWO YEARS WITH THE EMPLOYEE ASSISTANCE PROGRAM FOR A FEDERAL LAW ENFORCEMENT AGENCY. WE ALSO RECEIVE SMALL PRIVATE DONATIONS THROUGH SPECIAL EVENTS FUND RAISERS SUCH AS A YEARLY BASKETBALL GAME WITH AN AREA RADIO STATION, AND "RUN FOR COVER", A DISTANCE RUN WHERE THE WINNER RECEIVES A PAIR OF OLD COMBAT BOOTS.

OUR HISTORY HAS BEEN A SERIES OF PEAKS AND VALLEYS IN TERMS OF FUNDING, AN EXPERIENCE SHARED BY MOST COMMUNITY BASED AGENCIES. VETERANS DO NOT MAKE GOOD "POSTER BABIES" FOR FUND RAISING. IT IS DIFFICULT TO ACQUIRE DONATIONS AND ONE MUST BE CREATIVE IN SPONSORING FUND RAISERS. WE HAVE SURVIVED BUDGET CUTS AND CONTRACT RE-ORGANIZATIONS AS WELL AS CHANGES IN THE REIMBURSEMENT FORMULA UNDER THE V.A. CONTRACTS. WE HAVE FACED CUTS RANGING FROM 30% TO 60% IN MONIES AVAILABLE FOR PAYMENT OF SERVICES RENDERED TO VETERANS. WE HAVE BEEN ABLE TO ABSORB SUCH CUTS AND STILL MAINTAIN THE SAME LEVEL OF SERVICES TO VETERANS AND THEIR FAMILIES. OUR CLIENT LOAD, HOWEVER, HAS ENJOYED CONSISTENT GROWTH. WE HAVE SERVED THOUSANDS OF VETERANS AND THEIR FAMILIES AND CURRENTLY HAVE A CASE LOAD GREATER THAN EVER BEFORE. WE PROJECT THIS EXTENSIVE CASE LOAD TO CONTINUE TO INCREASE.

WE RECEIVED OUR FIRST CONTRACT FROM THE VA IN 1982. THE ELEMENTS OF THE CONTRACT HAVE BASICALLY REMAINED THE SAME OVER THE YEARS. THE CONTRACT ALLOWS US TO OFFER SERVICES TO A VETERAN FOR ONE YEAR FROM THE DATE HE OR SHE ENTERS OUR OFFICE. AT THE END OF A YEAR WE CAN REQUEST AN EXTENSION OF SERVICES BASED ON CLINICAL NEEDS FOR APPROVAL BY THE REGIONAL OFFICE OF THE CONTRACT/VET CENTER PROGRAM. THE CONTRACT REQUESTS THE UTILIZATION OF GROUP AS THE PRIMARILY MEANS OF SERVICE AS OPPOSED TO INDIVIDUAL SESSIONS. IF WE WISH TO HAVE A CLIENT IN BOTH GROUP AND INDIVIDUAL SERVICES, WE MUST MAKE A SPECIAL TREATMENT PLAN SUBJECT TO APPROVAL BY THE VET CENTER REGIONAL OFFICE. WE MUST ALSO HAVE CLIENTS SIGN A SHEET FOR EACH VISIT. THE SIGNATURE SHEET IS SENT TO THE VAMC'S BILLING OFFICE FOR PAYMENT. THE CONTRACT SPECIFICALLY BARS ANY ADVERTISEMENT AS OUTREACH IN THE COMMUNITY WE SERVE AND, MOST IMPORTANTLY, FOR PURPOSES OF THIS HEARING, LITTLE IF ANY FUNDING IS AVAILABLE FOR FAMILIES OF THE VETERAN UNDER THE VA CONTRACT.

THE V.A. FEE SERVICE PROGRAM, ANOTHER SOURCE OF FUNDING, REIMBURSES FOR SERVICES TO VETERANS WITH SERVICE CONNECTED DISABILITIES. THE VETERAN MUST LIVE OUTSIDE OF A SPECIFIED RADIUS FROM A V.A. MEDICAL CENTER. WE BILL AT A SET RATE FOR INDIVIDUAL AND A SEPARATE RATE FOR GROUP SESSIONS. THERE ARE NO FUNDS AVAILABLE THROUGH THIS PROGRAM FOR FAMILY SERVICES.

IN 1989 WE RECEIVED OUR FIRST GRANT FROM THE AGENT ORANGE CLASS ASSISTANCE PROGRAM. THE GRANT AFFORDED US THE ABILITY TO STRENGTHEN OUR ALREADY EXISTING FAMILY SERVICE COMPONENT. WE OFFERED OCCASIONAL SPOUSE SUPPORT GROUPS AND EDUCATIONAL WORKSHOPS FOR CHILDREN OF VETERANS. WE HAD A CLINICAL PSYCHOLOGIST WITH EXTENSIVE EXPERIENCE IN WORKING WITH CHILDREN WHO OFFERED INDIVIDUAL SERVICES TO CHILDREN OF OUR CLIENTS AT A DISCOUNT AND TO MANY ON A GRATIS BASIS. WE

FORMULATED A PROGRAM FOR FAMILIES BASED ON A 'SHOE STRING' BUDGET. WE BELIEVED THAT TREATING FAMILIES WAS AN INTEGRAL PART OF DEALING WITH THE VETERAN. NO MATTER WHAT PERSONAL ISSUES A CLIENT MUST DEAL WITH IN COUNSELING; HE OR SHE STILL EXISTED IN A FAMILY. THE FAMILY IS SEEN BY THE VETERAN AS HIS SQUAD; A SQUAD THAT HE IS RESPONSIBLE TO PROTECT. MANY VETERANS CAN BE SEEN AS OVER-PROTECTIVE OF THEIR CHILDREN. I HAD ONE VETERAN TELL ME HOW IT FELT TO TAKE HIS CHILD TO A PLAYGROUND. HE STATED "MOST PEOPLE SEE IT AS A PLACE FOR CHILDREN TO PLAY, I SEE IT AS A PLACE WHERE THEY CAN BE HURT FALLING OFF THE PLAYGROUND EQUIPMENT".

SINCE 1989, UNDER OUR AOCAP GRANT, OUR FAMILY PROGRAM'S SERVICE WAS EXPANDED. OUR CHILDRENS' SERVICES WAS ENHANCED TO OFFER MONTHLY CHILDREN'S PLAY GROUPS. STAFF TAKE CHILDREN OF VETS ON CAMPING TRIPS, BOWLING TRIPS, ICE SKATING, NATURE HIKES AND OTHER FORMS OF RECREATION. WE OFFER INFORMATIONAL GROUPS FOR CHILDREN OF VETERANS. A CREDENTIALED STAFF MEMBER AND A VETERAN STAFF MEMBER CO-LEAD A TWO HOUR SESSION DESCRIBING THE VIETNAM WAR AND THEIR FATHER AND MOTHER'S EXPERIENCES IN A GENERAL CONTEXT. THE PARENTS SPEND THE SAME TIME PERIOD WITH A STAFF MEMBER IN OUR RECEPTION AREA DISCUSSING GENERAL TOPICS OF THEIR CHOICE. WE OFFER SUPPORT GROUPS FOR TEENAGERS. WEEKLY SPOUSE GROUPS ARE OFFERED AT EACH OF OUR THREE OFFICES. INDIVIDUAL COUNSELING TO SPOUSES AND CHILDREN ARE PROVIDED, AND COUPLES COUNSELING IS OFFERED. NUMEROUS SPECIAL TOPIC WORKSHOPS FOR FAMILIES ARE SCHEDULED WHICH MAY INCLUDE A BANKER OR AN ACCOUNTANT OFFERING FINANCIAL MANAGEMENT AND DEBT MANAGEMENT ISSUES. COMMUNICATION SKILLS AND STRESS MANAGEMENT ARE EXAMPLES OF OTHER TOPICS PRESENTED. STAFF PROVIDES CASE MANAGEMENT SERVICES TO MEET THE SOCIAL SERVICE NEEDS OF THE ENTIRE FAMILY.

WE WERE ABLE TO PURCHASE THREE OUTREACH VEHICLES TO GO TO THE VETERAN'S HOME AND DEAL DIRECTLY WITH THE FAMILY. THESE VEHICLES RUN WEEKLY ROUTES THROUGHOUT OUR REGION. WE DRIVE FAMILY MEMBERS TO NEEDED MEDICAL APPOINTMENTS. WE DEVELOPED A FOOD BANK TO DELIVER FOOD TO FAMILIES DURING HARD TIMES. ON OCCASIONS STAFF MEMBERS HAVE ASSISTED CLIENTS IN REPAIRING AND MAINTAINING NECESSARY FARM EQUIPMENT. OUR CASE MANAGEMENT NEGOTIATES WITH HOSPITALS ON FORGIVING SIZEABLE MEDICAL BILLS FACED BY VETERAN FAMILIES WITH DISABLED CHILDREN. WE HAVE ASSISTED FAMILIES IN FINDING COMPUTERS AND OTHER NECESSARY EQUIPMENT FOR THEIR DISABLED CHILDREN. WE COORDINATE AND CASE MANAGE REFERRALS FOR CHILDREN TO CHILDREN REHAB HOSPITALS AT SPECIAL DISCOUNTED RATES. WE HAVE DEVELOPED A PROGRAM WHERE VETERANS AND THEIR FAMILIES CAN RECEIVE PHYSICALS BY AREA PHYSICIANS AT DISCOUNTED RATES.

WE NOW ARE A PART OF A NATIONAL NETWORK OF LOCAL, STATE-WIDE AND NATIONAL AGENCIES INTERESTED IN THE SPECIAL NEEDS OF VETERANS AND THEIR FAMILIES AND LEND SIGNIFICANT SUPPORT TO OUR CLIENTS. IMAGINE AN AGENCY HAVING THE CAPACITY TO CALL ANOTHER AGENCY IN GEORGIA TO ASSIST IN ACQUIRING A COMPUTER FOR A DISABLED CHILD AND SIMULTANEOUSLY CALLING A SEPARATE AGENCY IN CONNECTICUT TO ASSIST IN WORKING WITH HOSPITALS IN FORGIVING AND DECREASING MEDICAL BILLS. ON THE SAME DAY, HAVE THE ABILITY TO CALL A LEGAL CENTER ON BEHALF OF THE SAME CLIENT, IN WASHINGTON DC, TO ASSIST IN APPLYING FOR SOCIAL SECURITY BENEFITS FOR THE CHILD. AND, TO BE ABLE OFFER COUNSELING AND SUPPORT TO ALL MEMBERS OF THE FAMILY WHILE ACCOMPLISHING THE CASE MANAGEMENT GOALS. THIS SCENARIO IS BASED ON AN ACTUAL CASE AND IS ILLUSTRATIVE OF MANY OF THE CASES HANDLED BY OUR AGENCY. IT EXEMPLIFIES THE TOTALITY OF THE SERVICES WE CAN OFFER.

CASE MANAGEMENT IS A SUBSTANTIAL INGREDIENT IN THE HEALING PROCESS FOR THE VETERAN AND THE FAMILY. WE ARE ABLE TO BRING VALUED SUPPORT TO THE FAMILY AND SERVE AS A BRIDGE OR BUFFER FOR THE VETERAN IN DEALING WITH OUTSIDE AGENCIES. WE BECOME THE "POINT" OR THE GUIDE FOR THE FAMILY THROUGH THE PROCESS. WE SERVE AS A MEANS FOR THE VETERAN AND FAMILY TO VENTILATE ANY FRUSTRATIONS, AND WE ARE SEEN AS A SAFE PLACE TO BRING THEIR ANGER AND PAIN. WE ARE ALSO A BACKUP RESOURCE FOR THE TIMES

THEY ARE GIVEN THE RUN AROUND BY ANY OFFICE OR AGENCY. WE CHECK OUT THE APPROPRIATENESS AND COMPETENCY OF THE OTHER AGENCIES AND ARE ABLE TO GAGE THE POTENTIAL DIFFICULTIES AND PREPARE OUR CLIENT FOR THE PROCESS. WE CAN OFFER SUPPORT IN INSURING THAT SUCH AGENCIES ARE FULFILLING THEIR OBLIGATIONS. AS AN EXAMPLE, WE MET WITH A SCHOOL ADMINISTRATOR TO DISCUSS THE PROBLEMS A VETERAN'S CHILD WAS HAVING WITH A SPECIAL EDUCATION PROGRAM. IT SEEMED THE SCHOOL WAS NOT OFFERING THE DEGREE OF SERVICES MANDATED BY THE STATE AND FEDERAL GOVERNMENTS. OUR INTERVENTION LED TO THE SCHOOL EXPANDING THE SERVICES TO OUR CLIENT'S CHILD. THE VETERAN LATER STATED THAT WITHOUT SUCH INTERVENTION AND HELP HE COULD NOT HAVE ACHIEVED THE SAME RESULTS. WE OFFER SUPPORT AND ENCOURAGEMENT FOR THE FAMILY DURING THE PROCESS. WE MAKE THE COMMITMENT TO "WALK THE ROAD WITH THEM".

IT IS IMPORTANT TO NOTE THAT UP UNTIL 1989, THE ONLY MEANS FOR FUNDING FOR PRIVATE AGENCIES OFFERING COUNSELING TO VETERANS WAS THROUGH THE VA'S READJUSTMENT COUNSELING CONTRACT PROGRAM, I.E: VET CENTERS AND CONTRACTORS. THE PROGRAM WAS AND CONTINUES TO BE PRIMARILY FOCUSED ON THE VETERAN. THE CONTRACT IN THE EARLY STAGES OF ITS EVOLUTION, ALLOWED FOR REIMBURSED SERVICES TO A SPOUSE BASED ON A FORMULA OF ONE PAID VISIT FOR THE SPOUSE PER TEN VISITS BY THE VETERAN. ANY REIMBURSEMENT WAS AT THE DISCRETION OF THE VA'S REGIONAL OFFICE. I AM SURE THEY FACED LIMITED RESOURCES AND WERE FORCED TO MAKE DIFFICULT DECISIONS IN WHETHER OR NOT TO APPROVE PAYMENT. THE MAJORITY OF SERVICES TO A FAMILY BY A CONTRACTOR WAS ON A GRATIS BASIS. AS TIME PASSED THE VA ATTEMPTED TO ALLOW CONTRACTORS ON A SELECTIVE BASIS TO OFFER REIMBURSED SERVICES TO SPOUSES. THESE EXPERIMENTS WOULD LAST AT BEST FOR TWO TO THREE MONTHS. THE VETERAN ALSO HAD TO SIGN A RELEASE WHICH ALLOWED HIS/HER SPOUSE TO RECEIVE SERVICES UNDER THE CONTRACT. THE REASON FOR SUCH A RELEASE WAS THAT MONIES UNDER THE CONTRACT WAS EARMARKED ENTIRELY FOR THE VETERAN AND IN ORDER TO HAVE MONEY PAID FOR THE SPOUSE THE VETERAN HAD TO APPROVE THE REDISTRIBUTION OF FUNDS FOR THE SPOUSE.

IT IS WORTH NOTING THAT OVER THE YEARS THE CONTRACT HAS INCREASED ITS COVERAGE OF VETERANS FROM DIFFERENT ERAS. THE CONTRACT ONLY COVERED VIETNAM VETERANS IN 1982. IT NOW COVERS VETERANS FROM VIETNAM, LEBANON, GRENADA, PANAMA, AND DESERT STORM. THE COVERAGE FOR DESERT STORM OFFERS A MORE COMPREHENSIVE PACKAGE OF SERVICE THAN FOR VIETNAM VETERANS. THE CONTRACT ALLOWS FOR DIRECT SERVICES TO SPOUSES OF DESERT STORM VETERANS. WE BILL DIRECTLY FOR SERVICES TO SUCH SPOUSES. WE CANNOT, AT THIS TIME, BILL FOR VIETNAM VETERAN SPOUSES AT ALL.

THE VA CONTRACT PROGRAM TAKES INTO ACCOUNT THE DIFFICULT NATURE OF SERVING VETERANS. THE CONTRACT REQUIRES A VETERAN BE SEEN WITHIN FIVE DAYS OF HIS OR HER FIRST CONTACT. THEY REQUIRE A SYSTEM WITHIN THE CONTRACTOR'S AGENCY WHICH INSURES FOLLOW-UP AND MAKES IT DIFFICULT FOR A VETERAN TO FALL THROUGH THE CRACKS. THE CONTRACT SOLICITATION REQUIRES THE CONTRACTOR TO EXTENSIVELY ILLUSTRATE PAST HISTORY OF SERVICE TO VETS, NATURE OF SERVICE, AND A BREAKDOWN OF EXPERIENCE WITH VETS FOR EACH STAFF MEMBER. THE CONTRACT ALSO REQUIRES A SHOWING OF COMMITMENT TO SERVICE VETERANS AND THE ABILITY AND WILLINGNESS TO GO THE EXTRA STEP FOR A VETERAN. THE VA BACKS UP ITS DEMANDS ON CONTRACTORS THROUGH MANAGEMENT OF CONTRACTS BY TEAM LEADERS AT VET CENTERS. OUR EXPERIENCE HAS SHOWN THE TWO TEAM LEADERS WE CURRENTLY WORK WITH ARE HIGHLY COMPETENT AND DEDICATED. WE HAVE BEEN ABLE TO DISCUSS CLIENTS' NEEDS AND JOINTLY CREATE APPROPRIATE TREATMENT PLANS FOR THE VETERAN. THE RESULTS HAVE BEEN VERY EFFECTIVE.

THE VET CENTER PROGRAM'S STORE-FRONT, INFORMAL APPROACH IS VALUED BY THE VETERAN. THE VETERAN, ON THE OTHER HAND IS BOTH FEARFUL AND FRUSTRATED IN DEALING WITH THE VA'S MEDICAL CENTERS. THE INTAKE PROCESS CAN TAKE HOURS, AND MANY VETERANS HAVE DESCRIBED THE PROCESS AS CREATING MORE ANXIETY AND RAGE THAN THE PROBLEM WHICH BROUGHT THEM TO THE HOSPITAL IN THE

FIRST PLACE. MANY VETERANS LEAVE THESE FACILITIES BEFORE THE INTAKE PROCESS IN COMPLETED. WE HAVE FOUND THESE HOSPITALS TO NOT COMMUNICATE OR SHARE INFORMATION ON OUR CLIENTS WHEN WE HAVE REFERRED THEM TO THE HOSPITALS, AND IN SOME CASES THE HOSPITALS DO NOT EVEN COMMUNICATE WITH EACH OTHER IN TERMS OF MEDICATION MODIFICATION OR CHANGES. A VETERAN WILL BE ADMITTED TO ONE HOSPITAL AND SUBSEQUENTLY RELEASED AFTER IN-PATIENT TREATMENT. HE THEN RETURNS HOME AND IS GIVEN AN APPOINTMENT WITH ANOTHER HOSPITAL CLOSER TO HIS HOME. THAT HOSPITAL WILL CHANGE HIS MEDICATION WITHOUT INFORMING THE OTHER HOSPITAL OR WITHOUT INFORMING THE AGENCY PROVIDING OUT-PATIENT SERVICES. IT CAN TAKE MONTHS TO RECEIVE REQUESTED CLINICAL RECORDS FOR A CLIENT AFTER FILING THE APPROPRIATE RELEASES OF INFORMATION BY THE CLIENT. THESE VA MEDICAL CENTERS ARE SEEN BY THE VETERAN CLIENT AS UNWELCOME, COLD AND ISOLATED INSTITUTIONS, AND THESE FACILITIES DO NOT OFFER ANY SERVICES TO FAMILIES.

OUR FIFTEEN YEAR PASSAGE AND EVOLUTION HAS PLACED US IN A POSITION TO OFFER EXTENSIVE AND ENCOMPASSING SERVICES TO THE VETERAN AND FAMILY. WE OFFER SUCH SERVICES IN A REGION WITH LIMITED RESOURCES FOR THE VETERAN. OUR HISTORY IS AN EXAMPLE OF WHAT THE VA'S READJUSTMENT COUNSELING CONTRACT PROGRAM WAS ESTABLISHED TO ACCOMPLISH AS SET OUT IN LEGISLATION AND POLICY DECISIONS MANY YEARS AGO. IT HAS TAKEN PATIENCE AND COMMITMENT TO REACH THIS POINT. WE, AS ANY PRIVATE COMMUNITY BASED AGENCY, HAVE SURVIVED THROUGH BOTH GOOD AND BAD TIMES BY OUR ABILITY TO ACCOMPLISH OUR GOAL: SERVICE TO VETERANS AND THEIR FAMILIES. IF WE DO NOT DO OUR WORK WELL, THE VETERANS AND THEIR FAMILIES WILL GO ELSEWHERE OR NOWHERE AT ALL, AND WE WILL NOT SURVIVE. I BELIEVE THAT OUR FIFTEEN YEAR HISTORY IS A TESTIMONY TO THE QUALITY OF OUR WORK. MY FEAR IS THAT WHAT HAS BEEN CREATED WILL SOMEDAY DISAPPEAR BEFORE IT HAS COMPLETED THE MISSION.

THE EXTENSIVE SERVICES THAT AGENCIES LIKE COVER PROVIDES CANNOT CONTINUE ON GOOD INTENTIONS AND STAFF DEDICATION ALONE. WITHOUT A STABILIZATION OF FUNDING FOR THE VA'S CONTRACT PROGRAM AND A COMMITMENT TO FAMILY SERVICES, PROGRAMS LIKE OURS WILL DIE ON THE VINE, THE SERVICES WILL VANISH, AND VETERANS AND THEIR FAMILIES WILL HAVE THEIR HOPES DASHED ONCE AGAIN. AGENCIES LIKE OURS CAN AND WILL DIE A SLOW BUT CERTAIN DEATH THROUGH A SERIES OF CUTS HERE AND CUTS THERE UNTIL ALL THE GOOD WE HAVE CREATED WILL BE JUST SO MUCH HISTORY.

THAT CONCLUDES MY TESTIMONY, MR. CHAIRMAN. THANK YOU AGAIN FOR INVITING ME HERE TODAY. I WOULD BE HAPPY TO ADDRESS ANY QUESTIONS YOU MIGHT HAVE.

TESTIMONY OF

MILTON REAVES
VIETNAM VETERAN

BEFORE THE
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS
HOUSE VETERANS AFFAIRS COMMITTEE

MAY 18, 1994

GOOD MORNING CHAIRMAN EVANS AND MEMBERS OF THE COMMITTEE. THANK YOU FOR INVITING ME TO TESTIFY HERE TODAY.

MY NAME IS MILTON J. REAVES. I SERVED AS A LIGHT WEAPONS INFANTRYMAN IN VIETNAM. I WAS WOUNDED AND RECEIVE 10% SERVICE CONNECTED DISABILITY FOR THOSE WOUNDS. I AM 46 YEARS OLD AND HAVE BEEN TWICE DIVORCED. I HAVE THREE CHILDREN, AGES 9,10 AND 18. I AM ALSO HAVE SERVED TIME IN THE VIRGINIA STATE PENITENTIARY. MY LIFE HAD BEEN A HISTORY OF BRUSHES WITH THE LAW AND LIVING FAST AND EASY. I DRANK A LOT AND ALWAYS SEEMED TO BE IN A FIGHT. THE COPS KNEW WHO I WAS AND I STILL DID NOT KEEP A LOW PROFILE. UP UNTIL THE LAST FEW YEARS, I NEVER REALLY COMPLETED ANYTHING WELL OR FELT COMFORTABLE WITH WHERE I WAS GOING.

MY MILITARY SERVICE ENDED WITH A LESS THAN HONORABLE DISCHARGE. UPON MY RETURN FROM VIETNAM I TOOK AN ARMY TRUCK FOR A SPIN, BROKE RESTRICTION AND HAD PROBLEMS WITH CIVIL AND MILITARY AUTHORITIES. I AM PROUD OF ONE THING FROM THE MILITARY, MY COMBAT INFANTRY BADGE FOR SERVING IN COMBAT WITH THE NINTH INFANTRY DIVISION. I SERVED EIGHT MONTHS BEFORE BEING HIT. I ALSO SPENT YEARS DEALING WITH THE ARMY IN GETTING MY DISCHARGE UPGRADED.

I HAD HEARD OF COVER FOR A FEW YEARS. FRIENDS OF MINE HAD GONE THERE FOR SERVICES AND SAID I SHOULD ALSO TRY IT. I DIDN'T UNTIL LATE 1987 . I WAS FACING CHARGES AND DID NOT HAVE ANY PLACE TO TURN. MY CHILDREN LIVED WITH THEIR MOTHER AND I WAS NOT CLOSE TO MY PARENTS OR BROTHERS AND SISTERS. I FINALLY LISTENED TO KENNY, A VET FRIEND WHO HAD BEEN GOING TO COVER AND GAVE IT A SHOT. I DID NOT HAVE MUCH OF A CHANCE TO WORK WITH THE GROUP BECAUSE I WAS CONVICTED AND SENTENCED FOR A CHARGE. I WENT TO THE STATE PRISON IN STAUNTON. BUT, COVER WAS RUNNING GROUPS AT THE PRISON AND I WAS ABLE TO KEEP SEEING THEM WHILE IN CONFINEMENT. MY GIRLFRIEND WAS ALSO ABLE TO SEE A COUNSELOR AT COVER WHILE I WAS IN PRISON. I WAS RELEASED FROM PRISON IN MAY OF 1990. I THEN BEGAN TO PARTICIPATE IN COVER'S COMBAT GROUP WITH TOM AND INDIVIDUAL SERVICES WITH SWEP, A TWO-TOUR MARINE IN RECOVERY ON STAFF WITH COVER. I ALSO ATTENDED THEIR WEEKLY VET'S SUBSTANCE ABUSE GROUP.

COVER GAVE ME A SAFE PLACE TO COME. I COULD COME IF I HAD AN APPOINTMENT OR NOT. I COULD COME JUST TO SIT AND READ OR DRINK COFFEE. I HAD A PLACE TO GO TO WHEN THINGS FELT TIGHT. I FOUND DIFFERENT WAYS TO DEAL WITH HASSLES THAN I DID BEFORE. I COULD ALWAYS TALK TO THE FOLKS THERE ABOUT ANYTHING THAT MIGHT HAVE COME UP. THEY WORKED WITH ME IN HOW TO DEAL WITH MY CHILDREN AND HOW TO DEAL WITH MY EX-WIFE IN TERMS OF THE KIDS. THEY WORKED WITH ME ON NAM AND MY ANGER. WHILE AT WORK I WAS AWARDED EMPLOYEE OF THE QUARTER. I RODE A BIKE WHEREVER I WENT BECAUSE I HAD LOST MY DRIVERS LICENSE. I FELT I ALWAYS, NO MATTER WHAT, HAD A PLACE TO GO.

WHEN I GOT IN TROUBLE THE LAST TIME, COVER FOUND ME AN ATTORNEY IN CHARLOTTESVILLE. HE ALSO WAS A COMBAT VETERAN. I WAS FACING FIVE YEARS IN PRISON. THE ATTORNEY AND COVER WERE ABLE TO ARRANGE FOR GETTING MY TIME REDUCED TO TIME SERVED PLUS TWO AND A HALF MONTHS AND I WAS HOOKED UP WITH

COMMUNITY DIVERSION PROGRAM. THEY ALSO HOOKED ME UP WITH AN IN-PATIENT ALCOHOL TREATMENT PROGRAM FOR 28 DAYS. COVER SET UP MY AFTERCARE. IN 1993 I SUCCESSFULLY COMPLETED THE CDI PROGRAM, I PAID OFF ALL MY COURT FINES EARLY, WORKED FULL TIME, I CREATED A SMALL BUSINESS AND RECEIVED A SUB CONTRACT FROM THE CITY OF CHARLOTTESVILLE.

THEY ALSO HELPED MY CHILDREN TO UNDERSTAND ME AND MY PAST AND FOR ME TO UNDERSTAND THEM. MY CHILDREN ARE HAPPY AND EXCITED TO LEARN WHERE I HAVE COME FROM AND WHAT I DO NOW. THIS WAS BROUGHT ON BY THE COUNSELORS. MY ABILITY TO GAIN CONFIDENCE IN MYSELF AND TO MAKE CHANGE IN MY LIFE IN MANY WAYS WAS BASED ON SERVICES TO MY CHILDREN AND GIRLFRIEND. THEY LEARNED WHERE I WAS GOING AND WHAT I NEEDED TO DO AND I LEARNED WHAT THEY NEEDED AND HOW WE COULD ALL WORK TOGETHER. YOU CAN'T MAKE CHANGES IN YOUR LIFE UNLESS THE ONES CLOSE TO YOU ARE ON THE SAME PAGE. EVERYONE HAS NEEDS AND ONE CAN'T MAKE CHANGES WITHOUT THE OTHERS BEING INVOLVED.

COVER THROWS EVENTS FOR FAMILIES. THEY HAVE A CHRISTMAS PARTY EVERY YEAR WITH SANTA AND DINNER. MY KIDS HAVE A GREAT TIME AND GET TO MEET OTHER CHILDREN. THEY HAVE PICNICS AND OUTINGS FOR THE CHILDREN. MY SONS MET WITH A COUNSELOR ON A WEEKLY BASIS. THEY HAD A PLACE TO TALK ABOUT THEIR NEEDS. I HAD A PLACE TO COME AND UNDERSTAND THEIR NEEDS.

HANK CHILDRESS, MY ATTORNEY AND COVER HELPED WITH MY GETTING CUSTODY OF MY CHILDREN. THEY GUIDED ME THROUGH THE PROCESS AND WERE THERE WHEN I HAD PROBLEMS WITH THE SYSTEM. I HAD A BAD EXPERIENCE WITH AN INTAKE SERVICE WORKER AT JUVENILE AND DOMESTIC SERVICES. SHE WAS RUDE AND DISRESPECTFUL AND MADE STATEMENT ABOUT VETS IN GENERAL. WHEN I TOLD MARY JAMES AT COVER, SHE IMMEDIATELY WROTE A LETTER TO THE DIRECTOR AND FOLLOWED IT UP WITH A CALL. THE DIRECTOR EVENTUALLY APOLOGIZED AND THE WORKER WAS REMOVED FROM MY CASE. I FOUND OUT LATER THAT COVER WAS INVITED TO PRESENT A TRAINING PROGRAM TO THE JUVENILE AND DOMESTIC SERVICES' WORKERS. COVER BACKED ME UP WHEN I NEEDED HELP WITH SOMETHING I COULD NOT DEAL WITH ALONE. I NOW HAVE FULL CUSTODY OF MY TWO SONS.

HAD IT NOT BEEN FOR COVER, I SERIOUSLY BELIEVE MY ROAD WAS HEADED FOR DESTRUCTION. COVER TURNED MY LIFE AROUND. I MET A COUNSELOR WHO WALKED THE SAME PATH AND HAD THE ABILITY TO GET ME TO SEE THAT IT WAS NOT SO MUCH THE OUTSIDE WORLD THAT WAS THE PROBLEM. I ALSO HAD RESPONSIBILITY FOR MY ISSUES. I NEEDED TO FEEL I HAD POWER TO MAKE CHANGE.

I STILL STRUGGLE WITH SOCIETY'S BIAS AS A VIETNAM VET, AN AFRICAN AMERICAN MALE AND BEFORE COMING TO COVER MY RESPONSE TO THAT BIAS WAS RAGE, INDIFFERENCE, AND OUTRIGHT AGGRESSION. TODAY, I AM STAYING SOBER, BEING THE BEST FATHER I CAN BE, WORKING MY PROGRAM AND TAKING IT ONE DAY AT A TIME.

THANK YOU ONCE AGAIN FOR INVITING ME HERE TO TESTIFY ABOUT THE ISSUES OF VIETNAM VETERANS AND THE PROGRAMS THAT HELP THEM. I WOULD BE VERY HAPPY TO ANSWER ANY QUESTIONS YOU MIGHT HAVE.

Statement of

Michael McKelroy
Project Coordinator, Veterans Assistance Project
Team of Advocates for Special Kids (TASK)

Before
The Subcommittee on Oversight and Investigations
House Committee on Veterans Affairs

May 18th, 1994

Chairman Evans and Members of the Sub-Committee, Good Morning. Thank you for allowing me to present testimony here today on "Social Services for Vietnam Veterans and Their Families: Current Programs and Future Directions."

My Name is Michael McKelroy MSGT. USMC RET. I am a combat disabled Vietnam Veteran, with three tours in Nam, 66, 67, 68 and back to the world in 69. I'm presently employed by TASK - Team of Advocates for Special Kids, Anaheim, California, as the Vietnam Veterans Assistance Project Coordinator. TASK is an Agent Orange Class Assistance Program grantee.

TASK's main mission is to help parents access the education services and other support service systems for children with disabilities and provide support to families. In my testimony this morning I will address some selected issues that, based on my family's personal experience, represent significant needs and concerns among the Vietnam Veterans and their families.

Let me begin with my story: My wife, Anita, and I have 5 children. Our children are two daughters, Anna and Kathleen, and three sons, Mike Jr., Daniel, and Robert. We've always been a "military family." In 1985, I retired from the USMC after 23 years in the Corps. The family moved to Riverside, California.

At age 14 Mike Jr. began to have serious learning and discipline problems at Arizona Intermediate School in the Alvord School District. There were conferences with teachers and the principal. One teacher told Mike Jr. that he would never make it in school and he ought not to bother to attend. Mike had been suspended and received numerous on campus suspensions. Mike's mother was in constant communication with the school but it reached the point that Mike didn't want to go to school and had no self-esteem. We went to the school system and begged for help, and talked to the school principal, school counselor and teachers. The response to our cry for help was to be told that Mike was just lazy. They said that it appeared to the school professionals that it was obvious that mother and father were having marital problems and that was the reason that Mike was having the problems at school. The principal stated to the parents that all Mike needed was the hell beaten out of him and that would straighten him up and besides family problems were not the schools business. They never addressed his learning disabilities.

Mike dropped out of school at age 15 years and it wasn't long before he also became a part of the Juvenile Justice System for taking his mothers van for a joy ride. The judge ordered him to go to school, but he didn't. At age 17 he served 15 days in juvenile hall for failing to go to school. In the meantime his two sisters had finished high school and started their own life and Daniel had started having problems at school. With Daniel the systems solution was to put him on home study. He did complete Jr. High School and started High School but was expelled his first year. Daniel didn't finish high school. Later, both these boys were evaluated independently and were found to have learning disabilities. The parents worst fears were that these two boys would spend most if not all of their lives in the juvenile and adult justice system. By this time the pressure in the family had reached a boiling point. The family was about to break up. The school professionals' statements had become reality - there <u>were</u> marital problems between mom and dad. We blamed one another and felt that we were failures as parents. There was no one and nowhere for the family to turn. We didn't know about learning disabilities or Public Law 94-142 that

Congress passed that law that protects these children, and the system wasn't about to tell us about this law or inform us of our children's' rights to a Free Appropriate Education.

I didn't trust anyone that wasn't ex-military and had not done their time in the Nam, because, after all, if they had not been there, they were just hippies, druggers, and draft dodgers. I didn't believe that anyone could have PTSD. My drinking was starting to become a problem, stress on the family was tremendous, and there seemed to be no hope for this Vietnam veteran's family.

As I stated at the beginning of my testimony, this started in 1985, and now it's 1994. What has happened to this Vietnam veteran's family in these nine years? Mike Jr. is 21, married, the father of three children and finally has a job at $8.00 an hour. He doesn't have a high school education and still has some problems but he attempts to deal with them. Daniel is also married, has one child, and has started his own carpet cleaning business, working 10-12 hours a day 6 days a week. Anna has one son and Kathleen is attending college. As for Robert, he also has learning disability, but he is doing outstanding in school. Mom and Dad found help for themselves and their children, are proud grandparents, have a strong marriage and a family that stands by each other no matter what happens.

Three members of this family are here this morning; my wife, Anita, my youngest son, Robert, and me. How was it that my family was able to stay together and make things work, when other families in this day and time fall apart? The answer to this question is not complicated. It is because of the Agent Orange Class Assistance Program and TASK being a grantee that enabled my family to stay a family. When I found TASK, quite by accident, I was able to talk to another Vietnam Vet, who understood where I was coming from, and who also had a child with similar problems. For the first time, I realized that the children had a disability. We were referred to a very supportive counselor, we took TASK trainings and workshops, we made use of their referral system, and they helped me keep my son from being expelled and got him some assistance. Because of this program, my youngest son has the opportunity to be successful in school. But most important, my family, all of my family, sons, daughters, grandchildren, daughters-in-law, sons-in-law, are solidly united as a family should be. My wife and I are now employed by TASK, and Robbie spends many hours when school is "off track" in the office, picking up all kinds of information. He has called his own Individualized Educational Plan (IEP) meetings when he felt his educational program was inappropriate.

At this time, I would like to address the following issues that concern the items in your hearing invitation from the point of view of a vet and his family who have been there:

"Are some programs more successful in meeting the social service needs of veterans and their families? What types of programs are more successful? Why are they more successful?" The programs that address the total needs of the veterans and their families are more successful. The best example of this kind of program would be TASK and any program that works with the whole family or has effective liaisons with other programs. Often professionals start treatment of the veteran and assume that this will make the veteran whole again. They tend to look only at the war experience of the veteran. From personal experience I can say that the whole family must be treated to effect a cure or change in the veteran. It is only through programs that understand this that the treatment will work and the veteran and the family will be whole again.

These programs do best when they provide support for the veterans, their wives and children.

"Do veterans and their families have unique social service need? How are these unique needs related to military service and experience?" Veterans and their families are a unique group in themselves, especially the Vietnam Veterans, and their families. Problems often began when a veteran returned home, especially with a career military person. These folks may have spent years giving orders, but never acknowledged or even understood that he or she had a problem based on combat experience. Vietnam Vets struggle to deal with his or her own baggage from the war. With the additional stress of family problems, money problems, and adjustment are added, the vet feels that there is no one to talk to unless that other person has had the same combat experience. The vet knows that "if you haven't been there then you don't know what I'm about." Getting the vet to admit that he or she has PTSD and seek counseling for himself and the family is very difficult. Some times, just getting the vet to acknowledge that the war is over can be like climbing a mountain without shoes.

"Do social service providers generally understand these unique needs? What are the consequences of not recognizing these needs?"
Most social services providers have no idea what makes a Vietnam Veterans family unique unless they have been trained in this area or have been there themselves. From my own personnel experience I can state that if TASK, through the AOCAP,had not understood the unique needs of my family and been willing to work with me and my family I would have lost my family. The chances are that I would be one of the homeless veterans that you hear about. My sons would have been in the justice system and dependent upon the government for support. Most of the veterans' families with whom I deal daily have similar problem. The consequences of not recognizing and dealing with these needs results in children in the criminal justice system, welfare dependency, homelessness, broken marriages, suicide, and dependency on the mental health systems if the veteran can find his way through that system.

"Is there coordination among the providers of social services to veterans and their families? How do veterans and their families benefit from the networking of services and professional service-coordination?"
The AOCAP grantees network, collaborate, and utilize each other's expertise. This is especially true in California, where seven grantees are all networking and working towards one goal: making the vet and the family whole. As an example, the El Monte American GI Forum, which provides counseling and assessment, often requests that TASK attend IEP meetings as advocates for the family in addition to someone from the Forum providing family counseling. TASK and El Monte may refer vets to Southern California Veteran Service Council in Santa Monica for concrete services for the child, such as eye glasses and dental services. Vietnam Veterans of San Diego may provide assessments for children served by TASK and TASK may drive to San Diego to attend the IEP. I assist Vietnam Veterans of California - Santa Rosa Office and Sacramento Office with Standowns in Sacramento area and assistance with education issues. My family has attended three standowns. Grantees, such Swords to Plowshares in San Franciso call for technical assistance on educational issues. All of us in California work to coordinate our efforts to enhance the services provided the vet and the family. Some of our families are referred to AOCAP grantees across the nation because of their unique expertise.

Among other social service providers, this collaboration is not evident, nor is there an understanding of various services available to the veteran. We rarely receive a referral from the VA. Referrals we receive from other agencies, such as mental health, AFDC, department of developmental services, etc. are based purely on a need for assistance at the child's IEP. There is no recognition that one of the parents is a veteran, or that problems connected to combat may be influencing the child. There are cases when an agency knows the father is a veteran and they blame all of the child's difficulty or disability on the home life and wash their hand of any responsibility for the child.

"Does VA generally recognize military service-related unique social service needs of veterans and their families?"
The VA has failed and will continue to fail in their attempts to help the vet until they recognize the military-related unique social service needs of the veterans and their families. If my family and I had to depend on the VA for help that was needed to make my family whole, then I wouldn't have a family. The VA needs to realize that the Vietnam veterans' families are very unique and require services that address the needs of the whole family, not just the vet's needs. The AOCAP programs address the unique needs of the Vietnam veteran's family by bringing all of the AOCAP service programs together, sharing information resources and referrals to other AOCAP programs. When the VA realizes that this is the way to provide the services, then the VA programs will succeed and families will be saved.

"Is VA providing veterans and their families needed social services?" No. They provide treatment for substance abuse counseling and PTSD counseling for the veteran only, but do not even offer this service to family members, nor is there a referral service for families.

"Does VA coordinate the delivery of social services to veterans? Does VA coordinate the delivery of social services to veterans and their families with other social service providers?"
To my knowledge, vets do not leave VA with a list of social services agencies offering various help to them and their families. I have never received a single referral from the VA, and that's a shame. The different AOCAP programs throughout the United States could be the biggest asset the VA has to coordinate the delivery of needed services to the vet and the family. Saving time and money for the taxpayer, but more importantly, saving the vet and the vet's family.

I believe, based on working with these families for four years and on my own personal experience, that social service agencies and/or the VA cannot effect lasting results when treating the veteran unless they treat and provide services to the entire family. If they do not it is like doctor treating only the symptoms of a disease and not the cause.

Thank you very much for this opportunity to present to you this morning about issues that concern Vietnam veterans and their families. I would be happy to answer any questions you might have.

Statement of

Leslie Felton
Parent of a child receiving services from the
Vietnam Veterans Family Support Project (VVFSP)
Kennedy-Krieger Institute, Baltimore, Maryland

Accompanied by
Peter La Count, Project Coordinator, VVFSP
Kennedy-Krieger Institute

Before the
Subcommittee on Oversight and Investigations
House Veterans Affairs Committee

May 18, 1994

Peter La Count:

Good morning Mr. Chairman and committee members. My name is Peter La Count. I am the Project Coordinator for the Vietnam Veterans Family Support Project (VVFSP) at the Kennedy Krieger Institute in Baltimore, MD. Funded by the Agent Orange Class Assistance Program, VVFSP provides family-centered support services for families of Baltimore-area Vietnam Veterans who have children with disabilities. The services provided include:

* coordination of services
* home-based professional services
* financial assistance to help families purchase needed services
* educational workshops and support groups for parents

Leslie Felton is the head of a family that has been receiving services from VVFSP since July, 1991. Leslie has two children: Melissa, aged 10 and Devin, aged 9. Melissa has been diagnosed with Rolandic Epilepsy, sensory motor problems, and learning disabilities. The children's father, a Vietnam veteran, no longer lives in the home. The family has received educational services, family counseling, occupational therapy, and financial assistance services from VVFSP. Leslie and her family are an excellent example of how VVFSP has helped the family over barriers stemming from their unique needs as a family of a Vietnam Veteran. Without VVFSP, Leslie's family may very well have fallen through the cracks of the developmental disabilities and veterans assistance systems.

At this time, I would like to introduce the Committee to Leslie Felton who will talk about how these support services have benefitted her family.

Leslie Felton:

Good morning Mr. Chairman and Committee members. My name is Leslie Felton. I am the spouse of a Vietnam Veteran and mother of two children, one with a disability. The services that VVFSP provides to families has made a great difference in my life. As Mr. La Count stated before, over the three years that my family has been involved with the program, we have received a wide array of services. The services that we have received from VVFSP are as follows:

I. Family Therapy

Before receiving family therapy, we used to be the "Bickersons." The children and I did not know how to talk to one another. The kids and I had problems communicating because communication is not just two people talking back and forth. We did not really listen to the feelings, emotions, and outcries that we were all having. All of us were feeling a great deal of pain and did not know how to deal with it. The family therapy helped to evaluate the face value of every word, and every value behind the words. The therapy helped me to deal with some of my anger concerning their father, the kids' questions about their dad, and the divisions between me, him, and the children.

If this therapy had not been available, I do not know where I could have gone to get help. I suppose that we could have gone to an out patient clinic or I could have paid expensive co-payments; however, if we had done these things it could have really hurt us financially. Besides, having the therapist come to my home was such a great benefit. She was able to come to our home during a time that was convenient for us. If we had gone to a clinic, I might have had to take the kids out of school or go at some other inconvenient time to satisfy the clinic's schedule.

II. Occupational Therapy

It has helped me deal with seeing how my daughter Melissa was having difficulty. I thought that the difficulty that Melissa had in organization, hand writing, fear of riding a bike, and in throwing a ball was because she was not trying hard enough. The therapist taught Melissa and me that it was not that she did not want to do certain things, but that she needed help and guidance in doing them. Now she rides a bike and does not have as much difficulty with her handwriting. She is more organized with her school work and is a neater dresser. Melissa is also doing much better in school. Again, having the therapist come to my home made things a lot easier, also. I am a single parent trying to take care of my children and go to school. It would have been very stressful having to take a bus for an hour ride, with two children, to an office or a clinic for the occupational therapy. When the therapist can come to my home, I feel more relaxed, it saves me time, and the sessions were much more productive.

III. Educational Advocacy

Before Melissa received tutoring and help in school from VVFSP, she received "Unsatisfactory" grades in math from the first through the fourth grades. Now with resource help, she went from an "Unsatisfactory" to "Good"--a major, major accomplishment. Melissa and I and her schools had fought about math for years. Now that both Melissa and I are aware of her rights, the school system cannot push us around anymore. I am now able to attend school meetings and advocate for the services that I know my child has the legal right to receive.

The VVFSP educator gave me some ideas on how I could help Melissa at home. I bought a blackboard so that Melissa and I could do some of her math homework together. Having me help Melissa by our working together on her most difficult subject helped Melissa feel more relaxed and helped me to feel like I could take a more active part in her education.

IV. What types of programs are more successful when working with families of veterans?

Programs that help the family to assess their strengths and weaknesses or the family's needs and help you sort out what are the most significant issues, the greatest success when working with families of Vietnam Veterans. Staff persons who take into account what the family thinks is important in the helping process are more effective than those who treat families as if they are the same as all other families. From these lists of strengths and weaknesses, the staff people can help the family to develop a family program to fulfill those needs. Once this family plan is developed, everybody involved can adjust for the individual needs of the adults and children.

Also important are programs that view the family as a unit, but also recognize that there are distinct individuals in the family who have particular needs. The individuals may have problems like PTSD or substance abuse which are issues that can not be addressed only by working with the family. That individual must get help in realizing that he or she has a problem that is affecting the entire family. Effective programs when working with veterans recognize the needs of the family as a whole and the unique issues of the individuals in the family.

V. Why are programs like these more effective when working with families of veterans?

Programs that try to include all members of the family avoid a lot of confusion that might occur otherwise. Some programs that only work with the adults, or the children in the family, and leave out one or the other ending up making the omitted members of the family feeling left out. By including all members of the family in decisions regarding the family, everybody feels as though they are part of the unit. If

everybody feels as though they are important to the well being of the family, then there is a greater chance of everybody's needs being met.

VI. *Do* Veterans and their families have unique social service needs?

Yes. Many family problems of a Vietnam veteran come from drugs and abuse which are issues that the other family members can not fight. If the veteran has PTSD how do you fight that? If the veteran has problems with his or her own feelings of security because he doesn't trust anybody--how do you fight that? Even something so common place as the mailman knocking on the door and the veteran panicking over who is at the door adds a lot of stress to the family.

There are many issues with the families of Vietnam veterans that the family can not deal with on its own. The veteran needs to be convinced that he or she needs help, too.

The veteran, the spouse, and the kids tend to stick together no matter what kinds of horrors are going on in the family. This is not always a good thing. A non-veteran family with issues of abuse or drug addiction might split up in order to save the spouse or children from harm. In our family, I always ended up making excuses for my ex-husband's abusive behavior. I kept saying that this situation can not keep going on forever. Instead of removing myself from the situation, I stayed with him longer than was probably safe for us to do so. I think this same situation happens in a lot of families of Vietnam veterans. Even in this day and age where everybody is confessing about everything, the family of a Vietnam Veteran will not often talk about their family problems to others. If you don't talk about things, then the family problems can not get fixed.

I come from a military family. My father, all six brothers, and uncles are all in the military. It is only natural that I would meet and marry somebody with a military background. In observing the training that they have to go through, people in the military are taught to be sharp and ready in all situations.

My ex-husband's readiness made it difficult for us as a family. He was always ready to fight even though there was no longer a war. This "readiness" that he learned put him always on edge. As a family, we felt we had to prove to him that we were not the enemy. We all wanted to support him, but we could never prove it enough that we were on his side. If the veteran is never willing to trust, then you can never do enough to prove your love for him.

VII. How would our family's life be different if service from VVFSP had not been available?

I have asked myself this question over the many months. If there were no services available from VVFSP, things would be a thousand times worse. It is easy to condemn an abusive parent, but I could have easily have been one because I did not know how to deal with my kids. We all went through quite a strain after their father became ill and left home. I believe that if we had not had this program , the kids would have ended up living with another family member or I would have been completely unable to handle the situation at home. Furthermore, with help from VVFSP support services, I have since graduated from college with a bachelors degree in elementary education.

VIII. How had being a spouse of a Vietnam Veteran impacted upon my and my children's lives?

As a Vietnam Veteran who went through combat, my ex-husband was never at ease with anybody. He never trusted anyone. And after we had been together for a while, we became a possession to him. My ex-husband became abusive to us as a family. Not so much to the kids, but he was neglectful and to this day he is neglectful. My ex-husband was exposed to Agent Orange. He was in the area where it was sprayed and he was sprayed with it. He has cancer as a result of Agent Orange. My ex-husband is also an alcoholic and has a drug addiction problem. Furthermore, he is always in the attack mode. If we tried to wake him

up when he was asleep, he would try to attack us--just as if he were back in Vietnam. Ensuring our family's stability took more time than he was willing to give us. Soon it came to a point where we thought that our lives were in danger. He had become an abuser in several different ways. Being the spouse of a Vietnam Veteran has always been difficult. There are so many avenues for the veterans to get help, but for the veterans' family, there really are not a great deal of services available. I do not know of anywhere else that I could have gone to get the support that I have received through VVFSP. As far as I know these services are not available through any other organization. As a family it is very difficult to get services if the veteran is not willing to work with the family.

Our family was one of the fortunate ones. We were able to be linked up with the services that helped us to become a healthy, productive and loving family. We quite possibly could have been the exact opposite. Without this program, I don't know what I would have done. I have gained a lot of confidence in myself and my ability to raise my children. This program gave me the tools I needed to help my family over some very emotionally difficult obstacles.

Thank you once again for the opportunity to present testimony before your Committee. I hope you find this testimony useful. I would be very happy to answer any questions you might have.

Testimony of

Peggy St. Clair
Wife of a Vietnam veteran and
Service Coordinator for Project Access
University of Arkansas, University Affiliated Program
Little Rock, Arkansas

Before the
Subcommittee on Oversight and Investigations
House Veterans Affairs Committee

May 18, 1994

Chairman Evans and members of the House Veteran's Affairs Subcommittee, Thank you for the opportunity to address you today concerning the social services needs of Vietnam veterans and their families. My name is Peggy St. Clair and I am the wife of a Vietna vet. My husband, Lance St. Clair, served a tour of duty in Vietnam 1970. He also served elsewhere in Indochina. Upon his return to t United States, he married. His wife gave birth to a stillborn chil to a child with a disability. They divorced and we were married. gave birth to stillborn twins and two children with disabilities. family lives in Mountain Home, a small community of 9, 000 nestled in the mountain and lake region of extreme north central Arkansas. For the past year, I have been employed as a service coordinator fo a program funded by the Agent Orange Class Assistance Program (AOCAP) at the University of Arkansas University Affiliated Program

Today, I will address many of the points you listed in your hearing invitation within the contest of my overall testimony. I will rela the story of my family and the stories of several families with whom I work. I hope that this will illustrate the complexity of th social service needs we are experiencing over 20 years after the Vietnam war and the types of programs and services that are necessary to address these needs. I will also indicate some of the barriers that have been encountered by families from unresponsive service systems. The results of an informal survey of Vietnam vets in northern Arkansas will also be discussed to address an ever broader view of possible strategies to meet needs.

The birth of our daughter, Grace, in 1975 was the beginning of our journey through the maze of social services. Grace was born with spina bifida, a malformation in the spinal cord that resulted in lo body weakness. She has been diagnosed as having severe mental retardation and 11q-chromosome deletion which is so rare that she is one of only 14 of documented cases. She also has Bernard's syndrome, a platelet disorder that won't let the blood clot, and leukodystrophy. Leukodystrophy was the subject of a recent popular film, Lorenzo's Oil.

We were bewildered and overwhelmed by all of these problems. Medical expenses were astronomical. We did not have any idea where to go for help. When Grace was 8 months old, we were told by well meaning professionals to place her in an institution and go on with our lives. They were not sure if she would live. If she di beat the odds and survive, they could not predict the quality of he life. We chose to take her home not knowing what to expect. For two years we received no services in our rural county. When we moved 15 miles into another county, a public health nurse and a service coordinator from a regional developmental disabilities center were on our doorstep within 60 days asking what they could do to help. There were so many different problems I didn't even know what to ask for. It took several days for them to assist me i setting up a plan of therapy and doctors' appointments. They arranged for a physical therapist to come to our home to work with Grace. Hank, our service coordinator, accompanied me to appointments and coached me in how to get the information that I wanted and needed from the physicians and other service providers. The service coordinator, nurse, and therapist became our friends, showing a genuine concern for Grace and our family. As I gained th skills to be the advocate for our child, Hank slowly relinquished h

role to me. When new crises arose, Grace's introduction to public school for example, Hank was there. He attended the first 5 or 6 Individualized Educational Plan meetings with us, allowing me to take charge a little more with each one. Hank remains a very dear friend. These professionals helped us through a maze of agencies and services, provided us with good useful information, looked at a of our family needs - not just Grace's and helped us to become independent - not dependent. At this time, Grace has completed high school and lives in her own apartment with the help of a live-caregiver. She attends a day service center for training. During free time she is out in the community with her friends. Our young adult daughter loves coming home for brief visits and celebrations but prizes her new independent life-style. The social service support provided by our service coordinator 17 years ago allowed us to chose a future for Grace and our family much different than the one predicted when she was born.

With this history and the philosophy of family-friendly, community-based service coordination of the University of Arkansas Program, I have been able to successfully address the needs of the families of Vietnam vets that I work with in north central Arkansas. The veterans in this area are independent, proud, and generally distrustful of "systems". My status as the wife of a veteran has helped with the credibility. Since I have been employed by the University of Arkansas University Affiliated Program 12 months ago, I have received 57 referrals concerning Vietnam veterans who have children with disabilities. Most of the referrals have come direct from families as a result of our public awareness program and word-of-mouth from other families. These referrals have resulted in Individualized Family Service Plans for 25 families. Thirty-one families required information and referral to link them to appropriate social service organizations. A total of 44 families, including 33 vets, 20 children with disabilities, and 12 other fami members have benefited this year from our program in the 12 county area I serve. Our state-wide AOCAP-funded program has provided services to over 171 families since May, 1992. It is evid from the number of referrals received that families of Vietnam vets still have major needs that are exacerbated by the age of the children. As children of Vietnam vets become adolescents and young adults, services are less available, problems become more complex, and families often become overwhelmed and tired of pushing the system. Also many families have exorbitant back medical bills. week of hospitalization averages tens of thousands of dollars. The cost of multiple prescription drugs alone can bankrupt a family. A example is my daughter's leukodystrophy prescription, called Leucovorin. Leucovorin costs $1500 per month. Frankly, we don't have that kind of money at the end of each month. However, this treatment successfully halted bone marrow changes and has now been discontinued. When faced with the choice of their children's health or financial solvency, families feel they really have only o choice - their family.

Many of the referrals are the result of crisis situations that have developed because problems had not been addressed over the years. In November, the wife of a veteran who is 100% disabled contacted me. Her 13 and 9 year old children had threatened suicide. She had tried to get appointments at the local mental health facility to have the children evaluated. She was told that they could not be seen for three months. There was no heating fuel and all utilities were scheduled to be disconnected within the next

two weeks. I began to work on the problems. The next morning she called again. She had to take her daughter to the emergency room the previous night. Her 13 year old had taken an overdose of medication. The family was told again by the emergency room personnel that they would have to wait three months for help. I started making calls as soon as I completed my conversation with the mother. By that afternoon the children were evaluated at the local mental health facility and admitted to a hospital for treatme During the next few days I made arrangements with different private organizations and government social service agencies to provide funds to pay the utility bills, buy heating fuel, and gasol for the car so that the family could attend family counseling. I a worked with the local Department of Human Services to get them emergency Medicaid, and Social Security benefits for the children. Even though this family was over 100 miles away, we were able to get the help that they so desperately needed.

The family still has needs but the mother feels that our program helped keep her family together. The mother has learned how to access new services that are helping her family. But she is concerned that it took her so long to get the help she needed for h family. Her husband has been going to the VA for 10 years but ther has never been an effort to either address the family's needs for counseling nor the basic needs for decent living conditions.

The next family that I would like to tell you about involves a 17 y old young man who has a developmental delay. He has been in special education since the first grade. His family called to fin what their child's options were after he left high school this year They stated that they had not received any transition services from the school and in fact had been told that "the boy will only be goo for manual labor the rest of his life". The father is a disabled veteran who is currently trying to work a few hours a day to get back into the job force. They were discouraged, frustrated, and fe that they had no options. I referred this family to Rehabilitation Services and the young man will receive tutoring during the summer and be allowed to enter college in the fall under a special program for students with disabilities. The father will also be receiving assistance from Rehabilitation Services to locate the training he needs to work again. This family questions why they had not been prepared for their son's transition from public school into a train program. They now have the knowledge and skills to advocate for their 16 year old son who is also enrolled in Special education.

The last family that I would like to bring to your attention is ver similar to the previous one except that the family did not learn of their son's learning disability until after his graduation from hig school. Their son had never been in Special education, but they we told that he could not pass the college entrance exams because of mild retardation. The father could not believe that his son had be allowed to pass through school without being told there was a problem. Rehabilitation Services is working with this young man to diagnose his learning disability and assist him with further traini

As you can see, some of my work with families involves only a phone call or a packet of information. Others require hours of coordination of services between groups and agencies to provide for the needs of each family. I have collaborated with 75 groups, physicians, and private individuals during the past year. Orgoing

coordination and referrals will hopefully reduce the number of cris situations experienced by families.

Last year my husband and I traveled the 156 miles necessary to reach the VA hospital in Little Rock. Our trip took over three hou Lance had his Agent Orange physical to help determine if a dermatological condition and other health problems may be due to his exposure to herbicides in Vietnam. This exam also included a family history. We gave them detailed information on all of our children's disabilities and my husband's health problems. Not one referral was made for family services.

I thought this was an unusual practice and talked to other vets who stated that their families had never been asked if they needed services either. My concern led me to survey the families that I work with and 50 veterans from a local Vietnam veteran's organization to determine the role the VA should play in meeting th social service needs of families. The results concur with conclusi from my experience.

These suggestions are:

1. Better communication between the VA and the client. Communication should be between people. Even in such as vast system, clients need to feel that they are heard, and understood as individuals by individuals, that there is continuity of relationships (not a "take a number" approach) and that forms and documentation don't become more import ant than people.
2. Individualized care of the veteran. The plan of care for each veteran should reflect his/her needs and problems. Just as the lives of individuals are unique, so should be the approaches to intervening. Cookie cutter or assembly-line solutions are not accepted. Why spend time, money, and effort prescribing treatment that is unacceptable and will not be followed?
3. More accessible services. We have to travel 156 miles to Littl Rock to the VA. That may not sound far in freeway miles but the distance from Mountain Home to Little Rock is two-lane, mountainous road with numerous small communities along the way. Most of the citizens of our rural state face similar transportation problems. Just driving in the city is enough to intimidate clients even if they have access to a vehicle, gas money and can afford to miss work. The VA in Arkansas is in the process of setting up satellite clinics. Texarkana will have th first. Mountain Home is scheduled for the second. More of these are necessary for a vital VA system.
4. Family intervention by the VA. The mental and physical health the veteran's family should not be ignored by the VA. One of th most needed interventions is for counseling. Families, children, and spouses should be included in the treatment of the veteran. The physical health of the families must not be ignored. The veteran's health needs are addressed by the VA depending upon his "category". If the veteran is 100% disabled as the result o service related disability, CHAMPVA, may be requested for his dependents. Most veterans do not qualify for this service. Som resources can be located for children, but the spouses of the veterans are offered no supports or resources. CHAMPVA should be an option for all families.
5. Referrals for service coordination when a family has a child wi disabilities. As my personal story showed, service coordination an valuable service to families. Navigating the supersystems of

the VA, Medicaid, and SSI takes special knowledge, time, and patience that families in crisis do not have. Service coordinati can assure the families that they are receiving all the services, supplies and therapy to which they are entitled. Even if a fami has Medicaid for example, the family may not understand what all is covered under the program. Families rarely receive all t services and resources to which they are entitled or that they need to fully address their needs.

6. A directory of services available to the vet and his/her family

These suggestions fortify my convictions that services which are holistic, family-friendly, and community-based are what families need and want. They need to be able to have an agency that is willing to address all of the family needs concerning them. Most o these families had been involved in a band-aid approach by many of the agencies they have contacted. Few, if any agencies, prior to AOCAP really tried to look at the big picture.

Services also need to be available locally or have outreach components. For many families in northern Arkansas, distance is a major barrier to services. If services can be coordinated and networks established that link to support the veterans and their families, many of these problems can be addressed in a timely and effective way.

Thank you for your time and attention. I stand ready to answer any questions you may have about my testimony.

Testimony of
Bryan C. Smith, EdD
Center for Developmental Disabilities,
University of South Carolina School of Medicine

Before the
House Veterans' Affairs Subcommittee on Oversight and Investigations

May 18, 1994

Chairman Evans and members of the Subcommittee:

Thank you for inviting me to present testimony on the topic of "Social Services for Vietnam Veterans and Their Families."

I am the Director of the National Information System, a national information and referral project designed to connect families with children with disabilities who need services or information to the community resources that can provide them. The National Information System is part of the South Carolina University Affiliated Program and is currently funded by the Agent Orange Class Assistance Program. We began ten years ago as a federally funded demonstration project and since then we have concentrated our efforts on three separate populations. The latest, and possibly the most challenging has been families who believe they may have been affected by a veteran's exposure to Agent Orange during military service in Vietnam. At the outset, we thought that working with veteran families would be no different from working with other families having children with disabilities. The information and referral process and method would be the same; with the only difference being one or both parents were Vietnam veterans. It was quickly evident that the Vietnam experience placed strains on family structures that created situations that were decidedly unique. Little did we realize how multifaceted this population is and how complicated it would be to connect them with services.

Our primary objectives are to establish mechanisms by which effective communication and information sharing can occur; and to serve in a problem-solving capacity for veterans and their families. We focus on information related to childrens' disabilities and other health conditions and on the organizations that comprise the service delivery system. We provide assistance through a staff trained to understand and untangle the intricacies of the disability, health, and social service delivery systems. They help families identify and prioritize needs, explain the benefits and services available to them, and often give insight into issues related to a child's development. Most importantly, the staff helps the families understand how various agencies and processes work and how families can best navigate through various bureaucracies to access the services to which they are entitled. To make referrals, the staff uses a comprehensive database of over 115,000 services that includes Medicaid, Title V programs, special education programs, early intervention services, and private resources such as parent support groups, disability-related organizations, and pharmaceutical foundations.

Specific examples of the services we provide range from the somewhat simple task of referring a family to a disability-related support group to the more complicated mission of problem-solving and resolution. For example, we recently coordinated a full range of services for a veteran with an infant daughter who, hospitalized since birth, faced a 600 mile trip to another state to receive a liver transplant. In this case, we worked with the family

and Class Assistance Program grantees to coordinate air transportation for the child and family, investigated Medicaid reciprocity between the states, arranged housing, and enlisted various veteran and philanthropic organizations to provide financial support for expenses not covered through insurance, Medicaid, or other family resources.

The National Information System is a central part of the Class Assistance Program's network of service providers. Each member of this network is connected to all others by electronic mail, which facilitates transmission of casenotes, or family intake records, where we also list the referral resources we recommended to the families. The effectiveness of this network is sustained by the collaboration between our programs. An example of this level of cooperation is a national outreach initiative where we mailed personalized letters to approximately 75,000 members of the Agent Orange plaintiff class who had filed a claim on behalf of a child with a disability. The letter encouraged veterans and family members to contact us through our toll-free lines so that we could help them connect with appropriate services. We refer to Class Assistance Program grantees and transmit casenotes in situations where the grantee is able to provide some needed services, particularly service coordination.

Because of the role and position of the National Information System in relationship to other grantees and to families entering the network, we are able to provide descriptive data about the Vietnam veteran callers that point out significant, unique needs of this population. The data shows the most frequently needed assistance is for various types of support services (92.8%). From mid- 1989 to the present, the period captured in these statistics, there have been almost as many referrals (13,026) for support services as there have been clients (15,759). Not everyone needed this type of service, but some needed more than one of 28 different types of support services, including advocacy (13.8%). The next greatest service need was for financial assistance services (79.7%), followed by medical diagnosis and evaluation services (29.3%); and counseling, including psychiatric counseling (27.7%). Throughout the history of this activity, a dominant service need of veterans' families has been financial assistance services, primarily to help pay medical bills, including outstanding bills and pending ones. A service coordinator in the Chicago area recently summed up what he saw as the most frequent need of the families as "money... money to go to therapy, money to buy food, clothing, medicine, just basic things." Since grantees and other service providers have limited budgets and very few resources to help in this area, entitlement programs are a key source of assistance that veterans' families can access to help themselves. Although complex eligibility criteria often exist, families are assisted by grantees serving as effective advocates in overcoming this obstacle.

Those Vietnam veterans who made successful readjustments after the war and have families without complicated health problems are not likely to call the

National Information System. Generally, this type of service is tapped by families who have been unable to find satisfactory local resources to help them or when they perceive the problem to be beyond their ability to solve. For example, skin rashes and irregular immunological responses are commonly reported conditions that sound minor in comparison to many other acute or chronic diseases. But in this population, they are often very serious, even disabling, occurring in many family members and persisting for many years. Many veterans report their children have never been without the conditions and that they have been unable to find effective treatment.

The life situations that the callers have identified include a pattern of disability and chronic illness, social problems, and poverty that seem unparalleled in comparison to other families with whom we have had experience. The combination of various conditions, the service needs and the social milieu in which these families find themselves, is quite different from those who have used other information and referral services similar to the National Information System. The veterans' own disabling conditions place additional strains on family structures that are unique, and the family faces disadvantages in the form of isolation, economic deprivation, and the lack of access to adequate services. An equally notable characteristic of these families is the frequent presence of more than one child with multiple handicapping conditions.

Our staff has interviewed over 15,000 Vietnam veteran family members and have drawn some general observations on them. They reflect that most of these Vietnam veteran families:

- were already on multiple waiting lists to receive services from community service providers;
- had been denied help by an average of more than five agencies;
- had low income levels and limited financial resources;
- lived in urban inner cities or in remote rural areas; were not self-advocating;
- did not access some of the services to which they were entitled.

Our records also revealed that many Vietnam veteran families reported that they:

- were frustrated and angry;
- were divorced and remarried one or more times;
- had feelings of helplessness;
- felt themselves to be victims;
- felt their situations were hopeless;
- were disenfranchised and anti-institutional;
- were not members of a support network for their children.

A tally of the conditions and service needs does not begin to capture the toll that has been taken on families or the complexity of problems that are unique to Vietnam veteran families; problems that require special consideration in working with these families. There are three issues that I would like to discuss briefly that we, and our colleagues

throughout the network have seen as pervasive, interconnected problems for many of these families.

The Vietnam veteran or family member who calls us is often in a family constellation that is struggling with the debilitating consequences of primary and secondary PTSD, conditions that despite their destructive power, are still largely under-recognized and inadequately treated. Therapists in the network have described working with many children, most of whom are now approaching adulthood, who have grown up in an atmosphere where the Vietnam veteran parent's untreated PTSD demands that they "walk on eggshells" to maintain some measure of tranquility at home. Many of them have been exposed for years to substance abuse, angry outbursts, and sometimes, domestic violence. The effects of this are being manifested today in the children of Vietnam veterans as what has been characterized as secondary PTSD. In fact, it truly marks a second generation of individuals affected by a disorder that requires a level of awareness to diagnose and a commitment of time and resources to treat.

Compounding this issue is perhaps an even more common characteristic of the families that affects their ability to obtain services and presents implications for organizations that work with them. Many Vietnam veteran families, while needing a wide range of services, demonstrate a reluctance to initiate involvement with the organizations that could potentially assist them. They exhibit a particular distrust of and failure to pursue assistance from agencies that give even the slightest appearance of a governmental affiliation. Individual grantees, working in various parts of the country, were recently asked to provide their perspectives on several broad questions about the Vietnam veteran families that they have helped. There was an almost unanimous identification of the prerequisite need to establish a level of trust with the families they assisted before any progress could be made. For many families, the nature of the war, the age of the veterans during their service, readjustment issues, and negative attitudes toward Vietnam veterans appear to have compounded feelings of isolation and unsuccessful reassimilation into society for many families who are contacting us. These same issues are playing a role in how their families interact, or rather do not interact, with the service delivery system.

The reluctance of Vietnam veteran families to follow through with referrals to organizations that potentially could address some of their unmet needs was a phenomenon that we investigated on a small scale two years ago. It was perplexing to find that their lack of self-advocating behaviors is present even in situations where families appeared to be in desperate need of services and the usual obstacles, such as cost or availability of services were not issues. Quite simply, for a variety of reasons, the veteran family itself presents one of the largest single barriers to their accessing needed services. I sampled a variety of service providers to get their perspective on what they saw as possible barriers to families obtaining services. The reasons they gave as most important were: families are unable to pay for services (no insurance or Medicaid);

families do not think these services are necessary; and families have difficulties with transportation. From the providers' perspective, the "fault" is the veteran's, yet there are many barriers to these families.

In reality, these barriers may be present as a consequence of membership in a combination of subgroups, such as persons of minority or low socioeconomic status or people residing in geographic areas where accessible services are scarce. Many attributes that we have observed are also characteristics of a disadvantaged population. Health-related laws and policies in the U.S. have defined "disadvantaged" in various ways, but generally the category includes those who, by virtue of racial or ethnic heritage, economic status, or other factors, do not have access to the health care system. This definition would, in many cases, include the Vietnam veteran families that contact us. If the Vietnam veteran family was considered to be a disadvantaged family and not thought of as a veteran family, their lack of follow-through would not be considered to be so unusual.

While some obstacles facing these families are more problematic than others, many can be overcome. Noteworthy evidence of this has been seen in the fact that families were more likely to follow through with referrals when a local grantee was involved in a service coordinating capacity. It is a belief of the Class Assistance Program that Vietnam veterans and their families who are eligible for various programs and services can benefit greatly from quality case management and information and referral services to ensure equal access to services and benefits that are already available. This operational policy has amplified the effect of settlement funds, fostered development of clients' skills in using community programs and services, and represents a more holistic, integrated approach to serving people. Service coordination is based on a family-centered empowerment model in which services are oriented toward the family, rather than toward any individual, such as the veteran or child with a disability. Because Vietnam veteran families in need of services are characterized by a high incidence of family dysfunction, psychological problems and alienation, it is probably only marginally effective, at best, to offer single-faceted services such as counseling, rehabilitation or veterans benefits advocacy. The veterans' reluctance to self-advocate and their wide array of unique problems are the primary reasons why a specialized network of veteran family-focused services is needed, and service coordination to help the families connect with services, is critical.

The Class Assistance Program has funded projects that have been successful in making these connections by enhancing their abilities to interface with a broad range of service providers. Many grantees have been able to construct service configurations that are innovative, comprehensive and far more productive and effective than any strategies employed to date by other traditional veterans' services in their attempts to help many of the same clients. In most cases, the network of grantees is now employing a true "family systems approach" in the

provision of services to Vietnam veterans and their families. While the use of this service protocol is certainly new, and perhaps even radical, in its application to this population, its effectiveness has been clearly demonstrated.

Service coordination not only provides an avenue for more effective service delivery through integrated, family-focused approaches, it also facilitates leveraging goods and services on behalf of the Vietnam veteran families. We studied leveraging outcomes and its cost effectiveness to determine what impact, if any, these activities have made. The study was undertaken to be presented at the National Symposium this week. It has undergone and passed close scrutiny including several blind reviews to establish scientific credibility. I will make a copy of this study available to the committee, if you wish. Conducted at the end of 1993, data were collected from members of the plaintiff class who had entered the network through the National Information System. The results of the study showed an impact ratio of .036 between costs and monetary outcomes. A ratio of 1.00 means that cost and outcome are equal; while a ratio greater than 1.00 signals that the costs outweighed the outcomes. A ratio less than 1.00 suggests that outcome is greater than the monetary costs accrued. By taking the net benefits and dividing them by the net costs, a benefit cost ratio showed that for every Class Assistance Program dollar spent on services and equipment for this study group, there was a $27.58 return in outcomes, leveraged through either financial assistance or services received. This occurred although no grantee had operated with a specific mission of leveraging monies. The greatest proportion of these leveraged funds and services were for veteran's children; primarily from education and SSI.

Vietnam veterans and their families are a unique group of people with an assorted array of human service needs. The challenge they present for service providers lies in the fact that any family with such a diverse range of needs generally has difficulty obtaining help from the complex web of agencies and convoluted assortment of professionals that comprise the community-based service system. Veterans' families are frequently unable to navigate the service system successfully on their own.

Speaking as a professional with many years of experience in human services, I would like to take this opportunity to articulate some general policy recommendations that I see as critical to the futures of these families and to many others who face similar problems. These recommendations reflect many discussions with my colleagues at the University of South Carolina and with members of the Class Assistance Program network. We share a conviction that these issues must be addressed. We recommend the following:

1. If more comprehensive service strategies are to be realized, Veterans' services at a Federal level must be coordinated with other primary human service agencies such as the Department of Health and Human Services' Administration on Developmental Disabilities and Maternal and Child Health Bureau, as well as the Department of Education's Office of Special Education

and Rehabilitative Services and Office of Special Education Programs. Equally important, a concerted effort should be made to develop cooperative relationships, and even formal interagency agreements, between appropriate state, local and community human service resources, both private and public, to more effectively address the needs of veteran families.

2. The Department of Veterans Affairs should be charged with reorienting programs to address the needs of the veteran within the context of the family and to fit the needs of family members, where possible. Too many problems of the veteran impact the family, and too many problems of the family impact the veteran, for there to be two totally separate systems of care, i.e., the VA for the veteran and public or private providers for the other family members. The efficacy of approaching the family as the primary unit for service and the critical difference that can be made through the provision of service coordination was verified by our studies. We saw that when a veteran family needed help and received some form of service coordination from a grantee, the family was more likely to follow-through with recommended referrals than was a veteran family not helped by a local grantee. The situation is particularly critical when the person needing services is a child dependent upon other family members to take action to obtain those services. Failure to adequately address the multiple dimensions of the complex, unique needs of these families may well create diminished life chances and ultimately a negative, generational consequence.

In conclusion, I would like to point out the undeniable fact that the traditional service delivery system, which demands effective family functioning to successfully use its services, rarely meets the needs of many of the veterans' children and families with whom we have dealt. Instead, it pressures the families to adapt to the service delivery system. Neither more of the same, nor organizational restructuring of the system alone are strategies that can meet the veteran families' diverse needs. We have seen compelling evidence that family-focused approach and service integration offer a promising avenues worthy of careful and thorough exploration for the future.

Thank you once again for the opportunity to present testimony before this Subcommittee.

Statement of

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Before the
Subcommittee on Oversight and Investigations
of the
House Veterans Affairs Committee

May 18, 1994

Chairman Evans and Members of the Committee, thank you for inviting me to present testimony here today on the topic of "Social Services For Vietnam Veterans and their Families: Current Programs and Future Directions".

My name is Dr. Carl F. Calkins. I am a professor of Psychology and Director of the Institute for Human Development at the University of Missouri at Kansas City, a University Affiliated Program. I am also President of the American Association of University Affiliated Programs. One of our programs is funded by a grant from the Agent Orange Class Assistance Program (AOCAP) entitled, "The Missouri Vietnam Veterans Education and Resource System" (MOVVERS).

I appreciate the opportunity to speak with you today. The information that I am going to share with you describes some critical human service outcomes that the AOCAP has produced for Vietnam Veterans, their families and, in particular, their children who have disabilities. These outcomes suggest that a difference can be made at three levels; the systems level, where people receive and manage human services that are available; the family level, where lifestyles are significantly affected; and at the individual level, where choices are made and where quality of life is determined.

The first encounter that I had with AOCAP was in 1989. At that time, I was invited to assist in the formation of a partnership between the Health and Human Services-Administration on Developmental Disabilities, The American Association of University Affiliated Programs, and AOCAP. The essence of the partnership was the recognition that a number of Vietnam Veteran Families had children with disabilities and were having difficulty in accessing services.

Under federal law, the Administration on Developmental Disabilities (ADD) is mandated to provide leadership and support that will improve the quality of life for persons with developmental disabilities and their families. This is accomplished by establishing, in every state and territory, a planning council, a protection and advocacy council and a university affiliated program (UAP). These agencies are then directed to provide state-wide planning, an effective state-wide advocacy network, and a university linked state-wide demonstration, training, technical assistance, and information dissemination program, respectively. In terms of UAPs, there are 58 programs across the country that apply their expertise to improve services and systems of services. The UAP network is supported by a national office in Washington, D.C., the American Association of University Affiliated Programs (AAUAP).

There was a natural match between the goals of the AOCAP program and the disabilities network. These were, 1) services for families, 2) services for children with disabilities and 3) national support programs. Thus, the partnership forged a good match to assist in coordinating, identifying, or creating resources for families and children with disabilities. The result was a contract from AOCAP to AAUAP, to provide technical assistance at the national level and coordinate information dissemination efforts across the country. In addition, AOCAP contracted with 13 individual UAPs to demonstrate how case management or building the necessary linkages between veterans services, the developmental disability systems and other social services could take place. What has emerged is a framework for requisite systems change and necessary services for veterans, their families, and their children.

The results of these programs is quite informative to policy makers and those concerned with the management of more consumer beneficial and cost effective service programs. Over the next 2 days, a conference describing these outcomes and the full array of AOCAP

programs is being presented here in Washington. It is entitled, "The Legacy of Vietnam Veterans and their Families: Survivors of War-Catalysts for Change". My purpose in talking with you is to describe some of what we have learned from those programs within the UAPs. As I mentioned in my opening remarks, changes are taking place at the service systems levels (local and state), at the family level, and for individuals.

Since my UAP has an AOCAP-funded service program, let me first describe what we have learned from the Missouri Vietnam Veterans Education and Resource System (MOVVERS). For the last two years, we have been providing comprehensive family service coordination, information and educational services. We serve two very different types of clientele who hold little in common in terms of current lifestyle. One aspect of the population is rural, located in the south central part of Missouri known as the Ozark Mountain Area. The economy is poor and much of the population is undereducated. A number of the families have either lived in the area for generations or veteran fathers took their families and "went to the woods" as part of their reaction to the Vietnam war. The other group is urban and reside in the Kansas City metropolitan area. Some of these families are homeless and are a culturally diverse population.

While there is considerable diversity in lifestyles of these two groups, their perceived needs were consistent in regard to human services. They are: 1) the need for sensitivity and respect, 2) the need to be recognized as a family, in many cases, with multiple challenges, 3) the need for social support and community, 4) the need for information, and 5) the need for advocacy. Let me make a few brief comments about each of these needs and the necessary human service responses.

1) ***Sensitivity and Respect***

The predominant emotion that those veterans demonstrated was anger. They and their families perceived that the "system" had betrayed them both in their military life and in their civilian life. They often recited a litany of experiences with both Veterans' and health or social services agencies where claims were lost or mishandled, rejected, rough or insensitive treatment by organizations and, in some cases, by the community at large. Whether these are all real or true, we cannot prove, but it is significant that so many perceived and reported very similar sets of experiences. It also suggests the employees of provider systems must be well trained and follow the very best practices in their work with veterans and their families. As Dr. Jean Ann Summers states, "It implies total honesty and integrity making no promises one is unable to keep, following through without fail, and taking some immediate action that responds to a family's expressed or perceived needs rather than just a service provider's perception of family needs." It also implies personalized, individual attention-at systems level, small community-based programs people can trust.

2. ***Need to be recognized as a family, in many cases, with multiple challenges***

Many of the families we worked with were experiencing problems "all at once". The Veteran father may be unemployed and or have a partial disability for physical or emotional problems related to PTSD; the wife may be showing effects of "secondary" PTSD; and one or more of the children may have physical, emotional or learning related disabilities. What we have learned concerning these families is that one problem can be a barrier to solving others. For example, the father's difficulties with anger may impede his ability to advocate effectively for his children; the mother's emotional challenges may impede her ability to respond to her husband, and so on. Second, the total "stress pile up" effect is such that the family is living on the precipice of crisis at all times. For example, a relatively minor crisis such as a flat tire can lead --

because there are no alternatives and because the family "fuse" is so short – to a missed appointment with the school, to a denial of services because of the missed appointment, to a family argument about whose fault it was, to a crisis hotline call. The approach that works with these families is a single, responsive point of entry to services to put a package of services together. Many times these initial services are short term and informal rather than formal service system responses.

3. ***The need for social support and the community***
The perception that "others who have had a similar or related experience provide a great strength and support" was a constant reminder throughout any attempt to provide services. By and large Veterans' wives, sons, daughters or other family members responded well when peers were involved. This need has also been consistently expressed and responded to by families of children with disabilities in general. Some of the singular most effective programs we encountered were Sons and Daughters of Vietnam Veterans and Parent to Parent groups for families of children with disabilities. The implication for human services is often called consumer driven services. The point is, the more others of like background are involved in the design and delivery of those services, the more sensitive, appealing, and responsive those services will be. When their peers are involved, there is also the added confirmation that the veterans and their families are truly a part of the community at large.

4. ***The need for information and training. -***
There were continuing requests by families for information, whether it was about a disability, about a condition or at the most fundamental level (i.e., how does the system work?). Likewise, there was continuing anger that walking through the system hurdles was like walking through a mine field. One could be stopped completely at any given moment. It seems almost unbelievable in this day and age with information networks that there could be so much inconsistency in training and competency of the workers There is also a need for up-to-date knowledge and for coordinated efforts between veterans and human service systems/providers. There are many reports of very different responses to the same basic request. The implications of this need require that all agency personnel must be well trained and respond to requests for information quite diligently. Leadership of veterans and human service providers at the local and state level must understand and provide effective leadership with priorities and action to develop coordination between systems. MOVVERS staff in many cases had to supplement existing information to or figure out how a service system worked before a system could be accessed. Breakdowns often occurred where a service provider did not take the time to accurately pinpoint the exact nature of the information being requested. Agency techniques for taking calls, matching information to requests and follow up to requests were critical needs that, while often overlooked, could be corrected with training. In most cases, MOVVERS staff did this directly.

5. ***The need for advocacy***
In the simplest sense the need for advocacy was reflected by providing active help and guidance about the family's rights and procedures for accessing services. An example of a more complex situation, involved going to a meeting with school officials because a veteran was concerned about how he might react to a school official who was saying his child could not get physical therapy. The form of this advocacy took place with MOVVERS staff and with peers who had experienced similar problems. In many cases, the response of a service provider was markedly different with someone who had already been through "the mill", so to speak, present. The clear human service implication for advocacy,

speaks to the issue that for whatever reasons human services are not empowering and still over laden with bureaucratic or non-responsive procedures and personnel.

These are the five basic needs and responses to human services of what we have encountered with MOVVERS on behalf of Vietnam Veterans, their families, and children with disabilities. The overall conclusion that we make from our experience is that, through sound service coordination, the needs of Vietnam vets, their families and children can be effectively and efficiently met. The AOCAP projects across the country met similar challenges, results, and successes. The results have fine-tuned and coordinated diverse systems responses for a large number of families. Our problem is that we still do not have a capacity, a commitment, and a plan of action within these service systems to assume responsibility for sustaining the needed coordination and integration to provide the services AOCAP has found to be beneficial and effective for these vets and their families. The partnerships mentioned in the beginning of this testimony have become a forum for what is working. AOCAP was right on the mark in establishing families as a focal point for services. Service coordination facilitated these outcomes. The family is now considered by most human service programs as the focal point for effective, integrated services.

- The problem facing Vietnam vets/families/children before AOCAP was lack of access to services, lack of coordination between services, and lack of preparation of staff to deal with issues/needs and to collaborate with families.

- AOCAP has demonstrated that these deficiencies can be removed, families can be served;

- However, these changes were introduced/induced externally by AOCAP resources;

- Potential for Action - the systems coordination worked because of externally induced actions (service coordinators financed by AOCAP). AOCAP's resources will soon be depleted, therefore the stimulant or agent for the coordination will leave. Action is needed in the remaining days of AOCAP's support is how to orderly and effectively transition these learnings and service actions from external to internal resource commitments to the client and responsibility for service coordination between Veteran's Administration, Education and all other human service systems accountable to sustain the benefits (consumer and costs that has been demonstrated by AOCAP resources).

- There needs to be directives/mandates given to the federal agencies and from them to their state counterparts to mandate coordination and benefits to veterans and their families/children.

- Because of the effectiveness of these service strategies, UAPs will certainly carry on with the recognition of the unique needs of Vietnam veterans and their families, and to accommodate to those needs to the extent funding will permit.

- UAPs will continue to inform other human service agencies regarding the needs of Vietnam veterans and the effectiveness of the models and strategies employed by projects funded under the AOCAP umbrella.

In conclusion, I would like to point out one more pervasive need in Human Services and its implication for policy makers. That is, the need to move from a dependency model to an empowerment model. Much of the criteria for eligibility in Veterans services, Disability Related Services , and other social services seeks a deficit as its primary determinant. That deficit may be physical-mental or even functional in terms of working or

being a contributing member of the community. When the entire focus of related services provides only support targeted on defects, there is an overwhelming sense by the family that nothing positive can happen. When services are couched with empowerment, self-determination, and future oriented planning, another proactive sense takes over. This was most poignantly reflected by a Veteran dad who described a personal futures planning session for his child as the most positive thing that has happened ever in terms of services for his family. This technique seeks to find the child's and families' strengths and plan in regards to those outcomes. This process of building on strengths is not new. However, it is the essence of a wellness model. Many human services are moving in this direction. It requires that human services look to abilities rather than just disabilities. When this perspective is more fully embraced, human services as well as their recipients will be more responsive. The Agent Orange Class Assistance Program has brought the need for movement from a dependency model to an empowerment model both a reality and a necessary promise that should be kept in the future.

STATEMENT OF JOHN REISS, PH.D.

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BEFORE THE SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS
OF THE HOUSE VETERANS AFFAIRS COMMITTEE

MAY 18TH, 1994

INTRODUCTION

Chairman Evans and Members of the Committee, thank you for inviting me to present testimony here today on the topic of "Social Services for Vietnam Veterans and Their Families: Current Programs and Future Directions".

My name is John Reiss. I am the Associate Director of the Institute for Child Health Policy (ICHP) at the University of Florida, and have a faculty appointment as an Assistant Professor of Pediatrics in the University of Florida College of Medicine. I have also served on the faculty of the University's Department of Community Health and Family Medicine, Family Practice Residency Training Program. I hold a doctorate in Counseling Psychology.

My work with the Agent Orange Class Assistance Program has been carried out as part of a grant from the USPHS Maternal and Child Health Bureau (MCHB). This grant support's ICHP's National Center for Policy Coordination in Maternal and Child Health. The mission of this National Center is to:

- Provide an equitable forum for interaction between the Maternal and Child Health Bureau (MCHB) and other organizations regarding policy initiatives on behalf of children with special health care needs (CSHCN) and other children with special needs[1] by coordinating and capitalizing upon the critical mass of knowledge and skills which currently exist in diverse settings, including: local, state, and federal agencies; educational institutions; special projects; professional organizations; philanthropies; voluntary health organizations; and advocacy groups (the broader MCH community).

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1 CSHCN are individuals, age birth to 21, who have health problems that require more than routine and basic care. Children with other special needs are individuals, age birth to 21, who may not have chronic health problems, but have psychosocial, social, and learning problems that will affect their overall growth and development.

- Establish and implement a strategy to enhance timely interactive communication, including telecommunication efforts between MCHB and leaders and policy-makers concerned with CSHCN, for the purpose of disseminating new information relevant to CSHCN policy and programs in the public and private sectors at local/state/national levels; and
- Develop a technical assistance (TA) capacity and provide assistance to State CSHCN Programs in their efforts to initiate statewide public/private partnerships in a community-based, family-centered, culturally-competent system of primary and special health care services for all children.

More specifically, staff of the Center is to work in support of MCHB in fulfilling its roles and responsibilities[2] to:

- Assure the provision of comprehensive services needed for CSHCN who require targeted efforts.
- Assure that CSHCN and their families receive services in systems which promote healthy growth and development and which support integration into community life.
- Expand and enhance the capacity of public/private partnerships at the national, regional, state and local levels to collect, integrate, and use quantitative and qualitative analysis of MCH data to develop strategies, implement plans and evaluate program performance.
- Expand and enhance the capacity at the state, regional and local levels for high quality MCH service delivery.
- Expand links among federal/state/local public and private levels and sectors.
- Improve community-based maternal and child health, education and social systems to foster the development of coordinated, culturally-competent, comprehensive care.
- Assure that State CSHCN Programs have developed an infrastructure which fully integrates the services for CSHCN and their families, including primary care, into a comprehensive community-based system of services with particular emphasis on improving the capability and enhancing the capacity of state agency leadership for meeting the needs of such children and their families.
- Assure that State CSHCN Programs provide rehabilitation services for blind and disabled children under age 16 who receive Supplemental Security Income (SSI) under Title XVI of the Social Security Act to the extent medical assistance for such services is not provided under Title XIX (Medicaid).
- Meet Year 2000 Health Objective 17.20, to build family-centered, community-based, coordinated systems, comprehensive, culturally competent systems of services in all 50 states by the year 2000.

In 1990, MCHB asked the Institute's National Center to coordinate and support the Supplemental Security Income (SSI)/Children with Special Health Care Needs (CSHCN) Work Group. This work group coordinates the activities of federal and state programs and advocacy groups that serve SSI beneficiaries and applicants (blind and disabled children). During the last four years, the work group has designed and

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2 These roles and responsibilities are derived from the Year 2000 National Health Objectives, Omnibus Budget Reconciliation Act of 1989 (OBRA '89) Surgeon General's 1987 Call to Action, and MCHB's draft strategic plan for use of discretionary funds authorized under OBRA '89.

implemented a national strategy for informing parents and coordinating agencies at the federal, state and local levels, including parent and advocacy organizations about the SSI Program.

In the Fall, 1992, leadership of MCHB asked the National Center to undertake a similar effort on behalf of the children of Vietnam era veterans. In keeping with its mandate to forge effective public and private partnerships at the federal, state and local levels, MCHB worked with the leadership of AOCAP to initiate this working group to promote collaboration among state Title V CSHCN Programs, AOCAP grantees, and others. The initial meeting of the Work Group was held in December, 1992.

In my testimony this morning I will address many of the issues that have been posed by the subcommittee. I will do this by first describing the characteristics of the system of care which I, and others in the child health community, believe is needed. I will then outline the strengths and needs of the current systems of health and social services for Vietnam Veterans. My comments and recommendations are reflective of the work of the AOCAP/Title V Work Group membership; those who have hands-on day-to-day experience in working to meet the needs of children with special needs and their families. I hope that this testimony does justice to the dedication and commitment of the work group members, and clearly demonstrates that the complex needs of these children and families cannot be adequately met unless: 1) the service system focuses on the strengths as well as the needs of children and families; 2) the service system is encouraged to collaborate to serve the family as a whole (and not allowed to fragment the family according to organizational needs); and 3) sufficient long-term flexible resources are made available to support these families and the organizations that serve them.

WHAT IS NEEDED

As a counseling psychologist I know that, in order to be effective, helping professionals must strive to enhance the capability of those for whom we work, so that families can make their own decisions, set their own priorities and reach their own dreams. Further, since the family is the fundamental building block of our society, professionals and service agencies must focus on the family-as-a-whole as the unit of care. We must not allow categorical funding streams, or professional and organizational turf battles impede progress toward the development of service systems that children with special needs and their families really need; community-based service systems that: meet the health and health-related needs of all children and their families; address the physical, psychological, and social aspects of care; provide individualized attention for their special health care and related needs; and link health care and services with other needed services and programs including, but not limited to early intervention, educational, vocational, and mental health services.

As recently articulated by the leadership of the USPHS Maternal and Child Health Bureau, families need systems that are collaborative, family-centered, community-based, culturally competent, care-coordinated, comprehensive, universal, accessible, developmentally-oriented, and accountable. More specifically, such systems have the following characteristics:

- Collaborative

  At the state level, such systems are characterized by collaboration between State MCH and CSHCN programs, other relevant State health and non-health agencies, and provider and consumer groups to provide the impetus that will facilitate the development of service systems at the community level. Such systems also promote the institutionalization of family-centered, culturally competent and coordinated care at the community level.
  At the community level, such systems are characterized by public-private partnerships that link health-related and other community resources to form an organized network.
  In addition, such systems promote the participation of a broad range of families in the systems development process in order to assure that the systems address needs as seen from the family point of view

- Family-Centered
  Such system recognize the importance of the family and reflect this in the way services are planned and delivered. It facilitates parent/professional collaboration, responds to family needs, recognizes and builds on individual and family strengths, and respects the diversity of families.

- Community-Based
  Such systems respond to needs identified by the community and draw from the community to address needs. Services are provided in or near the home community to the extent possible. The area encompassed by a community depends on a number of factors including population density, political subdivisions, existing arrangements for provision of services, and availability of resources.

- Culturally Competent
  Such systems are organized so as to be sensitive to culture and competent to serve culturally diverse groups. Cultural competence refers to a program's ability to honor and respect culturally related beliefs, values, interpersonal styles, attitudes, and behaviors of families including the multicultural staff who are providing services. It incorporates these values at the policy, administration, and practice level. Multi-language materials and translation services are made available as needed.

- Care-Coordinated
  Within such systems, the array of services is coordinated to assure timeliness, appropriateness, continuity, and completeness of care.

- Comprehensive
  Such systems encompass primary (including prevention), secondary, and tertiary health care and address physical health, mental health, oral health, nutrition, health promotion, monitoring of development, parent/patient guidance, early intervention, and family planning. Such systems also address needs for emergency medical, substance use/abuse, specialized mental health, educational, vocational, social, recreational, and family support services.

- Universal
  Such systems are concerned with all children, adolescents, and their families in the community whether served by private providers or public programs. This includes children and adolescents with, or at risk for disabilities, chronic conditions, health-related educational problems, and health-related behavioral or emotional problems.

- Accessible
  Such systems address the issue of physical access by assuring that services are located conveniently and are augmented, as appropriate, by home visiting, mobile services, school-based health services centers, satellite services, and other means to bring care closer to consumers.
  Such systems address the issue of temporal access by assuring that a wide choice of service hours is made available.
  Such systems also address the issue of financial access by assuring that arrangements are made for financing mechanisms that bring needed services within the reach of all.

- Developmentally-Oriented
  Such systems takes into account the different kinds of needs that children, adolescents, and their families have at different stages of development by, for example:
  Helping expectant parents, new parents, and those who will provide care and services to understand the development of infants and young children;
  Addressing health-related behaviors with school-age children and youth;
  Providing adolescent services in an atmosphere of trust and honoring wishes for confidentiality in all appropriate circumstances.

- Accountable
  Such systems assure a mechanism to provide information concerning the performance and utilization of the community-based system of services.

STRENGTHS AND ISSUES

Through the Work Group it is evident that many AOCAP funded projects and state Title V Program for Children with Special Health Care Needs (CSHCN) share a commitment to serve children and families with special needs and to support the development of the type of effective systems described above.

AOCAP Projects, as a whole, have been effective in addressing unmet social services needs of veterans and their families. Because many of the staff are, themselves, Vietnam Veterans, AOCAP Projects have special expertise and experience in recognizing and understanding the specific, unique problems of Vietnam veterans and their families. The projects are also successful because they are designed to maximize and leverage resources, and to build networks not only for a specific client, but for all Vietnam Veterans. The care coordination and advocacy services that these project provide can serve as the glue that brings the pieces of the fragmented service system together in a coordinated fashion. In addition, AOCAP is founded on the philosophy that the family, rather than an individual family member should be the unit of care. This is especially important when serving children with special needs. Since the AOCAP Projects are also supported through private, but time limited funding, they have great flexibility. However, this type of funding also imposes a need for the Projects to institutionalize their activities through longer-term, more stable projects.

AOCAP Project staff feel that their Projects are more successful than more other services, such as those offered through the Veteran's Administration. The reported shortcoming of VA services include: the focus of the VA on the individual Vietnam Veteran rather than on the Veteran within the context of the family as a whole; the VA's "institutional" approach, which focuses on the services provided through the VA and fails to access or coordinate with services provided in the community; and the VA's "medical model" which focus on identifying and providing a short-term cure for problems rather on enhancing the ability of the Veteran and the family to participate in long-term growth and development.

It is my belief that state Title V CSHCN Programs have also been effective in addressing the needs of veterans and their families. Because Title V Programs are legislatively mandated to facilitate the development of family-centered, community-based, culturally competent, coordinated system of care for CSHCN and their families, these Programs are making available the types of services Vietnam Veteran families need. The philosophical basis of these state programs is to focus and build on the strengths of families, and to involve families not only in decision making about the care of their child but also in policy and program development for the service system as a whole.

However, to the best of my knowledge, these programs to not gather data regarding military service. Therefore, these programs do not have data on the effectiveness of their services for Vietnam Veteran families; nor do they have services that are specifically focused on this group. Thus, the children of Vietnam Veterans are one of many "special populations" for which Title V has a responsibility.

BARRIERS AND ISSUES

Through the Work Group, a number of barriers were identified that limit the effectiveness of AOCAP Projects and Title V CSHCN Programs in addressing the needs of CSHCN from the families of Vietnam Veterans.

BARRIERS TO COORDINATION. In general, it was noted that interorganizational coordination is difficult to achieve and requires a significant level of planning and on-going effort. It was also noted that organizations that have a legislative, funding, or programmatic mandate to coordinate were much more likely to work effectively with other agencies on behalf of families. In addition, a number of specific organizational factors were identified as barriers, some of which were particularly relevant to AOCAP Projects, and some to Title V Programs.

Specific factors associated with AOCAP Projects included: AOCAP staff's limited knowledge of pediatric health care needs and standards; limited experience with child health care systems, including state Title V CSHCN Programs; and limited information about alternative funding sources. Title V Program factors include: Title V and MCHB's limited focus on and experience with Vietnam Veteran families; limited knowledge of Post Traumatic Stress Disorder (PTSD) and the extent to which this syndrome affects services and resources needed; and limited information about AOCAP and its grantees. It was also recognized that differences across state Title V Programs, in terms of program name, eligibility criteria, and services poses a barrier to AOCAP's understanding and access to these programs.

VETERAN'S FAMILIES NEEDS AND ISSUES A number of family factors were also identified as barriers to children and families access to needed services. Some of these issues were particularly relevant to families of Vietnam Veterans. General family factors included: families' lack of awareness of available resources and services; families' failure to identify their child's problems and needs; and families' reluctance to accept and/or report their child's problems. Issues that were identified as related to the Vietnam veteran family member's war experiences were the veteran's distrust of governmental agencies and programs; the impact of Post Traumatic Stress Disorder on the family's ability to address the needs of a child with special needs; and the psychological impact of knowing that exposure to Agent Orange may have caused the child's health or developmental problems.

TASK FORCE FINDINGS

In order to address these issues, it was agreed that AOCAP grantees, Title V CSHCN Programs, and other projects supported by MCHB need to: 1) understand each program's mission, roles, and responsibilities; 2) understand the special health and social problems of Vietnam veterans and their families; 3) know about the broad range of services and resources available to address these problems through collaborative program efforts; and 4) develop and implement methods for effectively utilizing these resources through appropriate referrals. In order to overcome the barriers identified in the previous section, AOCAP/ MCHB Working Group members agreed that efforts needed to be made to achieve the following goals.

- Increase the awareness and understanding of health/ and social service organizations, professionals and veteran services groups about the special health and social services needs of Vietnam veterans' families.
- Ensure that Vietnam veterans' children who have special needs access and maximize all health and social service program benefits available to them, including insurance and entitlement programs.
- Ensure that services for Vietnam veterans' children with disabilities are family centered, comprehensive and coordinated, and provided in a manner that promotes the increased independence, productivity, and empowerment of the child and family.

GOAL 1: INCREASING AWARENESS

In regard to the first goal of increasing the awareness and understanding of health and social service organizations, professionals and veteran services groups about the special health and social services needs of Vietnam veterans' families, it was recognized that this involves both documenting the special needs of CSHCN from Vietnam Veteran's families and increasing the awareness of professionals and organizations at the Federal, state and local levels about these special needs.

With regard to the documentation of the special needs of CSHCN from Vietnam Veteran's families, it was recommended that data from AOCAP supported National Information System be analyzed to determine the incidence and prevalence of special problems and needs of Vietnam veteran families and compared to similar populations (as served by Title V CSHCN Programs); and b) that data on services provided to veterans' families with CSHCN through AOCAP and other health and social services agencies be collected and analyzed.

In order to provide this information/data to AOCAP grantees, state Title V CSHCN Programs and other public and private programs that serve CSHCN, it was recommended that a variety of strategies be used. Recommended strategies included developing a series of fact sheets and a more formal training curriculum to assist health professionals and veteran services groups in identifying and recognizing the special health and social services needs of Vietnam veterans' families. The fact sheets and the curriculum would then be made available to a broad range of professionals and organizations including American Legion Post Service officer (through state and county schools and conferences), State Veterans' Affairs Commissions, university veterans' advocates, University Affiliated Program (UAP) faculty and students, Title V CSHCN leadership and staff; and MCHB-SPRANS grantees. It was also recommended that informational articles be published in magazines and journals that reach the veteran, health, and social service communities.

GOAL 2: ENSURE ACCESS TO CARE

In regard to the second goal, of ensuring that Vietnam veterans' children who have special needs access and maximize all health and social service program benefits available to them, it was recognized that this involves both outreach to families and the provision of information and referral services

The recommended strategies for implementing a joint Title V/AOCAP outreach effort involved: a) selecting one or two states in which to develop a demonstration outreach program and identifying the current outreach activities of Title V, AOCAP, and other veterans' organizations in these states; b) jointly identifying where outreach coordination is possible and developing guidelines for implementing a coordinated outreach program; c) developing a joint prototype intake/application form that includes questions regarding Vietnam veteran status, training intake staff on implementing the intake/application form and conducting a needs assessment of identified AOCAP-eligible families; and d) disseminating the guidelines at meetings and conferences of the organizations involved.

It was also recommended that selected AOCAP grantees work with selected Title V CSHCN-affiliated clinics, and serve as an on-site resource for veterans' families that are being served. The recommended strategies for implementing this effort involve, first identifying one or two Title V CSHCN clinics with large patient loads (urban and rural) and assigning a AOCAP veterans' advocate who would assist veterans' families in meeting their basic needs; then developing and implementing compatible (AOCAP and Title V) protocols for referrals that includes service coordination and follow-up with AOCAP grantees, Title V CSHCN Programs, Supplemental Security Income (SSI) Program, special education, mental health, and vocational rehabilitation programs. It was recommended that training for AOCAP grantees and other veterans' groups then be implemented to ensure their awareness of all health and social service resources that may be available to veterans in their respective states. Such training could be carried out in collaboration with state Title V Programs, University Affiliated Programs, state veteran services officers and others with expertise in health and social service resources in their states.

It was also recommended that AOCAP Projects be made aware of and be listed as part of the State 1-800 Information and Referral services that are administered by each state Title V and Part H programs for infants and toddlers.

GOAL 3: ENSURING FAMILY-CENTERED CARE

In regard to the third goal of ensure that services for Vietnam veterans' children with disabilities are family centered, comprehensive and coordinated, and provided in a manner that promotes the increased independence, productivity, and empowerment of the child and family, it was recognized that MCHB and Title V CSHCN Programs is a significant resources. As noted above, a primary mission of MCHB and Title V CSHCN Programs is to promote the development of such systems of care.

It was recommended that AOCAP grantees be made aware of the information and training resources that have been developed through Title V Block Grant SPRANS Project funding to support the development of family-centered, community-based, coordinated, culturally competent systems of care. Information should also be provided about the various federal, state and local initiatives for children with special needs,

including Healthy Start, Part H of Public Law 99-457 (IDEA), and the American's with Disabilities Act (ADA).

It was also recommended that special emphasis be placed on improving veterans' families' access to quality primary and preventive care, including dental, vision, hearing, and immunizations services. Such efforts could include the development and/or dissemination of : a) a protocol for AOCAP intake screening that includes preventive issues (e.g., questions regarding children's immunizations and dental and eye examinations); b) parenting education and peer counseling materials to increase families' understanding of the need for primary and preventive care; c) a process of referrals to ensure that primary care providers to whom agency refers are competent and knowledgeable about PTSD and other problems unique to Vietnam veterans and their families; and d) a protocol for Title V programs to assist AOCAP grantees with identifying strategically located, competent health providers.

It was also recommended that AOCAP grantees be provided with information about the activities of MCHB and state Title V Programs to promote a) the formation of self-help support groups of families that empower these families to deal with their own problems and facilitate access to the system and b) the participation of families in the design, monitoring and evaluation of services provided through AOCAP grantees.

SUMMARY AND RECOMMENDATIONS

Based on the findings of the AOCAP/Title V Work Group, and on my experience on several other state and federal work group, it is my personal observation that current systems of services for children with special needs and their families are often characterized by duplication and fragmentation, and often do not make optimal use of available personnel and financial resources. Developing coordinated, family-centered systems is a complex, problematic process that involves addressing complex inter and intra agency program and policy issues. The primary problems encountered in systems change are to:

- Get the organizations and agencies responsible for addressing problems to reach consensus on the nature and extent of the common problems that they are facing and how they should be addressed;
- Overcoming organizations concerns about protecting their own identities, ideologies, roles and resources; and
- Getting agencies to address problems jointly by combining personnel and resources

The findings of the AOCAP/Title V working group constitute a draft statement of consensus regarding the problems of Vietnam Veteran families and their children with special needs and the ways in which AOCAP and Title V can work together to address these problems. Now, it is up to the staff of Title V Programs and AOCAP Projects to accept the challenge and to focus a measure of their limited financial and personnel resources on setting priorities and taking collaborative actions at the state and local levels.

In my opinion, the efforts of AOCAP and state Title V CSHCN Program to address the needs of Vietnam Veteran families and their children with special needs could be significantly enhanced through:

- Additional resources, to be made available to joint Title V CSHCN/AOCAP initiatives to enhance the availability and coordination of comprehensive, coordinated, family-centered health and social services to Vietnam Veterans families with children with special needs.

- Additional resources targeted to support joint Title V CSHCN/AOCAP/ Veteran's organization training efforts designed to improve the knowledge and skills of a broad range of providers to effectively work with Vietnam Veterans families with children with special needs in addressing their health and social service needs.

  Additional resources targeted to support joint Title V CSHCN/AOCAP training efforts designed to improve cross program knowledge and coordination regarding Vietnam Veterans families with children with special needs. Such training would involve not only Title V CSHCN Programs and AOCAP Projects, but would also include public and private providers of primary and specialty health care; and those who provide veteran's, mental health, child abuse, vocational, educational, social and other support services.

- Additional resources targeted to support efforts to train Vietnam Veterans families about the availability of, and how to access primary and specialty health care; and veteran's, mental health, child abuse, vocational, educational, social and other support services.

- The identification of Vietnam Veterans families with children with special needs as a population in need of special attention in various research, service, and training grant guidance and block grant guidance, as administered through the Maternal and Child Health Bureau, the Administration on Children and Families, the Department of Education, the Rehabilitative Services Administration, Department of Veterans Affairs, etc. This would help target existing service, research and training resources on this population. This would also help to document the number of Vietnam Veteran families with children with special needs, and to describe the extent to which their needs are not appropriately addressed.

- Changes in the Department of Veterans Affairs service system's organization and philosophy, so that it is more in keeping with the principles of family-centered, community-based, collaborative, culturally competent, care-coordinated, comprehensive care.

Statement of

Frank McCarthy

President
Vietnam Veterans Agent Orange Victims, Inc. (VVAOVI)
Founder
Brandie Schieb Children's Fund

Before the

Subcommittee on Oversight and Investigations
Committee on Veterans Affairs
U.S. House of Representatives

May 18, 1994

Good morning Chairman Evans and members of the Committee. I wish to thank you for inviting me to testify today on the subject of " Social Services for Vietnam Veterans and Their Families: Current Programs and Future Directions".

My name is Frank McCarthy. I am a combat disabled Vietnam Veteran and have been President of Vietnam Veterans Agent Orange Victims, Inc. (VVAOVI) for more than 16 years.

VVAOVI has provided a multitude of direct services for Vietnam Veterans and Agent Orange Victims for more than 17 years and the Agent Orange class action litigation (MDL-381) was conceived and initiated by our organization's founder, Paul Reutershan, in 1978.

I am a member of the Court appointed Board of Advisors to the Agent Orange Class Assistance Program (AOCAP) and the settlement fund of MDL -381 since 1984. I hold various positions with seven other traditional and non-traditional Veteran's service organizations throughout the nation and have worked in Veteran's affairs for the last twenty-two years of my life.

In order for me to give you an accurate understanding of current programs and future directions of social services for Vietnam Veterans and their families I must first give you a brief history, from my perspective, of where we have come.

Prior to the May 7, 1984 out of court settlement of MDL-381 our organization (VVAOVI) had more than 68 chapters and information points throughout the nation.

Our organization functioned and was created solely to address the needs of Agent Orange Victim Vietnam Veterans and their families. They came to us by the thousands with health care problems which encompassed the entire spectrum of chronic toxicity including a multitude of birth defects and disorders experienced by the Veteran's children.

Each chapter was funded and operated totally by either a Vietnam Veteran or family member who was adversely affected by Agent Orange. Today we only have one chapter in Darien, Connecticut.

One by one the chapters closed because those Veterans were dying of cancers, immunological and neurological illnesses most of which are now recognized and compensated by the Department of Veterans Affairs (VA) as Agent Orange related.

Those chapters whose directors were not dying of such illnesses had to close their chapters as well because the financial burden of providing direct one-on-one services and programs was so devastating that they could not continue on. Estimates of monies spent by those individuals and chapters are in the millions.

The dedication, selflessness and sacrifices of those Veterans and families will go down in history as one of the finest examples of courage and determination ever written. They epitomize the Agent Orange issue. They are the heart of America's Veteran community.

They did what they had to do regardless of the toll, simply because there was no one else to do it. There was no AOCAP. There was no settlement fund. There was only the sick, dying and suffering coming to them for help.

And, of course, there was the horrible and constant obstacles created by the controversy surrounding the cause and effect relationship between exposure to Agent Orange and illness.

The number one priority of those chapters and the main reason why Paul initiated the law suit was to "stop the suffering". The same suffering that has existed within the Vjetnam Veteran community ever since the first day Vietnam Veterans returned from the battlefields of Vietnam. The same suffering which AOCAP faces today and the same suffering which will exist when AOCAP is gone.

That suffering has many faces which transcend the Agent Orange issue. It is the ugly face of war. Post-traumatic Stress Disorder, cancers, neurological & immunological illnesses, social and economic devastation, illnesses endemic to Southeast Asia and a whole host of other ill health effects abound.

As any Vietnam Veteran will tell you, by far, the worst suffering of them all is the developmental disabilities experienced by our children. The children are why we fought and died in the war itself. They are the future of America.

They are the main priority of AOCAP and they must be seriously assisted by Health And Human Services and the Department of Veterans Affairs.

VVAOVI can no longer provide millions of dollars worth of help. No other Veteran's organization can do it alone and soon AOCAP will no longer exist. A huge void will exist in America. A hole, if you will, in the heart of the Veteran community that will tear at the very fabric of our nations humanity.

I will not attempt to detail the intricacies of the AOCAP program. You have received much more detailed testimony by its director Dennis Rhoades and others providing services with AOCAP funding.

What I do want you to realize, however, is that Judge Jack B. Weinstein, the AOCAP Administrators and Advisors dared to have the courage to stand up to the constant criticisms of squeaky Veteran wheels, legislative ineffectiveness, legal ignorance and precedence, medical and scientific inconclusion and traditional Veterans health care thought, and address our children's suffering head on. They did, in the words of Abraham Lincoln, "Determine that the thing can and shall be done, and then we shall find the way".

AOCAP dared to seal the social and health care cracks through which our children had fallen and battled the seemingly endless suffering. For this I shall always love them all. For this the Veteran's community as well as the nation shall always owe them a debt of gratitude and for this, I pray, Congress takes example from!

AOCAP, " found the way " by linking up the Veterans service delivery system with the family services and developmental disabilities delivery systems which created a triangle of positive energy directed towards the suffering Veterans and their children.

The results, some examples of which you have heard about today, have exceeded my greatest expectations. Lives of our children have been, literally, saved. Veteran families by the tens of thousands have received help which did not exist prior to AOCAP and, " the suffering " is on the ropes.

However, the crucial message I am here to deliver to you today is one of alarm. AOCAP, for all of its virtue is severely flawed, for it is mandated to cease operations soon. What this will mean to those of us who will be left to continue the fight against the suffering is shocking.

There will be no more funding of life giving programs and services. There will be nothing in place to combat the suffering and those small but effective Veteran's service organizations like VVAOVI will be cast back into the dark ages of inadequate funding, an overwhelming number of case loads and seemingly endless hopelessness.

Mr. Chairman and members of the Committee you must not let this happen. You must not let the light of help and hope created by AOCAP go out for our children.

You and you alone are the only source of power existing in America today who can help us to continue the fight against the suffering. You alone can make it possible for us to continue to stand when the AOCAP support structure is dismantled. You alone can make the difference between life and death.

Congress must " determine that the thing can and shall be done " by forcing Health and Human Services as well as the VA to cast aside the controversy surrounding the Agent Orange issue and bridge the gap in services which will exist when AOCAP ceases to exist.

Specifically, the VA must be directed to provide Vietnam Veterans and their families with family oriented programs and services, or, at the very least, third party contract with existing crucial AOCAP service providers.

For the last 17 years the VA has adhered to a political position regarding Vietnam Veterans claiming Agent Orange related ill health effects which prioritizes the financial compensation factor.

Until a recent court decision, and your successful legislation, Mr. Chairman, Veterans had to prove that Agent Orange caused their ill health problems, which essentially enabled the VA to solve its compensation fear, yet skirt its responsibility as advocate of the Vietnam Veteran. As a result the VA became our enemy.

The jewel of the AOCAP program is that it takes no political position whatsoever regarding cause and effect. If you are a Vietnam Veteran or family member and the Veteran served in the U.S. armed forces in Southeast Asia during the war, the services and programs of the AOCAP network are available to you.

Lawyers, adjudication and service officers and bean counters must no longer be a detriment to the vital help which the VA could and should provide to Vietnam Veterans and their families by mirroring AOCAP.

Let " end the suffering " be the main priority of the VA in its future dealings with the Agent Orange issue and the VA will no longer be the enemy of Agent Orange Vietnam Veterans and their families.

The future directions of social services for Vietnam Veterans and their families must include measures designed to prevent and/or minimalize the illnesses which advances in medicine and age insure that Veterans will experience. The VA, in particular must end its isolation and its refusal to engage in cooperative efforts to provide services and share information which may be helpful to veterans and their families.

Sharing important information regarding the various illnesses which the Veterans themselves have commonly associated with exposure to Agent Orange, as well as many other chemicals in Vietnam and daily living will save lives and in fact, save the VA money by decreasing necessary care for the Veteran in the future.

Prior VA administrations have told us that they could not make such information available to us because, " that would be practicing preventive medicine and the VA does not do that ". I submit to you Mr. Chairman, that the little money the VA spends for paper now is an investment against the ever increasing medical care costs it will surely have to pay in the future. Soon the Vietnam-era-Veteran population will out number the World War II population. The Testicular Cancer Self-Examination Guide, which I have enclosed, is a prime example of the kind of information which has contributed greatly in decreasing the unnecessary deaths of Vietnam Veterans from Testicular Cancer. It is also, unfortunately, an example of the VA's steadfast insistence on remaining isolated in its own closed system.

This guide is fast becoming unnecessary, because the average age of the Vietnam Veteran has passed the age of 40. Testicular cancer is rare after that age. However, our organization not only created this guide, but, during the last 13 years has distributed more than one million of them throughout the nation.

There is no greater example of the effectiveness of this guide as is demonstrated by the hundreds of Veterans who came to us after they had read the guide, checked themselves, detected the lump and quickly sought treatment which saved their lives. Their cancer was caught and treated before it spread and became terminal.

I will be haunted for the rest of my life by the voices and faces of those Veterans who came to us after reading the guide and told us of how much they wished they would have received the guide before the cancer spread and became irreversible.

When we first created this guide I brought it to the VA and asked them to distribute it. Instead of welcoming it the VA central office condemned it as inaccurate and called me an alarmist. What they don't know is that I sent a copy of this guide to every VA hospital in America. We sold tens of thousands of them to VA hospitals throughout the nation. They enthusiastically bought them up and reordered more when they ran out. Individual VA hospitals loved them because they had no credible nonpolitical medical Agent Orange information to give the Veterans and their families who were coming to them for help.

VA doctors and nurses needed help and truth about possible Agent Orange related illnesses to give to the Vets. They had to face the Veterans every day. The VA bureaucracy gave them "Worried About Agent Orange?" pamphlets.

We took the funds we received from the VA hospitals and had more copies of our guide made which we distributed to hundreds of Vietnam Veteran groups throughout the nation who could not afford to buy them. We distributed them to every VA Vet Center as well as individual Veterans for free. Similar anti-cancer information will save Vietnam Veteran lives.

Logic demands that if the VA now recognizes and compensates Veterans for over 40 different Agent Orange cancers, many of which are treatable if detected early, many lives and much money will be saved if they put out information about those diseases. Desert Storm Veterans are currently at the high risk age for contracting Testicular cancer. Who will inform them and distribute self-examination guides?

The future directions must not forget the class of Agent Orange victims and Vietnam Veteran families who are rarely, if at all, serviced by the VA or AOCAP. For the most part they are the poor, the homeless and the uninsured working class.

Those Vietnam Veteran's identity is clouded by stereotypes; the downtrodden, the drug and alcohol addicted, the criminal, the useless and the psychotic.

However, the reality is that they are the minority. The overwhelming majority are decent, law abiding and upstanding American citizens who have all of the Agent Orange and Vietnam related ill health problems of their Veteran peers except they have lost their auto, steel, manufacturer and various other blue collar jobs to the economic ills of the past decade and are now homeless.

They are the, " silent suffering ", unable to access the existing social services system due to the overwhelming task of just trying to survive.

I see them every day in Florida, especially when the harsh climate of winter hits the northern cities. I see them in every major city in America. They live in their cars and live from moment to moment, day to day, city to city, state to state. They are trapped in a world of uncertainty, fear and hopelessness over and above their chronic ill health problems. They comprise practically every racial, social, political, philosophical and religious entities existing within the Vietnam Veteran community. Their children age from new born to late twenties.

Vietnam Veterans and their families have been battling the injustices of being stereotyped, abandoned, bureaucratic disinterest and misunderstanding about their Agent Orange and Vietnam war related problems from the beginning of the war to date.

They have sought remedial and compensative measures from our nations highest authorities including the legislative, judicial and social services systems of America. They have marched in parades, demonstrated (including hunger strikes), testified before various city, county, state and most federal branches of the US government. In fact they helped create many laws in many states. They have sold their homes and businesses, spent millions of dollars paying lawyers and other supportive measures just to keep the class action law suit before the highest courts in America.

They have opened their hearts, minds and homes to the cold, harsh eyes of the various medias and their horror stories of suffering, death and birth defects have touched the hearts of the American public.

They have subjected themselves to a myriad of medical and scientific studies, and surveys which in many cases included extremely painful physical and psychological requirements such as, literally taking more than an ounce of flesh from individual Vietnam Veterans.

In turn they have had their health insurance canceled or denied. Their children have been discriminated against (because of their fathers exposure to Agent Orange) by the insurance and health industries.

Their futures are clouded by uncertainty, chronic pain, suffering, social deprivation and out right death.

AOCAP is doing about as much as it possibly can to fight the suffering. My praise is tainted by my fear of what life will be like when AOCAP is no more.

In closing, Mr. Chairman, members of the Committee, I wish you to know that I appreciate your continued support of programs and services for Vietnam Veterans and their families. I will make myself available for any questions and/or supportive documentation for any statements I have made in this testimony and I do pray to God that it makes a difference.

I will leave you with a thought best expressed recently by the First Lady, Hillary Rodham Clinton, " there isn't anything more important than taking care of our children ."

STATEMENT OF
DAVID H. LAW, M.D.
ACTING ASSOCIATE DEPUTY CHIEF MEDICAL DIRECTOR FOR CLINICAL PROGRAMS
BEFORE THE
HOUSE VETERANS' AFFAIRS COMMITTEE
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS
MAY 18, 1994

MR. CHAIRMAN AND MEMBERS OF THE COMMITTEE:

I AM PLEASED TO REPRESENT THE VETERANS HEALTH ADMINISTRATION AND TO DISCUSS WHAT THE DEPARTMENT OF VETERANS AFFAIRS DOES TO ASSIST VETERANS AND THEIR FAMILIES USING SOCIAL SERVICES.

WITH ME TODAY IS DR. LAURIE HARKNESS, CHIEF OF PSYCHIATRIC REHABILITATION. DR. HARKNESS IS FROM OUR HOSPITAL IN WEST HAVEN, CONNECTICUT, SO SHE IS OUT THERE ON THE FRONT LINES WORKING WITH VIETNAM VETERANS, THEIR SPOUSES AND THEIR CHILDREN.

THE SIGNIFICANT IMPACT OF WAR AND MILITARY SERVICE ON FAMILIES HAS BEEN RECOGNIZED THROUGHOUT OUR NATION'S HISTORY. IT HAS BEEN EXPERIENCED DIRECTLY BY MILLIONS OF OUR CITIZENS AND HAS BEEN A VERY PERSONAL EXPERIENCE OF THOSE PRESENT AT THIS HEARING THIS MORNING.

VA ONLY HAS AUTHORITY TO PROVIDE DIRECT TREATMENT TO A VETERAN'S FAMILY MEMBERS FOR COLLATERAL TREATMENT IN MENTAL HEALTH, REHABILITATION AND LONG TERM CARE PROGRAMS. VA DOES RESPOND TO THE OTHER NEEDS OF FAMILIES, THROUGH WELL-ESTABLISHED REFERRAL NETWORKS AND COMMUNITY PLANNING PARTNERSHIPS.

DISCHARGE PLANNING, INFORMATION AND REFERRAL, CASE MANAGEMENT SERVICES AND FAMILY CONSULTATION RANK HIGH AMONG THE MOST FREQUENTLY USED DIRECT SERVICES. IN THE PAST THREE MONTHS ALONE, FOR EXAMPLE, NEARLY A QUARTER MILLION VETERANS RECEIVED THOSE SERVICES FROM VA SOCIAL WORKERS. VET CENTER READJUSTMENT COUNSELORS ALSO PROVIDE COMMUNITY OUTREACH, PSYCHOLOGICAL COUNSELING AND REFERRALS TO OTHER COMMUNITY PROVIDERS THROUGH A NATIONWIDE NETWORK OF 202 COMMUNITY- BASED VET CENTERS. SINCE 1979 VET CENTERS HAVE COUNSELED NEARLY ONE-AND-A-HALF MILLION VETERANS AND FAMILY MEMBERS AND OVER 15 PERCENT OF THOSE SERVICES WERE FOR MARITAL AND FAMILY PROBLEMS.

CLINICAL STAFF ASSIGNED TO VA MEDICAL CENTERS, OUTPATIENT CLINICS, COMMUNITY BASED VET CENTERS AND VETERANS BENEFITS COUNSELORS IN VA's REGIONAL OFFICES PROVIDE PRIMARY LINKAGE AND REFERRAL SERVICES TO COMMUNITY SOCIAL SERVICE AGENCIES AND PROGRAMS.

VIETNAM VETERANS' PROBLEMS STEMMING FROM POST TRAUMATIC STRESS ARE NOT JUST INDIVIDUAL, THEY IMPACT THE ENTIRE FAMILY. FOR INSTANCE, A VETERAN WHO WORKED IN THE PAST, MAY NOT BE ABLE TO CONTINUE TO WORK DUE TO THE SEVERITY OF SYMPTOMS. THIS FORCES THE PARTNER TO GO TO WORK WHILE ALSO MANAGING THE HOUSEHOLD. THIS COMMON SCENARIO INCREASES A FAMILY'S STRESS LEVEL. IT CAUSES THE VETERAN TO FEEL RESENTFUL AND TO MISDIRECT ANGER TOWARD THE FAMILY. THE FALLOUT FREQUENTLY IS ON THE CHILDREN – CREATING A DYSFUNCTIONAL HOME ENVIRONMENT FOR ALL. LEFT UNTREATED, THE PATTERN CAN REPEAT ITSELF LEAVING BEHIND A LEGACY OF IMPAIRED INTERPERSONAL RELATIONSHIPS WITH CHILDREN AND SPOUSES.

MR. CHAIRMAN, WE IN VA APPLAUD THE EXCELLENT WORK WITH FAMILIES AND CHILDREN OF DISABLED VIETNAM VETERANS ACCOMPLISHED BY THE AGENT ORANGE CLASS ASSISTANCE PROGRAM, OR, AOCAP. IT HAS FILLED A CRITICAL GAP IN SERVICE DELIVERY TO A HIGHLY NEEDFUL POPULATION OF VETERANS' FAMILIES.

THE UNIQUE STRESSES THAT OCCUR IN MILITARY LIFE AND IN THE SUBSEQUENT TRANSITION TO VETERAN STATUS REQUIRE THERAPEUTIC INTERVENTION FROM ALL AVAILABLE RESOURCES. THE CONSEQUENCES OF NOT RECOGNIZING THESE NEEDS COULD RESULT IN VETERANS AND FAMILIES BEING ISOLATED WITH THE PROBLEM AND ALIENATED FROM THE COMMUNITY. THE LONG TERM CONSEQUENCES ARE ADDITIONAL SOCIAL PROBLEMS AND DYSFUNCTION COUPLED WITH GREATER COST TO THE FAMILY AND SOCIETY TO REPAIR OR REBUILD LIVES AT A LATER TIME.

AN IMPORTANT VA MISSION IS TO PROVIDE FOR THE MILITARY SERVICE-RELATED SOCIAL SERVICE NEEDS OF VETERANS AND THEIR FAMILIES. TO MEET THOSE NEEDS, VA HAS IMPLEMENTED PROGRAMS THAT DEAL WITH POST TRAUMATIC STRESS DISORDER, SUBSTANCE-ABUSE, AND FAMILY VIOLENCE. TO SUPPLEMENT EXISTING PROGRAMS AND RESOURCES, VA STAFF CALL UPON THE FULL RANGE OF PUBLIC, PRIVATE, NON-PROFIT AND SELF-HELP COMMUNITY ORGANIZATIONS AND RESOURCES TO ASSIST VETERANS AND THEIR FAMILIES TO OBTAIN NEEDED SERVICES.

IN LARGE METROPOLITAN AREAS, COMMUNITY SOCIAL SERVICE AGENCIES ABOUND AND VA SOCIAL WORKERS HAVE LITTLE DIFFICULTY MAKING REFERRALS OF VETERANS' FAMILY MEMBERS. IN SMALLER COMMUNITIES, FINDING APPROPRIATE AGENCIES WITH THE RIGHT SERVICES AVAILABLE FOR THE VETERANS' FAMILY MEMBERS BECOMES MORE OF A CHALLENGE. "MANAGING" A CASE ENCOMPASSES MUCH MORE THAN JUST PROVIDING HIGH QUALITY HEALTH CARE TO THE VETERAN. IT MEANS GETTING THE FAMILY THE SERVICES IT NEEDS SO THAT IT CAN SUPPORT THE VETERAN FOLLOWING A COURSE OF VA HOSPITALIZATION OR OUTPATIENT CARE. ALSO, WITHOUT EFFECTIVE COORDINATED CASE MANAGEMENT SERVICES, SOME FAMILIES AT HIGH SOCIAL RISK MAY NOT RECEIVE NEEDED SERVICES.

VA PROGRAMS THAT MEET THE SOCIAL SERVICE NEEDS OF VETERANS AND THEIR FAMILIES SHARE CERTAIN CHARACTERISTICS. THEY SYSTEMATICALLY ADDRESS THE BIOLOGICAL, PSYCHOLOGICAL, SOCIAL AND VOCATIONAL NEEDS OF THE VETERAN. BASED ON A FAMILY NEEDS ASSESSMENT, THEY INCORPORATE A HOLISTIC APPROACH AND SEEK SOLUTIONS TO THE SOCIAL NEEDS THROUGH USE OF THE FAMILY, VA PROGRAMS AND COMMUNITY RESOURCES. THE SUCCESSFUL PROGRAMS FOCUS ON HEALTHY FAMILY RELATIONSHIPS, ENCOURAGE INDEPENDENCE AND PERSONAL RESPONSIBILITY, USE VOLUNTEERS AND PROGRAM GRADUATES, AND PROVIDE CASE MANAGEMENT AND CARE COORDINATION SERVICES. SOME EXAMPLES OF A WIDE RANGE OF LOCALLY-DEVELOPED VA PROGRAMS INCLUDE:

- VA PTSD PROGRAMS OFFERING INPATIENT AND OUTPATIENT COUNSELING, FAMILY COUNSELING, AND CHILDREN AND ADOLESCENT COUNSELING. BY INCLUDING FAMILIES AS PART OF THE VETERAN'S TREATMENT, THE FAMILY MAY GAIN AN UNDERSTANDING OF THE VETERAN'S PTSD SYMPTOMS AND BE MADE AWARE OF THE TREATMENT PROCESS AND PROGRESS. FAMILY PROBLEMS RELATED TO THE VETERAN'S ILLNESS ARE ALSO ADDRESSED.

- VIETNAM VETERANS LIAISON UNITS AND POST TRAUMATIC STRESS DISORDER RESIDENTIAL REHABILITATION PROGRAMS. MEDICAL CENTERS WORK WITH A LARGE AND DIVERSE GROUP OF VIETNAM VETERANS AND THEIR FAMILIES AND OFFER A WIDE RANGE OF SOCIAL SERVICES. SERVICES INCLUDE FAMILY AND MARITAL COUNSELING, INCLUDING A COMMUNITY-BASED WEEKLY FAMILY AND SIGNIFICANT OTHERS GROUP, AGENT ORANGE INFORMATION AND REFERRAL AND CARE AND COORDINATION SERVICES WITH COMMUNITY SOCIAL SERVICES.

- VA AND AOCAP WILDERNESS INQUIRY PROGRAM. THIS PROGRAM AUGMENTS VA PTSD TREATMENT SERVICES AND TARGETS THE NEEDS OF THE VETERANS' CHILDREN. IT PROVIDES A POSITIVE WILDERNESS EXPERIENCE THAT ALLOWS PARTICIPANTS TO SEE THEIR OWN POTENTIAL, TO LEARN RECREATIONAL SKILLS, AND TO INCREASE SELF-RELIANCE AND SELF-ESTEEM.

- VA HOSPITAL AND VET CENTER OUTDOOR CHALLENGE GROUP. THIS IS A COUNSELING PROGRAM FOR VIETNAM AND POST-VIETNAM WAR ZONE VETERANS AND SPOUSES. THE PROGRAM COMBINES THE EXPERIENCES OF TEAM-BUILDING, OUTDOOR TRIPS AND CONFIDENCE-BUILDING. THE CHALLENGE GROUP HAS INCORPORATED CHILDREN INTO ITS PROGRAM.

- COUPLES GROUP FOR VIETNAM VETS AND WIVES OR PARTNERS.

- VIETNAM VETERAN'S CHILDRENS GROUP. THE GOAL OF THIS PROGRAM IS TO ASSESS AND TREAT THE IMPACT OF THE VETERANS PTSD ON THE VETERANS' CHILDREN.

MR. CHAIRMAN, THE DEVELOPMENT OF AOCAP AND OTHER VOLUNTARY SERVICE ORGANIZATION-SUPPORTED COMMUNITY BASED SOCIAL SERVICES HAS MADE A MAJOR CONTRIBUTION TO VETERANS' FAMILIES AND THE SOCIAL SERVICE NETWORK. IT HAS PROVIDED A FULL RANGE OF COMMUNITY SOCIAL SERVICES WHICH ARE ESSENTIAL FOR THE EFFECTIVE DELIVERY OF HEALTH CARE SERVICES TO VETERANS AND THE HEALTHY FUNCTIONING OF THEIR FAMILIES. OUR STAFFS APPRECIATE THE SERVICES PROVIDED BY THESE COMMUNITY SERVICE PROGRAMS. WE ALSO APPRECIATE THE NETWORKING WE HAVE BEEN ABLE TO ESTABLISH WITH THE COMMUNITY AGENCIES FUNDED BY AOCAP. THEY ARE SKILLED IN WORKING WITH DISABLED CHILDREN OF VIETNAM VETERANS. WE HAVE COORDINATED WITH MANY OF THOSE AGENCIES TO MEET THE PSYCHOLOGICAL AND SOCIAL NEEDS OF VETERANS WHOSE CHILDREN WERE UNDERGOING CONCURRENT MEDICAL CARE IN THE COMMUNITY.

MR. CHAIRMAN, THIS CONCLUDES MY TESTIMONY. MY COLLEAGUE AND I WILL BE PLEASED TO ANSWER ANY QUESTIONS YOU MAY HAVE.

WRITTEN COMMITTEE QUESTIONS AND THEIR RESPONSES

THE SECRETARY OF VETERANS AFFAIRS
WASHINGTON

OCT 7 1994

The Honorable Lane Evans
Chairman, Subcommittee on Oversight
and Investigations
Committee on Veterans' Affairs
House of Representatives
Washington, DC 20515

Dear Mr. Chairman:

Enclosed is follow-up information to the May 18, 1994, post-hearing questions regarding Social Services for Vietnam Veterans and Their Families.

In our answer to Question 4, we indicated that, "The requested data regarding Vet Center referrals is being collected in the field and will be transmitted as soon as it has been received, reviewed and collated." The data has been processed and is enclosed for your review.

We regret the delay in getting this information to you and appreciate the opportunity to submit this information for the record.

Sincerely yours,

Jesse Brown

Jesse Brown

Enclosure
JB/rlh

Putting Veterans First

QUESTIONS SUBMITTED BY
HONORABLE LANE EVANS, CHAIRMAN
SUBCOMMITTEE ON OVERSIGHT & INVESTIGATIONS
COMMITTEE ON VETERANS' AFFAIRS

SOCIAL SERVICES FOR VIETNAM VETERANS AND THEIR FAMILIES: CURRENT PROGRAMS AND FUTURE DIRECTIONS

MAY 18, 1994

QUESTIONS FOR DR. DAVID H. LAW
ACTING ASSOCIATE DEPUTY CHIEF MEDICAL DIRECTOR
FOR CLINICAL PROGRAMS
DEPARTMENT OF VETERANS AFFAIRS

Question 1: Dr. Law as your testimony notes, "Vietnam veterans' problems stemming from post-traumatic stress are not just individual, they impact the entire family."

What services are VA authorized to provide directly or indirectly to veterans for problems stemming from post-traumatic stress?

What services are VA authorized to provide directly or indirectly to family members of veterans for problems stemming from post-traumatic stress?

What services are VA authorized to provide directly or indirectly to veterans and their family members for problems stemming from post-traumatic stress?

What important services are VA not authorized to provide directly or indirectly to veterans for problems stemming from post-traumatic stress?

What important services are VA not authorized to provide directly or indirectly to the family members of veterans for problems stemming from post-traumatic stress?

What important services are VA not authorized to provide directly or indirectly to veterans and their family members for problems stemming from post-traumatic stress?

Identify the types of services or treatment not currently authorized to be provided directly or indirectly by VA to veterans for problems stemming from post-traumatic stress which would be expected to provide more effective treatment to these veterans if provided by VA.

Identify the types of services or treatment not currently authorized to be provided directly or indirectly by VA to veterans' family members for problems stemming from post-traumatic stress which would be expected to provide more effective treatment to these family members if provided by VA.

Identify the types of services or treatment not currently authorized to be provided directly or indirectly by VA to veterans and their family members for problems stemming from post-traumatic stress which would be expected to provide more effective treatment to these veterans and their family members if provided by VA.

Answer: The Readjustment Counseling Service (RCS) administers a nationwide system of 202 community-based Vet Centers located in 50 states, Puerto Rico, the District of Columbia, the Virgin Islands, and Guam. The Vet Center mission is to provide community outreach and counseling to assist Vietnam era veterans, and since April 1991 veterans of Lebanon, Grenada, Panama, the Persian Gulf and Somalia. This includes assisting in resolving war-related psychological difficulties (including post-traumatic stress disorder) and helping these veterans attain a well-adjusted

post-war family and work life. As currently provided at Vet Centers, readjustment counseling is a highly specialized set of social, economic, and psychological services specifically designed for post-war readjustment.

Working in small teams of three to five, Vet Center counselors provide a mix of community outreach, psychological counseling and supportive social services within a non-medical rehabilitative setting. Specifically the mix of services include: psychological counseling and psychotherapy (individual, group and family), outreach, networking and referral for other needed services (VA and non-VA), employment counseling, education/career counseling, crisis counseling, community education, substance abuse aftercare and referral, consultation to professionals, and conjoint services at VA medical facilities and regional offices. All of these services are directly available to the veteran, and indirectly available to veterans' family members. Psychological counseling regarding the veterans' post-traumatic stress disorder (PTSD) is, however, directly available to family members, where family member means spouse, children or other socially defined significant person(s). This includes legal guardians as well.

Since the inception of the Vet Centers in 1979, they have seen over 1.4 million veterans and family members. On an annual basis the Vet Centers, system-wide, provide services to approximately 140,000 veterans and 25, 000 family members. Family treatment can be an important adjunct to direct treatment of the veteran with PTSD to improve the clinical management of the effect of family relations on the course of the PTSD in the veteran and reciprocally of the impact of the veteran's PTSD on the quality of family relations with particular reference to the development of second generation symptomology in the veteran's children. Vet Centers have been authorized to provide family counseling (to the extent needed for the veteran's readjustment) as part of readjustment counseling from the onset which has contributed significantly to the general success of Vet Centers. The RCS in-service training program also features continuing education for service providers in family counseling and PTSD. Family therapy at Vet Centers is also provided in some cases to assist veterans and family members with emotional reactions to possible exposure to herbicides in Vietnam and to refer the family to medical facilities (VA and non-VA) for treatment of possible related medical problems.

With particular reference to treatment for war-related PTSD, VA has developed a spectrum of integrated programs ranging from the community-based Vet Centers to the VA Medical Center-based programs such as the PTSD Clinical Teams (PCTs), the Special Inpatient PTSD Units (SIPUs) and the other various specialized inpatient and outpatient programs. The ability of clinicians operating in VA medical centers and outpatient clinics to provide clinical services to the families of veterans is constrained by law to the provision of "collateral" care: limited treatment in support of the care of the primary patient, the veteran. Contact with a patient's family is essential in the care of many who suffer from mental disorders, including Post-traumatic Stress Disorder (PTSD). Information on the patient's condition, and education of family members on how to best help the veteran are some of the advantages of such contacts. Many VAMC-based programs are currently providing ongoing group and/or family therapy for the spouses and children of veterans being treated for PTSD. Taken collectively, these programs address the full range of clinical needs presented by veterans with war-related PTSD, with particular reference to the residuals of primary war trauma in the veteran and the secondary trauma of post-war breakdown in relationship between the veteran and his or her family members.

Question 2: Your statement refers to the isolation and alienation of Vietnam veterans and their families.

Which VA programs are meeting the needs of these veterans and how effective are these problems?

Which VA programs are meeting the needs of the families of these veterans and how effective are these programs?

How could the needs of these veterans be better met by VA?

How could the needs of the families of these veterans be better met by VA?

Answer: VA's Vet Centers are a highly utilized and successful service for helping veterans resolve war-related psychological trauma and achieve post-war readjustment to civilian life. As referenced above, the Vet Centers, systemwide, see approximately 140,000 veterans and an additional 25,000 family members per year. The non-medical community-based service delivery system is highly popular with the veteran public and results in a steady flow of satisfied customers and positive media coverage nationwide. There has been no negative media coverage of these services anywhere nationwide for the past approximately eight years. Many referrals are from former veteran clients. Vet Centers have become an honored and valued community institution throughout the United States, earning a respected role among community service agencies. They have provided an effective bridge between an entire generation of war veterans and the Department of Veterans Affairs, and now furnish access to the VA system for younger war veterans. Also Vet Center services are highly economical, with a cost per veteran and cost per visit far below that of the most closely comparable services at medical facilities. In addition, due to effective quality management, Vet Center client suicide rate is one-fifth that of the general population of comparable age range.

Another major source of effectiveness of Vet Centers is that a clear focus on the mission has been maintained for fourteen years. Since 1979 the mix of services and various program emphases have been refined by experiences within the initiating mission definition. So structured, the Vet Centers are a community-centered service whose ultimate service objective is the readjustment of the veteran to the civilian community. Family and work adjustment are seen as integral to successful post-war civilian readjustment, but the family group is itself seen as embedded in a social and cultural environment with which it must maintain an adaptive interchange if the veteran is to achieve a successful post-war homecoming. The character of readjustment counseling and its effectiveness, are also tied to the fact that 60 percent of the service providing staff are war-zone veterans, and another 25 percent war era veterans.

Precise data on all the services provided to the families of Vietnam veterans through VA medical facilities would require a special survey, as this information is not routinely tracked. It would involve checking on those services provided by general mental health programs as well as our specialized PTSD units. The Northeast Program Evaluation Center notes that of veterans seen by our PTSD Clinical Teams (PCTs), about 10 percent received some family therapy, and for 5 percent , this was a substantial part of their treatment. It must be noted that of the veterans who use PCTs, 32 percent are divorced, and 9 percent never married. Also, 25 percent are living alone (The Long Journey Home III: The Third Progress Report on the Specialized PTSD Programs, May 1, 1993). These conditions may reflect some of the ravages of PTSD on successful family life, but they also may prevent the use of family therapy for these particular veterans.

Concerning the final two questions, VA believes that the needs of veterans and their families are being met to the fullest extent the law currently allows.

Question 3: AOCAP has "filled a critical gap in service delivery to a highly needful population of veterans' families," according to your prepared statement. How should this critical gap be filled in the absence of AOCAP? What role could VA play in filling this critical gap?

Answer: While VA has and should continue to provide a wide range of benefits and services to veterans whose health may have been adversely affected by exposure to Agent Orange and other potential environmental hazards encountered during their service in Vietnam, there are some restrictions on our efforts. Although some veterans have alleged that their exposure to Agent Orange has resulted in birth defects among their children, this has not been demonstrated in scientific investigations. We realize that some AOCAP-funded organizations have provided valuable services to some Vietnam veterans with children suffering with birth defects and that some organizations may be negatively impacted by the termination of AOCAP. A number of public and private organizations, nevertheless, will continue to provide important services to these veterans and their families. VA officials will continue to provide advice and referral information regarding appropriate community resources. Given the limits of VA's authority in this area, VA is doing as much as it can in this regard consistent with the authority provided by Congress.

Question 4: According to your written statement, VA often refers Vietnam veterans and their families to other agencies. Other witnesses, however, reported very few referrals made by VA.

How many or what percent of the Vietnam veterans and their families referred to other agencies by VA (a) received or (b) did not receive services from the agencies to which they were referred by VA? Describe the method(s) used by VA to track the results of the referrals VA makes to other agencies?

What factors reduce the number of Vietnam veterans and their families referred by VA to other agencies?

Referrals, without active case management and service coordination, do not insure the receipt of needed services or effective treatment. How many Vietnam veterans and their families referred by VA to other agencies are receiving active case management and service coordination from VA?

What prevents VA from providing active case management and service coordination to veterans and their family members for problems stemming from post-traumatic stress?

Answer: RCS understands the importance of case management and follow-up coordination in relation to referral services for veterans and family members. The features of effective referral services on behalf of veterans include: (1) community outreach and networking to locate and evaluate other needed providers in the community for services not directly provided by Vet Centers, (2) education and consultation to prospective referral sources regarding the special needs of veteran clients, (3) case-management for tracking and integrating the efforts of variable service providers in a coordinated case treatment plan and (4) follow-up to ensure that anticipated outcomes have in fact been achieved. This is long standard practice for Vet Centers when involved in community interventions on behalf of veterans.

The requested data regarding Vet Center referrals is being collected in the field and will be transmitted as soon as it has been received, reviewed and collated.

As noted above, information about numbers of veterans' families referred for services are not available and would require a special survey of the field. Case management as an approach to ensuring continuity of care is becoming standard practice in VA mental health services. The Admissions and Aftercare Coordinators assigned to Specialized Inpatient PTSD Units with large waiting lists are one example of the application of case management concepts to PTSD care.

Questions Submitted by Honorable Lane Evans

Follow-up Information to May 18, 1994
Hearing on Social Services for Vietnam Veterans and Their Families: Current Programs and Future Directions

Questions for Dr. David H. Law

Question 4:

During the first two quarters of fiscal year 1994, the Vet Centers system-wide referred a total of 3,937 Vietnam veterans and family members to other service providers (VA and non-VA) for family related problems. During the same period of time, 3,197 (or 81 percent) of these referrals were judged effective by Vet Center staff, i.e., successful contact was made with the referral source and the anticipated service was provided. Case management and coordination were actively provided on an ongoing basis by Vet Center staff for 2,855 (or 73 percent) of the cases referred.

The following activities were undertaken by Vet Center staff system-wide to track and follow-up on the course and outcome of case referrals of Vietnam Veterans and family members.

- Telephonic follow-up and/or case staffings
- Personal follow-up and/or case staffings
- Direct contact with client & referral agency for case review
- Letters to referral agency and/or veteran for follow-up
- Written case reports from referral agency
- Veterans and/or families continue in treatment at Vet Center for other issues and report progress of referral
- Referral agency involved in Vet Center staffing sessions pertaining to veteran and family
- Case management oversight by Vet Center staff
- Hand carry and personal escort of client to referral agency

The following activities were undertaken by Vet Center staff system-wide to provide case management for referrals of Vietnam Veterans and family members.

- Case reviews and clinical supervision between Vet Center and referral agency
- Telephone calls to and from referring agency for case related consultations and treatment summaries
- Sharing of case treatment summaries and case reports through client release of information
- Direct involvement at the referral agency by Vet Center staff through case staffing and supervision
- Referral agency providing care invited to the Vet Center to consult with staff and participate in the referral process, treatment planning and case review
- Collaborative plans developed between Vet Center and referral agency to ensure that positive outcomes of needed services are achieved
- Interagency clinical staff meetings to develop conjoint treatment plans and strategies
- Individual clinical supervision of Vet Center counselors regarding case follow-up for referrals
- Clinical consultation between Vet Center and referral agency staff
- Direct contact maintained with veteran by scheduled appointments at the Vet Center for referral feedback and case follow-up
- Continuation of the veteran's counseling at the Vet Center for other or related problems

For those referrals that were not successful, the following variables were operative in impeding and disrupting the referral.

- Unavailability of suitable resources and trained staff
- Client resistive to treatment
- Relapses for chemical dependency
- Unforeseen family emergencies or catastrophes
- Divorce or separation during treatment
- Financial problems
- Veteran does not meet the criteria for treatment at VAMC under the means test
- Legal Issues
- Distance from available resource
- Lack of commitment to treatment by one or more family members
- Trust issues related to referral agency
- Family resistance to the referral
- Lack of confidence in the referral source
- Referral sources did not understand combat PTSD and how if affects family members
- Some community resources do not include war-related readjustment issues in the assessment and counseling process
- Veterans' denial of problems/issues
- Many veterans are unable to pay and/or do not have medical insurance for services available through private agencies
- Veterans discouraged about all the rituals of paperwork required from the referral agency
- Lack of adequate transportation
- Working clients' schedules conflicted with community service hours of referral agency
- Inaccessibility of VAMC for non-service connected Veterans to receive mental health outpatient care
- Delayed appointment schedules

Question 5A: Your written testimony describes several locally initiated programs which respond to the needs of Vietnam veterans and their families. Please identify the VA facility at which each locally initiated program described in your written statement is located and provide the cost for each of these locally initiated programs.

Answer: VA PTSD Programs: Enclosed is the PTSD Directory dated April 1994, which includes the location of all VA PTSD Programs as well as the Coordinator/ Director, of the program, phone number, etc. Except where stated, the cost for the programs identified below are funded through allocations provided for our PTSD programs.

Vietnam Veterans Liaison Unit (VVLU): The VVLU operates as the "Front-Door" for Vietnam veterans' services at the West Los Angeles VA Medical Center. VVLU promotes a comfortable, safe, humane, "Safety zone" where veterans and their families can learn about a variety of services designed to help them. Those services include:

(1) Basic VA information
(2) Crisis - counseling
(3) Group and individual counseling
(4) Family/Marital counseling--including a community-based weekly family/significant others group
(5) Employment/vocational resources
(6) Veteran educational workshops/family workshops
(7) Referral to other VA programs
(8) Working on future and unmet veterans needs
(9) Agent orange information/referrals

The VVLU has been providing these services for over 11 years.

Again, these comprehensive services are provided in a caring and humane environment that utilizes staff, community, volunteers, and former clients to create a dynamic, problem-solving program that "keeps it simple" within a large, complex medical center. The VVLU provides services to "link" the veterans and their families to services outside the VVLU. In the case of needs that have been identified and are not being met, the VVLU has worked to establish and implement new programs. VVLU has served over four thousand veterans and their families every year since 1983 and the key is knowing the clients and their needs.

Post Traumatic Stress Disorder Residential Rehabilitation Programs (PRRP): The Department of Veterans Affairs currently has ten PRRP's systemwide, the locations of which are included. The PRRP provides comprehensive social services to Vietnam veterans and their families, making the transition to the community. The PRRP is the "home-coming and debriefing" that many of the Vietnam veterans never received. The PRRP teaches communication and family skills and actively involves family and significant others in all aspects of inpatient and outpatient care. The PRRP encourages veterans and their families to view problems and solutions within the family system. PRRP also encourages full community participation.

The VA/AOCAP Wilderness Inquiry Program: As reported in the April 1994, VFW Magazine, the program provided a father-son trip to the Canadian North and was comprised of clients in the PTSD clinic at the Hines VA Medical Center in Illinois. This program augmented VA PTSD treatment services to veterans by including the children in the AOCAP funded event. The non-profit Wilderness Inquiry is funded by corporate and individual donations, foundations, fund-raising and federal funds. Some 30 - 50 percent of revenues come from trip participants.

VA Medical Center/Vet Center Outdoor Challenge Group: The Outdoor Challenge Program is a collaborative effort of the Vet Centers in Evanston and Springfield, Illinois, and the North Chicago and Hines VA Medical Centers. It is comprised of a four session counseling program, during which participants will join in a variety of challenging outdoor experiences. Participants are selected from Vietnam and post Vietnam conflict zone veterans in counseling at one of the Chicago VA Medical Centers or Vet Center facilities. The program is funded by the North Chicago VA Medical Center and a variety of organizations which have donated funds for patient activities.

Couples Groups for Vietnam Veterans and Wives or Partners: This is essentially one of the treatments of choice in all PTSD and Vet Center programs when there is a spouse or partner available for inclusion into the treatment program. Veterans and/or spouses/partners are also seen individually, as determined by the clinician to meet the comprehensive needs of the client situation.

Vietnam Veterans Children's Group: The Topeka VA Medical Center developed this program to assess and treat the impact of the PTSD experience on veterans' children. This is accomplished through age - appropriate education, discussion, therapeutic play and caring.

Question 5B: Does each VA facility have a program which responds to the needs of Vietnam veterans and their families? Please identify these programs. Please identify each VA facility which does not have a program which responds to the needs of Vietnam veterans and their families.

Answer: The enclosed list shows that we have 141 specialized PTSD programs at 99 VA Medical Centers. In addition the 202 Vet Center programs respond to the specialized needs of the Vietnam veterans and their families. Also, enclosed is the Vet Center Program Directory for April 1994. Facilities that do not have designated PTSD programs often have staff that have received training which qualifies them to provide the intervention. Although all VA facilities should be capable of responding to the needs of Vietnam veterans and their families, services throughout VA are uneven. The isolated rural VA Medical Centers which treat smaller Vietnam veteran populations do not have the number of admissions to merit the more specialized PTSD programs. Some facilities offer extensive services while others are limited to the availability of trained personnel and resources.

Question 5C: How does each of the locally initiated programs described in your written testimony as responding to the needs of Vietnam veterans and their families supplement other programs at those VA facilities which also respond to the needs of Vietnam veterans and their families?

Answer: The locally initiated VA Medical Center programs described in the written testimony in most instances were developed as an outgrowth of an existing PTSD program. They were started to address an identified need or resource which the Vietnam veteran and family required for this comprehensive treatment. They are often viewed as an aspect of a "continuum of care" in providing a holistic approach in resolving the social needs of the family. It should also be noted that PTSD is a complex, many-faceted syndrome. With the establishment of PTSD treatment units, hospital staff in other programs became aware and knowledgeable that the underlying or primary cause of the problems their veteran clientele are experiencing may be related to traumatic stress. The specialized PTSD programs receive referrals from all existing VA Medical Center treatment programs, medical and psychiatric. Although there are a number of referrals from the medical and surgical programs the majority of requests reviewed are from the psychiatric, substance abuse and homeless programs. The referral process is two way and the quality of the overall treatment benefits to the veteran are enhanced.

Relationships with the local community programs described in the testimony have grown over a period of time and have enhanced and extended treatment and agency resources to Vietnam veteran and their families. An example is AOCAP. AOCAP, at several of their locations nationwide, are not only working closely with VA Medical Center and Vet Center staff but are working at VA facilities locations to serve their clientele. This arrangement strengthens both programs, provides more treatment options and most importantly benefits the veteran and his family.

Question 5D: At how many additional VA facilities could a locally initiated program like those described in your written testimony as responding to the needs of Vietnam veterans and their families be beneficial to Vietnam veterans and their families?

Answer: As mentioned above, most of the locally initiated programs are an outgrowth of existing PTSD programs. In the past when our Department has solicited the VA Medical Centers for Requests for Proposals (RFPs) for funding of specialized PTSD programs we have always received more requests for new or expanded programs than the funding would allow. An extensive review process was required to select the most deserving requests and rarely were any programs funded to meet the documented financial request of the program.

Question 6: Please comment on "family-centered veteran services" and describe how they differ from traditional veteran services. Why are "family-centered veteran services" important and what are the advantages and disadvantages of this approach compared to traditional veteran services?

Answer: Family-centered or systems approaches are distinguished from other more traditional individual psychological approaches by the following attributes: (1) since problems are defined in transactional or relational terms, the onus for change does not rest on the client alone, (2) the unit of client-therapist attention is expanded to include the life space or the social field of relevant interpersonal systems, (3) human beings are viewed as active, purposeful, goal-seeking organisms whose development and functioning are outcomes of transactions between themselves and their environment, (4) a reorienting of intervention procedures toward more adaptive transactions with an improved environment.

As referenced above, family-centered therapy can be an important adjunct to direct treatment of the veteran with PTSD specifically to improve the clinical management of the effect of family relations on the course of the PTSD in the veteran and reciprocally of the impact of the veteran's PTSD on the quality of family relations. As a psychological condition, however, PTSD adheres in the individual personalities of those exposed to extreme environmental stress. The mechanism of influencing family members is via the behavior of the victim which, in its extreme expressions, can become an environmental stressor for other family members. Also, the behavior of other family members can trigger intrusive recollections of traumatic memories and/or defensive avoidance behaviors in the veteran. Family triggers and reactive behaviors on the part of the veteran would all be individualized on a case-by-case basis specific to the particulars of the veteran's traumatic experiences and recollections. Depending on the intrusive/avoidant cycling of PTSD symptomology, the veteran's influence on family members could range from abusive anger to neglectful distancing. Fear of loss and unresolved grief in the veteran could also result in over-controlling attitudes and behaviors in relation to older children who developmentally require increased latitudes for growing autonomy.

Question 7: Compare the cost of traditional veteran services with the cost of "family-centered veteran services." Are "family-centered veteran services more costly or more cost-effective for providing effective treatment to veterans than traditional veterans services?

Answer: It is not possible to answer the question directly, because VA does not have a history of providing family-centered services for veteran's families. Therefore, there is no basis for comparing costs of services under the two models. The Persian Gulf Family Support Program is one of the few programs intentionally designed around the principles of family-centered services. However, two cases may be informative. First, among many public social service agencies, family preservation programs have shifted their attention from the child as the primary client to the child's family as the client. When this family-centered model is used, several benefits are derived:

(a) There is a decreased need for expensive foster care.

(b) The likelihood of childhood illness and injury is reduced.

(c) Adjudication costs are reduced.

(d) The need for alcohol and drug treatment is reduced.

(e) Publicly-subsidized child care enables the adults in the family to more easily enter or re-enter the work force.

(f) Caregivers of the frail or ill elderly have needs that are often overlooked. Satisfaction of the client and the caregiver are often enhanced under the family-centered model.

Question 8: Is trauma treatment likely to be less successful if it is not family oriented? Please explain your answer.

With regard to effectively addressing the problems experienced by veterans and their family members which are related to the veteran's military experience, discuss the importance of addressing the needs of the family as a unit.

Answer: The use of family therapy in the treatment of PTSD in war veterans is a valuable tool depending on the clinical features of the case. For some cases, treatment of PTSD in the veteran will not be as effective if appropriate attention is not given to the family, with particular attention to family environments which function to maintain the veteran's PTSD symptoms by either protecting the veteran or by being victimized by the veteran. Again, it is helpful to be mindful of the fact that, psychologically, PTSD is a collection of symptoms which adhere in the survivor's individual personality, the therapeutic recovery from which is also personal and individualized according to the victim's particular personality, traumatic experiences and recovery environment.

Psychotherapy for PTSD begins with the telling of the story of the events before, during and after the major traumatic event. In addition, the therapeutic working through for PTSD consists in the systematic linking of the current PTSD symptoms (behaviors, thoughts, feelings, dreams, defenses, etc.) with the actual war-related traumatic memories. Family therapy sessions may need to be worked into the therapeutic equation to address immediate family relationship problems and help prepare the veteran for more intensive revisiting of traumatic memories, or alternatively may be important in a later phase of therapy, after some of the individual trauma work has concluded, to help reconnect the veteran to his/her social environment. Additionally, in some cases, individual processing of traumatic material may be accomplished in conjoint marital sessions if the veteran's marriage provides a sufficiently supportive and trusting environment for the required intensity of this work.

Question 9: Your prepared statement refers to "well-established referral networks and community planning partnerships." Please provide several examples of these networks and partnerships.

Answer: (1) Principle: In service networks, resources are known and accessed regularly. Example: The VA mental hygiene clinician is familiar with school-based counseling options for children. The clinician knows how to refer veterans' children to school and community mental health resources for children and adolescents.

(2) Principle: Referral processes are two way--from VA and to VA. Example: A judge orders a veteran into a community program for domestic violence. The counselor recognizes that the veteran might also have a chemical dependency problem and refers him to the VA substance abuse program. Likewise, the VA clinician might recognize that a veteran in the PTSD program is subjecting his family members to violent behaviors and might refer the family to the domestic violence program in the community.

(3) Principle: Services are coordinated for the time that multi-agency resources are needed to serve the veteran and his/her family. Example: An ill, homeless veteran with physical disabilities could live more or less independently in the community if accessible housing could be located. VA works with the local housing authority to locate suitable, accessible housing. VA provides medical care and physical therapy or rehabilitation and coordinates services with the housing authority as long as the veteran requires services.

(4) Principle: Service quality is based on the effectiveness of the network of agencies, rather than just one agency. Example: VA develops a new program to assist formerly hospitalized veterans with chronic mental illness to live in the community. It works within the VA hospital to prepare clients for living in the community. It also works with community housing sources to develop suitable housing arrangements (some supervised, some independent) and with the county recreation department to develop leisure time activities for veterans and other members of the community. The quality of services in each agency and the quality of the community living program depends on the effectiveness of the network that VA has organized.

(5) Principle: Service networks involve planning for non-duplicated services based on agreements on resource sharing. Example: VA's supported work program works with the community mental health center to develop support groups for community members who have recently entered the work force. Veterans are referred to the support groups. In addition, the community job service and VA work with local industry to create new jobs for veterans enrolled in the supported work program. The industry involves VA and community counselors in their in-service program to help their employees understand the needs of workers with chronic mental illness. Because of VA's initiative, these programs and resource sharing agreements benefit veterans and the entire community.

Additional information regarding community referral networks for Vet Centers is being collected from the field and will be transmitted as soon as it has been received and aggregated.

Question 10: Discuss the transgenerational effects of combat related PTSD on a veteran's family and children.

Answer: See response to Question 8 above.

ATTACHMENT TO QUESTION 5B

DEPARTMENT OF VETERANS AFFAIRS

READJUSTMENT COUNSELING SERVICE

VET CENTER PROGRAM DIRECTORY

APRIL 1994

ALPHABETICAL BY STATE AND CITY

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SUITE A	FTS:	799-6342
RIVERSIDE,CA 92571	FAX:	714/352-0301

CALIFORNIA, SACRAMENTO
TEAM #: 0638 SUPPORT FACILITY: PLEASANT HILL, CA VANCSC
DATE OPENED: 04/011/86
TEAM LEADER: I. MICHAEL COHEN, ED.D.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	916/978-5477
1111 HOWE AVENUE		
SUITE 390	FTS:	460-5477
SACRAMENTO, CA 95825	FAX:	916/978-5550

CALIFORNIA, SAN DIEGO
TEAM #: 0618 SUPPORT FACILITY: SAN DIEGO, CA VAMC
DATE OPENED: 02/26/80
TEAM LEADER: RICHARD TALBOTT, M.S.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	619/294-2040
2900 6TH AVENUE		
SAN DIEGO, CA 92103	FTS:	895-7226
	FAX:	619/294-2535

CALIFORNIA, SAN FRANCISCO
TEAM #: 0620 SUPPORT FACILITY: SAN FRANCISCO, CA VAMC
DATE OPENED: 06/16/80
TEAM LEADER: DENVER MILLS, M.A.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	415/431-6021
25 VAN NESS AVENUE		
SAN FRANCISCO, CA 94102	FTS:	470-3991
	FAX:	415/431-9826

CALIFORNIA, SAN JOSE
TEAM #: 0615 SUPPORT FACILITY: PALO ALTO, CA VAMC
DATE OPENED: 01/17/80
TEAM LEADER: JOHN GONZALES, M.S.W.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	408/993-0829
1022 WEST HEDDING		
SAN JOSE, CA 95126	FTS:	466-7750
	FAX:	408/249-3469

CALIFORNIA, SANTA BARBARA
TEAM #: 0643 SUPPORT FACILITY: WEST LOS ANGELES, CA VAMC
DATE OPENED: 03/15/86
ACT. TEAM LEADER: JOSEPH NARKEVITZ, M.F.A./M.A.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	805/564-2345
1300 SANTA BARBARA STREET		
SANTA BARBARA, CA 93101	FTS:	NONE
	FAX:	805/963-7662

CALIFORNIA, SEPULVEDA
TEAM #: 0605 SUPPORT FACILITY: SEPULVEDA, CA VAMC
DATE OPENED: 01/26/80
TEAM LEADER: DAVID ALCARAS, M.A.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	818/892-9227
16126 LASSEN STREET		800/637-6524
SEPULVEDA, CA 91343		NONE
		818/892-0557

CALIFORNIA, UPLAND
TEAM #: 0637 SUPPORT FACILITY: LOMA LINDA, CA VAMC
DATE OPENED: 03/12/86
TEAM LEADER: HOUSTON A. LEWIS, JR., M.S.W.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	714/982-0416
313 N. MOUNTAIN AVENUE		
UPLAND, CA 91786	FTS:	NONE
	FAX:	714/931-0536

CALIFORNIA, VISTA
TEAM #: 0642 SUPPORT FACILITY: SAN DIEGO, CA VAMC
DATE OPENED: 09/06/85
TEAM LEADER: GARY MCKAY, M.S.W.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	619/945-8941
1830 WEST DRIVE		
SUITE 103/104	FTS:	NONE
VISTA, CA 92083	FAX:	619/945-7263

COLORADO, BOULDER
TEAM #: 0527 SUPPORT FACILITY: DENVER, CO VAMC
DATE OPENED: 09/12/85
TEAM LEADER: STEWART BROWN, PH.D.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	303/440-7306
2128 PEARL STREET		
BOULDER, CO 80302	FTS:	NONE
	FAX:	303/449-3907

COLORADO, COLORADO SPRINGS
TEAM #: 0525 SUPPORT FACILITY: DENVER, CO VAMC
DATE OPENED: 08/31/81
TEAM LEADER: CLIFFORD BROWN, M.S.W.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	719/471-9992
416 E. COLORADO AVENUE		
COLORADO SPRINGS, CO 80903	FTS:	NONE
	FAX:	719/632-7571

COLORADO, DENVER
TEAM #: 0504 SUPPORT FACILITY: DENVER CO VAMC
DATE OPENED: 02/20/80
TEAM LEADER: EDWARD SALDIVAR, M.S.W.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	303/433-7123
1815 FEDERAL BLVD.		
DENVER, CO 80204	FTS:	322-2595
	FAX:	303/458-8864

CONNECTICUT, HARTFORD
TEAM #: 0117 SUPPORT FACILITY: NEWINGTON, CT VAMC
DATE OPENED: 01/16/81
TEAM LEADER: IRMA GIBSON, M.S.W.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	203/240-3543
370 MARKET STREET		203/240-3544
HARTFORD, CT 06120	FTS:	
	FAX:	203/240-3415

CONNECTICUT, NEW HAVEN
TEAM #: 0116 SUPPORT FACILITY: WEST HAVEN, CT VAMC
DATE OPENED: 02/22/80
TEAM LEADER: BERNARD JONES, M.S.W.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	203/932-9899
141 CAPTAIN THOMAS BLVD.		
WEST HAVEN, CT 06516	FTS:	203/933-1827
	FAX:	203/933-1827

CONNECTICUT, NORWICH
TEAM #: 0127 SUPPORT FACILITY: NEWINGTON, CT VAMC
DATE OPENED: 01/21/86
ACT. TEAM LEADER: JANE THOMSON, M.S.W.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	203/887-1755
100 MAIN STREET		203/887-7934
NORWICH, CT 06360	FTS:	240-3191
	FAX:	203/887-6343

DELAWARE, WILMINGTON
TEAM #: 0215 SUPPORT FACILITY: WILMINGTON, DC VAMC
DATE OPENED: 06/25/80
TEAM LEADER: MARK KAUFKI, ED.D.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	302/994-1660
VAMROC BUILDING 2		
1601 KIRKWOOD HIGHWAY	FTS:	487-5360
WILMINGTON, DE 19805	FAX:	302/633-5250

DISTRICT OF COLUMBIA, WASHINGTON
TEAM #: 0214 SUPPORT FACILITY: WASHINGTON, DC VAMC
DATE OPENED: 04/25/80
TEAM LEADER: WAYNE MILLER, M.A.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	202/543-8821
801 PENNSYLVANIA AVENUE, SE		
LOWER LEVEL	FTS:	745-8400
WASHINGTON, DC 20003	FAX:	202/543-2681

FLORIDA, FORT LAUDERDALE
TEAM #: 0311 SUPPORT FACILITY: MIAMI, FL VAMC
DATE OPENED: 04/18/81
TEAM LEADER: BOBBY WHITE, M.S.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	305/356-7926
315 N.E. 3RD AVENUE		
FT. LAUDERDALE, FL 33301	FTS:	356-7373
	FAX:	356-7609

FLORIDA, JACKSONVILLE
TEAM #: 0305 SUPPORT FACILITY: GAINESVILLE, FL VAMC
DATE OPENED: 03/31/80
TEAM LEADER: REGINALD LAWRENCE, B.A.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	904/232-3621
1833 BOULEVARD STREET		
JACKSONVILLE, FL 32206	FTS:	NONE
	FAX:	904/232-3167

FLORIDA, MIAMI
TEAM #: 0310 SUPPORT FACILITY: MIAMI, FL VAMC
DATE OPENED: 03/01/80
TEAM LEADER: ED CALVO

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	305/859-8387
2700 SW 3RD AVENUE		
SUITE 1A	FTS:	350-6856
MIAMI, FL 33129	FAX:	350-7870

FLORIDA, ORLANDO
TEAM #: 0314 SUPPORT FACILITY: TAMPA, FL VAMC
DATE OPENED: 03/18/82
TEAM LEADER: LEONARD PORTER, M.S.W.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	407/648-6151
5001 S. ORANGE AVENUE, SUITE A		
ORLANDO, FL 32809	FTS:	820-6151
	FAX:	407/648-6104

FLORIDA, PALM BEACH
TEAM #: 0326 SUPPORT FACILITY: MIAMI, FL VAMC
DATE OPENED: 12/13/85
TEAM LEADER: WILLIAM WEITZ, PH.D.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	407/585-0441
SPECTRUM CENTRE		
2311 10TH AVENUE, N. #13	FTS:	350-6790
LAKE WORTH, FL 33461	FAX:	407/585-1330

FLORIDA, PENSACOLA
TEAM #: 0321 SUPPORT FACILITY: BILOXI, MS VAMC
DATE OPENED: 12/04/85
ACT. TEAM LEADER: LARRY RAPPE

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	904/435-8761
202 W. JACKSON STREET		
PENSACOLA, FL 32501	FTS:	
	FAX:	904/438-6625

FLORIDA, SARASOTA
TEAM #: 0320 SUPPORT FACILITY: BAY PINES, FL VAMC
DATE OPENED: 11/01/85
TEAM LEADER: FRED MCLAUGHLIN, B.A.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	813/952-9406
1800 SIESTA DRIVE		
SARASOTA, FL 34239	FTS:	NONE
	FAX:	813/366-2672

FLORIDA, ST. PETERSBURG
TEAM #: 0301 SUPPORT FACILITY: BAY PINES, FL VAMC
DATE OPENED: 03/24/80
TEAM LEADER: JOSEPH ADCOCK, M.A.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	813/893-3791
2837 1ST AVENUE, NORTH		
ST. PETERSBURG, FL 33713	FTS:	826-3791
	FAX:	813/893-3210

FLORIDA, TALLAHASSEE
TEAM #: 0325 SUPPORT FACILITY: LAKE CITY, FL VAMC
DATE OPENED: 10/04/85
TEAM LEADER: GREGG BROWN, B.A.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	904/942-8810
249 E 6TH AVENUE		
TALLAHASSEE, FL 32303	FTS:	965-8810
	FAX:	904/942-8814

FLORIDA, TAMPA
TEAM #: 0318 SUPPORT FACILITY: TAMPA, FL VAMC
DATE OPENED: 07/09/81
TEAM LEADER: RON MOONEYHAN, M.A.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	813/228-2621
1507 W. SLIGH AVENUE		
TAMPA, FL 33604	FTS:	826-2621
	FAX:	813/228-2868

GEORGIA, ATLANTA
TEAM #: 0304 SUPPORT FACILITY: ATLANTA (DECATUR), GA VAMC
DATE OPENED: 01/23/80
TEAM LEADER: LYNWOOD BRADLEY, M.S.W.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	404/347-7275
77 PEACH STREET PLACE, N.W.		
ATLANTA, GA 30309	FTS:	257-7264
	FAX:	404/347-7269

GEORGIA, SAVANNAH
TEAM #: 0323 SUPPORT FACILITY: CHARLESTON, SC VAMC
DATE OPENED: 12/05/85
TEAM LEADER: JAMES MILLER

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	912/652-4097
8110 WHITE BLUFF ROAD		
SAVANNAH, GA 31406	FTS:	652-4097
	FAX:	912/652-4204

GUAM, AGANA
TEAM #: 0648 SUPPORT FACILITY: HONOLULU, HI VARO
DATE OPENED: 08/22/88
TEAM LEADER: SALVADOR UEDA, M.S.W.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	011671471716
U.S. NAVAL HOSPITAL		
PSC 490 BOX 7613	FTS:	550-7252
FPO-AP 96540-1600	FAX:	011671472716

HAWAII, HILO
TEAM #: 0635 SUPPORT FACILITY: HONOLULU, HI VARO
DATE OPENED: 08/22/88
TEAM LEADER: ALBERT IGNACIO, M.S.W.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	808/969-3833
120 KEAWE STREET, SUITE 201		
HILO, IH 96720	FTS:	NONE
	FAX:	808/969-3835

HAWAII, HONOLULU
TEAM #: 0609 SUPPORT FACILITY: HONOLULU, HI VARO
DATE OPENED: 05/29/80
TEAM LEADER: STEPHEN T. MOLNAR, M.A.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	808/541-1764
1680 KAPIOLANI BLVD.		
SUITE F	FTS:	551-1764
HONOLULU, HI. 96814	FAX:	808/541-3600

HAWAII, KAUAI
TEAM #: 0633 SUPPORT FACILITY: HONOLULU, HI VARO
DATE OPENED: 08/22/88
TEAM LEADER: ROMY CASTILLO, M.S.W.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	808/246-1163
3367 KUHIO HIGHWAY		
SUITE 101	FTS:	NONE
LIHUE, HI 96766	FAX:	808/246-9349

HAWAII, KONA
TEAM #: 0636 SUPPORT FACILITY: HONOLULU, HI VARO
DATE OPENED: 08/22/88
TEAM LEADER: RONALD BOXMEYER, M.S.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	808/329-0574
POTTERY TERRACE, FERN BUILDING		808/329-0575
75-5995 KUAKINI HWY, SUITE 415	FTS:	NONE
KAILUA-KONA, HI 96740	FAX:	808/329-0776

HAWAII, MAUI
TEAM #: 0634 SUPPORT FACILITY: HONOLULU, HI VARO
DATE OPENED: 08/22/88
ACT. TEAM LEADER: BOB MORTON

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	808/242-8557
TING BUILDING		
35 LUNALILO, SUITE 101	FTS:	NONE
WAILUKU, HI 96793	FAX:	808/242-6846

IDAHO, BOISE
TEAM #: 0503 SUPPORT FACILITY: BOISE, ID VAMC
DATE OPENED: 02/28/80
TEAM LEADER: MIKE MIRACLE, M.S.W.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	208/342-3612
1115 W. BOISE AVENUE		
BOISE, ID 83706	FTS:	554-7568
	FAX:	208/342-0327

IDAHO, POCATELLO
TEAM #: 0531 SUPPORT FACILITY: SALT LAKE CITY, UT VAMC
DATE OPENED: 07/10/85
TEAM LEADER: DONALD ROTH, M.P.A.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	208/323-0316
1975 SOUTH 5TH STREET		
POCATELLO, ID 83201	FTS:	NONE
	FAX:	208/232-6258

ILLINOIS, CHICAGO
TEAM #: 0410 SUPPORT FACILITY: CHICAGO (WESTSIDE), IL VAMC
DATE OPENED: 01/14/80
TEAM LEADER: GERALD HAYES, M.A.

ADDRESS	TELEPHONES	
VRC	COMMERCIAL:	312/684-5500
1514 E. 63RD STREET		
CHICAGO, IL 60637	FTS:	886-5738
	FAX:	312/684-8225

ILLINOIS, CHICAGO
TEAM #: 0420 SUPPORT FACILITY: NORTH CHICAGO, IL VAMC
DATE OPENED: 03/22/86
TEAM LEADER: BETSY TOLSTEDT, PH.D.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	708/332-1019
565 HOWARD STREET		
EVANSTON, IL 60602	FTS:	NONE
	FAX:	708/332-1024

ILLINOIS, CHICAGO HEIGHTS
TEAM #: 0407 SUPPORT FACILITY: CHICAGO (LAKESIDE), IL VAMC
DATE OPENED: 01/14/83
TEAM LEADER: EARNEST WEBB, PH.D.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	708/754-0340
1600 HALSTED STREET		
CHICAGO HEIGHTS, IL 60411	FTS:	NONE
	FAX:	708/754-0373

ILLINOIS, EAST ST. LOUIS
TEAM #: 0422 SUPPORT FACILITY: ST. LOUIS, MO VAMC
DATE OPENED: 11/01/85
TEAM LEADER: ROSE JOHNSON, M.S.W.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	618/397-6602
1269 N. 89TH STREET SUITE 1		
EAST ST. LOUIS, IL 62203	FTS:	618/482-9484
	FAX:	618/397-6541

ILLINOIS, MOLINE
TEAM #: 0430 SUPPORT FACILITY: IOWA CITY, IA VAMC
DATE OPENED: 07/20/85
TEAM LEADER: PATRICK WALSH, L.C.S.W.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	309/762-6954
1529 16TH AVENUE		
ROOM #6	FTS:	NONE
MOLINE, IL 61265	FAX:	309/762-8298

ILLINOIS, OAK PARK
TEAM #: 0411 SUPPORT FACILITY: HINES, IL VAMC
DATE OPENED: 03/03/80
TEAM LEADER: JEANNE DOUGLAS, PH.D.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	708/393-3225
155 SOUTH OAK PARK AVENUE		
OAK PARK, IL 60302	FTS:	886-6480
	FAX:	708/383-3247

ILLINOIS, PEORIA
TEAM #: 0417 SUPPORT FACILITY: DANVILLE, IL VAMC
DATE OPENED: 08/06/82
ACT. TEAM LEADER: PATRICK WALSH, L.C.S.W.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	309/671-7300
3310 N. PROSPECT STREET		
PEORIA, IL 61603	FTS:	309/671-7300
	FAX:	309/671-7311

ILLINOIS, SPRINGFIELD
TEAM #: 0421 SUPPORT FACILITY: ST. LOUIS, MO VAMC
DATE OPENED: 03/21/86
TEAM LEADER: DONNA BUECHLER, R.N.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	217/492-4955
624 SOUTH 4TH STREET		
SPRINGFIELD, IL 62702	FTS:	217/373-4955
	FAX:	217/492-4963

INDIANA, EVANSVILLE
TEAM #: 0418 SUPPORT FACILITY: MARION, IL VAMC
DATE OPENED: 09/09/81
TEAM LEADER: JACKIE WEBER, M.S.W.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	812/473-5993
311 N. WEINBACH AVENUE		812/473-6084
EVANSVILLE, IN 47711	FTS:	812/465-6536
	FAX:	812/332-6558

INDIANA, FORT WAYNE
TEAM #: 0406 SUPPORT FACILITY: FORT WAYNE, IN VAMC
DATE OPENED: 05/13/80
TEAM LEADER: EDWARD DAX, A.C.S.W.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	219/460-1456
528 WEST BERRY STREET		
FORT WAYNE, IN 46802	FTS:	NONE
	FAX:	219/460-1390

INDIANA, GARY
TEAM #: 0412 SUPPORT FACILITY: CHICAGO (LAKESIDE), IL VAMC
DATE OPENED: 06/20/86
ACT. LEADER: PHILLIP MEYER, M.S.W.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	219/887-0048
2236 WEST RIDGE ROAD		
GARY, IN 46408	FTS:	NONE
	FAX:	219/887-2429

INDIANA, INDIANAPOLIS
TEAM #: 0413 SUPPORT FACILITY: INDIANAPOLIS, IN VAMC
DATE OPENED: 07/17/80
TEAM LEADER: STEVEN GROSS, M.S.W.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	317/927-6440
3833 MERIDIAN		
INDIANAPOLIS, IN 46208	FTS:	NONE
	FAX:	317/927-6447

IOWA, CEDAR RAPIDS
TEAM #: 0431 SUPPORTS FACILITY: IOWA CITY, IA VAMC
DATE OPENED: 02/02/93
SATELLITE COORDINATOR: PHILLIP ROSS, R.N.

ADDRESS	TELEPHONES	
VET CENTER SATELLITE	COMMERCIAL:	319/362-0409
3349 SOUTH GATE COURT		
CEDAR RAPIDS, IA 52404	FTS:	
	FAX:	319/362-4081

IOWA, DES MOINES
TEAM #: 0405 SUPPORT FACILITY: DES MOINES, IA VAMC
DATE OPENED: 01/12/80
ACT. TEAM LEADER: CHARLES ZIMMERMAN, M.A., M.S.W.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	515/284-4929
2600 MARTIN LUTHER KING, JR. PKWY		
DES MOINES, IA 50310	FTS:	515/284-4929
	FAX:	515/284-4931

IOWA, SIOUX CITY
TEAM #: 0428 SUPPORT FACILITY: SIOUX FALLS, SD VAMC
DATE OPENED: 08/16/81
TEAM LEADER: JOHN SABATA, M.S.W.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	712/255-3808
706 JACKSON		
SIOUX CITY, IA 51101	FTS:	NONE
	FAX:	712/255-3725

KANSAS, WICHITA
TEAM #: 0426 SUPPORT FACILITY: WICHITA, KS VAMC
DATE OPENED: 11/21/79
TEAM LEADER: LEON HAVERKAMP, M.S.W.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	316/265-3260
413 S. PATTIE		
WICHITA, KS 67211	FTS:	NONE
	FAX:	316/265-3623

KENTUCKY, LEXINGTON
TEAM #: 0203 SUPPORT FACILITY: LEXINGTON, KY VAMC
DATE OPENED: 03/20/82
TEAM LEADER: JOHN FOLEY, M.S.W.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	606/276-5269
1117 SOUTH LIMESTONE STREET		
LEXINGTON, KY 40503	FTS:	352-4899
	FAX:	700/352-4880

KENTUCKY, LOUISVILLE
TEAM #: 0202 SUPPORT FACILITY: LOUISVILLE, KY VAMC
DATE OPENED: 08/08/80
TEAM LEADER: PHIL GOUDEAU

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	502/894-6290
1355 S. 3RD STREET		
LOUISVILLE, KY 40208	FTS:	548-6290
	FAX:	700/548-6294

LOUISIANA, NEW ORLEANS
TEAM #: 0717 SUPPORT FACILITY: NEW ORLEANS, LA VAMC
DATE OPENED: 04/16/80
TEAM LEADER: HARRY J. DOUGHTY, M.S.W.

ADDRESS	TELEPHONES	
VRC	COMMERCIAL:	504/943-8386
1529 N. CLAIBORNE AVENUE		
NEW ORLEANS, LA 70116	FTS:	
	FAX:	504/589-5912

LOUISIANA, SHREVEPORT VET CENTER
TEAM #: 0704 SUPPORT FACILITY: SHREVEPORT, LA VAMC
DATE OPENED: 09/05/85
TEAM LEADER: LOTTIE TRIPLETT-FITTS, M.S.W.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	318/425-8387
BLDG. 3, SUITE 260		
2620 CENTENARY BLVD.	FTS:	
SHREVEPORT, LA 71104	FAX:	318/425-8386

MAINE, BANGOR
TEAM #: 0121 SUPPORT FACILITY: TOGUS, ME VAMC
DATE OPENED: 01/04/82
TEAM LEADER: JOSEPH DEGRASSE, B.S.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	207/947-3391
352 HARLOW STREET		207/947-3392
BANGOR, ME 04401	FTS:	833-7309
	FAX:	207/941-8195

MAINE, CARIBOU
TEAM #: 0119 SUPPORT FACILITY: TOGUS, ME VAMC
DATE OPENED: 10/15/92
SATELLITE COORDINATOR: FREEMAN COREY, M.S.W.

ADDRESS	TELEPHONES	
VET CENTER SATELLITE	COMMERCIAL:	207/496-3900
228 SWEDEN STREET		207/493-6770
CARIBOU, ME 04736	FTS:	NONE
	FAX:	207/493-6773

MAINE, LEWISTON
TEAM #: 0129 SUPPORT FACILTIY: TOGUS, ME VAMC
DATE OPENED:
ACT. TEAM LEADER: JOE DEGRASSE, B.S.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	207/783-0068
PLEASANT STREET PLAZA		
475 PLEASANT STREET	FTS:	NONE
LEWISTON, ME 04240	FAX:	207/783-3505

MAINE, PORTLAND
TEAM #: 0115 SUPPORT FACILITY: TOGUS, ME VAMC
DATE OPENED: 02/08/80
TEAM LEADER: PATRICIA RIKER, R.N.C.S., M.S.W.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	207/780-3584
475 STEVENS AVENUE		207/780-3585
PORTLAND, ME 04103	FTS:	
	FAX:	207/780-3545

MAINE, SANFORD
TEAM #: 0130 SUPPORT FACILITY: TOGUS, ME VAMC
DATE OPENED:
ACT. TEAM LEADER: JACK HANSEN, R.N.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	207/490-1513
441 MAIN STREET		207/490-1520
SANFORD, NE 04073	FTS:	NONE
	FAX:	207/490-1609

MARYLAND, BALTIMORE
TEAM #: 0201 SUPPROT FACILTY: BALTIMORE, MD VAMC
DATE OPENED: 03/13/80
TEAM LEADER: JAMES WORKMAN, M.S.W.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	410/539-5511
777 WASHINGTON, BLVD.		
BALTIMORE, MD 21230	FTS:	962-1815
	FAX:	410/539-0162

MARYLAND, ELKTON
TEAM #: 0209 SUPPORT FACILITY: PERRY POINT, MD VAMC
DATE OPENED: 02/22/80
TEAM LEADER: LON D. CAMPBELL

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	410/398-0171
7 ELKTON COMMERCIAL PLAZA		410/398-0172
SOUTH BRIDGE STREET	FTS:	956-6189
ELKTON, MD 21921	FAX:	410/398-0173

MARYLAND, SILVER SPRING
TEAM #: 0213 SUPPORT FACILITY: WASHINGTON, DC VAMC
DATE OPENED: 04/25/80
TEAM LEADER: JOE COX, M.S.W.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	301/589-1073
1015 SPRING STREET		301/589-1236
SUITE 101	FTS:	745-8397
SILVER SPRING, MD 20910	FAX:	301/588-4882

MASSACHUSETTS, BOSTON
TEAM #: 0101 SUPPORT FACILITY: BOSTON, MA VAMC
DATE OPENED: 02/12/80
TEAM LEADER: TOM HANNON, R.N.C.S.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	617/424-0665
665 BEACON STREET		
BOSTON, MA 02215	FTS:	835-6195
	FAX:	617/424-0254

MASSACHUSETTS, BROCKTON
TEAM #: 0104 SUPPORT FACILITY: BROCKTON, MA VAMC
DATE OPENED: 03/28/80
TEAM LEADER: ANDRE BOURQUE, M.ED.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	508/580-2730
1041L PEARL STREET		508/580-2731
BROCKTON, MA 02401	FTS:	840-6674
	FAX:	508/586-8414

MASSACHUSETTS, LOWELL
TEAM #: 0125 SUPPORT FACILITY: BEDFORD, MA VAMC
DATE OPENED: 09/20/85
TEAM LEADER: JAMES LAWRENCE, M.A.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	508/453-1151
73 EAST MERRIMACK STREET		508/452-9528
LOWELL, MA 01852	FTS:	565-6642
	FAX:	508/441-1271

MASSACHUSETTS, NEW BEDFORD
TEAM #: 0128 SUPPORT FACILITY: PROVIDENCE, RI VAMC
DATE OPENED: 09/19/85
SATELLITE COORDINATOR: NEAL BUCHANAN, MED

ADDRESS	TELEPHONES	
VET CENTER SATELLITE	COMMERCIAL:	508/999-6920
468 NORTH STREET		508/999-1805
NEW BEDFORD, MA 02740	FTS:	
	FAX:	508/997-3348

MASSACHUSETTS, SPRINGFIELD
TEAM #: 0103 SUPPORT FACILITY: NORTHAMPTON, MA VAMC
DATE OPENED: 05/26/82
TEAM LEADER: SUZANNE LITTLE, M.S.W.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	413/737-5167
1985 MAIN STREET		413/737-5168
NORTHGATE PLAZA	FTS:	
SPRINGFIELD, MA 01103	FAX:	413/733-0537

MASSACHUSETTS, WORCESTER
TEAM #: 0126 SUPPORT FACILITY: BROCKTON, MA VAMC
DATE OPENED: 01/13/85
TEAM LEADER: JOHN WILDER, M.A.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	508/752-3579
108 GROVE STREET		508/752-3526
WORCESTER, MA 01605	FTS:	840-6978
	FAX:	508/793-1512

MICHIGAN, GRAND RAPIDS
TEAM #: 0403 SUPPORT FACILITY: BATTLE CREEK, MI VAMC
DATE OPENED: 10/22/82
TEAM LEADER: CLYDE POAG, M.S.W.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	616/243-0385
1940 EASTERN AVENUE, S.E.		
GRAND RAPIDS, MI 49507	FTS:	616/456-2329
	FAX:	616/243-5390

MICHIGAN, LINCOLN PARK (DETROIT)
TEAM #: 0401 SUPPORT FACILITY: ALLEN PARK, MI VAMC
DATE OPENED: 05/09/80
TEAM LEADER: CHET MCLEOD, M.A.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	313/381-1370
1766 FORT STREET		
LINCOLN PARK, MI 48146	FTS:	378-3798
	FAX:	313/381-2450

MICHIGAN, OAKPARK (DETROIT)
TEAM #: 0402 SUPPORT FACILITY: ALLEN PARK, MI VAMC
DATE OPENED: 05/09/80
ACT. TEAM LEADER: CHET MCLEOD, M.A.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	313/967-0040
20820 GREENFIELD ROAD		313/967-0041
OAKPARK, MI 48237	FTS:	378-3791
	FAX:	313/967-3210

MINNESOTA, DULUTH
TEAM #: 0429 SUPPORT FACILITY: MINNEAPOLIS, MN VAMC
DATE OPENED: 05/18//84
TEAM LEADER: THOMAS MARTIN, M.S.W.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	218/722-8654
405 E. SUPERIOR STREET		
DULUTH, MN 55802	FTS:	218/720-5211
	FAX:	218/723-8212

MINNESOTA, ST. PAUL
TEAM #: 0416 SUPPORT FACILITY: MINNEAPOLIS, MN VAMC
DATE OPENED: 03/18/80
TEAM LEADER: MARK MULVIHILL, B.A.

ADDRESS	TELEPHONES	
VRC	COMMERCIAL:	612/644-4022
2480 UNIVERSITY AVENUE		
ST. PAUL, MN 55114	FTS:	780-4621
	FAX:	612/725-2234

MISSISSIPPI, BILOXI
TEAM #: 0322 SUPPORT FACILITY: BILOXI, MS VAMC
DATE OPENED: 08/15/85
TEAM LEADER: HARRY BECNEL, PH.D.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	601/388-9938
2196 PASS ROAD		
BILOXI, MS 39531	FTS:	
	FAX:	601/388-9253

MISSISSIPPI, JACKSON
TEAM #: 0709 SUPPORT FACILITY: JACKSON, MS VAMC
DATE OPENED: 04/04/80
TEAM LEADER: GLENN CURTIS, M.S.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	601/965-5727
4436 N. STATE STREET		
SUITE A3	FTS:	
JACKSON, MS 39206	FAX:	601/965-4023

MISSOURI, KANSAS CITY
TEAM #: 0408 SUPPORT FACILITY: KANSAS CITY, MO VAMC
DATE OPENED: 11/25/79
TEAM LEADER: ROBERT WAECHTER, M.A., M.P.A.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	816/753-1866
3931 MAIN STREET		816/753-1974
KANSAS CITY, MO 64111	FTS:	816/374-6778
	FAX:	816/753-2328

MISSOURI, ST. LOUIS
TEAM #: 0414 SUPPORT FACILITY: ST. LOUIS, MO VAMC
DATE OPENED: 06/30/80
TEAM LEADER: GARY COLLINS, M.S.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	314/231-1260
2345 PINE STREET		
ST. LOUIS, MO 63103	FTS:	278-6424
	FAX:	314/289-6539

MONTANA, BILLINGS
TEAM #: 0509 SUPPORT FACILITY: MILES CITY, MT VAMC
DATE OPENED: 04/16/80
TEAM LEADER: ROBERT PHILLIPS, M.S.W.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	406/657-6071
1948 GRAND AVENUE		
BILLINGS, MT 59102	FTS:	585-6071
	FAX:	406/657-6603

MONTANA, MISSOULA
TEAM #: 0528 SUPPORT FACILITY: FT. HARRISON, MT VAMC
DATE OPENED: 05/31/85
TEAM LEADER: RICHARD JOHNSON, M.S.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	406/721-4918
500 N. HIGGINS AVENUE		406/721-4919
MISSOULA, MT 59802	FTS:	585-3015
	FAX:	406/329-3006

NEBRASKA, LINCOLN
TEAM #: 0427 SUPPORT FACILITY: LINCOLN, NE VAMC
DATE OPENED: 12/02/81
TEAM LEADER: LAWRENCE OBRIST, A.C.S.W.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	402/476-9736
920 L STREET		
LINCOLN, NE 68508	FTS:	402/437-5298
	FAX:	402/476-2431

NEBRASKA, OMAHA
TEAM #: 0424 SUPPORT FACILITY: OMAHA, NE VAMC
DATE OPENED: 11/19/79
TEAM LEADER: NORM MCCORMACK, M.S., M.P.A.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	402/553-2068
5123 LEAVENWORTH STREET		
OMAHA, NE 68106	FTS:	402/221-3148
	FAX:	402/553-6966

NEVADA, LAS VEGAS
TEAM #: 0505 SUPPORT FACILITY: LAS VEGAS, NV VAOPC
DATE OPENED: 05/28/80
TEAM LEADER: MATT WATSON, M.S.W.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	702/388-6369
704 SOUTH 6TH STREET		
LAS VEGAS, NV 89101	FTS:	388-6369
	FAX:	702/388-6664

NEVADA, RENO
TEAM #: 0506 SUPPORT FACILITY: RENO, NV VAMC
DATE OPENED: 04/24/81
TEAM LEADER: MIKE LOY, M.S.W., M.P.H.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	702/323-1294
1155 W. 4TH STREET		
SUITE 101	FTS:	470-5855
RENO, NV 89503	FAX:	702/322-8123

NEW HAMPSHIRE, MANCHESTER
TEAM #: 0108 SUPPORT FACILITY: MANCHESTER, NH VAMC
DATE OPENED: 03/24/80
TEAM LEADER: CARYL AHERN, M.S.W.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	603/668-7060
103 LIBERTY STREET		603/668-7061
MANCHESTER, NH 03104	FTS:	666-7412
	FAX:	666-7404

NEW JERSEY, JERSEY CITY
TEAM #: 0102 SUPPORT FACILITY: EAST ORANGE, NJ VAMC
DATE OPENED: 06/23/80
TEAM LEADER: LE ROY ADDISON, M.S.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	201/645-2038
115 CHRISTOPHER COLUMBUS DRIVE		
JERSEY CITY, NJ 07302	FTS:	NONE
	FAX:	201/645-5969

NEW JERSEY, LINWOOD (ATLANTIC CITY)
TEAM #: 0230 SUPPORT FACILITY: WILMINGTON, DE VAMC
DATE OPENED: 01/09/86
TEAM LEADER: JOSEPH STEELE, M.A.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	609/927-8387
CENTRAL PARK EAST		
222 NEW ROAD, BLDG. 2, SUITES	FTS:	927-8387
LINWOOD, NY 08221	FAX:	609/653-1272

NEW JERSEY, NEWARK
TEAM #: 0112 SUPPORT FACILITY: EAST ORANGE, NJ VAMC
DATE OPENED: 06/13/80
TEAM LEADER: FELIX E. DE JESUS, M.S.W.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	201/645-5954
77 HALSEY STREET		
NEWARK, NJ 07102	FTS:	341-3425
	FAX:	201/622-5905

NEW JERSEY, TRENTON
TEAM #: 0114 SUPPORT FACILITY: LYONS, NJ VAMC
DATE OPENED: 06/23/82
TEAM LEADER: BOB OSENENKO, ED.D.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	609/989-2260
171 JERSEY STREET		609/989-2261
BUILDING 36	FTS:	
TRENTON, NJ 08611-2425	FAX:	609/989-2265

NEW MEXICO, ALBUQUERQUE
TEAM #: 0515 SUPPORT FACILITY: ALBUQUERQUE, NM VAMC
DATE OPENED: 01/11/80
TEAM LEADER: BLAS FALCON, M.S.W.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	505/766-5900
1600 MOUNTAIN ROAD NW		
ALBUQUERQUE, NM 87104	FTS:	474-4501
	FAX:	505/766-5939

NEW MEXICO, FARMINGTON
TEAM #: 0516 SUPPORT FACILITY: ALBUQUERQUE, NM VAMC
DATE OPENED: 01/19/81
SATELLITE COORDINATOR: RICHARD WAMBOLDT, M.S.W.

ADDRESS	TELEPHONES	
VET CENTER SATELLITE	COMMERCIAL:	505/327-9684
4251 E. MAIN, SUITE B		505/327-9685
FARMINGTON, NM 87402	FTS:	NONE
	FAX:	505/327-9519

NEW MEXICO, SANTA FE
TEAM #: 0520 SUPPORT FACILITY: ALBUQUERQUE, NM VAMC
DATE OPENED: 08/09/85
TEAM LEADER: RAY ATENCIO, M.S.W.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	505/988-6562
1996 WARNER STREET		
WARNER PLAZA, SUITE 5	FTS:	476-6562
SANTA FE, NM 87505	FAX:	505/988-6564

NEW YORK, ALBANY
TEAM #: 0111
DATE OPENED: 03/27/82
TEAM LEADER: JAMES GARRETT, PH.D.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	518/438-2505
875 CENTRAL AVENUE		
ALBANY, NY 12206	FTS:	641-2465
	FAX:	518/458-8613

NEW YORK, BABYLON (LONG ISLAND)
TEAM #: 0120 SUPPORT FACILITY: NORTHPORT, NY VAMC
DATE OPENED: 01/29/83
TEAM LEADER: GASPER FALZONE, M.S.W./C.S.W.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	516/661-3930
116 WEST MAIN STREET		
BABYLON, NY 11702	FTS:	
	FAX:	516/422-5677

NEW YORK, BRONX
TEAM #: 0110 SUPPORT FACILITY: BROX, NY VAMC
DATE OPENED: 11/24/80
TEAM LEADER: WALTER SAMPSON, M.S.W.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	718/367-3500
226 EAST FORDHAM ROAD		718/367-3501
ROOM #220	FTS:	
BRONX, NY 10458	FAX:	718/364-6867

NEW YORK, BROOKLYN
TEAM #: 0105 SUPPORT FACILITY: BROOKLYN, NY VAMC
DATE OPENED: 08/28/80
ACT. TEAM LEADER: MIKE MANDA, PSY.D.

ADDRESS	TELEPHONES	
VRC	COMMERCIAL:	718/330-2825
165 CADMAN PLAZA, EAST		718/330-2826
BROOKLYN, NY 11201	FTS:	
	FAX:	718/330-7672

NEW YORK, BUFFALO
TEAM #: 0107 SUPPORT FACILITY: BUFFALO, NY VAMC
DATE OPENED: 02/07/80
TEAM LEADER: DAVID KOWALEWSKI, M.S.W.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	716/882-0505
351 LINWOOD AVENUE		716/882-0508
BUFFALO, NY 14209	FTS:	
	FAX:	716/882-0525

NEW YORK, HARLEM
TEAM #: 0133 SUPPORT FACILITY: NEW YORK, NY VAMC
DATE OPENED: 06/28/93
TEAM LEADER: ERIC GLAUDE, M.S.W.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	212/961-8121
55 WEST 125TH STREET		
NEW YORK, NY 10027	FTS:	
	FAX:	212/369-2374

NEW YORK, NEW YORK (MANHATTAN)
REAM #: 0106 SUPPORT FACILITY: NEW YORK, NY VAMC
DATE OPENED: 10/10/80
TEAM LEADER: ANN TALMAGE, M.S.W.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	212/944-2931
120 WEST 44TH STREET		212/944-2917
NEW YORK, NY 10036	TS:	265-2917
	FAX:	212/944-2904

NEW YORK, ROCHESTER
TEAM #: 0124 SUPPORT FACILITY: BATAVIA, NEW YORK VAMC
DATE OPENED: 06/02/86
TEAM LEADER: JOHN SCKOROHOD, M.S.W.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	716/263-5710
134 SOUTH FITZHUGH STREET		
ROCHESTER, NY 14608	FTS:	963-5710
	FAX:	716/263-5756

NEW YORK, STATEN ISLAND
TEAM #: 0132 SUPPORT FACILITY: BROOKLYN, NY VAMC
DATE OPENED: 01/10/85
TEAM LEADER: MICHAEL MANDA, PSY.D.

ADDRESS	TELEPHONES	
VET CENTER	OMMERCIAL:	718/816-4799
150 RICHMOND TERRACE		718/816-4499
STATEN ISLAND, NY 10301	FTS:	264-1780
	FAX:	718/816-6899

NEW YORK, SYRACUSE
TEAM #: 0131 SUPPORT FACILITY: SYRACUSE, NY VAMC
DATE OPENED: 12/16/85
TEAM LEADER: MARY FEAR, B.S.N.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	315/423-5690
210 NORTH TOWNSEND STREET		315/423-5691
SYRACUSE, NY 13203	FTS:	950-5690
	FAX:	315/423-6581

NEW YORK, WHITE PLAINS
TEAM #: 0123 SUPPORT FACILITY: MONTROSE, NY VAMC
DATE OPENED: 07/23/82
TEAM LEADER: ROGER PAULMENO, B.S.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	914/682-6250
200 HAMILTON AVENUE		914/682-6251
WHITE PLAINS MALL	FTS:	887-6250
WHITE PLAINS, NY 10601	FAX:	914/682-6263

NEW YORK, WOODHAVEN (QUEENS)
TEAM #: 0109 SUPPORT FACILITY: BROOKLYN, NY VAMC
DATE OPENED: 09/10/80
TEAM LEADER:o PAULETTE PETERSON, PH.D.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	718/296-2871
75-10B 91 AVENUE		718/296-2932
WOODHAVEN, NY 11421	FTS:	
	FAX:	718/296-4660

NORTH CAROLINA, CHARLOTTE
TEAM #: 0317 SUPPORT FACILITY: SALISBURY, NC VAMC
DATE OPENED: 04/28/82
TEAM LEADER: LORETTA TWICKLER, RN

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	704/333-6107
223 S. BREVARD STREET		
SUITE 103	FTS:	672-6805
CHARLOTTE, NC 28202	FAX:	704/344-6470

NORTH CAROLINA, FAYETTEVILLE
TEAM #: 0315 SUPPORT FACILITY: FAYETTEVILLE, NC VAMC
DATE OPENED: 05/02/80
TEAM LEADER: TOMI CACDONOUGH, PH.D.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	919/323-4908
4 MARKET SQUARE		
FAYETTEVILLE, NC 28301	FTS:	699-7424
	FAX:	919/323-0251

NORTH CAROLINA, GREENSBORO
TEAM #: 0327 SUPPORT FACILITY: SALISBURY, NC VAMC
DATE OPENED: 12/03/85
TEAM LEADER: MAURICE MURPHY, C.M.S.W.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	910/333-5366
2009 ELM-EUGENE STREET		
GREENSBORO, NC 27406	FTS:	333-5366
	FAX:	910/333-5046

NORTH CAROLINA, GREENVILLE
TEAM #: 0319 SUPPORT FACILITY: DURHAM, NC VAMC
DATE OPENED: 02/11/86
TEAM LEADER: HAROLD MCMILLION, ED.D.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	919/355-7920
150 ARLINGTON BOULEVARD		
SUITE B	FTS:	NONE
GREENVILLE, NC 27858	FAX:	919/756-7045

NORTH DAKOTA, FARGO
TEAM #: 0406 SUPPORT FACILITY: FARGO, ND VAMC
DATE OPENED: 03/26/80
TEAM LEADER: CARL SORONEN, M.S.W.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	701/237-0942
1322 GATEWAY DRIVE		
FARGO, ND 58103	FTS:	783-3638
	FAX:	701/237-5399

NORTH DAKOTA, MINOT
TEAM #: 0404 SUPPORT FACILITY: FARGO, ND VAMC
DATE OPENED: 04/13/82
TEAM LEADER: JAMES SAUVAGEAU, M.ED.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	701/852-0177
2041 3RD STREET, N.W.		
MINOT, ND 58701	FTS:	NONE
	FAX:	701/852-5225

OHIO, CINCINNATI
TEAM #: 0204 SUPPORT FACILITY: CINCINNATI, OH VAMC
DATE OPENED: 05/07/80
TEAM LEADER: DENNIS CARROLL, M.S.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	513/569-7140
30 EAST HOLLISTER STREET		
CINCINNATI, OH 45219	FTS:	569-7140
	FAX:	513/569-7143

OHIO, CLEVELAND
TEAM #: 0206 SUPPORT FACILITY: CLEVELAND, OH VAMC
DATE OPENED: 05/23/80
TEAM LEADER: LINDA HADDEN-ROBINSON, L.I.S.W.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	216/671-8530
11511 LORAIN AVENUE		
CLEVELAND, OH 44111	FTS:	290-4916
	FAX:	216/671-6578

OHIO, CLEVELAND HEIGHTS
TEAM #: 0205 SUPPORT FACIILTY: CLEVELAND, OH VAMC
DATE OPENED: 05/23/80
TEAM LEADER: EUGENE HARRIS, M.S.W.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	216/932-8471
2134 LEE ROAD		
CLEVELAND HEIGHTS, OH 44118	FTS:	290-4915
	FAX:	216/932-1781

OHIO, COLUMBUS
TEAM #: 0221 SUPPORT FACILITY: COLUMBUS, OH VAOPC
DATE OPENED: 06/20/80
TEAM LEADER: LAWRENCE ENDICOTT, M.S.W.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	614/228-3853
222 E. TOWN STREET		
COLUMBUS, OH 43215	FTS:	469-6753
	FAX:	614/228-3866

OHIO, DAYTON
TEAM #: 0225 SUPPORT FACILITY: DAYTON, OH VAMC
DATE OPENED: 05/09/80
TEAM LEADER: RAY BLANFORD, M.S.W.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	513/461-9150
6 SO. PATTERSON BOULEVARD		513/461-9151
DAYTON, OH 45402	FTS:	950-1139
	FAX:	513/461-9371

OKLAHOMA, OKLAHOMA CITY
TEAM #: 0718 SUPPORT FACILITY: OKLAHOMA CITY, OK VAMC
DATE OPENED: 04/02/80
TEAM LEADER: PETER SHARP, M.S.W.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	405/270-5184
3033 N. WALNUT		
SUITE 101W	FTS:	
OKLAHOMA CITY, OK 73105	FAX:	405/270-5125

OKLAHOMA, TULSA
TEAM #: 0723 SUPPORT FACILITY: MUSKOGEE, OK VAMC
DATE OPENED: 04/02/82
TEAM LEADER: STEPHEN CRAIG, M.S.W.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	918/581-7105
1855 EAST 15TH STREET		
TULSA, OK 74104	FTS:	
	FAX:	918/581-7107

OREGON, EUGENE
TEAM #: 0626 SUPPORT FACILITY: ROSEBURG, OR VAMC
DATE OPENED: 09/11/81
ACT. TEAM LEADER: CLIFF KAYLOR

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	503/465-6918
1966 GARDEN AVENUE		
EUGENE, OR 97403	FTS:	425-6918
	FAX:	503/465-6973

OREGON, GRANTS PASS
TEAM #: 0645 SUPPORT FACILTIY: WHITE CITY, OR VAD
DATE OPENED: 01/10/86
TEAM LEADER: WAYNE PRICE, M.S.W.

ADDRESS	TELEPHONES	
VET CENTER SATELLITE	COMMERCIAL:	503/479-6912
615 NORTH WEST 5TH STREET		
GRANTS PASS, OR 95726	FTS:	NONE
	FAX:	503/474-4589

OREGON, PORTLAND
TEAM #: 0617 SUPPORT FACILITY: PORTLAND, OR VAMC
DATE OPENED: 02/15/80
TEAM LEADER: RAY T. MOORE, PH.D.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	503/273-5370
8383 N.E. SANDY BLVD., SUITE 110		
PORTLAND, OR 97220	FTS:	424-5370
	FAX:	503/273-5377

OREGON, SALEM
TEAM #: 0640 SUPPORT FACILITY: PORTLAND, OR VAMC
DATE OPENED: 02/28/86
TEAM LEADER: CARL WHALEY, M.S.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	503/362-9911
318 CHURCH N.E.		
SALEM, OR 97301	FTS:	422-5754
	FAX:	503/364-2534

PENNSYLVANIA, ERIE
TEAM #: 0222 SUPPORT FACILITY: ERIE, PA VAMC
DATE OPENED: 08/07/85
TEAM LEADER: JACK S. EHRHARDT, M.S.W.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	814/453-7955
G. DANIEL BALDWIN BLDG., SUITE 1&2		
1000 STATE STREET (LOBBY)	FTS:	453-7955
ERIE, PA 16501	FAX:	814/456-5464

PENNSYLVANIA, HARRISBURG
TEAM #: 0218 SUPPORT FACILITY: LEBANON, PA VAMC
DATE OPENED: 05/07/82
ACT. TEAM LEADER: JAN YUPCAVAGE, M.S.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	717/782-3954
1007 NORTH FRONT STREET		
HARRISBURG, PA 17102	FTS:	782-3954
	FAX:	717/782-3791

PENNSYLVANIA, MCKEESPORT
TEAM #: 0220 SUPPORT FACILITY: PITTSBURGH (HD), PA VAMC
DATE OPENED: 12/07/81
TEAM LEADER: DUANE BROKENBEK, M.S.W.

ADDRESS	TELEPHONES	
	COMMERCIAL:	412/678-7704
500 WALNUT STREET		
MCKEESPORT, PA 15132	FTS:	365-4563
	FAX:	4112/678-7780

PENNSYLVANIA, PHILADELPHIA
TEAM #: 0210 SUPPORT FACILITY: PHILADELPHIA, PA VAMC
DATE OPENED: 02/07/80
TEAM LEADER: RONALD GREEN, M.S.W.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	215/627-0238
1026 ARCH STREET		
PHILADELPHIA, PA 19107	FTS:	597-0544
	FAX:	215/597-6362

PENNSYLVANIA, PHILADELPHIA
TEAM #: 0219 SUPPORT FACILITY: PHILADELPHIA, PA VAMC
DATE OPENED: 04/01/80
TEAM LEADER: JUAN MALAVE, M.S.W.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	215/924-4670
101 E. OLNEY AVENUE		
BOX C-7	FTS:	951-5438
PHILADELPHIA, PA 19120	FAX:	215/951-5434

PENNSYLVANIA, PITTSBURGH
TEAM #: 0211 SUPPORT FACILITY: PITTSBURGH (HD), PA VAMC
DATE OPENED: 04/01/80
TEAM LEADER: DAVID MCPEAK, M.A., M.P.A.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	412/765-1193
954 PENN AVENUE		
PITTSBURGH, PA 15222	FTS:	365-4530
	FAX:	412/365-4440

PENNSYLVANIA, SCRANTON
TEAM #: 0229 SUPPORT FACILITY: WILKES-BARRE, PA VAMC
DATE OPENED: 10/10/85
TEAM LEADER: CAROL ARMILLEI, M.S.W.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	717/344-2676
959 WYOMING AVENUE		
SCRANTON, PA 18509	FTS:	344-2676
	FAX:	717/344-6794

PUERTO RICO, ARECIBO
TEAM #: 0309 SUPPORT FACILITY: SAN JUAN, PR VAMC
DATE OPENED: 03/27/86
TEAM LEADER: JUAN FREYTES, M.S.W.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	809/879-4510
52 GONZALO MARIN STREET		809/879-4581
ARECIBO, PR 00612	FTS:	NONE
	FAX:	806/879-4944

PUERTO RICO, PONCE
TEAM #: 0312 SUPPORT FACILITY: SAN JUAN, PR VAMC
DATE OPENED: 03/28/86
TEAM LEADER: LUISARDO CARMONA-ORTIZ, M.S.W.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	809/841-3260
35 MAYOR STREET		
PONCE, PR 00731	FTS:	NONE
	FAX:	809/841-3165

PUERTO RICO, SAN JUAN
TEAM #: 0307 SUPPORT FACILITY: SAN JUAN, PR VAMC
DATE OPENED: 12/18/80
TEAM LEADER: EDWINO RIVERA-AYALA, B.A.

ADDRESS	TELEPHONES	
VRC	COMMERCIAL:	809/749-4487
CONDOMINO MEDICAL CENTER PLAZA		809/749-4488
SUITE LC8A & LC9, LA RIVIERA	FTS:	NONE
RIO PIEDRAS, PR 00921	FAX:	809/749-4416

RHODE ISLAND, CRANSTON (PROVIDENCE)
TEAM #: 0113 SUPPORT FACILITY: PROVIDENCE, RI VAMC
DATE OPENED: 05/16/80
TEAM LEADER: BERNE GREENE, M.S.W.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	401/467-2046
789 PARK AVENUE		401/467-2056
CRANSTON, RI 02910	FTS:	838-5236
	FAX:	401/528-5253

SOUTH CAROLINA, COLUMBIA
TEAM #: 0324 SUPPORT FACILITY: COLUMBIA, SC VAMC
DATE OPENED: 07/13/85
TEAM LEADER: MIKE WOLFORD, PH.D.

ADDRESS	TELEPHONES	
VET CENTER SATELLITE	COMMERCIAL:	803/765-9944
1513 PICKENS STREET		
COLUMBIA, SC 29201	FTS:	NONE
	FAX:	803/799-6267

SOUTH CAROLINA, GREENVILLE
TEAM #: 0316 SUPPORT FACILITY: COLUMBIA, SC VAMC
DATE OPENED: 03/06/82
TEAM LEADER: DAVID HOLLINGSWORTH, M.S.W.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	803/271-2711
904 PENDELTON STREET		
GREENVILLE, SC 29601	FTS:	NONE
	FAX:	803/370-3655

SOUTH CAROLINA, NORTH CHARLESTON
TEAM #: 0303 SUPPORT FACILITY: CHARLESTON, SC VAMC
DATE OPENED: 05/30/80
TEAM LEADER: SCOTT FREDERICK, A.C.S.W.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	803/747-8387
5603A RIVERS AVENUE		
NO. CHARLESTON, SC 29418	FTS:	259-7377
	FAX:	803/566-0232

SOUTH DAKOTA, RAPID CITY
TEAM #: 0423 SUPPORT FACILITY: FORT MEADE, SD VAMC
DATE OPENED: 01/22/82
TEAM LEADER: EUGENE SUMMERS, M.S.W.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	605/348-0077
610 KANSAS CITY STREET		605/348-1752
RAPID CITY, SD 57701	FTS:	605/782-7296
	FAX:	605/348-0878

SOUTH DAKOTA, SIOUX FALLS
TEAM #: 0425 SUPPORT FACILITY: SIOUX FALLS, SD VAMC
DATE OPENED: 11/10/79
TEAM LEADER: MICHAEL DAFOE, M.A.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	605/332-0856
601 S. CLIFF AVENUE		
SUITE C	FTS:	782-4552
SIOUX FALLS, SD 57104	FAX:	605/330-4554

TENNESSEE, CHATTANOOGA
TEAM #: 0722 SUPPORT FACILITY: MURFEESBORO, TN VAMC
DATE OPENED: 03/14/86
TEAM LEADER: JAMES CECIL, M.S.W.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	615/752-5234
425 CUMBERLAND STREET		
SUITE 140	FTS:	
CHATTANOOGA, TN 37404	FAX:	615/752-5239

TENNESSEE, JOHNSON CITY
TEAM #: 0701 SUPPORT FACILITY: MOUNTAIN HOME, TN VAMC
DATE OPENED: 12/05/85
TEAM LEADER: RICHARD SHAMBAUGH, M.S.W.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	615/928-8387
1615 W. WALNUT STREET		
JOHNSON CITY, TN 37604	FTS:	NONE
	FAX:	615/928-6320

TENNESSEE, KNOXVILLE
TEAM #: 0720 SUPPORT FACILITY: NASHVILLE, TN VAMC
DATE OPENED: 01/09/82
TEAM LEADER: RONALD COFFIN, M.S.S.W.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	615/545-4680
2817 EAST MAGNOLIA AVENUE		
KNOXVILLE, TN 37914	FTS:	
	FAX:	615/545-4198

TENNESSEE, MEMPHIS
TEAM #: 0719 SUPPORT FACILITY: MEMPHIS, TN VAMC
DATE OPENED: 05/01/80
TEAM LEADER: WILLIAM FARGO, M.A.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	901/722-2510
1835 UNION, SUITE 100		
MEMPHIS, TN 38104	FTS:	
	FAX:	901/722-2533

TEXAS, AMARILLO
TEAM #: 0702 SUPPORT FACILITY: AMARILLO, TX VAMC
DATE OPENED: 06/14/86
TEAM LEADER: PEDRO GARCIA, JR., M.S.W.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	806/354-9779
3414 OLSEN BLVD.		
SUITE E	FTS:	
AMARILLO, TX 79109	FAX:	806/354-9837

TEXAS, AUSTIN
TEAM #: 0703 SUPPORT FACILITY: TEMPLE, TX VAMC
DATE OPENED: 05/25/85
TEAM LEADER: JOHN FERGUSON, M.S., A.N.P.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	512/416-1314
1110 WEST WILLIAM CANNON DR.		
SUITE 301	FTS:	
AUSTIN, TX 78745	FAX:	512/416-7019

TEXAS, CORPUS CHRISTI
TEAM #: 0705 SUPPORT FACILITY: SAN ANTONIO, TX VAMC
DATE OPENED: 08/03/85
TEAM LEADER: STEPHEN SIMMONS, ED.D.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	512/854-9961
3166 REID DRIVE, SUITE 1		
CORPUS CHRISTI, TX 78404	FTS:	
	FAX:	512/854-4730

TEXAS, DALLAS
TEAM #: 0706 SUPPORT FACILITY: DALLAS, TX VAMC
DATE OPENED: 05/11/80
TEAM LEADER: MATT J. MENGER, PH.D.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	214/361-5896
5232 FOREST LANE		
SUITE 111	FTS:	
DALLAS, TX 75244	FAX:	214/655-7347

TEXAS, EL PASO
TEAM #: 0707 SUPPORT FACILITY: EL PASO, TX VAOPC
DATE OPENED: 02/19/80
TEAM LEADER: CARLOS RIVERA, M.S.S.W.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	915/772-0013
SKYPARK II		
6500 BOEING, SUITE L-112	FTS:	
EL PASO, TX 79925	FAX:	915/772-3983

TEXAS, FORT WORTH
TEAM #: 0708 SUPPORT FACILITY: DALLAS, TX VAMC
DATE OPENED: 07/11/82
TEAM LEADER: AARON STRICKLAND, M.S.W.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	817/921-9095
1305 W. MAGNOLIA		
SUITE B	FTS:	
FORT WORTH, TX 76104	FAX:	817/921-9438

TEXAS, HOUSTON
TEAM #: 0710 SUPPORT FACILITY: HOUSTON, TX VAMC
DATE OPENED: 02/12/80
TEAM LEADER: VASTINE HIGHTOWER, M.S.W.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	713/653-3121
503 WESTHEIRMER		
HOUSTON, TX 77006	FTS:	
	FAX:	713/653-3138

TEXAS, HOUSTON
TEAM #: 0711 SUPPORT FACILITY: HOUSTON, TX VAMC
DATE OPENED: 11/02/85
ACT. TEAM LEADER: VASTINE HIGHTOWER, M.S.W.

ADDRESS	TELEPHONES	
VRC	COMMERCIAL:	713/682-2288
701 N. POST OAK ROAD		
HOUSTON, TX 77024	FTS:	
	FAX:	713/653-3110

TEXAS, LAREDO
TEAM #: 0712 SUPPORT FACILITY: SAN ANTONIO, TX VAMC
DATE OPENED: 04/22/80
ACT. TEAM LEADER: HILARIO MARTINEZ, M.S.W.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	210/723-4680
6020 MCPHERSON ROAD		
SUITE 1A	FTS:	
LAREDO, TX 78041	FAX:	210/723-9144

TEXAS, LUBBOCK
TEAM #: 0714 SUPPORT FACILITY: AMARILLO, TX VAMC
DATE OPENED: 04/26/86
TEAM LEADER: RAYMOND J. GEYE, M.S.S.W.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	806/792-9782
3208 34TH STREET		
LUBBOCK, TX 79410	FTS:	
	FAX:	806/792-9785

TEXAS, MCALLEN
TEAM #: 0715 SUPPORT FACILITY: SAN ANTONIO, TX VAMC
DATE OPENED: 02/01/83
TEAM LEADER: EVARISTO FLORES, M.S.W.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	210/631-2147
801 NOLANA LOOP		
SUITE 115	FTS:	NONE
MCALLEN, TX 78504	FAX:	210/631-2430

TEXAS, MIDLAND
TEAM #: 0716 SUPPORT FACILITY: BIG SPRING, TX VAMC
DATE OPENED: 04/04/86
TEAM LEADER: ARTHUR MCKAY, M.S.W.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	915/697-8222
3404 WEST ILLINOIS		
SUITE 1	FTS:	NONE
MIDLAND, TX 79703	FAX:	915/697-0561

TEXAS, SAN ANTONIO
TEAM #: 0721 SUPPORT FACILITY: SAN ANTONIO, TX VAMC
DATE OPENED: 04/02/80
TEAM LEADER: HILARIO MARTINEZ, M.S.W.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	210/229-4025
231 W. CYPRESS STREET		
SAN ANTONIO, TX 78212	FTS:	
	FAX:	210/229-4032

UTAH, PROVO
TEAM #: 0532 SUPPORT FACILITY: SALT LAKE CITY, UT VAMC
DATE OPENED: 11/08/85
SATELLITE COORDINATOR: RAY ROSS, M.S.W.

ADDRESS	TELEPHONES	
VET CENTER SATELLITE	COMMERCIAL:	801/377-1117
750 NORTH 200 WEST		
SUITE 105	FTS:	NONE
PROVO, UT 84601	FAX:	801/377-0227

UTAH, SALT LAKE CITY
TEAM #: 0514 SUPPORT FACILITY: SALT LAKE CITY, UT VAMC
DATE OPENED: 01/04/80
TEAM LEADER: JAMES ANDERSON, M.S.W.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	801/584-1294
1354 EAST 3300, SOUTH		
SALT LAKE CITY, UT 84106	FTS:	588-1294
	FAX:	801/487-6243

VERMONT, SOUTH BURLINGTON
TEAM #: 0118 SUPPORT FACILITY: WHITE RIVER JUNCTION, VT VAMC
DATE OPENED: 01/02/80
TEAM LEADER: FRED FOREHAND, M.S.W.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	802/862-1806
359 DORSET STREET		
SOUTH BURLINGTON, VT 05403	FTS:	951-6765
	FAX:	802/865-3319

VERMONT, WHITE RIVER JUNCTION
TEAM #: 0122 SUPPORT FACILITY: WHITE RIVER JUNCTION, VT VAMC
DATE OPENED: 09/04/81
TEAM LEADER: TIM BEEBE, M.A.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	802/295-2908
GILMAN OFFICE CENTER, BLDG. #2		802/295-2943
HOLIDAY INN DRIVE	FTS:	832-3267
WHITE RIVER JUNCTION, VT 05001	FAX:	802/296-3653

VIRGIN ISLANDS, ST. CROIX
TEAM #: 0306 SUPPORT FACILITY: SAN JUAN, PR VAMC
DATE OPENED: 01/08/84
SATELLITE COORDINATOR: ROGER HODGE, M.S.W.

ADDRESS	TELEPPHONES	
VET CENTER SATELLITE	COMMERCIAL:	809/778-5553
BOX 12, R.R. 02		
VILLAGE MALL, #113	FTS:	NONE
ST. CROIX, VI 00850	FAX:	809/778-9497

VIRGIN ISLANDS, ST. THOMAS
TEAM #: 0308 SUPPORT FACILITY: SAN JUAN, PR VAMC
DATE OPENED: 01/01/81
SATELLITE COORDINATOR: MEL VANTERPOOL, A.A.

ADDRESS	TELEPHONES	
VET CENTER SATELLITE	COMMERCIAL:	809/774-6674
HAVENSIGHT MALL		
ST. THOMAS, VI 00801	FTS:	NONE
	FAX:	809/774-5384

VIRGINIA, NORFOLK
TEAM #: 0207 SUPPORT FACILITY: HAMPTON, VA VAMC
DATE OPENED: 05/16/80
TEAM LEADER: DENNIS PATTERSON, M.S.W.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	804/623-7584
2200 COLONIAL AVE., SUITE 3		
NORFOLK, VA 23517	FTS:	441-3501
	FAX:	804/441-6621

VIRGINIA, RICHMOND
TEAM #: 0217 SUPPORT FACILITY: RICHMOND, VA VAMC
DATE OPENED: 05/27/82
TEAM LEADER: DANIEL DOYLE, PH.D.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	804/353-8958
3022 W. CLAY STREET		
RICHMOND, VA 23230	FTS:	698-1192
	FAX:	804/353-0837

VIRGINIA, ROANOKE
TEAM #: 0226 SUPPORT FACILITY: SALEM, VA VAMC
DATE OPENED: 10/22/85
TEAM LEADELR: MICHAEL SHEARER, M.S.W.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	703/342-9726
320 MOUNTAIN AVENUE, S.W.		
ROANOKE, VA 24016	FTS:	982-6429
	FAX:	703/982-6405

VIRGINIA, SPRINGFIELD
TEAM #: 0228 SUPPORT FACILITY: WASHINGTON, DC VAMC
DATE OPENED: 06/26/86
TEAM LEADER: ROBERT TECKLENBURG, M.A., M.P.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	703/866-0924
7024 SPRING GARDEN DRIVE		
BROOKFIELD PLAZA	FTS:	921-6891
SPRINGFIELD, VA 22150	FAX:	703/866-1944

WASHINGTON, SEATTLE
TEAM #: 0507 SUPPORT FACILITY: SEATTLE, WA VAMC
DATE OPENED: 03/07/80
TEAM LEADER: DON JOHNSON, PH.D.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	206/553-2706
2230 EIGHTH AVENUE		
SEATTLE, WA 98121	FTS:	399-2706
	FAX:	206/553-0380

WASHINGTON, SPOKANE
TEAM #: 0510 SUPPORT FACILITY: SPOKANE, WA VAMC
DATE OPENED: 10/26/81
TEAM LEADER: LINDA PARKES, M.S.W.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	509/327-0274
WEST 1708 MISSION STREET		
SPOKANE, WA 99201	FTS:	442-0274
	FAX:	509/325-7927

WASHINGTON, TACOMA
TEAM #: 0508 SUPPORT FACILITY: TACOMA, WA VAMC
DATE OPENED: 12/20/79
TEAM LEADER: STEPHEN FITZGERALD, PH.D.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	206/473-0731
4801 PACIFIC AVENUE		
TACOMA, WA 98409	FTS:	396-6940
	FAX:	206/589-4026

WEST VIRGINIA, BECKLEY
TEAM #: 0231 SUPPORT FACILITY: BECKLEY, WV VAMC
DATE OPENED: 07/19/88
TEAM LEADER: ERNEST NICHOLS, M.S.W.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	304/252-8220
101 ELLISON AVENUE		304/252-8229
BECKLEY, WV 25801	FTS:	924-4500
	FAX:	700/924-4504

WEST VIRGINIA, CHARLESTON
TEAM #: 0223 SUPPORT FACILITY: HUNTINGTON, WV VAMC
DATE OPENED: 09/14/85
TEAM LEADER: FRED MURRAY, M.S.W.M.S.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	304/343-3825
512 WASHINGTON STREET WEST		
CHARLESTON, WV 25302	FTS:	347-5128
	FAX:	304/347-5303

WEST VIRGINIA, HUNTINGTON
TEAM #: 0208 SUPPORT FACILITY: HUNTINGTON, WV VAMC
DATE OPENED: 05/23/80
SATELLITE COORDINATOR: FRED MURRAY, M.S.W.S.

ADDRESS	TELEPHONES	
VET CENTER SATELLITE	COMMERCIAL:	304/523-8387
1005/1007 6TH AVENUE		
HUNTINGTON, WV 25701	FTS:	924-2985
	FAX:	304/529-5910

WEST VIRGINIA, MARTINSBURG
TEAM #: 0224 SUPPORT FACILITY: MARTINSBURG, WV VAMC
DATE OPENED: 11/17/85
TEAM LEADER: LAUREN GOODALE, M.ED.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	304/263-6776
105 S. SPRING STREET		304/263-6777
MARTINSBURG, WV 25401	FTS:	940-4680
	FAX:	700/940-4684

WEST VIRGINIA, MORGANTOWN
TEAM #: 0216 SUPPORT FACILITY: CLARKSBURG, WV VAMC
DATE OPENED: 05/11/82
TEAM LEADER: EDDIE PAINTER, M.S.W.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	304/291-4001
1191 PINEVIEW DRIVE		304/291-4002
MORGANTOWN, WV 26505	FTS:	291-4001
	FAX:	304/291-4932

WEST VIRGINIA, PRINCETON
TEAM #: 0232 SUPPORT FACILITY: BECKLEY, WV VAMC
DATE OPENED: 07/25/88
TEAM LEADER: SAMMIE HEFLIN, M.S.W.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	304/425-5653
905 MERCER STREET		304/425-5661
PRINCETON, WV 24740	FTS:	425-5653
	FAX:	304/425-2837

WEST VIRGINIA, WHEELING
TEAM #: 0233 SUPPORT FACILITY: PITTSBURGH (HD), PA VAMC
DATE OPENED: 12/12/88
TEAM LEADER: JOHN LOONEY, M.S.W.

ADDRESS	TELEPHONES	
VET CENTER	COMMERCIAL:	304/232-0587
1070 MARKET STREET		
WHEELING, WV 26003	FTS:	232-0587
	FAX:	304/232-1031

WISCONSIN, MADISON
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SPECIALIZED MENTAL HEALTH AND OTHER PROGRAMS

JUN 6 1994

FACILITY	STA NUM	R E G	HCHV HCMI	CHC	DROP IN	O/R	PRRTP	SH	SBA	VASH	VBA INIT	VI	VV TR	DCHV DCHV	SH	HWH	LONG TERM PSYCH	PTSD EBTPU	NC	PCT	PRRP	PSU	SIPU	SUPT
ALBANY, NY	500	1	1		1			1				1	1											
ALBUQUERQUE, NM	501	4																		1				
ALEXANDRIA, LA	502	3																						
ALLEN PARK, MI	553	2			1	1					1					1								
ALTOONA, PA	503	1																						
AMARILLO, TX	504	3																						
AMERICAN LAKE, WA	505	4								1				1		1							1	1
ANCHORAGE, AK	363	4				1	1					1		1		1					1			
ANN ARBOR, MI	506	2	1																	1				
ASHEVILLE, NC	637	3														1								
ATLANTA, GA	508	3	1							1		1	1			1				1				
AUGUSTA, GA	509	3	1													1							1	
BALTIMORE, MD	512	1	1								1					1		1		1				
BATAVIA, NY	513	1																						
BATH, NY	514	1	1													1								
BATTLE CREEK, MI	515	2														1				1			1	
BAY PINES, FL	516	3			1					1				1		1							1	1
BECKLEY, WV	517	1																						
BEDFORD, MA	518	1								1		1	1	1		1								
BIG SPRING, TX	519	3														1								
BILOXI, MS	520	3												1		1				1				
BIRMINGHAM, AL	521	3	1		1											1				1				
BOISE, ID	531	4														1		1		1				
BONHAM, TX	522	3																						
BOSTON (OPC), MA	750	1	1					1																
BOSTON, MA	523	1														1			1	1				
BREVARD COUNTY, FL	547	3																						
BROCKTON, MA	525	1												1		1				1				1
BRONX, NY	526	1				1												1		1				
BROOKLYN, NY	527	1		1	1	1			1	1	1			1						1				
BUFFALO, NY	528	1	1					1		1						1				1			1	

ATTACHMENT TO QUESTION 5B

SPECIALIZED MENTAL HEALTH AND OTHER PROGRAMS

FACILITY	STA NUM	R E G	HCHV HCMI	CHC	DROP IN	O/R	PRRTP	SH	SSA	VASH	VBA INIT	VI	VV TR	DCHV DCHV	SH	HWH	LONG TERM PSYCH	PTSD EBTPU	NC	PCT	PRRP	PSU	SIPU	SUPT
BUTLER, PA	529	1												1		1								
CANANDAIGUA, NY	532	1												1		1	1			1				
CASTLE POINT, NY	533	1																						
CHARLESTON, SC	534	3	1									1				1				1				
CHEYENNE, WY	442	4	1													1				1				
CHICAGO (LS), IL	535	2														1								
CHICAGO (WS), IL	537	2				1		1								1				1				
CHILLICOTHE, OH	538	2																		1				
CINCINNATI, OH	539	2	1							1				1		1		1						
CLARKSBURG, WV	540	1																		1				
CLEVELAND, OH	541	2	1	1						1	1			1		1							1	
COATESVILLE, PA	542	2			1									1	1	1				1			1	
COLUMBIA, MO	543	2																						
COLUMBIA, SC	544	3														1								
COLUMBUS (OPC), OH	757	2																						
DALLAS, TX	549	3	1	1	1				1	1	1	1	1	1		1				1				
DANVILLE, IL	550	2																		1				
DAYTON, OH	552	2	1											1		1					1			
DENVER, CO	554	4	1													1		1		1				
DES MOINES, IA	555	2												1		1		1						
DUBLIN, GA	557	3												1										
DURHAM, NC	558	3																		1				
EAST ORANGE, NJ	561	1	1																					
EL PASO (OPC), TX	756	3														1				1				
ERIE, PA	562	1																						
FARGO, ND	437	2	1													1								
FAYETTEVILLE, AR	564	3																		1				
FAYETTEVILLE, NC	565	3														1								
FORT HARRISON, MT	436	4														1								
FORT HOWARD, MD	566	1														1								
FORT LYON, CO	567	4															1							

SPECIALIZED MENTAL HEALTH AND OTHER PROGRAMS

FACILITY	STA NUM	R E G	HCHV HCMI	CHC	DROP IN	O/R	PRRTP	SH	SSA	VASH	VBA INIT	VI	VV TR	DCHV DCHV	SH	HWH	LONG TERM PSYCH	PTSD EBTPU	NC	PCT	PRRP	PSU	SIPU	SUPT
FORT MEADE, SD	568	2														1								1
FORT WAYNE, IN	569	2																						
FRESNO, CA	570	4														1								
GAINESVILLE, FL	573	3														1				1				
GRAND ISLAND, NE	574	2																						
GRAND JUNCTION, CO	575	4														1								
HAMPTON, VA	590	1	1							1				1		1				1				
HINES, IL	578	2	1							1						1				1				
HONOLULU (OPC), HI	459	4														1				1				
HOT SPRINGS, SD	579	2										1		1		1								
HOUSTON, TX	580	3	1					1								1				1				
HUNTINGTON, WV	581	1	1																					
INDIANAPOLIS, IN	583	2	1					1		1						1								
IOWA CITY, IA	584	2																		1				
IRON MOUNTAIN, MI	585	2														1								
JACKSON, MS	586	3	1													1		1		1				
KANSAS CITY, MO	589	2	1					1								1				1				
KERRVILLE, TX	591	3																						
KNOXVILLE, IA	592	2														1	1				1			1
LAKE CITY, FL	594	3														1								
LAS VEGAS (OPC), NV	758	4																						
LEAVENWORTH, KS	686	2												1		1								
LEBANON, PA	595	1	1									1	1			1	1							
LEXINGTON, KY	596	2														1								
LINCOLN, NE	597	2														1				1				
LITTLE ROCK, AR	598	3	1					1		1				1		1						1	1	
LIVERMORE, CA	599	4																						
LOMA LINDA, CA	605	4				1				1						1				1				
LONG BEACH, CA	600	4	1													1								
LOS ANGELES (OPC), CA	752	4	1							1										1				
LOUISVILLE, KY	603	2	1															1						

SPECIALIZED MENTAL HEALTH AND OTHER PROGRAMS

FACILITY	STA NUM	R E G	HCHV HCMI	CHC	DROP IN	OR	PRRTP	SH	SSA	VASH	VBA INIT	VI	VV TR	DCHV DCHV	SH	HWH	LONG TERM PSYCH	PTSD EBTPU	NC	PCT	PRRP	PSU	SIPU	SUPT
LYONS, NJ	604	1												1	1	1	1					1	1	
MADISON, WI	607	2																						
MANCHESTER, NH	608	1														1								
MARION, IL	609	2																						
MARION, IN	610	2														1				1			1	
MARLIN, TX	611	3																						
MARTINEZ, CA	612	4														1								
MARTINSBURG, WV	613	1												1		1					1			
MEMPHIS, TN	614	3														1				1				
MIAMI, FL	546	3	1							1						1				1			1	
MILES CITY, MT	617	4																						
MILWAUKEE, WI	695	2			1	1		1			1	1		1		1						1		
MINNEAPOLIS, MN	618	2	1								1							1		1				
MONTGOMERY, AL	619	3																						
MONTROSE, NY	620	1												1		1							1	
MOUNTAIN HOME, TN	621	3	1											1		1				1				
MURFREESBORO, TN	622	3															1			1				
MUSKOGEE, OK	623	3														1								
NASHVILLE, TN	626	3	1							1														
NEW ORLEANS, LA	629	3	1							1						1		1		1				1
NEW YORK, NY	630	1	1		1				1	1										1				
NEWINGTON, CT	627	1																						
NORTHAMPTON, MA	631	1															1						1	
NORTH CHICAGO, IL	556	2												1		1							1	
NORTHPORT, NY	632	1																						
OKLAHOMA CITY, OK	635	3	1									1	1			1				1				
OMAHA, NE	636	2																		1				
PALM BEACH COUNTY, FL	548	3																						
PALO ALTO, CA	640	4												1					1	1		1	1	
PERRY POINT, MD	641	1	1													1	1			1				
PHILADELPHIA, PA	642	1	1													1				1				

SPECIALIZED MENTAL HEALTH AND OTHER PROGRAMS

FACILITY	STA NUM	R E G	HCHV HCMI	CHC	DROP IN	O/R	PRRTP	SH	SSA	VASH	VBA INIT	VI	VV TR	DCHV DCHV	SH	HWH	LONG TERM PSYCH	PTSD EBTPU	NC	PCT	PRRP	PSU	SIPU	SUPT
PHOENIX, AZ	644	4	1													1				1			1	
PITTSBURGH (HD), PA	645	1	1	1				1			1			1		1				1				1
PITTSBURGH (UD), PA	646	1																						
POPLAR BLUFF, MO	647	2																						
PORTLAND, OR	648	4	1									1		1	1	1				1	1			
PRESCOTT, AZ	649	4												1		1								
PROVIDENCE, RI	650	1				1		1				1				1				1				
RENO, NV	654	4														1								
RICHMOND, VA	652	1																						
ROSEBURG, OR	653	4	1													1		1						
SAGINAW, MI	655	2																						
SALEM, VA	658	1														1							1	
SALISBURY, NC	659	2	1																	1			1	
SALT LAKE CITY, UT	660	4	1							1						1				1				
SAN ANTONIO, TX	671	3	1							1						1				1				
SAN DIEGO, CA	664	4	1							1						1				1				
SAN FRANCISCO, CA	662	4	1	1						1	1	1	1			1		1		1				1
SAN JUAN, PR	455	3																		1				
SEATTLE, WA	663	4				1		1								1		1		1	1			
SEPULVEDA, CA	665	4																						
SHERIDAN, WY	666	4														1	1				1			
SHREVEPORT, LA	667	3														1								
SIOUX FALLS, SD	438	2														1				1				
SPOKANE, WA	668	4																						
ST. CLOUD, MN	656	2														1	1			1				
ST. LOUIS, MO	657	2	1											1		1				1				
SYRACUSE, NY	670	1	1							1														
TAMPA, FL	673	3	1					1		1		1				1				1				
TEMPLE, TX	674	3														1					1			
TOGUS, ME	402	1														1				1			1	
TOMAH, WI	676	2				1		1				1				1							1	

SPECIALIZED MENTAL HEALTH AND OTHER PROGRAMS

FACILITY	STA NUM	R E G	HCHV HCMI	CHC	DROP IN	O/R	PRRTP	SH	SSA	VASH	VBA INIT	VI	VV TR	DCHV DCHV	SH	HWH	LONG TERM PSYCH	PTSD EBTPU	NC	PCT	PRRP	PSU	SIPU	SUPT
TOPEKA, KS	677	2														1	1			1			1	
TUCSON, AZ	678	4	1					1		1						1				1				
TUSCALOOSA, AL	679	3																		1				
TUSKEGEE, AL	680	3	1														1			1			1	
WACO, TX	685	3														1	1			1			1	
WALLA WALLA, WA	687	4	1													1								
WASHINGTON, D.C.	688	1	1						1	1						1				1				
WEST HAVEN, CT	689	1				1		1		1	1					1		1	1		1		1	1
WEST LOS ANGELES, CA	691	4	1	1			1		1	1	1	1		1		1					1		1	
WHITE CITY, OR	692	4												1		1								
WHITE RIVER JUNCTION, VT	405	1														1		1	1	1				
WICHITA, KS	452	2														1				1				
WILKES-BARRE, PA	693	1	1					1								1								
WILMINGTON, DL	460	1																						
TOTALS			57	6	9	11	2	17	5	29	11	16	7	33	3	108	13	15	4	74	10	4	25	9

SPECIALIZED MENTAL HEALTH AND OTHER PROGRAMS

REGION 1		R	HCHV											DCHV			LONG							
	STA	E			DROP						VBA		VV				TERM	PTSD						
FACILITY	NUM	G	HCMI	CHC	IN	O/R	PRRTP	SH	SSA	VASH	INIT	VI	TR	DCHV	SH	HWH	PSYCH	EBTPU	NC	PCT	PRRP	PSU	SIPU	SUPT
ALBANY, NY	500	1	1		1			1				1	1											
ALTOONA, PA	503	1																						
BALTIMORE, MD	512	1	1								1					1		1		1				
BATAVIA, NY	513	1																						
BATH, NY	514	1	1													1								
BECKLEY, WV	517	1																						
BEDFORD, MA	518	1								1		1	1	1		1								
BOSTON (OPC), MA	750	1	1					1																
BOSTON, MA	523	1														1			1	1				
BROCKTON, MA	525	1												1		1				1				1
BRONX, NY	526	1				1												1		1				
BROOKLYN, NY	527	1		1	1	1			1	1	1			1						1				
BUFFALO, NY	528	1	1					1		1						1				1			1	
BUTLER, PA	529	1												1		1								
CANANDAIGUA, NY	532	1												1		1	1			1				
CASTLE POINT, NY	533	1																						
CLARKSBURG, WV	540	1																		1				
EAST ORANGE, NJ	561	1	1																					
ERIE, PA	562	1																						
FORT HOWARD, MD	566	1														1								
HAMPTON, VA	590	1	1							1				1		1				1				
HUNTINGTON, WV	581	1	1																					
LEBANON, PA	595	1	1									1	1			1	1							
LYONS, NJ	604	1												1	1	1	1					1	1	
MANCHESTER, NH	608	1														1								
MARTINSBURG, WV	613	1												1		1					1			
MONTROSE, NY	620	1												1		1							1	
NEW YORK, NY	630	1	1		1				1	1										1				
NEWINGTON, CT	627	1																						
NORTHAMPTON, MA	631	1															1						1	
NORTHPORT, NY	632	1																						

SPECIALIZED MENTAL HEALTH AND OTHER PROGRAMS

REGION 1		R	HCHV											DCHV			LONG							
	STA	E			DROP						VBA		VV				TERM	PTSD						
FACILITY	NUM	G	HCMI	CHC	IN	O/R	PRRTP	SH	SSA	VASH	INIT	VI	TR	DCHV	SH	HWH	PSYCH	EBTPU	NC	PCT	PRRP	PSU	SIPU	SUPT
PERRY POINT, MD	641	1	1													1	1			1				
PHILADELPHIA, PA	642	1	1													1				1				
PITTSBURGH (HD), PA	645	1	1	1				1			1			1		1				1				1
PITTSBURGH (UD), PA	646	1																						
PROVIDENCE, RI	650	1				1		1				1				1				1				
RICHMOND, VA	652	1																						
SALEM, VA	658	1														1							1	
SYRACUSE, NY	670	1	1							1														
TOGUS, ME	402	1														1				1			1	
WASHINGTON, D.C.	688	1	1						1	1						1				1				
WEST HAVEN, CT	689	1				1		1		1	1					1		1	1		1		1	1
WHITE RIVER JUNCTION, VT	405	1														1		1	1	1				
WILKES-BARRE, PA	693	1	1					1								1								
WILMINGTON, DL	460	1																						
TOTALS - REGION 1			18	2	3	4	0	7	3	8	4	4	3	10	1	25	5	4	3	17	2	1	7	3

SPECIALIZED MENTAL HEALTH AND OTHER PROGRAMS

REGION 2		R	HCHV											DCHV			LONG							
	STA	E			DROP						VBA		VV				TERM	PTSD						
FACILITY	NUM	G	HCMI	CHC	IN	O/R	PRRTP	SH	SSA	VASH	INIT	VI	TR	DCHV	SH	HWH	PSYCH	EBTPU	NC	PCT	PRRP	PSU	SIPU	SUPT
ALLEN PARK, MI	553	2			1	1					1					1								
ANN ARBOR, MI	506	2	1																	1				
BATTLE CREEK, MI	515	2														1				1			1	
CHICAGO (LS), IL	535	2														1								
CHICAGO (WS), IL	537	2				1		1								1				1				
CHILLICOTHE, OH	538	2																		1				
CINCINNATI, OH	539	2	1							1				1		1		1						
CLEVELAND, OH	541	2	1	1						1	1			1		1							1	
COATESVILLE, PA	542	2			1									1	1	1				1			1	
COLUMBIA, MO	543	2																						
COLUMBUS (OPC), OH	757	2																						
DANVILLE, IL	550	2																		1				
DAYTON, OH	552	2	1											1		1					1			
DES MOINES, IA	555	2												1		1		1						
FARGO, ND	437	2	1													1								
FORT MEADE, SD	568	2														1								1
FORT WAYNE, IN	569	2																						
GRAND ISLAND, NE	574	2																						
HINES, IL	578	2	1							1						1				1				
HOT SPRINGS, SD	579	2										1		1		1								
INDIANAPOLIS, IN	583	2	1					1		1						1								
IOWA CITY, IA	584	2																		1				
IRON MOUNTAIN, MI	585	2														1								
KANSAS CITY, MO	589	2	1					1								1				1				
KNOXVILLE, IA	592	2														1	1				1			1
LEAVENWORTH, KS	686	2												1		1								
LEXINGTON, KY	596	2														1								
LINCOLN, NE	597	2														1				1				
LOUISVILLE, KY	603	2	1															1						
MADISON, WI	607	2																						
MARION, IL	609	2																						

SPECIALIZED MENTAL HEALTH AND OTHER PROGRAMS

REGION 2		R	HCHV											DCHV			LONG							
	STA	E			DROP						VBA		VV				TERM	PTSD						
FACILITY	NUM	G	HCMI	CHC	IN	OVR	PRRTP	SH	SSA	VASH	INIT	VI	TR	DCHV	SH	HWH	PSYCH	EBTPU	NC	PCT	PRRP	PSU	SIPU	SUPT
MARION, IN	610	2														1				1			1	
MILWAUKEE, WI	695	2			1	1		1			1	1		1		1						1		
MINNEAPOLIS, MN	618	2	1								1							1		1				
NORTH CHICAGO, IL	556	2												1		1							1	
OMAHA, NE	636	2																		1				
POPLAR BLUFF, MO	647	2																						
SAGINAW, MI	655	2																						
SALISBURY, NC	659	2	1																	1			1	
SIOUX FALLS, SD	438	2														1				1				
ST. CLOUD, MN	656	2														1	1			1				
ST. LOUIS, MO	657	2	1											1		1				1				
TOMAH, WI	676	2				1		1				1				1							1	
TOPEKA, KS	677	2														1	1			1			1	
WICHITA, KS	452	2														1				1				
TOTALS - REGION 2			12	1	3	4	0	5	0	4	4	3	0	10	1	29	3	4	0	19	2	1	8	2

SPECIALIZED MENTAL HEALTH AND OTHER PROGRAMS

REGION 3		R	HCHV											DCHV			LONG							
	STA	E			DROP						VBA		VV				TERM	PTSD						
FACILITY	NUM	G	HCMI	CHC	IN	O/R	PRRTP	SH	SSA	VASH	INIT	VI	TR	DCHV	SH	HWH	PSYCH	EBTPU	NC	PCT	PRRP	PSU	SIPU	SUPT
ALEXANDRIA, LA	502	3																						
AMARILLO, TX	504	3																						
ASHEVILLE, NC	637	3														1								
ATLANTA, GA	508	3	1							1		1	1			1				1				
AUGUSTA, GA	509	3	1													1							1	
BAY PINES, FL	516	3			1					1				1		1							1	1
BIG SPRING, TX	519	3														1								
BILOXI, MS	520	3												1		1				1				
BIRMINGHAM, AL	521	3	1		1											1				1				
BONHAM, TX	522	3																						
BREVARD COUNTY, FL	547	3																						
CHARLESTON, SC	534	3	1									1				1				1				
COLUMBIA, SC	544	3														1								
DALLAS, TX	549	3	1	1	1				1	1	1	1	1	1		1				1				
DUBLIN, GA	557	3												1										
DURHAM, NC	558	3																		1				
EL PASO (OPC), TX	756	3														1				1				
FAYETTEVILLE, AR	564	3																		1				
FAYETTEVILLE, NC	565	3														1								
GAINESVILLE, FL	573	3														1				1				
HOUSTON, TX	580	3	1					1								1				1				
JACKSON, MS	586	3	1													1		1		1				
KERRVILLE, TX	591	3																						
LAKE CITY, FL	594	3														1								
LITTLE ROCK, AR	598	3	1					1		1				1		1						1	1	
MARLIN, TX	611	3																						
MEMPHIS, TN	614	3														1				1				
MIAMI, FL	546	3	1							1						1				1			1	
MONTGOMERY, AL	619	3																						
MOUNTAIN HOME, TN	621	3	1											1		1				1				
MURFREESBORO, TN	622	3															1			1				

SPECIALIZED MENTAL HEALTH AND OTHER PROGRAMS

REGION 3		R	HCHV											DCHV			LONG							
	STA	E			DROP						VBA		VV				TERM	PTSD						
FACILITY	NUM	G	HCMI	CHC	IN	O/R	PRRTP	SH	SSA	VASH	INIT	VI	TR	DCHV	SH	HWH	PSYCH	EBTPU	NC	PCT	PRRP	PSU	SIPU	SUPT
MUSKOGEE, OK	623	3														1								
NASHVILLE, TN	626	3	1							1														
NEW ORLEANS, LA	629	3	1							1						1		1		1				1
OKLAHOMA CITY, OK	635	3	1									1	1			1				1				
PALM BEACH COUNTY, FL	548	3																						
SAN ANTONIO, TX	671	3	1							1						1				1				
SAN JUAN, PR	455	3																		1				
SHREVEPORT, LA	667	3														1								
TAMPA, FL	673	3	1					1		1		1				1				1				
TEMPLE, TX	674	3														1					1			
TUSCALOOSA, AL	679	3																		1				
TUSKEGEE, AL	680	3	1														1			1			1	
WACO, TX	685	3														1	1			1			1	
TOTALS - REGION 3			16	1	3	0	0	3	1	9	1	5	3	6	0	28	3	2	0	23	1	1	6	2

SPECIALIZED MENTAL HEALTH AND OTHER PROGRAMS

REGION 4		R	HCHV											DCHV			LONG							
	STA	E			DROP						VBA		VV				TERM	PTSD						
FACILITY	NUM	G	HCMI	CHC	IN	O/R	PRRTP	SH	SSA	VASH	INIT	VI	TR	DCHV	SH	HWH	PSYCH	EBTPU	NC	PCT	PRRP	PSU	SIPU	SUPT
ALBUQUERQUE, NM	501	4																		1				
AMERICAN LAKE, WA	505	4								1				1		1							1	1
ANCHORAGE, AK	363	4				1	1					1		1		1					1			
BOISE, ID	531	4														1		1		1				
CHEYENNE, WY	442	4	1													1				1				
DENVER, CO	554	4	1													1		1		1				
FORT HARRISON, MT	436	4														1								
FORT LYON, CO	567	4															1							
FRESNO, CA	570	4														1								
GRAND JUNCTION, CO	575	4														1								
HONOLULU (OPC), HI	459	4														1				1				
LAS VEGAS (OPC), NV	758	4																						
LIVERMORE, CA	599	4																						
LOMA LINDA, CA	605	4				1				1						1				1				
LONG BEACH, CA	600	4	1													1								
LOS ANGELES (OPC), CA	752	4	1							1										1				
MARTINEZ, CA	612	4														1								
MILES CITY, MT	617	4																						
PALO ALTO, CA	640	4												1					1	1		1	1	
PHOENIX, AZ	644	4	1													1				1			1	
PORTLAND, OR	648	4	1									1		1	1	1				1	1			
PRESCOTT, AZ	649	4												1		1								
RENO, NV	654	4														1								
ROSEBURG, OR	653	4	1													1		1						
SALT LAKE CITY, UT	660	4	1							1						1				1				
SAN DIEGO, CA	664	4	1							1						1				1				
SAN FRANCISCO, CA	662	4	1	1						1	1	1	1			1		1		1				1
SEATTLE, WA	663	4				1		1								1		1		1	1			
SEPULVEDA, CA	665	4																						
SHERIDAN, WY	666	4														1	1				1			
SPOKANE, WA	668	4																						

SPECIALIZED MENTAL HEALTH AND OTHER PROGRAMS

REGION 4		R	HCHV											DCHV	•		LONG							
	STA	E			DROP						VBA		VV				TERM	PTSD						
FACILITY	NUM	G	HCMI	CHC	IN	O/R	PRRTP	SH	SSA	VASH	INIT	VI	TR	DCHV	SH	HWH	PSYCH	EBTPU	NC	PCT	PRRP	PSU	SIPU	SUPT
TUCSON, AZ	678	4	1					1		1						1				1				
WALLA WALLA, WA	687	4	1													1								
WEST LOS ANGELES, CA	691	4	1	1			1		1	1	1	1		1		1					1		1	
WHITE CITY, OR	692	4												1		1								
TOTAL - REGION 4			13	2	0	3	2	2	1	8	2	4	1	7	1	26	2	5	1	15	5	1	4	2

SPECIALIZED MENTAL HEALTH AND OTHER PROGRAMS

REGION SUMMARY		R	HCHV											DCHV			LONG							
	STA	E			DROP						VBA		VV				TERM	PTSD						
FACILITY	NUM	G	HCMI	CHC	IN	O/R	PRRTP	SH	SSA	VASH	INIT	VI	TR	DCHV	SH	HWH	PSYCH	EBTPU	NC	PCT	PRRP	PSU	SPU	SUPT
REGION 1			16	2	3	4	0	7	3	9	4	4	3	10	1	25	5	4	3	17	2	1	7	3
PERCENT OF TOTAL			28	33	33	36	0	41	60	28	36	25	43	30	33	23	36	27	75	23	20	25	28	33
REGION 2			12	1	3	4	0	5	0	4	4	3	0	10	1	29	3	4	0	19	2	1	8	2
PERCENT OF TOTAL			21	17	33	36	0	29	0	14	36	19	0	30	33	27	23	27	0	26	20	25	32	22
REGION 3			16	1	3	0	0	3	1	9	1	5	3	6	0	29	3	2	0	23	1	1	6	2
PERCENT OF TOTAL			28	17	33	0	0	18	20	31	9	31	43	18	0	26	23	13	0	31	10	25	24	22
REGION 4			13	2	0	3	2	2	1	8	2	4	1	7	1	28	2	5	1	15	5	1	4	2
PERCENT OF TOTAL			23	33	0	27	100	12	20	28	18	25	14	21	33	24	15	33	25	20	50	25	16	22
TOTALS			57	6	9	11	2	17	5	29	11	16	7	33	3	108	13	15	4	74	10	4	25	9
TOTAL PERCENTAGE			100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100	100

To: Honorable Lane Evans, Chairman
Subcommittee on Oversight and Investigations
Committee on Veterans' Affairs
Social Services for Vietnam Veterans and Their Families
Current Programs and Future Directions

Response to Questions for Thomas D. Schroeder
Executive Director
Rock Island County Council on Addictions (RICCA)
East Moline, Illinois 61244

1. Coordinating receipt of the social services needed by Vietnam Veterans and their families is one type of assistance provided by the Vietnam Veterans and Families Assistance Program. Based on your experience with V.A., does V.A. effectively coordinate the social services needed by veterans and their families? How could V.A. better coordinate the services needed by veterans and their families?

Our experience through the Vietnam Veterans and Families Assistance Program has resulted in a perceived inconsistency in the delivery of service to the families of Vietnam era veterans by the V.A. The systemic structure of the V.A. means that the veteran is often treated in isolation, and services to the family are delivered from a piecemill perspective, referred to one or many local social service providers, or not provided at all. Families consequently come to the Vietnam Veterans and Families Assistance Program with a feeling of disgust and distrust as a result of their experiences with the V.A.

Families of Vietnam era veterans could be better serviced by the V.A. through the adoption of a family systems/wholistic approach that involves true case management of the numerous issues facing the Veteran and his or her family. Families need and deserve comprehensive planning and advocacy for the multitude of employment/housing/health/education/communication issues they face.

2. Why are Vietnam veterans and their families who have been assisted by the Vietnam Veterans and Families Assistance Program more likely to identify and receive social services from community resources?

The Vietnam Veterans and Families Assistance Program successfully tears down many of the artificial barriers inherented in social services delivery to families. The program case workers travel to the homes of the veteran families when necessary to meet with the family on their terms and at their convenience. The difficult paperwork required by the VA, SSA, or other federal, state or local entities is tacked by the case worker and the family jointly. The family is dealt with as a wholistic unit, with careful attention paid to the effect of any service on all members of the family.

At every step of service coordination or delivery, families are treated with respect and dignity. It is important to note that the case workers of the Vietnam Veterans and Families Assistance Program are Vietnam Veterans who have been serviced or disserviced by bureaucracy laden programs, and are therefore extremely cognizant of the need to treat families with humane compassion and empathy.

The treatment families receive from the Vietnam Veterans and Families Assistance Program results in families being more likely to seek and secure services from other community resources.

3. How do the social service needs of the families served by the Vietnam Veterans and Families Assistance Program differ significantly from other families? How has the Vietnam Veterans and Families Assistance Program informed the community resource programs of the differences?

Families served by the Vietnam Veterans and Families Assistance Program differ significantly from other families in many ways. Exposure of the Veteran to Agent Orange directly creates a seemingly endless list of physical / psychological / behavior problems for the Veteran and his/her children, and coping/adaptation problems for other family members. To complicate the family situation further, the medical and social service community has traditionally been slow and resistant to recognize and identify health issues of Agent Orange exposure, and consequently families have endured mis-diagnosis, failed treatment and systemic ignorance. Families served by the Vietnam Veterans and Families Assistance Program are therefore reluctant to trust the program, hesitant to open up to the caseworkers, frustrated by past experiences, and wary of placing hope in the services provided by the program.

The program has attempted to inform the community by conducting inservice workshops for many community resource programs; speaking to service organizations, veterans organizations and community groups, and by working directly with school system administrators, counselors, social workers and psychologists to assist the school systems in designing procedures to identify Agent Orange history and exposure in children of Vietnam era veterans.

Institute for Human Development

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October 13, 1994

UMKC

Honorable Lane Evans
Committee on Veterans' Affairs
335 Cannon House Office Building
Washington, DC 20515

Dear Lane,

I am sorry it has taken me a while to respond to your questions following my testimony. The problem, as you posed it, is, "According to your prepared statement, 'Our problem is that we still do not have a capacity, a commitment, and a plan of action within these service systems to assume responsibility for sustaining the needed coordination and integration to provide the services AOCAP has found to be beneficial and effective for these vets and their families.' What needs to be done to solve this problem? Are you optimistic it will be solved?" In response to your last question, I am optimistic they can be solved. However, the organizational changes necessary within Veterans services and some social services are significant. I have tried to outline an initial plan, the required outcomes, and necessary actions and strategies that could be implemented.

The issue of commitment comes first. This can be realized in terms of outcomes and specific values. In order to change the existing service system, a new way of thinking about services and the responsibility for their delivery must be embraced. The focus or outcome of such thinking must consider creating a lifestyle that can help veterans and their families contribute in local community life. It means that we need to create an alternative to traditional planning efforts that will enable people to think about their future, solve problems and work with natural supports that already exist in the community, as well as government support. This is the essence of what is working for existing AOCAP programs. We have been able, through planning tools like personal futures planning, to help change people, to re-imagine what is possible and to reevaluate our own roles and investments in making these ideals possible.

In contrast, traditional services and planning emphasize the deficits and needs of people, overpower them with endless goals and tracking procedures, and assign responsibility for decision making to professionals with narrow perspectives. These professionals often maintain the status quo of the existing organizational structure by focusing on accomplishments that are only possible within existing programs and structure. The messages that are given undermine the service recipients' confidence and growth with the not so subtle message: "You are the problem. You need to be fixed. You must learn to adapt. We (the professionals) will keep you out of the community until you are ready."

On the other hand, if service agencies and their staff listen to what veterans and their families are telling them, they find many activities, people, and experiences that offer clues as to what conditions in their settings need to change. If the outcome is the desire to be part of community life, it is then the professionals' job to negotiate needed organizational changes that may stand in the way. Central to this is the belief that "it is our job to work to negotiate needed organizational changes that will establish the link to community lifestyles." In this process families, caring supportive friendships, and other natural supports (i.e., churches) are essential to an individual's well being.

In addition to the characteristics of AOCAP I outlined in my testimony, e.g. sensitivity and respect; need to be recognized as a family; need for social support in the community; the need for information and training; and the need for advocacy, (Calkins, May 1994) there are 5 outcomes that must be sought by any reorganization of existing services. These are:

1. **A Positive View of People**
   The definitive outcome noted here seeks the capacities or strengths in individuals or families. The result is that debilitating effects of dealing with labels, diagnosis or associated disabilities is compensated by a capacity-seeking process that generates a view of the future and constructive energy that helps people change.

2. **Motivation by Inspiration and Success**
   The outcome here is the future vision that comes from success through individual decision making which others support. When one feels in control, he can create, invent, or seek answers that may not be readily apparent in the existing service delivery system.

3. **Personal Empowerment**
   Empowerment is an outcome that is revealed by joint problem solving with agencies, friends, and families. An individual takes responsibility for his or her own lifestyle.

4. **Community Involvement and Development**
   The outcome that results by community involvement and development is a long term solution that will sustain over time. The characteristics of this outcome are available resources, relationships, and opportunities that renew one's lifestyle over time. It also results in less requirements on government support or other social services.

5. **Organizational Change**
   The outcome that is sought here is continuous returning of system responses. With the preceding outcomes in mind, the system continuously seeks to make itself more responsive to individuals and families. There must be an allowance

to reinforce growth and change. In essence, new directions for development (e.g., community) are sought and new ways to respond to people are learned.

Lane, I realize that the preceding comments seek an ideal, but that is what must be agreed on first. The next step is to create a structure that will assure the preceding outcomes. I would propose that you create a Bureau of Community and Family Services within the structure of Veterans Affairs. Their intent would be to invest in the existing AOCAP structure. Their mission would be to support the development of community and family supports for veterans within each state. As a Bureau, they would not provide any services directly, but contract with providers in each state. The Bureau could provide two types of funds.

The first would be community development funds. These funds would be targeted at leveraging existing resources, e.g., benefits at national, state and local levels, grants, program development and networking with other agencies. As an example, one case coordinator in our AOCAP project in Missouri generated over $1,105,760 in national, state and local resources in two years serving ninety-eight veterans and their families. Likewise, using this same principle, University Affiliated Programs generate $28 for every federal dollar allotted in their core grant. These funds are directed at capacity building in the existing system. I would suggest that a minimum allotment of $200,000 be allocated to a state and channeled through a UAP program.

Secondly, some purchase of service (POS) dollars are needed to directly support families. We know when we invest in families, the veterans get better also. POS could come from redirected resources within Veteran Affairs. There is also now National Family Support legislation as well as similar support in most states. The POS funds could amount to $500,000 for each state and be directed to existing AOCAP programs. Family support dollars are cost effective because they decrease long term effects of disabilities and prevent expensive alternatives like institutionalization.

With a community development structure and Family Support POS dollars in place, the outcomes associated with the current AOCAP programs could be maintained. A pilot program for 10 states would cost $7 million. This level of organizational change would require ongoing training of federal, state and local agencies. However, that training could be expected from the development funds. The structure that I have outlined would provide movement from a depending model to an empowerment model of services and supports.

Lane, I realize this is just an outline, but I would be glad to work with you to fill in the details. A newly formed National Alliance of Veterans and Families Services would be very helpful as well. Gary May is the current President. This organization has just formed from the existing AOCAP programs.

I hope this is helpful. Please do not hesitate to contact me for further assistance.

Sincerely,

Carl F Calkins

Carl F. Calkins
Director

Florida State
UNIVERSITY
Psychosocial Stress Research Program
103 Sandels Building
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October 13, 1994

The Honorable Lane Evans, Chairman
Subcommittee on Oversight
and Investigations ***via fax: 202-225-2629***
U. S. House of Representatives
Committee on Veterans' Affairs
338 Cannon House Office building
Washington, DC 20515

Dear Congressman Evans:

Thank you for your letter of May 25. Unfortunately, I only received a fax copy of this important letter today. I am responding immediately, since the subject you address is so vitally important.

In your letter you posed six questions. I will restate each and attempt to answer them here as fully as possible and hope that you will ask me to clarify as you see the need. I assure you that I will respond immediately after receiving your correspondence.

1. What are "family-centered veteran services" and how do they differ from traditional veteran services? Why are "family-centered veteran services" important and what are the advantages and disadvantages of this approach compared to traditional veteran services?

Family-centered (FC) veteran services are those that focus on the well-being of the veteran's family and family-like support system, as well as the veteran so that the family functions as an effective support system. Thus, FC veteran services considers the needs of everyone in the family in the assessment and service delivery plans. FC veteran services are important because of their advantages. More than any institution, agency, or group, the family knows the veteran better and, with sufficient resources, can provided the kind of individualized care most needed by the veteran all of the time and for the rest of the veteran' life. Considerable research has supported the tenet that patient compliance in following pre- and post-operative care, for example, is directly related to the quality of the marital relationship. Traditional care, in contrast, include family members only as "next of kin" and are viewed only as a component to patient/client/recipient services. Often medical decisions are made, for example, with no regard for the best interests of the family and, in the case of the location of treatment, may literally remove the veteran from the care and attention of family members. FC veteran services would always conduct a family impact assessment to

determine if the services provided would enhance or diminish the quality of family relationships, especially marital relationships.

2. Compare the cost of traditional veteran services with the cost of "family-centered veteran services." Are "family-centered veteran services" more costly or more cost-effective for providing effective treatment to veterans than traditional veteran services? Please provide evidence which supports your response.

The costs of FC services are far less than the more traditional veteran services in that the latter services inadequately calculate the hidden value of family member attention to and provisions for the needs of the veteran. In the case of combat-related PTSD, for example, family members know better than anyone else how the veteran is functioning and how it is affecting everyone in the family, including the children. Treatment services that focus exclusive on the veteran must assess the veteran without this vital knowledge known only to family members. Moreover, information about the veteran's war experiences, the post-war adjustments, and other vital information and insights the veteran shares with therapists are critical in helping the family recover from the secondary traumatic stress they have experienced in living with the veteran. They too need sufficient attention to their own war at home.

It is difficulty to provide evidence for the position of the cost-effectiveness of FC veteran services, since such services do not exist at this time. However, I will send a copy to my colleagues in the American Association for Marriage and Family Therapists and the Division on Family Psychology of the American Psychological Association for their comments and possible evidence to show the cost effectiveness of mental health services that are family-centered. I believe that there are similar groups that focus on medical, dental, and vocational services that could respond as well.

3. What are your recommendations regarding the provision of "family-centered veteran services" by VA?

Unfortunately I am unfamiliar with the current provisions to comment with any authority. From my limited knowledge, I know that there are very few family-centered or "systems informed" mental health professionals and even fewer that focus on benefits, vocational education, and medical and dental services. This is very unfortunate. The movement toward managed care in which family practitioners provide a primary role as a service "gatekeeper," illustrates the direction in which the VA Medical system must go: Attending to the health needs of all family members for the benefit of each one, including the veteran.

4. Please comment on the social costs and consequences of "secondary traumatic stress."

There is now ample evidence emerging from the scientific literature based on studies in the Israel, the Netherlands, Canada, as well as in the US that the social costs and

consequences of secondary traumatic stress (STS) is enormous. The costs can be viewed from the point of view of both professional service providers and from the point of view of family members and other supporters of the traumatized, such as combat veterans with PTSD. My most recent book, *Compassion Fatigue: Secondary Traumatic Stress from Treating the Traumatized* (New York: Brunner/Mazel, 1995) documents the high turnover rate among those who work with traumatized people. This is especially true among child protection workers, nurses in critical care units, and 911 dispatchers. But it is also true among those who work with combat veterans. Until recently the simple explanation of "burnout" satisfied most who were concerned. However, we now know that STS or compassion fatigue is the real reason. It is a special form of burnout associated with the nature of the clientele and the inability of the professional to both derive a sense of satisfaction for their efforts to relieve the suffering and their inability distance themselves from their clientele.

The suffering of family members, especially the children, who serve as supporters to the traumatized, has gone unnoticed until the last decade. It was first documented in the spouses (especially the wives) of combat veterans and POWs (see "interpersonal adjustment among Vietnam veterans," in my 1978 book, *Stress Disorders Among Vietnam Veterans: Theory, Research, and Treatment),* then among the families of the Americans held hostages held by Iran in 1980, Holocaust survivor children, family violence and other abuse, and a wide variety of traumatizing situations.

The result of this is an impaired family system that is ineffective in function for its members and, in turn, becomes a burden on its community and country when these problems are left unattended. Children, for example, exposed to a family member with active PTSD most often develop the parallel symptoms of STSD, do poorly in school--socially and intellectually, and do not reach their potential. I would be happy to provide you with a full list of references that document these problems.

5. Describe the possible generational consequences and costs of not providing family-centered veteran services.

In addition to what is noted above, when left unattended, families do the best they can. Often this effort to cope runs counter to treatment plans emerging from traditional veteran services providers. In the case of children of a veteran who is heavily medicated, for example, they frequently lose respect for their parent veteran, assume that this is the natural and normal costs to military service, and a sense that your country has a limited commitment to those "who bore the battle." Moreover, any services for the children, most often delivered outside the context of veteran services, will not fully integrate the services delivered to the veteran. As a result the integrity of the family is compromised and the natural support and caring is undermined. Again, there are ample published works that address this issue and can be made available to the Committee.

6. Is the trauma treatment likely to be less successful if it is not family oriented? Please explain your answer.

As noted above, trauma treatment focused exclusively on the individual traumatized person is flawed in at least two ways. As noted in my book, *Treating Traumatized Families* (San Francisco: Jossey-Bass, 1989), disclosures by the traumatized person that specifies what happened, why they believe it happened, why they acted and felt as they did during and following the event, and their concerns about similar events in the future are all critical information to the person's supporters. This information enables them to understand and often accept how and why the family member behaved as they did and do. Traditional treatment programs are also flawed because they do not address the full impact of the traumatic experiences for other family members. Memories of a father screaming in the middle of the night, for example, leave lasting negative impressions that must be addressed fully and candidly to eliminate the negative consequences for the children who experienced them. Finally, by focusing on the traumatized family, not just the veteran, there is greater likelihood that everyone one will recover at a similar rate and that the treatment will be lasting and enable the family to be even stronger and more prepared for other crises that confront them.

Thank you again for your interest in my opinions regarding my testimony before your important Committee. Please let me know if I can be of further assistance.

Sincerely,

Charles R. Figley, Ph.D.
Professor and Director

cc: Michael Bowers, AAMFT Executive Director
Ronald F. Levant, Division 43 (Family Psychology) of the APA

JUL 22 1994

Honorable Lane Evans
Chairman
Subcommittee on Oversight & Investigations
Committee on Veterans' Affairs

Social Services For Vietnam Veterans And Their Families: Current Programs And Future Directions

1. In your opinion, what is the relationship, if any, between the trauma you experienced due to combat and the less than honorable discharge you received?

The traumatic relationship between my combat experiences and the less than honorable discharge I received had and contines to have special problems, many of them relating to psychological readjustment to civilian life. Because of my bad discharge and combat experiences I became dependent on alcohol. I couldn't keep a job. I had no skills or training that would get me a decent job. I couldn't get help from the VA with the less than honorable discharge. Due to the unpopularity of the war, my combat experiences and less than honorable discharge, I returned home to a society that made me feel different and alone. As an African American Vietnam veteran, I felt even more alienated because I represent a small minority of society that have always been subject to racism and discrimination. In addition, my Vietnam combat experiences and less than honorable discharge perhaps will always have a lasting and powerful effect on my life.

2. Are you currently eligible for all VA benefits?

Yes, I am currently eligible for most VA benefits.

Sincerely,
M. J. Reaves

Agent Orange Class Assistance Program
P.O. Box 27413
Washington, D.C. 20038-7413
(202) 289-6173

July 6, 1994

Honorable Lane Evans, Chairman
Subcommittee on Oversight and Investigations
Committee on Veterans Affairs
335 Cannon House Office Building
Washington, D.C. 20515

Dear Mr. Chairman,

Attached are my responses to the questions you posed in your letter of May 25, 1994, as a followup to the May 18th subcommittee hearing on social services for Vietnam veterans and their families.

I appreciate the opportunity to furnish information on the experience of the Agent Orange Class Assistance Program in assisting Vietnam veterans and their families.

Sincerely yours,

Dennis K. Rhoades
Executive Director

1. **According to your testimony, 72 AOCAP network programs provide broad based social services to Vietnam veterans and their families and have provided services to over 150,000 persons to date.**

A. How many additional individuals in this class would be expected to benefit from, but have not yet received, broad based social services like those provided by AOCAP network programs? What is the basis of your estimate?

Assessing the universe of need among AOCAP-eligible veterans and their families is difficult, because the class itself does not conform to the veteran population cohorts which the federal government tracks through the census. The court has defined a member of the class as any person who served in Vietnam between 1962 and the end of 1971, which is the time period during which Agent Orange was used. In addition, however, the class also includes the veteran's parents, spouse, and children. For operational purposes, we have estimated that the class includes 2.5 - 3 million veterans, as well as another 8-10 million relatives. The class itself is therefore large. To estimate the number of persons in the class needing services, certain inferences can be made from available statistical data. First, according to the Research Triangle Institute, approximately 15% of veterans who served in Vietnam suffer from Post Traumatic Stress Disorder (PTSD) to one degree or another. As Dr. Charles Figley has pointed out in his testimony, PTSD is likely to have negative ramifications for the veterans' family. Second, national studies have shown that approximately two to two and one half percent of all children in the United States have developmental or other chronic disabilities. The children of Vietnam veterans, however, are unusual in this regard. Data collected by the National Information System at the University of South Carolina indicate that the families of Vietnam veterans differ from other families in that there is a higher rate of disability within the family (i.e., Vietnam veterans are likely to have more than one child with a disability) and that the children are more likely to have multiple disabilities.

B. How much financial support does AOCAP provide annually to network programs and how many individuals receive services on an annual basis from AOCAP network programs?

The Assistance Program currently provides $12.3 million per year to the 72 projects in the Vietnam Veterans Family Assistance Network. This support assists approximately 40,000 individuals annually.

2. **The provision of services to Vietnam veterans' children with developmental or other chronic disabilities and related services to families have been a high priority for AOCAP. What other services have been priorities for AOCAP?**

AOCAP also places a high priority on the family, both as a unit of care and as a resource for healing. In evaluating early grants, we began to recognize the high degree of dysfunction among many of the families served by the network. Grantees further reported that the incidence of dysfunction often appeared to be directly related to Post Traumatic Stress Disorder (PTSD). This evaluation paralleled the findings of the National Vietnam Veterans Readjustment Study which reported that "...70% (of all Vietnam veterans with PTSD) have been divorced ... and 49% have high levels of marital or relationship problems." Currently, the Veterans Administration (VA) -- through its Readjustment Counseling Program -- provides very little family counseling. Thus, through its network of grantees, the Assistance Program is filling a large gap in treating the effect of PTSD on families and in bringing a family centered approach to bear on the problems of Vietnam veterans.

Equally important, given limited resources and the large size of the class, we were determined to magnify the impact of settlement funds by using limited settlement dollars to leverage resources available through government and private agencies. Thus, one of the priorities of the AOCAP program has been the network's use of service coordination. Such coordination amplifies the impact of settlement funds, fosters development of class members' skills in using community programs and services, and represents a more holistic, integrated approach to serving people.

3. Will the social service needs of Vietnam veterans and their families be met without AOCAP-like provided support in the future?

AOCAP's current program emphasis was developed precisely because many of the social service needs of Vietnam veterans and their families were not being met either through the veterans services system or the broader human services system. Moreover, it is doubtful that any legislation, either pending or recently passed, yet addresses the broad spectrum of social service needs of Vietnam veterans and their families. In designing AOCAP's service network, we sought to fill gaps in the service system as evidenced by testimony from the court's Fairness Hearings, the large numbers of letters and phone calls we took from members of the class, and the original claims made against the settlement. During the five and half years of AOCAP's operation, there has been little movement on the part of the federal government to fill these gaps. In part, this is attributable to the fact that the Vietnam Veterans Family Assistance Network has itself taken the initiative to meet the social services needs of the class. Additionally, however, there has continued to be little recognition - especially in the relatively isolated world of veterans affairs - that these gaps exist at all.

4. How can VA better meet the social service needs of Vietnam veterans and their families?

First, the VA needs to become a family-oriented agency, adopting the family as the unit of care rather than the individual veteran. The concept of a "dependent" has a quaint, antiquated ring to it in our contemporary society. The family is the veteran's primary support system, and its dynamics are often vital to the readjustment and rehabilitation of the individual veteran.

Second, the VA should take a more holistic approach to service provision, i.e., service coordination. How many VA service providers are currently conversant with SSI, or the peculiarities of Medicaid? For too many, I suspect, once the avenues of VA benefits and services are explored and exhausted, veterans and their families in need are turned away rather than assisted in examining alternatives.

Third, the VA's services and programs are among a shrinking minority which are still operated directly by the federal government. As I indicated in my testimony, the trend toward decentralization of programs is now over a generation old. Large scale national categorical programs are becoming rarer as we approach the end of this century. This is not to suggest that the veterans services system should in some way be defederalized, and responsibility for services shuffled out to the states. That particular avenue is frought with dangers in and of itself, as the Department of Labor has so clearly demonstrated over the years. What it does suggest is that the VA, its medical centers, counseling functions and other programs, needs to become considerably more community-oriented and community intergrated. Effective coordination of services with state and local agencies can only be achieved if the VA becomes, either directly or through contracting out, an active, visible partner in the human services system at both the state and local levels.

5. A. What have traditional social service providers learned about the unique social service needs of Vietnam veterans and their families from AOCAP network programs?

Perhaps the first lesson that social service providers learn (and need to learn) is that the Department of Veterans Affairs does not provide all of the services needed by a veteran and his or her family. Too often, the VA is perceived as providing such a broad constellation of assistance that other public agencies are somehow absolved of the responsibility for serving what they perceive as this "special population group."

Within the social services system, it has become apparent that, in order to provide appropriate service coordination to veterans' families, a multitude of agencies often must be dealt with i.e. housing, developmental disabilities, veterans, mental health, alcoholism/substance abuse, employment, education. Many of these systems are interacting for the first time, and all have widely variant regulations/eligibility criteria etc. Maneuvering among these groups to put together any kind of service(s) package often requires innumerable hours of effort.

Within the developmental disability community in particular, it has only been recently that the needs and issues facing the entire family - rather than the individual - have been considered when providing services. This is particularly relevant when dealing with a veteran's family because in addition to the disability factor, issues such as PTSD and secondary PTSD (as well as other problems specific to the veteran and his or her family) may be adding stressors to the family unit.

There is a major need for training within and among service systems regarding the special needs of veterans and their families. This ultimately leads to both increased understanding and better coordination of services.

B. How have traditional social service providers responded to what they have learned about the unique social service needs of Vietnam veterans and their families?

When veterans' families are initially perceived as a "special population", there is often a reticence about the potential (and unknown) cost of serving a "new" group of people. The fact is that service rationing is very often a reality, particularly in states and communities which are financially strapped. Eventually, in many cases, the systems come to recognize that they are, in all likelihood, already serving the veterans' family in some capacity. Without the knowledge that a member of the family is a veteran, however, problems peculiar to the families of some veterans (e.g., secondary PTSD) may go unrecognized. Very often, these families will appear unresponsive to conventional counseling and service strategies to the bafflement of the service provider.

Many social services providers have thus expressed a strong interest in receiving more information/training on the unique needs of Vietnam veterans' families. To date, no comprehensive and coordinated initiative has taken shape although we are currently in discussion with the Bureau of Maternal and Child Health (MCH) at the Department of Health and Human Services (HHS) on development of one such project. Providers have also indicated that the service coordination function developed by the AOCAP network has provided an important link between systems that have not previously dealt extensively with each other on a local, state or federal level (specifically veterans and HHS).

C. How can information about the unique social service needs of Vietnam veterans and their families be widely and effectively disseminated to traditional social service providers?

As mentioned previously, we have begun discussions with MCH regarding development of a training video and accompanying manual on Vietnam veteran/family needs. AOCAP training projects could be disseminated as models to help demonstrate how to effectively meet and respond to family issues and to systematically develop service responses at the local level. As part of this concept, we are exploring usage of a regional telecommunication process to disseminate information as widely and cost effectively as possible. We would like to explore similar initiatives with the developmental disabilities and education fields. Additionally, we would like to work with the VA on training in areas such as incorporation of spouse and family issues when dealing with veterans.

6. In your opinion, what actions should the federal government and particularly the Department of Health and Human Services take to respond to the unique needs of Vietnam veterans and their families when AOCAP financial assistance is no longer provided to community-based social service agencies for this purpose?

Based on the experience of the AOCAP network the two major emerging areas of need appear to be appropriate service coordination and increased public awareness vis a vis on-going training and technical assistance efforts. We would like to further explore the following actions:

--Development of a federal interagency task force consisting of the VA, HHS (MCH & ADD), Education, National Institute of Mental Health and Defense (we strongly feel that the issues facing all vets and currently active military personnel are similar enough on many levels to warrant broadening the AOCAP model accordingly) to send a signal to states and localities of both the importance of this issue and the intention of a collaborative approach in dealing with it.

--Inclusion in various agency RFP's of Vietnam veterans as a targeted/special popluation, thereby allowing programs interested in providing services equal access to existing funding streams.

--Development of special collaborative projects (i.e. through SPRANS grants) in demonstrated areas of need. One specific idea would be the support for emerging grass roots regional consortia to address Vietnam veterans issues. Another concept could be the previously mentioned training/technical assistance initiative.

QUESTIONS SUBMITTED BY
HONORABLE LANE EVANS, CHAIRMAN
SUBCOMMITTEE ON OVERSIGHT & INVESTIGATIONS
COMMITTEE ON VETERANS' AFFAIRS

SOCIAL SERVICES FOR VIETNAM VETERANS AND THEIR FAMILIES:
CURRENT PROGRAMS AND FUTURE DIRECTIONS

MAY 18, 1994

QUESTIONS FOR MS. EILEEN PENCER
VICE PRESIDENT, CHIEF PROGRAM OFFICER
LOWER EASTSIDE SERVICE CENTER, INC.
NEW YORK, NY

1. **Before receiving financial support from AOCAP, did the Lower Eastside Service Center provide Vietnam veterans and their families social services which they needed?**

Before receiving financial support from Agent Orange Class Assistance Program (AOCAP), the Lower Eastside Service Center (LESC) provided substance abuse services for Vietnam veterans in accordance with New York State Division of Substance Abuse Services' guidelines. Social services were provided only for substance abusing clients (in this case, veterans) - not their families. In the course of providing services to these veterans, we learned that they had special needs and that their needs (and those of their families) were not being adequately addressed. Thus, when AOCAP funding became available, LESC seized the opportunity to access this funding resource that promoted a family-centered approach and enabled LESC to provide Vietnam veterans and their families the social services they needed. LESC's broad range of social services, made possible by AOCAP funding, would no longer be available if AOCAP funding were discontinued.

How have the social services provided to Vietnam veterans and their families by the Lower Eastside Service Center changed since the Lower Eastside Service Center has received financial support from AOCAP?

As a result of financial support received from AOCAP, LESC currently provides through Vietnam Veterans Family Services Center (VVFSC) specialized services for Vietnam veterans and their families and through our outpatient and residential services, a broad continuum of treatment and service coordination for this treatment population. VVFSC's services include individual, couples and family therapy; group therapy for children, adolescents, adult children of Vietnam veterans and women; PTSD and secondary PTSD counseling/education as well as case management services.

LESC's coordinated service delivery system has significantly enhanced the quality of social services provided to Vietnam veterans and their families. VVFSC staff provide training for other agency staff to view clients from a family-centered perspective, sensitize them to veterans' and veterans' families' distinct needs and familiarize them with the established network of veterans' community services. Through LESC program staffs' consolidated team effort, Vietnam veterans and their families receive the social services they need as LESC strives to provide consistency of care for veterans and their families agencywide.

What changes will occur in the services the Lower Eastside Service Center provides to Vietnam veterans and their families if the financial support provided by AOCAP is no longer provided?

Once AOCAP financial support is no longer provided, specialized family services now available to Vietnam veterans and their families will be discontinued. The implications of this loss at LESC would be far-reaching in that there would be a dismantling of social services benefitting Vietnam veterans and their families agencywide and a resultant void in the field since these specialized services would be unavailable elsewhere.

VA Vet Center clients and staff would also directly experience a loss on many levels, the most important being a significant reduction in specialized family services. However, the greatest loss would be suffered by whole categories of families, eligible under AOCAP guidelines, who would subsequently be denied these same services under VA eligibility guidelines.

2. **What is a "family-centered 'systems'" approach and why should it be used? How could VA use a "family-centered 'systems'" approach?**

To view families from a systems perspective is to recognize that "relationships formed among family members are extremely powerful and account for a considerable amount of human behavior, emotion, values, and attitudes. Moreover, like strands of a spiderweb, each family relationship, as well as each family member, influences all other family relationships and all other family members." (Figley, Helping Traumatized Families, 1989, p. 4)

LESC's selection of "family-centered 'systems' treatment" as a core value corresponds to an ever-growing trend in the field of social services. This treatment approach has gained widespread recognition by renowned mental health professionals in the human services field as a cost-effective and efficient mental health treatment intervention for a broad range of individual and family needs. For example, recognized authorities in family therapy such as Salvador Minuchin, Jay Haley and Charles Figley (the latter, a Vietnam veteran who has become a leading figure in this area) have educated legions of professionals in the social services field on the merits of the family-centered systems approach, pointing out that this type of intervention has been far more successful than individual and/or group treatment in the rehabilitation of families.

In general, the family-centered systems approach addresses the needs of the entire family constellation, confronts problems enmeshed in the veteran's interpersonal network and includes veteran's family members as equal partners in the veteran's rehabilitation. This treatment approach is based on the premise that the family support system can, with direction and guidance, serve as a valuable vehicle for promoting recovery and healing and that family system intervention is essential and key to achieve permanent change.

VA Medical Centers are not suited and could not apply a family-centered systems approach within the structure of their existing medical model. However, VA Vet Centers could more easily integrate a family systems approach through contract for service agreements with community based agencies (see below).

3. Describe your partnership with VA. What are the advantages, disadvantages and results of this partnership? How could this partnership be modified and improved?

LESC has established a unique partnership with VA through an integrated service delivery model with VA Vet Centers where we have established satellite clinics and our family therapists provide services. LESC family therapists function as an integral part of the VA Vet Center treatment team, participate in case conferences, receive and make referrals and collaborate in shared cases.

The principal advantage of our complementary partnership with VA lies in bridging the gap in services to families who are ineligible for these services based upon VA eligibility requirements. As a result of this synergy, both the quality of services provided to Vietnam veterans by VA Vet Centers and the effectiveness of family treatment provided by LESC are immeasurably enhanced. Neither VA nor LESC can accomplish alone what we have been able to accomplish together.

The principal disadvantage of our partnership with VA is that, while our relationship is collaborative, accommodations in treatment focus and clinical decisions are in keeping with the VA model and not LESC's family-centered systems model. That is, family treatment is provided as an auxiliary service to the veteran. Moreover, due to our informal partnership with VA, sensitivity must be exercised in reaching clinical decisions and a delicate political balance adhered to, in order to maintain our partnership.

The paradigm for providing family-centered systems treatment is most effective when implemented in the context of a community based organization. Thus, VA Vet Centers, developed upon the community based model, are better suited to integrate the enriched family-centered systems approach. VA Vet Centers, positioned as they are within the community, could capitalize on the LESC precedent by integrating family services and expanding their service delivery model. For example, VA Vet Centers could formalize partnerships with community based agencies through "contracts for services" similar to Medicaid's contracts for case management services for veterans, families and/or children with complex needs.

4. Have veterans and/or family members been referred to your agency by VA?

Veterans' families have been referred to LESC by VA, primarily from VA Vet Centers.

If referrals have been made to your agency by VA:

(a) Do you know why VA made these referrals;

These referrals were made to fill unmet needs and bridge the gap in services to families who were otherwise ineligible for these services from VA. VA recognizes that LESC family therapists provide specialized services such as PTSD, secondary PTSD counseling and education as well as war trauma counseling unavailable in community mental health agencies.

VA Vet Centers have made referrals to LESC primarily because of our on-site physical presence, easy access and availability. The disparity between the number of referrals received from VA Vet Centers and VA Medical Centers points to the significance of these variables.

(b) How many referrals have been made by VA; and

Of 180 families, approximately 57 families have been referred by VA: approximately 80% from VA Vet Centers; approximately 20% from VA Medical Centers.

(c) Do you know why more referrals have not been made by VA?

Overall, more referrals have not been made as VA considers the veteran to be the primary client, the family, an adjunct to the veteran's care. Until VA considers family participation essential to the veteran's rehabilitation and a formalized service partnership is established, family service referrals will remain at a minimum.

If referrals have not been made to your agency by VA, do you know why VA has not referred veterans and/or family members to your agency?

Not applicable.

QUESTIONS AND ANSWERS
SUBMITTED TO:
HONORABLE LANE EVANS, CHAIRMAN
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS
COMMITTEE ON VETERANS' AFFAIRS

BY: Thomas M. James, JD
Managing Director
Community Outreach to Vietnam Era Returnees
Charlottesville, Virginia

SOCIAL SERVICES FOR VIETNAM VETERANS AND THEIR FAMILIES
CURRENT PROGRAMS AND FUTURE DIRECTIONS

1. How can VA be more successful in meeting the unique social service needs of veterans and their families?

The VA should strengthen the existing Vet Center programs and Contract Programs under the Readjustment Counseling Program for veterans. These store front vet centers and community based contractors have direct access to the veterans and their families. Many have existed for many years and are well entrenched in their respective communities. They have a working knowledge of community resources and how to access such resources for their clients. They are better able to case manage the needs of the clients by offering support and guidance through any of the needed programs.

The V.A. Medical Centers are not seen as part of the community by the veterans. Their formal and institutionalized process does not afford the veteran the flexibility necessary to reach needed resources. Time has shown many veterans fall through the cracks of such large centers.

2. Have any veterans\and or family members been referred to your agency by the VA?

It is worth noting that as a contractor to the VA under the Readjustment Counseling Program any client we service regardless of the source of their intake is considered to be technically a referral from the VA. The contract states that any client serviced by a contractor agency under the VA program is to be considered a direct referal from the vet center overseeing the contract. Most of our clients come to our office based on referrals by current or past clients of our agency. We call the vet center to get approval for services for an initial three visits for evaluation followed by our providing a treatment plan and psych/social to the Vet Center. At that time the Vet Center will approve 15 visits under the program. The veteran in most situations has never been to or seen the authorizing vet center. The Vet Center, however, is desgnated by the wording of the contract as the refering source. This policy covers all veterans seen under the contract program as well as their spouses.

The contractor must follow the same procedures for approval of services to a spouse. The spouse is then considered to be a referral by the VA to the contractor. We may see hundreds of veterans and their families during a year and all of them would be considered under the contract as being a VA referral.

We have received approximately six referrals from VAMC's for services by our agency during the last fourteen years. These clients were either completing an in - patient substance abuse program at the VAMC and were in need of after care or they had gone through the Desert Storm "VA program at VAMC's. These programs include meeting with a social worker and discussing any problems they might have and then being given a list of possible resources. The veteran is responsible for making the contact. It is also worth noting the VAMC's in many cases will work to have the veterans serviced through the clinics within the hospital.

Our agency, in its fifteen years of direct service to veterans and their families, has never as of yet received a referral of a spouse or child of a veteran from any VA Medical Center. Any spouse or child we have serviced has entered our program through word of mouth referral from other clients or from referrals from hospitals and organizations within our community.

Chairman Evans to Mr. Raymond Swope

June 9, 1994

U.S. House of Representatives
Committee on Veterans' Affairs
335 Cannon House Office Building
Washington, DC 20515

1. What changes and improvements in services provided to Vietnam veterans and their families have occurred as a direct result of the partnership between AOCAP and Universal Family Connection?

The changes and improvements we have created has resulted in the following:

A central place where V.A., State, and local agencies can refer Vietnam veterans with families.

We provide coordinated case management to reduce waste fragmentation and duplication of services.

2. According to your prepared statement, your agency has been "very successful" in meeting unique social service needs of veterans and their families.

What are the unique needs of Vietnam veterans and their families and what explains the success of your agency? Please provide several examples of their success.

For eighteen years Universal Family Connection has provided family counseling services. Vietnam veterans are unique because they bring their military experiences along with mental and emotional disorders to the family unit.

The family has to cope with the Veterans symptoms of Post Traumatic Stress Disorder and their fear of being exposed to a chemical with unknown risk.

The success of UFC is due in part to our linkage agreements with other social service providers. The success of our agency is due to our combine service approach. We help with Social Security, V.A. Disability, Public Aid, Food Stamps, Handicap Permits, ect. We are a One - Stop - Shop.

We have a manageable caseload, therefore, the Veterans are seen in a timely fashion. Secondly, we are community-based, therefore, very accessible to families.

Examples of Success:

Every client who enters our office is a success story. These people can't be measured in dollars or statistics. When they come in they are confused, hurt, and tired from dealing with the system. We give them honest answers and they leave with hope. How can you measure that!

One of our clients came to us four years ago. He was receiving 50% for a service connected disability for PTSD. His four children are all disabled. His wife is manic depressive. He could not pay his mortgage and didn't have food. In the last four years we helped this family get on Social Security. We are assisting his grandchild, who is also disabled, to get S.S.I. At this time, we have helped this family to receive $11,000.00 in back benefits from S.S.A. Additionally this family has received $10,000.00 in additionally benefits for the children. This client also received a $500.00 check to help with his mortgage. UFC also provided assistance with food clothing and medical card.

Why were we able to help him and his family when others failed? We know about the programs in the community. We built a trusting relationship with the veteran and his family. We listened and coordinated our services with other community-based organizations.

3. How can VA be more successful in meeting the unique social service needs of veterans and their families?

How should VA be reconfigured, as recommended in your statement?

Which services should VA obtain from community-based social service agencies and why should VA purchase these services instead of providing them directly?

Often times the V.A. can't provide services for the veterans. There is a 25 year old lack of trust. Veterans benefit from agencies like ours.

The V.A. should conduct outreach through community based, non-profit, social service agencies. Families need a "One-Stop-Shop", not a huge impersonal monolith.

What the V.A. should purchase is not a list of services. They should purchase systems which are designed to meet the needs of the individuals. One family may need a home, the next psychological counseling, the next a special wheelchair, the next Social Security, the next CHAMPVAS, the next may simply need information. They need to purchase services from agencies like ours which are multi-faceted.

Dear Mr. Evans,

Here is my response to the recent set of questions you sent to go along with me testimony.

1. Why are AOCAP supported organizations seemingly so successful in cuttinf through the bureacracy to help veterans and their families?

Aocap supported organizations are family focused and community based. They ask the family what their needs are and work through community resourves to to help the family access the support necessary to meet those needs. AOCAP organizations work collaboratively with agencies, organizations,and individuals. They cross the boundaries of bureaucracies.

2. Have veterans and/or family members been referred to your agency by the VA?

Yes

If referrals have been made to your agency by VA:

(a) Do you know why VA made these referrals;

The family of a Vietnam vet had a child with a disability.

(b) How many referrals have been made by Va;

Nine out of the total 177 families who have been eligible for our services and who have elected to to work with us on an individualized family service plan were referrals from the VA medical Centers and Vet Centers in Arkansas.

(c) Do you know why more referrals have not been made by VA?

No, the director of our program and the veteran's liaison made a presentation at an inservice meeting to all of the social workers at the VAMC at the beginning of the grant period. The program director has met with and advised the Agent Orange Physical coordinator, physician, and Vet Center administrator. The service cordinator in the northwest corner of of the state has worked closely with theVAMC in her region of the state. The service cordinator in central Arkansas has made quarterly visits to the VA to leave materials and keep them advised as to the status of our program.

3. How can the VA be more successful in meeting the socail service needs of veterans and their families?

In addition to the suggestions made in my original testimaony, the VA must provide more local services and become a true member of the community in which veterans and their families live. They must become more aware of the needs of the families and veterans and local resources available.

4. Your testimaony refers to a public awreness program. Please desrcribe this program.

Our public awareness program focuses on three areas, state, regional, and local. The statewide public awareness has been accomplished through meeting with the leaders of all of the human service and veterans organizations and providing information to them. We have participated in state meetings and inservice programs. Our press release has appeared in the state newspaper and in every local newspaper in the state. Local and state radio stations have recieved our public service announcements. Service coordinators have contacted the hauman service and veteran organizations in their regions. Perhaps the best method of public awareness has been on the local level. All our service coordinators are encouraged to participate on the resource committee in their community. When their community sees them as a valid and valuable resource, referrals are made and the word is spread. Most of our refferals come from the families themselves. They hear about us from others that we have been able to assist.

Mr. Evans , thank you for this opportunity to answer these questions . I will gladly answer any further questions that you may have.

Peggy St. Clair

REPLY
HONORABLE LANE EVANS, CHAIRMAN
SUBCOMMITTEE ON VETERANS' AFFAIRS
SOCIAL SERVICES FOR VIETNAM VETERANS AND THEIR FAMILIES: CURRENT PROGRAMS AND FUTURE DIRECTIONS

June 27, 1994

by Bryan C. Smith, EdD
Director of the National Information System
Center for Developmental Disabilities
University of South Carolina
Columbia, SC

Dear Chairman Evans and members of the Subcommittee:

I am very pleased to have this opportunity to respond to the questions posed in your letter of May 25, 1994. The basis of this reply to the questions posed by the subcommittee have been taken primarily from two studies that the National Information System staff conducted recently and presented at the Agent Orange Class Assistance Program's National Symposium held in Washington, DC in May of 1994.

Question 1a *Can Vietnam veterans and their families be served effectively without service coordination services?*

Vietnam veterans and their families cannot be helped effectively without service coordination because of the complex web of agencies, confusing eligibility requirements and the array of professionals with vastly differing roles and missions that constitute the service delivery system. Even the most informed family members and experienced professionals can have difficulty determining which agency has the responsibility or expertise to respond to a particular need. In families where the parents are not well informed or able to be effective advocates of their family's needs, the challenges are even greater.

The existing structure of services, including veteran, child, and disability-related services is a fragmented system of care and one that predictably allows children to fall through the cracks created by the restrictive eligibility criteria of the service systems intended to help them. The Class Assistance Program's success has demonstrated that the coordinated provision of family-centered services is a viable alternative for Vietnam veterans and their families. They have shown that service networks can effectively make the necessary linkages between the community-based services and the centralized, specialty services needed to provide comprehensive care to veterans and their children with disabilities or chronic illnesses.

In contrast to the principles of family-centered care, public policy has historically addressed the needs of returning veterans as ones specific to the veteran. The traditional system of veterans benefits and services is veteran-directed, providing services and benefits to the veteran directly and with little regard to the veteran's family configuration, except in relation to certain income allowances and burial entitlements, with no services available to the veteran's family members from that system. Members of the veteran's family, characterized as "dependents," are generally recognized as having needs only if the veteran is disabled or deceased. Even the Vet Centers, which are designed to be more flexible and progressive in their service delivery approach, deal with family issues only in the context of their impediment to the veteran's "readjustment" counseling program.

Children's health depends on a complex array of factors with medical care as only one element of the matrix. Family, home and community environments, adequate nutrition, and healthy lifestyles may be as important to children's health as timely access to appropriate medical care. Parental behavior has an important impact not only on the physical health and development of children, but on their mental and emotional health as well. The health and development of many veterans' children have been adversely affected by years of exposure to substance abuse, angry outbursts, and sometimes, domestic violence. The effects of this are being manifested today in the children of Vietnam veterans as what has been labeled as "secondary PTSD." This condition truly marks a second generation of individuals affected by a disorder that requires a level of awareness to diagnose and a commitment of time and resources to treat.

The services supported by the Class Assistance Program, unlike many large publicly

funded programs, are based on the premise that flexibility and creative solutions are best suited to the diverse needs of veterans and their family members. Conventional responses and uniformity were never conditions for funding service providers. Instead, insistence on and monitoring of program quality and responsiveness were the standards. As a result, the Class Assistance Program network (from this point referred to as, the network) emphasized personal empowerment through assertive service coordination by community-based grantees. A defining characteristic has been the recognition that families are the primary decision makers for themselves and their children, making the family the unit of service for this newly formed network.

Service coordination is rooted in a family-centered empowerment model in which services are oriented toward the family, rather than toward any individual, such as a veteran or a child with a disability. A central premise underlying the emphasis on service coordination is that for this population, it is probably only marginally effective, at best, to offer single-faceted services such as counseling or rehabilitation to just the veteran, spouse or child. Too many problems of the veteran impact the family, and too many problems of the family impact the veteran, for them to be separated and to expect them to manage without professional guidance in obtaining the services they need. These families often need help because of their children with disabilities and a frequent incidence of family dysfunction, psychological problems, and alienation. Because the problems faced by Vietnam veteran families are generally chronic, multi-faceted and complicated, service coordination became an essential component of the network. The process begins with outreach to Vietnam veteran families and ends with the satisfactory resolution of their presenting problems. The dominant service goals are access to appropriate services, continuity of care, and means to achieve the families' well being. Persistent underservice and access barriers are the pervasive problems that service coordinators frequently address in serving veteran families. Within this framework, the service coordinator continually moves in the direction of acting in a consultative capacity and with each contact, the families' need for involvement with service coordination diminishes as they become more proficient at independently navigating the service delivery maze. Ideally, this builds a residual of family empowerment and increased future capacity for self-advocacy.

Since persons with disabilities generally have their conditions, or effects of the conditions, throughout their lives, their need for services continues; and as they get older, their service needs change. This dynamic state places considerable responsibility on family members to assume an important and active role in obtaining services that may be offered through a variety of resources. In one of the National Information System (NIS) studies, it was clearly shown that when a grantee was a central service coordination resource, it made a critical difference in families getting the services they needed. This critical component of the network facilitated the necessary linkages between community-based services and centralized specialty services and improved the delivery of comprehensive care to veteran's children.

Question 1b *Compare the needs of Vietnam veterans and their families for service coordination with others who need social services.*

The Vietnam veteran family's need for service coordination is different from others because the nature and magnitude of their problems are different. A consistent finding by grantees who provide counseling is that, especially for Vietnam veterans, counseling strategies are only minimally effective if they do not involve the family. This holds true even when the veteran's PTSD is the central focus.

In providing a national information and referral service to Vietnam veterans and their families, the NIS has been able to help over 16,000 persons. Of these, over half (52%) received referrals for some sort of assistance in accessing services. This level of requests clearly points to the broad need for service coordination. While it may be considered desirable for veterans and other family members, it is absolutely essential to Vietnam veteran families having children with disabilities.

Before serving Vietnam veteran families, the NIS had operated four other national information and referral programs. The one most comparable to the current program was the National Information System for Health Related Services (HRS) that served families with children, ages 0-21, with disabilities and special health care needs. For both the NIS and HRS, caller data was collected on the same forms and the staff used the same interview techniques. While there were some similarities between the families and children in these two groups, there were differences and unique characteristics that were readily apparent.

The magnitude of these differences is significant. In each characteristic cited, the

other population (HRS users) had a very small number or rate. For example, almost all (non-veteran) families, contacting the HRS to seek services, had only one child with one disability. In contrast, 29.4% of the Vietnam veteran families contacting the NIS to obtain services had more than one child with a disability, and 54.7% of the children with disabilities had multiple disabilities with an average of 2.9 conditions per child. It was not uncommon for a veteran to have as many as six or seven children, all having disabling conditions. Perhaps the critical difference, as it relates to the need for service coordination, was that most of the Vietnam veteran parents of a child with disabilities also had disabilities themselves, usually service-connected.

The NIS data were collected from over 16,000 client callers who were either veterans or family members seeking services for themselves or for their children with disabilities. Consequently, any conclusions from the NIS data can only be implied to the group being helped by the NIS, not to all Vietnam veterans or their family members. Therefore, the statistics described here are descriptive, presenting what has been observed over the five years of this project. Over 930 different diagnosed conditions have been reported by callers. The most common categorically grouped children's conditions were: birth defects (18.1% of the children who needed help from the NIS had conditions in this category); learning disabilities (17.6%), skin abnormalities (12.3%), immune deficiencies (12.0%), and asthma (7.8%).

Overall, the health status of the members of Vietnam veterans' families who used the NIS appear to be below an acceptable standard. Identified problems included a pattern of disability and chronic illness as well as social problems and poverty that seem unparalleled in comparison to other families, including those of other era veterans. The incidence of many serious conditions within this population, particularly in children, appeared to be well above those who used other information and referral services similar to the NIS. In addition, the veterans' own disabling conditions have placed strains on family structures that are decidedly unique. Many veteran families face additional disadvantages as isolation, low socioeconomic status, and the lack of access to adequate services, including transportation.

Question 2a *Is service coordination more costly or a more cost-effective means of providing effective treatment to veterans?* ***Question 2b*** *What evidence supports your response?*

The efficacy of service coordination was verified in both NIS studies and demonstrated by the fact that many private sector organizations, including health insurance companies, have adopted this approach as an efficiency or cost containment move. An example of validating service coordination for veteran families was shown by the finding that veterans' families were more likely to follow-through with recommended referrals when service coordination was provided than when the families were left on their own to pursue help. The studies revealed that there was a reluctance of some families to follow-through with referrals to organizations that potentially could address some of their unmet needs. Self-advocating behaviors were absent even in situations where there appeared to be a desperate need of services and the usual obstacles, such as cost or availability of services were not issues. Quite simply, for a variety of reasons, the Vietnam veteran family itself can be its own barrier to accessing needed services and service coordination is a means by which this barrier can be overcome.

By maintaining the family-focused approach to services and taking necessary actions to reduce a lack of follow-through in seeking needed services, all family members benefit. But it is particularly critical when the person needing services is a child dependent upon other family members taking action to obtain those services. Veterans' families, like most families facing similar problems, need assistance from a variety of service providers. They need a service system that provides advocacy, specialized educational services, general health services, specialized nursing services, social services, and financial planning. Further, many need specialized therapies, such as nutrition, respiratory, hearing and speech, occupational and physical therapy. Given the variety of services many of these families need, they quite often need an advocate and the assistance provided by some form of service coordination.

One of the studies conducted last year by the NIS was an impact analysis intended to determine if the network cost-effectively leveraged other resources to help Vietnam veterans and their families. Leveraging, which was used as a measure of cost-effectiveness, refers to the fiscally quantifiable outcomes of a grantee obtaining services or funds from another resource through advocacy, a service coordination function. This type of study is a systematic approach to evaluating the relative outcomes of an activity and it examines the costs, benefits, and uncertainties to determine if the initiative was a

beneficial means of meeting its objective. An impact analysis is an estimate and as such, the conclusions drawn are subject to the level of accuracy of the data used. One of the statistically significant study findings was that a benefit cost ratio showed that for every Class Assistance Program dollar spent on services and equipment for this study group, there was a $27.58 return in outcomes, leveraged through either financial assistance or services received. Further investigation in the study showed that non-respondents probably introduced bias that underestimated, not overestimated, the acquisition of benefits, and the $27.58 is a realistic, and probably conservative, finding.

Grantees were not charged with the task of leveraging financial support by the Class Assistance Program. However, helping a family obtain entitlements and services from other providers was a critical part of grantee's service coordination function. The fact that grantees had considerable success in leveraging public and private sector resources may have been due to their unique skills in advocating and interpreting how various agencies and processes work and their knowledge of how to navigate through various bureaucracies to access resources and services to which family members are entitled. It may also be an indicator of the underserved nature of this population, implied by the apparent failure of the traditional system to champion the issues to obtain entitlements for veterans or their family members.

Question 2b *What evidence supports your response?*

The following references, the last four of which will be published in the proceedings of the AOCAP National Symposium, support my response to Question 2a:

Falik, M., Lipson, D., Lewis-Idema, D., Ulmer, C., Kaplan, K., Robinson, G., Hickey, E., & Veiga, R. Case Management for Special populations: Moving Beyond Categorical Distincions. Journal of Case Management. 2:2 Summer, 1993 pp. 39-46.

Smith, B., Mayfield-Smith, K., & Sudduth, D. Impact Analysis of the AOCAP Network. National Symposium: Catalysts for Change. May, 1994. 29 pp. (The impact of a service delivery system's ability to leverage resources on behalf of Vietnam veteran families)

Smith, B., Mayfield-Smith, K., & Sudduth, D. Barriers to Services for the Vietnam Veteran Family. National Symposium: Catalysts for Change. May, 1994. 26 pp. (Barriers to services for Vietnam veteran families having children with disabilities, including the family itself, geographical, legal and institutional obstacles)

Smith, B., Mayfield-Smith, K., & Sudduth, D. Some Lingering Consequences of The Vietnam War on Veterans and their Families. National Symposium: Catalysts for Change. May, 1994 26 pp. (A descriptive paper reporting the observations made on veterans' and veterans' children with disabilities)

May, G. & Smith, B. The Potential for Systematic Change in Delivery of Services to Vietnam Veteran Families. National Symposium: Catalysts for Change. May, 1994. 29 pp. (A comparison of three service delivery systems and their abilities to help Vietnam veterans and their families having children with disabilities)

RESPONSE OF JOHN REISS, PH.D.

Associate Director
Institute for Child Health Policy

Assistant Professor of Pediatrics
University of Florida

Facilitator
AOCAP/Title V Working Group

TO QUESTIONS SUBMITTED BY
HONORABLE LANE EVANS, CHAIRMAN
SUBCOMMITTEE ON OVERSIGHT AND INVESTIGATIONS
OF THE HOUSE VETERANS AFFAIRS COMMITTEE

SOCIAL SERVICES FOR VIETNAM VETERANS AND THEIR FAMILIES:
CURRENT PROGRAMS AND FUTURE DIRECTIONS

JULY 6TH, 1994

Chairman Evans, thank you for this opportunity to response to follow-up questions to the testimony I presented to the Subcommittee on Oversight and Investigations on May 18, 1994 regarding "Social Services for Vietnam Veterans and Their Families: Current Programs and Future Directions". My response to your two questions are as follows.

1. I am not aware of any empirical studies regarding 1) factors which effected the degree to which the social service needs of Vietnam veterans and their families were met prior to AOCAP or 2) the costs of providing needed services and the costs of the consequences of not providing needed services.

   However, based on my work with the AOCAP/Title V Work Group and my extensive experience with programs for children with special health care needs and their families, I would like to offer the following observations and recommendations.

   First, health and social services systems focus primarily on addressing the needs of those families that actively seek services. Because, in general, the demand for services exceeds available resources, limited time, effort, and resources are devoted to outreach. In addition, most service programs have an individual rather than a family orientation. Thus program eligibility criteria and services focus on a individual family member rather than the family as a whole.

   Based on information provided by AOCAP grantees, it is evident that many Vietnam veterans and their families have had negative experiences with the health and social services system; and do not have confidence in the capability of the "system" to address the full range of their family needs. Because programs tend to be categorical, and address a specific presenting problem of one individual, families with multiple needs must seek out assistance from a multiplicity of programs, each with its own eligibility criteria, application forms, waiting periods, a staff. The lack of a single point of contact and good interagency coordination thus poses a significant time and psychological barrier for those who do not expect that their efforts to access the system will, in fact, result in needed assistance.

The reported shortcoming of Veteran's Administration services system include: the focus of the VA on the individual Vietnam Veteran rather than on the Veteran within the context of the family as a whole; the VA's "institutional" approach, which focuses on the services provided through the VA and fails to access or coordinate with services provided in the community; and the VA's "medical model" which focuses on identifying and providing a short-term cure for problems rather on enhancing the ability of the Veteran and the family to participate in long-term growth and development.

Based on information provided by state Title V Children with Special Health Care Needs (CSHCN) Programs, Vietnam veterans and their families have not been seen as a population group that is in need of targeted outreach and special assistance. While CSHCN Programs do have a family focus and consider the needs of the parents as well as the child, information about parent's military service status is not typically gathered as part of the program's standard intake process. Thus Vietnam veteran families have not been readily identified. In addition, Title V staff tend not to have special training regarding the needs of Vietnam Veteran's families or strategies for treating Post Traumatic Stress Disorder (PTSD). While, state Title V CSHCN Programs have not been optimally responsive to these families, it is my belief that these programs have been of assistance in addressing some of the needs of veterans and their families. Because Title V Programs are legislatively mandated to facilitate the development of family-centered, community-based, culturally competent, coordinated system of care for CSHCN and their families, these Programs are making available the types of services Vietnam Veteran families need. The philosophical basis of these state programs is to focus and build on the strengths of families, and to involve families not only in decision making about the care of their child but also in policy and program development for the service system as a whole.

AOCAP funded projects were specifically designed to reach out to and work with Vietnam veterans families. Because many of the staff are, themselves, Vietnam Veterans, AOCAP Projects have special expertise and experience in recognizing and understanding the specific, unique problems of Vietnam veterans and their families. The projects are also successful because they are designed to maximize and leverage resources, and to build networks not only for a specific client, but for all Vietnam Veterans. The care coordination and advocacy services that these project provide can serve as the glue that brings the pieces of the fragmented service system together in a coordinated fashion. In addition, AOCAP is founded on the philosophy that the family, rather than an individual family member should be the unit of care.

From the perspective of state Title V CSHCN Program leadership and the USPHS Maternal and Child Health Bureau, AOCAP Projects have provided much needed assistance to Vietnam Veteran families with children with special health needs. They have also developed special knowledge and skills, which could be of great value to state Title V CSHCN Programs.

One of the goals of the AOCAP/MCHB Work Group is to help to institutionalize the knowledge and skills that have been developed through the AOCAP Projects. Within the constraints of existing personnel and fiscal resources, selected AOCAP Projects and state Title V CSHCN Programs will work together, in order to improve the capability of Title V Programs to address the needs of Vietnam Veteran families with CSHCN. However, the children of Vietnam Veterans are one of many "special populations" for which Title V has a responsibility. Thus additional resources should be made available to both support the ongoing activities of projects specifically targeted for Vietnam veteran families and to fund additional state agency (i.e. Title V) staff who have special expertise in working with Vietnam veteran families.

As noted above, I am not aware of any empirical studies which quantify and compare the costs of providing needed services to Vietnam veteran families with children with special needs to the costs of the consequences of not providing these services. However, the professional community that provides services to children with special needs and their families agree that prevention and early intervention is, in the long run, less costly than not providing needed services. This family-centered, coordinated, early intervention approach to addressing the needs of families is at the heart of both the Individuals with Disabilities Education Act (IDEA), Part H and the Maternal and Child Health Bureau's State Systems Development Initiative (SSDI).

Currently, there is a general lack of data regarding the costs and outcomes of services for CSHCN and their families. It should be noted that the Office of the Assistant Secretary for Planning and Evaluation (OASPE) of the Department of Health and Human Services is currently soliciting applications to conduct children's disability policy research. As is noted in this announcement, "Policy issues revolve around a comprehensive set of services, including health care, education and income supports. Little information on children with disabilities exists at the national level and even less is known about the use, cost, and impact of services for these children...A patchwork of public programs have been enacted to provide families (with children with special needs) with a range of supports....Growing program rolls and increasing costs give rise to a number of policy issues. The lack of data on disability among children, as well as on their service use and costs complicates analysis of policy options." [Federal Register, Vol 59, No. 96 pp. 26234-26235 (May 19, 1994)].

This request for applications outlines a comprehensive set of questions related to children with disabilities and their families, including definitions and measurement; demographic and socio-economic characteristics; service use, expenditures and effectiveness; private costs of care; financing of services and supports; and system organization. The results of this research initiative will be generally informative to your subcommittee regarding the costs of care and the consequences of unmet needs. A number of demographic characteristics are identified in the grants announcement as being of interest, including type of disability, severity of disability, family income, age, gender, race, SSI/non-SSI participation and coverage by Medicaid. However, "military service status" is not specifically identified, therefore, information specifically about Vietnam veteran families might not be developed through this research initiative. Because, through our work with the AOCAP/Title V Work Group, we are aware of the need for Vietnam veteran family-specific data, the research proposal we plan to submit in response to OASPE's solicitation will include Vietnam veteran families as a population of special interest.

2. In regard to examples of services for children with disabilities that are family centered, comprehensive, coordinated, promote increased independence, productive and empowerment for the child and families, I am pleased to provide you with the names of the following organizations. This list is not all inclusive, but is reflective of my familiarity and long-term working relationship with these programs, agencies, and organizations. Since you are familiar with AOCAP funded projects, I have not included these on the list. I would suggest that your staff contact programs directly to gather additional information.

Deborah Allen, Director
Division of Children with Special health Need
Bureau of Family and Community health
Massachusetts Department of Public Health
150 Tremont Street, 4th Floor
Boston, MA 02111
Phone: 617-727-6941; FAX 617-727-6496

Cathy Chapman, Program Manager
Children with Special Health Needs
Division of Parent health Services
Department of Health
PO Box 47880
Olympia, WA 98504-7880
Phone: 206-753-0908; FAX 206-586-3890

J. Michael Cupoli, Director
Children's Medical Services Program
DHRS
Building 5, Room 129
1317 Winewood Blvd.
Tallahassee, FL 32399-0700
Phone: 904-487-2690; FAX 904-488-3813

Nancy Hoyme, Health Services Administrator
Children Special Health Services Programs
South Dakota Department of Health
118 W. Capitol Pierre, SD 57501
Phone: 605-773-3737; FAX 605-773-3683

Cassie Lauver, Director
Services for Children with Special Health Care Needs
Kansas Dept. of Health and Environment
900 SW Jackson, 10th Floor Topeka, KS 66612-1290
Phone: 913-296-1313; FAX 913-296-6231

John Nackashi, Medical Director
Pediatric Care Coordination Program
Associate Professor of Pediatrics
University of Florida College of Medicine
(Member, American Academy of Pediatrics
Committee on Children with Special Needs)
Gainesville, FL 32610
Phone 904-395-0552; FAX 904-338-9830

Richard Nelson, Director
Iowa Child Health Specialty Clinic
University of Iowa
Iowa City, IA 52242
Phone: 319-356-1118; FAX 319-356-3715

Ronald Uken, Chief
Children's Special health Care Services
Child and Family Services
Michigan Department of Public health]
PO Box 30195
Lansing, MI 48909
Phone: 517-335-8961; FAX 517-335-8560

Jerry Wiley, Medical Consultant
Children and Youth Section
North Carolina Dept. of Environment, Health, and Natural Resources
PO Box 27687 Raleigh, NC 27611-7687
Phone: 919-733-7437; FAX 919-733-0488

Other organizations with special expertise in family-centered systems of care for children with disabilities and their families are:

Betsy Anderson
Federation for Children with Special Needs
95 Berkeley Street, Suite 104
Boston, MA 02116
Phone: 617-482-2915

Beverly Johnson
Institute for Family Centered Care
5715 Bent Branch Road
Bethesda, MD 20816

William Sciarillo
Association for the Care of Children's Health
7910 Woodmont Avenue, Suite 300
Bethesda, MD 20814
Phone: 301-654-6549

Finally, as I noted in my written testimony to the subcommittee, the USPHS Maternal and Child Health Bureau's Division of Services for Children with Special Health Needs has provided significant leadership in supporting the development of family-centered systems of care for children with disabilities and their families. This has involved both the support of systems development by state Title V CSHCN Programs and the support of demonstration projects through the Bureau's Special Projects of Regional and National Significance (SPRANS) funding initiatives. Additional information about these MCHB initiated activities is available from the Bureau's representative to the AOCAP/Title V Work Group:

John Shwab, Chief
Habilitative Services Branch
HRSA/MCHB/DSCSHN
Parklawn Building, Room 18A27
5600 Fishers Lane
Rockville, MD 20857
Phone: 301-443-1080

In my written and oral testimony I made the recommendation that state and local efforts to improve services to Vietnam Veterans and their families could be enhanced by a federal initiative to identify:

> ...Vietnam Veterans families with children with special needs as a population in need of special attention in various research, service, and training grants, as administered through the Maternal and Child Health Bureau, the Administration on Children and Families, the Department of Education, the Rehabilitative Services Administration, Department of Veterans Affairs, etc. This would help target existing service, research and training resources on this population. This would also help to document the number of Vietnam Veteran families with children with special needs, and to describe the extent to which their needs are not appropriately addressed.

As you are aware, the National AOCAP Symposium was held during the week of your hearing. During the Symposium I had the opportunity to meet and learn from many AOCAP grantees, and to discuss in detail barriers and strategies for facilitating interorganizational collaboration on behalf of Vietnam Veterans and their families.

Based on these discussions, I would like to suggest, for your consideration, a strategy for helping to target existing federal service, research and training resources on Vietnam Veterans families with children with special needs. This strategy would involve the implementation of a federal interagency work group, comprised of representatives of those federal agencies/organizations that have a direct responsibility for these families. A preliminary list of these agencies is included in my testimony, as cited above. I would also recommend that the Maternal and Child Health Bureau be identified by Congress as the lead in this effort, because of their legislated responsibility for and extensive experience in systems development for children with special health care needs and their families. I would also suggest that Congress clearly charge other identified agencies with addressing the needs of Vietnam Veteran families through active participation in the Work Group, the develop of a federal plan of action on behalf of these families, and the allocation of existing resources for these families.

Thank you, again, for this opportunity to respond to follow-up questions regarding social services for Vietnam veteran families with children with special needs.

Social Services for Vietnam Veterans and Their Families:
Current Programs and Future Directions

June 13, 1994

Questions Submitted to
Honorable Lane Evans, Chairman
Subcommittee on Oversight and Investigations
Committee on Veterans' Affairs

Questions from Peter La Count
Project Coordinator
Vietnam Veterans Family Support Project (VVFSP
Kennedy Krieger Institute
2911 E. Biddle Street
Baltimore, MD 21213

1. If the Vietnam Veterans Family Support Project did not exist, who would provide family-centered support services to Baltimore-area Vietnam veterans and their families?

Under the direction of the Department for Individual and Family Resources of the Kennedy Krieger Institute, the Vietnam Veterans Family Support Project (VVFSP) has been operating since July, 1990 to provide support services for families of Baltimore-area Vietnam veterans who have children with disabilities. The project currently provides services to 46 families of Vietnam veterans. The services provided include:

* coordination of services to help families find and coordinate community resources and assist families in advocating for their special needs;

* home-based professional services provided by a special educator, occupational therapist, physical therapist, social worker and speech-language pathologist, who work with the children and families in their homes;

* financial assistance to help families purchase needed services or equipment; this may include assistance to obtain respite care, see a medical specialist, or buy special equipment for the child with disabilities;

* educational workshops and support groups for parents to help families make contact with other families and provide information on a variety of topics including self-advocacy, planning for the child's future and understanding educational placements.

Services are targeted to Vietnam veterans and their families who have children between the ages of birth and 21 with disabilities. Disability is defined very broadly and includes developmental and physical disabilities, and chronic health problems. To be eligible for services the veteran must have served in or near Vietnam between

1961 and 1972 and the family must reside in the Baltimore metropolitan area. Families from other parts of the state are referred to appropriate services in their areas. Families are eligible for services even if the veteran does not live with them.

If VVFSP did not exist, I do not believe that there would be any programs that would or could provide family-centered support services to Baltimore-area Vietnam veterans and their families. The U.S. Department for Veterans Affairs is not sanctioned to work with the veteran's families. There may be some well-meaning therapists and professionals who will work with the families only if the veteran is willing to seek out help first. However, these instances are few and far between. In the majority of the cases, the veteran is the only person in the family receiving services. If the veteran refuses services, has an aversion to "institutional" help, or is in denial of the need for services, then the family will not get the assistance that they need. Many families will fall through the cracks of both the veterans' assistance and developmental disabilities systems without programs like VVFSP.

Families may fall through the cracks of the veterans assistance and developmental disabilities systems for one or more of the following reasons:

1) most veterans assistance and developmental disabilities systems require that the veteran and his or her family seek them out for assistance; VVFSP and other Agent Orange Class Assistance Program (AOCAP) funded agencies have conducted systematic outreach measures to locate the veteran and their families i.e. to bring the program to the families;

2) many veterans who have undiagnosed cases of Post Traumatic Stress Disorder may be in denial of family problems or be fearful of letting potential helpers inside the home;

3) unlike the Department for Veterans Affairs (VA) our program can provide services to families if an adult in the family (adult child, spouse, uncle, aunt, etc.) requests assistance from VVFSP; the veteran need not be living in the home or be alive for the family of the Vietnam veterans to receive services;

4) many Vietnam veterans are mistrustful of all "institutions" due to past unpleasant experiences in military hospitals, the Department for Veterans Affairs (VA) etc.; therefore, these veterans may be more likely to isolate themselves and their families from outsiders whom they may view as threatening; these veterans are less likely to seek help from educational, medical, and/or mental health "institutions" that may be of benefit to the veteran and their families;

5) many families of Vietnam veterans fall through the cracks of the veterans and developmental disabilities systems because the veterans systems do not know how or are not equipped to work with families; the developmental disabilities programs do not have experience working with veteran's issues; the two systems do not communicate with one another.

I believe that the success of the Vietnam Veterans Family Support Project comes from our ability to recognize the specific needs of the veteran and his/her family; a

knowledge of, and an ability to access both the veterans assistance and developmental disabilities systems so that veterans and their families can benefit from both systems; and, from "word of mouth" veterans and veterans organizations in the Baltimore metropolitan area have come to know our program as one that works effectively with veterans and their families.

2. Has the Vietnam Veterans Family Support Project been successful in educating other social service agencies and providers in the community about the uniqueness of veterans and their families?

VVFSP has had some success with educating social service providers in the community concerning the uniqueness of veterans and their families. Program staff have in their day-to-day contact with numerous local, state, and national social service organizations communicated the needs of the veteran and his or her family. VVFSP staff have collaborated with groups as diverse as the Department of Social Services, local public and private schools, local Kiwanis Clubs, VA Veterans Centers, along with hundreds of other programs and services in the Baltimore metropolitan area.

VVFSP has had the most success in educating social service agencies and providers in the community by simply letting them know that VVFSP exists. By conducting outreach activities staff are making local agencies aware of our goals and objectives. Given this information, agencies are able to refer families of Vietnam veterans who have children with disabilities to our program. In this manner, families referred to VVFSP are receiving family centered and veteran oriented support services. VVFSP is then able to assist with support services in connecting families to the various service and support agencies in the areas in which the families live.

Rather than having a great deal of insight into the unique needs of veterans and their families, I believe that most agencies refer families to VVFSP because of our organizations history of successful family-centered, home-based support services. Because of the paucity of literature and educational opportunities for professionals to learn about the unique needs of veterans and their families, most agencies do not often interpret the veteran family who has a child with a disability as needing veteran-centered services. Most professionals do not associate the veteran's problems such as psychiatric disorders, alcohol and drug abuse, heightened feelings of anxiety, uncontrolable rages, flashbacks, emotional isolation, physical and emotional abuse of spouse and/or children, etc. as relating to latent Post Traumatic Stress Disorder (PTSD). Professionals who are not versed in the needs of veterans and their families may interpret each barrier manifested by the veteran as separate and unrelated. On the contrary, often these issues are related to war induced trauma that has gone untreated for decades.

As one agency, our ability to educate social service providers in the community concerning the unique needs of veterans and their families is limited. Greater emphasis needs to be placed in research to identify the needs of the veteran and his or her family. University programs, when educating future social service providers, need to offer courses and create opportunities for individuals to become more aware of the unique needs of the veteran and his or her family.

3. Why do social service agencies and providers in the community fail to recognize the uniqueness of veterans and their families?

VVFSP has met with some barriers in communicating the unique needs of veterans and their families. Some of these barriers include:

A paucity of training and research on the effects of war on the family- Unless a social service worker has experience working with a veteran and his/her family this worker may not recognize the needs of the veteran family. University and other training programs do not offer many (if any) courses describing the treatment methods of choice when working with families of veterans. When these individuals begin working in the "field" they have learned few skills to recognize the needs of the veteran and his/her family. Furthermore, since university programs do not teach treatment models for veterans and their families there is little opportunity for research in this area while in school. Therefore, when social service providers enter the work force there is virtually no literature that supports the notion that veterans and their ` families have unique needs.

Through divorce or separation the veteran often does not live with the children. One of the latent effects of war and Post Traumatic Stress Disorder (PTSD) on families is the high rate of divorce and/or separation in families of veterans. When the veteran does not live with the family he or she is not able to tell the "story" behind the involvement in war. The secondary trauma that may be exhibited by spouses and children caused by the veterans PTSD associated flashbacks and violence, substance abuse, or feelings of alienation may not be readily identified by the family or social service worker as war related and, thus, unique to the veteran and his/her family. If this war related secondary trauma is not addressed therapeutically, then the roots of the family's trauma may never be uncovered. Family and/or individual therapy with the veteran and or the veteran's family may not ensue. Such therapy could help to heal wounds with the veteran, the spouse, and children while helping the family to understand the war related reasons behind the family's trauma.

Newly traumatized persons manifest different symptoms than those living with trauma that occurred years or decades ago. Many social service providers are unaware or untrained in working with those living with long-term trauma. Veterans living today who experienced trauma resulting in PTSD twenty or more years ago often exhibit a wide array of symptoms. Left untreated, PTSD can result in numerous cognitive, physical, behavioral, and social problems that may be misinterpreted by service providers and family members as being unrelated to trauma occurring during war. Other difficulties that the veteran can experience over time include: anxiety, dissociative disorders, impulsive or depressive symptoms, employment difficulties, and legal problems. A social service provider who identifies the veteran's primary dysfunction as substance abuse or depression (for example) may treat that individual within the existing treatment facilities that include all other substance abusers or persons with depression. Misidentification of the root cause of the trauma may result in inappropriate and ineffective treatment for the veteran. In

fact, treating an isolated symptom may only agitate other symptoms manifested by the veteran. For instance, the veteran having left a emotional family therapy session may only self-medicate through alcohol and exacerbate his or her alcoholism. Therefore, it is essential that service providers gain a greater understanding of the trauma associated with war and its lasting legacy.

Unless AOCAP programs such as the Vietnam Veterans Family Support Project continue to exist to educate social service programs on the unique needs of the veteran and his or her family, these family's needs will not not be met. Programs such as VVFSP help to bridge the gap between the developmental disabilities and veterans assistance systems. Without such programs, combined with the dearth of literature available to social service providers on the unique needs of the veteran and his or her family, I do not believe that the needs of the veterans' family will be met.

Thank you for allowing me to provide this additional testimony on behalf of the families of Vietnam veterans with whom we work and others. I hope that you find it useful.