

# Social Work in the Department of Veterans Affairs: Lessons Learned

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This article provides an overview of the practice of social work in the U.S. Department of Veterans Affairs (VA) and the role social workers have played in VA's transformation into a leading provider of health care. VA is the nation's largest employer of workers with MSW degrees, with more than 4,400 assigned to VA medical centers and clinics across the country. Social workers in VA provide the full range of psychosocial services, serve as mental health clinicians, and hold leadership roles within and outside social work.

## HISTORICAL PERSPECTIVE

The VA has a long history of providing for the psychosocial needs of veterans. In 1926 a Veterans Bureau Order first established social services and resulted in the hiring of 36 social workers from the Civil Service register. These early hospital social workers functioned under the medical officer and assisted veteran inpatients with their social problems. Their duties included

securing complete and trustworthy social histories on neuropsychiatric cases; assisting the neuropsychiatrist in affording satisfactory treatment by solving social problems which interfered with such treatment; investigating the home environment and cooperating with the Guardianship Officer in ascertaining and promoting the social adjustment of incompetent patients in their communities; and contacting, cooperating with, and securing the aid of social service agencies in the respective regional territories. (Black, 1926, pp. 1-4)

Most of the patients had diagnoses of tuberculosis or psychiatric disorders.

By 1930, when the Veterans Bureau was replaced with the Veterans Administration, there were 97 VA social workers and 18 junior social workers who qualified by training or experience as caseworkers

assigned to 72 different duty stations across the country. These VA employees carried the designation of psychiatric or medical social worker and assisted veterans in receiving treatment and restorative services necessary to support their return to community living. Of the first 50 psychiatric social workers appointed, only 20 were college graduates with some social work training. Many had been recruited from the American Red Cross (Grant, 1932).

After World War II and the influx of more than 16 million combat veterans, the focus of VA social workers shifted to providing social treatment for emotional and environmental factors that affected the health of veterans, their ability to use medical care, and their adjustment to illnesses and injuries. In 1946 there were 98 VA hospitals and 186 social workers. The preferred educational requirement was a BSW. By 1950, the complexity of the health care needs of veterans, including those suffering from "battle fatigue," resulted in the need for VA social workers to have more advanced training. The minimum educational requirement became an MSW from an accredited school of social work. By 1953 there were 1,352 social workers working in more than 200 VA hospitals (Kyle, 1980).

## EXPANSION IN NUMBERS AND ROLES

As the number of social workers continued to grow in the 1960s, VA medical centers created social work departments (services) with social work chiefs to lead them (Kyle, 1980). To prepare social workers for these new leadership roles, the Social Work Administrative Leadership Training (SWALT) program was created in 1963. Over the next 34 years, 508 SWALT trainees graduated, with 362 going on to become a social work chief or assistant chief (Moses, 1996).

In 1989 the Veterans Administration was converted to cabinet status, becoming the Department of Veterans Affairs and the largest of the 14 cabinets

in the executive branch of the federal government. Numbering more than 3,000, VA social workers were assigned to all VA treatment programs and coordinated major medical center programs, such as the Community Residential Care Program, the Contract Community Nursing Home Program, the Spinal Cord Injury Program, and the Women Veterans Program (Burton, 2004). Seen as the primary liaisons with family members of veterans and with community agencies, social workers were the logical choice to assist the family members of Gulf War veterans. The Veterans' Medical Programs Amendments of 1992 (P.L. 102-405) was signed on October 9, 1992, authorizing the VA to screen Gulf War veterans and to provide marriage and family counseling. VA social workers were tasked with developing and overseeing the Persian Gulf Family Support Program. By May 1993 social workers had screened more than 33,000 Gulf War veterans and provided counseling services to 627 families at 36 VA medical centers (Moses, 1993).

## **REORGANIZATION AND DECENTRALIZATION**

In the early 1990s, as the U.S. health care industry faced dramatically rising costs and community hospitals struggled to become more streamlined and cost-effective, some members in Congress began talking about replacing VA health care with a voucher system. In 1994 Dr. Kenneth Kizer, formerly director of the California State Health Department, was named VA under secretary for health. Recognizing that drastic measures were needed if the VA were to survive, Dr. Kizer charged a task force with developing ways for the VA to move from a bureaucratic, antiquated system of hospitals to a health care system. His *Vision for Change* (Kizer, 1995), *Prescription for Change* (Kizer, 1996), and *Journey of Change* (Kizer, 1997) publications served as roadmaps and strategic plans for reducing inpatient beds, implementing primary care, opening community-based clinics, standardizing health care services, and simplifying eligibility for health care. Over the next five years, more than 50 percent of VA medical centers reorganized into product or care lines, decentralizing services and reducing the number of middle management positions. In 1995 there were 171 VA medical centers. By 2001 consolidations and mergers had reduced that number to 163 (Burton, 2004). Inpatient beds plummeted from 53,200 in 1995 to 21,000 in 2001. The

downsizing of the federal government and elimination of many supervisory positions resulted in a much smaller VA workforce, with 21,000 fewer employees in 2001 than in 1995. But during the same period, the number of VA patients increased from 2.9 million to 4.1 million, and VA saw a 32 percent decrease in inpatient admissions and a 35 percent increase in outpatient visits. The cost to treat an individual veteran decreased by 24 percent (2003). Dr. Kizer's visionary changes saved VA health care from vouchers and resulted in a much leaner and more efficient operation.

But with massive reorganizations of VA medical centers, social workers found themselves working for care line managers who were typically physicians and nurses. Problems arose with coverage across care lines, competency assessments, and supervision for licensure. The impact of downsizing was felt in social work staffing, with the number of VA social workers falling from 4,221 in 1995 to 3,704 in 2000 ("VSSC Employee Data," 2006).

The downsizing trend also affected VA headquarters in Washington, DC. The Office of Social Work Service, which had been staffed with a director and three social work section chiefs in 1995, had been reduced to an acting director and a social work program manager in 1998. The new under secretary for health, Dr. Thomas Garthwaite, understood the need to have discipline-specific leaders in headquarters to provide guidance to clinical staff in VA medical centers. The position of director of social work, which had been vacant for six years, was announced and filled in 2000.

## **THE REBIRTH OF VA SOCIAL WORK**

There were significant challenges to revitalizing social work. The morale of staff social workers in VA medical centers tended to be low; many felt they had lost their professional identities in the "care line" world. Hiring freezes and reduction of positions often meant greatly increased workloads for social workers. In VA headquarters, a series of acting directors had resulted in low visibility for social work.

The new director of social work held monthly conference calls for VA social workers and provided them with information about new programs, policies, and opportunities. She published a Veterans Health Administration directive on "Social Work Professional Practice" (Manske, 2002), which described the essential social work functions that

must be available in each VA medical center, regardless of organizational structure. The directive also required medical centers without centralized social work departments to appoint a social work executive to oversee the practice of social workers and outlined the functions to be performed by that executive. Although the social work executive was typically not the immediate supervisor, she or he was involved in hiring, promotions, competency assessments, and performance appraisals of all medical center social workers. The executive also offered or arranged for supervision for licensure and ensured that all social workers met the requirement to become licensed at the independent practice level within three years of hire. Having a social work executive helped social workers feel more connected with one another and better represented. The information flow from VA headquarters to staff social workers greatly improved. Annual virtual “focus groups” with social workers at each VA medical center ensured that the director of social work was in step with practice issues in the field. She also ensured that social work played a part in the development of all new VA clinical programs.

### **SOCIAL WORK AND CARE COORDINATION**

In 1999 Dr. Robert Roswell, director of Veterans Integrated Service Network (VISN) 8 (which includes the VA medical centers in Florida and Puerto Rico), found that 2 percent of patients in his catchment area were consuming 20 percent to 30 percent of his health care resources each year. Dr. Roswell wanted to reduce the associated costs of unnecessary outpatient visits and admissions. VA nurses and social workers responded to the challenge and collaborated to create the VISN 8 Community Care Coordination (CCC) program, which involved VA social workers and nurses serving as care coordinators to monitor veterans in their homes using telehealth technologies. The target population was veterans with chronic diseases who had frequent admissions and who were high users of VA health care resources. The CCC program sought to replace “just in case” routine outpatient appointments with “just in time” appointments based on need determined through daily in-home monitoring. Early results were impressive. In 2000 the 791 veterans who had been enrolled in the CCC program showed a 40 percent reduction in VA emergency room visits, 63 percent reduction in hospital admissions, 60 percent reduction in bed days of

care, 64 percent reduction in nursing home placements, and 88 percent reduction in nursing home bed days of care (Ryan, 2000). The VA under secretary for health was so impressed, he created an Office of Care Coordination (OCC) and asked social work to assist in implementing the program VA-wide. By 2005 more than 50,000 veterans were enrolled in OCC programs (Darkins, 2006).

### **SOCIAL WORK AND SEAMLESS TRANSITION**

The next challenge for VA social workers came with the wars in Afghanistan and Iraq. More than 505,000 military personnel who served in Operation Iraqi Freedom and Operation Enduring Freedom (OIF/OEF) had been released from active duty. More than 20,000 were severely wounded and evacuated to Walter Reed Army Medical Center and other military treatment facilities (MTFs). The transfer of injured service members from field hospitals to the Landstuhl Regional Medical Center in Germany to MTFs in the United States happened within days of injury rather than weeks. The volume of new casualties arriving each week presented challenges for MTF staff, who had to free beds to care for injured soldiers. The MTFs did not have space to keep injured troops hospitalized or typically did not offer long-term accommodations for outpatients (Kang, 2006).

The VA has traditionally had a passive role in assisting war casualties. In the past, service members in the process of separating from active duty were invited to attend a one-hour workshop on VA benefits provided by the Veterans Benefits Administration division of the VA. But it was left to each new veteran to contact VA to apply for those benefits, including health care services. The VA is a large, complex bureaucracy with a wide variety of benefit programs and many entry points. It was very difficult for new veterans to navigate the system, despite VA benefits briefings. Compounding the problem was the fact that many of the troops serving in support of OIF/OEF are activated members of the National Guard and Reserves, who often are less knowledgeable about VA benefits and services than those on regular active duty. There had to be a better way, and the VA Office of Social Work Service knew that social workers could play a key role.

The VA Office of Seamless Transition was created in August 2003 to address problems that OIF/OEF veterans were experiencing in trying to gain access to VA benefits. Former Secretary of Veterans

Affairs Anthony J. Principi charged a VA task force with making it easier for new veterans to apply for benefits and to receive health care. The secretary noted that VA had one chance to create a positive impression on new veterans—the first time the new veteran talked to a VA employee to request health care, disability benefits, vocational rehabilitation, or other benefits available to them. Red tape and obstacles had to be eliminated to ensure that new combat veterans received world-class services.

But how best to help new veterans make that smooth transition from military to veteran status? Because the majority of combat casualties were seen at the Walter Reed Army Medical Center, the director of social work suggested assigning a full-time VA social worker to Walter Reed to serve as a liaison in helping Army social workers and case managers transfer severely injured or ill OIF/OEF soldiers to VA medical centers. This effort was so successful that within weeks the workload had increased to the point that a second VA social worker was needed to assist with transfers and discharge planning. It soon became apparent that OIF/OEF soldiers were also being treated at other large Army medical centers, so VA social workers were assigned to work at Brooke Army Medical Center at Fort Sam Houston, Texas; Darnall Army Community Hospital at Fort Hood, Texas; Eisenhower Army Medical Center at Fort Gordon, Georgia; and Madigan Army Medical Center at Fort Lewis, Washington. Since the National Naval Medical Center at Bethesda, Maryland, was beginning to see Marine casualties, the VA social workers assigned to Walter Reed began providing seamless transition services at Bethesda as well (Perez, 2006).

The VA social worker liaisons work closely with MTF staff, particularly social workers and case managers, to help them become familiar with the treatment services available at VA medical centers. The VA social worker liaisons meet with the injured service members and their families, talk about VA health care, and identify the nearest VA medical center that can provide the needed services. The VA liaisons arrange for inpatient beds and outpatient appointments at VA medical centers. They are critical links between the MTF and the VA, ensuring that there is no disruption in treatment when soldiers are transferred to a VA medical center.

It was not sufficient to just have VA social workers at the MTFs. For the transfer to go smoothly, an identified VA employee needed to be at the receiv-

ing end. In the fall of 2003, the VA asked each VA medical center to identify a seamless transition point of contact, who would make the logistical arrangements for transfers of care, and a seamless transition case manager to follow the service members and coordinate their care. The majority of the case managers are social workers, who assist active duty service members and new veterans with psychosocial needs and also serve as the liaison with the family and, for those still on active duty, with the treatment staff at the MTF.

Seamless transition has been a phenomenal success. VA senior leaders have testified before Congress on the resulting improved access to VA services. Nearly 23,000 OIF/OEF service members and veterans have received information about VA benefits, and more than 5,900 have received help with VA benefits applications. VA social workers have provided assistance to more than 15,000 OIF/OEF patients in MTFs, arranging transfers for 5,399 to VA medical centers (Perez, 2006). MTF staff, active duty service members, families, and veterans are delighted with the results—easier access, world-class service, and expedited processing of claims.

A by-product of seamless transition has been an improved image for VA social workers. VA senior leaders have been very impressed with the spirit and enthusiasm that social workers have brought to seamless transition and with their knowledge of networking and coordinating care. Proposals for expansion of seamless transition to all severely injured and ill active duty service members, not just those who served in combat, have included proposals to assign VA social workers to all MTFs.

## **SOCIAL WORK AND POLYTRAUMA REHABILITATION**

As more and more OIF/OEF service members were transitioned to VA medical centers for rehabilitation, the number with multiple traumatic injuries increased. Recognizing that treating patients with polytraumatic injuries requires comprehensive and coordinated rehabilitation, Under Secretary for Health Jonathan Perlin conceived a plan in 2005 to convert VA's four Traumatic Brain Injury Rehabilitation Centers to Polytrauma Rehabilitation Centers. The centers would offer concurrent rehabilitation for head injuries, spinal cord injuries, amputations, visual impairment, posttraumatic stress disorder, and other medical and mental health disorders. Because these active duty patients were

transitioning from a military environment (MTF) to a community environment (VA medical center), it was imperative that VA provide supportive services to OIF/OEF patients and their families. Dr. Perlin required that Polytrauma Centers have a ratio of one social worker case manager for every six patients (Manske, 2005b). Social work was given responsibility for family support and long-term case management for polytrauma patients.

## **SOCIAL WORK AND DISASTER RESPONSE**

Another tragedy offered yet another opportunity for VA social workers to show their mettle. In the aftermath of Hurricane Katrina, the VA was called into action to provide health care services to evacuees. Nearly 50 VA social workers were deployed to the Gulf Coast to work in evacuation centers (Manske, 2005a). They reunited families, arranged for temporary housing, helped evacuees apply for FEMA and other benefits, and provided comfort and compassion. Many had Red Cross training and offered counseling services to veterans and nonveterans alike. The VA social work newsletter, *Synergy*, devoted its January 2006 issue to the stories of these social workers. Most reported that working with hurricane survivors was life altering for them and helped them get back in touch with their social work roots, reminding them why they chose to become social workers (Summers, 2006).

## **THE FUTURE**

Social work in the VA has experienced a rebirth, with social workers playing key roles in care coordination, seamless transition, polytrauma rehabilitation, and disaster response. At no time in the past decade have social workers been more respected or been viewed as more critical to the VA mission. However, to maintain that level of respect and credibility, VA social workers and social work leaders have many new challenges.

The demand for demonstrating evidence-based practice and measuring outcomes to psychosocial interventions will increase as the VA continues to set higher and higher standards for the quality of health care provided to veterans. Social work leaders will be challenged to justify social worker positions, and social workers will be expected to meet or exceed national productivity standards. Anticipated retirements will require renewed focus on social work succession planning and workforce development to ensure that social workers are pre-

pared to move into specialty treatment programs and into leadership roles. And the growing number of OIF/OEF veterans entering the VA system will challenge social workers to meet the expectations of a new and more diverse generation of veterans.

The Office of Social Work Service's annual strategic plan addresses all of these challenges. On the horizon are new training programs on data-driven decision making for social work leaders, which emphasizes the importance of accurate workload tracking and guides leaders on using workload data to justify and request resources. Also in the planning stages are a new VA Social Work Mentoring and Preceptor Program, a conference on social work and seamless transition, and presentations on caring for the next generation of veterans. VA social work has become an integral part of interdisciplinary care for veterans. And VA social workers are leading the way. **HSW**

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