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Bulletin of the History of Medicine, Volume 95, Number 4, Winter 2021, pp. 528-557 (Article)

Published by Johns Hopkins University Press
DOI: https://doi.org/10.1353/bhm.2021.0056

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SUMMARY: In 1979, the U.S. Congress approved funding for an outpatient, community-based "readjustment counseling" program to be overseen by the Veterans Administration (VA) and accessible to those who had served in the military during the era of the war in Vietnam. Today, three hundred Vet Centers are located throughout the country and their doors are open to veterans of a variety of conflicts; they outnumber VA hospitals two to one. This article explores conditions undergirding the establishment of the first Vet Centers and the program's broader implications, as well as the general issue of why public health systems change over time. Highlighting dynamics of how the VA gradually "deinstitutionalized" in the mid-twentieth century, it focuses on trends related to war and health, notions of federal responsibility, health activism and rights of people from marginalized groups, and connections between political ideology and medical diagnoses and treatment.

KEYWORDS: health policy, health care, veterans, deinstitutionalization, health system, Vietnam War, community-based counseling, health reform

For most of the 1960s, members of the Special Medical Advisory Group of the Veterans Administration (VA)—consisting of some of the United States' premier physicians—never uttered the word "Vietnam." They

I thank colleagues who have provided thoughtful feedback on earlier iterations of this article at conferences and beyond, including Beth Bailey, Stephen Ortiz, Okezi Otovo, and Bianca Premo. I am also grateful to the organizers and attendees of the Culpeper Seminar in the Department of Anthropology, History & Social Medicine at the University of California, San Francisco and the Dorothy M. Bernstein Lecture in the History of Psychiatry at the University of Minnesota Program in the History of Science, Technology, and Medicine for providing me with the opportunity to present portions of this work, and for sharing insightful remarks and questions. Max Cleland, Shad Meshad, Bill Weitz, and Bobby White graciously offered their impressions and memories, and I deeply appreciate their generosity. Finally, I am thankful for trenchant and helpful comments from the *Bulletin*'s editors and anonymous reviewers.

were focused on other issues and questions. Most pressingly: how could the VA—the agency tasked with overseeing a health system accessible to former service members—cost-effectively handle rising rates of chronic diseases among aging veterans of World War I, World War II, and the Korean War?

One of the group's first discussions about the escalating conflict in Southeast Asia appears to have been in December 1968, when Lyndon Johnson's VA administrator, William Driver, ominously said, "As long as we have . . . something in excess of three million men under arms, we are going to continue to get in the veteran population something like 70,000 new war veterans every month." "One of the things that has given me concern," one physician noted, "is Congress' feeling that, somehow, you take care of the veteran when he is wounded . . . then maybe when he gets to be an old man. . . . But in between . . . you can go and spend your money on something else . . . there is no real thinking."[1]

Within a year, and for decades to come, Congress would be forced to do some "real thinking." As veterans of the war in Vietnam returned home with injuries and illnesses, some charged the VA with negligence, or worse, active malfeasance. Their efforts helped bring about a variety of structural changes within the VA medical system, including the 1979 establishment of the Vet Center counseling program.

The nationwide initiative, a product of complex forces in and beyond the world of veterans' health, proved both dynamic and lasting. In the early 1980s, the VA opened more than a hundred stand-alone mental health clinics, mainly in strip malls and storefronts in neighborhoods accessible to working-class people. Initially, Vet Centers offered individual and group therapy to veterans who served during the era of the war in Vietnam, and who experienced so-called "readjustment problems." In 1979, the VA defined the latter term as "low-grade motivational or behavioral impairment which interfered with . . . normal interpersonal relations, job or educational performance, or overall ability to cope . . . with . . . daily life problems."[2] Employees in each Vet Center generally had freedom to devise therapy sessions and social events as they saw fit, but the facilities

1. "Veterans Administration Minutes of the Semi-Annual Meeting of the Special Medical Advisory Group" (December 9, 1968), 8, Record Group 15, Records of the Department of Veterans Affairs, Department of Medicine and Surgery, Records of Advisory Committees, box 19, National Archives and Records Administration, Washington, D.C. Here, I use the shorthand "VA" to refer to the U.S. federal bureaucracy overseeing veterans' benefits, which has gone by various names since its 1921 establishment, including the Veterans' Bureau, Veterans' Administration, and, most recently, Department of Veterans Affairs.

2. "Veterans' Health Care Amendments of 1979, S. 7," § Hearing before the Committee on Veterans' Affairs (1979), 56.

had some broad commonalities: they were staffed by mental health professionals as well as Vietnam War veterans, and one of their core missions was to offer services to those who might have been skeptical of VA hospitals and the massive government bureaucracy they represented. Vet Center staff could wear T-shirts and jeans and they aimed to keep paperwork to a minimum; the slogan, "Help without Hassles," adorned the coffee cups and pens they gifted to clients.[3] Today, more than three hundred Vet Centers are located in cities and towns throughout the country and their doors are open to veterans of a variety of conflicts; they outnumber veterans' hospitals two to one.

Scholars have shown that health-related experiences of U.S. military veterans are both distinctive and impactful. Former service members are part of a "protected public" in the amorphous U.S. welfare state, in part because they have conditional access—an "entitlement"—to their own centrally administered, federally funded medical care program.[4] For generations, veterans have helped to shape public awareness of health and disability by enduring and defining medical consequences of military service.[5] Meanwhile, representations of veterans' health conditions, such as posttraumatic stress disorder and ailments stemming from exposure to Agent Orange, have been central to shaping public and political debates about wars' legacies.[6]

3. Jessica L. Adler, William Weitz Oral History, December 16, 2016, War and Health Collection, Florida International University Libraries, Florida International University, Miami.

4. Rosemary Stevens, *A Time of Scandal: Charles R. Forbes, Warren G. Harding, and the Making of the Veterans Bureau* (Baltimore: Johns Hopkins University Press, 2016); Jessica L. Adler, *Burdens of War: Creating the United States Veterans Health System* (Baltimore: Johns Hopkins University Press, 2017). The phrase "protected public" is from Paul Starr, *Remedy and Reaction: The Peculiar American Struggle over Health Care Reform* (New Haven, Conn.: Yale University Press, 2011), 41.

5. Beth Linker, *War's Waste: Rehabilitation in World War I America* (Chicago: University of Chicago Press, 2011); John M. Kinder, *Paying with Their Bodies: American War and the Problem of the Disabled Veteran* (Chicago: University of Chicago Press, 2015); Audra Jennings, *Out of the Horrors of War: Disability Politics in World War II America* (Philadelphia: University of Pennsylvania Press, 2016); Susan L. Smith, *Toxic Exposures: Mustard Gas and the Health Consequences of World War II in the United States* (New Brunswick, N.J.: Rutgers University Press, 2017).

6. Wilbur J. Scott, *Vietnam Veterans since the War: The Politics of PTSD, Agent Orange, and the National Memorial* (Norman: University of Oklahoma Press, 2004); Mark Boulton, *Failing Our Veterans: The GI Bill and the Vietnam Generation* (New York: New York University Press, 2014); Leslie J. Reagan, "'My Daughter Was Genetically Drafted with Me': US-Vietnam War Veterans, Disabilities and Gender," *Gender Hist.* 28, no. 3 (November 2016): 833–53.

While important aspects of veterans' health-related experiences have been explored, much remains unknown about late twentieth-century transitions and programs within the VA medical system—the largest integrated health care system in the United States—including what they reveal about broader health care practices and policies. Historical analyses of signature VA programs can provide perspective not just on war and health, but also on changing notions of federal responsibility; trends related to health activism and rights for marginalized groups; connections between political ideology and medical diagnoses and treatment; and transitions in conceptions of how care should be delivered and accessed. In short, the Vet Center story offers a case study of how a public health system can change over time, and the complex ways it can be shaped by—and impact—the individuals it is intended to serve.

At least three interrelated forces led to the establishment of Vet Centers—and a particular and lasting model of community-based mental health counseling in the VA. The first "force for change" was the larger health care context: Vet Centers built upon an ongoing and sweeping popular movement toward deinstitutionalization and community-based care prevalent both in the mainstream health system and, as I demonstrate, the VA. Second, veterans and their advocates made compelling arguments for why they should have access to a new type of counseling program; they provocatively described their wartime and homecoming experiences, and the potential power of therapeutic care to alleviate an array of social problems. Finally, Vet Centers were instituted because politicians, government officials, and health experts fought for almost a decade alongside veterans to ensure the program would become a legislative reality. In the 1980s and 1990s, as the facilities became contested sites in larger debates about the legacy of the war in Vietnam, they survived, in part, because advocates strategically expanded their mission.

The Context and Precedent of "Deinstitutionalization"

In June 1967, about a year and a half before the VA's physician Advisory Group discussed the potential fallout of ongoing hostilities in Southeast Asia, Max Cleland arrived in Vietnam and penned a letter to his parents in Georgia: "Few people get to defend freedom," he wrote, "in its hour of greatest danger."[7] Cleland spent his yearlong tour like many other officers

7. "Max Cleland Letter to Parents" (June 17, 1967), Max Cleland Papers, box 51, folder: personal letters to parents during Vietnam War, 1967–1968, Jimmy Carter Library, Atlanta, Ga.

in-country: journeying from idealism to skepticism. "I've already got a reputation as a go-getter," he told his parents in July 1967, after receiving his assignment as a signal officer for the First Cavalry Division.[8] By March 1968, he reported, "how hard it is to muster the personal courage to put myself on the line for this country."[9]

About a month after Cleland wrote that letter, he volunteered for a military operation that would mark the beginning of his journey from soldier to wounded veteran—a journey that laid the foundation for his later, pivotal role as a government official who helped secure funding for the Vet Center program. The last to deboard a helicopter at the crew's hilltop destination, Cleland noticed a grenade on the ground. Assuming it had fallen from his vest and that it was not live, he reached down to pick it up. Then, everything went white. Cleland knew almost immediately that the explosion had taken his right arm and right leg; he thought something may be wrong with his left leg as well.[10]

When he could safely return to the United States in late April 1968, the Army sent Cleland to its flagship hospital, Walter Reed Army Medical Center, where he was assigned to one of the eight beds in the Officer Amputee Ward. He and fellow patients—all young veterans—formed a small community and sardonically called their recovery space the Snake Pit. Cleland, whose legs and right arm had been amputated, was among the most severely injured. In some moments, he could remain hopeful. In others, his thoughts reflected the popular perception that physical impairment inevitably led to helplessness; he worried that he would spend the rest of his life, as he put it, "lying in a hospital bed."[11]

Cleland's case was extreme in a variety of ways, but his long-term fear hints at a broad reality of both the military and civilian health systems in the United States: they were heavily centered on large-scale institutions.

8. "Max Cleland Letter to Parents" (July 17, 1967), Max Cleland Papers, box 51, folder: personal letters to parents during Vietnam War, 1967–1968.

9. "Max Cleland Letter to Parents" (March 18, 1968), Max Cleland Papers, box 51, folder: personal letters to parents during Vietnam War, 1967–1968.

10. Max Cleland, *Heart of a Patriot: How I Found the Courage to Survive Vietnam, Walter Reed and Karl Rove* (New York: Simon & Schuster, 2010); Max Cleland, *Strong at the Broken Places* (Atlanta: Longstreet Press, 2001).

11. Cleland, *Heart of a Patriot* (n. 10), 69, 71. Here, I use "impairment" as defined by Beth Linker and Nancy J. Hirschmann—"a natural part of biological life"—as opposed to "disability," which "refers to what society, social conditions, prejudices, biases, and the built environment have produced by treating certain impairments as marks of inferiority." Nancy J. Hirschmann and Beth Linker, eds., *Civil Disabilities: Citizenship, Membership, and Belonging, Democracy, Citizenship, and Constitutionalism* (Philadelphia: University of Pennsylvania Press, 2015), 4–5.

Around the World War I years, the military began relying on stateside hospitals as ideal sites for both research and care. While institutions like Walter Reed were hardly prepared in the late 1960s for an onslaught of severely injured service members from Vietnam, they were home to physicians with an increasing number of specialties, and they were offering ever more diverse services. Hospitals were a focal point of care in the civilian health system as well. The 1946 Hill-Burton Act, which was renewed for the following three decades, provided funds for a certain number of hospital beds in every region of the country. The law helped ensure that states devoted disproportionate resources to building large-scale facilities, which became hubs in an increasingly expensive and market-oriented care model.[12]

Around the time Cleland served in Vietnam, progressive and radical practitioners and activists were mobilizing against systemic shortfalls. In the mid-1960s, physician H. Jack Geiger, a founder of Physicians for Social Responsibility and an activist in the civil rights organization, the Medical Committee for Human Rights, won federal funding to establish the first of what would become a network of community health centers focused on addressing "the social, economic, environmental, and political circumstances that determine… ill health."[13] Beyond federally supported programs, a diverse array of groups—Black power activists, medical students, feminists, hippies, farm workers—called for accessible and affordable clinics and care as a means of fostering community empowerment.[14] In a case of what may be called "social movement spillover," Vet Center

12. James A. Rohrer, "The Political Development of the Hill-Burton Program: A Case Study in Distributive Policy," *J. Health Polit. Policy Law* 12, no. 1 (Spring 1987): 137–52; Rosemary Stevens, *In Sickness and in Wealth: American Hospitals in the Twentieth Century* (New York: Basic Books, 1990); Christy Ford Chapin, *Ensuring America's Health: The Public Creation of the Corporate Health Care System* (New York: Cambridge University Press, 2015).

13. H. Jack Geiger, "The First Community Health Center in Mississippi: Communities Empowering Themselves," *Amer. J. Pub. Health* 106, no. 10 (October 2016): 1738–40; John Dittmer, *The Good Doctors: The Medical Committee for Human Rights and the Struggle for Social Justice in Health Care* (New York: Bloomsbury, 2009), chap. 3; Thomas J. Ward, *Out in the Rural: A Mississippi Health Center and Its War on Poverty* (New York: Oxford University Press, 2016).

14. Alondra Nelson, *Body and Soul: The Black Panther Party and the Fight Against Medical Discrimination* (Minneapolis: University of Minnesota Press, 2011); Merlin Chowkwanyun, "The New Left and Public Health: The Health Policy Advisory Center, Community Organizing, and the Big Business of Health, 1967–1975," *Amer. J. Pub. Health* 101, no. 2 (February 2011): 238–49; Jennifer Nelson, *More than Medicine: A History of the Feminist Women's Health Movement* (New York: New York University Press, 2015); Nancy Tomes, *Remaking the American Patient: How Madison Avenue and Modern Medicine Turned Patients into Consumers* (Chapel Hill: University of North Carolina Press, 2016), especially the section on "consumer health movements," 258; Beatrix Hoffman, "'¡Viva La Clinica!': The United Farm Workers' Fight for Medical Care," *Bull. Hist. Med.* 93 (2019): 518–49.

proponents would soon echo some of their ideas.[15] The more progressive among them may have been impacted by direct contact with health and civil rights activists; in the early 1970s, Vietnam veterans worked in a Black Panther–sponsored clinic in Berkeley, California, and, as one Panther member recalled, "'they taught us a lot.'"[16]

Vet Center advocates were influenced not only by the ideals underpinning community health centers, but also by similar impulses pervading debates about care for people with mental illnesses. After playing important roles in World War II mobilization, prominent mental health professionals aiming to expand their reach and relevance argued that community-based clinics, funded with federal dollars, could serve people with mental illness more effectively and economically than problematic large-scale asylums. They maintained that newly available psychotropic drugs would enable patients to live productive lives outside of institutions and that community-based care was superior because it allowed patients to more readily adapt to their environments. The latter could benefit people with "acute mental disorders," practitioners suggested, as well as those who had "mental problems but who were not mentally ill." Their arguments helped bring about the 1963 passage of the Community Mental Health Centers Act, which provided funding for the construction of community-based mental health clinics, hastened the depopulation and closure of hundreds of asylums, and signaled a new age in the provision of treatment for people with mental illness.[17] Despite the genuine and high hopes undergirding the act, in the decades following its passage, many former asylum patients were overlooked or neglected, while others, due to a variety of complex forces, were "transinstitutionalized"—placed in nurs-

15. David S. Meyer and Nancy Whittier, "Social Movement Spillover," *Soc. Problems* 41, no. 2 (May 1994): 277–98.

16. Nelson, *Body and Soul* (n. 14), 100. Some Black Panther leaders overseeing community service programs in the 1960s and 1970s were veterans of the war in Vietnam who "possessed a sense of militancy that could not be placated by marching and sit-ins." Andrew Witt, *The Black Panthers in the Midwest: The Community Programs and Services of the Party in Milwaukee, 1966–1977* (New York: Routledge, 2007), 50.

17. Hans Pols, "War and Military Mental Health," *Amer. J. Pub. Health* 97, no. 12 (2007): 2132–42; Gerald N. Grob, *From Asylum to Community: Mental Health Policy in Modern America* (Princeton, N.J.: Princeton University Press, 1991); Gerald N. Grob, *The Mad among Us: A History of the Care of America's Mentally Ill* (New York: Free Press, 1994); Gerald N. Grob, "Mental Health Policy in the Liberal State," *Law and Psychiatry* 31 (2008): 89–100. For perspective on Grob's seminal work, Deborah Doroshow, Matthew Gambino, and Mical Raz, "New Directions in the Historiography of Psychiatry," *J. Hist. Med. & Allied Sci.* 74, no. 1 (2019): 15–33. On the idealization of the concept of "community," Zoe M. Adams and Naomi Rogers, "'Services Not Mausoleums': Race, Politics, and the Concept of Community in American Medicine (1963–1970)," *J. Med. Humanit.* 41 (2020): 515–29.

ing homes, prisons, and other institutional or restrictive settings.[18] Even as some radical psychiatrists began to raise concerns in the 1970s about community-based counseling—including that it could serve as "a weapon of the establishment"—Vietnam veterans and their advocates continued to doggedly request it, viewing it as just the opposite.[19]

When Max Cleland returned home, the VA health system, like the military and civilian health systems, was reliant on large-scale facilities. In 1971, VA patients were, on average, fifty-two years old and were more likely to be suffering from chronic diseases than those in community hospitals. They were also more likely to be "medically indigent." Those characteristics help explain why, in 1971, the average hospital stay in the VA system was twenty-four days, versus eight days in community hospitals.[20]

After World War II, VA officials recognized the utility of conjuring creative models for treatment outside of costly hospitals. By 1968, the agency's seventeen-year-old "community care program" had placed approximately forty thousand hospital patients in, as one annual report put it, "foster homes, halfway houses, nursing homes, and other special supervised living arrangements." The passage of Medicare and Medicaid in 1965, which accelerated the depopulation of state asylums as governments strove to locate patients in facilities where the cost of care could be covered by the federal government, likely propelled the VA initiative; in 1968, the agency placed approximately nine thousand former VA hospital patients in nursing homes.[21] Meanwhile, the VA reported a general decline in demand for treatment related to non-service-connected conditions among elderly

18. Gerald N. Grob and David Mechanic, "The Plight of the Mentally Ill in America," in *History and Health Policy in the United States: Putting the Past Back In,* ed. Rosemary A. Stevens, Charles E. Rosenberg, and Lawton R. Burns (New Brunswick, N.J.: Rutgers University Press, 2006), 237; Liat Ben-Moshe, "Why Prisons Are Not 'The New Asylums,'" *Punishment Soc.* 19, no. 3 (2017): 272–89; Anne E. Parsons, *From Asylum to Prison: Deinstitutionalization and the Rise of Mass Incarceration* (Chapel Hill: University of North Carolina Press, 2018).

19. Lucas Richert, *Break on Through: Radical Psychiatry and the American Counterculture* (Cambridge, Mass.: MIT Press, 2019), 58; David F. Musto, "Whatever Happened to 'Community Mental Health'?," *Pub. Interest* 39 (1975): 53–79.

20. Paul Starr, *The Discarded Army: Veterans after Vietnam,* The Nader Report on Vietnam Veterans and the Veterans Administration (New York: Charterhouse, 1973), 72–98.

21. "Administrator of Veterans Affairs Annual Report, 1968" (Washington, D.C.: Government Printing Office, 1969), 36 (on community care), 22 (on nursing homes). Bruce C. Vladeck, *Unloving Care: The Nursing Home Tragedy* (New York: Basic Books, 1980); Emily K. Abel, *The Inevitable Hour: A History of Caring for Dying Patients in America* (Baltimore: Johns Hopkins University Press, 2013).

veterans due to the availability of Medicare.[22] Though accessible to only some, the VA's health system was deeply impacted by broader health policies and realities.

Long-term chronic neuropsychiatric patients were of particular interest to VA officials and others concerned with the system's sustainability. As early as 1948, a physician from the VA's Medical Advisory Group referred to the outlook for that patient population as "alarming." "The World War II patients," he noted, "are being added to World War I patients" and could spend more than a month institutionalized.[23] Throughout the 1950s and 1960s, the VA encouraged psychiatric patients to seek care at its outpatient mental hygiene clinics, where social workers and clinical psychologists worked under the supervision of psychiatrists.[24] By 1967, the VA oversaw sixty-nine such clinics and thirty-four day treatment centers for so-called neuropsychiatric patients. That year, the agency tallied more than one million visits to the outpatient facilities and contract physicians.[25]

In the outpatient settings, VA mental health professionals reported that they were adopting innovative therapeutic methods centered on group counseling—a treatment strategy that would eventually become familiar to many Vet Center clients. A 1959 report noted that sixteen thousand neuropsychiatric patients took part in "small meaningful task oriented groups." By 1962, that number had increased to almost twenty-one thousand.[26] A VA psychiatrist based in the Mental Hygiene Unit of the VA's Boston Office reported in 1949 that he used group discussions to alleviate "feelings of uniqueness, stigma, and isolation."[27] The VA's initiative reflected a larger trend. In the 1930s and 1940s psychologists began counseling their private practice and institutionalized clients in groups, guided in part by the notion that "the group is conceptualized as a 'reexperiencing of the family

22. "Administrator of Veterans Affairs Annual Report, 1967" (Washington, D.C.: Government Printing Office, 1968), 13.

23. "Minutes: Meeting of the Special Medical Advisory Group" (December 3, 1962), 21–23, Record Group 15, Records of the Department of Veterans Affairs, Department of Medicine and Surgery, Records of Advisory Committees, box 13.

24. "Administrator of Veterans Affairs Annual Report, 1951" (Washington, D.C.: Government Printing Office, 1952), 34.

25. "Administrator of Veterans Affairs Annual Report, 1967" (n. 22), 28.

26. "Minutes: Meeting of the Special Medical Advisory Group" (n. 23), 21–23.

27. Cited in Nicolas Rasmussen, "Group Weight Loss and Multiple Screening: A Tale of Two Heart Disease Programs in Postwar American Public Health," *Bull. Hist. Med.* 92, no. 3 (January 2018): 474–505, quotation on 492. Also see Benjamin Kotkov, "Technique and Explanatory Concepts of Short-Term Group Psychotherapy," *J. Psychology* 28, no. 2 (1949): 369–81.

constellation' . . . a cooperative educational exercise."[28] Apart from the potential interpersonal benefits, group therapy was more efficient than one-on-one psychotherapy in institutions like VA hospitals and clinics, which were chronically underfunded and understaffed.

VA reports suggested that outpatient psychiatric care was hardly without its challenges. A 1952 study described the agency's experiences with 1,216 patients in its mental hygiene clinics across the country. Mostly World War II veterans, they were, on average, twenty-nine years old; 63 percent were diagnosed with what the VA termed "psychoneurotic reaction, predominantly anxiety type" and 17 percent as schizophrenic. While "administrative procedures" varied in each clinic, treatment generally consisted of an intake "interview" and subsequent meetings with a psychiatrist. About 30 percent of veterans who were referred to the clinics were advised that no further counseling was necessary. Of the 768 who were told to continue treatment, 27 percent opted not to return and about 40 percent discontinued services after five so-called interviews.[29]

While Vet Center advocates would soon embrace the concept of outpatient care, they would also argue that the VA's treatment models were tired and inaccessible. New veterans, they maintained, needed new alternatives.

Vietnam Veterans and the Pain and Utility of Difference

Given that the VA medical system was, in the 1960s and 1970s, predominantly serving chronically ill and aging patients, it is hardly surprising that, when Max Cleland was discharged to the Washington, D.C. veterans' hospital from Walter Reed, he found the transition ruthlessly abrupt. Placed in a bed in a large room housing thirty former service members, Cleland felt a long way from his friends in the Snake Pit. He later recalled, "It seemed like a place for rotting away, for being controlled, for being forgotten." The "low moans" of a patient who was dying of mustard gas poisoning, he recalled, "echoed in our ward."[30] Magazine and newspaper

28. Raymond J. Corsini and Danny Wedding, *Current Psychotherapies* (Belmont, Calif.: Brooks/Cole, 2011), 72, 79; George R. Leddick, "The History of Group Counseling," in *The Oxford Handbook of Group Counseling,* ed. Robert K. Conyne (New York: Oxford University Press, 2011); Saul Scheidlinger, "The Group Psychotherapy Movement at the Millennium: Some Historical Perspectives," *Int. J. Group Psychother.* 50, no. 3 (2000): 315–39.

29. Sol L. Garfield and Max Kurz, "Evaluation of Treatment and Related Procedures in 1,216 Cases Referred to a Mental Hygiene Clinic," *Psychiatric Quart.* 26 (1952): 414–24.

30. Cleland, *Heart of a Patriot* (n. 10), 85, 91.

exposes about shortfalls in VA services underscored the idea that the veterans' health system was in shambles.[31]

When Cleland was asked to offer his reflections on VA health care to the Senate Subcommittee on Veterans' Affairs in 1969, he did more than describe dire conditions in facilities. "We have a new ball game with these young men coming back," he said. Vietnam veterans, Cleland argued, were more likely than their predecessors "to have doubts about the validity of [their] sacrifice." "To the devastating psychological effect of getting maimed," Cleland argued, "is the added psychological weight that it may not have been worth it, that the war may have been a cruel hoax, an American tragedy, that left a small minority of young American males holding the bag."[32] Though Cleland's statement was gendered, it highlighted an emerging theme in the way Vietnam veterans—men and women from diverse racial and ethnic backgrounds—explained their wartime experiences and in the way they lobbied for health entitlements like community-based counseling.

By the early 1970s, counselors and therapists—some, informed by antiwar ideals, and others, by their experiences working inside the military and VA bureaucracies—aimed to understand and define veterans' homecoming challenges. In New York, psychiatrists Robert J. Lifton and Chaim Shatan facilitated meetings of the Vietnam Veterans Against the War (VVAW), enabling participants to intertwine discussions of personal struggles with antiwar sentiments.[33] At a Boston VA clinic, psychologist Sarah Haley worked with patients she suspected of having war trauma, analyzed their symptoms, and published her findings.[34] In Southern California, social worker Shad Meshad, who served as an Army Medical Service Corps officer in Vietnam, was hired by the chief of staff at the Brentwood VA hospital to run a Vietnam veterans' clinic and administer what he called "off-site rap groups" in neighborhoods where transient Vietnam veterans lived.[35]

31. E.g., Charles Child, "From Vietnam to VA Hospital: Assignment to Neglect," *Life*, May 22, 1970.

32. "Examination of the Problems of the Veterans Wounded in Vietnam," § Hearings before the Subcommittee on Veterans' Affairs of the Committee on Labor and Public Welfare (1969), 273.

33. Andrew E. Hunt, *The Turning: A History of Vietnam Veterans Against the War* (New York: New York University Press, 1999), 86–88; Gerald Nicosia, *Home to War: A History of the Vietnam Veterans' Movement* (New York: Three Rivers Press, 2001), 160; Patrick Hagopian, *The Vietnam War in American Memory: Veterans, Memorials, and the Politics of Healing* (Amherst: University of Massachusetts Press, 2009), 54; Richert, *Break on Through* (n. 19), 16–18.

34. Hunt, *The Turning* (n. 33), 86–88, 198–99; Chaim F. Shatan, "'A True Child of Trauma'—Sarah Haley, 1939–1989," *J. Traumatic Stress* 3, no. 3 (1990): 477–81; Nicosia, *Home to War* (n. 33), 193–94.

35. Hagopian, *Vietnam War in American Memory* (n. 33), 56.

Meshad, who went on to help shape the Vet Center program, was hardly alone in his belief that veterans of the war in Vietnam constituted a distinct marginalized population. He searched for ailing former service members not only at the Venice Pier, where some were living homeless, but also in facilities like the Hollywood Sunset Free Clinic, which had been established in the 1960s with the goal of increasing access to care among people who were underserved.[36] Meshad and others made it their mission to ensure that former service members were aware of the VA-administered care and benefits uniquely accessible to them.

By the early 1970s, counselors working with Vietnam veterans began making arguments in newspaper editorials and professional journals that helped justify the need for a special readjustment counseling program. Chaim Shatan, who had worked with VVAW groups in New York, maintained that young former service members had "persistent guilt about outliving their comrades," a connected "desire to atone," and a general "rage" toward society.[37] William Mehady, who served as an army chaplain in Vietnam, argued that "deeply ingrained characteristics of the American soul . . . died for the soldiers in the jungles of Vietnam."[38]

While the notion of Vietnam veterans' exceptionalism has been called into question,[39] there were particularities and upheavals unique to the Vietnam era that fostered feelings of isolation that so-called rap groups and, eventually, Vet Centers intended to address. The issue of "bad paper"—the military's seeming increasing willingness to issue "other than honorable," "undesirable," or "administrative" discharges—is a prime example. Department of Defense policy stipulated that less than honorable discharges could be issued for anything from an "inability to expend effort constructively" and alcoholism to "financial irresponsibility"

36. Jessica L. Adler, Shad Meshad Oral History, May 14, 2018, 68, War and Health Collection. Also see Gregory L. Weiss, *Grass Roots Medicine: The Story of America's Free Health Clinics* (Lanham, Md.: Rowman & Littlefield, 2006).

37. Quoted in Nicosia, *Home to War* (n. 33), 170; Hagopian, *Vietnam War in American Memory* (n. 33), 64–65.

38. William P. Mehady, *Out of the Night: The Spiritual Journey of Vietnam Vets* (Greyhound Books, 1986), 96. Also see Robert Jay Lifton, *Home from the War: Vietnam Veterans: Neither Victims nor Executioners* (New York: Simon & Schuster, 1974); Charles R. Figley, *Stress Disorders among Vietnam Veterans: Theory, Research* (New York: Routledge, 1978).

39. Eric T. Dean, "The Myth of the Troubled and Scorned Vietnam Veteran," *J. Amer. Stud.* 26, no. 1 (April 1992): 59–74; Edgar Jones, "Historical Approaches to Post-Combat Disorders," *Philos. Trans. Roy. Soc. Biol. Sci.* 361 (2006): 533–42; Simon Wessely and Edgar Jones, "Psychiatry and the Lessons of Vietnam: What Were They and Are They Still Relevant?," *War Soc.* 22, no. 1 (2004): 89–103. See note 44 for related references on the development of the posttraumatic stress disorder diagnosis.

and "homosexual or other aberrant tendencies."[40] Bad paper could bar veterans from receiving benefits and lead to major employment challenges.[41] While service members had long been faced with the prospect of receiving other than honorable discharges for any array of offenses,[42] those released from service between 1970 and 1972 were at an increased risk. From 1965 to 1969, there were an average of 11,500 undesirable discharges annually. By 1972, they had skyrocketed to more than 40,000.[43]

Veterans and their advocates argued that the increase in administrative discharges was directly connected with a variety of external forces, including a shameful failure to recognize the mental health consequences of war. In the wake of World War II, "gross stress reaction" was listed as a war-related diagnosis in the American Psychiatric Association's first *Diagnostic and Statistical Manual,* published in 1952. But when the updated version was released in 1968, no similar condition was included.[44] One important outcome, according to veterans and their advocates, was that thousands of less than honorable discharges were issued due to the military's failure to identify particular behaviors as being related to service-connected mental health issues.[45]

Expanding on traditional care models like the clinical "interviews" undertaken by psychiatrists in the VA's existing mental hygiene clinics, counselors who worked with Vietnam veterans justified the importance of their work, in part, by pointing out that they regularly helped clients

40. Norman B. Lynch, "The Administrative Discharge: Changes Needed?," *Maine Law Rev.* 141 (1970): 147–48.

41. Marcy L. Karin, "'Other Than Honorable' Discrimination," *Case Western Reserve Law Rev.* 67, no. 1 (2016): 135–91.

42. On the use of administrative discharges in the early twentieth century, see Margot Canaday, *The Straight State: Sexuality and Citizenship in Twentieth-Century America* (Princeton, N.J.: Princeton University Press, 2011), chap. 2.

43. Peter Slavin, "The Cruelest Discrimination: Vets with Bad Paper Discharges," *Bus. Soc. Rev.* 14 (1975): 25–33.

44. Some of the same arguments used to justify Vet Centers helped ensure the inclusion of PTSD in the 1980 edition of the American Psychiatric Association's *Diagnostic and Statistical Manual.* Hannah S. Decker, *The Making of DSM-III: A Diagnostic Manual's Conquest of American Psychiatry* (Oxford: Oxford University Press, 2013), 274–75; Allan V. Horwitz, *DSM: A History of Psychiatry's Bible* (Baltimore: Johns Hopkins University Press, 2021), chap. 4. Also, on PTSD, see Allan Young, *The Harmony of Illusions: Inventing Post-Traumatic Stress Disorder* (Princeton, N.J.: Princeton University Press, 2001); Jerry Lembcke, *PTSD: Diagnosis and Identity in Post-Empire America* (Lanham, Md.: Lexington Books, 2013); Allan V. Horwitz, *PTSD: A Short History* (Baltimore: Johns Hopkins University Press, 2018).

45. Karin, "'Other Than Honorable' Discrimination" (n. 41); Stephanie Smith Ledesma, "PTSD and Bad Paper Discharges: Why the Fairness to Soldiers Act Is Too Little, Too Late," *Elon Law Rev.* 10 (2017): 189–237; Adler, William Weitz Oral History (n. 3), 19–21.

submit requests to have their discharge classifications changed. Daniel J. Naylor, vice president of Vets House in Madison, Wisconsin, and Jack McCloskey, outreach counselor for Swords to Plowshares in San Francisco, told members of Congress in 1976 that their locally based nonprofits ensured discharge reviews for hundreds of veterans.[46] Their efforts represented a growth in the purview of what postwar therapy should accomplish; it could serve as a means not just of healing, they suggested, but of veteran empowerment.

While grassroots efforts centered largely on the needs of male former service members, women veterans made cogent claims about the specificity of the Vietnam veteran experience, even as they drew attention to the extra barriers they faced. "When I got back, I learned real quick not to talk about the war," said Army nurse Lily Jean Adams, who served at a large Army base in Cu Chi. "It was a very alone feeling."[47] Adams was one of 265,000 women who served between 1969 and 1975, and one of about 11,000 who were considered in-theater in Vietnam.[48] For some women who helped to shape VA health care in the 1970s and 1980s, exiting the military served as a political awakening. Recounting her health care activism in the late 1970s, nurse Lynda Van Devanter wrote, "The VA had not, in more than half a century of existence, ever published anything that gave the least idea that women were entitled to veterans benefits."[49]

Black veterans, too, drew attention to their unique war-related experiences and thereby helped lay the groundwork for the establishment of Vet Centers. Between 1959 and 1969, African Americans constituted 11 percent of the U.S. population, 12.6 percent of those who served in Vietnam, and 15 percent of the war's casualties.[50] Many Black Americans

46. "Veterans Omnibus Health Care Act of 1976, S. 2908 and Related Bills," § Hearings before the Subcommittee on Health and Hospitals of the Committee on Veterans' Affairs (1976). See 623 for Naylor testimony and 634 for McCloskey testimony.

47. Ron Steinman, *Women in Vietnam: The Oral History* (TV Books, 2000), 67; Kara Dixon Vuic, *Officer, Nurse, Woman: The Army Nurse Corps in the Vietnam War* (Baltimore: Johns Hopkins University Press, 2011).

48. Jean Dunlavy, "A Band of Sisters: Vietnam Women Veterans' Organization for Rights and Recognition, 1965–1995" (Ph.D. diss., Boston University, 2009), 3–6.

49. Lynda Van Devanter, *Home Before Morning: The Story of an Army Nurse in Vietnam* (New York: Warner Books, 1984), 301. Jessica L. Adler, "To Recognize Those Who Served: Gendered Analyses of Veterans' Policies, Representations, and Experiences," in *The Routledge Handbook of Gender, War, and the U.S. Military*, ed. Kara Dixon Vuic (New York: Routledge, 2017), 303–22.

50. John Sibley Butler, "African Americans in the Military," in *The Oxford Companion to American Military History*, ed. John Whiteclay Chambers (Oxford: Oxford University Press, 2000), 7–9. Amy Rutenberg notes that "26 percent of black enlisted personnel had combat assignments, a number well out of sync with the percentage of African Americans

were skeptical of a war effort they viewed as deeply imperialistic, a draft apparatus that disproportionately endangered people from poor communities, and a military where racism was commonplace.[51] Black and Hispanic service members reported to a task force in 1972 that "administrative discharges were used to get rid of minority group service members considered 'outspoken' or 'militant.'"[52]

Bobby White, who deployed to Vietnam in 1969 from Miami, Florida, as an infantryman, recalled being "consciously aware of the fact that I did not have equal rights back home in America," but also "that my immediate job in Vietnam was to do the soldiering." White spent his yearlong tour on search-and-destroy missions, as he recalled, "seeing the daily carnage of dead comrades, others injured, and terrifying realities of war." When he returned home, he experienced sleeplessness, nightmares, and flashbacks of firefights. In 1975, he started a discussion group of Vietnam veterans at the Miami college where he was studying psychology.[53]

The implementation of the readjustment counseling program, in fact, could be considered a key moment when veterans from marginalized groups took more visible ownership of the veterans' health system. Underrepresented groups had contributed to war efforts, and faced extra barriers when attempting to access veterans' benefits throughout U.S. history, but the era of the war in Vietnam was different.[54] In the social context of the 1970s, as activists fought for rights and therapists main-

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in the American population at large." Amy J. Rutenberg, *Rough Draft: Cold War Military Manpower Policy and the Origins of Vietnam-Era Draft Resistance* (Ithaca, N.Y.: Cornell University Press, 2019), 165–66.

51. Wallace Terry, ed., *Bloods: An Oral History of the Vietnam War by Black Veterans* (New York: Random House, 1984); Kimberly Phillips Boehm, *War! What Is It Good For?* (Chapel Hill: University of North Carolina Press, 2013); Gerald F. Goodwin, "Race in the Crucible of War: African American Soldiers and Race Relations in the 'Nam'" (Ph.D. diss., Ohio State University, 2014); John A. Wood, *Veteran Narratives and the Collective Memory of the Vietnam War* (Athens: Ohio University Press, 2016); Daniel Lucks, "African American Soldiers and the Vietnam War: No More Vietnams," *Sixties* 10, no. 2 (2017): 196–220.

52. Slavin, "Cruelest Discrimination" (n. 43), 28.

53. Bobby White, "The Bobby White Story," in *Post 8195: Black Soldiers Tell Their Vietnam Stories,* ed. Bobby White (Silver Spring, Md.: Beckham, 2013), 31–50, quotations on 36 and 37.

54. See, e.g., Larry M. Logue and Peter Blanck, *Race, Ethnicity, and Disability: Veterans and Benefits in Post–Civil War America* (New York: Cambridge University Press, 2010); Louis Woods, "Virtually 'No Negro Veteran . . . Could Get a Loan': African-American Veterans, the GI Bill, and the NAACP's Relentless Campaign against Residential Segregation, 1914–1960," *J. Afr. Amer. Hist.* 98, no. 3 (2013); Jessica L. Adler, "Mediating the Economic Impacts of Military Service: Race and Veterans' Welfare After the War in Vietnam," in *The Military and the Market,* ed. Jennifer Mittlestadt and Mark R. Wilson (Philadelphia: University of Pennsylvania Press, forthcoming).

tained that people deserved to gather and be heard, stories like those of Lily Jean Adams and Bobby White helped underscore the notion that many Vietnam veterans were isolated and underserved. Veterans who were from marginalized groups understood that the injustices they faced were rooted in larger political and social realities and also that connecting them with wartime service and mental health could be productive. Once the Vet Center program was established, they became some of its most visible leaders. Bobby White, we will see, went on to serve as the director of the Fort Lauderdale, Florida, Vet Center; Lynda Van Devanter trained Vet Center counselors to provide treatment for women beneficiaries.[55]

Political Maneuvering for Readjustment Counseling and Concretizing the Program

When Max Cleland testified in Congress in 1969, he did so in front of a committee headed by a freshman senator from California, Alan Cranston. An opponent of the war in Vietnam, Cranston put forth legislation to fund a veterans' readjustment counseling program repeatedly between 1970 and 1979.[56] Early supporters of the initiative focused on the government's responsibility to a socially isolated population and the potentially dire consequences of inaction. Harvard professor of psychiatry Gerald Caplan told Cranston's committee in 1970 that, without access to specialized counseling services, young veterans might "retire into apathy and . . . disinterest in their surroundings . . . [or] fly off the handle."[57] Caplan's viewpoints were of a piece with his ongoing work; at Harvard in 1964, he had established one of the first training programs for fellows in community mental health and psychiatry.[58] Historian Murray Polner, who would soon publish a book about the experiences of recently returned veterans, maintained, "If you want the disadvantaged veteran to respond to offers of assistance and to smooth his path of readjustment . . . you will have to start . . . turning back to those most concerned, the power to shape and administer their own programs."[59]

55. White, "Bobby White Story" (n. 53); Adler, Shad Meshad Oral History (n. 36), 93.

56. Scott, *Vietnam Veterans since the War* (n. 6), 54.

57. "Unemployment and Overall Readjustment Problems of Returning Veterans," § Subcommittee on Veterans' Affairs of the Committee on Labor and Public Welfare (1970), 49, 201.

58. David L. Cutler and Charles Huffine, "Heroes in Community Psychiatry: Professor Gerald Caplan," *Commun. Ment. Health J.* 40, no. 3 (June 1, 2004): 193. Also see Gerald Caplan, *Principles of Preventive Psychiatry* (New York: Basic Books, 1964).

59. "Unemployment and Overall Readjustment Problems of Returning Veterans" (n. 57), 49, 201; Murray Polner, *No Victory Parades: The Return of the Vietnam Veteran* (New York: Holt, Rinehart & Winston, 1971).

In the late 1960s and early 1970s, VA officials and others viewed such ideas as an affront. Roger Kelley, assistant secretary of defense, argued that "the problem which Dr. Caplan described . . . is atypical . . . most of the young men who have been exposed to combat conditions can be described as psychologically and otherwise normal people." Donald Johnson, who headed the VA under Richard Nixon, concurred, expressing dismay that an ongoing war could be blamed for mental illness and joblessness. That an expansive counseling program was necessary, Johnson said, was no "more true for Vietnam [veterans] than [veterans of] prior wars."[60] Kelley and Johnson's sentiments echoed those of World War II veteran Olin Teague, the powerful head of the House Veterans Affairs Committee, who was known to block legislation providing new entitlements.[61]

What may have been most unique about veterans of the war in Vietnam who advocated for better care was not necessarily the nature of their health maladies but their ability to spotlight long-standing problems of the VA health system and mobilize alongside health professionals, politicians, and others for remedies that aligned with the ideals of the moment. At a 1971 congressional hearing about veterans' drug abuse, Korean War veteran John West told Cranston's committee that when he served in the early 1950s, at least 20 percent of his company was addicted to heroin. "I know the attitude of some people is that this is . . . something that started yesterday. This is not true."[62] Indeed, at meetings of the VA's Special Medical Advisory Group from the 1940s through the 1970s, alcoholism and drug abuse were consistently discussed as matters of concern. Still, at the hearing where West testified and beyond, addiction among Vietnam veterans was the main focus, as was their preference for specially-tailored community-based programs.

Over time, mental health professionals and veterans who came together in rap groups and beyond presented common, authoritative perspectives, and new arguments. There was, they maintained in congressional hearings, "an overriding concern that this country and this Government have been shamefully lax in responding to the mental health care needs of this

60. "Unemployment and Overall Readjustment Problems of Returning Veterans" (n. 57), 124–26, 136.

61. Boulton, *Failing Our Veterans* (n. 6), 38.

62. "Drug Addiction and Abuse Among Military Veterans," § Subcommittee on Health and Hospitals of the Committee on Veterans' Affairs and Subcommittee on Alcoholism and Narcotics of the Committee on Labor and Public Welfare (1971), 15–17; Jeremy Kuzmarov, *The Myth of the Addicted Army: Vietnam and the Modern War on Drugs* (Amherst: University of Massachusetts Press, 2009).

Nation's younger veterans."[63] Veterans' representatives maintained that available programs and the VA's hospital-centered model did not suit the purpose. Hospitalization, as Cranston put it in 1976, was "the worst kind of treatment for low-grade psychiatric disorders."[64]

By 1979, when readjustment counseling had been debated and discussed in Congress at least four times, and as veterans continued to draw attention to shortfalls of existing programs, political circumstances had changed. The war was long over, so arguments like those made by Nixon's VA chiefs about threats to morale were moot. While calls for more services remained likely to go unheeded during the presidency of Nixon's successor, Gerald Ford, who urged "Americans to shake off the Vietnam experience as one might a bad nightmare," Jimmy Carter sent different signals when he assumed office in 1977. The war in Vietnam, Carter maintained in the early years of his presidency, had been a debacle made possible by policy mistakes at the highest levels of government; the Americans who fought were victims.[65] His administration's willingness to define and reckon with the social costs of the war helped pave the way toward enhanced veterans' benefits, including the establishment of Vet Centers. Related shifts in Congress also facilitated the creation of new programs. Ever fewer World War II veterans were in seats of power, and by 1980 there were nineteen members of the Vietnam veterans congressional caucus.[66] Meanwhile, for the first time a Vietnam veteran was at the helm of the VA; in 1977, Carter appointed Max Cleland as the agency's administrator.

Now, medical professionals from within the ranks of the federal bureaucracy were testifying in favor of a readjustment counseling program tailored to Vietnam veterans. Bolstering Cranston's prior arguments that traditional hospitals and large-scale facilities were not suitable for the purpose, James J. Crutcher, chief medical director of the VA, maintained in 1979 that, "The definite trend of treating people with emotional adjustment problems in the VA specifically and in the country at large is that the patient has more rapid rehabilitation when the environment is not a hospital but rather a social environment."[67] Readjustment counseling, designed by and for Vietnam veterans, Crutcher said, could "'remove the

63. "Veterans Omnibus Health Care Act of 1976, S. 2908 and Related Bills" (n. 46), 630–31.

64. Ibid., 625.

65. Robert J. McMahon, "Rationalizing Defeat: The Vietnam War in American Presidential Discourse, 1975–1995," *Rhetoric Pub. Aff.* 2, no. 4 (1999): 529–49.

66. Boulton, *Failing Our Veterans* (n. 6), 204.

67. "Veterans' Health Care Amendments of 1979, S. 7" (n. 2), 77.

stigma and maybe the reluctance of an individual . . . to go through the route of a mental hygiene clinic or a psychiatric admission.'"[68]

There remained at least one potential barrier to the approval of a readjustment counseling program: politically powerful national veterans' groups with membership skewed toward World War II–era service members, which generally favored devoting resources to medical and geriatric services. At a 1979 congressional hearing about readjustment counseling, a Veterans of Foreign Wars leader stopped short of opposing the new program but wondered "where the funding and the personnel are going to come from." American Legion representatives argued that existing VA services were adequate to answer the needs of the newest cohort of veterans and that creating new community-based centers was "unnecessary and potentially expensive . . . at a time when there is great concern about reduction of services." A representative of the Disabled American Veterans (DAV) hoped that covering costs of the new program would not equate to "robbing Peter to pay Paul."[69]

While such statements help explain why some young veterans were skeptical of traditional veterans' groups, they offered only a partial view of prevailing perspectives. The DAV, for example, actively undertook outreach efforts to veterans of the war in Vietnam in the late 1970s.[70] And as early as 1976, Larry M. Ross, executive director of the Paralyzed Veterans of America, told members of Congress that "intensive readjustment counseling to veterans who served in the Armed Forces after August 4, 1964 is a very welcome program" that was "sorely needed."[71] In the end, as some old-guard veterans' groups prioritized increases in medical benefits, and Vietnam veterans fought for readjustment counseling, each of the cohorts likely helped both causes; Cranston and his committee, it would become clear, were reluctant to answer one constituency but not the other. The legislation that eventually established Vet Centers also provided an expansion in access to preventive health services that had been hard fought by groups like the American Legion.[72]

Ultimately, three political factors helped pave the way to congressional funding for the outpatient clinics. First, Cranston offered an important

68. Ibid., 413.

69. Ibid., 311, 360–61, 394.

70. Mehady, *Out of the Night* (n. 38), 89.

71. "Veterans Omnibus Health Care Act of 1976, S. 2908 and Related Bills" (n. 46), 774.

72. "An Act to Amend Title 38, United States Code, to Revise and Improve Certain Health Care Programs of the Veterans' Administration, to Authorize the Construction, Alteration, and Acquisition of Certain Medical Facilities, and to Expand Certain Benefits for Disabled Veterans; and for Other Purposes," Pub. L. No. 96–22, 93 Stat. (1979).

concession to hesitant members of Congress in exchange for their support: the House Veterans Affairs Committee, no longer under the grip of Olin Teague, and the Senate Veterans Affairs Committee would gain oversight over the construction and location of certain VA facilities. Elected officials with vested local interests coveted the opportunity to control the process of policy implementation.[73]

Another factor that helped readjustment counseling become a legislative reality was the personal proclivity of Max Cleland, an ally of Cranston's since his 1969 congressional testimony. In addition to witnessing firsthand the depressing conditions in many VA facilities, Cleland was moved by personal experiences not directly connected with his wartime service. In the mid-1970s, he was dating a woman who was addicted to alcohol. At meetings of Al-Anon, where friends and family of people with alcoholism gathered, he said, he was struck by what he called fellow participants' "straightforward, amazing, brutal honesty." In 1977, when Cleland became head of the VA, he was "extremely familiar personally with the power of a group to help in . . . readjustment." He recalled telling Jimmy Carter about Cranston's legislation and arguing, "'We got to support this.'"[74]

Beyond the strategic stipulations within the legislation and the strong convictions of Cleland, broad political forces helped ensure the implementation of the long-stalled readjustment counseling program. Veterans' health services were both guided by and protected from larger social and economic constraints. Their connection with Jimmy Carter's Commission on Mental Health, which was intended to address growing concerns about fragmented and unwieldy services nationwide, is illustrative. Meeting between 1977 and 1979, the commission produced reports that undergirded the Mental Health Systems Act of 1980, signed into law by Carter and eventually overturned by incoming president Ronald Reagan.[75] "Vietnam War veterans" was one of approximately two dozen of the commission's named "task panels" charged with highlighting challenges faced by particular subpopulations.[76] Like other panel reports—on groups including "American Families," "the Elderly," and "Special Populations," such as "Asian/Pacific Americans," "Black Americans," "Hispanic Americans," and "Physically Handicapped Americans"—the veteran-focused panel argued that government assistance and mental health services could

73. Boulton, *Failing Our Veterans* (n. 6), 136.

74. Jessica L. Adler, Max Cleland Oral History, April 6, 2017, 2–3, War and Health Collection.

75. Gerald N Grob, "Public Policy and Mental Illnesses: Jimmy Carter's Presidential Commission on Mental Health," *Milbank Quart.* 83, no. 3 (2005): 425–56.

76. Ibid., 433–37.

help alleviate social and economic problems. But unlike its counterparts, the veteran task panel could point to a distinct federal entity that ostensibly bore responsibility for targeted interventions. "The VA," the veterans' panel said, should "implement a personal readjustment program designed to provide comprehensive, preventive mental health care, psychosocial readjustment assistance, counseling, and other services."[77]

Path dependency, and the existence of the VA bureaucracy, afforded former service members special protections.[78] When the ill-fated Mental Health Systems Act was passed in October 1980, it contained no measures related to veterans; by that point, the readjustment counseling program was operating as a standalone program overseen by the VA.[79] When social problems were identified, it appeared, veterans were more likely than fellow citizens to receive sustained, albeit conditional, federal assistance.

In June 1979, Congress enacted Public Law 96-22 stipulating that the VA would "furnish counseling . . . to assist [Vietnam veterans] in readjusting to civilian life."[80] In terms of laying out plans for operations, the law was vague. But Cleland had asked counselors and mental health professionals who had been leading rap groups and researching Vietnam veterans' experiences—including Shad Meshad and William Mehady—to devise a community-based, noninstitutional structure based on, as Mehady recalled, "anything . . . we knew of that seemed to work anywhere in the country." During an all-night meeting, they outlined a plan in which local centers, staffed mainly by qualified Vietnam veterans, would be under the purview of regional offices and remain relatively autonomous from the larger VA bureaucracy.[81] Five months after the passage of the legislation in 1979, plans were under way for eighty-five "storefront facilities . . . staffed by outreach teams that will go into the community to locate and assist

77. Task Panel Reports Submitted to the President's Commission on Mental Health, Vol. III, Appendix (Washington, D.C.: Government Printing Office, 1978), 1327, https://babel.hathitrust.org/cgi/pt?id=mdp.39015046956457&view=1up&seq=5.

78. Paul Pierson, "Increasing Returns, Path Dependence, and the Study of Politics," *Amer. Polit. Sci. Rev.* 94, no. 2 (2000): 251–67, https://doi.org/10.2307/2586011.

79. "Mental Health Systems Act," Pub. L. No. 96-398 (1980).

80. An Act to Amend Title 38, United States Code, to Revise and Improve Certain Health Care Programs of the Veterans' Administration, to Authorize the Construction, Alteration, and Acquisition of Certain Medical Facilities, and to Expand Certain Benefits for Disabled Veterans; and for Other Purposes.

81. Mehady, *Out of the Night* (n. 38), 88–90. Circulars published in the early 1980s noted that "academic background and work experience considered relevant to center counseling functions" included "academic degrees in psychology, social work, or counseling, and experience in readjustment, crisis and emergency, or community-based counseling." "Vietnam Veterans: A Profile of VA's Readjustment Counseling Program" (Washington, D.C.: Government Accountability Office, August 1987), 43.

Vietnam-era veterans." Rather than focusing on individual psychiatric treatment, the program would be centered on, as a 1979 congressional report said, "peer counseling in a non formal setting so as to encourage the participation of those veterans distrustful of normal VA and government efforts."[82]

Impacts and Meanings of Vet Centers

Soon after the first Vet Centers opened, workers and clients determinedly testified to their importance. Lindsay Roux, who served in Laos, reported in congressional testimony in 1981 that, when he returned home to Georgia, "the memories, confusion and learned traits remained even though my wife, family, and friends told me to put it out of my mind." After the Atlanta VA hospital referred Roux to the city's new Vet Center, he recalled, "I arrived shaking so hard I could hardly get a cigarette in my mouth." Thanks to the help of counselors, Roux said, "and getting involved in the peer rap groups at the center, I was able to overcome many of my problems."[83]

But even as new Vet Centers were opened across the country, the program became a symbol of Carter-era ideals at a moment dominated by new right conservatism, and there was much uncertainty about its future. As they touted the program's profound impacts, Vet Center advocates accused high-ranking VA officials of acquiescing to reckless penny-pinching mandated by appointees of President Reagan. A Democratic congressman from Oklahoma maintained during congressional hearings in 1981, "The VA's implementation of this program is a model for bureaucratic government at its very worst." Earlier in the same hearing, William Mehady, the former army chaplain who had written of Vietnam veterans' unique needs, and who helped design the Vet Center program, provided examples of what he viewed as intransigence from the VA's Central Office: "There are many ways to administer a program to death."[84] Mehady was putting his finger on a larger reality. The VA was hardly immune to the Reagan administration's broad attack on presumed federal largesse; its inflation-adjusted budget authority decreased slightly between 1980 and

82. "Veterans' Day 1979: An Historical Perspective—Senator Cranston Aids Veterans," in Congressional Record—Senate (Washington, D.C.: Government Printing Office, 1979), 31924.

83. "Statement of Lindsay Roux," in Congressional Record, Extensions of Remarks, Vol. 127, Part 11 (Washington, D.C.: Government Printing Office, 1981).

84. "VA Vietnam Veterans' Readjustment Counseling Program," § Hearing before a Subcommittee of the Committee on Government Operations (1981), 136, 54.

1990—constituting the most protracted stagnation in VA funding to occur between 1940 and 2012.[85]

At this volatile moment, Vet Centers became impetuses for and loci of activism. In March 1981, journalist Myra Macpherson reported that Reagan's Office of Management and Budget "called for obliterating [Vet Centers] by September [1981]—even as the president pins medals on Vietnam veterans, an act many of them see as a see as a flag-waving attempt to prime another generation of youths for new, massively funded military adventures."[86] *The Veteran,* the official publication of the VVAW, noted in the spring of 1981 that Vet Centers in Chicago, Milwaukee, and Los Angeles had become "hubs of action," where veterans gathered to mobilize for protests against proposed budget cuts.[87] By the fall of the same year, the VVAW maintained that Vet Centers "faced continual problems with V.A. heavies who are at a loss to explain why simple things like electric, water and phone bills aren't paid regularly."[88] *The Veteran* noted in the spring of 1982 that, "out campaigning, Reagan was clear that vets benefits were among his untouchable as far as the budget was concerned." But "once in office the story has been entirely different . . . unless vets say STOP, the cuts will continue."[89] A year later, *The Veteran* reported that there was again a possibility that Vet Center funding may be slashed and impelled readers, "We can't afford to get trashed again—Save the Vet Centers!"[90]

The dramatic semantics were not really just about Vet Centers. They were about what they represented. In the Reagan years, ideals about the rehabilitation of veterans became a focal point in debates about the very legacy of the war in Vietnam. Scholars have argued that the Reagan administration aimed to curtail what it deemed "negative stereotype(s)" of Vietnam veterans, including their supposed struggles with trauma.[91] Vet

85. The VA's share of the budget was approximately $58.5 million in 1980 and $51.8 million in 1990, in 2011 inflation-adjusted dollars. Christine Scott, "Veterans Affairs: Historical Budget Authority, FY1940–FY2012" (Washington, D.C.: Congressional Research Service, 2012), 4; Paul Pierson, *Dismantling the Welfare State?: Reagan, Thatcher and the Politics of Retrenchment* (New York: Cambridge University Press, 1994).

86. Myra Macpherson, "Pulling the Rug from under Vietnam Vets Again," Washington Post, March 15, 1981; Myra MacPherson, *Long Time Passing: Vietnam and the Haunted Generation* (New York: Doubleday, 1984).

87. "Vets Protest Cutbacks," *The Veteran* 11, no. 2 (1981): 4–5.

88. "Broken Promises: Vietnam Vets Hit Again, Vet Centers to Close?," *The Veteran* 11, no. 4 (December 1981): 1.

89. "Decent Benefits for All Vets: No VA Cuts!," *The Veteran* 12, no. 2 (May 1982): 1.

90. "Campaign Update: Vet Centers," *The Veteran* 13, no. 1 (March 1983): 15.

91. Hagopian, *Vietnam War in American Memory* (n. 33), 202; Christian G. Appy, *American Reckoning: The Vietnam War and Our National Identity* (New York: Viking Penguin, 2015).

Centers stood as an institutionalized monument to the war's alleged dark long-term impacts. By maintaining that the Vietnam War was a righteous cause, and that its veterans were noble fighters, Reagan and his supporters were ostensibly undercutting a primary justification for the existence of a nationwide, federally funded outpatient counseling program.

The ideological opposition of the Reagan administration may have made it more difficult for Vet Center workers to fulfill their mandate, but it failed to entirely undercut a program that appealed to a variety of groups for different reasons. Congress sustained funding for Vet Centers throughout the 1980s because of bureaucratic inertia, clients' powerful statements about their effectiveness, and employees' urgent arguments that many troubled Vietnam veterans had yet to be reached. At least some politically conservative veterans embraced Reagan's rhetoric of nobility and honor, but also maintained that their wartime and postwar experiences brought about jarring feelings of displacement and isolation.[92] In the July 1980 issue of the *Vet Center Voice*, leaders of a Vet Center in Detroit, Michigan, decried "draft dodgers," "protesters," antiwar activist Jane Fonda, and the VVAW. Still, they reported, center rap sessions were "a needed release of some enormous lonely pressure. We are beginning to envision our Center as a last stop on a long journey home."[93] Indeed, because they were locally based and focused, some Vet Centers seem to have offered a haven where distinct veteran populations sought like-minded friends and counselors, who could reinforce their worldview.[94] Despite being funded by a federal bureaucracy, the program's design showcased a moment when some turned to "a growing network of community-based islands of resistance to the Great Society dream of a nationalized system of social provision."[95]

The focus on local autonomy had an additional implication: it helped ensure that Vet Centers made the VA more accessible to marginalized veterans and spotlighted their perspectives in a bureaucracy that had historically overlooked them. A 1987 VA report indicated that a relatively large proportion of all Vet Center clients—more than 20 percent—were Black.[96] That was likely due, in part, to the efforts of an increasingly diverse VA workforce determined to ensure accessibility. Bill Weitz, a psychologist

92. Kathleen Belew, *Bring the War Home: The White Power Movement and Paramilitary America* (Cambridge, Mass.: Harvard University Press, 2018), chap. 1.

93. "Detroit Vet Center," *Vet Center Voice* 1, no. 5 (July 21, 1980): 13.

94. MacPherson, *Long Time Passing* (n. 86), 227–47.

95. David Farber, "Democratic Subjects in the American Sixties: National Politics, Cultural Authenticity, and Community Interest," in *The Conservative Sixties*, ed. David Farber and Jeff Roche (New York: Peter Lang, 2003), 8–20, quotation on 20.

96. "Vietnam Veterans" (n. 81), 27.

who headed the Miami Vet Center in the early 1980s, recalled recruiting therapists and counselors who were women, Hispanic, and African American—representing the cross-section of people who would ostensibly be served in the facility.[97] Bobby White, the psychologist who worked at the Fort Lauderdale Vet Center in the 1980s, remembered that positions of authority could be hard fought for Black counselors. Around 1985, he was promoted to be director of the center where he had worked for five years, only after confronting a supervisor about the disproportionate number of white staffers at the management level and pointing out his qualifications for the job. White continued in his post for more than two decades, eventually holding group therapy sessions in a local majority Black Veterans of Foreign Wars post, to ensure African Americans could easily attend.[98]

As Black Vietnam veterans utilized new services and earned positions of authority—by 1984 a nationwide "African American working group" had been established within the readjustment counseling program—they educated others in the VA system.[99] "Issues of racism are a big part of most black veterans' participation in counseling," Lee Jones told the *Voice* in 1983. Jones, himself a Black veteran, was working as an outreach technician at the Vet Center in Seattle, Washington, and would go on to become the center's director. "Counselors," he noted, "must deal with the veterans' feelings of being alone in a predominantly white society."[100] The *Voice* reported that many Black veterans responded positively to being part of all-Black counseling groups and to working with Black therapists.[101] As they formed networks at Vet Centers, they were creating an alternative approach to psychiatric counseling; although accessible only based on veteran status, it eschewed racist tropes long-embraced by practitioners and health administrators as explanations for social and economic inequities.[102]

97. Adler, William Weitz Oral History (n. 3).

98. Jessica L. Adler, Robert N. "Bobby" White Oral History, October 2020–January 2021, War and Health Collection.

99. On the working group, see *Vet Center Voice,* 5, no. 5 and 4, no. 6; Ron E. Armstead, "The Role, Accomplishments, and Challenges of the Congressional Black Caucus Veterans Braintrust" (William Monroe Trotter Institute, University of Massachusetts Boston, September 2016), 30.

100. Gary L. Sorenson, "Racism Issues Block Progress for Many Black Veterans," *Vet Center Voice* 4, no. 7 (1983), State Historical Society of North Dakota, Bismarck. On Lee Jones, see "Honoring Mr. Lemanuel 'Lee' Jones" (Government Printing Office, May 25, 2011), *Congressional Record*—House 157, no. 73, p. H. 3414.

101. Gary L. Sorenson, "Multi-level Approach Helps Counselor Reach Black Veterans," *Vet Center Voice* 4, no. 7 (1983), State Historical Society of North Dakota, Bismarck.

102. Mical Raz, *What's Wrong with the Poor? Psychiatry, Race, and the War on Poverty* (Chapel Hill: University of North Carolina Press, 2013); Dennis Doyle, *Psychiatry and Racial Liberalism in Harlem* (Rochester, N.Y.: University of Rochester Press, 2016); Nic John Ramos, "Pathologizing the Crisis: Psychiatry, Policing, and Racial Liberalism in the Long Community

Tensions could mount as ideas about distinctive perspectives were tested. In January 1987, two Black clients filed a complaint with the Richmond, Virginia, Vet Center and shared it with the NAACP. They were concerned, they said, that the center displayed posters and banners that "glorified war and symbolized racism." The Richmond center responded by instituting an "all-Black" combat veterans' group. The move spurred allegations of special treatment by some white clients, who eventually opted to cease using the center.[103]

As Vet Centers served diverse clientele, a deinstitutionalization trend evident in the VA as early as the 1950s continued and accelerated. Between 1967 and 1991, the veteran population increased slightly, from 25.8 million to 26.6 million (Figure 1) as the total number of hospital beds in operation in VA hospitals fell from approximately 115,200 to 66,700 and the number of beds in VA psychiatric hospitals dropped from about 56,200 to 20,000. The number of patients in hospitals decreased from 103,000 in 1967 to 44,900 in 1991, while the number of patients in neuropsychiatric hospitals fell from 56,600 to just 13,700 in the same period (Figure 2).[104]

Demographics, data classification, and transinstitutionalization could help explain the trends. By 1980, when the VA was overseeing care for millions of aging World War II and Korean War veterans, the agency's annual report not only distinguished between general, surgical, and psychiatric hospitals, but also featured two other categories of institutions: domiciliary and nursing home facilities. That year, there were an average of 12,700 domiciliary patients and 22,000 nursing home patients whose care was funded by the VA.[105] By 1991, the number of VA beneficiaries receiving domiciliary care had dropped slightly, to about 10,200, but the number of patients in nursing homes had climbed to more than 30,400.[106] It appears that at least some beneficiaries who would have been classified as inpatient VA "hospital" patients in the 1950s may have been siphoned off as "nursing home" patients by the 1990s, their care likely funded, at least in part, by other public programs like Medicare.

While the Vet Center program hardly explains everything about deinstitutionalization trends in veterans' care—the total number of psychiatric

Health Movement," *J. Hist. Med. & Allied Sci.* 74, no. 1 (2018): 57–84. Martin Summers, *Madness in the City of Magnificent Intentions: A History of Race and Mental Illness in the Nation's Capital* (Oxford: Oxford University Press, 2019).

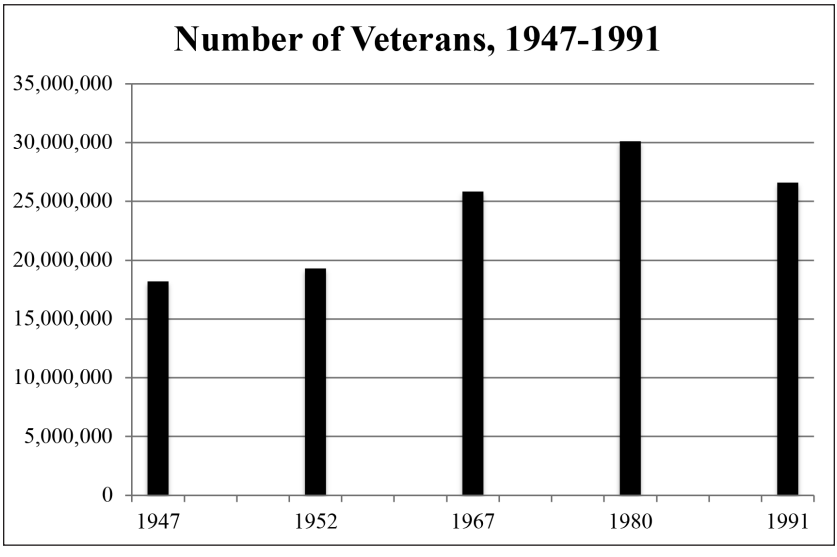
103. Gloria Reid, "Clinical Issues in a Black Veterans Group," *Vet Center Voice* 13, no. 3 (1987), State Historical Society of North Dakota, Bismarck.

104. "Administrator of Veterans Affairs Annual Report, 1967" (n. 22), 202, 308; "Annual Report of the Secretary of Veterans Affairs, 1991" (Washington, D.C.: Government Printing Office, 1991).

105. "Administrator of Veterans Affairs Annual Report, 1980" (Washington, D.C.: Government Printing Office, 1980), 102.

106. "Annual Report of the Secretary of Veterans Affairs, 1991" (n. 104), 31.

Figure 1. Data derived from VA Annual Reports, 1947, 1952, 1967, 1980, 1991

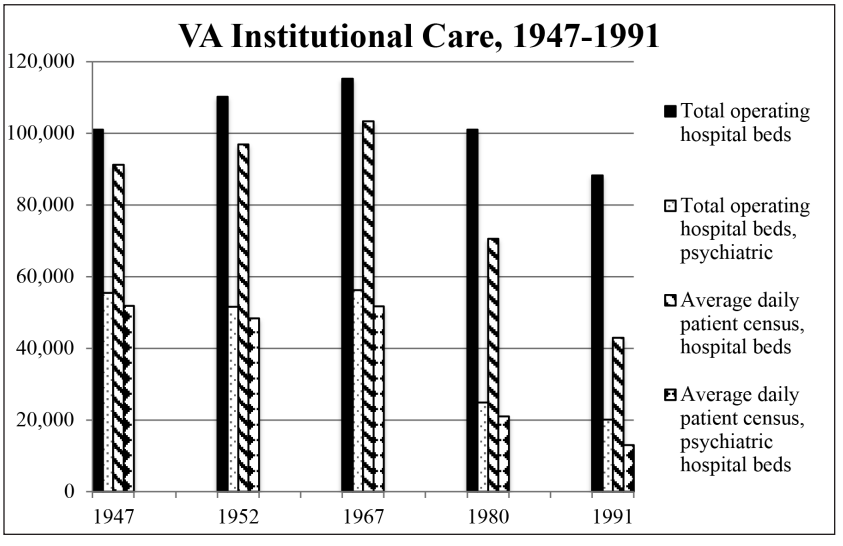


Sources: "Administrator of Veterans Affairs Annual Report, 1947" (Washington, D.C., U.S. Government Printing Office, 1947), p. 1 (total veterans tallied as 18.2 million). "Administrator of Veterans Affairs Annual Report, 1952" (Washington, D.C., U.S. Government Printing Office, 1953), p. 1 (total veterans tallied at 19.3 million). "Administrator of Veterans Affairs Annual Report, 1967" (n. 22), p. 308 (total number of veterans tallied at 25.84 million). "Administrator of Veterans Affairs Annual Report, 1980" (Washington, D.C., U.S. Government Printing Office, 1980), p. 4 (total number of veterans tallied at approximately 30 million). "Annual Report of the Secretary of Veterans Affairs / Department of Veterans Affairs" (Washington, D.C., U.S. Government Printing Office, 1991), p. 1 (total number of veterans tallied at 26.6 million).

beds was steadily declining well before readjustment counseling was operational—the story of its origins sheds light on how veterans and their advocates perceived, and attempted to exercise control over, the health care system intended to serve them. The 305,000 veterans who visited Vet Centers between 1981 and 1985 heralded a broader change in the veterans' health care apparatus: as larger proportions of VA beneficiaries sought care from the agency in the late twentieth century for a variety of reasons, they generally did so as outpatients.[107]

107. "Vietnam Veterans" (n. 81), 23–24; Jessica L. Adler, "Veterans, Like Other Working- and Middle-Class Americans, Increasingly Rely on Public Health Programs," *Amer. J. Pub. Health* 108, no. 3 (2018): 298–99.

Figure 2: Data derived from VA Annual Reports, 1947, 1952, 1967, 1980, 1991



Sources: "Administrator of Veterans Affairs Annual Report, 1947" (Washington, D.C., U.S. Government Printing Office, 1947), p. 96 (hospital beds tallied as 101,000 and psychiatric beds tallied as 55,513; census of patients in hospitals tallied at 91,224 and in psychiatric hospitals tallied at 51,907). "Administrator of Veterans Affairs Annual Report, 1952" (Washington, D.C., U.S. Government Printing Office, 1953), p. 143 (total operating hospital beds tallied at 110,243 and total operating psychiatric beds tallied at 51,626; total patients remaining in hospitals tallied at 96,888 and in neuropsychiatric hospitals, 48,318). "Administrator of Veterans Affairs Annual Report, 1967" (n. 22), p. 202 (total operating hospital beds tallied at 115,193 and total operating psychiatric beds tallied at 56,203; average daily patient census in hospitals tallied at 103,394 and in psychiatric hospitals, 51,667). "Administrator of Veterans Affairs Annual Report, 1980" (Washington, D.C., U.S. Government Printing Office, 1980), p. 102 (total operating hospital beds tallied at 101,056 and average daily patient census in hospitals tallied at 70,251), p. 17 (total operating psychiatric hospital beds tallied at 24,332 and average daily patient census in "psychiatric bed sections" calculated as 21,018). "Annual Report of the Secretary of Veterans Affairs / Department of Veterans Affairs" (Washington, D.C., U.S. Government Printing Office, 1991), p. 31 (operating hospital beds tallied at 88,201 and operating psychiatric beds tallied at 20,049), p. 31 (average daily patient census tallied at 44,928 in hospitals and 13,689 in psychiatric beds).

By the early 1990s, the ideological winds had shifted, not only because of conscious efforts to alter the nature of discussions about the Vietnam War, but also because of the emergence of a new cohort of veterans—those coming home from the Persian Gulf. Little more than a decade after the establishment of the first Vet Centers, in the wake of a new conflict, advocates reconfigured the original arguments used to justify the counseling

program's necessity. Senator Dennis DeConcini (D–Ariz.) maintained in 1991 that "the expansion of Vet Center eligibility to veterans who served after 1975 is a chance to provide early intervention."[108] Ideals about the need to provide special benefits for veterans of the war in Vietnam had given way to a widespread sentiment that the benefits those veterans helped to establish should be readily accessible to their younger counterparts—even if those younger counterparts had been warmly welcomed home after serving as part of an all-volunteer force during a relatively well-received war.[109] Republican Alan Simpson (Wyo.) articulated the viewpoint of fellow skeptical fiscal conservatives when he said of the proposed (and eventually adopted) expansion: "It's good politics. It's good emotion. But it is absurd."[110]

The Vet Center program would soon grow further still—in large part because elderly former service members made demands indicating that their needs were not so different from those of Vietnam veterans and their younger "post-1975" counterparts. In the 1980s and 1990s, people who served during World War II and the Korean War began arriving at Vet Centers and seeking counseling services. "'It appears that some,'" said Arthur Blank, one of the original directors of the program, "'are those [who were] previously undiagnosed and untreated.'"[111] By 1996, Vet Centers were conditionally opened not just to Vietnam veterans and post-1975 veterans, but also to older veterans who had been on active duty in combat zones, and others who were deemed to be particularly at risk for service-related trauma.[112]

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The Vet Center story suggests that at least three general conditions can impel transitions in public health care systems: changing conceptions of

108. "Persian Gulf War Veterans' Assistance Act of 1991, Report 102-16 to Accompany S. 386" (102nd Congress, 1st Session, February 26, 1991), 11.

109. Beth Bailey, *America's Army: Making the All-Volunteer Force* (Cambridge, Mass.: Harvard University Press, 2009); Jennifer Mittlestadt, *The Rise of the Military Welfare State* (Cambridge, Mass.: Harvard University Press, 2015).

110. "VA Mental Health Programs," § Hearing before the Committee on Veterans' Affairs (1993), 19. Persian Gulf veterans gained access to readjustment counseling via a law passed in April 1991: "The Persian Gulf Conflict Supplemental Authorization and Personnel Benefits Act of 1991," Pub. L. No. 102–25, 105 Stat. (1991), 88–89.

111. Quoted in David Kieran, *Forever Vietnam: How a Divisive War Changed American Public Memory* (Amherst: University of Massachusetts Press, 2014), 67.

112. "Vet Centers (Readjustment Counseling)," Department of Veterans Affairs, https://www.vetcenter.va.gov/eligibility.asp.

how illness should be treated, changing social constructions of disease, and forceful stakeholder advocacy that focuses on governmental obligations and liability. Vet Centers came about because advocates proactively took control of, and redefined, the VA's ongoing deinstitutionalization process in order to ensure that services could appeal to a specific group—veterans of the war in Vietnam, who argued they had unique and devastating wartime and homecoming experiences. Supporters ensured the program would last, in part, by broadening its mission and base of eligible clients. In the twenty-first century, Vet Centers serve as social service organizations of sorts, offering programs ranging from yoga and resume-writing classes to food assistance and homelessness outreach, alongside individual and group counseling. Even as they remain stand-alone clinics governed by their own branch within the VA, they are "instituted" within the agency—central to the overarching system.

Here, we find a partial explanation for why the VA health system grew throughout the twentieth century. In a country where health care could be unaffordable and inaccessible, new generations of veterans fought for more varied VA services based on contemporary beliefs about medicine, disease, and federal responsibility. The dismay of new generations prompted an awakening by older veterans—a reckoning that they, too, deserved more and better. Vietnam veterans, for their part, expanded the very notion of what the VA's outpatient mental health care apparatus should aim to accomplish. The ideal of being granted "help without hassles" was both highly adaptable and widely appealing.

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