



DACOWITS

Defense Advisory Committee on Women in the Services

2009 Report



Cover pictures posted clockwise, starting from top left

Picture 1: U.S. Air Force Senior Airman Lauren Badger, assigned to Detachment 3, 732nd Expeditionary Security Forces Squadron, removes the barrel of an M-2 .50-caliber machine gun at Forward Operating Base Falcon, Iraq, on Jan. 30, 2009. DoD photo by Senior Airman Daniel Owen, U.S. Air Force. (Released)

Picture 2: U.S. Army Sgt. Jennifer Peters provides security for her fellow soldiers during a military operation on urban terrain exercise as part of mobilization training at Fort Dix, N.J., on Jan. 10, 2008. Peters and soldiers from the 186th Military Police Company, Iowa Army National Guard, are receiving training from the 72nd Field Artillery Brigade for their upcoming deployment. DoD photo by Staff Sgt. Russell Lee Klika, U.S. Army. (Released)

Picture 3: Army Maj. Ladda "Tammy" Duckworth of the Illinois Army National Guard's 1st Battalion, 106th Aviation Regiment, narrates the "Salute to Fallen Asian Pacific Islander Heroes." during the Defense Department's Asian Pacific American Heritage Month luncheon and military awards ceremony in Arlington, Va., June 2. An Army Black Hawk helicopter pilot, Duckworth suffered the loss of both legs when a rocket-propelled grenade penetrated her helicopter beneath her feet and exploded at her knees in Iraq.

Picture 4: Cpl. Christina M. Long, 23, a native of Cuyahoga, Ohio, and assistant team leader searches an Iraqi woman entering Fallujah. The Female Searching Force searches every woman entering the city to ensure they are not trafficking drugs, weapons, or anything else that could be considered harmful or illegal within the city. (Released) Photo by 1st Lt. Sara E. Hope

Picture 5: Staff Sgt. Ramon Padillo, his daughter Emily, 3, and wife Judith pose with Elmo and Rosita from Sesame Street after the "Talk, Listen, Connect: Deployments, Homecomings, Changes," DVDs launched in April 2008. Padillo, a wounded warrior, and his family were featured on the DVD. Photo Credit: Linda Spillers Copyright 2008 Sesame Workshop

Picture 6: U.S. Army Capt. Marry Nolan, Prevention Medical officer, has a conversation with an Iraqi woman in the village of Sudoor, Diyala, Iraq, on Dec. 18, 2009. U.S. soldiers and Iraqi army soldiers gave food and school supplies to individuals living in an abandoned hotel. DoD photo by Spc. Anderson Savoy, U.S. Army. (Released)

Picture 7: Construction Electrician 2nd Class Alicia Morgan, assigned to the Naval Mobile Construction Battalion (NMCB) 74 convoy security element, provides entry control point security at a road project site. NMCB-74 has been charged with improving key convoy routes in Helmand Province, Afghanistan. (U.S. Navy photo by Mass Communication Specialist 2nd Class Michael Lindsey/Released)

Defense Department Advisory Committee on
Women in the Services (DACOWITS)
4000 Defense Pentagon, Room 2C548A
Washington, District of Columbia 20301-4000

23 March 2010

We, the appointed members of the Defense Department Advisory Committee on Women in the Services (DACOWITS), do hereby submit the results of our findings and offer our recommendations to improve the policies, procedures, and climate within the Department of Defense.

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DACOWITS

DEFENSE DEPARTMENT

ADVISORY COMMITTEE ON

WOMEN IN THE SERVICES

2009 REPORT

In collaboration with ICF International

ICF INTERNATIONAL

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EXECUTIVE SUMMARY

Since it was first chartered by Congress in 1951, the mission of the Defense Department Advisory Committee on Women in the Services (DACOWITS) has been to provide the U.S. Department of Defense (DoD) advice and recommendations on matters and policies relating to the recruitment, retention, and advancement of women in the Armed Forces. Additionally, since 2002, that mission has encompassed family matters related to the recruitment and retention of a highly qualified professional military. As has been its practice in recent years, DACOWITS selected for the 2009 research cycle one topic from each of these two domains, as follows: a) Women in Combat: The Utilization of Women in the Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) Theatres of Operations, and b) Support for Families of Wounded Warriors.

For each topic, DACOWITS formulated research questions establishing the parameters of the inquiry. The overarching research questions for the first topic, Women in Combat: The Utilization of Women in the OIF/OEF Theatres of Operations, included:

- What are the combat experiences of female Service members who deploy in support of OIF and OEF?
- What are the implications of these experiences for women and the military as a whole?

DACOWITS undertook the wounded warrior family support inquiry as a follow-up to a 2008 study it had conducted at DoD request on the same topic. Whereas the earlier study gathered data from family members only, the current study focuses primarily on tapping the provider perspective. Thus, the overarching research questions for the second topic, Support for Families of Wounded Warriors, included:

- Is there evidence of recent progress in the military's efforts to support the needs of wounded warrior family members?
- How well is the military supporting the needs of family members?
- What can the military do to further improve the support provided to family members?

Consistent with the Committee's previous research efforts, it took a multipronged approach to answering these research questions, including (1) reviewing existing resources, such as statistics, survey data, briefings, academic literature, news reports, and other available data, and (2) collecting primary data at military sites through focus groups, short surveys, meetings, and observation. The primary data collection, which took place between May and August 2009, entailed site visits to eight military installations and "virtual site visits" to Iraq and Afghanistan via video teleconferences (VTCs) held at the Pentagon. During these in-person and virtual site visits, teams of Committee members conducted 42 focus groups with a total of 454 individuals.

ICF International provided research support to the Committee, as it has done under contract to Office of the Secretary of Defense (OSD) continuously since 2002.

Chapter I of this report provides an introduction to the Committee's 2009 research and background information pertaining to each of the two topics. Chapters II and III, respectively, present the findings for each topic. Highlights of these findings are presented separately in the two subsequent sections.

A. ROLES WOMEN PERFORM IN THE OIF AND OEF THEATRES OF OPERATIONS

Focus group participants reported working in a variety of jobs while deployed in support of OIF and OEF. The majority said that female Service members work outside their military occupational specialty (MOS) while in theatre and perform jobs that do not match their pre-deployment expectations. Some participants noted that the practice of working outside their MOS or otherwise performing unexpected jobs is not unique to women. DACOWITS discussed with military leaders in the focus groups whether gender is considered when assigning personnel to combat jobs or missions. Many leaders said that it is one's capabilities rather than his or her gender that influence personnel utilization decisions.

Most focus group participants reported that they or the females with whom they served had been involved in combat roles while deployed to OIF or OEF, e.g., in a combat theatre of operations, exposed to the possibility of hostile action from a threat to self or unit, and/or in a situation where they received hostile fire. The focus groups also described specific combat roles in which women have served, such as serving outside the wire—whether on convoys, as drivers, or otherwise traveling between camps—and participating in female search teams, including the Lioness program. For the most part, female focus group participants shared feelings of satisfaction and pride about their combat experiences.

DACOWITS asked focus group participants how well were females prepared to handle the combat situations they encountered in theatre, in terms of both training and equipment. On the brief mini-survey, the majority of female and male focus group participants indicated that the training they received in preparation for their most recent deployment was adequate. In focus group discussions, however, most participants shared that the combat training female Service members received was deficient in terms of amount and/or quality, and some participants noted that the adequacy of training was not gender dependent. With respect to equipment, the majority of focus group participants acknowledged that the equipment provided to female Service members tends to be inadequate. They mentioned gender-neutral examples of inadequate equipment, such as poor quality or outdated equipment, or tardy issue of equipment, as well as

gender-specific examples of inadequate equipment, such as equipment that is not sized or designed for the female physique.

The Committee asked focus group participants to share their thoughts concerning the military impacts of women serving in combat—on mission, casualties, and morale. For the most part, participants said that women serving in combat has a positive impact on mission accomplishment, citing reasons such as helping to accommodate cultural considerations in the area of operations, helping to maintain personnel strength, and providing a unique perspective on the mission. Most participants said that women serving in combat does not impact unit casualty rates. Finally, the majority of focus group participants expressed that having females in combat not only does not erode morale but can be a positive influence, since women often serve as confidants for male peers and are more likely than men to organize morale-boosting celebrations.

DACOWITS also asked female study participants to discuss the impact of their combat experience on their military career intent and their opportunities for advancement within the military. The overwhelming majority of female focus group participants reported that their combat experience has indeed influenced their future plans. More often, military women said that their combat experience has caused them to want to separate from the military sooner than they had planned, which some attributed to family concerns related both to the risks associated with combat and the protracted absence associated with deployment. As for the impact of female combat experiences on military career opportunities, participants most commonly said that their combat experiences had positively impacted their career opportunities. In some cases, they explained, having this combat experience was positive in the sense that *not* having it would have rendered them less competitive for advancement.

When asked their opinions regarding how women should be utilized in theatre, the overwhelming majority of study participants indicated that women should be able to fill all roles in the military for which they are qualified. When asked what would be legitimate reasons for not allowing women to serve in combat roles, most focus group participants cited none.

B. SUPPORT FOR FAMILIES OF WOUNDED WARRIORS

By examining study participants' mini-survey responses, and comparing 2008 and 2009 mini-survey results, DACOWITS was able to draw some general conclusions about recent progress made in supporting families of wounded warriors. While family member responses were consistently less positive than provider responses, results for both of these stakeholder groups suggest that, overall, progress has been made. The proportions of family members satisfied with family support, by stage of support and area of support, increased—substantially, in some instances—from 2008 to 2009. Between 2008 and 2009, the percentage of family members who reported being well informed increased from 51 percent to 62 percent. In addition, study

participants, particularly providers, indicated that many conditions and practices recommended by DACOWITS in 2008 were in place by summer 2009.

Notwithstanding the question of progress, this inquiry also yielded an appreciation for strengths and weaknesses inherent in the support available to wounded warrior family members as of summer 2009. These findings were based chiefly on the provider focus groups, which were attended by 90 providers at six locations. Provider mini-survey results augmented the provider focus group findings, as did focus group and mini-survey results from a 30-person family member sample.

The most salient findings comprised those that were echoed across all six locations and/or by an overwhelming large number of focus group participants. These themes pertained to family support overall, family participation in support services, and a shortage of providers for the wounded warrior community:

- Providers characterized the care system as highly family-centered, describing a focus on the family as both givers and recipients of care. While mini-survey results indicated that smaller proportions of family members than providers were satisfied with available care, a number of family members spoke very positively about the support their families received—for example from warrior transition unit cadre (WTU). Provider and family member mini-survey results did highlight a potential gap in services to address families' psychological well-being. Furthermore, although support groups have the potential to bolster families' psychological well-being, dedicated support groups for wounded warrior family members do not appear to be prevalent.
- Providers cited poor family participation as the primary barrier preventing them from supporting families as fully as possible. Providers linked poor family participation to a number of factors, including difficulty identifying and reaching family members, family and Service member resistance, logistical obstacles such as physical distance between providers and families, and ineffective marketing.
- The shortage of providers, particularly behavioral health specialists, also emerged as a salient finding. Providers mentioned the difficulties they encounter finding staff—military, civilian, or contract—with the right qualifications to provide the specialized care needed by the wounded warrior community. Providers and family members alike discussed the extremely high caseloads that result from the shortage of providers, and how these caseloads impede optimal service delivery. What is more, there appears to be a dearth of formal training dedicated to working with families of the wounded.

Somewhat less salient, but nevertheless important, findings pertained to information and education for family members and long-term care:

- While the mini-survey results revealed that a high percentage of providers were satisfied with support for wounded warrior families in the area of information/education, in focus group discussions providers acknowledged that the sheer amount of information and services available to family members overwhelms them. Providers recognized the need for a clearly designated "go-to" person for families and suggested that a single point of contact could alleviate the stresses experienced by families inundated with information and services from well-intentioned providers.
- Mini-survey results reinforced continuity of care issues raised during the focus group discussions. In particular, providers expressed concern about the nation's readiness to sustain care for patients and families after they leave the treatment facility, if not the military, and return to their civilian communities across the country.

Additional key findings generated by the provider focus groups, many in response to targeted questioning, pertained to rules and regulations that constrain providers from supporting wounded warriors and the families as they would like, support for patients with Post-Traumatic Stress Disorder (PTSD) and Traumatic Brain Injury (TBI) as opposed to outward injuries, the extent to which medical providers share condition-related information with families, and how needs and program effectiveness are assessed. DACOWITS further identified a number of "emerging issues" that, although anecdotal in nature, have face validity and/or mirror known concerns. Examples of emerging issues discussed in this report include the importance of caring for the care provider (e.g., behavioral health specialists), a scarcity of relevant guidance to help programs and care providers deliver optimal service to the wounded warrior community, obstacles that prevent wounded warrior programs from readily accepting support offered by private organizations, and inadequate support for the reintegration process, particularly for wounded warriors diagnosed with PTSD/TBI and their families.

DACOWITS sought not only to gather perspectives on the state of wounded warrior family support, but also to elicit ideas on how to enhance it. Thus, coverage of this topic concludes with suggestions offered by the study participants, and promising and best practices that DACOWITS members observed or heard about while in the field.

Chapters IV and V of the report present topline findings and corresponding Committee recommendations for each of the two 2009 topics.

I. INTRODUCTION

The Defense Department Advisory Committee on Women in the Services (DACOWITS) was established in 1951 with the mandate to provide the Department of Defense (DoD) with advice and recommendations on matters and policies relating to the recruitment and retention, treatment, employment, integration, and well-being of highly qualified professional women in the Armed Forces. Under the current charter, in place since 2002, the Committee also provides advice and recommendations on family issues related to the recruitment and retention of a highly qualified professional military. (See Appendix A for current charter.) The individuals who comprise the Committee are appointed by the Secretary of Defense to serve in a voluntary capacity for three-year terms. (See Appendix B for biographies of the 2009 DACOWITS Committee members.)

The DACOWITS charter authorizes the Committee to advise the DoD through the Principal Deputy Under Secretary of Defense (Personnel and Readiness) (PDUSD (P&R)). Each year, the Office of the Deputy Under Secretary frames for the Committee the salient concerns related to the integration of military women and family issues in the Armed Forces. Based on this guidance, the Committee then selects a specific topic (or topics) to investigate. These topics form the basis of the Committee's research activities for the year and for the annual report it provides to the Secretary of Defense. With this guidance in mind, and based on a series of briefings provided by DoD and other proponents, the Committee chose to examine two topics during the 2009 research cycle: Women in Combat: The Utilization of Women in the Operation Iraqi Freedom (OIF) and Operation Enduring Freedom (OEF) Theatres of Operations, and Support for Families of Wounded Warriors.

The Committee's research on Women in Combat: The Utilization of Women in the OIF/OEF Theatres of Operations was intended to address the following overarching research questions:

- What are the combat experiences of female Service members who deploy in support of OIF and OEF?
- What are the implications of these experiences for women and the military as a whole?

The Committee's research on Support for Families of Wounded Warriors was intended to address the following overarching research questions:

- Is there evidence of recent progress in the military's efforts to support the needs of family members?
- How well is the military supporting the needs of wounded warrior family members?
- How can provider support of family members be enhanced?
- What can the military do to further improve the support provided to family members?

This report presents literature and research on the two topics selected by the Committee this year, including the research conducted by DACOWITS. Consistent with the efforts of previous years, the Committee took a multipronged approach to answer the research questions, including (1) the use of existing resources, such as statistics, survey data, and other available research findings and (2) the collection of data at military sites through focus groups, limited surveys, meetings, and observation.

The primary data collection involved site visits to eight military installations between May and August 2009. (See Appendix C for installations visited.) In addition to the in-person military site visits, "virtual site visits" were made to Iraq and Afghanistan via video teleconferences held at the Pentagon.

During these in-person and virtual site visits, teams of Committee members conducted 42 focus groups with a total of 454 individuals. In most cases, the site visit teams were composed of two DACOWITS members, who facilitated the focus groups, and a scribe, responsible for recording a transcript of the session. Exhibit I-1 identifies the number of focus groups conducted for each of the two topics and the number of individuals who attended them.

Exhibit I-1:
Number of Focus Groups and Focus Group Participants, by Topic

	Support for Families of Wounded Warriors			**Women in Combat: The Utilization of Women in the OIF/OEF Theatres of Operations**					**Overall**
	Family members	Providers	*Total*	Junior enlisted females	Female leaders	Junior enlisted males	Male leaders	*Total*	
Number of focus groups	4	7	*11*	7	16	1	7	*31*	**42**
Number of participants	30	88	*118*	87	156	12	81	*336*	**454**

The resulting session transcripts served as the basis for data analysis. In addition to the focus group discussion responses, DACOWITS gathered limited demographic and background data from focus group participants via brief mini-surveys.[1] The remainder of this Introduction

[1] See Appendices D, E, and F, respectively, for copies of the focus group protocols and mini-surveys, and detailed mini-survey results.

provides background information related to both topics and provides context for DACOWITS' 2009 research activities, findings, and recommendations.

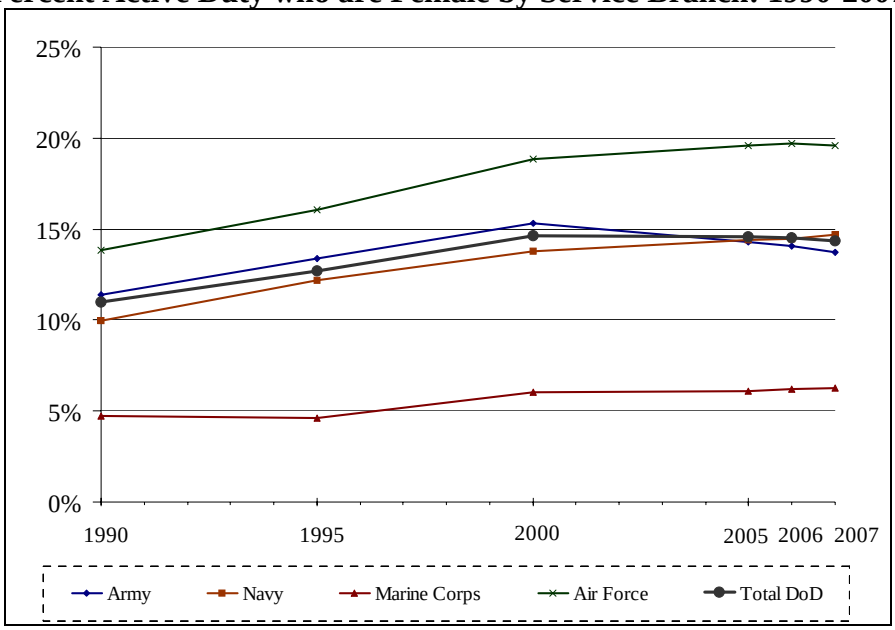
A. BACKGROUND: WOMEN IN COMBAT: THE UTILIZATION OF WOMEN IN THE OIF/OEF THEATRES OF OPERATIONS

This section provides background information on the changing roles of women in the U.S. military, the roles women are currently playing in the OIF and OEF theatres of operations, and the implications of women serving in combat roles.

The Changing Roles of Women in the U.S. Military

The representation of women in the U.S. military has steadily increased in the last two decades (see Exhibit I-2). In 1990, women comprised 11 percent of the Active Duty population (12 percent of officers and 11 percent of enlisted personnel), compared to 14 percent in 2007 (15 percent of officers and 14 percent of enlisted personnel). This trend also exists among the Reserve and Guard populations; in 1990 women represented 14 percent of officers and 13 percent of enlisted personnel in the Selected Reserve, compared to 18 and 17 percent, respectively, in 2007. An exception to the overall trend is in the Army, which, since 2000, has seen a slight decline in women as a percentage of the overall force.

Exhibit I-2:
Percent Active Duty who are Female by Service Branch: 1990-2007



Source: *Demographics 2007: Profile of the Military Community* (Defense Manpower Data Center (DMDC))

The Roles of U.S. Military Women Prior to September 11, 2001

The roles of women in the U.S. military have also changed over time. Women have served unofficially in our military from the country's very beginnings in the Revolutionary War, when women enlisted using male pseudonyms, and officially since 1901. The government recruited women to serve as nurses in the Armed Forces during the Civil War, but they did not receive military status for this work.[2] Since that time, a number of significant legal and policy changes have expanded the roles open to women in uniform.

After Word War II, a war in which women served in many military jobs with the exception of air or land combat jobs or jobs at sea, the Armed Services Integration Act of 1948 allowed women to be a permanent part of our military.[3] This act included limitations on the jobs that women could fill and instituted a ceiling limiting the participation of women to no more than two percent of the military.[4] In 1967, the Women's Armed Services Integration Act was modified, which lifted the two-percent restriction and opened senior officer military ranks to women. A few years later, in 1972, the Navy further expanded the roles of women by allowing limited entry into all enlisted ranks, by opening assignments on a hospital ship to women, and opening up additional

[2] Manning, L. (2008). *Women in the Military: Where They Stand (6 ed)*. Women's Research and Education Institute.
[3] Iskra, D. M. (January, 2007). Attitudes Toward Expanding Roles for Navy Women at Sea: Results of a Content Analysis. *Armed Forces & Society*.
[4] Ibid.

occupational fields, including maintenance, public affairs, and intelligence.[5] By the late 1970s, all of the U.S. services academies were open to women.

A decade later (1988), the DoD "Risk Rule" was announced, which identified a universal standard used in the evaluation of positions and units open to women. This policy resulted in the opening of roughly 30,000 new billets to women, but any units in support of ground combat operations continued to be closed to them.[6] The "Risk Rule" memo included a ground combat rule, which stated that "women shall be excluded from assignment to units below the brigade level whose primary mission is to engage in direct combat on the ground."[7]

The 1990s proved to be another decade of change for women in the military. In 1990–1991, more than 40,000 women Service members were deployed to serve in the first Persian Gulf War. In 1993, Congress repealed previous restrictions prohibiting women from operating combat aircraft or serving on combatant ships. The following year, Secretary of Defense Les Aspin repealed the "Risk Rule" and established the current DoD assignment policy for women.[8] This resulted in tens of thousands of billets opening up to women in the Army and Marine Corps. The same year, Congress opened up most Navy combatant ships to women, although submarines and some smaller ships still remain closed to female Service members.[9] Recent activity, including September 25, 2009, congressional testimony by Admiral Mike Mullen, chairman of the Joint Chiefs of Staff, suggests that the ban on women in submarines may soon be lifted. In his testimony, Mullen said, "I believe we should continue to broaden opportunities for women. One policy I would like to see changed is the one barring (women's) service aboard submarines."[10] Navy Secretary Ray Mabus has also voiced similar views saying, "I believe women should have every opportunity to serve at sea, and that includes aboard submarines."[11]

The Roles of U.S. Military Women Following September 11, 2001

The 2006 Defense Authorization Act mandates that the Secretary of Defense must notify Congress of any change in the ground combat exclusion policy or any change in the positions open or closed to women. The Secretary must submit a report to Congress that includes a description of the proposed changes, a justification of the changes, and an impact analysis.

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[5] Manning, L. (2008).
[6] Ibid.
[7] Ibid.
[8] Harrell, M. (2009, February 18). *Assessing the Assignment Policy for Army Women.* Briefing provided to DACOWITS.
[9] Manning, L. (2008).
[10] Reuters (2009, September 28). Military May Lift Ban on Women in Submarines. *Reuters.* Retrieved September 29, 2009, from http://www.reuters.com/article/oddlyEnoughNews/idUSTRE58R36S20090928.
[11] McMichael, W.H. & Scutro, A. (2009, September 27). SecNav, CNO: Women Should Serve on Subs. *NavyTimes*. Retrieved September 29, 2009, from http://www.navytimes.com/news/2009/09/navy_roughead_subs_092409w/.

The current DoD policy guiding women's service is the Direct Ground Combat Assignment Policy (DGCAP). DGACP is an assignment policy, and therefore imposes restrictions on the assignment of female Service members in theatre, rather than on their employment or utilization.[12] The policy states that "military women can be assigned to all positions for which they are qualified, except that women shall be excluded from assignments to units below the brigade level whose primary mission is to engage in direct combat on the ground."[13] DGCAP is implemented according to each Service's warfighting doctrine. Units and positions are coded to identify them as direct ground combat or not direct ground combat.[14] DoD's assignment policy also allows each Service to impose additional restrictions within prescribed DoD guidelines.

Each military Service branch also has its own assignment policy for female Service members. The Army's assignment policy, for example, allows female Soldiers to serve in any enlisted or officer role except those in specialties, positions or units (battalion size or smaller) that are assigned a routine mission to engage in direct combat, or which collocate routinely with units assigned a direct combat mission.[15] The Army and DoD policies differ slightly, primarily over a difference in one word – the Army policy uses "routinely" where DoD policy uses the word "primary". The Army policy includes a restriction on collocation – one of the approved additional restrictions made optional to each Service's individual policy. Each of the other Services also has its respective policy on the assignment of its female Service members.

Today, American women in uniform are deploying regularly in support of OIF and OEF, and serving alongside their male counterparts in theatre. More than half (53%) of female Service members have been deployed since September 11, 2001 (see Exhibit I-3), and of those who have been deployed since September 11, almost half (44%) have deployed two or more times (see Exhibit I-4).

Exhibit I-3:
Service Members Deployed since September 11, 2001

	Female	Male
Overall	**53%**	**71%**
Enlisted	52%	71%
Officer	59%	76%

Source: *November 2008 Status of Forces Survey of Active Duty Members: Tabulations of Responses*, compiled by DMDC

[12] OSD Staff Judge Advocate Office. (2009, May 27). *Direct Ground Combat Assignment Policy (DGCAP) and DACOWITS.* Briefing provided to DACOWITS.
[13] Harrell, M. (2009, February 18).
[14] OSD Staff Judge Advocate Office. (2009, May 27).
[15] Harrell, M. (2009, February 18).

Exhibit I-4: How Many Times Have You Been Deployed? (Of Those Deployed Since September 11, 2001)						
	Enlisted		Officers		Total (Enlisted & Officers)	
	Female	Male	Female	Male	Female	Male
OIF:						
Once	58%	40%	54%	38%	57%	40%
Twice	29%	34%	31%	37%	29%	35%
Three Times or More	13%	26%	15%	26%	14%	26%
OEF:						
Once	84%	72%	80%	64%	83%	71%
Twice	13%	21%	15%	26%	13%	21%
Three Times or More	3%	8%	5%	11%	3%	8%
TOTAL*:						
Once	56%	38%	52%	35%	87%	74%
Twice	26%	31%	27%	30%	8%	16%
Three times or More	18%	32%	20%	35%	5%	9%

*Total includes deployment to OIF, OEF, Operation Noble Eagle (ONE), and Other
Source: *November 2008 Status of Forces Survey of Active Duty Members: Tabulations of Responses,* DMDC

Occupations of Women in OIF/OEF

Today's Service members, both male and female, are filling a variety of occupations in the U.S. military. Exhibit I-5 and Exhibit I-6 display how Service members in each gender are occupationally "distributed." The first exhibit shows that, among Active Duty Enlisted personnel, males are concentrated in infantry, gun crew, seamanship and mechanical/repair occupations, and females tend to be concentrated in support and administration jobs. Among Active Duty Officers, females are concentrated in healthcare occupations, whereas males are concentrated in tactical operations jobs.

Exhibit I-5: Occupational Profile of Active Duty Enlisted Personnel in DoD by Gender		
	Females	**Males**
Support & Administration	33.9%	12.9%
Healthcare	15.9%	5.3%
Service and Supply	11.7%	9.7%
Power/Mechanical Repair	10.9%	21.9%
Student/Trainee/Other	6.8%	6.3%
Infantry, Gun Crew, and Seamanship	5.8%	21.3%
Electronic Equipment Repair	4.9%	8.6%
Communications and Intelligence*	4.2%	6.2%
Technical Specialty	3.6%	3.5%
Crafts	2.2%	4.3%

*Data on intelligence specialists not available. Columns may not sum to 100% for this reason and/or due to rounding.
Source: DMDC data from February 2008 drawn from *Women in the Military*, 6th ed.

Exhibit I-6: Occupational Profile of Active Duty Officers in DoD by Gender		
	Females*	**Males***
Healthcare	40.8%	12.2%
Tactical operations	12.2%	42.5%
Supply and Logistics	11.3%	8.5%
Engineering and Maintenance	11.2%	15.0%
Administrative	9.8%	4.1%
Student/Trainee/Other	8.4%	11.0%
Scientific and Professional	6.2%	6.1%
General Officer and Flag	0.1%	0.5%
Intelligence	*Unavailable*	*Unavailable*

* Percentages calculated without intelligence specialists
Source: DMDC data from February 2008 drawn from *Women in the Military*, 6th ed.

Nature of Warfare in OIF/OEF

Many have argued that the nature of warfare in OIF and OEF is unlike that of any other major war the U.S. military has fought before. Military leaders describe the current war as "asymmetric and noncontiguous: there are not front and rear areas."[16] A U.S. Marine Corps officer is quoted in a 2007 article saying, "When you walk into the middle of a country like Iraq, there are no front lines…You are in harm's way whether you're in a city or on one of the many

[16] Putko, M. (2008). The Combat Exclusion Policy in the Modern Security Environment. *Women in Combat Compendium.*

bases."[17] A journalist reporting from Afghanistan recently noted, "The nature of the war has also done much to change the debate over combat roles. Any trip off the heavily secured bases now effectively invites contact with the enemy."[18] The asymmetric warfare and absence of front lines result in a new type of battlefield, spread over larger geographic regions, involving a larger proportion of the deployed force. Thus, as the nature of warfare is changing, so are the roles of America's warriors.

Combat Roles of Women in OIF/OEF

Today, both male and female Service members assigned to jobs traditionally thought of as non-combat are exposed to hostile action. A recent survey of Active Duty Service members found that, of those who have been deployed since September 11, 2001, 85 percent of females and 90 percent of males report serving in a combat zone or an area where they drew imminent danger pay or hostile fire pay (see Exhibit I-7). Almost half (42%) of females, and more than half (58%) of males, also report that they were involved in combat operations (see Exhibit I-7).

Exhibit I-7:
Percentage of Service Members Deployed to Combat Zone or Involved in Combat Operations by Gender and Enlisted/Officer Since September 11, 2001

	Since September 11, 2001, have you been deployed to a combat zone or an area where you drew imminent danger pay or hostile fire pay? (% reporting "Yes")	**Were you involved in combat operations?** (% reporting "Yes")
Females:		
Overall	**85%**	**42%**
Enlisted	84%	43%
Officers	90%	38%
Males:		
Overall	**90%**	**58%**
Enlisted	89%	58%
Officer	92%	58%

Source: *November 2008 Status of Forces Survey of Active Duty Members: Tabulations of Responses,* compiled by DMDC.

[17] Johnson, L II. (Mar/Apr, 2007). Duty Bound: Women in Iraq Risk Their Lives to Serve Their Country. *The Crisis.* (Quote attributed to Capt. Vernice Armour, U.S. Marine Corp helicopter pilot)
[18] Myers, S. L. (August 17, 2009). Women at Arms: Living and Fighting Alongside Men, and Fitting In. *The New York Times.* Retrieved August 18, 2009, from http://www.nytimes.com/2009/08/17/us/17women.html?pagewanted=1.

As female Service members are serving alongside their male counterparts in OIF/OEF, they are also being wounded in action (see Exhibit I-8).

Exhibit I-8:
Number of Females and Males Wounded in Action in OIF and OEF

	TOTAL	Army	Navy	Marines	Air Force
OIF[1]					
Females	604	531	5	41	27
Males	30,738	21,149	626	8,576	387
Total	*31,342*	*21,680*	*631*	*8,617*	*414*
OEF[2]					
Females	20	16	1	0	3
Males	2,959	2,445	50	365	99
Total	*2,979*	*2,461*	*51*	*365*	*102*

Source: 1: DMDC, March 2003 through June 2009
2: DMDC, October 2001 through June 2009

The Lioness Program and Female Engagement Teams

Two programs that specifically recruit and utilize women in combat situations are the Lioness Program and the Female Engagement Teams (FETs). The Lioness Program involves a group of female Service members in Iraq who are attached to all-male combat units. The female Service members search local (i.e., Iraqi) women when needed, in an attempt to defuse any cultural tensions caused by American men interacting with local women. The FETs are all-female Marine units used in Afghanistan to interact with local women and gather intelligence.

Public awareness of these programs has increased with recent media coverage[19], and specifically with the release of *Lioness*, a documentary film that "tells the story of a group of female Army support soldiers who were part of the first program in American history to send women into direct ground combat."[20] A newspaper article printed soon after the film's release argues that *Lioness* "makes the point that the nature of the Iraq war – fuzzy front lines and guerrilla tactics – has thrust more female soldiers…into enemy fire than ever before."[21]

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[19] Media coverage of FETs includes: Burton, M. (2009, March 10). All-Female Marine Team Conducts First Mission in Southern Afghanistan. *Defense.gov News Article*. Retrieved December 22, 2009, from http://www.defense.gov/news/newsarticle.aspx?id=53416; de Montesquiou, A. (2009, August 14). Marines Try a Woman's Touch to Reach Afghan Hearts. *ABC News*. Retrieved December 21, 2009, from http://abcnews.go.com/International/wireStory?id=8329941.

[20] *Room 11 Productions.* Lioness: About the Film. Retrieved September 24, 2009, from http://lionessthefilm.com/about_the_film/.

[21] Lee, F. R. (2008, November 4). Battleground: Female Soldiers in the Line of Fire. *The New York Times*. Retrieved March 18, 2009, from http://www.nytimes.com/2008/11/05/arts/television/05lion.html?scp=1&sq=Battleground:%20Female%20Soldiers%20in%20the%20Line%20of%20Fire&st=cse.

Media Portrayal of the Roles of Women in OIF/OEF

The American media are noticing and publicizing the combat roles women are playing in the current conflicts. A recent newspaper article describes the expanding roles of women serving in combat:

> Before 2001, America's military women had rarely seen ground combat. Their jobs kept them mostly away from enemy lines, as military policy dictates. But the Afghanistan and Iraq wars, often fought in marketplaces and alleyways, have changed that. In both countries, women have repeatedly proved their mettle in combat… women have done nearly as much in battle as their male counterparts' — patrolled streets with machine guns, served as gunners on vehicles, disposed of explosives, and driven trucks down bomb-ridden roads. They have proved indispensable in their ability to interact with and search Iraqi and Afghan women for weapons, a job men cannot do for cultural reasons…[22]

Another separate article recently addressed the utilization of female Service members in tasks outside their assigned Military Occupational Specialty (MOS), such as searching Iraqi women, which, the author argues, "[puts] them as much at risk as any male counterpart."[23] A recent article in *Air Force Print News Today* discusses the changing role of women in war: "Times are changing… [Women] are becoming more and more present in combat environments today – many of them in command positions."[24] A 2005 *USA Today* article quotes an Army lieutenant on this issue, "Women in combat is not really an issue…It is happening."[25]

Implications of Women Serving in Combat Roles

As the roles of women in the U.S. military continue to expand, concerns have been raised in the press and by retired military commanders about the potential impact of women in combat on mission performance, unit cohesion, and the well-being of the women involved (e.g., in areas such as hygiene and health care). Although under the current assignment policy women cannot be assigned to roles which primarily entail combat, in the shifting landscape of today's war, women increasingly find themselves in combat roles. As women have increasingly filled these roles out of military necessity, DACOWITS finds little evidence that the organizational performance of the military has been negatively impacted. These topics are examined in more detail below.

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[22] Alvarez, L. (2009, August 16). Women at Arms: G.I. Jane Breaks the Combat Barrier. *The New York Times.* Retrieved August 18, 2009, from http://www.nytimes.com/2009/08/16/us/16women.html?fta=y.
[23] Myers, S. L. (2009)
[24] Martinez, R. (2008). Women Take Command in Combat. *Air Force Print News Today*.
[25] Moniz, D. (2005). Female Amputees Make Clear that All Troops are on Front Lines. *USA Today*. Retrieved March 16, 2009, from http://www.usatoday.com/news/nation/2005-04-28-female-amputees-combat_x.htm.

Impact of Women in Combat on Mission Accomplishment

As the nature and location of U.S. conflicts abroad have changed, new roles that can only be filled by females have become essential to mission accomplishment. Women have made significant contributions to OIF/OEF by gathering intelligence from other women and from children who would be unlikely to share their information with male service members. Similarly, females are uniquely equipped to search women and children in Muslim countries. Gathering intelligence and conducting searches are critical to counterinsurgency (COIN) operations, and in certain circumstances, these tasks can be done most effectively by women. Not only are women uniquely capable of performing specific tasks in certain areas of the world, some male unit commanders have attested to their ability to perform in combat situations at the level of their male peers.[26] Female Service members have shown they can fill a spectrum of vital combat roles that are typically filled by men, from organizing patrols to defending base camps.[27] Women make significant contributions to the mission, both by carrying out tasks for which they are more culturally suited than men, and, in many cases, performing the same tasks as their male colleagues.

Impact of Women in Combat on Unit Cohesion

Some have argued that the presence of women in the combat environment may negatively impact military performance by causing a deterioration of *cohesion*, a characteristic of many high performing teams both within and outside the military. [28] Arguments in support of this position stress that women's inclusion in combat units represents a threat to male bonding, which seen as the main source of cohesion and which is created and maintained through a continuous emphasis on masculinity (e.g., as in the basic training environment). One rationale for this argument is that "accepting women…as equals would challenge the sense of 'masculine warrior' spirit critical to turning boys into effective soldiers. It would destroy the in-group cohesion built on a sense of male superiority constructed in part through its contrast with the other."[29]

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[26] Grosskruger, P.L. (2008). Women Leaders in Combat: One Commander's Perspective. *Women in Combat Compendium.*

[27] Twitchell, R.E. (2008). The 95th Military Police Battalion Deployment to Iraq—Operation Iraqi Freedom II. *Women in Combat Compendium*.

[28] Review and critique of common arguments made against women in combat are provided in the following sources: Rosen, L.N, Knudson, K. H., & Fancher, P. (Spring 2003). Cohesion and the Culture of Hypermasculinity in U.S. Army Units. *Armed Forces & Society*; Kier, E. (1999). Discrimination and Military Cohesion: An Organizational Perspective. *Beyond Zero Tolerance: Discrimination in Military Culture*. Ed. Fainsod Katzenstein, M & Reppy, J. Lanham: Rowman & Littlefield Publishers, Inc.

[29] Kier, E. (1999). See also Segal, D.R. (1989). *Recruiting for Uncle Sam*. Lawrence: University of Kansas Press. It is interesting to note that very similar unit-cohesion arguments were used in opposition to integrating African Americans into the military in the 1930s and 1940s, and that the argument continues to surface within the context of the debate on the military integration of gays and lesbians.

A great deal of empirical research has been conducted, particularly in the 1970s and 1980s, on the relationship between military cohesion and performance, and the results have been mixed.[30] Although some studies have found a positive correlation between unit cohesion and performance, there is not much evidence of a *causal* relationship. Even granting for the moment the premise that cohesion does, in fact, enhance military performance, there is little empirical evidence that the presence of women in military units reduces cohesion. An alternative research perspective characterizes cohesion as a *result*, not a cause, of high performance—that is, cohesion is an emergent group process that takes place when a group (which can contain individuals with very similar or very different characteristics) successfully accomplishes a difficult task by sharing hardship and working together towards a common goal. Additionally, and the military's recent direct experience would seem to largely contradict the claim that women disrupt cohesion. In a recent article describing the impact, or perhaps lack thereof, of women's increased roles in combat in OIF/OEF on unit cohesion, the author reports, "The wars in Iraq and Afghanistan are the first in which tens of thousands of American military women have lived, worked and fought with men for prolonged periods...They have reshaped life on bases across Iraq and Afghanistan…And they have done so without the disruption of discipline and unit cohesion that some feared would unfold…"[31]

Impact of Women in Combat on Sexual Behavior Between Service Members

The introduction of women to war zones has also led to concerns about sexual behavior between Service members, which has historically been prohibited.[32, 33, 34] There were fears that large numbers of female Service members may become pregnant and need to be sent home, leaving positions vacant and compromising unit readiness.[35] While male and female Service members do have relationships in theatre, birth control is readily available, and pregnancies, although they do occur, are relatively infrequent.[36] What is more, there has been no demonstrated impact on military performance.[37] According to recently retired battalion commander Peter Mansoor,

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[30] Segal, D.R. (1989)
[31] Myers, S. L. (2009).
[32] Ibid.
[33] Brown, D. (2008, May 15). Ban on Sex for Soldiers in Afghanistan Lifted…Sort of. *Military.com*. Retrieved March 16, 2009, from http://www.military.com/features/0,15240,167950,00.html .
[34] General Order Number 1 (GO-1), Headquarters Multi-National Corps—Iraq, Baghdad, Iraq, APO AE 09342, Dated April 4, 2009. Retrieved August 18, 2009, from http://www.tac.usace.army.mil/deploymentcenter/tac_docs/GO-1.pdf .
[35] Iskra, D. M. (2007).
[36] Data prepared by the Armed Forces Health Surveillance Center show that in 2008, less than one percent (0.93%) of deployed women had a pregnancy-related theatre medical encounter, and only 5 (less than a tenth of one percent) had pregnancy-related medical evacuations. (Data sources: Theater Medical Encounters (TMDS), TRAC2ES, and DMSS)
[37] Myers, S. L. (2009).

"With good leadership and mentorship, we have been able to keep those problems to a minimum."[38]

Impact of Women in Combat on Military Women's Professional Development and Well-Being

The opportunity for female Service members to serve in combat roles also may have implications on the professional development and overall well-being of females in uniform. Some military leaders argue that, if the assignment policy for military women were to explicitly allow women to serve in combat, this could create more opportunity for promotion for female Soldiers and signal to the American public that the military offers men and women equal opportunity.[39]

At the same time, it is possible that more intensive involvement in combat operations may have mental health consequences for women, as combat jobs carry more mental health risk than jobs without exposure. A 2006 study found that women in combat support occupations "were not at a higher risk for mental health problems" than their female counterparts working in non-combat military occupations.[40] A 2001 study compared the impact of stress from personal and work experiences on job performance levels for men and women in uniform, and found that "although some gender differences exist in the experience or report of stress and depression, the performance of men and women in the military is equally likely to suffer following exposure to work-related and health-related stressors or as a function of depression. Indeed, the job functioning of military women appears less likely than that of men to be impaired by certain types of stress, negative coping, and substance abuse."[41]

Thus, although the scientific literature is limited on this topic, preliminary research suggests that expanding the combat roles available to women does not pose a unique risk to women greater than what is experienced by their male counterparts. It also suggests that the impact of on-the-job stress in the military on job performance is no greater for women than for men, and that in some regards the impact may be less for women than men when faced with similar stressors.

Looking Ahead

Undoubtedly, the nature of the wars in Afghanistan and Iraq has altered traditional understandings of combat and consequently changed the roles played by female Service

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[38] Ibid.
[39] Lindon, M. R. (2008). Impact of Revising the Army's Female Assignment Policy. *Women in Combat Compendium.*
[40] Lindstrom, K. E., Smith, T. C.,Wells, T. S., Wang, L. Z., Smith, B., Reed, R. J., Goldfinger, W. E., & Ryan, M.A.K. (November 2, 2006). The Mental Health of U.S. Military Women in Combat Support Occupations. *Journal of Women's Health*.
[41] Bray, R. M., Camlin, C. S., Fairbank, J.A., Dunteman, G. H. & Wheeless, S.C. (Spring 2001). The Effects of Stress on Job Functioning of Military Men and Women. *Armed Forces & Society*.

members in combat zones. The positions current female Service members hold more closely emulate the conventional combat roles of male counterparts than did those of their predecessors. Through assignment to positions that now entail greater risk of combat exposure than before, this generation of female Service members is making contributions to mission accomplishment in new ways and in larger numbers. Secretary of the Army John McHugh stated at his 2009 senate confirmation hearing, "Women in uniform today are not just invaluable, they're irreplaceable."[42] Reflecting on the role of women in today's military, West Point professor of sociology Dr. Morten Ender has noted in a recent volume on American Soldiers in OIF/OEF, "[The] real-world exposure may push women's military roles closer with those of men once the dusts of Afghanistan and Iraq have cleared and the military and policy makers reflect and reevaluate what men and women have accomplished together..."[43]

B. BACKGROUND: SUPPORT FOR FAMILIES OF WOUNDED WARRIORS

According to DoD records, between October 2001 and June 2009, 34,321 military personnel supporting Operations Iraqi Freedom and Enduring Freedom were wounded in action (WIA). Seventy percent of those WIA Service members were Army Soldiers and 26 percent were Marines.[44] Approximately one-half of the WIA were treated in-theatre and returned to duty within 72 hours.[45] The more seriously injured WIA were medically evacuated, first to Landstuhl Regional Medical Center in Germany, and then to a stateside military medical center. For every medically evacuated wounded warrior, there is a "wounded" family. The support that is available for these family members was the focus of DACOWITS's second 2009 research topic. We present background information on this topic under the following three headers:

- The needs of wounded warriors and their families
- Policies and programs for the wounded warrior community
- Adequacy of existing supports for families.

Each of these topics is presented in turn.

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[42] Alvarez, L. (2009).
[43] Ender, M. (2009). *American Soldiers in Iraq: McSoldiers or Innovative Professionals?* Routledge.
[44] Department of Defense Manpower Data Center, OIF and OEF U.S. Casualty Status and OIF and OEF Military Wounded in Action as of October 8, 2009. Retrieved September 1, 2009, from http://www.defenselink.mil/news/casualty.pdf.
[45] Ibid.

The Needs of Wounded Warriors and Their Families

The wounded warrior community comprises two key sub-populations: the Service members and their families. Below, we provide an overview of the characteristics of these two sub-populations.

Wounded Warriors

The casualties of the OIF and OEF differ from those of previous wars. The asymmetric battlefield, coupled with the insurgents' heavy use of improvised explosive devices (IEDs), have left our troops vulnerable to injuries of the head, face, or neck, including Traumatic Brain Injury (TBI); severe soft-tissue, bone, and vascular injuries often requiring amputation.[46] The operational tempo of the current war has required many Service members to deploy to Iraq or Afghanistan multiple times, exposing them to high levels of cumulative combat stress and further increasing their risk for Post-Traumatic Stress Disorder (PTSD).[47] It has been reported that almost one in five combat veterans suffer from TBI and/or PTSD; not only are these conditions prevalent, but they can be difficult to diagnose and slow to emerge.[48]

Medical and technological advances, in areas such as body armor and battlefield medicine and evacuation, have reduced combat mortality rates.[49] Whereas the ratio of injuries to fatalities during the Vietnam era was three-to-one, for veterans of OIF/OEF this ratio is seven-to-one.[50] The number of severely injured wounded warriors who survive, and the severity and complexity of their injuries, are unprecedented. Military medicine uses three categories to classify the acuity of war injuries and to estimate the likelihood of return to duty.[51]

- Category I (CAT I): recovering Service member
    - Has a mild injury or illness
    - Is expected to return to duty in less than 180 days

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[46]Gawande, A. (2004). Notes of a Surgeon: Casualties of War–Military Care for the Wounded from Iraq and Afghanistan. *The New England Journal of Medicine*; (2007). Broken Reed, *The Economist.*

[47] Hoge, C., Castro, C. A., Messer, S. C., McGurk, D., Cotting, D. I. & Koffman, R. L. (2004). Combat Duty in Iraq and Afghanistan, Mental Health problems, and Barriers to care. *The New England Journal of Medicine (*351); Seal, K.H., Bertenhal, D., Miner, C. R., Sen, S. & Marmar, C. (2007). Bringing the War Back Home. *Archives of Internal Medicine.*

[48] Okie.S. (2005). Traumatic Brain Injury in the War Zone. *New England Journal of Medicine,(352)*; *Rand Report,* (April 2008), Invisible Wounds of War.

[49] Gawande, A. (2004)

[50] Christensen, E., Hill, C., Netzer, P., Farr, D., Schaefer, E. & McMahon, J. (April 2009). Economic Impact on Caregivers of the Seriously Wounded, Ill, and Injured. *CNA.*

[51] Roberts, S. (Deputy Director of Care Coordination).(2009, May 28). *Office of Transition Policy and Care Coordination.* Briefing provided to DACOWITS; Materia, J. (2009, Feb 19) *Senior Oversight Committee, Serving Our Wounded Ill and Injured: Wounded Warrior Update*. Briefing provided to DACOWITS

    - Receives primarily local outpatient and short-term inpatient medical treatment and rehabilitation

- Category II (CAT II): recovering Service member (seriously injured, or SI)
    - Has a serious injury or illness
    - Is unlikely to return to duty in less than 180 days
    - May be medically separated from the military

- Category III (CAT III): recovering Service member (very seriously injured, or VSI)
    - Has a severe/catastrophic injury or illness
    - Is highly unlikely to return to duty
    - Will most likely be medically separated from the military

In 2007, the Dole-Shalala Commission estimated that approximately 3,100 Service members were seriously or severely injured or ill, based on the numbers qualifying to receive Traumatic Service Members Group Life Insurance (TSGLI).[52] The Center for Naval Analysis (CNA) has estimated that, annually, approximately 720 Service members receive injuries or are diagnosed with illnesses severe enough that they require the assistance of a non-medical caregiver.[53] Patients in this category suffer from conditions such as TBI, PTSD, amputations, serious burns, poly-trauma, spinal cord injuries, and blindness.[54]

Typically, VSI and SI patients are medically evacuated from the theatre of operations to Landstuhl Regional Medical Center in Germany, after which they are admitted for treatment to one of four military medical centers (Walter Reed Army Medical Center, National Naval Medical Center, San Antonio Military Medical Center, or Naval Medical Center San Diego). Their average inpatient stay at these facilities is 30–45 days, depending on their condition and the treatment required. This is followed by an extended period of treatment and rehabilitation—often on an outpatient basis—at a military treatment facility, poly-trauma hospital of the Department of Veterans Affairs, or civilian hospital. Inpatient and outpatient stays average 333 days but can last several years.[55]

The wounded warrior's path from injury to recovery, rehabilitation, and reintegration is long, painful, and difficult. Many are incapacitated and must rely, at least for a time, on a non-medical caregiver for help with basic daily living requirements. It has been estimated that, on average, VSI and SI Service members are reliant on the assistance of a non-medical caregiver for

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[52] *Serve, Support, Simplify,* (July 2007).
[53] Christensen, E. et al., (2009).
[54] *Serve, Support, Simplify,* (July 2007).
[55] Christensen, E. et al. (2009).

approximately 19 months, although an estimated 43 percent need caregiver assistance for the long term.[56] In addition, many VSI and SI Service members require extensive professional support—medical as well as non-medical—as they endeavor to re-build their lives. Many can no longer do the work for which they were trained, if they can work at all. After an in-depth physical evaluation process,[57] most VSI and SI Service members are medically retired from the military. As veterans, they then look to Veterans Affairs (VA), rather than DoD, for health care and assistance on their path toward personal and professional rehabilitation and reintegration.

A CNA survey (N=248 VSI/SI respondents) revealed the following demographic profile, which CNA calculates is fairly representative of the larger VSI/SI population (see Exhibit I-9).

Exhibit I-9:
Demographic Profile of Very/Seriously Injured Survey Respondents (N=248)[58]

Characteristic	Percent
Service and Active Component/Reserve Component Status	
Army	
Active Component	39%
Guard and Reserve	12%
Marine Corps	
Active Component	31%
Guard and Reserve	5%
Navy	
Active Component	5%
Guard and Reserve	2%
Air Force	
Active Component	5%
Guard and Reserve	1%
Age and Gender	
Male under 30	42%
Male 30 or older	53%
Females under 30	2%
Females 30 or older	4%
Pay Grade	
E1-E3	13%
E4-E6	48%

[56] Christensen, E. et al. (2009).
[57] A combined DoD/VA Disability Evaluation Board process, which will make this process shorter and less daunting for the Service member, has been piloted and is in the process of being implemented more broadly from "Senior Oversight Committee, Serving Our Wounded, Ill and Injured: Update and the Way Ahead" Briefing provided to DACOWITS by Executive Director, Senior Oversight Committee.
[58] Christensen, E. et al. (2009).

Exhibit I-9: Demographic Profile of Very/Seriously Injured Survey Respondents (N=248)[58]	
E7-E9	23%
O1-O3	8%
O4 and above	7%
Marital Status	
Married	52%
Single	29%
Separated or divorced	20%
Parental Status	
Children	52%
No children	49%

We see that VSI/SI war casualties are concentrated in Army and Marine Corps ground services, with males comprising 95 percent of the population. On other demographic dimensions (e.g., rank, family status), the VSI/SI population mirrors the general military population.[59] In the following section, we describe the characteristics and experiences of wounded warrior families.

Family Members of Wounded Warriors

CNA also provided demographic information regarding survey respondents' caregivers.[60] While the large majority had one or more family members, loved ones, or friends who supported and assisted them while they were receiving care, the most frequent "primary support givers" were wives and mothers.[61] Nearly one-third of primary support givers were younger than 30; a comparable percentage was between ages 30 and 39, and nearly one-quarter were between ages 40 and 54. DACOWITS observed that prior to their Service member's injury, some family members, particularly spouses of junior Service members and Guard and Reserve members, have minimal exposure to the military.[62]

When a Service member receives a classification of VSI or SI, indicating that their life may be in jeopardy, the military notifies the next of kin and provides transportation to the Service member's bedside. The family member(s) abruptly leaves his or her home, job, and other family responsibilities to be with their Soldier, Sailor, Airman, Marine, or Coast Guardsman. While family members may return home temporarily, for all intents and purposes many relocate for the

[59] Office of the Deputy Under Secretary of Defense (Military Community and Family Policy) under contract with ICF International. (2007). *Demographics 2007: Profile of the Military Community.*
[60] Ibid.
[61] Ibid.
[62] Defense Advisory Committee on Women in the Services (DACOWITS). (2008, October 17). *Support for Families of Wounded Warriors: Summary of DACOWITS Focus Groups*.

duration of their wounded warrior's treatment and rehabilitation—a year-long period on average. In some cases, a family member is compensated as a Non-Medical Attendant (NMA) for the hands-on assistance he or she provides during the inpatient period.[63]

Having a wounded Service member has profound and far-reaching impacts for the family. Caregivers are thrust into unfamiliar roles and environments. They become their Service member's assistant, encourager, comforter, advocate, spokesperson and, in time, chauffeur and personal manager. Caregivers must learn to maneuver within complex military and healthcare bureaucracies, interact with multiple military and healthcare personnel and providers, and become conversant in terminology related to both of these worlds.[64]

Serving in this role is not only challenging but costly, even though financial and in-kind support is available for caregivers (and discussed below). The CNA survey revealed that approximately 75 percent of caregivers had quit, or taken time off from, their jobs or their schooling. Some lost their jobs because the length of their Service member's inpatient and outpatient treatment phases exceeded the amount of unpaid leave authorized by the Family Medical Leave Act (FMLA).[65] CNA observed that parents of single Service members stand to lose not only their income but their health insurance if they choose to remain by the side of their wounded warrior. Additional costs incurred by caregivers, according to the CNA Survey, include changing their housing or location (approximately 11%), new child care arrangements (approximately 33%), and new financial obligations (approximately 41%).[66]

While fulfilling these roles on their Service member's behalf, family members often face a deep sense of loss and uncertainty about the future. Rightfully, they may be sad, stressed, and overwhelmed. Among some families, this scenario may trigger or aggravate family dysfunction or clinical depression.[67] Certain categories of wounded warrior family members are particularly vulnerable to emotional or psychological distress. Research suggests that spouses of Service members diagnosed with PTSD and TBI may be especially prone to psychiatric symptoms, i.e., at risk of secondary trauma.[68] Children are at risk as well. Indicators of mental health issues among military children, such as numbers of counseling visits and psychiatric hospitalizations,

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[63] *Serve, Support, Simplify*, (July 2007).
[64] Ibid.
[65] As amended by the national Defense Authorization Act in January 2008, FMLA allows employees to take up to 26 weeks within a 12-month period.
[66] Christensen, E. et al. (2009).
[67] Marsh, N.J., et al. (2002). Caregiver Burden During the Year Following Severe Traumatic Brain Injury. *Journal of Clinical and Experimental Neuropsychology*.
[68] Arzi, N.B., et al. (2000). Secondary Traumatization Among Wives of PTSD and Post-Concussion Casualties: Distress, Caregiver Burden and Psychological Separation. *Brain Injury*.

rose dramatically in 2008.[69] We infer that this increase in mental health treatment activity is related to increased parental deployment, since it coincided with a surge in deployment tempo. Upon return from deployment, Service members' combat experiences can affect their behavior and mood, which in turn can impact their families and children.[70]

> "There is no such thing as 'an injured Service member'—we should be thinking, 'injured *family'*."[71]

When injury results from a parent's deployment, children understandably experience even greater distress. The children of war wounded deal with stressors such as fear of losing their injured parent, separation from their non-injured parent (i.e., the patient's caregiver), change in living arrangements and routines, hospital visits, and change in one or both parents' parenting abilities. Furthermore, while the effects of combat-related parental TBI on children require further study, parental brain trauma of non-combat origin has been linked with outcomes such as diminished parenting ability, family violence and family disintegration.[72]

In the following section, we provide an overview of the initiatives that have been put into place to address the needs of the wounded warrior community.

Policies and Programs for the Wounded Warrior Community

An elaborate infrastructure of medical and non-medical supports has been established to meet the needs of wounded warriors through every stage of care. Consistent with traditions of family support within both the military and healthcare communities, these programs embrace the needs of families as well. Overviews of these programs are presented under the following headers:

- Federal Wounded Warrior Initiatives
- Service-Level Wounded Warrior Initiatives
- Wounded Warrior Initiatives of Private Organizations

Each category is addressed in turn.

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[69] *Associated Press.* (2009, July 8). More Troops' Kids Seeking Counseling. Retrieved September 1, 2009, from www.military.com/news/article/more-troops-kids-seeking-counseling.html.
[70] Lamberg, L. (2008). Redeployments Strain Military Families, *Journal of the American Medical Association*.
[71] Ibid. (Dr. Cozza, S., Associate Director, Center for the Study of Traumatic Stress, Child and Family Programs, Uniformed Services University of Health Sciences quoted in Lamberg).
[72] Cozza, S. J. (2008, October 8). *Children and Families of Combat Veterans*. Briefing presented to AUSA Military Family Forum III.

Federal Wounded Warrior Initiatives

The overarching blueprint for the system of care for wounded warriors is shaped by observations, recommendations, and mandates from a variety of authoritative sources, including the 2008 and 2009 National Defense Authorization Acts.[73] The *President's Commission on Care for America's Wounded Warriors* (PCCWW), initiated at President George W. Bush's direction in the wake of the February 2007 revelations of unsatisfactory conditions for wounded warrior outpatients at Walter Reed Army Medical Center (WRAMC), has been particularly influential. The final report of this commission, led by former Secretary of Human Services Donna Shalala and former Senator Bob Dole, was released July 2007.[74] The "Dole/Shalala Report" made six overarching recommendations, all of which affected families:

1. Implement comprehensive recovery plans
2. Restructure disability and compensation systems
3. Improve care for people with post-traumatic stress syndrome and traumatic brain injury
4. Strengthen support for families[75]
5. Transfer patient information across systems
6. Support Walter Reed Army Medical Center until closure.

To identify corrective actions and address these and other recommendations and mandates, totaling more than 500, the Federal Government mobilized a team of officials from the DoD and VA, co-chaired by the respective Deputy Secretaries. Called the Senior Oversight Committee (SOC), this body was charged with formulating a comprehensive policy of care, management, and transition support for Service members and veterans with a serious or severe injury or illness and their families. The committee members, all senior DoD and VA proponents, were organized into eight "lines of action": 1) Disability System, 2) TBI/PTSD, 3) Case Management, 4) DoD/VA Data Sharing, 5) Facilities, 6) Clean Sheet Design[76], 7) Legislative and Public Affairs, and 8) Personnel, Pay, and Financial Support. In November 2008, lines of action 1, 3, and 8 were incorporated into a new DoD organization, the Transition Policy and Care Coordination (TPCC) Office, whose mission is to "ensure equitable, consistent, high-quality care coordination and

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[73] For example: Returning Global War on Terror Heroes, Nicholson, April 2007; Independent Review Group, West/Marsh, April 2007; DoD Task Force on Mental Health; Arthur, MacDermid, and Kiley; September 2007; Veterans Disability Benefits Commission, Scott Commission, October 2007; President's Commission on Care for America's Returning Wounded Warriors (PCCWW), Dole/Shalala, July 2007; DoD/VA Care Transition Process for Service Members Injured in OIF/OEF, by DoD Inspector General, June 2008.

[74] Wikipedia (2009, July 26). Walter Reed Army Medical Center Neglect. Retrieved August 5, 2009, from http://en.wikipedia.org/wiki/Walter_Reed_Army_Medical_Center_neglect_scandal; *Serve, Support, Simplify*. (July 2007).

[75] Action steps under strengthening support for families included expanding family eligibility for TRICARE respite care, and aide and attendant care; expanding caregiver training; and covering families under the Family Medical Leave Act (FMLA).

[76] Charged with "thinking outside the box"

transition support for members of the Armed Forces, including wounded warriors and their families, through appropriate interagency collaboration, responsive policy and effective program oversight." Four lines of action were incorporated into existing DoD organizations, and one line of action—Clean Sheet Design—was deemed completed.[77]

The SOC's efforts have yielded the "Recovery Coordination Program," whose mission is to "…improve the way recovering Service members and veterans with a serious or severe injury or illness, and their families, are supported across all stages of care."[78] The four cornerstones of the Recovery Coordination Program include:

- Comprehensive, customized **recovery plans** to meet the personal and professional goals of each Service member and their families. Recovery plans are intended to encompass medical and non-medical needs, both near-term and long-term, and to be holistic in nature.
- **Recovery care coordinators** (RCCs) who oversee the development of the recovery plans and the delivery of services to Service members and their families. As of spring 2009, there were 33 RCCs supporting the needs of the active duty community at 13 wounded warrior program locations. An additional 100 Army Wounded Warrior Program Advocates had been trained as RCCs.[79]
- **Recovery teams** of multidisciplinary medical and non-medical care providers who provide coordinated support to Service members and their families
- An extensive online **National Resource Directory and Wounded Warrior Resource Center** for Service members and their families (www.nationalresourcedirectory.org). This Web site developed by the Departments of Defense, Labor, and Veterans Affairs is a "one-stop yellow book" for use by Service members, veterans, family members, RCCs, and providers. It includes a directory of more than 10,000 services and resources available through governmental and non-governmental organizations to support all stages of the recovery process, and links to the 24/7 Wounded Warrior Resource Center call center.[80]

In practice, there are two Recovery Coordination Programs. Recovering Service members who are *seriously* injured or ill (SI, CAT II) and are enrolled in the Recovery Coordination Program are assigned a DoD Recovery Care Coordinator. *Severely* injured or ill Service members (VSI, CAT III) who are enrolled in the *Federal* Recovery Coordination Program are assigned a VA-provided *Federal* Recovery Coordinator. Although the Federal Recovery Coordinator is a VA

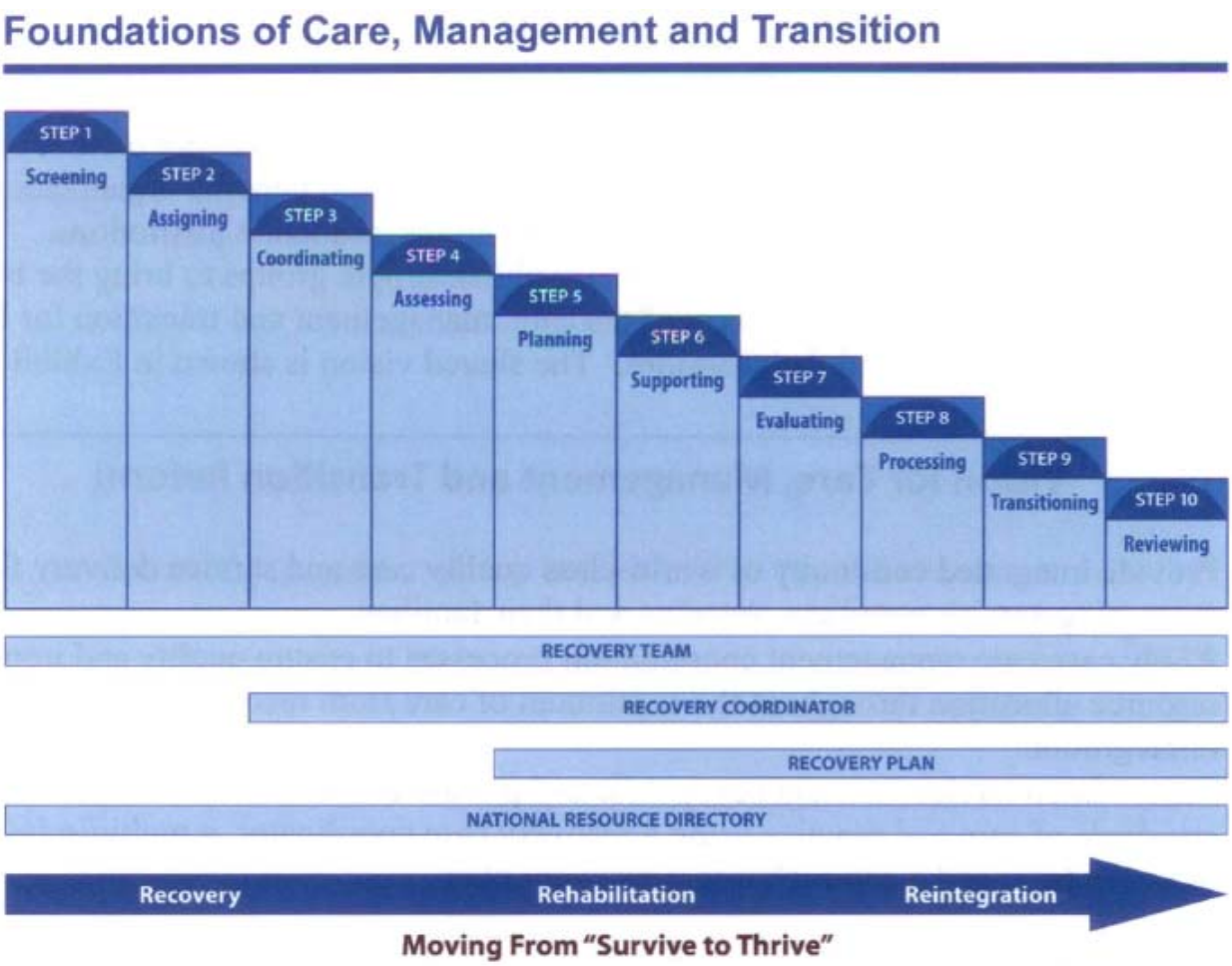
[77] Roberts, S. (2009, May 28); Materia, J. (2009); Dr. Davis, L. (2009).
[78] Department of Defense, (2009, September 15). The Foundations of Care, Management and Transition Support for Recovering Service Members and Their Families.
[79] Roberts, S. (2009, May 28)
[80] Ibid.

asset, he or she begins working with the Service member, family, and multidisciplinary providers while the Service member is an active-duty patient of the Military Treatment Facility. In addition, the VA has full-time social worker liaisons who work with the recovery teams at the military treatment facilities to facilitate optimal care. As of summer 2009, 27 liaisons were assigned to 13 treatment facilities, and VA anticipated deploying liaisons to additional facilities.[81]

A uniform 10-step process has been established to facilitate a methodical and gap-free continuum of care for Service members and their families through each stage of the recovery process, including a smooth transition from DoD to VA, if appropriate. This process, which is to be followed by both Recovery Coordination Programs, is depicted graphically in Exhibit I-10.

[81] Pueschel, M. (2009, June 11). Liaisons Provide Wounded Warriors Smooth Transitions to VA Care. *U.S. Department of Defense Military Health System.* Retrieved September 1, 2009, from www.health.mil/Press/Release.aspx?ID=760.

Exhibit I-10:
Foundations of Care, Management and Transition[82]



Among additional SOC accomplishments particularly relevant to families are the establishment of the Center for Excellence for Psychological Health and Traumatic Brain Injury and the pilot program to streamline the disability evaluation system, which Soldiers and family members historically have experienced as protracted and complex, if not also adversarial.

Service-Level Wounded Warrior Initiatives

While the Army, Air Force, Navy, and Marine Corps support their respective wounded warriors and families through separate programs, they share a common framework for delivering recovery

[82] Department of Defense, (2009, September 15).

care, based on the Recovery Care Program and the 10-step process described above. Exhibit I-11 identifies the key members of the multidisciplinary recovery team across each branch of Service.

Exhibit I-11:
Multidisciplinary Recovery Team Members[83]

Multidisciplinary Recovery Team Members		
Role	**Recovering Service Member** ***Active Duty Status***	**Recovering Service Member** ***Veteran Status***
Primary Care Manager	Physician	
Medical Care Case Manager	Nurse	
Non-Medical Care Manager	Army – Army Wounded Warrior Case Manager and Warrior Transition Unit Squad Leader Navy – Non-Medical Care Manager Air Force – Family Liaison Officer Marine Corps – Patient Advocate Team	OEF/OIF Program Manager Liaison Transition Patient Advocate VA Liaison
Recovery Coordinator – CAT II Recovering Service Member	DOD Recovery Care Coordinator	
Recovery Coordinator – CAT III Recovering Service Member	DOD/VA Federal Recovery Coordinator	

In the following section, we introduce these Service-level programs with emphasis on the Army program, which serves the largest population.

Support for Army Wounded, Ill, and Injured and Their Families

At the center of the Army's program for wounded warriors are the Warrior Transition Units (WTUs). While the mission of the WTUs is to provide comprehensive care management to support Soldiers' recovery and transition, WTUs are structured like an Army line unit. Each recovering WTU Soldier is assigned a "triad of care" comprising the primary care manager (i.e.,

[83] Ibid.

physician), a nurse care manager, and a squad leader.[84] Like line units, WTUs are supposed to establish family readiness groups.[85]

> "We want a family program where we have literally interviewed each family and built a program that's right and appropriate for that family—whether a Soldier is living with parents, siblings or spouses or far away."[86]

When the WTUs were established in 2007, eligibility was open to "any injured Soldier who could benefit". Eventually, the Army's 36 WTUs served a population of more than 12,000 Soldiers. More recently, the Army concluded that the large number of "routine" cases assigned to the WTUs was "diluting the case management resources" available for the more serious cases. Consequently, in July 2008, the Army established more stringent criteria for WTU assignment. To make better use of WTU resources, the Army also is streamlining the 36 WTUs by closing three and restructuring six others. The staff-to-Soldier ratios for the triad of care will remain unchanged: one primary care manager to 200 Soldiers, one nurse case manager to 20 Soldiers, and one squad leader to 10 Soldiers. In May 2009, the WTUs had a combined population of approximately 9,500 Active-Duty Soldiers; this number is expected to decline to 8,500 by summer 2010.[87]

To further support recovering Soldiers and their families, the Army has established Soldier and Family Assistance Centers (SFACs) at nearly every installation with a WTU. SFACs provide a broad array of services to family members, such as information and referral; linkage with private organizations offering material support; child care; lodging assistance (for those lacking invitational travel orders); help with military entitlements and benefits; help with travel claims; transportation arrangements; vehicle registration; translation; Internet access; counseling related to financial management, stress, and employment/career, and more. SFACs also support the creation and delivery of support groups for families, such as injury-specific support groups and WTU family readiness groups.[88]

The Army has established an additional nine regional Community-Based WTUs (CBWTUs), to allow Guard and Reserve Soldiers to recover closer to their hometowns. Like the regular WTUs, the CBWTUs have Army cadre and medical case managers. Unlike the regular WTUs, assigned Soldiers normally live at home and receive treatment locally through TRICARE. BG Gary

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[84] Association of the U.S. Army (AUSA). (April 2009). Key Issues relevant to Taking Care of Soldiers and Families: Wounded Warrior Care.
[85] Langer, E. (2009, February 19). *U.S. Army Wounded Warrior Program (AW2).* Briefing provided to DACOWITS.
[86] Leipold, J.D. (2009, May 12). Warrior Transition Command Stands Up at Pentagon. Retrieved September 1, 2009, from www.army.mil/-news/2009/05/12/20970,
[87] Leipold, J.D. (2009, May 26). Declining numbers prompt Army to restructure WTUs. Retrieved September 1, 2009, from www.army.mil/-news/2009/05/26/21634,
[88] Langer, E. (2009, February 19).

Cheek, Warrior Transition Command Commander, noted that the creation of CBWTUs reflects the Army's recognition of how important families are to their Soldier's successful recovery and transition.[89]

A subset of the WTU population is enrolled in the Army Wounded Warrior Program (AW2). AW2 serves the needs of the Army's most severely wounded, ill, and injured and their families.[90] Soldiers enrolled in the AW2 program—4,681 as of July 2009—suffer from conditions such as severe blindness/vision loss, deafness/hearing loss, fatal/incurable disease, loss of limb, paralysis/spinal cord injury, permanent disfigurement, PTSD, severe burns, and TBI. Of these, PTSD, TBI, and loss of limb are the most frequent. AW2 Soldiers and their families are assigned an AW2 Advocate who provides personalized, holistic support and assistance for as long as necessary. This support may pertain, for example, to benefits information, financial counseling, career guidance, education opportunities, local resources, medical/physical evaluation board process, continuing on active duty or active reserve, and coordination with other agencies. The Army has more than 120 AW2 Advocates throughout the country, at locations with large concentrations of AW2 Soldiers, such as VA Poly-trauma Centers, VA facilities, Military Treatment Facilities, and most military installations.

Support for Marine Corps Wounded, Ill, and Injured and their Families

The Marine Corps' Wounded Warrior Regiment (WWR) supports the total force, including active-duty, reserve, retired, and former Marines. As of July 2008, the WWR was tracking and supporting a population of 8,850 Marines wounded in OIF/OEF since September 2001, the vast majority of them already separated from the Marine Corps. The WWR has two battalions—Wounded Warrior Battalion-West (WWBN-W) at Camp Pendleton, CA, and Wounded Warrior Battalion-East (WWBN-E) at Camp Lejeune, NC. Recovering Marines and their families receive support from a Medical Case Manager (MCM) and a Non-Medical Case Manager (NMCM), who work in concert with the RCC.

Call centers are an important component of WWR operations. The 24/7 Sergeant Merlin German Wounded Warrior Call Center—a service for active duty, reservists, and former Marines—receives and answers calls on demand and also conducts targeted outreach to various at-risk populations. In addition, WWBN-E and WWBN-W call centers conduct outreach with active duty Marines (including mobilized reservists) and their families in remote areas or isolated.

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[89] STAND-TO! (2009, April 16). Community Based Warrior Transition Units: What is it? Retrieved September 1, 2009, from www.army.mil/standto/archive/2009/04/16.

[90] AW2 is for those "who have, or are expected to receive, an Army disability rating of 30% or greater in one or more specific categories or a combined rating of 50% or greater for conditions that are the result of combat or are combat related." U.S. Army Medical Department; Army Wounded Warrior Program (AW2). (2009, August 13). Retrieved September 1, 2009, from www.AW2.army.mil.

Mission Statement:

The Wounded Warrior Regiment will provide and facilitate assistance to wounded/ill/injured Marines, Sailors attached to or in support of Marine units, and their family members, throughout the phases of recovery.[91]

Support for Navy Wounded, Ill, and Injured and Their Families

The Navy Safe Harbor Program tracks and has oversight responsibility for all wounded, ill, or injured Sailors. As of February 2009, this population numbered approximately 5,000 (the "daily snapshot"). Of those, approximately 365 Service members classified as seriously or catastrophically wounded, ill, or injured were enrolled in the Safe Harbor Seriously Wounded, Ill, and Injured (SWII) Program. The Safe Harbor SWII Program enrolls approximately 250 Service members annually. Upon program entry, they are assigned to the Safe Harbor Company and, upon program exit, most are assigned to Safe Harbor for Life.

Recovering Service members (RSMs) and their families are assigned a Safe Harbor Recovery Team comprising: a Safe Harbor Non-Medical Care Manager, a Medical Care Case Manager, a Primary Treatment Provider, a Specialist(s), and others as required, all of whom work in coordination with the Recovery Coordinator. Non-Medical Care Managers help RSMs and families obtain assistance from existing support services dealing, for example, with pay and personnel issues, invitational travel orders, lodging, child and youth programs, recreation and leisure, transportation, legal and guardianship issues, education and training benefits, commissary and exchange access, respite care, and TBI/PTSD services. As necessary, Non-Medical Care Managers provide more customized support. Safe Harbor also provides non-medical care management for high risk *non-seriously* wounded, ill, or injured Sailors—annually, this population consists of approximately 100 Sailors.[92]

Mission Statement:

Safe Harbor is the Navy's lead organization for coordinating the non-medical care of wounded, ill, and injured Sailors, Coast Guardsmen and their family members. Through proactive leadership, we provide a lifetime of individually tailored assistance designed to optimize the success of our Shipmates' recovery, rehabilitation, and reintegration activities.[93]

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[91] United States Marine Corps. *Wounded Warrior Regiment*. Briefing provided to DACOWITS.
[92] Watkins, K. (Commanding Officer, Navy Safe Harbor Program). (2009). *Taking Care of Our Sailors and Their Families.* Briefing provided to DACOWITS.
[93] Ibid.

Support for Air Force Wounded, Ill, and Injured and Their Families

As of spring 2009, 397 wounded Airmen and their families were receiving support from the Air Force Warrior and Survivor Care Program. This program comprises two phases: 1) the *Survivor Assistance Program* provides care and assistance from the time of injury until treatment is complete, and 2) the *Air Force Wounded Warrior (AFW2) Program*, formerly known as Palace Helping Airmen Recover Together (HART), phases in "…when wounded Airmen begin their transition either back to their Air Force job or to the civilian community."[94] Members of the Air Guard and Air Force Reserve also receive support through the Air Force Warrior and Survivor Care Program.

The cornerstone of the Air Force Warrior and Survivor Care Program is the Family Liaison Officer (FLO), who the Air Force describes as "the Commander's personal representative to help the family in any and all matters needed or requested."[95] The FLO is the family's connection to the Air Force, provides linkage to support services, and generally ensures that the family's needs are met. Seriously and very seriously injured Airmen are assigned FLOs by officials at Andrews Air Force Base, which is the first stop of wounded Airmen upon air-evacuation from Germany. The FLO engages with the family, initially wherever their Airman is being treated, for as long as the family needs them—at least until the wounded Airman returns to duty or separates from the military. Although RCCs are another focal point for non-clinical case management within the Air Force program, as of spring 2009 the Air Force had RCCs only in the National Capital Region and San Antonio, TX. It hopes to be fully resourced by the end of Fiscal Year 2010.

> "The FLO is the key to taking care of Airmen and their families…especially when they are away from their home unit."[96]

The second part of the Air Force Warrior and Survivor Care Program, AFW2, concentrates on the delivery of transition services. These include, for example, relocation assistance, financial counseling, employment services, etc. As appropriate, AFW2 facilitates civilian employment with the Air Force or elsewhere within the Federal Government, and coordinates assistance from the VA and the Department of Labor. Wounded Airmen receive AFW2 case management for at least five years.[97]

While differences are apparent in how each Service serves the wounded, ill, and injured community, the expectation is that families' needs are comprehensively addressed regardless of

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[94] Goulter, T. (AF/A1SZ). (2009). *Air Force Warrior and Survivor Care Program.* Briefing presented to DACOWITS; Myers (AF/A1S).
[95] Ibid.
[96] Ibid.
[97] Ibid.

their Service affiliation, as conveyed in DoD publications such as "Keeping It All Together: For wounded, ill, and injured Service members."[98]

Wounded Warrior Initiatives of Private Organizations

Private organizations, both national and local, form an integral component of the infrastructure that supports the wounded warrior community. Many family members who participated in the earlier DACOWITS study emphasized how heavily they relied on the support—often financial or tangible—that such organizations provided. A sampling of organizations and programs that wounded warrior family members have identified include: Blue Star Moms, Catholic Charities, Coalition to Support America's Heroes, Families of Injured Soldiers and Spouses, Hope for the Warriors, Operation Comfort, Operation First Response, Operation Home Front, Operation Second Chance, Semper Fi Fund, Soldiers' Angels, The Care Coalition, Walter Reed Society, Wounded Warrior Project, and Yellow Ribbon Fund.[99]

Adequacy of Existing Supports for Families

Data from DACOWITS and other research organizations have shown that a great many families of wounded warriors have benefited from assistance in myriad realms of their lives from a host of governmental and non-governmental organizations. Shaping effective, responsive programs is an iterative process, however, and various assessments and inquiries have been undertaken to track needs, monitor program implementation, and inform program refinements. For example, the General Accounting Office reviewed the progress of the SOC in generating policy to reform the wounded warrior care and transition process, and assessed the WTU program; the Office of the Secretary of Defense assembled a committee to formulate joint wounded warrior program metrics and conducted a baseline survey of the Recovery Coordination Program; the Chairman of the Joint Chiefs established a Joint Staff Wounded Warrior Integration Team to evaluate all programs that affect the wounded warrior community and promote best practices, and the Army and the Marine Corps implemented wounded warrior surveys.[100] Highlighted below are findings from two studies that focused specifically on wounded warrior *family* issues, including the DACOWITS study of support for families of wounded warriors and the CNA study of the economic impact on caregivers of the seriously wounded, ill, and injured.

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[98] Department of Defense. (n.d.). *Keeping It All Together: For wounded, ill, and injured service members and their families.* Retrieved September 1, 2009, from www.woundedwarriorresourcecenter.com/kiat.pdf.
[99] DACOWITS, (2008, October 17). Support for Families of Wounded Warriors: Summary of DACOWITS Focus Groups. Prepared by ICF International.
[100] United States Government Accountability Office. (July 2009). Recovering Service Members: DoD and VA Have Jointly Developed the Majority of Required Policies but Challenges Remain; Miles, D. (2008, May 7). New Joint Staff Team Evaluates Wounded Warrior Programs. *American Forces Press Service.* Retrieved September 1, 2009, from http://www.defenselink.mil/news

Study of Support for Families of Wounded Warriors[101]

In summer 2008, in response to concern expressed by the Secretary of Defense that family members of wounded warriors might be experiencing inconsistent levels of support from DoD and the individual Services, the Principal Deputy Under Secretary of Defense for Personnel and Readiness (PDUSD-P&R) asked DACOWITS to conduct a short but intensive data collection effort with family members of wounded warriors.[102] In collaboration with ICF International, DACOWITS launched a series of focus groups with 76 family members at seven wounded warrior sites and gathered data from an additional 14 family members via telephone interviews.

DACOWITS asked family members to rate their level of satisfaction with support in six areas—1) overall, 2) logistics (e.g., movement to and between facilities), 3) finances (e.g., reimbursements), 4) information/education (e.g., about benefits and services), 5) emotional support (e.g., stress management), and 6) assistance/advocacy (e.g., reducing red tape). About half of the family members indicated satisfaction with the support they received overall, and many observed that there have been dramatic improvements in wounded warrior family support over time. Inconsistencies in level of service were evident, however, and they expressed greater satisfaction with concrete types of support, such as logistics and finances, than with less tangible types of support, such as emotional support or advocacy.

The strongest finding to emerge from this data call was that family members wanted the military to do a better job of communicating with them and sharing information—related, for example, to administrative matters, the Service member's ongoing treatment, provider roles, available support resources, and facility layout. Family members frequently were unaware of the existence of a Family Readiness Group (FRG) or comparable support group for families, and many reported that they looked to other wounded warrior family members for information.

The importance of having a go-to person, to advocate on behalf of the family as well as the Service member, was evident in the study participants' remarks, but access to such an advocate differed by Service and condition. Each Air Force family was assigned a Family Liaison Officer, but family members from other branches of Service did not necessarily have a comparable resource. Several family members of Service members with TBI or PTSD noted that they needed assistance and advocacy during the interim between emergence of his or her symptoms and receipt of a formal diagnosis, but neither was available. While the Federal and DoD Recovery

[101] DACOWITS, (2008).
[102] Office of the Under Secretary of Defense (Personnel & Readiness). (2008, August 1). Memorandum on Care of Wounded Warrior Families Review by the Defense Department Advisory Committee on Women in the Services.

Coordination Program coordinators may fill this need today, at the time of this study most family members had not heard of the Recovery Coordinator Programs or coordinators.
DACOWITS explored the financial implications of caring for a wounded warrior. Families reported strong support from the military in the areas of initial transportation to the Service member's bedside and lodging, which the military typically provides on the medical center campus. Certain family members were paid for serving as a Non-Medical Attendant (NMA). Family members described financial hardships related to lack of information, difficult paperwork, slow reimbursements, and seemingly unfair eligibility criteria. For example, they questioned why some were eligible for NMA status and others were not, and why NMA eligibility ceases when wounded warriors transition to outpatient status. A few families, often parents who abandoned their jobs and homes to care for their severely injured wounded warrior over a lengthy period, faced extreme financial difficulties. Many families reported receiving varied forms of assistance, including financial aid, from private organizations.

DACOWITS asked family members where they turned for emotional support. While some family members described receiving emotional support—e.g., from the unit, a chaplain, the WTU, or support groups—a comparable proportion of them felt emotionally unsupported. Some were unaware that potential sources of emotional support were available to them, such as FRGs or counseling.

Finally, family members expressed mixed reactions to the medical support provided to their Service members. Many were highly satisfied with the medical care their loved one was receiving, as well as the professionalism and dedication of the medical staff. At the same time, some described a lack of a dialogue between themselves and the healthcare providers, which they found frustrating, demeaning, and contrary to the best interests of the patient.

Study of Economic Impact on Caregivers of the Seriously Wounded, Ill, and Injured [103]

Tasked by the SOC to address issues of personnel, pay, and financial support, the Principal Deputy Assistant Secretary of the Air Force for Manpower and Reserve Affairs (SAF/MR) contracted CNA to estimate the economic impact on caregivers of the seriously wounded, ill, and injured. To inform its understanding of caregiving needs and the caregiver role, CNA conducted a survey of seriously wounded, ill, and injured Service members and interviews with case managers at six military medical treatment facilities. Many of CNA's findings surrounding caregiving needs and the caregiver role are referenced earlier in this chapter.

CNA found that many caregivers incurred new financial obligations, some of which remained unmet. Not surprisingly, the percentage of caregivers who were encumbered with these financial

[103] CNA

obligations was correlated with the number of hours per week that they devoted to the caregiver role, which presumably was associated with the severity of their Service member's condition. Both out-of-pocket expenses and lost earnings and benefits contribute to caregivers' financial circumstances. The former, as both DACOWITS and CNA discovered, are largely covered by DoD and private programs. Lost earnings and benefits are not covered, however, which, as DACOWITS learned previously, can have catastrophic consequences. Using data from the Bureau of Labor Statistics Current Population Survey, CNA calculated that caregivers lose an average of $60,300 in income and benefits over a 19-month caregiving period. These and related calculations helped to fuel and guide federal policy aimed at easing the financial burden on caregivers.

In the course of gathering data related to financial burden, CNA also gained insights into other aspects of the caregiver experience. CNA's findings were highly consistent with those reported by the DACOWITS study.

CNA identified a problem with caregiver access to information about available resources, observing that it tended to vary with Service affiliation and location. CNA noted recent initiatives to ensure that information about resources is consolidated and imparted to family members more systematically, such as through Army SFACs, newcomer orientations, and resources such as the Office of the Secretary of Defense (OSD) "Compensation and Benefits Handbook" and the online National Resource Directory. CNA also noted a problem with when information is provided, observing that families tended to be inundated with resource information immediately upon their arrival, at a time when they were too engrossed in their Service member's condition to assimilate it.

CNA observed several forms of apparent inequity in benefit eligibility, all of which inevitably affect caregivers, whether directly or indirectly. Certain resources are available to combat veterans but not to seriously injured or ill Service members who are serving outside the combat theatre—a differentiation that families of the non-combat injured can find offensive. Many private organizations provide recreational opportunities to Service members but not to caregivers, although caregivers also would benefit from access to these outlets. CNA noted that military treatment facilities recognize this need and are developing respite programs for family members. Also, the National Defense Authorization Act 2008 provides for a respite care benefit for caregivers through TRICARE, the military health plan. Thirdly, Service members with physical injuries, particularly amputation, tend to receive more benefits than those with less visible wounds such as TBI and PTSD (e.g., until recently, Service members with diagnoses of TBI or PTSD did not qualify for TSGLI). Finally, CNA found that reserve component personnel may be ineligible for a permanent-change-of-station (PCS) move to the military treatment facility where they are being treated, and may not have the same follow-on treatment venue options as their Active-Component counterparts.

Many CNA study participants raised the need for educational assistance for spouses who must replace their Service members as the primary breadwinner for the family. The New GI Bill (Post-9/11 Veterans education Assistance Act of 2008) may go a long way toward addressing this need by allowing Service members to transfer their education benefits. Additionally, Department of Labor programs targeting veteran employment, such as "America's Heroes at Work" and "REALifelines," can also assist caregivers. The study participants also discussed the challenge of simultaneously caring for one's children and one's wounded, ill, or injured Service member, which they noted is partially addressed by the availability of free child care at military treatment facilities (on average 12 to 16 hours per month).

The DACOWITS and CNA reports—published October 2008 and April 2009, respectively—documented that progress has been made in our efforts to support the families of the wounded, ill, and injured *and* that much work remains to be done. The tenor of these reports echoes in May 2009 Congressional testimony by wounded warriors and family members before the Armed Services and Veterans Affairs Committees, which the Military Officers Association of America summarized as follows: "Wounded warriors and family members in attendance agreed that things are improving, but said the government is nowhere close to actually delivering seamless care and transition services."[104] DACOWITS undertook the current wounded warrior family support research, presented in Chapter III, to further understanding of needed and available levels of support for wounded warrior families—and to help to narrow the gap between them.

C. ORGANIZATION OF REPORT

Chapter I provides context and background information related to the 2009 DACOWITS research. The remainder of the report comprises four chapters:

- Chapter II – Women in Combat: The Utilization of Women in the OIF/OEF Theatres of Operation
- Chapter III – Support for Families of Wounded Warriors
- Chapter IV – 2009 DACOWITS Findings and Recommendations: Women in Combat: The Utilization of Women in the OIF/OEF Theatres of Operation
- Chapter V – 2009 DACOWITS Findings and Recommendations: Support for Families of Wounded Warriors

Chapters II and III provide a detailed description of the Committee's primary research findings for each topic, drawn from the data collected on site and supplemented as appropriate with data

[104] Military Officers Association of America (MOAA). (October 2009). Wounded and Families: Care Isn't Seamless Yet. Retrieved September 1, 2009, from http://www.moaa.org/lac_issues_update_090501.htm#issue2.

from the literature and surveys. Chapters IV and V include a summary of the Committee's major findings on each topic and provide formal recommendations. Appendices are provided in the back of the report.

II. WOMEN IN COMBAT: THE UTILIZATION OF WOMEN IN THE OIF/OEF THEATRES OF OPERATIONS

DACOWITS selected the topic of women in combat to gain insight into the combat experiences of our women in uniform and the resulting implications. Recent popular media coverage of women deployed in support of OIF/OEF has provided increased visibility of women serving in combat roles. In an attempt to better understand their experiences, DACOWITS employed a systematic research methodology to gather and analyze the experiences and implications of women in combat. Using a pre-tested focus group protocol and a short survey instrument distributed during its 2009 focus groups, DACOWITS captured the combat experiences of female Service members, opinions on women in combat from male and female Service member participants, and participants' views on the implications of women in combat on both the military and on the women serving in these roles. This chapter summarizes DACOWITS' findings on this topic in 2009.

The chapter begins with a description of the 2009 focus group participants and the qualitative analysis methodology used in the report. The remainder of the chapter highlights specific findings concerning the following domains:

- Roles Women Perform in the OIF and OEF Theatres of Operations
- Combat Preparedness of Female Service Members
- Implications of Women Serving in Combat
- Perspectives on the Roles Women Should Serve in the Military
- Leader Understanding of DoD Assignment Policy for Women

In addition to conducting 31 focus groups on these topics, DACOWITS hosted two panel discussions on women in combat with previously deployed female Service members—one with enlisted women and one with female officers. Comments resulting from these panels are included with the study findings as appropriate. Where applicable, the Committee's focus group findings are supplemented with results from mini-surveys completed by participants.

A. CHARACTERISTICS OF FOCUS GROUP PARTICIPANTS

Understanding the demographic and background characteristics of the focus group participants provides context for the overall themes and individual comments that emerged during the sessions. During spring/summer 2009, DACOWITS conducted a total of 31 focus group sessions on the topic of women in combat, Focus groups were held at eight locations, plus six "virtual site visits" to Iraq and Afghanistan, which were conducted via video teleconferences (VTCs) at the Pentagon. A total of 336 participants attended the focus groups, with an average of 11 participants per session, representing the entire Active Component (AC) Services and some

elements of the Reserve component (RC). Each focus group session included Service members who had deployed to OIF and/or OEF, including junior female Service members, senior female Service members, junior male Service members, and senior male Service members.[105] The overall demographic characteristics of the focus group participants are presented in Exhibit II-1.

Exhibit II-1:
Women in Combat: The Utilization of Women in the OIF/OEF Theatres of Operations
Demographic Profile of Focus Group Participants (N=339*)

Variable	N	Percent**
Gender:		
Female	238	70%
Male	101	29%
Total	**339**	**100%**
Service:		
Army	93	28%
Marine Corps	49	15%
Navy	48	14%
Air Force	45	13%
Reserves***	44	13%
Coast Guard	30	9%
Army National Guard	27	8%
Total	**336**	**100%**
Pay Grade:		
E1-E4	52	15%
E5-E6	92	27%
E7-E9	94	28%
O1-O3 (including Warrant and Chief Warrant Officers)	62	18%
O4-O6	39	12%
Total	**339**	**100%**
Marital Status:		
Married	184	55%
Single, but with a significant other	58	17%
Single, with no significant other	54	16%
Divorced or legally separated	40	12%
Widowed	1	0.3%
Total	**337**	**100%**
Respondents with Children:		
Yes	138	41%
No	199	60%
Total	**337**	**100%**

[105] For this study, DACOWITS defined junior Service members as those in ranks E1 through E6, and senior Service members as those in ranks E7 through E9 and all officers.

Exhibit II-1: Women in Combat: The Utilization of Women in the OIF/OEF Theatres of Operations Demographic Profile of Focus Group Participants (N=339*)		
Length of Military Service:		
Under 3 years	20	6%
3-5 years	61	18%
6-10 years	61	18%
11-15 years	64	19%
16-20 years	68	20%
More than 20 years	62	19%
Total	**336**	**100%**

* 32 participants reported that they had not been deployed and are excluded from this table.
**Percentages may not sum to 100% due to rounding.
***The Reserve participants included 35 Army reservists. The remainder was Marine Corps or Air Force Reservists, or Air Guard.

As Exhibit II-1 shows, the majority (70%) of focus group participants were female. It is worth noting that the qualitative information collected by DACOWITS from these 238 female service members represents one of the richest sources of data on women's perspectives and experiences related to combat that has been gathered in recent years. The Army was the most represented Service, with over a quarter (28%) of participants, and the Marine Corps, Navy, Air Force, and Reserves were more or less equally represented, each comprising between 13 and 15 percent of the study participants. The Coast Guard and Army National Guard were also represented, each comprising slightly fewer than ten percent of the study participants. More than half (55%) of participants were junior or senior Noncommissioned Officers (NCOs) (E5-E9), and almost a third (30%) were officers (O1-O6, and including Warrant and Chief Warrant Officers), and more than half (58%) of study participants had served more than ten years in the military. The majority of participants were married (55%), and less than half (41%) had children. For a complete summary of the demographic characteristics of these focus group participants, see Appendix F.

B. QUALITATIVE ANALYSIS METHODOLOGY

The methodology used by DACOWITS to identify salient themes related to women in combat from the 2009 focus groups varied little from the approach the Committee has employed in the seven previous years under its revised charter. Specifically, the Committee employs the services of a professional research contractor (ICF International) to assist in the development of focus group and survey instruments tailored specifically for the topic at hand. Contractor research staff serve as scribes, accompanying the Committee members/facilitators to each focus group, and generate a near-verbatim transcript from the session. Each individual focus group transcript is then content-analyzed to identify major themes and sub-themes, and the resulting transcript-level findings are entered into a sample-wide database for further analysis. The purpose of the

sample-wide analysis is to determine the most salient comments throughout the focus group sessions, i.e., themes that appear most frequently within and across focus group sessions. These comments, or findings, are presented at the beginning of each substantive section of this chapter, followed in turn by less salient findings and select noteworthy non-salient findings.

C. ROLES WOMEN PERFORM IN THE OIF AND OEF THEATRES OF OPERATIONS

This section discusses focus group and mini-survey findings concerning the following sub-topics:

- Jobs female Service members performed in the theatres of operations
- Combat experiences of female Service members deployed to OIF/OEF
- How female Service members feel about their combat experiences

The section concludes with a summary.

Jobs Female Service Members Performed in the Theatres of Operations

Mini-surveys completed by each participant offer a top-level view of women's roles in the theatres of operations. More than a third of female participants (35%) and more than half of male participants (56%) reported deploying more than once in support of OIF or OEF (Exhibit II-2).

Exhibit II-2:
How many times have you been deployed in support of OIF/OEF?[1]

	Females[2]	**Males**[3]	**Overall**[4]
Once	65%	44%	58%
Twice	27%	46%	33%
Three times or More	8%	10%	9%
Total	**100%**	**100%**	**100%**

*Not every participant answered each question. Percentages may not sum to 100% due to rounding.
1. 32 participants reported that they had not been deployed and are excluded from this table.
2. N=207, 3. N=100, 4. N=307

To better understand the overall experiences of deployed female Service members, DACOWITS asked participants about the jobs they performed in theatre, and to what extent this matched their expectations and their military occupational specialty (MOS) assignment. More than half of female (55%) and male (55%) participants reported working outside their MOS while in theatre (Exhibit II-3).

Exhibit II-3: While in theatre, did you work outside your MOS?*[1]			
	Females[2]	**Males**[3]	**Overall**[4]
No	45%	48%	46%
Yes, occasionally	26%	17%	23%
Yes, frequently	29%	35%	31%
Total	**100%**	**100%**	**100%**

* Not every participant answered each question. Percentages may not sum to 100% due to rounding.
1. 26 participants reported that the question did not apply to them because they had not been deployed in support of OIF/OEF and they are excluded from this table.
2. N= 209, 3. N= 100, 4. N= 309

In addition, the mini-survey data show that more than a fifth of female (22%) and male (21%) participants reported not performing the job assignment that they received prior to their deployment to OIF or OEF (Exhibit II-4).

Exhibit II-4: While in theatre, did you perform the job assignment that you received prior to deployment?*			
	Females[1]	**Males**[2]	**Overall**[3]
Yes	78%	79%	78.4
No, my assignment changed after I deployed	22%	21%	21.6
Total[4]	**100%**	**100%**	**100%**

* Not every participant answered each question. Percentages may not sum to 100% due to rounding.
1. N= 207, 2. N=99, 3. N= 306
4. 29 participants reported that the question did not apply to them because they had not been deployed in support of OIF/OEF and they are excluded from this table.

Female study participants, both junior and senior, were asked in the focus group discussions, "What was your job while you were deployed? Is it what you expected? Did you work outside of your MOS while in theatre?" Leaders, both female and male, were asked, "What jobs did junior women fill while deployed? Approximately what percentage worked outside their MOS?" Participants listed a variety of jobs women are performing in theatre, including, but not limited to cooks, intelligence, security, medics, Military Police (MPs), mechanics, electricians, heavy equipment operators, mail clerks, and drivers. The focus group participants also explained that, with great regularity, women are serving outside their MOS while in theatre and performing jobs that they did not expect to do prior to deploying.

> "Initially, when told about the deployment, I was told something completely different…I was not told up front what I would be doing!"
>
> —Senior female Service member (currently deployed)

"I was actually assigned to an Army battalion. We got assigned to them after training. We didn't expect to do that job. While I was there I had three different jobs within the eight months that we were there. We were told we were going to work one job and then got there and were told something else. It was frustrating…"
—Senior female Service member

"There are many different jobs [junior female Service members] can be tasked with…[T]hey show up at the deployment location and that's where the decision is really made for what type of work they will do there. Sometimes it's hit or miss on whether or not they are working in something they have been trained to do."
—Senior male Service member

"I was set up to do entry control when I got to Iraq so we were responsible for checking the [Iraqi] females and some vehicles. I wasn't expecting to do this at all. We had on-the-spot training. They put me in this role because I was a female and they needed me to do this right away."
—Junior female Service member

Occasionally, participants mentioned that the practice of working outside their MOS or otherwise performing unexpected jobs is not unique to women, and happens with both female and male Service members.

"Men and women would work in and out of their MOS."
—Senior male Service member

"[T]he percentage [of females] working out of their MOS was probably about 30 percent, which was pretty consistent with the males…"
—Senior male Service member (currently deployed)

"Everyone works outside the MOS some."
—Senior female Service member (currently deployed)

Less regularly, participants reported that women are primarily only performing jobs as expected within their MOS.

"I've always done my MOS. I have never done anything else."
—Junior female Service member (currently deployed)

"The vast majority [of junior women] worked their MOS."
—Senior female Service member

"I can't think of anyone who was deployed and working outside of their MOS."
—Senior female Service member

"[Junior female Service members] were all doing the job within their rating."
—Senior male Service member

Gender as a consideration in assigning personnel to combat jobs or missions

DACOWITS asked female and male leaders, "When you're assigning junior Service members to jobs or missions that might involve combat, how does the person's gender figure into your decision process?" Most frequently, the military leaders who participated in the focus groups reported that a Service member's capabilities are a higher consideration than gender when assigning personnel to combat jobs or missions.

"You assign the best person with the best skills to the job and that's it."
—Senior female Service member (currently deployed)

"There's no consideration for whether someone is female or male. It's just about who can do that job."
—Senior male Service member (currently deployed)

"…whoever knows the job and can do the job…gender does not play into who gets it."
—Senior male Service member (currently deployed)

"I believe in equity…so I try not to look at gender. I look at the mission and how to do it best. That's the goal. The person and their abilities is the consideration."
—Senior female Service member

Less frequently, leaders reported that gender may play a role in their job assignment decision-making process, depending on various factors, including the logistics of the particular mission, cultural considerations within the theatres of operations, and the number of males in the particular unit or location, as leaders often do not want to have a female by herself without other females at a particular location.

The logistics of the particular mission and location

"[It is] based on the situation, what the mission is. You have to take into account - logistically."
—Senior female Service member

"In logistics you have to pay attention to gender. For an FOB (Forward Operating Base), you need separate areas and separate heads. In normal combat, we don't worry about that. We only had so many portable toilets and we had to factor in just a few for females. We also needed a place for them to stay. Just for those factors, gender was important."
—Senior male Service member

"The only thing that makes it matter occurs if the facilities at that specific location-whether it be billeting or if certain equipment can't get there because it's landlocked-some locations cannot support females. Other than that it just matters who can do the job."
—Senior male Service member (currently deployed)

Local cultural considerations

"It had more to do with the specific scenario you were going into and the Afghan Army…You never wanted a female medic alone with the Afghan Army - where that culture could affect something that occurred."
—Senior female Service member

"Depends…We had certain boats that had people with other nationalities that didn't respect women, so we didn't want to put them in that position."
—Senior male Service member

"We couldn't assign females to do certain jobs. Because their culture and by the Soldier being a female, they could only do certain jobs."
—Senior female Service member

The number of males in the particular unit or location

"[T]here were a few times where I had to change their initial assignment, because they were female going to a base where there were all men. I couldn't do that to them. You need to have another female with them. There were certain times when you had to think about gender because of the gender percentages."
—Senior female Service member

"Certain units I can't assign a female, because there are no other females there…"
—Senior female Service member

Combat Experiences of Female Service Members Deployed to OIF/OEF

On both the mini-survey and during the focus group discussions, DACOWITS asked study participants a series of questions related to the combat experiences of female Service members. The mini-survey asked study participants to report their experience with a series of situations that may be considered combat. The majority of female participants reported that they were physically in a combat theatre of operations (66%), exposed to the possibility of hostile action from a threat to self or unit (74%), and in a situation where they received hostile fire (56%). A small percentage of female participants (8%) reported that they were in a situation where they fired their weapon (Exhibit II-5).

Exhibit II-5:
While deployed in support of OIF/OEF, were you…*

	Percent Responding "Yes, Regularly", or "Yes, Irregularly"		
	Females[1]	Males[2]	Overall[3]
Physically in combat theatre of operations?	66%	49%	70%
Exposed to the possibility of hostile action from a threat to yourself or your unit?	74%	84%	77%
In a situation where you fired your weapon?	8%	14%	11%
In a situation where you received hostile fire (e.g., gunfire, rockets/mortars, IEDs, suicide bomber, ambush)?	56%	55%	56%

* Not every participant answered each question. Percentages may not sum to 100% due to rounding.
1. N=209, not all participants answered each question. 2. N=101, not all participants answered each question.
3. N= 310, not all participants answered each question.

Focus group participants were asked to share the first words that come to their minds when they hear the word "combat." A variety of responses were provided, including, but not limited to, combat pay, convoy, deployment, enemy, explosions, fighting, fired upon, firing weapon, hostile, IEDs, in danger or harm's way, injury, kill, mortar, patrol, rockets, sirens, smoke, suicide bombers, war, and weapons. They were then read the following definition of combat, which they were then instructed to consider for the subsequent discussion on women in combat:

> When one is physically in a combat theatre of operations where one is exposed, on a regular or irregular basis, to the possibility of hostile action from a threat, either to self or unit, requiring defensive or offensive measures which may involve the use of arms to keep from harm.

Female Service members were asked in the focus groups, "Considering this definition of combat, were you involved in any combat situations during your deployment(s) in support of OIF/OEF? If so, please tell me a little bit about the circumstances and your role." Leaders, both female and

male, as well as junior males, were asked, "Considering this definition of combat, were any of the junior females with whom you served involved in any combat situations during your deployment(s) in support of OIF/OEF? If so, please tell me a little bit about the circumstances and their role."

The overwhelming majority of focus group participants reported, with a show of hands, that they or the females with whom they served had been involved in combat roles while deployed to OIF or OEF. Participants rarely reported that females were not involved in combat.

> "Let's face it, we're saying that women will not be in combat, and then they get there, and they are in combat…These youngsters have been to war and in combat….These women are as far forward as anyone can get."
> —Participant, Female Officer Panel

Combat experiences of female Service members

Participants described a variety of combat roles in which women served and the circumstances of these combat situations. The most common combat role cited was being present in the theatres of operations, where there is a blurry front line, if any, and where every Service member is in harm's way and can be fired upon, even inside the wire.

> "The nature of today's engagements do not lend to a clear distinction between front lines and rear. Everywhere you are, you're in combat and in harm's way."
> —Participant, Female Officer Panel

> "It's not traditional combat anymore...When you are in a foreign country, you are at threat."
> —Senior female Service member

> "The environment and how it's become an austere asymmetrical situation - these women are in combat."
> —Participant, Female Officer Panel

> "Simply being on camp [is combat]. The mortars came through on a regular basis. We had secured off a little area and I got to actually run the checkpoint and fire at an Iraqi vehicle. One came in the wrong way and I shot and killed one person."
> —Junior female Service member

> "The base was always under attack."
> —Senior male Service member

"There were always attacks and the threat. You always have to look at everyone and wonder if they are going to do something bad to you. In Iraq…you can't let your guard down."
—Senior female Service member

"Males and females were always in combat."
—Senior male Service member

Another common combat role of females serving in OIF and OEF mentioned by participants is serving outside the wire, either on convoys, as drivers, or otherwise traveling between camps.

"We had a female who received a bronze star. She was on the team while an IED exploded and killed her team. She was there in direct combat and she administered self-aide and medical aide to help save some of those folks from worse injuries…Women in some career fields were exposed to it every single day and they were in combat and in convoys where they face danger going to the location, in the location, and coming back from the location. It doesn't get more into the line of combat than that."
—Senior female Service member

"We took several hits on the convoy…We lost our staff sergeant and that was a huge loss. We took in IEDs and mortars. That was the worst. But we took it in all the time and there were a lot of close calls. We would have a suicide bomber hit the gate and there would be pieces from him hitting my car. You would just never know what to expect."
—Senior female Service member

"I was on a convoy…We got hit by an IED so I think that counts as combat."
—Senior female Service member

"The junior females I served with were truck drivers on the road; they were doing convoys. In the truck, [the enemy] can't tell if it's a guy or a girl."
—Senior female Service member (currently deployed)

"Just traveling between camps they were exposed…Traveling was combat."
—Senior male Service member

"Most of [the junior females I supervised] were truck drivers or mechanics. They were exposed daily to combat situations."
—Senior male Service member

Occasionally, participants mentioned female search teams, including the Lioness program, as a recent combat role in which women have served.

"I was attached to an infantry unit where I was in support of the Lioness program… There were nine of us females, and we had roughly seven days training, and we supported the combat unit to search females. So I was attached to them for about a month and a half… We did a fact finding mission where we entered houses if there was a large group of females to be searched."
—Participant, Female Enlisted Panel

"We needed women to work with the Iraqi women. It was not voluntary…"
—Senior female Service member

"They served as part of the Lioness program."
—Senior female Service member

"Females are at our entry control point where they are specifically used to search female workers coming on board or to search vehicles."
—Senior male Service member (currently deployed)

"Junior females…are used for doing female searches. They need them out there."
—Senior female Service member (currently deployed)

"The female search teams had a possibility of hostile action."
—Senior male Service member

Some participants cited females firing their weapons or being fired upon as combat experiences faced by female Service members deployed to OIF and OEF.

"I shot and killed one person."
—Junior female Service member

"I was shot at and all those good things."
—Junior female Service member

"My job is doing the security and I took a couple pop shots on the truck…We are the bomb kickers; we get the IEDs before they can blow anyone up. We found a couple, thank God. They would shoot at us all the time."
—Junior female Service member

"It was at night and they started firing on us from caves and tunnels around there….They started firing at us and we returned fire. I was exposed to the incoming rounds…"
—Senior female Service member

A few participants shared the experiences of female Service members involved in remote combat, where they are actively engaged with the enemy from a remote location. Although not the typical combat experiences of either gender, this brings to light an emerging type of combat experience.

"During a duty day they are CONUS [Continental United States] but they are killing 5 guys because they pulled the trigger when their targets are on cue and then they drive home to their wife and kids or their husband and kids…We try to make sure they are safe over there while deployed but we overlook the people sitting in the box with the Unmanned Aerial Vehicles."
—Senior male Service member

"We have a lot of young people doing things like the intelligence reach-backs and it's from bases at home. It's the jobs for the young troops like observers who watch on-screen or the pilots of the unmanned aircrafts. They have the stress of following this target for a long time. It's stressful even though they aren't threatened in terms of death, they are responsible for choosing whether or not to hit that target and then they go home to their husband or wife after they may have killed someone."
—Senior male Service member

"We have people here who live on base and all day are watching combat on a live intelligence screen…These stresses are new to us but it can create full-blown PTSD. It's a new frontier that we are now trying to wrap our brains around. Technology has changed warfare."
—Senior male Service member

How Female Service Members Feel About Their Combat Experiences

As female Service members frequently perform unexpected jobs in theatre and often serve in combat roles, DACOWITS wanted to know how women feel about these experiences. Female focus group participants were asked their feelings about having served in a combat role. The most common responses were positive, and often female Service members were pleased and proud to have served in combat.

Proud of combat experience

"People look towards me for guidance now, based on my experiences. The pin is a big deal. We are very proud to have it."
—Senior female Service member

"Professionally, I feel proud."
—Senior female Service member

"I loved it. I'm as patriotic as they come. My family's all proud."
—Senior female Service member

"I think it's great…When I come home, my boys say they are proud of me and they want to join now and I hope they do. I'm proud and it's an awesome feeling."
—Junior female Service member

"I feel pretty good about it. I don't know that I agree with the politics of what we're doing, but I feel proud."
—Senior female Service member

Other positive feelings toward combat experiences

"Women are so limited by what they can do in combat so when the opportunity actually comes up, it gives us a great sense of accomplishment. I want to be able to shoot. I work so hard and I want to say I can do this, too…It's awesome."
—Senior female Service member

"I wouldn't have changed anything. It was a really good experience and I wouldn't take any of it back."
—Junior female Service member

"It's really interesting to see a female who's been in combat. They say, 'Wow, that's great!'"
—Junior female Service member

"You find out you have inner strength you did not know you had. You find out no matter what happens, you can deal with it during that crisis."
—Senior female Service member

"For me, it was one of the best experiences of my life...I grew up a lot as a person. I hardened up a lot."
—Senior female Service member (currently deployed)

"It was the best experience I've ever had…I love it and can't wait to do it again."
—Senior female Service member

Less frequently, female focus group participants expressed a neutral position about serving in combat, viewing it simply as part of their job.

"There's no draft in the military right now. We joined knowing that we have the responsibility of protecting the country and if you don't have combat over time, then you were very lucky."
—Senior female Service member

"I was doing my job. It's not really a big deal."
—Senior female Service member

"I didn't think twice about it because it's what we're supposed to do when we sign up."
—Senior female Service member

"I don't think about it. It's my job. I go with the flow…"
—Senior female Service member

A few female participants indicated they would have preferred more combat opportunities.

"Many women want to do what we are talking about. I want to get that pin. I haven't had that opportunity. Women need more opportunities. It's career essential for us."
—Junior female Service member

"Men get more experiences and more chances. Women don't get the opportunities so it's a lot slower for advancement. They will take a man over a woman."
—Junior female Service member

"Some people assume women don't want to go but it's not true. It's irritating when they think we don't want that."
—Junior female Service member

"They send the males first. The FOBs are made just for the males and we just can't go because there aren't the female facilities. I would have loved to have gone but it wasn't available for me. It's a fight for females to get out there and be a part of it."
—Senior female Service member

A very small number of female participants reported negative feelings about their combat experience.

"About three weeks back our company was very close to mortar attacks. I'm pretty shaken up about that and I can't wait to go home."
—Junior female Service member (currently deployed)

Sporadically, female focus group participants with combat experience said family considerations negatively impact their feelings toward their combat experience.

"My family and I were very close before I deployed for a year. I spent lots of time with them. But now that I'm back I'm very disconnected from my family. I have not yet reintegrated with my family."
—Senior female Service member

"It tears down my family every time I go. Based on my family, I wouldn't go. I've been twice. I've fulfilled my obligation."
—Junior female Service member

"I feel bad because I'm a single mom and I have a 7-year-old daughter. I hate to say it but she gets more attention when she's with my parents when I am deployed because I have PT [Physical Training] at 6 am and have to work late. When I'm downrange she's getting all of that. Its weird because it's like why would you want to leave your child and go back to war? But that's when her needs get better met."
—Senior female Service member

Summary: Roles Women Perform in the OIF and OEF Theatres of Operations

This section summarizes the findings on the roles women perform in the OIF/OEF theatres of operations.

<u>Jobs Female Service Members Performed in the Theatres of Operation</u>

DACOWITS focus group participants reported working in a variety of jobs while deployed in support of OIF/OEF. The majority said that female Service members work outside their MOS while in theatre and perform jobs that do not match their pre-deployment expectations. Some

participants, however, provided the caveat that the practice of working outside their MOS or otherwise performing unexpected jobs is not unique to women, as it happens with both female and male Service members.

DACOWITS discussed with military leaders who participated in the focus groups how gender is considered when assigning personnel to combat jobs or missions. Leaders often said that a Service member's capabilities are a higher consideration than one's gender when making such decisions. Some leaders shared instances when one's gender does come into play when deciding who to assign to combat jobs or missions, which depend on a variety of factors, including the logistics of the particular mission, cultural considerations within the theatre of operations, and the number of males in the particular unit or location, as leaders often do not want to have a female by herself without other females at a particular location.

Combat Experiences of Female Service Members Deployed to OIF/OEF

DACOWITS asked study participants a series of questions related to the combat experiences of female Service members. The majority of female participants reported that they were physically in a combat theatre of operations, exposed to the possibility of hostile action from a threat to self or unit, or in a situation where they received hostile fire. Most focus group participants reported that they or the females with whom they served had been involved in combat roles while deployed to OIF or OEF. Participants rarely reported that females were not involved in combat.

A variety of combat roles were identified in which women have served. The most commonly cited combat roles include being present in the theatre of operations, where every Service member is in harm's way and can be fired upon, and serving outside the wire, either on convoys, as drivers, or otherwise traveling between camps. Other combat roles of women mentioned by participants include female search teams, including the Lioness program, and females firing their weapons or being fired upon.

How Female Service Members Feel About Their Combat Experiences

DACOWITS understands that female Service members may perform unexpected jobs in theatre and also may serve in combat roles, and they wanted to know how women feel about these experiences. For the most part, female focus group participants shared positive feelings toward their combat experiences. They often were pleased and proud to have served in combat, and a few indicated that they would like to have greater combat opportunities. Some female focus group participants expressed neutral feelings about serving in combat, viewing it simply as part of their job. Very few participants shared negative feelings about their combat experience, and rarely family considerations were brought up as a rationale for their negative feelings toward their combat experience.

D. COMBAT PREPAREDNESS OF FEMALE SERVICE MEMBERS

Following the discussion about the combat experiences of female Service members, DACOWITS asked focus group participants how well prepared females were to handle these combat situations, in terms of both training and equipment. This section is presented in two main parts, as follows:

- Adequacy of female Service members' combat training
- Adequacy of equipment issued to female Service members

The section concludes with a summary.

Adequacy of Female Service Members' Combat Training

The majority of both female (72%) and male (73%) focus group participants indicated on the mini-survey that the training they received prior to their most recent deployment in preparing them for combat was somewhat or very adequate (Exhibit II-6).

Exhibit II-6:
Please rate the adequacy of the training you received prior to your most recent deployment in preparing you for combat*

	Females[1]	Males[2]	Overall[3]
Very adequate	31%	32%	31%
Somewhat adequate	41%	41%	41%
Neither adequate nor inadequate	11%	9%	10%
Somewhat inadequate	11%	12%	11%
Very inadequate	3%	5%	4%
I did not receive any combat-related training prior to my most recent deployment	3%	2%	3%
Total	**100%**	**100%**	**100%**

* Not every participant answered each question. Percentages may not sum to 100% due to rounding.
1. N= 209, 2. N= 101, 3. N= 310

To learn more about the training they received, female focus group participants were asked, "What kind of training did you receive in preparation for your deployment to a combat theatre? Was it adequate?" Male participants were asked similar questions about their understanding of the training female Service members received. Although participants indicated a fairly high level of combat training adequacy on the mini-survey, most shared in the focus group discussions that the combat training female Service members received was deficient in one or more aspects. These aspects included: insufficient amount of training, absence of training, inadequate training, insufficient length of training, and poor training methods.

Insufficient amount of training

"I received minimal training."
—Senior female Service member (currently deployed)

"I was issued a weapon, but I never felt more unsafe…Having a weapon and knowing how to use it are different things. I was given almost no information or instruction. I had equipment but not training."
—Senior female Service member

"The training was here's your weapon, have a nice day, go shoot it on the range. No one showed us how to clean it or anything. I was so uncomfortable."
—Senior female Service member

"I didn't get a lot of training."
—Junior female Service member

Absence of training

"We didn't have any training for the last deployment…I called home and said, if I die out here, it's because we didn't get…training."
—Senior female Service member

"No, I was not trained for the job I did downrange prior to deploying."
—Junior female Service member

"I had no training. It was a last minute exodus."
—Senior female Service member

"We had no training or simulation lab. We were given a weapon and told to go shoot."
—Senior female Service member

Inadequate training

"These women are attached regardless of policy; these women are attached to combat units. Each one of these women is trained 100% in-depth for their assignment, not for their attachment. Shooting, we're all trained to shoot. But for the Lioness program, they're not trained to do searches and patrols. Females are not offered the same kind of training as their male counterparts due to their assignments. Females are now receiving training in theatre to get them up to speed, which is not enough."
—Participant, Female Officer Panel

"[The training] was not adequate to prepare me to be in the direct line of fire… I'd say we could have been better prepared."
—Senior female Service member (currently deployed)

"I think my training was not adequate since I was going into a combat zone. I didn't have training enough for that."
—Senior female Service member

"My training wasn't adequate for things I had to do outside my MOS."
—Junior female Service member

"Our training was entirely inadequate…That's a lot of people that aren't trained to do the job they now have to do in real life. You're hoping on a prayer when you get there."
—Senior female Service member

"We do logistics and run convoys and we weren't prepared for it. We were very lucky we didn't lose anyone along the trip."
—Junior female Service member

"I was issued a weapon, but I never felt more unsafe. It was very nerve racking, surrounded by [others] who couldn't fire it well. Having a weapon and knowing how to use it are different things. I was given almost no information or instruction. I had equipment but not training."
—Senior female Service member

Insufficient length of training

"Mine was just a week. Force fed and short."
—Junior female Service member

"[Training] was not adequate. It was useless because they pushed us through so fast we couldn't learn it."
—Junior female Service member

"We were not well prepared…We only did one week of good training for us - for our unit."
—Junior female Service member

"At first, it was two weeks of training and that got shortened to three days of training and then it got shortened again to one day of training and then they told me I don't have to go at all."
—Senior female Service member

Poor training methods

"They gave us a binder and then 3 days later we were deployed. We were told to read everything."
—Junior female Service member

Less frequently, participants reported that the training they received was adequate to do the job they performed in theatre.

"We did the rifle range, the pistol range, the heat training every time. I was prepared."
—Senior female Service member

"I agree that I'm adequately prepared and had appropriate skills training commensurate with what I need to do here."
—Senior female Service member (currently deployed)

"Training was more than adequate. We did everything-convoys, the medical part was gross, but it was my best experience in training."
—Senior female Service member

"They actually mimic a combat situation. It was very adequate."
—Senior female Service member

"It was adequate, but training can always be better."
—Senior female Service member

It should be noted that some participants indicated the adequacy of training was the same for females and males, and was not dependent upon one's gender.

"[The men] had done the same training as we had. They weren't prepared for it either."
—Junior female Service member

"[The women] were side by side with us the entire time, so they got whatever we got."
—Junior male Service member

"It was the same for men and women."
—Senior male Service member

"We just trained everybody together. We never separate our females from our males."
—Senior female Service member

Adequacy of Equipment Issued to Female Service Members

DACOWITS asked female focus group participants, "What kind of equipment did you receive for your deployment to a combat theatre? Was it adequate?" Male participants were asked similar questions in relation to the training female Service members received. The majority of focus group participants reported that the equipment provided to female Service members was inadequate in some capacity, including, but not limited to poor quality or outdated equipment, lack of necessary equipment, tardy issue of equipment, and equipment not sized or designed for women.

Poor quality or outdated equipment

"We had vests that were rejected by [other Service branches] as not good enough for combat, and that's what we were issued, even though we were in combat."
—Junior female Service member

"The equipment needs to be stepped up some."
—Senior female Service member

"Our equipment sucked; it was horrible. It was 30 years old."
—Senior female Service member

"They gave us Kevlars. Mine was recalled. My husband had one that failed the ballistics test…I thought that was poor."
—Junior female Service member

Lack of necessary equipment

"We were not issued weapons. In 2007, we didn't have Kevlar, we didn't have anything. Yet we were asked to go into harm's way. We didn't have what we needed to protect or defend ourselves."
—Senior female Service member

"We had an M9 and only 2 magazines. It was 60 shots and that was it. When…there is an IED, it wouldn't have been enough to protect ourselves."
—Senior female Service member

"We didn't have enough plates for all the jackets so we had to split them up depending upon where we though the fire might come from. If we thought it would be from behind, the people in back would get them! Our vehicles were horrible and a lot of them didn't have all of their doors because people were stealing them…We didn't have the right equipment at all."
—Junior female Service member

"Our unit wasn't prepared for anything. There were Soldiers without Kevlar or plates inside their vests. We were all the way in Iraq and there were so many Soldiers without equipment and we were far in, almost near Baghdad."
—Junior female Service member

"We didn't have enough weapons for each of us to carry…"
—Senior female Service member

Tardy issue of equipment

"I had to get to Iraq to get my M4...I was going into a combat environment without any weapon."
—Senior female Service member

"More needs to be focused on the speeding of getting us the equipment that we need."
—Senior female Service member

"Just to get the vests we needed, it was three to four weeks after we deployed that we finally got them…We started to try to get them three to four months before we deployed."
—Senior female Service member

Equipment not sized or designed for women

A number of participants identified a scarcity of body armor in small sizes. They also commented that the uniform and gear are cumbersome to remove for urination.

Equipment not sized for women

"We do tend to run out of smaller sizes more often. I'm not sure why we run out of the smaller sizes first."
—Senior male Service member (currently deployed)

"My things didn't fit me at all."
—Senior female Service member

"When I put on my jacket with the new SAPI (Small Arms Protective Inserts), I could barely walk because it was so big."
—Senior female Service member

Equipment not designed for women

"It's so hard to pee with that on. You can't take it off."
—Junior female Service member

"The pants were also not designed for women. Guys are so lucky."
—Junior female Service member

"I think they need more females in R&D [Research and Development]. They need to design things for women because right now it's completely ignored. If you are dealing with chemicals and wearing one of the new suits, you need to take everything off to pee. It's dangerous!"
—Junior female Service member

Less frequently, participants believed that female Service members received too much equipment, which was sometime a hindrance to performing their jobs.

"I had unnecessary stuff like 4 pairs of boots and desert camouflage uniforms which I did not need. I needed the vests, helmet, and everything but I didn't need all of that."
—Junior female Service member

"I think we had too many rounds. We were given so many and had to keep track of them and were responsible for them at all times. We didn't need them though."
—Junior female Service member

"We brought a lot of things that we never needed. When we got there they gave us more things that we don't need...Sometimes it can be overwhelming."
—Junior female Service member

"We got a bag of equipment with things we don't use…It's extra weight in the planes and on us and we need to have it with us all the time. We have to carry everything."
—Senior female Service member (currently deployed)

Some participants reported that the equipment females received was adequate to do their job in the combat theatre.

"We had full Kevlar and all the battle things. I had an M16, 203. We had tons of gear. Masks, everything."
—Junior female Service member

"We had boots, camouflage, everything. I think we had plenty."
—Junior female Service member

"I got everything I needed."
—Senior female Service member

"My equipment was adequate…I have no complaints in that regard."
—Senior female Service member (currently deployed)

A few participants mentioned that the adequacy of the equipment was not dependent upon one's gender; rather that females and males received the same equipment.

"There are still way too many things people have to carry. We're grappling with that. There should be a trade off between weight and how well we can run. The only real difference between men and women would be that there's a little bun or tuft of hair in the back. You can't see the difference when we're all decked out."
—Senior male Service member

"The gear is the same for men and women. It's as adequate as it is for anyone."
—Senior male Service member

Summary: Combat Preparedness of Female Service Members

DACOWITS asked focus group participants how well prepared females were to handle combat situations, in terms of both training and equipment. The majority of both female and male focus group participants indicated on the mini-survey that the training they received prior to their most recent deployment in preparing them for combat was somewhat or very adequate. Although participants indicated a fairly high level of combat training adequacy on the mini-survey, most shared in the focus group discussions that the combat training female Service members received was deficient in one or more aspects, including insufficient amount of training, absence of training, inadequate training, insufficient length of training, and poor training methods. Some participants reported that the training they received was adequate to do the job they performed in theatre. It should be noted that some participants indicated the adequacy of training was the same for females and males, and was not dependent upon one's gender.

The majority of focus group participants reported that the equipment provided to female Service members was inadequate in some capacity, including, but not limited to poor quality or outdated equipment, lack of necessary equipment, tardy issue of equipment, and equipment not sized or designed for women. Several participants said that the equipment issued was not adequate for women in particular, due to a scarcity of body armor in small sizes and because the uniform and gear are cumbersome for women to remove for urination. Some participants believe that female Service members received too much equipment, which was at times a hindrance to performing their jobs. A few participants mentioned that the adequacy of the equipment was not dependent upon one's gender, rather that females and males received the same equipment.

E. IMPLICATIONS OF WOMEN SERVING IN COMBAT

DACOWITS asked focus group participants to share their thoughts concerning the military and personal impacts of women serving in combat. This section presents the themes that emerged from their discussions under the following four headers:

- Impact of women in combat on mission accomplishment
- Impact of women in combat on unit casualties
- Impact of women in combat on unit morale
- Impact of women in combat on women's career plans and opportunities.

The section concludes with a brief summary.

Impact of Women in Combat on Mission Accomplishment

Focus group participants were asked to share their opinions on the impact that using women in combat has on mission accomplishment. The large majority of participants expressed the belief that women serving in combat has a positive impact on mission accomplishment. Frequently, participants said that the mission impact of women serving in combat varied, depending on various factors. Less regularly, they said the mission impact was negative. Each of these positions is summarized below.

Mission Impact of Women in Combat Is Positive

The most prevalent position of the study participants was that women serving in combat has a positive mission impact. They cited a variety of reasons for this, including allowing for greater sensitivity to cultural considerations (e.g., the Lioness program and women otherwise searching women and children), helping to maintain personnel strength, and lending a unique perspective on the mission.

Presence of women during the mission allows for greater sensitivity to cultural issues surrounding gender

> "Only women can search females over there, so it helped with mission accomplishment."
> —Senior female Service member

> "The Lioness program has really helped. It's great to have this program there because then we can work on mission accomplishment."
> —Senior female Service member

> "For Lioness missions, they have to be used to search the females. They were necessary for this part of the mission."
> —Senior female Service member

> "We had women go along to certain missions in case we might have to talk to Iraqi women. That was a necessity."
> —Senior male Service member (currently deployed)

Women in theatre provide needed personnel strength

> "It was essential. The women were helping with the shortage."
> —Senior female Service member

"If you take those women away you're loosing at least a piece of your mission accomplishment. There aren't enough men…to get the job done."
—Senior female Service member

"It would have been bad if we didn't have the female Soldiers. They did the same job as everyone else. We would have been short without them."
—Senior male Service member

Women participating in the mission bring a unique perspective or approach

"Women always bring a different dynamic…Women think outside the box on an emotional level or on a different level. We can use it to help them do their job better. It definitely helps our ability to collect because we think differently."
—Junior female Service member

"For detainee ops, it's good to have women there. When the male detainees curse, the women are more direct and get them to behave. The male guards are more combative. The women are also 'on guard' more than the males who relax sometimes. It's a different style."
—Junior female Service member

"I think females play a vital role in the Military. They think more globally."
—Junior female Service member

"The women were more careful. They are more careful with details."
—Senior male Service member

<u>Mission Impact of Women in Combat Varies</u>

Participants also frequently said that the impact of women serving in combat on mission accomplishment depends on the mission at hand and the individual female who is in the combat situation.

"I think it depends on the situation in combat. I'm for women in combat, if you can do the job…In some combat situations, women should not be on the front line. But other times - searches - I think that's great to use them for that."
—Senior female Service member

"I think it depends on the job you are doing and where you are at."
—Junior female Service member

"It depends on the situation."
—Senior female Service member

"I have seen it both help and hurt. It can go either way…I've seen it go either way: where it can help or hurt."
—Junior female Service member

Mission Impact of Women in Combat Is Negative

Less frequently, participants cited ways in which females serving in combat negatively impacts mission accomplishment. These include men being distracted by women and wanting to protect them, women not being as physically strong and therefore not able to do the same job as a man, logistical issues such as hygiene, and women impacting personnel strength by getting pregnant and then sent home.

Men want to protect women

"That's [the men's] problem if we're a distraction to them. They need to deal with it, and they're not. They can't see us as Soldiers. They see us as their mothers, aunts, wives. I think that's their problem."
—Senior female Service member

Women are not as physically strong as men

"An average female can't do the same things as the average male. Physically they are different."
—Senior male Service member

"There's a percentage who physically aren't adapted to all the jobs. Dealing with heavy equipment, MRAPs [Mine Resistant Ambush Protected Vehicles], doubling up on armor, welding; those skills are mainly male dominated."
—Senior male Service member (currently deployed)

Biological/logistical concerns

"When a woman has to relieve herself, it's not as easy as for men. So what they do is not drink as much water, so they may become dehydrated, which is a problem. We also had major sanitary problems."
—Senior male Service member

"They have some concerns like hygiene and facilities."
—Senior male Service member (currently deployed)

Women can get pregnant and can be sent home

"I know people who try to get pregnant so they don't have to go. That certainly takes away from the mission."
—Senior female Service member

"Pregnancies, of course. That affects it."
—Junior female Service member

"A lot of females try to get out of deployment by getting pregnant…They think, 'I can get pregnant, and I can go home'. They don't think about the consequences, just getting out off the situation."
—Junior female Service member

Impact on Mission Accomplishment Gender-Neutral

Occasionally, participants said that women serving in combat has no more of an impact on mission accomplishment than do men.

"Gender doesn't play a role. Everyone does their jobs."
—Senior female Service member

"Men and women are all trained the same. We can get the job done."
—Junior female Service member

"For me, when you think about combat with the uniform, it's just a solider. It's no different. I expect for that female to do the same thing as that male."
—Senior male Service member (currently deployed)

"When it comes down to it, it doesn't matter whether you're woman or man."
—Senior female Service member

"Women in combat can serve just as good as men. It doesn't impact [mission accomplishment]; it doesn't hinder it."
—Senior female Service member

Impact of Women in Combat on Unit Casualties

When asked how using women in combat impacts unit casualties, the overwhelming majority of participants said that the gender of the person in combat does not impact unit casualties.

"I don't think it makes any difference in unit causalities."
—Senior female Service member (currently deployed)

"Shrapnel will penetrate male or female skin the same way."
—Junior female Service member

"They just want to kill an American Soldier. It doesn't matter what gender."
—Junior female Service member

"I don't see where it influences the amount of casualties at all. It's all about the flag. They don't care."
—Junior female Service member

"If hit by an IED, it doesn't matter if you're male or female."
—Senior female Service member

Impact of Women in Combat on Unit Morale

DACOWITS asked focus group participants to share their thoughts on how the presence and participation of women in combat affects unit morale. The majority of focus group participants expressed that having females in combat does not negatively impact unit morale. Many reported that the presence of females has a positive impact on unit morale, as women often serve as a confidant to their male peers and women organize celebrations that boost unit morale.

Women as confidant

"If at all, I think it's in a positive way. Many guys have problems at home and as a female, they felt comfortable coming to me and talking about it with me…I think it helped them to have a female around to talk about personal things with."
—Senior female Service member (currently deployed)

"I think women are naturally more nurturing. The men being able to talk to the women for just a second can help them too."
—Senior female Service member

"A lot of the men out there would find the women in theatre and talk to them about their relationships back home with girlfriends and wives."
—Senior female Service member

Women organize celebrations that boost morale

"The little extras that females contribute are wonderful. Like she would set up trips, tours, and no one else in our unit thinks about that. The woman's touch contributes to the morale."
—Senior male Service member

"For Christmas and New Years we put together a dinner. We helped the morale for sure. We organized football games and movies. They guys would never had done that."
—Junior female Service member

"Where I was it upped morale a bit because my folks would get the job done and add a little flare to things like that. Around Christmas time it did pick people up. You saw smiles on people's faces. It's stereotypical but the girly touch helped. We still got the job done but we made people smile too."
—Senior female Service member

"The impact of having women there is huge. We went all out and made Christmas a big celebration for everyone out there. It was a surprise. The guys would not have done it but they enjoyed it. They really appreciated it."
—Senior female Service member

Some participants reported that females have no more impact on unit morale than males.

"Male or female, when you treat everyone the same, you don't have a problem."
—Senior female Service member

A minority of participants, most of whom were male, expressed that having females in combat negatively impacts unit morale. They cited reasons such as sexual tension and harassment, female emotionality, having to exercise discretion or decorum to avoid offending females, and differential Physical Training (PT) standards.

Sexual tension and harassment

"It increases significantly sexual harassment."
—Senior female Service member

"If a woman beats out a guy for a gunner…they might think she is giving out sexual favors. This happens everywhere."
—Junior female Service member

Emotionality

"They are the only ones that have had any issues with anyone else. They have issues with each other and they are roommates. Males handle conflict differently…They have had significantly more heartache and headache than the others."
—Senior male Service member (currently deployed)

Having to exercise discretion or decorum

"I know groups with females have lower morale. All male units don't have to go through the gender sensitivity training which makes people happy. There are less issues…I know morale is definitely higher for all male units."
—Senior male Service member (currently deployed)

"You just never know if the [gender] card's going to come out. So you have to be careful around them to not offend them."
—Senior male Service member

"It killed morale. You had to handle [females] with kid gloves."
—Senior male Service member

Differential PT standards

"There was a guy at 59 years old who had to run a mile two minutes shorter than a 21 year old female. It was a big disparity and a huge morale killer."
—Senior male Service member

Impact of Women in Combat on Women's Career Plans and Opportunities

DACOWITS asked female study participants to discuss the impact of their combat experience on their career plans in the military as well as on their opportunities for career advancement within the military. Each of these topics is discussed in turn.

<u>Impact on Military Career Plans</u>

Although the large majority of female (71%) and male (77%) Service members indicated on the mini-survey that their combat experiences did *not* influence their military career plans (Exhibit II-7), the focus group results told a somewhat different story. In these discussions, the

overwhelming majority of female participants reported that their combat experience has indeed influenced their future plans. We summarize separately below the positions of those who feel compelled by their combat experience to leave the military earlier than planned and those who now intend to stay longer.

Exhibit II-7:
If you selected "yes" to any of the above scenarios*, how did these experiences influence your military career plans?**

	Females[1]	Males[2]	Overall[3]
Did not influence my military career plans at all	71%	77%	73%
Made me want to stay in the military longer than I had planned	15%	16%	15%
Made me want to leave the military earlier than I had planned	14%	7%	12%
Total	**100%**	**100%**	**100%**

*Scenarios include: physically in combat theatre of operations; exposed to the possibility of hostile action from a threat to yourself or your unit; in a situation where you fired your weapon; and in a situation where you received hostile fire (e.g., gunfire, rockets/mortars, IEDs, suicide bomber, ambush).
** Not every participant answered each question. Percentages may not sum to 100% due to rounding.
1. N= 169; 2. N= 87; 3. N=256

Impact on military career plans: Influence to leave

Frequently, military women said that their combat experience has caused them to want to separate from the military sooner than they had planned. Some among them attributed this to family concerns. In certain instances, this was due to the risks associated with combat, while in other instances it was because, independent of combat risk, deployments require a protracted separation from their families.

Risks associated with combat

"I know that dying is an everyday thing but when you come so close to dying, it makes you think about your family more. It makes you want to be with your family more."
—Junior female Service member (currently deployed)

"I'm done…I'm not going to put myself in danger and leave my kid without a mom."
—Senior female Service member

Length of deployments

"Combat made me think more. I always wanted to stay in (the service), but because I have a small child and had to be away for a year, coming and going was hard."
—Senior female Service member

"I have 2 kids so deployments are tough. My husband and I are both in the military and we've had 4 deployments since 2004 so it has definitely impacted my decisions. I probably won't stay."
—Junior female Service member

"I was a single [Service member] and it pushed me to keep going. Now I have a son and a husband and I'm going to leave because of the deployment. I don't want someone else to raise my son."
—Junior female Service member

"It's the separation from the family, not just the combat…It's not just getting shot at; it's missing my family."
—Senior female Service member

"I'm currently working on getting out because I want to have more time with my family. Has combat changed my perspective? No. And if I couldn't have kids, I would totally give 20 years and stay in the Army…It's now time for me to do my family thing."
—Senior female Service member

Impact on military career plans: Influence to stay

Less frequently, female study participants indicated that combat experience has influenced them to stay in the military longer than they had planned.

"I learned a lot. I became confident and I wanted to stay and train young [Service members]. It made me want to stay in."
—Junior female Service member

"It made me want to stay and go do it again."
—Senior female Service member

"I will try to stay longer with this. It convinced me to stay in."
—Senior female Service member

Impact on Military Career Opportunities

When asked whether their combat experiences had impacted their military career opportunities, female Service members provided mixed responses. Their most common response was that their combat experiences had indeed impacted their career opportunities and, in most cases, this impact was positive.

"I was pushed ahead of my peers because of the combat experience, so yes."
—Junior female Service member

"It directly impacted my selection this year."
—Senior female Service member

"Combat experience gives you the extra points you need for awards."
—Junior female Service member

"It was probably positive for my career because I made O6. Other people didn't make it so I think my combat experience was a distinguisher."
—Senior female Service member

"If you have combat experience, you stand a better chance for being picked for promotion than someone without combat experience, all other things being equal."
—Junior female Service member

In some instances, female participants indicated that having this combat experience impacted their career opportunity positively in the sense that that *not* having it would leave them deficient and less competitive for advancement.

"It was a check in the box because we all have to do it at some point…You need to [do it] to be competitive. It just keeps you par."
—Senior female Service member

"It's expected that we would do it."
—Senior female Service member

A few female study participants mentioned that deploying to a combat theatre, not necessarily the combat experience itself, hinders career growth by limiting educational opportunities.

"It could definitely be a hardship and a hindrance being deployed and not being able to take the classes I need. It's a timing issue more than anything, trying to coordinate everything with the schools and registration. It has nothing to do with the combat environment; just being away hurts my advancement."
—Senior female Service member (currently deployed)

A few female participants were unsure of the impact of their combat experience on their career opportunities, but they were hopeful that it would be positive.

"It may have impacted promotion. I will find out soon."
—Senior female Service member

"Hopefully it will help advancement."
—Senior female Service member

"It may or may not enhance [military career opportunities]."
—Senior female Service member

Sporadically, female study participants said that their combat experience had no impact on their military career opportunities.

"No, it didn't influence my career opportunities or my career plans."
—Senior female Service member

"It didn't have any impact on me at all."
—Junior female Service member

Summary: Implications of Women in Combat

DACOWITS asked focus group participants to share their thoughts concerning the military and personal impacts of women serving in combat. This section summarizes the themes that emerged from their discussions.

Impact on the Military (Including Mission Accomplishment, Unit Casualties, and Unit Morale)

Focus group participants shared their opinions on the impact that using women in combat has on mission accomplishment. For the most part, participants said that women serving in combat have a positive impact on mission accomplishment. The reasons cited for this positive impact include allowing for greater sensitivity to cultural considerations, helping to maintain personnel strength, and providing a unique perspective on the mission. Frequently, participants said that the mission impact of women serving in combat varied, depending on factors such as the mission at hand and the individual female serving in the combat situation. Less often, they said the mission impact was negative, for reasons including men being distracted by women and wanting to protect them, women not being as physically strong and therefore not able to do the same job as a man, logistical issues such as hygiene, and women impacting personnel strength by getting pregnant and then sent home. Occasionally, participants said that any impact on mission accomplishment is gender-neutral, in that women serving in combat have no more of an impact on mission accomplishment than do men.

Participants also shared their thoughts on the impact of using women in combat on unit casualties. Most said that the gender of the person in combat does not have an impact on unit casualties.

When asked about the impact of women in combat on unit morale, the majority of focus group participants expressed that having females in combat does not have a negative impact. Many said that the presence of females has a positive impact on unit morale, as women often serve as a confidant to their male peers and because women organize celebrations that boost unit morale. The idea of gender-neutrality was also identified here, as some participants reported that females have no more impact on unit morale than males. A minority of participants expressed that having females in combat negatively impacts unit morale. They cited reasons such as sexual tension and harassment, female emotionality, having to exercise discretion or decorum to avoid offending females, and differential PT standards.

Impact on the Military Careers of Female Service Members

DACOWITS asked female study participants to discuss the impact of their combat experience on their military careers, including their military career plans and their opportunities for career advancement within the military. Although most female study participants indicated on the mini-survey that their combat experiences did *not* influence their military career plans, the focus group results told a somewhat different story. In the focus group discussions, the overwhelming majority of female participants reported that their combat experience has influenced their future plans, either to leave the military earlier than planned or to stay longer than planned. More often, military women said that their combat experience has caused them to want to separate from the military sooner than they had planned. Some attributed this to family concerns, including consideration of the risks associated with combat and simply the length of time away from the family resulting form deployments. Less often, female study participants indicated that their combat experience has influenced them to stay in the military longer than they had planned.

Regarding the impact of female combat experiences on military career opportunities, participants provided mixed reports. Most commonly, they said that their combat experiences had positively impacted their career opportunities. For example, some indicated that having this combat experience impacted their career opportunity positively in the sense that that *not* having it would leave them deficient and less competitive for advancement. A few said that deploying to a combat theatre, not necessarily the combat experience itself, hinders career growth by limiting educational opportunities. Very few female study participants said that their combat experience had no impact on their military career opportunities.

F. PERSPECTIVES ON THE ROLES WOMEN SHOULD SERVE IN THE MILITARY

DACOWITS sought to understand not only the study participants' experiences related to women in combat but also their opinions. To this end, the Committee asked all focus group participants to share their thoughts on how women should be utilized in theatre. They were also asked, "What are legitimate reasons for not allowing women to serve in combat roles?" Their responses are summarized separately below in two sections.

Roles in Which Women Should Be Utilized

The overwhelming majority of study participants indicated, either directly or indirectly, that women should be able to fill any and all roles in the military.

> "Any at all. I don't think women should be restricted."
> —Junior female Service member (currently deployed)

> "They should be able to do all roles."
> —Junior female Service member

> "I think it should be open if they want to. There are some women who probably want to be [in infantry]. Why not? We're supposed to be one. You're telling me she can't do it just because she's female?"
> —Senior male Service member

> "They're capable of anything we are. As long as they're doing the same training and stuff, then I'm all for it."
> —Junior male Service member

Some participants added the caveat that all positions in the military should be open to women in uniform, as long as they are capable and qualified for the job.

> "If the females can do the job without any hindrance, why not allow them to do it? If you can do it and you want to do it, by all means go ahead and do the job."
> —Senior male Service member (currently deployed)

> "I think we should do anything we are qualified to do."
> —Senior female Service member

"You should do the role you think you can do. Females aren't allowed to be grunts but some females are able to do this type of work."
—Junior female Service member

"It should only depend on physical strength…"
—Senior male Service member

"All MOSs should be opened up if they meet the standard. It should be across the board…Create a standard based on what the job requires."
—Senior female Service member

A number of participants specifically said that gender should not influence the military roles available to an individual, thereby indicating that all roles should be open to women in uniform.

"However it works for the men, it should be the same exact position for the women."
—Senior female Service member

"I think men and women have the same capabilities and it shouldn't be a gender issue. I know it's a culture thing. Even outside the military we have these issues. But we are strong…"
—Senior female Service member

"I don't think gender should play an issue when you have the capability and willingness to do your job."
—Senior female Service member (currently deployed)

"In my personal opinion, if the female has the training or the knowledge or ability, I think it shouldn't matter what their gender is. It's capability that matters."
—Senior female Service member (currently deployed)

A few study participants responded that women should be allowed to serve in any capacity in the military in which they are needed.

"Wherever they are needed really."
—Senior female Service member (currently deployed)

"In whatever roles the Armed Forces need."
—Senior female Service member

Sporadically, study participants said that women should be allowed to serve in any roles in which they are currently allowed. Unfortunately, this position is somewhat ambiguous in that "what is currently allowed" in practice versus on paper may differ.

"I think it's working the way it is now."
—Senior female Service member

"I think they have it right. It should stay how it is."
—Senior male Service member

Reasons for Not Allowing Women to Serve in Combat Roles

When asked to list what they consider to be legitimate reasons for not allowing women to serve in combat roles, most focus group participants cited none. The few who did offered the following reasons: women in the combat theatre are a distraction to men; men instinctively want to protect women in combat situations, which can put lives as well as the mission in jeopardy; supporting women in theatre logistically is difficult; women are not viewed as equal by local cultures, which impedes the mission; and some segments of the American public are against women serving in combat.

Women may be a distraction to the men in a combat theatre

"I think its distracting to have women outside the wire. I think its distracting for men. I think its distracting to have women on the front line."
—Junior female Service member

"Women can be distractions. It's a terrible distraction to have females in combat roles…It's a big distracter with even fewer women around. I'm in an infantry unit. When any woman walks through, we all stare because there just aren't women usually. If that female goes down, it might really mess things up because everyone would be watching for her."
—Senior male Service member (currently deployed)

Men want to protect women in combat situations

"If she looks really good then there's a man who wants to protect her and follow her wherever she goes. That's a danger."
—Senior male Service member

"For a lot of men, their instinct is for them to take care of the women. You need to have a clear head and be able to focus on the mission rather than focusing on protecting an individual."
—Junior female Service member (currently deployed)

Logistical considerations

"Peeing standing up and menstrual cycles. They need to make an apparatus that women can stand and pee."
—Senior female Service member

"The hygiene part is hard to deal with. Combat showers and baby wipes are only going to go so far."
—Junior female Service member

Impact on mission accomplishment due to local cultural considerations

"Dealing with other cultures…Often you can't send a woman to do something because the local culture can't handle it."
—Senior male Service member

"It's the culture thing that causes the problem. It distracts from the mission and causes more harm than good."
—Senior female Service member

Views of American public against women serving in combat

"The American public knows we are out there, they are not stupid. They won't accept it though, it's a generational gap. Our generation and below can do this. It's generational."
—Senior female Service member

"There's a political side to it as well. The Americans aren't ready to see women get killed."
—Senior male Service member

Summary: Perspectives on the Roles Women Should Serve in the Military

DACOWITS sought to understand Service members' opinions on the roles of women in uniform. When asked to share their opinions regarding the roles in which women should be utilized, the overwhelming majority of study participants indicated that women should be able to fill any and all roles in the military. Some participants added the caveat that all roles should be open to

women in uniform as long as they are capable and qualified for the job. Again, the idea of gender-neutrality was addressed, as several participants said that gender should not influence the military roles available to an individual, thereby indicating that all roles should be open to women in uniform. A few think that women should be allowed to serve in any capacity in the military in which they are needed. And a very small number of study participants said that women should be allowed to serve in any roles in which they are currently allowed. Unfortunately, this position is somewhat ambiguous in that "what is currently allowed" in practice versus on paper may differ.

When asked to share what they think are legitimate reasons for not allowing women to serve in combat roles, most focus group participants cited none. The small number who did provide reasons listed the following: women in the combat theatre are a distraction to men; men instinctively want to protect women in combat situations, which can put lives as well as the mission in jeopardy; supporting women in theatre is logistically difficult; women are not viewed as equal by local cultures, which impedes the mission; and some segments of the American public are against women serving in combat.

G. LEADER UNDERSTANDING OF DOD ASSIGNMENT POLICY FOR WOMEN

In an attempt to better understand the extent to which the current DoD assignment policy for military women is known and implemented in theatre, DACOWITS asked study participants in leadership roles, both female and male, "What is your understanding of the current policy relating to women serving in combat? In practical terms, how well are you able to implement this policy in theatre?" Frequently, senior focus group participants were unaware of the current policy or unsure of what it is.

> "I really don't know what the policy is. Sorry, I have no answer."
> —Senior female Service member (currently deployed)

> "I don't know of any policy."
> —Senior female Service member

> "I'm not aware of any policy available for women in combat."
> —Senior female Service member (currently deployed)

> "I personally don't know exactly what the regulation states and I'm not going to pretend that I do."
> —Senior male Service member (currently deployed)

"It's hazy to me. I would love more information about what it is they can do and what the limitations are."
—Senior male Service member (currently deployed)

Less frequently, participants shared some understanding of the policy, relating to either the assignment or to the utilization of women in the military.

"They can be a part of anything but infantry."
—Senior male Service member

"I could be wrong, but female Marines shouldn't be assigned to units where their direct mission is combat…The units that have direct combat as their mission - that's closed to women…Female Marines are expected to go into combat and all are rifleman. They bleed and die just like male Marines. They fight side by side. We have problems with the wording on attachments."
—Senior male Service member

"I know the policy. There are no women in combat armed units. Like field artillery - and you are not to have women in that unit…If you have a women's name on that role, that's a break of policy."
—Senior female Service member

"They can't be in direct ground combat."
—Senior female Service member

"My understanding is that women aren't supposed to have combat MOSs. This is laughable because we're all in there together. We're not picking and choosing who goes on the convoy. We just do our jobs."
—Senior male Service member

"The DoD policy is that women will not be in direct combat roles, but then you have to define what direct combat roles are. It's exactly what we all did out there."
—Senior female Service member

Although not directly asked, some participants offered their opinions on the current assignment policy of military women. Most often, those who shared their opinions said that it is either an unfair policy or that it is outdated.

Policy unfair

"It doesn't give much justice to women who have been in the Army and serving their country."
—Senior female Service member (currently deployed)

"It sends the wrong message and sets the wrong mindset."
—Senior male Service member (currently deployed)

"I know many enlisted females who have been in direct combat. If they hear the policy they would laugh but also be offended. They would think that it was a slap in the face."
—Senior female Service member

Policy outdated

"I'm familiar with some of the restrictions that detail women's missions relating to combat and quite frankly I think its naive and outdated and it doesn't give much justice to women who have been in the Army and serving their country. It seems as if is outdated and serves to protect other peoples' priorities rather than the people who are on the ground."
—Senior female Service member (currently deployed)

"As I understand it, my perspective is that the law is outdated. It was designed for an all-linear battlefield where infantry is up front. Now it's outdated and you have females embedded within infantry unit."
—Senior male Service member (currently deployed)

"What we're going through now is very different than other wars in history. There are fewer front lines and we're all susceptible to attack. I feel like it doesn't apply any more."
—Senior female Service member (currently deployed)

Some participants also said that the current policy is not enforced, as women are currently serving in combat.

"If there's a policy, there's no way to enforce it. Our service is all combat."
—Senior female Service member

"They aren't allowed in direct combat, but women are there anyways. I've seen them."
—Senior male Service member

"Women aren't allowed in combat, but it happens."
—Senior male Service member

"It's almost like don't ask don't tell."
—Senior female Service member

"We're not supposed to be in combat and a lot of other things, but we all know what we're actually doing…For manning purposes, women aren't supposed to go in certain areas in some units. But you know what? They are in those units."
—Senior female Service member (currently deployed)

"The current policy states that women aren't supposed to be in a combat situation but you can't take that to heart. Because in reality, it just happens."
—Senior female Service member

Sporadically, participants said that the policy should be changed as a result of the experiences of those serving in combat in support of OIF and OEF.

"I think we should get rid of low level restrictions-such as the below brigade level rule and collocation…The line in the sand isn't there anymore."
—Senior female Service member (currently deployed)

"I think the policy needs to be re-written to make it clearer."
—Senior female Service member

"I think my only general comment would be that how this came about is kind of archaic. It needs to be updated and changed to the time."
—Senior male Service member (currently deployed)

Some of the participants from both the enlisted and the officer panels also shared their opinions that the current assignment policy should be changed.

"Women are in combat now, so there's no point in having something that stops me from doing my job. So I wholeheartedly agree that the exclusion policy should be abolished."
—Participant, Female Enlisted Panel

"I would request no exclusion. Do not discriminate against me because I'm female."
—Participant, Female Enlisted Panel

"I do think the policy needs to be reevaluated, because it impacts funding and training. We need that clarification, because women are in that environment, and is the institution taking the necessary steps to align itself with written policy compared to what we're actually doing?"

—Participant, Female Officer Panel

Summary: Understanding of the Current DoD Assignment Policy for Military Women

DACOWITS wanted to know the extent to which the current DoD assignment policy for military women is known and implemented in theatre, so they asked study participants in leadership roles about their understanding of the current policy relating to women in combat and how well they are able to implement this policy in theatre. Most often, senior focus group participants were unaware of the current policy or unsure of what it is. Less often, participants shared some understanding of the policy, relating to either the assignment or to the utilization of women in the military.

Although participants were not directly asked about their opinions on the current assignment policy of military women, some shared their views. Most often, those who shared their opinions said that it is either an unfair policy or that it is outdated. Some participants also said that the current policy is not enforced, as women are currently serving in combat. A few focus group participants and some members of both the enlisted and officer panels on this topic think that the policy should be changed as a result of the experiences of females who have served or are serving in combat in support of OIF and OEF.

III. SUPPORT FOR FAMILIES OF WOUNDED WARRIORS

Having a wounded warrior affects families—particularly caregivers—in a myriad of ways. For every wounded warrior, there is also a "wounded family." Recognizing the profound and sustained upheaval that families of wounded warriors experience, DoD and Service-level wounded warrior initiatives target the needs of the wounded warrior community as a whole, including families and Service members. Secretary of Defense Gates' concern about the quality of wounded warrior family support triggered DACOWITS's initial study of wounded warrior family support, in summer 2008. That effort revealed families were receiving better support than during the early years of OIF/OEF, but gaps remained. Twelve months later, DACOWITS returned to the field to re-assess the adequacy of wounded warrior family support, with an emphasis on obtaining the provider perspective absent from the 2008 effort.

This chapter presents the collective views and perspectives of the individuals who participated in the 2009 DACOWITS focus groups on wounded warrior family support. These focus group participants included wounded warrior family members as well as providers of medical and non-medical support to the wounded warrior community. The chapter is organized into five sections, as follows:

- Characteristics of the focus groups and focus group participants
- Qualitative analysis methodology
- Evidence of recent progress in support for wounded warrior families
- How well wounded warrior families are being supported
- How support for wounded warrior families can be further improved

The last three of these sections correspond to the three major research questions posed by DACOWITS at the outset of this study. The findings presented here were informed first and foremost by the focus groups DACOWITS conducted with family member and provider stakeholders. These findings were augmented by mini-surveys completed by the focus group participants and informed by briefings presented to DACOWITS during its 2009 meetings and the external data sources summarized in Chapter I.[106]

Although DACOWITS did not expressly solicit providers' input regarding the characteristics of wounded warrior families, many providers in the focus groups shared views on this topic. To ensure the views of these providers are accounted for, and because they offer insight into

[106] These outside sources traditionally include select items from DoD Status of Forces (SOF) Surveys, which are based on large military samples; however, the SOF Surveys included no items directly relevant to this topic. DACOWITS also requested access to Service-specific wounded warrior survey results, but none were available.

potential complexities and challenges inherent in working with this population, they are summarized in Appendix G.

A. CHARACTERISTICS OF THE FOCUS GROUPS AND FOCUS GROUP PARTICIPANTS

The Committee gathered data on wounded warrior family support at six locations. Five of these locations were Active Component sites (Army, Air Force, Navy, and Marine Corps); the sixth was an Army National Guard site. At these locations, the Committee conducted 11 focus groups with a total of 120 individuals. Seven focus groups were held with providers (90 participants) and four were held with family members (30 participants). The provider focus groups were uniformly large, ranging in size from 7 to 22 participants; the family member focus groups varied in size from 2 to 13.[107] Background characteristics and job titles of the provider participants are presented in Exhibits III-1 and III-2, respectively.

Exhibit III-1:
Wounded Warrior Family Support—Provider Focus Groups Demographic Profile of Participants (N=90)

Variable	N (%)	Percent
Service Affiliation:		
Army	26	30%
Navy	25	28%
Marine Corps	14	16%
Army National Guard	6	7%
Joint	6	7%
Air Force	5	6%
Does not apply	5	6%
Army Reserve	1	1%
Employment Status:		
Military	35	39%
Civil Service	27	30%
Contractor	25	28%
Other	3	3%
Organizational Affiliation:		
Warrior Transition Unit	35	40%
Hospital	30	35%
Soldier and Family Assistance Center	7	8%
Service-level Wounded Warrior	6	7%
Other	6	7%
"Mental Health"	2	2%
Private Organization	1	1%

[107] DACOWITS typically strives for focus groups of 6 to 8 participants.

Exhibit III-1: Wounded Warrior Family Support—Provider Focus Groups Demographic Profile of Participants (N=90)		
Variable	**N (%)**	**Percent**
Education:		
Some college credit but no degree	7	8%
Associate's degree	9	10%
Bachelor's degree	27	30%
Graduate or professional degree	46	52%

The providers were a diverse group, of which 30 percent were affiliated with the Army, 28 percent with the Navy and 16 percent with the Marine Corps. Many of the provider participants were military (39%), although civil service personnel and contractors were also prevalent (30% and 28%, respectively). Most were affiliated with the local WTUs (36%) or hospitals (35%). They were a highly educated cohort, 82 percent having at least a bachelor's degree, and more than half (52%) possessing graduate or professional degrees.[108]

Many types of personnel play a role in the delivery of holistic medical and non-medical support to wounded warriors and their families. This diversity is reflected in the job titles held by the provider participants.

Exhibit III-2: Wounded Warrior Family Support—Provider Focus Group Provider Job Titles (N=90)		
Job Categories and Job Titles	**N**	**Percent**
Case Manager	22	25%
Mental Health Job Title	8	9%
Military Job Title	8	9%
Family Assistance Job Title	7	8%
Nurse	5	6%
AW2 Advocate	5	6%
Therapist	4	5%
Transition Assistance Job Title	4	5%
Ombudsman	3	3%
Recovery Coordinator	3	3%
Federal Recovery Coordinator	2	2%
Trauma Coordinator	2	2%
Physician	2	2%

[108] One of the six sites, Bethesda National Naval Medical Center, contributed more than a quarter of the 90 providers who participated in the study as well as a disproportionate share of the physicians (or other highly educated providers).

Exhibit III-2: Wounded Warrior Family Support—Provider Focus Group Provider Job Titles (N=90)		
VA Liaison for Healthcare (Includes A "Wounded Warrior Liaison")	1	1%
Chaplain	0	0
Other	12	(4%
Total	88	100%

Case managers comprised the most common job category (25%) of provider participants. It also should be noted that, based on their job titles, approximately 25% of the provider participants performed management-level functions in addition to or rather than frontline service delivery, (e.g., Case Manager Supervisor; Director, Psychological Health; Company Commander; SFAC Director; Supervisory Nurse; Assistant Director, Clinical Support). Copies of the provider mini-survey and complete provider mini-survey results are available in Appendix E and Appendix F.

Exhibit III-3 presents the demographic profile of participants in the family member focus groups.

Exhibit III-3: Wounded Warrior Family Support—Family Member Focus Groups Demographic Profile of Participants (N=30)		
Variable	**N**	**Percent**
Relationship to Service Member:		
Spouse	23	77%
Other	4	13%
Parent	3	10%
Total	**30**	**100%**
Service of Service Member:		
Army	18	62%
Army National Guard	6	21%
Marine Corps	3	10%
Navy	2	7%
Total	**29**	**100%**
Pay Grade of Service Member:		
E3-E4	11	39%
E5-E6	11	39%
E7-E8	4	14%
O3	1	4%
O5	1	4%
Total	**28**	**100%**
Nature of Service Member's Injury:*		
Poly-trauma**	20	67%
PTSD	15	50%
Traumatic Brain Injury	12	40%
Spinal Cord Injury	5	17%

Exhibit III-3: Wounded Warrior Family Support—Family Member Focus Groups Demographic Profile of Participants (N=30)		
Limb Loss	3	10%
Other	3	10%
Burn	2	7%
Total	**60**	N/A
Recovery Stage of Service Member:		
Follow-Up/Rehabilitation	21	72%
Outpatient/Partial Hospitalization	6	21%
Initial Hospitalization	3	10%
Total	**30**	**100%**

*Family members could mark more than one injury; therefore column total exceeds 100%

** This term refers to Service members who suffered multiple injuries

The large majority of participating family members were spouses (77%). In most cases, the participants' Service members were junior to mid-grade enlisted personnel (39% E1-E4; 39% E5-E6). The most common wounded warrior conditions were PTSD (50%) and TBI (40%), and nearly three-fourths of the Service members were in the rehabilitation stage (72%). Importantly, the family member sample was small and overrepresented the Army (62% AC and an additional 21% National Guard), the service that has suffered the largest percentage of severely wounded. A copy of the family member mini-survey is presented in Appendix E, and complete mini-survey results are available in Appendix F.

B. QUALITATIVE ANALYSIS METHODOLOGY

The methodology used by DACOWITS to identify salient themes related to support for wounded warrior family members from the 2009 focus groups varied little from the approach the Committee has employed in the seven previous years under its revised charter. Specifically, the Committee employs the services of a professional research contractor (ICF International) to assist in the development of focus group and survey instruments tailored specifically for the topic at hand. Contractor research staff serve as scribes, accompanying the Committee members/facilitators to each focus group, and generate a near-verbatim transcript from the session. Each individual focus group transcript is then content-analyzed to identify major themes and sub-themes, and the resulting transcript-level findings are entered into a sample-wide database for further analysis. The purpose of the sample-wide analysis is to determine the most salient comments throughout the focus group sessions, i.e., themes that appear most frequently within and across focus group sessions. These comments, or findings, are presented at the beginning of each substantive section of this chapter, followed in turn by less salient findings and select noteworthy non-salient findings.

C. EVIDENCE OF RECENT PROGRESS IN SUPPORT FOR WOUNDED WARRIORS

DACOWITS undertook the current research as a follow-up to its 2008 study on the same topic. Accordingly, one of the Committee's research questions was whether progress is being made in DoD's capacity to support the needs of wounded warrior family members. Recognizing this is a shifting landscape, with ongoing legislative changes and implementation of SOC reforms, DACOWITS sought to identify signs of positive change since its pulsing some 12 months earlier. To attempt to address this question of progress, DACOWITS relied on both quantitative and qualitative methods, including the mini-survey and the focus group data. These approaches are discussed under the following two sections:

- Mini-survey results related to current conditions and practices in wounded warrior family support
- Focus group results related to recent progress in wounded warrior family support

Findings from each source are described below.

Mini-Survey Results Related to Recent Progress in Wounded Warrior Family Support

Through the mini-survey, DACOWITS sought to gauge if participants believed families had access to specific support services and whether specific "best practices" were in place to support families. The mini-survey used a 5-point Likert scale (1 = strongly agree; 5 = strongly disagree) to assess participants' levels of agreement that these services and practices—such as family support groups, information for families, etc.—had been implemented and were accessible.[109] The majority of provider participants reported each of these supports and practices was in place. This was not true of family member participants, who frequently indicated they were uncertain whether such resources existed. Examples of these disparate provider and family member viewpoints are provided in Exhibit III-4.

[109] Because the mini-survey was not administered to random samples, results may not be representative of the views of the general populations of providers or family members of the wounded.

Exhibit III-4: 2009 Provider and Family Member Perceptions of Available Support		
Select practices recommended by DACOWITS in 2008	**% agree that practice is in place**	
	Providers (n=90)	**Family Members (n=30)**
Information for wounded warrior family members can be found at a *central* installation or hospital location	75%	32%
There are *town hall meetings* (i.e., group meetings for wounded warriors, family members, and officials to exchange information and concerns)	78%	54%
Transportation support is provided for wounded warrior families (for example, bus/van or gasoline gift card)	77%	36%
The Warrior Transition Unit (WTU) has a *support group for WTU Families* (may or may not be called Family Readiness Group [FRG])	55%	39%

Thus, more than three-quarters of providers (81%) but not quite one-third of family members (32%), indicated information can be found at a central location, and more than half of providers (55%), as compared to 39 percent of family members, said the WTU has a support group for families. We note that centralized information and support groups for families are elements that DACOWITS earlier found to be key in effectively supporting wounded warrior family members. See Appendix F for complete summaries of provider and family member mini-survey results.

On the whole, the provider perspective suggests that recommended and best practices have been broadly implemented, whereas the family member perspective suggests that families are not consistently aware of, or do not believe they have access to, these supports and practices. Interestingly, the provider perspective within sites is not uniform. By-site analysis reveals disagreement among providers at the same site regarding available support and practices (e.g., in response to whether the local WTU has a support group for family members, 13 of 18 providers said "yes" and the other 5 said "no"). What could account for these discrepancies in viewpoints between providers and family members and within providers? We suspect they reflect variation in awareness among family members and different types of providers, which could be improved by more strategic communication with, and robust marketing to, family members, as well as more systematic communication and coordination among providers.

The mini-survey also assessed study participants' satisfaction with various aspects of support for wounded warrior families. Comparisons of family member satisfaction levels in 2008 and 2009, based on comparable mini-survey questions, provide additional evidence of progress. For example, the following areas of support saw substantial increases in the percentage of satisfied

families: helping children cope with the Service member's injuries, assistance/advocacy, and information/education. While this is an encouraging observation, the two family member samples are not necessarily comparable and the sample sizes lack the statistical power to generalize these mini-survey results to the overall population of wounded warrior families.

Focus Group Results Related to Recent Progress in Wounded Warrior Family Support

Participants were asked during the focus group discussions what improvements they have observed in the last 8-10 months in the support that is available for family members of wounded warriors. While there were notable individual testaments expressing visible accomplishments, "improvement" was not a consistent theme in response to this line of inquiry. Among the testimonies of progress that the Committee members did hear, several providers mentioned that they now work with a larger and more varied staff—e.g., a Recovery Care Coordinator, transition coordinators, more nurse case managers, and retired military personnel. Providers also remarked how the scope of available family support has grown. Several family members echoed the expanded scope of services.

> "There's been a huge paradigm shift on the approach to families. The doctors, when they come to see the patients, ask where the family is if they're not there. That says a lot to how the mind set and the approach to care has changed. Family centered care is important. The families have already been sent out to Germany to the bedside…, and they'll be flying in with the wounded warriors."
> —Provider

> "One thing that works very well is the amount of support that's out there for family members…We work well with the squad leaders. This morning, I got a call. I was referred by X. If you look at it, years ago, you didn't have that, or you only had one or two. Now you have AW2, ombudsmen…"
> —Provider

> "My husband was injured in 2003. Back then, they had nothing set up, but, this is amazingly different than it was back then. It's obvious that somebody has done something to make it better for the Soldiers. It's like night and day."
> —Family member

> "They are trying to work the kinks out. I personally have seen that if I tell them what isn't working, they try to fix it."
> —Family member

Summary: Evidence of Recent Progress in Support for Wounded Warrior Families

The evidence of recent progress in this arena, while sparse, tends to be positive. It was not uncommon for focus group participants to remark upon improvements they have witnessed, although such comments were not consistent enough to characterize them as a theme. By asking providers and family members whether certain wounded warrior family support conditions and practices in were in place, DACOWITS was able to gauge the extent to which previously targeted areas for improvement have been addressed. It would appear from provider responses that earlier DACOWITS recommendations have been broadly implemented at the six sites visited. Family member responses were not as encouraging, however.

Finally, certain discrepancies in mini-survey responses—between family members and provider, and among providers of various types, were noteworthy. The family member viewpoint was consistently less positive than the provider viewpoint. While admittedly based on a small sample of family members, this finding reinforces the uniqueness of the customer perspective, and the importance of capturing and responding to it. As for providers, it was not unusual for participants at the same site to disagree regarding available supports and practices. This finding underscores how one's role within the service delivery system—e.g., family member, medical provider, non-medical provider, and so forth—influences one's awareness of available services. It also highlights a need to strengthen communication and improve marketing to family members, and to ensure systematic communication and coordination among providers.

D. HOW WELL WOUNDED WARRIOR FAMILIES ARE SUPPORTED

The second key research question DACOWITS sought to answer was how well the military is supporting the needs of wounded warrior family members. Here we were looking not at progress but a snapshot in time, much as we did 12 months earlier. Most of the focus group protocol questions were designed to address this particular research question and, in this section, we present the qualitative findings that these protocol questions elicited. We focus this discussion on the findings yielded by the responses of the 90 providers who participated in seven focus groups at six locations—collectively offering a perspective that was not gathered during 2008. Where applicable, we integrate findings from the smaller family member dataset, which was based on the input of 30 family members who participated in four focus groups at four locations, and relevant data from the mini-surveys.

Our findings are organized into two main sub-sections, as follows:

- Key findings
- Emerging issues

Emerging issues are concerns that were not expressed consistently across sites or participants, but are judged by the Committee to be noteworthy.

Key Findings

We present findings in order of salience. The topic areas with the strongest findings—that is, those for which similar observations were made by the largest numbers of participants across the largest number of sites—are presented first.

Findings are presented under the following key topics:

- Family support
- Family participation
- Providers
- Coordination among providers
- Information for families
- Support for PTSD/TBI versus outward injuries
- Rules and regulations
- Condition-related communication with families
- Assessment of program effectiveness
- Continuity of care

As participants discussed each of these topics, DACOWITS heard stories of strengths, as well as weaknesses and shortfalls. Although the focus of this discussion is on the overall state of wounded warrior family support across the six sites, certain important site-specific circumstances were apparent, and these are summarized at the end of this Key Findings section. Additionally, several site-specific findings are presented under the "Emerging Issues" section.

<u>Family Support</u>

DACOWITS learned from its 2008 study that families tend to feel the most well cared for by the military at the earliest stages of the treatment and recovery process, during which their Service helps them travel to the wounded warrior's bedside and provides on-campus lodging. Provider and family member 2009 mini-survey results corroborated that satisfaction with this stage of support is particularly high, as Exhibit III-5 demonstrates.

Exhibit III-5: Provider and Family Member Satisfaction with Support for Wounded Warriors by Stage		
Stage	**Percent Satisfied or Very Satisfied**	
	Providers (n=90)	**Family Members (n=30)**
Support getting you to the member's bedside after you were notified	84%	68%
Support while member undergoes inpatient care	87%	65%
Support during outpatient care or partial hospitalization	78%	52%
Support during follow-up care	73%	55%

The mini-survey results demonstrate that large majorities of providers are satisfied with family support at every stage. Once again, the consistent disparity between the provider and family member perspective is noteworthy, with smaller proportions of family members than providers reporting satisfaction with support at every stage.

To further understanding of the effectiveness of available support at this critical stage, DACOWITS asked the study participants the following broad question: "Apart from these two areas—support for getting to the bedside and lodging during the inpatient and outpatient periods—from your perspective, what is working well for family members of wounded warriors?" DACOWITS followed this question with its converse: "What is working less well for family members of wounded warriors?"

A large number of providers conveyed a strong conviction that a comprehensive, multifaceted, and family-centered continuum of care exists for families. Across most sites and varied disciplines, both medical and non-medical providers spoke of a focus on the family. They described a focus on the family as *givers* of care for their wounded warrior.

> "We invite the families into the room as much as possible. We've included a couch that pulls out into a bed so that they can stay if they need to. We want family members to be available to help take care of the wounded warriors, because it's a very important part of the patient care."
>
> —Provider

"In reference to CBWTU, we bring the Soldiers home and they get the care in the community. We encourage the family member to come in and get involved with the plan of care then. Once they leave us, they are the eyes and ears of the Soldier. Then at any time, they can call and give us an alert. We encourage them to come and be a part of their care."
—Provider

Providers also described a focus on the family as *recipients* of care.

"Our culture is really family-centered care. With younger residents, everyone communicates this attitude to them, that they're to look for families, talk to families, and be available to families. They are automatically offering help to any family member that's there to provide help for stress, including individual or family therapy. We have a chaplain that's on the trauma service who immediately goes in and introduces himself. We have young mothers and young pregnant wives. They are hooked up with the OB [Obstetrics] unit immediately… You need to be available for your wounded family member, so we'll do what it takes to be sure you can do that."
—Provider

"Sometimes the families are very complex and there are many needs throughout the family that need to be taken care of--like financial support, other counseling, and other things. There are many complex family issues."
—Provider

"The families know they have us as resources. The wounded warrior Battalion is great for them and they know they can call us, our toll free number, to have their questions answered. This is a great resource for them."
—Provider

Providers noted that the support they extend to families can be hands-on and logistical, such as dealing with household minutia associated with a family member's hasty departure upon notification.

"Yes, it's the little things that count. We try to find someone to walk the dog that is in Ohio or we find their medications or find help for the autistic daughter. There are a lot of details that we deal with because we know there's a lot left at home when they come here. We need to tell employers that we have someone injured and please don't fire their mothers or fathers because they are here. We deal with a lot of those little things."
—Provider

"The family needs to be by the service member's bedside for a long time and the military will take care of all the things they leave behind. They do more that just getting them to the service member, but help the family the whole way."

—Provider

The positive perspective expressed by providers during the focus group discussions and recounted above is reinforced by mini-survey results showing consistently high levels of satisfaction with various areas of family support. Exhibit III-6 presents the mini-survey findings regarding provider and family member satisfaction by type of support.

Exhibit III-6:
Provider and Family Member Satisfaction with Support by Type

Support By Area	Percent Satisfied or Very Satisfied	
	Providers (n=90)	Family Members (n=30)
Overall Support	84%	67%
Finances (e.g., advances, reimbursements)	69%	56%
Logistics (e.g., movement to and between treatment facilities; condition of facilities)	67%	52%
Information/education (e.g., info about available benefits and services, how to care for injuries, etc.)	85%	59%
Emotions (e.g., stress management, coping with grief/depression)	71%	48%
Assistance/advocacy (e.g., reducing red-tape, case management, respite care)	72%	52%
Support helping children cope with a Service member's injuries	45%	44%

Consistent with previously reported mini-survey results, family members expressed considerably lower levels of satisfaction than providers with each type of support. Nevertheless, a fair number of family members spoke glowingly about the support that they and their Service member had received.

"I've been waiting nonstop since he was deployed to get him into daycare. …X was just awesome. Two days later, it'll happen. She was just somebody - SFAC. She was meant to help the families."

—Family Member

"The ombudsmen are really good. They lost my husband's medical records. The ombudsman had it done within an hour and a half."

—Family Member

"All I have to do is call his case manager and ask him what's going on."
—Family Member

"Dad had had a heart attack. We got here, and I said, "I wonder if we could stay at the Fisher House and help and be here, and my sister could get a break" (she is his primary caregiver). It was Friday night at 7:00 in the evening and he had a key and said 'here you are.' It was just spectacular."
—Family Member

The warrior transition unit, in particular, received high praise from several family members.

"On the military side, I've been very welcome. They see the benefit of seeing loved ones with them."
—Family Member

"Squad leaders. They're very understanding. He was actually injured [squad leader] in Afghanistan and so he understands what my husband's going through. And the doctors - they all work together to have that support."
—Family Member

"If it wasn't for the wounded warrior Battalion, I don't know what we would be doing. He joined the Marine Corps because he wanted to change his life. The Corps is his identity. You are a Marine first and then you do your job. Walking through the ward here in the wounded warrior Battalion after being gone a while, 15 guys come over and talk to us. We've always identified with our unit as a family and the family takes care of other Marines."
—Family Member

"When my husband was in regular unit, he had so many appointments, and trying to juggle work and appointments…since coming to WTU. He checks in in the morning. If he has physical therapy in the morning, he doesn't need to let them know. He doesn't have to juggle separate work and medical."
—Family Member

The mini-survey results of both family members and providers underscore a possible service gap—in the area of support for family psychological well-being. Specifically, satisfaction with support was markedly lower for the area of "helping children cope with Service member's injuries" than for other areas (45% of providers and 44% of families, respectively, were satisfied). A similarly low percentage of families (48%) were satisfied with support in the related

area of "emotions." This issue did not emerge as a theme in the provider or family member focus groups, although several spouses commented on the stresses of adapting to a changed husband and father. It remains unclear whether these mini-survey results reflect a shortage in needed services, a failure of marketing, or a combination thereof. At one site, when DACOWITS spoke with wounded warriors informally, their message was clear: "We are being well taken care of—please look after our families."

Support groups are a potential source of social and psychological support for families, and are commonplace within both the military and medical communities (e.g., family readiness groups, cancer support groups). DACOWITS addressed support groups with the study participants through both the mini-survey and the focus group protocol. According to their mini-survey responses, almost all of the providers at each site knew of at least one support group for families. Their responses to the question, "What kinds of support groups are available to family members of wounded warriors?," suggest, however, that the support groups of which providers are aware do not necessarily provide support, for families, about coping with their wounded, injured, or ill Service members. That is, providers mentioned gatherings of various types (e.g., welcome briefings, information sessions) for various populations (e.g., survivors, wounded warriors) on various topics (e.g., reintegration, PTSD/TBI) but, by and large, they did not identify ongoing, dedicated support groups for family members of wounded, ill, or injured personnel. It should be noted also that no examples were cited of condition-specific support groups for family members of individuals with cognitive impairment, which was an earlier DACOWITS recommendation. Family readiness groups also were mentioned infrequently in this context.[110]

Providers at an acute care facility noted they had tried to establish a support group for families but found that the family member population was too small and, moreover, families at this facility were not yet ready to engage in a support-group type of experience. Thus, we are reminded that family support groups are not necessarily called for at all wounded warrior venues, or seen as useful by all family members.

> "It's too early when they're acute. Family members want to be by their patient's bedside, and it's too early to discuss their feelings. Sometimes they find each other in the waiting rooms, but for the most part they lean on their own family. We tried, but they didn't really want it."
>
> —Provider

[110] Several providers alluded to groups offered by the hospital or counseling center without describing these groups. A few providers named local initiatives related to reintegration, survivors, wounded warriors, PTSD, or TBI. Only one of these resources—"Hope for the Warriors"—was clearly a support group for wounded warrior family members.

"One difference is that it's available at Walter Reed. They have 800 people and we have 50. They have a population that is smaller here, but it still happens. We are trauma and they are rehab so there are more things for them."

—Provider

DACOWITS's inquiry into availability of support groups for wounded warrior family members was a cursory one and the qualitative findings are merely suggestive. We believe further investigation is warranted, however, given the potential value that such support groups may offer families during a time of intense stress and upheaval.

Family Participation

To gain insight into the provider perspective on service delivery for wounded warrior families, DACOWITS asked providers about the circumstances in which they work. The primary question was, "What are the barriers that prevent you from supporting wounded warrior family members as you would like?" DACOWITS also asked providers about the barriers that prevent their colleagues from adequately supporting wounded warrior family members. The barrier they named most frequently was lack of family participation. This theme was expressed at each of the six sites visited, and was among the most salient themes to emerge from the provider focus groups. The providers attributed poor participation to several factors, including difficulty identifying and contacting family members, unpersuasive marketing, resistance on the part of Service members and families, and physical distance between providers and families. These are barriers with which military family support providers have grappled for many years.[111] Quotes and themes regarding each of these barriers to family participation are presented below.

Inability to identify and contact wounded warrior families impedes participation

In some cases, providers do not know who the Service members' family members are or how to reach them.

"I have no contact information on spouses. It's such a fluid unit. The form asks questions that didn't need to be on there. I'm creating a database. I'll be able to reach them with a newsletter - with community information. I'm getting a lot more support now than when I first came in…"

—Provider

[111] Booth, B., Segal, M., & Bell, B. (2007).*What we know about Army families: 2007 update. Prepared for Family and Morale, Welfare & Recreation Command.*

"I didn't know there were benefits for me because no one contacted me."
—Family Member

Unpersuasive marketing impedes participation

Even when providers do have access to contact information, some question the effectiveness of their efforts to inform family members about available support.

"Family participation is a big one (all agree). This is key. We have newsletters, conferences, picnics, etc. Not all the families come. I don't know if it's a misconception or confusion or what, but we need to get the word out and they don't always come."
—Provider

"It's about people getting the information and not wanting to participate in the programs."
—Provider

"What we find is that family members are often not informed about what services we have—even though we pass out this information."
—Provider

Resistance impedes participation

There may be resistance on the part of both Service members and families.

"… Service members often don't want their wives involved. There are many things available to them, but we can't make them use everything we have."
—Provider

"It all falls back on the Soldier to address it to the family. That's not always gonna' happen. That's where we come in…ask a Soldier's permission to speak to their family about their condition."
—Provider

"Families don't want to come back because they are struggling and the wounded warrior struggles because of this."
—Provider

"… As the Marines are coming in and adjusting, the families are only participating relative to what the Marine is doing. The more the Marine is doing, the families will slowly catch up and get involved."
—Provider

The military family support community has long recognized how some Service members will actively discourage their families from participating in military or unit activities.[112] In the case of wounded warriors, however, Service member discouragement of family participation in these activities is particularly counterproductive, given the role the family plays in recovery and their critical need for information. It may be advisable for the military to more vigorously emphasize, and facilitate, family participation—in some cases, even over objection from the wounded Service member, if there could be a tangible benefit to their recovery.

Distance impedes participation

Providers also noted how challenging it is to elicit participation from families who do not live nearby.

"We have more trouble getting family members into our support center when family members are dispersed geographically. We are constantly trying to send out information and plan activities but if we're lucky we will get about ten family members to come. We also have SFAC which we work with, but getting the service members' family members into the center is extremely difficult."
—Provider

"We have the problem that the family is not with them. We do what we can without them, so that is a barrier."
—Provider

"... Another barrier is we have CBWTUs (and our families) are all over and SFAC can't reach out and touch families. I would like part of my staff to contact these families, to share – 'a new program for child care is in your area'... It would be great if we had some sort of contact—a community-based SFAC…"
—Provider

[112] Booth et al. (2007).

While connecting families with services clearly presents challenges, DACOWITS also heard stories of success in this area.

> "As a recovery care coordinator, I think building personalized relationships with the families is great. We do home visits which helps us build a rapport and gain their trust. Meeting with the families on a regular basis lets us understand their needs over time."
> —Provider

> "Yes, the families of Marines and Sailors will all be able to come here and enjoy our resources. We have officers who go out to those families and give them briefs and let them know how to see us. I would say 90 percent of families ask for their services, which is great."
> —Provider

> "I know that this is working. Word is getting out. We get calls at the office from wives and family members. They are using the agencies…"
> —Provider

The process of connecting with the target population—"outreach"—is a vital component of effective service delivery. As such, further study of outreach efforts with wounded warrior families may be warranted.

Providers

To more fully appreciate the circumstances under which providers operate, DACOWITS asked providers what other types of professionals or services could meaningfully improve the level of support provided to family members. This line of questioning generated much discussion, at each of the six sites, about an overall shortage of providers to effectively meet the needs of both wounded warriors and their families. This, too, was among the most salient themes to emerge from the provider focus groups.

> "With the limited number of providers, we also have the issue of needing to take care of the Active Duty members first and foremost. We need to make sure the Active Duty members always have priority to get into the clinic because they need to be able to go deploy and get back out there. I'm lucky because here if we get overwhelmed and have our psychiatrist quit like just happened, we can call the nearby Army facility and ask for help. The Active Duty population is getting sicker and along with the lack of providers it means we have less and less resources for the non-Active Duty members who need it too. By sicker and sicker, I mean PTSD and other things that are increasing now."
> —Provider

"It's not like you can walk away from the family to take care of the patient. You're always wearing at least five hats."
—Provider

"I need more staff. I can only do so much. I speak to all the neurologists and psychiatrists and there are many things I would like to implement. There are only 24 hours in a day so there's only so much I can do."
—Provider

The focus group participants identified shortages of many different types of providers, e.g., physicians, pediatricians, psychiatrists, social workers, and case managers. Shortages of behavioral health/mental health specialists were mentioned most frequently.

"From a case management point of view, it's been nice to have the same case managers, but we don't have the same thing in mental health. There's been turnover a lot there. They rotate them overseas and back. There's a national shortage issue."
—Provider

"Lack of providers in mental health…We try to bridge nicely with Fort X, but the referral resources are so limited for mental health."
—Provider

"Looking from the community-based military, I have areas that have no coverage, no behavioral health resources. I have 3 within my piece of the world, for over 15,000 people, plus 2 are OSD resources. There needs to be a means to be where Dr. X sends a group of providers who are certified, to meet needs in that community. There is a means in place to certify these people, but no means to pay them. We're fortunate in GA. We've got 13 Active installations."
—Provider

"Staffing is a problem. We have only two occupational therapists, only two speech therapists, who are doing both inpatient and outpatient services."
—Provider

The shortage of providers creates excessively high caseloads that providers say impede optimal service delivery.

> "The medical staff at…work very hard, but I believe that there's not enough of them…We've focused on the WTU and that's great, but we have the division. There's not enough behavioral health doctors, not enough nurse case managers...When we speak to those nurse case managers, you can't call them, because they're overworked. Their caseload is unbelievable."
>
> —Provider

> "…The goal is to have between 1 and 18 [Soldiers per nurse case manager]…I have 23 cases."
>
> —Provider

> "We have an AW2 that is stretched pretty thin. He calls us for assistance with the family members, which is fine because we see this as our responsibility. He has 40 cases right now and he is always scrambling for resources. With his job description, he is working with sexual assault cases, doing family assistance, working with wounded warriors, and more. He is stretched so thin that with the resources he has, he cannot meet their needs."
>
> —Provider

Similar to the "barrier" questions posed to providers, DACOWITS asked family members "What prevents providers from being more helpful to you?," and "What other types of providers, if any, could meaningfully improve the level of support you are receiving as the family member of a wounded warrior?" Family members at two locations echoed providers' concerns about caseload size, singling out the caseloads carried by warrior transition unit cadre.

> "[There are] not enough people. Too many people to be taken care of, not enough to actually take care of others without dealing with their own issues."
>
> —Family Member

> "I think the cadres are just overwhelmed -a squad leader for every 10 Soldiers. They're responsible for the families and Soldiers themselves. They work like 24/7."
>
> —Family Member

> "We don't need a new type, just more of them. I know civilians were very helpful for us when we were in [Name of city]."
>
> —Family Member

Factors such as Base Realignment and Closure (BRAC), deployment, PCS, and compensation contribute to the shortage of providers and affect the mix of labor categories that provide support for the wounded warrior community. Providers observed that, due to PCS and deployment, there is high turnover among military providers. DACOWITS notes that backfilling deployed physicians, in particular, is particularly challenging in settings characterized by remote location and high operational tempo. At the same time, there are numerous constraints affecting the longevity of contract personnel, not the least of which are low compensation and lack of job security.

> "And our rapidly rotating staff, with deployments. You lose institutional memory. And it's hard to have consistency with the caregivers."
> —Provider

> "Human resources and budget are a problem. We can't pay them enough. They move to VA, etc., where they can get paid more money."
> —Provider

> "The BRAC on your back is very hard. It's the same thing with case management. We had one year where we couldn't fill any contracts. Then we could have them, and there aren't many folks who can fill the roles. It would have been better to have civilians from the beginning…"
> —Provider

> "…We can't get people up here on anything other than contracts."
> —Provider

> "… Within the psychology field, we have mostly civilian contractors who get two weeks of leave per year in the mental health clinic and they don't get a lot of benefits. The turnover is high as a result. The caregivers come in and want to do some good but then they get burned out. In my opinion, mental health providers need a minimum of 4 weeks off per year to refresh and recharge because the material can be very heavy and difficult. Also there is no job stability, because many of the caregivers are contractors. This means that at any point I can get a phone call that says, 'we no longer need your services so please pack up your office'. …"
> —Provider

Often, it is civil service employees who provide the continuity in wounded warrior operations. As one provider observed, "In all hospitals, the civilians are the stability, as the military and contractors are constantly changing."

At a few sites, providers observed that it can be difficult to find staff—military, civilian, or contract—qualified to fill specialized roles within the wounded warrior community.

> "And the other piece that I'm dealing with on a daily basis is that we bring contractors in to fill positions on the fly, and you have people that don't know anything about military medicine or this facility, and they come in and don't get it. And that makes it very difficult."
> —Provider

> "There is also no formal training for dealing with psychological treatments and there is a huge variance for the training of staff members. People are recruited from all over and may have no experience with military. No regulation for … TBI care. If there is a mismatch, there can be a problem. If you are not comfortable working with someone with half a head, they will leave."
> —Provider

> "The Army is not a chronic care provider. Medical providers know nothing about the Military. Advocacy groups are in place, but they may not have the medical background. We have all these pieces that don't do a good job coordinating all of this..."
> —Provider

In response to 2008 expressions of dissatisfaction by some family members with how providers, particularly doctors and nurses, treated them, DACOWITS sought a more detailed understanding of how providers learn to work with wounded warrior family members. DACOWITS thus asked providers, "What training have you received regarding the role of family members in the wounded warrior recovery process?" While it appears a family focus may often be inherent in the training of physicians and nurses, dedicated training for medical and non-medical providers working with families of the wounded, to include on-the-job training, appears to be uncommon.

> "As a family physician, one of the emphases is that we treat the family, not the individual. We incorporate them into the treatment plan. I've been trained in it. As far as WTU, we haven't had anything specific to it."
> —Provider

> "We have met with nurse case managers about us getting more training. Non-medical people are being trained, the information referral people, I mean, but no one there is a clinician. We would like to see more training."
> —Provider

"Being the family Support person…, the only training that is available is focused on Family Readiness Groups. But this is about transition, reintegration, sustainment. We find that offensive. I came as a social worker. I have that training that I paid for. The training needs to be geared toward the support - how do we get them comfortable for their new reality? In the WTB [Warrior Transition Brigade] world, it needs to go back to support because we're not talking about deploying anymore."
—Provider

"All of my training has been for the warrior."
—Provider

While a diverse host of providers support the wounded warrior community—as illustrated by the types of providers that participated in this study (see Exhibit III-2) and reflected in providers' comments—there is indication that families receive most of their support from a more narrow sub-set of providers. DACOWITS posed to family members questions such as, "Where do you turn for all the information you need as the family member of a wounded warrior?," "Which types of providers stand out as particularly helpful to you?," and, "Which types of stand out as particularly unhelpful to you? Based on their responses, it appears that family members interact most with case managers (including medical case managers and nurse case managers), squad leaders, other cadre members, chaplains, and the Soldier and Family Assistance Center.

Coordination Among Providers

Recognizing that coordination is a crucial issue, based on both its previous research and the proliferation of case manager positions in support of the wounded warrior community (e.g., WTU case managers, Federal Recovery Care Coordinators, and DoD Recovery Care Coordinators), DACOWITS asked providers and family members how effectively providers coordinate with each other on behalf of families. Many participants at most sites reported that the support and services they provide family members are well coordinated and integrated. On the whole, they feel that they coordinate effectively with one another on behalf of patients and families. In some cases, providers attributed effective coordination to established initiatives or system.

"It has also become a one-stop shop instead of having everything spread out. We will have the hospital, resource center, Fisher House, etc., all on base."
—Provider

> "We have multidisciplinary rounds with the doctors, nurses, recovery care coordinators, etc., everyone all in one room to discuss the patient care and working together. This helps us all understand what the plan is going to be."
> —Provider

> "We have family services meetings with many representatives there. We have Marine spouses who are a liaison to this meeting. That gives them a direct link to the programs and we are also able to hear and see their problems that way."
> —Provider

> "We have the Central Savanna River Round Table. Community, federal organizations - we ask what can we do as a community to support families. The Department of Labor links spouses with education. …Local colleges - they can get education at affordable costs. It takes a village, and ours in this area has come forward. I think it's been a huge success. It was community-initiated. We've had job fairs come out of it, resume-writing tailored to their medical condition. We've taken it from grassroots level and built it up..."
> —Provider

A family member shared an example of effective coordination by her husband's providers:

> "Mine are really good. The psychologist actually sends letters to the others. They are great. Whenever someone wants to change a medicine, they talk to the other medical staff about it. We try to keep them aware of each other, not just through the case manager."
> —Family Member

In other cases, providers attributed effective coordination to less formal mechanisms, such as good communication and collaborative relationships with their peers.

> "We're able to identify when there are issues as a result of injury that are affecting the family and refer them to family social work services. We have a cooperative relationship with them, and can communicate about what kind of progress is being made—family therapy, couples therapy. I've seen that—all in the same building."
> —Provider

> "I think the way the wounded warrior group is set-up is good because it is multilayered. There's a lot of communication between the people here and we can catch the problems working together as a group."
> —Provider

"That's the beauty of this place. The Marine checks in and meets a lot of people and he will be comfortable enough to tell someone if there is a problem and then we tell each other (all agree). There are so many resources out there and they know we all talk to each other so they will be able to find the help they need."
—Provider

Providers at several sites shared limited examples of disorganization and inefficiency, suggesting areas in which coordination could be improved.

"This is so large, and this information is so overwhelming. I don't know whose door to go into, who has the lane? Who does resumes? I had six organizations this week come in who offered the same services. There's nobody who's really the gatekeeper. That's one of the barriers that I'm seeing. It's so big, and nobody's crossing lanes. Sure, everyone has fantastic programs, but you're not getting them to me. A brochure? It just goes in a bag."
—Provider

"There's a lot of different services doing different things and we're not communicating with one another... I can't talk to the AMEDD [Army Medical Department, U.S. Army] side. We're supposed to be a one-stop shop, but we couldn't do it because we couldn't get the logistics - the computers in my building. We're all trying to help these people, but we're not allowed to talk to one another. What's common knowledge [here] is not common knowledge across the parking lot."
—Provider

"It's a lot of layering and too much almost. We're unsure of who's supposed to do what. There is too much overlap."
—Provider

A family member put it this way: "…they're all trying to get into the glove at the same time. They can't do that. They're all doing it their own way." Family member and Service member testimony at Senate hearings corroborated that coordination of care remains an issue. As an Army lieutenant colonel and double amputee stated, "There are a lot of people trying to help. Sometimes, they are stepping on each other."[113]

[113] "Wounded Warriors Hearing Held in Senate." AUSA legislative update, May 4, 2009. Retrieved September 21, 2009, from http://newsmanager.commpartners.com/ausalu/textonly/2009-05-04.html.

Information for Families

While the mini-survey results revealed that the majority of providers were satisfied with the military's support for families in almost every area,[114] the area in which the largest majority was satisfied (approximately 84%) was information/education. Nevertheless, in response to DACOWITS's question regarding what is working less well, large numbers of providers at most of the sites acknowledged that families are overwhelmed by the volume of information they receive about the plethora of services offered to them.[115] This is problematic, providers explained, because families have difficulty isolating the relevant resources that can help them most at any given point.

> "The volume of information is overwhelming. There should be a centralized place for everything. There's so much to keep track of. Military OneSource does a lot, but not everything."
> —Provider

> "They are completely overwhelmed and can't even process [what's going on]. They need one person to deal with them and follow them. There are too many business cards handed out. I think they are going through a process of denial at first and need many steps to get to acceptance. We hurt this process by giving them so much different information."
> —Provider

> "I would streamline all the support services. Many of the services are overlapping and there are so many support groups. If I was a family member, I wouldn't know where to turn to because there is so much information and it is all very confusing. A clearinghouse should be made to centralize the information." (Many agree.)
> —Provider

It was suggested that the abundance of well-meaning providers offering information and services to families fosters an environment in which the family lacks a clearly designated "go-to" person. In a similar vein, a wounded warrior testifying in May 2009 before the Senate Armed Services Personnel Subcommittee spoke of a "diffusion of responsibility" that seems to occur when many

[114] Fewer than half of the providers expressed satisfaction with the military's support for families in the area of helping children cope with a Service member's injuries; this topic is addressed under Emerging Issues.
[115] It should be noted that the issue of overlapping services is not unrelated to inefficiency, addressed earlier.

different providers are involved.[116]

> "There's been a diffusion of responsibility because you have so many people trying to take care of you. We have great intentions, and the resources are out there. It's just trying to pair them up. I have an example. …I had a Soldier who could list 10 different coordinators… and there was not that one person, and he ended up navigating himself."
> —Provider

> "I feel that that's where we're lacking as well. We have the case managers—we wear many hats, and we also have a social worker who overlaps our jobs. I think Soldiers sometimes fall through the cracks. It would help if we had a family advocate person. It's difficult—one person would really help the Soldiers."
> —Provider

> "I know someone who had 12 case managers. It was a mess. They only want one case manager."
> —Provider

A few providers noted that care must be taken to deliver information at times when it can be best assimilated by the receiver.

> "Sometimes I think we overwhelm the family with too much. There may be some redundancy with our services. It may be too much too soon, and I think we need to temper that. We need to back off until they can handle it."
> —Provider

> "The deluge of information is another problem. There's so much information, it's important to tell them the key things at the right time. If not, they don't use the information properly. Continued follow-up is a big piece."
> —Provider

Based on the input of the admittedly small family member sample of 30, information did not appear to be quite as salient a concern for family members as for providers. Family members addressed the subject infrequently during the focus groups. On the mini-survey, although family members were less likely than providers to report satisfaction with military support in this area (59% versus 84%, respectively), more family members were satisfied with support in this area

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[116] "Wounded Warriors Hearing Held in Senate." AUSA legislative update, May 4, 2009. Retrieved September 21, 2009, from http://newsmanager.commpartners.com/ausalu/textonly/2009-05-04.html.

than in any other. That said, it is important to keep in mind that more than a third of the family members who responded to the mini-survey did not express satisfaction with military support in this area and did not rate themselves as "well-informed." In this respect, results from both providers and family members suggest that information for families remains a concern.

Note that in this report we distinguish the general topic of information for families from the specific topic of communication with families about their Service member's condition, which is addressed separately in a subsequent section of this chapter.

Support for Patients with PTSD/TBI versus Outward Injuries

During its 2008 focus groups with family members, DACOWITS members detected a sentiment among families of Service members with diagnoses of PTSD or TBI that the attention they received was not equal to that accorded Service members with physical, or outward, conditions. By way of example, families of PTSD/TBI victims are not notified at the time of injury or flown to the bedside and, until recently, they were not eligible to serve as non-medical attendants (NMAs).[117] Recognizing the prevalence of PTSD and TBI among today's wounded, DACOWITS sought further insight into how the experiences of their families and asked providers, "How does the support that family members receive vary as a function of whether their wounded warrior has a diagnosis of PTSD/TBI as opposed to a physical condition?" For the most part, there was agreement among providers that they interact differently with PTSD/TBI families, in large part because these conditions tend to be elusive, difficult for medical personnel to diagnose, and difficult for patients and families to understand.

> "I think linking the support up is different, but the services are always there. You come home and you don't always realize things. When you have more subjective disorders like PTSD/TBI, there's often a lag time in realizing things are wrong."
> —Provider

> "The support is there for all Service members, but the service member recognizes a problem easier if it is physical. They think they are fine but the spouse wants them to get help."
> —Provider

> "I think it's harder for a family to understand a brain injury. A physical injury such as amputation is much easier to understand."
> —Provider

[117] NDAA 2010 provides for more inclusive eligibility

"It can also be more intense than a physical aspect."
—Provider

"People with a prosthetic limb or a visible injury are much more likely to bring their family members in while with PTSD or TBI cases we may never meet the spouse."
—Provider

Due to the effects of PTSD and TBI on memory, concentration, and interpersonal relationships, providers may be particularly likely to encourage the involvement of family members in these patients' recovery plans.

"From a medical standpoint - I'm really going to push that your wife needs to be here more than for peripheral injuries."
—Provider

Other factors also lead to differential treatment of families, such as battle injury versus non-battle injury, phase of treatment (e.g., acute care versus ongoing treatment/rehabilitation), and individual patient/family circumstances, including their level of interest in receiving support.

"The support is always different. It's always going to be individualized." (Many agree.)
—Provider

"It depends on their injury. If they want that support, they will get it. There are people who don't want anything to do with it. It depends on the ethos."
—Provider

Thus, the 2009 providers did not corroborate earlier impressions from family members that the support for Service members who carry psychological diagnoses, and their families, is inferior to their counterparts with more obvious conditions. This finding may reflect an improvement in our understanding and treatment of PTSD and TBI, which could be expected given recent DoD emphasis in this area.[118] Conversely, this also could be a function of provider bias.

Rules and Regulations

With some regularity, providers offered examples of rules and regulations that inhibit their ability to do their jobs. Rules and regulations were mentioned in response to various questions

[118] Consider, for example, the recent establishment of the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury, funded in 2008.

including, “What are the barriers that prevent you from supporting wounded warrior family members as you would like?,” and “What is working less well for family members of wounded warriors?” Providers are constrained, for example, in terms of support they can offer family members who are not dependents (e.g., lodging and medical attention). At one site, providers indicated the accountability system recognizes only their work with Service members, discouraging them from supporting families, and denies them credit for time spent on case management or communication with commanders. At another site, contract personnel reported contractual obstacles that similarly discouraged optimal support of families.

> “The way that the policy letters are written as to what I can do in my role…I can only get credit if I’m treating a Soldier with a diagnosis. That prevents us from doing family support/education groups… To freely open our services to family members for support—we just can’t… We have to base it on our job description… It’s a tremendous limitation. In my case, if the service member expresses a need to have the family member in for treatment, I can bring them in for only one visit, and then I have to find them other resources. I can’t, by policy, see them as a couple.”
>
> —Provider

> “You only get relative value units by seeing patients. If you’re not generating them, you don’t get funding…. You can’t, and we realize this.… We’ve always been held accountable for productivity. As the Army’s changing financing—the bottom line is to show that we’re using the money appropriately... The issue of productivity is a big deal.”
>
> —Provider

> “The problem is that contractors… cannot work outside of normal working hours but spouses need briefings which are not only available during normal working hours but also at night.”
>
> —Provider

> “Because I am not a direct service, I had to amend my contract to travel for training and it took months for this to happen.”
>
> —Provider

In a similar vein, several providers observed also that TRICARE rules significantly disadvantage some wounded warriors and families.

> “TRICARE reimbursements are so pathetic. Trying to get care at home is much better for the family, but it is so hard because there is so little reimbursement.”
>
> —Provider

"They (civilian doctors) don't accept TRICARE because of the slowness of being reimbursed."
—Provider

"The TRICARE availability for these Marines needs to be increased. (Many agree.) The co-payment is going to kill these kids, especially the ones in remote locations."
—Provider

"If they cannot get in CBWTU—they cannot go into the VA until they're totally off Active Duty. For continuing care to continue, if TRICARE could step in while in Active Duty so they can get continuing care, families won't be stressed. It's not happening that way. One went home and didn't have that and he was ready to kill himself."
—Provider

Condition-Related Communication with Families

In its 2008 study, DACOWITS learned that some family members felt unacknowledged by medical personnel and inadequately informed about their Service member's condition. To follow up on these concerns, DACOWITS posed to providers the question, "How much information do wounded warrior's medical providers give family members about his or her condition?" Providers were divided in their responses. They concurred that communication break-downs occur, and that some patients and family members do not understand the patient's diagnosis or prognosis.

"Judging from the phone call feedback, they are not getting a whole lot of information, because they're not understanding their diagnoses. They don't know what they're taking medication for… Soldiers don't know it; the families don't know it. I automatically give them an information sheet on each thing that they have so they can share it with their families."
—Provider

"Relation to where the families are. We're still practicing under the same model about seeking care where your family is. But we're not set up to communicate well with the ones who are not here."
—Provider

"Families need more education for their service member's condition. It needs to be tailored to the education of the spouse."
—Provider

"Non-family members like fiancés sometimes don't get the info because they don't fit in the system exactly."
—Provider

Family members were asked the same question as providers: "How much information has your wounded warrior's medical providers given you about his or her condition?" Several family members corroborated that the information they were provided about their Service member's condition was inadequate.

"Not being informed medically about what's going on with my husband. When I first got here the doctors were open (he's a TBI patient). It's almost like they didn't want me to be involved with it. They want him to function on his own. For the last month or so I stayed. It was like the medical side didn't want me to be here with him. The cadre could see the benefit from me being there. But the medical side wanted him to function on his own."
—Family Member

"My wife and sister-in-law had to be forceful in getting information from the doctors. They weren't resistant when we pressed them for information. I believe its just part of the medical community to be reserved in sharing that information. My line is CYA [Cover Your Ass]. I don't want to tell you something and then be held liable later on... It has made them gun-shy to be useful to the people they are serving. If you can convince them that you're not trying to undermine them for information you want to know… The nurses give it to us and doctors give it to them... Occasionally you come across a doctor who's just a regular guy. We had a nurse like that they other day. He sat down and talked to us about the procedures. That's a rare occurrence, but it relieved our anxieties."
—Family Member

"We don't get a lot of information from our doctors, but our case manager went out of the way to get us more info."
—Family Member

"Communication with the wives. Even when we sign the HIPAA (Health Insurance Portability and Accountability ACT), even when we print out the schedules, there's no communication with the spouses so we know what they're supposed to be doing."
—Family Member

To an extent, HIPPA requirements contribute to this communication break-down with families.

> "With HIPPA it has gotten really ridiculous. Someone calls to set up an appointment and the service member hangs up the phone because he has no clue what's going on. We need to be able to talk to the spouses to make sure they are getting what they need."
> —Provider

> "I have Marines who come with their wives and others that don't want their wives at all. It's documented and completely up to the Marine." (Many agree.)
> —Provider

> "They have to ask the patient first. They have to ask the wounded warrior if it's ok to share this information because otherwise it can be a HIPPA violation. A lot of wounded warriors don't want their family to know about it."
> —Provider

While providers acknowledged that information sharing with families is imperfect, they also seemed to believe that medical personnel take affirmative steps to keep families informed. An understanding that families need this information seems to be inherent in providers' comments.

> "Yes, the physicians are good at communicating with the families which is great. They are very good at that."
> —Provider

> "Any time a Soldier goes to an appointment down in Syracuse or anything, they give the spouse information on the treatment and recovery."
> —Provider

> "If the family doesn't understand what's going on, the doctor will call and explain everything. I think they do a good job."
> —Provider

> "We encourage them to bring their spouses and make double copies of everything for them."
> —Provider

Several family members affirmed that they receive the information they need:

"When he actually told me he needed to talk to someone, I knew it was serious. We waited a very long time. Now when he sees someone I try to go to the first appointment so we can keep track of everything together. Luckily, I have kids as old as 16 so the big kids help the little kids while I'm out, thank God. My husband has no memory. Now they send me emails so I can keep track of things for him."
—Family Member

"Our chain is pretty good. They care. If I have a question, I just walk in and ask what's going on."
—Family Member

"I'm overall very pleased with the info we got - medical updates and all that. When he left there to fly to Walter Reed, but then there was a gap [in information] - where was he coming and all that…maybe this time maybe that time. So, I just left and drove over to X. There was not a lot of information when we got here. Then he was air-vaced. After that, everything was great. So, by and large, it was great."
—Family Member

A few providers discussed additional factors that can influence the sharing of information with family members. Some factors are straightforward, such as a doctor's bedside manner and whether families are physically present when the doctor makes rounds. Others factors are more subjective, and we glean from them insight into the dilemmas that medical personnel face as they grapple with what information to share with family members and how. Their comments remind us of the complexity and dynamic nature of effective communication.

"It depends on the individual doctor. Some are very good at that; others are not as free with their information."
—Provider

"One challenge is that doctors are around at 6 or 7a.m. and the family comes in later so they don't hear anything [from each other]. It's hard to communicate to them all the information."
—Provider

"It's also that we don't know the future of the injury. We try to prepare them as much as we can for what's going on acutely, but it's hard."
—Provider

"But then there's a breakdown of information and I think that's the nature of the beast. People hear things that aren't always said. An anxious family needs more information though. Telling them everything that's going on makes it easier for them instead of just giving them hope. Knowing the progression of things is very important [to cope with it]."
—Provider

Assessment of Program Effectiveness

Now that several years have passed since the release of the watershed Dole-Shalala Report, and initiatives on behalf of the wounded warrior community are beginning to mature, DACOWITS wanted to know whether mechanisms have been put into place to promote evidence-based family support programs and practices. To that end, DACOWITS asked providers, "In what ways are the needs of wounded warrior families and the effectiveness of support programs, being systematically assessed?" Most participant responses applied to assessment of support for the wounded warrior community as a whole, rather than for families specifically. It would appear from these responses that some assessment efforts are in place. Assessment, particularly assessment of outcomes, is not the norm, however. Providers mentioned assessment efforts such as the following:

"There are some [assessments] at the Bureau level for effectiveness of case management, and the family care is part of that."
—Provider

"For the AW2 Program, which extended eligibility to families on needs basis, they do have a portion that assesses the non-medical part, for families and transportation... AW2 is assessing family needs."
—Provider

"We actually have surveys at the Battalion level, which they fill out. There's also a transition team which gives them a survey. Battalion-level surveys are quarterly and range on different subjects like case management and other areas."
—Provider

"All of our information on each individual case is in a computer database. Our project manager every Friday briefs that to someone above him - through the ombudsman program. Pie charts…the amount of different types of complaints, resolutions, timeframes…"
—Provider

One site mentioned an interactive customer service evaluation system that is in place but under-utilized by service recipients, and feedback generated by the annual Army-level AW2 Army Family Action Plan (AFAP) process. As often, however, providers lamented an absence of assessment.

> "We have no feedback loop mechanism yet to know how they're doing."
> —Provider

> "This is not happening very much."
> —Provider

> "We don't have checklists yet."
> —Provider

> "No outcomes on anything."
> —Provider

It appears many would welcome empirical data to guide program improvements.

> "In outcome data, I think we're looking at subjective evidence. Globally, there is almost zero evidence that we can benchmark against. How do you evaluate whether a marriage enrichment program works? We're just adding people in to try to fix the problem, but we have no objective data on how the program works. We can't even tell how well PTSD intervention works. They can never go back to work. There's a global lack of any outcome data. But maybe the best we can get is family feedback."
> —Provider

> "We're at a point where we need to check things. I'm not sure what's missing exactly. We might need to market our services more. A pulse check is needed to see if things are effective as the programs are intended. We need to know if the service members are actually prepared for their transition."
> —Provider

> "There are no assessments and no way to know what the family needs. We need metrics (All agree). There is universal consensus. We are always assessing needs individually, but not system-wide. There is something being done with the Army and maybe we will be able to adopt that here."
> —Provider

Continuity of Care

Providers raised issues related to continuity of care periodically, during discussions of what is working well, what is working less well, and other topics. Several providers remarked that continuity of care is going well. At the same time, some expressed concern about the availability of care over the long term. That is, they worry that sustained care is not available after treatment and rehabilitation are complete, after Service members are discharged from the military, and/or after Service members and families return to their home communities. Although this issue targets the well-being of the Service member, it also impacts the family.

Providers highlighted examples of effective continuity of care.

> "From the time the Service member is injured, the Marine Corps gives them orders and makes sure they are dealt with from Germany, to Bethesda, to home. We are there from point of injury to the civilian sector and beyond."
> —Provider

> "I think the transition process is a lot smoother as well, and there's a lot more support."
> —Provider

> "Once the service members are released, they still have a safe harbor case manager and we're always checking in."
> —Provider

> "Non-medical management has also helped a lot with the continuum of care."
> —Provider

Despite these successes, providers shared doubts about the capacity of the current system of supports to adequately meet the long-term needs of the wounded warrior community.

> "We've seen a number of them come back recently, and we still give them all we can. Case management does a great job, as well as Federal Recovery Care Coordinators, keep in touch so that if there's an issue, we'll track it and help them. We still need to look at longer term."
> —Provider

> "Somehow we still don't have what we need with all of these programs. I think long term is going to be the big problem with us, for both the warriors and the families. They don't go away."
> —Provider

"After-care for after they leave the service. I would increase care provided after discharge. The VA is working very hard to keep up with those leaving, but they haven't been sufficiently beefed up to provide adequate support to the family members and the service members once they go."

—Provider

"Long-term efforts for screens for PTSD. We need to have same level of quality for long term. We need to connect PTSD to any traumatic incident, not just combat." (Many agree.)

—Provider

Providers expressed particular concern about the availability of continued care for Service members and families as they return to their communities.

"Community programs in small town America need help… We need to make sure they are plugged back in once they leave here. We have put things in place on our end, but the care needs to be delivered once they are discharged."

—Provider

"They need to have more people in outlying areas. The service members need support services and facilities closer to them instead of making them always come here. It would be so much easier for them to get assistance if it were closer to them."

—Provider

Mini-survey results reinforce providers' expressed concerns about continuity of care and the nation's readiness to meet the needs of the wounded warrior community over the long term. When asked to rate their satisfaction with the support provided for four stages of care—getting to the Service member's bedside, during inpatient care, during outpatient care or partial hospitalization, and during follow-up care—providers were less likely to express satisfaction with the latter stages of care than with the earlier stages of care. (Exhibit III-5 illustrates providers' and family members' declining levels of satisfaction by stage.) Both qualitative and quantitative findings underscore the need for a sustained focus on continuity of care as patients and families transition from stage to stage, including care that follows Service members and families into their civilian communities when they leave the military.

Emerging Issues

As explained earlier, certain ideas were not expressed with sufficient regularity to be deemed themes. Those that DACOWITS considers noteworthy nonetheless are presented below as

"emerging issues." While perhaps isolated within our study sample, these issues could be emblematic of broader challenges or could foretell looming issues. Consequently, the Committee believes they merit attention.

Emerging issue: Providers at two locations suggested that those who care for wounded warriors and their families need support for dealing with the unique stressors of their role and their work environment.

> "I would teach the fellow nurses that they need to take care of themselves. They internalize it a lot, and they can get overwhelmed. In order to be an effective leader at work, you need to take care of yourself. We have a tendency to take care of everybody else and not ourselves."
> —Provider

> "Also, we work with so many complex things. It would be great to have training in compassion support. How should we debrief and deal with stress reduction? All providers could be helped by this. [There needs to be] care for the caregiver!"
> —Provider

> "There should also be education for staff in how to deal with trauma. People talk to each other and ask why they are so drained. They need to know about this." (Many agree.)
> —Provider

Emerging issue: Providers at two locations alluded to a dearth of relevant guidance to help them effectively carry out their role.

> "WTB is not anything like another unit. You can't give an SOP [standard operating procedure] to me and state what I'm supposed to do. It doesn't apply. I'm making it up as I go."
> —Provider

> "Provide an overall training program - how we can appropriately intervene for the Soldiers? How we can help more, be of more service?"
> —Provider

Emerging issue: At three sites, providers mentioned obstacles that prevent them from taking fuller advantage of the support that private organizations offer.

"We have a lot of support from charities that want to give. Some of the Marines feel pressure to participate. For example, things with crowds like baseball games. They don't feel comfortable to deal with it though and the organizations need to understand that. The education piece is needed."
—Provider

"It's illegal to ask charities for specific items, which has been a problem. We can't get specific charitable donations for this reason, even if we know something that a Marine needs."
—Provider

"We have funding issues. We are supposed to pay for things like healthy snacks for family members but we can't solicit donations. What are we supposed to do, just wait around for someone to call me and say, 'I'd like to donate money?' We can't go out and ask for money. We've come up with creative ways to get money but it would be a lot easier if our hands weren't tied in this way. We also sometimes get donations and then we are told we may not see this money again. We are sometimes told that we have to give it to the treasury and it may not come back to us."
—Provider

Emerging issue: Several stakeholders at two sites, including family members and one provider, questioned the wisdom of staffing warrior transition units with wounded warriors.

"Their own injuries and not enough people. Too many people to be taken care of, not enough to actually take care of others without dealing with their own issues."
—Family Member

"It's hard to have injured taking care of injured. There are not enough healthy people around to give care."
—Family Member

"It would be helpful to have non-injured people taking care of people. I understand why they do it, but they still need outside people."
—Family Member

"Like in Walter Reed, having wounded warriors helping other wounded warriors is not a good idea. A wounded warrior having a cognitive brain injury means they can't help everyone because they don't have the capacity. They really shouldn't have this program. Non-patients should be used."
—Provider

Emerging issue: The transfer process across wounded warrior locations, e.g., between WTUs or to a CBWTU, was described as difficult by providers at two sites.

> "Transferring a Soldier from this WTU to another…they came up with a system that would eliminate all the red tape, but that's not true. It takes a couple months or longer to move a Soldier that's here but wanted to be at X."
>
> —Provider

> "He's got a back injury. Med [i.e., the doctors] has fixed his situation, but there was an eight-week break between his appointments. I've been trying to get him in CBWTU in Michigan. He needs to get close to home."
>
> —Provider

> "Meanwhile, they're not with families and not all issues are addressed. They must be eligible for the CBWTU Program. As case manager, we have to start their program all over again. A new PCM [primary care manager], and they need to explain all over again. Many have had surgical interventions. A lot of them [doctors] don't want to deal with someone else's handiwork. The length of time that they're there… They have to start that all over again. Sometimes it takes a month to get them into their primary care manager…getting them with a specialist, if they've had surgery, that will accept them."
>
> —Provider

Emerging issue: At two sites providers observed that differences across the military components (e.g., acronyms) may deter families from availing themselves of support from the closest military installation. We note this obstacle is endemic to family support services across DoD.

> "I would make it standard across DOD so there aren't so many pigeonhole programs. Then if I was at a place near an Army location, I could walk on base and say, 'we used to have this at the Air Force Base and I'd like help here.' It would be helpful to not have them all use different languages and not understand each other."
>
> —Provider

> "… A lot of times… they're not aware of all our acronyms. It would be great if we could just have someone in the Army with us all the time. They want to take care of the Soldiers. They're on one side, we're on the other. It's the little things we need to do. It's very important for all the DoDs [i.e., military components]. They HAVE to communicate. We need a representative from one of the branches there to make things smoother."
>
> —Provider

"I'm Army and I was Army so I can speak Army but we had a Captain come out to a Fort and there was an Air Force wife there too. Most of us were Army but his whole brief was geared to Fort X and the Army. I thought, 'ugh you're scaring this Air Force wife half to death' because part of his responsibility was to speak to everyone, not just the Army. I asked them to get smart about joint services. Get yourselves thinking about who you are talking to, what services their spouses are coming from, and address that."
—Family Member

Emerging issue: Providers at two sites—one active and one reserve—expressed concern that Soldier and family reintegration is not adequately supported. These concerns may be particularly relevant for wounded warriors with diagnoses of PTSD or TBI, and their families.

"He's done within one month of deployment, [and then] back here. That Soldier gets back here and he's only thinking of one thing - going on 30 days leave. He goes through all these checkpoints in one day. If I had a magic wand and could fix something, I'd change the process of reintegrating him back into civilian life. You are in Iraq and within 3, 4 days, you're right back there. It's a huge change. I think it's easier for the older Soldiers. They have more of a support system. But when you look at the young 18-, 19-year-olds. What's the age group of PTSD? How many are married, how many are unmarried?"
—Provider

"Reintegration. We've got to reintegrate families with these Soldiers, even if it's two weeks coming for fun time as well as learning. You have to learn how to communicate again. We have to make sure we're arming our families and Soldiers with the tools for the reintegration as well as what that will look like. Have them there to teach them that. We train our Soldiers to be Soldiers, but not to be warriors in transition."
—Provider

Emerging issue: Providers at one site commented that the protracted length of the disability evaluation process is extremely troublesome for Service members and their families.

"A big stressor is how long they are held here. Sometime it can be years. They want to move on with their lives but they can't. We try to help them by getting their resumes together and giving them training. They can't leave until the medical boards are done though. We hold onto them for a long time because of this. That makes it hard."
—Provider

"The med board process. It has integrated the programs and eliminated redundancy, but has also lengthened the process. If the VA is backed up, the Service members have to wait 2-3 months for an appointment. If it's going to be integrated, it has to be across the board. This makes them not want to take advantage of what we have here. They have tunnel vision about leaving because of this. So this impacts the family also because the service member can't get back to them because of how long the med board process takes."

—Provider

Emerging issue: Several family members reported difficulty obtaining reimbursement for what they consider to be legitimate expenses.

"I had to drive to Bethesda and then we stayed at the Naval lodge and no one ever paid for anything. They took pay away from him actually."

—Family Member

"There was a little confusion there. My husband called me to tell me he was going to be medevaced to Germany and he said he was going to Walter Reed afterwards. I had a sister in DC so I was waiting on hearing from the advocate. I had spoken with someone who told me to fly to DC and that they would reimburse me for the flight and housing. I got there and then they told me they didn't know me…"

—Family Member

"At Walter Reed, instead of putting him in a nursing home, they gave me a per diem of around $65 a day to feed him, bathe him, clothe him, etc. and get me something to eat. I asked if CBWTU could give me a per diem and they said no. Even though Walter Reed said it would be transferred…"

—Family Member

Emerging issue: Family transportation challenges were cited as a problem by several providers at one site. We believe these challenges are related both to geographic dispersion of families in that area and to a lack of co-location of the WTU and the treatment facility.

"Another thing is the transportation. We are not supposed to do that for the family members or the service members. If they don't drive, we don't know what to do with them though because we can't get them here. We have these situations and it puts a tremendous strain on the military side. Some volunteers are used for driving service members but you need to deal with the liability issues."

—Provider

> "The families have 2, 3, 4 children. It's very hard to shuttle the service member. Getting transportation is a big problem. We are working on a care for the care givers so we can help this problem."
>
> —Provider

Emerging issue: One provider shared a perspective about "new programs." Understanding how providers react to new programs may have implications for how best to introduce new programs to the field.

> "We're doing new programs all the time, and we're trying to figure out how they fit into what we do. Sometimes they just pop up, and we have to figure out how we can use them. The Recovery Care Coordinators just popped into our lives, and no one really explained why they are here. So there's a real learning curve."
>
> —Provider

Summary: How Well Wounded Warrior Families Are Supported

The findings presented in this section of the report offer a picture of strengths and weaknesses inherent in the support available to wounded warrior family members as of summer 2009. The findings are based on responses from 90 providers who participated in focus groups, and completed mini-surveys, at six locations. These findings were augmented by focus group and mini-survey results from 30 wounded warrior family members engaged at four of the six locations. Several themes were echoed across all six locations and/or by an overwhelming large number of focus group participants. These themes—which pertained to family support overall, family participation in support services, and a shortage of providers for the wounded warrior community—were the most salient key findings.

Providers characterized the care system as highly family-centered, describing a focus on the family as both givers and recipients of care. While mini-survey results indicated that smaller proportions of family members than providers were satisfied with available care, a number of family members spoke very positively about the support their families received—for example, from WTU cadre. Provider and family member mini-survey results did highlight a potential gap in services to address families' psychological well-being. Furthermore, although support groups have the potential to bolster families' psychological well-being, support groups specifically oriented to the concerns of wounded warrior family members do not appear to be prevalent. Further assessment of available support for families' psychological needs, and of the prevalence and role of support groups for wounded warrior family members may be warranted.

Providers cited poor family participation as the primary barrier preventing them from supporting families as fully as possible. Providers linked poor family participation to a number of factors,

including difficulty identifying and reaching family members, family and Service member resistance, logistical obstacles such as physical distance between providers and families, and unpersuasive marketing. To overcome these fundamental challenges in a critical component of the service delivery process, further study should be considered.

The shortage of providers, particularly behavioral health specialists, also emerged as a salient finding. Providers mentioned the difficulties they encounter finding staff—military, civilian, or contractor—with the right qualifications to provide the specialized care needed by the wounded warrior community. Providers and family members alike discussed the high caseloads that result from the shortage of providers, and how these caseloads impede optimal service delivery. What is more, there appears to be a dearth of formal training dedicated to working with families of the wounded.

Another important finding, albeit somewhat less salient than those described above, pertained to the information and education available to wounded warrior families. While the mini-survey results revealed that a high percentage of providers (84%) were satisfied with support for families in this area, in focus group discussions providers acknowledged that the sheer amount of information and services available to family members overwhelms them. Providers recognized the need for a clearly designated "go-to" person for families and suggested that a singular point of contact could alleviate the stresses experienced by families inundated with information and services from well-intentioned providers. We note that, on one hand providers claim to be short-staffed and, on the other, they recognize families are overwhelmed by the number of staff offering them support. This is not as paradoxical as it may seem: the root issue for families seems to be not how many providers there are but how these providers are utilized, and their efforts coordinated, on the family's behalf.

Concerns related to continuity of care for wounded warriors over the long-term also emerged as a moderately salient finding. Mini-survey results reinforced continuity of care issues raised during the focus group discussions. In particular, providers expressed concern about the nation's readiness to sustain care for patients and families after they leave the treatment facility, if not the military, and return to their civilian communities across the country. DACOWITS urges DoD, VA, and the Reserve Components to recognize and collaboratively plan for the long-term needs of the wounded warrior community.

The focus groups and mini-surveys generated additional key findings, many in response to targeted questioning, related to rules and regulations that constrain providers from supporting wounded warriors and the families as they would like, support for patients with PTSD/TBI as opposed to outward injuries, the extent to which medical providers share condition-related information with families, and how needs and program effectiveness are assessed. In addition, DACOWITS identified a number of "emerging issues"—a label we assign to issues that are

raised by very few individuals at only one or two sites but seem to have face validity and/or to mirror known concerns and thus warrant inclusion in this report. Examples of emerging issues that DACOWITS identified include the importance of caring for the care provider (e.g., behavioral health specialists), a scarcity of relevant guidance to help programs and care providers deliver optimal service to the wounded warrior community, obstacles that prevent wounded warrior programs from readily accepting support offered by private organizations, and inadequate support for the reintegration process, particularly for wounded warriors diagnosed with PTSD/TBI and their families. Interestingly, this reintegration concern was expressed at both an active and a reserve site.

E. HOW SUPPORT FOR WOUNDED WARRIOR FAMILIES CAN BE FURTHER IMPROVED

DACOWITS sought not only to understand providers' and families' perspectives on the state of wounded warrior family support, but also to elicit their thoughts on how to enhance it. To this end, DACOWITS asked study participants several specific questions, such as what aspect of family support they would change if they were in charge of services and programs for wounded warriors and family members, and what more they would teach family support providers. In this section, we present participants' suggestions in response to these and other questions. We also identify promising and best practices related to family support that DACOWITS members observed or heard about while in the field. This content is presented in five key areas:

- Family support
- Providers
- Coordination among providers
- Information for, and communication with, families
- Continuity of care

A sixth header, "Miscellaneous" is used to capture content that does not fit within these five. Recommendations of the DACOWITS members, based on the findings presented throughout this chapter, are offered in Chapter V.

Family Support

This broad topic encompasses the needs of wounded warrior family members and available support. Providers and family members offered several recommendations related to support for families' emotional well-being.

Although spouses of PTSD/TBI patients often become responsible for managing their husband's, or wife's schedule and providing transportation, spouses unfortunately are not always aware of

their husband's appointments. One suggested it would be helpful if spouses could be apprised of "where the Soldiers are supposed to be." Two suggestions were offered:

- Send mass or targeted emails from WTU to spouses informing them of their Service member's schedule.
- Develop and distribute to spouses a WTU checklist of processes and resources. This would help all spouses understand and execute their role as a member of the recovery team while their Service member is assigned to the WTU, and it may be particularly helpful to spouses of PTSD/TBI patients.

Additional recommendations related to family support include:

- Develop and distribute to spouses a flowchart that graphically depicts the medical evaluation board process, the possible outcomes, and the next steps associated with each of these outcomes. This helps them to understand the process and to begin to envision, and psychologically prepare for, their future.
- Proactively educate military families, especially younger ones, to enhance their readiness to cope with the stressors of military life, including stressors associated with having a wounded, ill, or injured member.
- Educate families of PTSD/TBI patients and ensure the educational content and approach are geared to the level of education of the audience.
- Offer more support groups for family members of PTSD/TBI patients.
- Ensure schools are sensitive to, and equipped to address, the emotional needs of children of wounded warriors.
- Offer free counseling for families. (This is already available through Military OneSource, although it is possible not all family members are aware of, or eligible for, this service.)

One provider noted that efforts to promote wounded warrior family well-being should leverage existing programs, such as pre-deployment, deployment, and post-deployment programming.

Providers

Participants' suggestions addressed both the quality and number of wounded warrior providers. When asked what more they would teach family support providers, a number of study participants offered suggestions. They recommended training for personnel outside the helping professions in areas of interpersonal communication such as listening skills and empathy. One suggested that, when non-medical personnel join the warrior transition unit cadre, they need training in the information-processing limitations of individuals with cognitive impairments (i.e., PTSD or TBI). Another suggested that providers new to the military would benefit from training

in warrior culture. At one site, outreach training was recommended as a means of encouraging more family involvement:

> "We invite people in here often. I think we need to go to them and teach the trainers to go out and be more proactive." (Many agree.)
>
> —Provider

They noted that providing this training would require resources. One provider addressed the shortage of behavioral health professionals, recommending that secure positions be created and efficient hiring practices established so needed resources will be available for the wounded warrior community.

> "…We need to take care of psychiatrists and psychologists so that they can care for the wounded warriors. Some options may be things like using the GS [United States General Schedule Pay Scale] systems for these positions to allow job security or to make them direct service. Psychologists don't know who to contact when they are even looking for these types of jobs. They often call the base and then are directed to call this third-party company that makes so much money just to manage the contracts…"
>
> —Provider

Coordination Among Providers

The DACOWITS members encountered several site-specific best practices that promote coordination.

- Including designated spouse liaisons in regular family services meetings ensures the family perspective is represented during these coordination sessions.
- A statewide public/private provider conference promotes optimal use of resources and enhances communication and coordination across stakeholder groups.

Information for, and Communication with, Families

Several study participants addressed how families are overwhelmed by the volume of information pertaining to them and need one designated individual to function as their "go to" person for information and advocacy.

> "There's a lot to take in, so to have one person who from the beginning, who understands the medical side, and knows about VA benefits, as an advocate from the beginning is the gate guard at the door, and knows that patient and family well enough to know what they need, that would be very helpful. I know the case managers do this to a certain extent."
>
> —Provider

> "I think the answer might lie in: if I need some help, I want to have one place to find the answer. I don't want to get bumped around constantly because I'm in the National Guard and I'm in the VA system too. I want one place to get the answers."
>
> —Family Member

A reservist suggested that Guard and Reserve personnel should be trained in this role and paired with individual Guard and Reserve Service members/families.

Study participants mentioned additional solutions to help families effectively assimilate information. One suggested creating a clearinghouse to centralize all information related to support for wounded warriors and family members. We note that both a national clearinghouse (www.NationalResourceDirectory.org) and site-specific repositories already exist. Thus, to a large extent, this becomes a suggestion for improved marketing of centralized information resources. Several family members also offered recommendations for mass emails, a warrior transition unit Web site, and more timely information dissemination.

Continuity of Care

This topic spans the care provided Service members and families under both the DoD and the VA systems. DACOWITS found that at least one medical treatment facility has started bringing Service members and families back for a comprehensive follow-up evaluation 12 months after discharge from the WTU. This is a 5-day, "head-to-toe" evaluation (i.e., medical, psychological, social, etc.) focused on assessing how successfully the Service member and family are transitioning and determining what further services might be needed. Our understanding is that this outreach is extended to all former WTU members, including those who are no longer in active duty status. DACOWITS views this as a best practice in the effort to provide continuity of care over the long term.

To ensure the long-term needs of the wounded warrior community can be met wherever they may reside after leaving the military, it was recommended that more community-based treatment facilities be established. Recognizing the incremental toll that having a wounded family member can take on those who care for them, and that family members themselves are at risk for secondary traumatization, a medical provider recommended long-term plans for screening, and treatment, of PTSD among family members:

> "After care for after they leave the service. I would increase care provided after discharge. The VA is working very hard to keep up with those leaving, but they haven't been sufficiently beefed up to provide adequate support to the family members and the service members once they go."
>
> —Provider

"There needs to be seamless care, especially when it gets out to the small places. PTSD comes out for a long time. Like with the hurricanes and people that helped, all have PTSD. This is more than just war. It's the family, too."
—Provider

Miscellaneous

The study participants' remaining recommendations dealt primarily with the logistical and financial challenges faced by wounded warrior families. It was suggested that, while the Service member is being treated, families need to be reimbursed more fully for the expenses they incur traveling between their home and the care site and that their child care needs need to be better addressed. For later in the care process, presumably after Service members leave the military, it was suggested that families need better TRICARE coverage and, for those who want to stay in the National Capital Region beyond the outpatient period, help with affordable housing.

To the credit of many across government, the military, the VA, and the civilian sector, significant scrutiny, energy, and resources continue to be devoted to the expansion and refinement of the continuum of care for the wounded warrior community. This is a dynamic arena in which change remains a constant. While the 2009 DACOWITS study was underway, for example, SOC recommendations have continued to be implemented, policy supporting the education and employment needs of wounded warrior spouses has been enacted,[119] the Government Accountability Office (GAO) has initiated a study of the Federal Recovery Care Program,[120] and First Lady Michelle Obama has declared supporting military families a personal priority during her husband's administration.[121] In this fluid environment, as we endeavor to shape the best possible continuum of care, we must continue to systematically pulse and analyze the perspectives of key stakeholders, including America's heroes, their family members, and providers.

[119] The Post-9/11 GI Bill, effective August 2009, permits Service members to transfer education benefits to spouses. The Office of Personnel Management (OPM) has finalized the rules allowing federal agencies to hire military spouses for noncompetitive appointments in the civil service, under specified conditions.
[120] Personal communication, Ms. Melinda Darby, former Executive Director, Senior Oversight Committee
[121] "Michelle Obama focuses on military families." Posted by Foon Rhee, deputy national political editor, "Political Intelligence." March 12, 2009.

IV. 2009 DACOWITS FINDINGS AND RECOMMENDATIONS: WOMEN IN COMBAT: THE UTILIZATION OF WOMEN IN THE OIF/OEF THEATRES OF OPERATIONS

This chapter summarizes the experiences and views of Service members who participated in the 2009 DACOWITS focus groups and panel discussions, including male and female officers and enlisted personnel, on the topic of women in combat and their roles in the OIF/OEF theatres of operations. It also presents recommendations of the DACOWITS Committee resulting from these findings. (For the full presentation of DACOWITS findings on this topic, see Chapter II of this report.)

The chapter is organized under five major headings, as follows:

- Experiences of Women in the OIF and OEF Theatres of Operations
- Implications of Women Serving in Combat
- Combat Preparedness of Female Service Members
- Impact of Serving in Combat on the Military Careers of Female Service Members
- Perspectives on the Roles Women Should Serve in the Military and Understanding of the Current DoD Assignment Policy for Military Women

1. Experiences of Women in the OIF and OEF Theatres of Operations

a. Findings

i. Service members report that females often work outside their MOS while in theatre and perform jobs that do not match their pre-deployment expectations and training. It should be noted that male Service members also perform unexpected jobs while in theatre.

ii. Service members generally think that the combat training that most female Service members received prior to deployment to the OIF or OEF theatres of operations was deficient in one or more aspects, to include absence of training, insufficient amount or length of training, inadequate training, and poor training methods (such as online or virtual combat training).

iii. Military leaders often said that a Service member's capabilities are a higher consideration than one's gender when assigning personnel to combat jobs or missions. There are times when one's gender may come into play, such as mission logistics, cultural considerations, and the gender composition in a particular unit or location (leaders do not like to isolate female Service members from female peers).

iv. Most Service members reported that they or the females with whom they served had been exposed to the hostilities of combat while deployed to OIF or OEF. The combat

experiences of female Service members ranged from firing weapons and being fired upon, traveling on convoys, and participating in female search teams (e.g., Lioness program), to simply being present in the theatre of operations, where, in today's asymmetric battlefield, every Service member is in harm's way and can be fired upon.

b. Recommendation

i. Considering the fluidity of today's battlefield, DACOWITS recommends that the Services ensure that all personnel not possessing a combat arms MOS (i.e., currently all female Service members and many males) receive, at a minimum, a baseline of combat-related training prior to deployment to a combat theatre of operations. This should include "hands-on" weapons qualification and familiarization up to and including crew-served weapons (e.g., mounted light, medium, and heavy machine guns), defensive and offensive convoy measures, perimeter defensive tactics, etc.

2. Implications of Women Serving in Combat

a. Findings

i. Most Service members shared that women serving in combat have a positive impact on both mission accomplishment and unit morale, and said that men and women are equally susceptible to becoming casualties. Among reasons cited for the positive impact of women on mission accomplishment and unit morale were fostering greater sensitivity to cultural considerations, helping to maintain personnel strength, and providing a unique perspective on the mission. Some Service members believe that the mission impact of women serving in combat varies with the mission at hand and the individual female serving in the combat situation.

ii. Most female Service members reported that they were pleased and proud to have served in combat.

b. Recommendation

i. DACOWITS recommends that DoD and the Services develop and implement a strategic communications plan to increase public awareness of the positive contributions of women serving in combat roles in the current conflicts. DACOWITS believes that greater public awareness will lead to increased understanding, acknowledgement, acceptance, and appreciation of the contributions made by women in uniform.

3. Combat Preparedness of Female Service Members

a. Finding

i. Most Service members reported that the equipment provided to females in theatre was inadequate in some capacity. They noted, for example, poor quality or outdated equipment, lack of necessary equipment, tardy issue of equipment, and equipment not sized or designed for women.

b. Recommendations

i. DACOWITS recommends that the Services issue sufficient quantities of equipment, in sizes that are fit for practical use by female Service members.

ii. DACOWITS recommends that DoD and the Services invest in research and development of equipment designed specifically for use by women. DACOWITS notes that improved equipment for women can facilitate the success of women in combat, mission readiness and mission accomplishment. For example, due to the difficult logistics of urinating while wearing their normally issued clothing and equipment, particularly in austere environments, women often minimize fluid intake, placing them at risk for dehydration and urinary tract infections.

4. Impact of Serving in Combat on the Military Careers of Female Service Members

a. Findings

i. The overwhelming majority of female Service members reported that their combat experience has influenced their future plans, either to leave the military earlier than planned or to stay longer than planned. Women planning to leave earlier attribute this to family concerns, the risks associated with combat, and the protracted absences away from the family that are necessitated by high operational tempo.

ii. Most female Service members said that their combat experiences had positively impacted their military career opportunities. Some indicated that not having combat experience would make them less competitive for advancement, while others indicated their deployments limited their Professional Military Educational (PME) opportunities.

b. Recommendation

i. DACOWITS repeats its 2008 recommendation to further consider and study off/on ramps (e.g., Career Intermission Pilot Program [CIPP]) for all branches of Service to determine the return on investment of such programs.

5. Perspectives on the Roles Women Should Serve in the Military and Understanding of the Current DoD Assignment Policy for Military Women

a. Findings

i. The overwhelming majority of Service members indicated that women should be able to fill any and all roles in the military as long as they are capable and qualified for the job. Most also think there are no legitimate reasons for not allowing women to serve in combat roles.

ii. Military leaders were often unaware or uncertain of the current policy related to women serving in combat. Comments ranged from the policy being unfair or outdated, to not enforced (as women are currently serving in combat).

b. Recommendations

i. DACOWITS recommends that DoD and the Services ensure that a refresher on the DoD and Service-specific assignment policies for military women is included in all Professional Military Education (PME) courses.

ii. DACOWITS recommends that the current assignment policy for military women be evaluated and changed as a result of the experiences of females who have served or are serving in combat in support of OIF and OEF.

iii. DACOWITS supports the application across all Services of the following recommendations outlined in the 2007 RAND report, *Assessing the Assignment Policy for Army Women:* [122]

    a. Nature of warfare

[122] Harrell, M., Castaneda, L.W., Schirmer, P., Hallmark, B.W., Kavanagh, J., Gershwin, D., Steinberg, P. (2007). *RAND.* Assessing the Assignment Policy for Army Women.

1. *Recraft the assignment policy for women to make it conform—and clarify how it conforms—to the nature of warfare today and in the future, and plan to review the policy periodically.*

b. Utilization

1. *Clarify whether and how much the assignment policy should constrain military effectiveness, and determine the extent to which military efficiency and expediency can overrule the assignment policy.*

2. *If unit sizes (or levels of command) are specified in the assignment policy, make apparent the reason and intent for specifying unit size, given that modularization and the context of an evolving battlefield may negate this distinction.*

3. *Consider whether the policy should remain focused on assignment to units rather than the employment of individual women.*

c. Colocation/Collocation

1. *Determine whether colocation (proximity) and collocation (proximity and interdependence) are objectionable, and clearly define those terms should they be used in the policy.*

d. Other

1. *Make clear the objectives or intent of any future policy.*

2. *Consider whether a prospective policy should exclude women from units and positions in which they have performed successfully in Iraq.*

3. *Given that the assignment policy is unusual because of the legal requirement to report policy changes to Congress, consider the extent to which an individual service policy should differ from overall DoD policy.*

4. *Determine whether an assignment policy should restrict women from specified occupations or from both occupations and units.*

V. 2009 DACOWITS FINDINGS AND RECOMMENDATIONS: SUPPORT FOR FAMILIES OF WOUNDED WARRIORS

The purpose of this chapter is two-fold. It highlights findings from the 2009 DACOWITS focus groups participants, including care providers and family members of wounded warriors, regarding the support that is available for wounded warrior families. It also presents DACOWITS's recommendations for further improving the continuum of care for this community. All of the recommendations are based on the collected data; some are suggestions made by study participants or are promising or best practices that the DACOWITS members learned of or observed while on site. (For the full presentation of DACOWITS findings on this topic, see Chapter III of this report/)

The chapter is organized under eight major headings, as follows:

- Evidence of recent progress in support for wounded warrior families
- Family support
- Family participation
- Providers
- Information for families
- Support for families of wounded warriors with PTSD/TBI versus outward injuries
- Continuity of care
- Other findings and recommendations.

In several instances, findings and/or recommendations are captured under more than one heading.

1. Evidence of Recent Progress in Support for Wounded Warrior Families

a. Findings

i. DACOWITS found some progress in support for wounded warrior families since its earlier pulsing in 2008, but much work remains in the effort to establish a seamless continuum of care and transition services for the wounded warrior community.

ii. Certain discrepancies in mini-survey responses—between family members and providers, and among providers of various types—were noteworthy. The family member viewpoint on available services and practices was consistently less positive than the provider viewpoint. Also, providers at the same location often provided different responses regarding available services and practices.

b. Recommendation

i. Mini-survey findings underscore how one's role within the service delivery system—e.g., family member, medical provider, non-medical provider, and so forth—influences their awareness of available services. DACOWITS recommends DoD develop and initiate a comprehensive strategic communications plan for imparting critical information to wounded warrior family members and establish mechanisms to ensure systematic information-sharing and communication across medical and non-medical disciplines working at the same site.

2. Family Support

Two topics related to family support are addressed in this section: Warrior Transition Units WTUs) and the psycho-social needs of wounded warrior family members.

2.1 Warrior Transition Units

a. Finding

i. Participants stated that the creation of the WTUs, and more recently the community-based WTUs, was a significant turning point in the care of wounded warriors and their family members. A number of family members spoke very positively about the support their families received—for example from WTU cadre. At the same time, some WTU providers suggested their delivery of optimal service to the wounded warrior community is hampered by insufficient implementation guidance.

b. Recommendations

i. DACOWITS recommends the Services continue to support the establishment and operation of WTUs and CBWTUs, to include generating implementation guidance, promoting smooth transitions across care venues, and identifying and disseminating best practices.

ii. A marriage of two innovative concepts, the CBWTU is designed to fulfill the mission of the WTU while allowing eligible reservists to recover in their home communities. DACOWITS recommends the Army conduct a formative evaluation of this ambitious new program, which will inform development of implementation guidance, identification of best practices, and program improvements.

iii. DACOWITS recommends the Army and sister Services explore the feasibility of broadening the scope of the CBWTUs mission to include a role in support of non-

wounded geographically dispersed Active Component Service members and their families.

iv. DACOWITS recommends the Services develop and distribute to spouses/significant others a WTU checklist of processes and resources. This will help them better understand and execute their role as a member of the recovery team while their Service member is assigned to the WTU, and it may be particularly helpful to spouses of PTSD/TBI patients.

2.2 Psycho-Social Needs of Family Members

a. Findings

i. Mini-survey results highlighted a potential gap in services to address families' psychological well-being, particularly with respect to helping children cope with the Service member's injuries. Irrespective of combat injury, the need for psychological services among children in military families was reinforced by recently released results of a RAND study suggesting that this sub-population may be more prone to emotional and behavioral difficulties than their counterparts in civilian families.[123]

ii. Although support groups are a potential source of social and psychological support for wounded warrior families, and are commonplace within the military and medical communities, DACOWITS found that support groups specifically targeting the concerns of wounded warrior family members were not prevalent.

a. Recommendations

i. DACOWITS recommends DoD assess and identify any gaps in the continuum of care in place to address the psychological needs of children and family members affected by a Service member's injury. DACOWITS also recommends that DoD initiate programs, as appropriate, avoiding unwitting duplication of services and employing proven methods (i.e., evidence-based), as feasible.

ii. DACOWITS recommends DoD ensure schools are sensitive to, and equipped to address, the emotional needs of children of wounded warriors.

[123] *RAND News Release*. (2007). Longer Parental Deployment Linked to More Emotional Challenges for Military Children.

iii. DACOWITS recommends DoD ensure wounded warrior families are familiar with the free counseling available to them through such sources as Military OneSource and Military Family Life Consultants**.**

iv. DACOWITS recommends DoD further assess the prevalence and effectiveness of support groups available for wounded warrior family members.

v. DACOWITS recommends DoD and the Services support the consistent establishment of *injury-specific* support groups for family members of wounded warriors (e.g., family members of wounded warriors with TBI, family members of wounded warriors with amputations, family members of wounded warriors with burns, etc.).

3. Family Participation

a. Finding

i. Providers cited poor family participation as the primary barrier preventing them from fully supporting families. They linked poor family participation to a number of factors, including difficulty identifying and reaching family members, family and Service member resistance, logistical obstacles such as physical distance between providers and families, and the inability to reach families with information about available programs.

b. Recommendations

i. The process of connecting with the target population, i.e., outreach, is a vital component of effective service delivery. DACOWITS recommends further study of the factors that impede successful outreach with, and participation by, the wounded warrior family member population.

ii. DACOWITS recommends DoD implement a robust and comprehensive strategic family member communications campaign that includes proactive outreach and spans pre-deployment through transition of wounded warrior to civilian community. (The U.S. Marine Corps' Sergeant Merlin German 24/7 Call Center is an example of a robust outreach capability.)

iii. DACOWITS recommends DoD develop and deliver outreach training to better equip wounded warrior programs and providers to encourage family involvement. Leverage any existing outreach curricula and best practices of programs that enjoy relatively high levels of family member participation.

iv. DACOWITS recommends the Services highlight and promote the importance of family member participation through strong and persistent command emphasis.

4. Providers

a. Findings

i. Participants frequently reported a shortage of providers, resulting in high caseloads and compromised service delivery. Shortages of behavioral health specialists were mentioned most frequently.

ii. There appears to be a lack of family-oriented training for the diverse spectrum of providers that interface with families of the wounded.

b. Recommendations

i. DACOWITS recommends DoD undertake a coordinated campaign to recruit, train, and retain the labor force needed to sustain the continuum of care that wounded warriors and their families need. Emphasis should be placed on creating efficient hiring practices, secure positions, professional development opportunities, and competitive compensation packages for behavioral health professionals.

ii. DACOWITS recommends DoD develop and provide training to help varied categories of medical and non-medical providers better understand and address the needs of the families of wounded warriors.

iii. DACOWITS recommends DoD provide “effective communication” training (e.g., listening skills) for care providers from outside the helping professions (e.g., WTU squad leader) to enhance their capacity to successfully support families and wounded warriors.

iv. DACOWITS recommends DoD provide “military orientation” training (e.g., warrior culture, military community and lifestyle, family support resources, etc.) for care providers who are new to the military environment to enhance their capacity to successfully support families and wounded warriors.

5. Information for Families

a. Finding

i. Providers acknowledged that the sheer amount of information and services available to family members, as well as the host of medical and non-medical providers that families encounter, can be overwhelming. They identified the need for families to have a clearly designated “go-to” person.

b. Recommendations

i. DACOWITS recommends the Services help families manage the overwhelming volume of information and the large number of providers with whom they and their wounded warrior interface by clearly identifying one provider who is responsible for providing and distilling important information and advocating on their behalf. (The Air Force Family Liaison Officer is a prime example of such a “go-to” person.) For wounded warriors who have been assigned multiple case managers, reconcile and explicitly communicate to families their respective duties and specify the “go-to” person.

ii. DACOWITS recommends the Reserve Component explore the feasibility of training Guard and Reserve personnel as “go-to” resources for the family members of Guard and Reserve wounded.

iii. DACOWITS recommends hospitals provide the family of each newly wounded warrior a binder for storing, organizing, and keeping track of pertinent information. Upon receipt, the binder will contain articles and other information tailored to the patient’s and family’s needs (e.g., names of doctors and other providers, key contact information, medications, and appointments). Over time, the family will add to the binder, using it as a centralized repository of critical information.

iv. To help families better understand the complicated medical evaluation board process, DACOWITS recommends DoD develop and distribute a flowchart depicting the process, the possible outcomes, and the next steps associated with each of these outcomes. This tool this helps families begin to envision and psychologically prepare for their future.

6. Support for Families of Wounded Warriors with PTSD/TBI Versus Outward Injuries

a. Findings

i. Due to memory impairment or other cognitive deficits the wounded warrior may experience as a result of PTSD or TBI, the spouse or parent may assume responsibility for managing the patient's calendar. Family members noted they often have difficulty fulfilling this responsibility because they are not informed of the patient's appointments and care plans, or are not in communication with the patient's care providers.

ii. Providers indicated that, because of the special challenges faced by wounded warriors with PTSD and/or TBI, they are more apt to encourage family members of PTSD/TBI patients to accompany the patient to his or her appointments.

iii. Some concern was voiced that the necessary focus on war injuries detracts from attention to the reintegration needs of wounded warriors and their families. This concern, which was expressed at both an active and a reserve site, may be particularly salient for wounded warriors diagnosed with PTSD/TBI and their families.

b. Recommendations

i. DACOWITS recommends DoD and the Services ensure all non-medical WTU cadre have a baseline understanding of the information-processing limitations that may accompany PTSD/TBI and the resultant need for the primary caregiver (e.g., spouse or parent) to manage the PTSD/TBI patient's calendar and play a central role in the PTSD/TBI patient's recovery plan.

ii. DACOWITS recommends DoD establish mechanisms to ensure providers communicate appointment schedules to primary caregivers who may be responsible for managing their wounded warrior's calendar.

iii. DACOWITS recommends the Services continue to educate families of PTSD/TBI patients. Ensure educational content and delivery are geared to the level of education of the audience.

iv. DACOWITS recommends the Services ensure the availability of dedicated support groups targeting the needs of family members of wounded warriors with PTSD/TBI.

v. DACOWITS recommends DoD explore by what means wounded warriors receive reintegration training and whether the level of reintegration training they receive is commensurate with that provided to non-wounded combat veterans. If a shortfall is

discovered, establish mechanisms to ensure the wounded warrior community, including family members, receives the needed reintegration support. Addressing reintegration needs may be particularly important for wounded warriors and families dealing with conditions that may not have outward manifestations, such as PTSD and TBI.

vi. DACOWITS recommends the Services develop and distribute to spouses/significant others a WTU checklist of processes and resources. This will help them better understand and execute their role as a member of the recovery team while their Service member is assigned to the WTU, and it may be particularly helpful to spouses of PTSD/TBI patients.

7. Continuity of Care

a. Finding

i. Providers expressed concern about the nation's readiness to sustain care for Service members and families as they return to civilian communities. Some noted that family members are at risk for secondary traumatization resulting from the incremental toll of caring for a wounded loved one.

b. Recommendations

i. DACOWITS believes it is imperative that DoD, VA, and the Reserve Components recognize and collaboratively plan for the long-term needs of the wounded warrior community. Several specific recommendations follow.

a. DACOWITS recommends DoD and VA establish more community-based treatment facilities to ensure the long-term needs of the wounded warrior community can be met wherever they may reside after leaving the military.

b. DACOWITS recommends DoD and VA plan for long-term screening and treatment *of family members* (i.e., caregivers) for PTSD and other stress-related conditions.

c. To determine how well wounded warriors and their families are adapting and to identify the need for additional services, DACOWITS recommends the Services bring them back for a comprehensive follow-up evaluation (e.g., medical, psychological, social, and so on) one year following discharge from the WTU. This includes wounded warriors who have left the military.

8. Other Findings and Recommendations

a. Findings

i. By and large, providers reported that the services they provide family members are well coordinated and integrated. In some cases, however, there is disorganization and inefficiency, suggesting that coordination could be improved.

ii. While some efforts to assess the needs of the wounded warrior community and the effectiveness of support programs are in place, assessment—particularly outcome assessment—is not the norm. It appeared to DACOWITS that many providers would welcome empirical data to guide program improvements.

iii. Providers at several sites mentioned administrative obstacles that prevent wounded warrior programs from more readily accepting support offered by private organizations.

iv. Some concern was voiced that the necessary focus on war injuries has detracted from the amount of attention paid to the reintegration needs of wounded warriors and their families. This concern, which was expressed at both an active and a reserve site, may be particularly salient for wounded warriors diagnosed with PTSD/TBI and their families.

v. During the Committee's site visits, it appeared that injured warriors were not treated equally in all circumstances. Warriors who sustained their conditions in combat may be paid more attention than warriors who sustained their conditions outside of combat. For example, celebrities and dignitaries visiting troops at military treatment facilities in the National Capitol Region tend to spend time with those wounded in action, while possibly bypassing other critically injured or ill military personnel. DACOWITS is also aware of a perception among some family members that warriors with physical wounds (e.g., missing limbs) are paid more attention than warriors whose wounds are less visible (e.g., TBI/PTSD). These distinctions among wounded warriors--whether real or perceived--impact both the wounded warrior and their family.

Leadership seems to recognize that wounded warriors and families must feel they are receiving equal treatment, regardless of the nature or circumstances of their condition. DACOWITS concurs that it is imperative that all warriors who are sick or injured receive the best possible treatment the Department of Defense can provide and that no patient in any facility should be made to feel--whether by design, default, or omission--like a second-class citizen.

b. Recommendations

i. To further promote coordination across programs and providers, DACOWITS recommends the Services convene recurring statewide public/private provider conferences that promotes optimal use of resources and enhances communication and coordination across stakeholder groups.

ii. To further promote coordination across programs and providers, DACOWITS recommends identifying a patient-designated liaison who will attend recurring family services staff meetings to ensure the family perspective is represented during these coordination sessions.

iii. DACOWITS recommends DoD and the Services expedite current efforts to establish meaningful metrics that will permit ongoing assessment and refinement of the continuum of care for the wounded warrior community, to include the support provided to wounded warrior families.

iv. DACOWITS recommends wounded warrior programs be provided clear and easy-to-follow guidance on the rules that apply to working with private organizations.

v. DACOWITS recommends DoD explore by what means wounded warriors receive reintegration training and whether the level of reintegration training they receive is commensurate with that provided to non-wounded combat veterans. If a shortfall is discovered, establish mechanisms to ensure the wounded warrior community, including family members, receives the needed reintegration support.

VI. APPENDICES

A. DACOWITS Charter

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APPENDIX A:
DACOWITS CHARTER

APPENDIX A:
DACOWITS CHARTER

Charter Defense Department Advisory Committee on Women in the Services

CHARTER DEFENSE DEPARTMENT ADVISORY COMMITTEE ON WOMEN IN THE SERVICES

A. Official Designation: The Committee shall be known as the Defense Department Advisory Committee on Women in the Services (hereafter referred to as the Committee).

B. Objectives and Scope of Activities: The Committee, under the provisions of the Federal Advisory Committee Act of 1972 (5 U.S.C., Appendix, as amended) shall provide the Secretary of Defense, through the Under Secretary of Defense (Personnel and Readiness) and within the staff cognizance of the Principal Deputy Under Secretary of Defense (Personnel and Readiness), independent advice and recommendations on matters and policies relating to the recruitment and retention, treatment, employment, integration, and well-being of highly qualified professional women in the Armed Forces. In addition, the Committee shall provide advice and recommendations on family issues related to the recruitment and retention of a highly qualified professional military. The Under Secretary of Defense (Personnel and Readiness) may act upon the Committee's advice and recommendations.

C. Committee Membership: The Committee shall be composed of not more than fifteen Committee Members, who represent a distribution of demography, professional career fields, community service, and geography, and selected on the basis of their experience in the military, as a member of a military family, or with women's or family-related workforce issues. Committee Members appointed by the Secretary of Defense, who are not full-time Federal officers or employees, shall serve as Special Government Employees under the authority of 5 U.S.C. § 3109. Committee Members shall be appointed on an annual basis by the Secretary of Defense, and shall normally serve no more than three years on the Committee; however, when necessary the Secretary of Defense may authorize a Committee Member to serve longer than three years on the Committee.

The Secretary of Defense, based upon the recommendation of the Under Secretary of Defense (Personnel and Readiness) shall select the Committee's Chairperson. Committee Members shall, with the exception of travel and per diem for official travel, serve without compensation. In addition, the Under Secretary of Defense (Personnel and Readiness) or designee may invite other distinguished Government officers to serve as non-voting observers of the Committee, and appoint consultants, with special expertise, to assist the Committee on an ad hoc basis.

D. Committee Meetings: The Committee shall meet at the call of the Designated Federal Officer, in consultation with the Chairperson, and the estimated number of Committee meetings is four per year.

The Designated Federal Officer shall be a full-time or permanent part-time DoD employee, and shall be appointed in accordance with established DoD policies and procedures. The Designated

Federal Officer and/or Alternate Designated Federal Officer shall attend all Committee and subcommittee meetings.

The Committee shall be authorized to establish subcommittees, as necessary and consistent with its mission, and these subcommittees or working groups shall operate under the provisions of the Federal Advisory Committee Act of 1972, the Government in the Sunshine Act of 1976 (5 U.S.C. § 552b, as amended), and other appropriate federal regulations.

Such subcommittees or workgroups shall not work independently of the chartered Board, and shall report all their recommendations and advice to the Board for full deliberation and discussion. Subcommittees or workgroups have no authority to make decisions on behalf of the chartered Committee nor can they report directly to the Department of Defense or any Federal officers or employees who are not Committee members.

E. Duration of the Committee: The need for this advisory function is on a continuing basis; however, it is subject to renewal every two years.

F. Agency Support: The Department of Defense, through the Under Secretary of Defense (Personnel and Readiness), shall provide support as deemed necessary for the performance of the Committee's functions, and shall ensure compliance with the requirements of 5 U.S.C. Appendix, as amended. Additional information and assistance as required may be obtained from the Military Departments and other agencies of the Department of Defense, and from the Department of Homeland Security, in the case of the U.S. Coast Guard, as appropriate.

G. Termination Date: The Committee shall terminate upon completion of its mission or two years from the date of this Charter is filed, whichever is sooner or unless the Secretary of Defense extends it.

H. Operating Costs: It is estimated that the operating costs, to include travel costs and contract support, for this Committee is $575,000.00. The estimated personnel costs to the Department of Defense are 5.0 full-time equivalents (FTEs).

I. Recordkeeping: The records of the Committee and its subcommittees shall be handled according to section 2, General Records Schedule 26 and appropriate DoD policies and procedures. These records shall be available for public inspection and copying, subject to the Freedom of Information Act of 1966 (5 U.S.C § 552, as amended).

J. Charter Filed: April 17, 2008

APPENDIX B:
BIOGRAPHIES OF DACOWITS MEMBERS

APPENDIX B:
BIOGRAPHIES OF DACOWITS MEMBERS

Denise W. Balzano -- McLean, Virginia
Denise Balzano is a co-founder of Balzano Associates, a grass roots lobbying firm. She has served as Assistant to the Vice President and Chief of Staff for Marilyn Quayle and as Executive Director of the Republican Women's Federal Forum. Ms. Balzano is a member of the National Board of Childhelp, one of the nation's oldest and largest child abuse treatment and prevention programs, and serves as a pro-bono lobbyist for this nonprofit organization. Ms. Balzano received a B.A. in political science from Hollins College, Virginia, and an M.A. in International Relations from Georgetown University.

The Honorable Diana Denman -- San Antonio, Texas
As a presidential appointee under President Ronald Reagan, she served as the Peace Corps Advisory Co-Chairman and a member of the Institute of Museum Services Board. She currently serves on the Jamestown Foundation Board, WHINSEC (Western Hemisphere Institute for Security Cooperation) Board of Visitors, Department of Defense, and DACOWITS. With her committed interest in foreign policy and National Defense issues, she has served as an Election Observer in the counties of Russia, Ukraine, Honduras, and Nicaragua.

Mrs. Kerry H. Lassus -- Fort Belvoir, Virginia
Mrs. Kerry H. Lassus has been in government service at both the federal and state levels, having served as an Assistant District Attorney in Louisiana, as Director of Consumer Affairs for U.S. Forces Korea in Seoul, Korea, and in the Office of General Counsel for the Panama Canal Commission. She holds a J.D. from Tulane University and a B.A. in Political Science from the University of New Orleans. As an editor/legal writer for the National Legal Research Group, Mrs. Lassus has authored/edited more than 25 legal publications. Mrs. Lassus is an Army spouse and continues to be involved in volunteer work for both the civilian and military communities. She is currently a Sales Director with Mary Kay Inc.

Dr. Mary Ann Nelson, Chairperson -- Lafayette, Colorado
Mary Nelson has taught mathematics at all levels over the past 40 years, and is currently an Applied Mathematics instructor at the University of Colorado at Boulder and the Applied Math Director of Assessment. Her focus is improvement of college mathematics teaching. Previous college teaching positions included George Mason University, the University of Maryland Overseas Division, and Front Range Community College. Dr. Nelson has a B.S. and an M.S. in mathematics from Marquette University and George Mason University, respectively and a Ph.D. in mathematics from the University of Colorado at Boulder. She completed her dissertation in Research and Evaluation Methodology from the University of Colorado, Boulder. She was an Army spouse for 26 years including ten years in Germany and two in Moscow, Russia. In Moscow, she managed an Agency for International Development (U.S.AID) program through the Commerce Department, which brought scientists and businessmen from all over the former Soviet Union to the United States for internships.

CSM Roberta Santiago, USAR Retired -- Castro Valley, California
Roberta Santiago served in U.S. Army Reserve for twenty four years in a variety of assignments including senior legal specialist, personnel staff NCO, senior financial sergeant, first sergeant of a Cargo Transportation Company and command sergeant major of three U.S. Army Reserve hospitals. Her last Army Reserve assignment was as the Command Sergeant Major of the 352nd Combat Support Hospital, Oakland, California. She has been a federal civil servant for more than thirty years working for the Departments of Justice, Army, Navy, and Homeland Security in resource management, human resources, and reserve program management. She has extensive experience volunteering with the Association of the United States Army at the local and national level supporting the Army through interaction with local installations, reserve and National Guard units, local joint services organizations, and family support groups. She currently serves as a Department of Homeland Security civilian for the U.S. Coast Guard, Force Readiness Command, in Alameda, California.

Colonel Felipe (Phil) Torres, USMC Retired -- Helotes, Texas
Phil Torres served in the U.S. Marine Corps for more than 34 years and rose from Private to Colonel. He served in a variety of command, joint, and staff assignments in the infantry, law enforcement, corrections, security, and other arenas. He is a Vietnam veteran and the recipient of the third highest combat decoration, the Silver Star Medal, for actions while serving as an Infantry Platoon Sergeant. His last assignment prior to retiring in 2000 was as the Base Inspector, Marine Corps Bases Japan. Since culminating his Marine Corps career he has been a Leadership, Management, and Teamwork Consultant and an Independent Security Contractor/Consultant in the United States and overseas. He is presently on the staff of Henley-Putnam University, is involved in security training for different organizations, and is active in volunteer civic responsibilities. He received his M.A. in Management from Webster University in San Diego, California; his B.A.A.S. (cum laude) in Occupational Education from Southwest Texas State University in San Marcos, Texas; and has done Ph.D. course work in Organizational Leadership at the University of the Incarnate Word in San Antonio, Texas.

APPENDIX C:
INSTALLATIONS VISITED

APPENDIX C:
INSTALLATIONS VISITED

2009
INSTALLATIONS VISITED FOR FOCUS GROUPS

Site	Members	Dates
National Naval Medical Center, Bethesda, MD	Dr. Mary Nelson, Mrs. Denise Balzano, and Col (Ret) Phil Torres	19 May 09
Camp Lejeune, North Carolina	Col (Ret) Phil Torres and Mrs. Denise Balzano	9-10 June 09
VTCs with Afghanistan	Col (Ret) Phil Torres and Mrs. Kerry Lassus	6 & 8 July 09
Langley AFB, Virginia	Dr. Mary Nelson and CSM (Ret) Roberta Santiago	15-16 July 09
Balboa Naval Hospital San Diego, California	Mrs. Kerry Lassus and The Honorable Diana Denman	16-17 July 09
Georgia National Guard, Fort Gordon, Georgia	Dr. Mary Nelson and Mrs. Denise Balzano	17-19 July 09
Toledo Coast Guard, Port Clinton, Ohio	CSM (Ret) Roberta Santiago	18 July 09
Fort Drum, New York	Dr. Mary Nelson and Mrs. Kerry Lassus	21-22 July 09
VTCs with Iraq	Mrs. Denise Balzano and Mrs. Kerry Lassus	27 July 09
Watertown Reserve Center, Watertown, New York	CSM (Ret) Roberta Santiago	1 Aug 09

APPENDIX D:
FOCUS GROUP PROTOCOLS

APPENDIX D-1:
DACOWITS 2009 WOMEN IN COMBAT FOCUS GROUP PROTOCOL – FEMALE LEADERS

SESSION INFORMATION

FEMALE LEADERS

Location:

Date:

Time:

Facilitator:

Recorder:

# of Participants present for entire session:

# of Participants excused:

Reason(s) they were excused:

_____

_____

THE FOCUS GROUP KICK-OFF: KEY POINTS TO COVER

- **Distribute and gather mini-surveys (can occur before or after introductions)**

- **Welcome attendees**
  - Thank you for taking the time to join our discussion today.
  - I am ___ (insert name) and I am a member of the Department of Defense Advisory Committee on Women in the Services (DACOWITS), and this is ___ (introduce partner), also a member of DACOWITS.

- **Introduce/define DACOWITS**
  - "Department of Defense Advisory Committee on Women in the Services"
  - DACOWITS is responsible for advising the Department of Defense on issues relating to integration of women in the Armed Forces and military family matters.
  - Every year, with input from the Office of the Secretary of Defense, DACOWITS selects specific topics on which to prepare a report for the Secretary of Defense.
  - Current topic under examination:
    - Women in combat: the utilization of women in the OIF/OEF theatre of operations

- **Explain DACOWITS data collection process**

- Committee members visit sites across the military.
- Hold focus groups with Service members and their family members to tap their experiences/perspectives.

- **Describe how the focus group session will work**
  - This session is intended for participants who are female Service member leaders.
  - We have scripted questions.
  - The session will last approximately 90 minutes, and we will not take a formal break.
  - Each of us has a role to play.
    - I serve as an impartial data gatherer and discussion regulator, with help from my co-moderator.
    - Our scribe serves as recorder—note s/he is taking no names.
    - You serve as subject matter experts.

- **Emphasize that participation is voluntary**
  - Your participation in this session is voluntary.
  - While we would like to hear from everyone, feel free to answer as many or as few questions as you prefer.
  - If you would prefer to excuse yourself from the focus group at this time, you are free to do so.
  - You may also excuse yourself at any point during the focus group if you so wish.

- **Address confidentiality**
  - Information you share is confidential to the maximum extent permitted by law; in fact, my colleagues and I sign a confidentiality agreement pledging to safeguard the confidentiality of the information we gather in these sessions.
  - No information will be attributed to you by name.
  - You should likewise treat what you hear in this room with confidentiality.

- **Explain ground rules**
  - Speak clearly and one at a time.
  - There are no right or wrong answers.
  - We want to hear the good and the bad.
  - We respect and value differences of opinion.
  - Please avoid sidebar conversations.

- **Conduct introductions**
  - Our scribe, ___ (insert name), is with ICF International, a research firm hired to record these sessions.

WARM-UP/INTRODUCTIONS

We are here today to hear about your experiences, both as women and as leaders, relating to your deployment in support of Operations Iraqi and Enduring Freedom (OIF/OEF). Before we get started, let's go around the room and please tell us:

1. How many years you have served in (branch of service).

2. Your career field or MOS.

3. Where and when you have deployed *most recently* to support OIF/OEF, and whether this was your first deployment.

PERSONAL EXPERIENCES

Today we'll be discussing your own personal experiences as well as your perspective as a leader of junior female Service members. We'll begin with a discussion of your own experiences, and then we'll move onto a discussion of the experiences of junior women.

4. What was *your* job while you were deployed?
    a. Is it what you expected?
    b. Did you work outside of your MOS while in theatre? If so, please explain.

We're interested in learning more about any experiences you and junior women may have had in combat situations. Before we begin to discuss combat experiences, I'd like to first discuss what combat means.

5. When you hear the word "combat", what are the first words that come to mind? (*Moderator – please go around the room and ask each participant to share two or three words)*

I will read a general definition of combat that I'd like everyone to consider as you answer the remaining questions relating to combat. Please let me know if at any time during the discussion you'd like for me to re-read this definition.

Combat - When one is physically in a combat theater of operation where one is exposed, on a *regular or irregular* basis, to the possibility of hostile action from a threat, either to self or unit, requiring *defensive or offensive* measures, which *may* involve the use of arms to keep from harm.

6. Considering this definition of combat, were *you* involved in any combat situations during your deployment(s) in support of OIF/OEF? (*SHOW OF HANDS*)

7. If involved in any combat situations while deployed for OIF/OEF, please tell me a little bit about the circumstances and your role.

8. What kind of training did you receive in preparation for your deployment to a combat theatre? Was it adequate?

9. What kind of equipment did you receive for your deployment to a combat theatre? Was it adequate?

10. How do you feel about having served in a combat role?

11. Did your combat experiences impact…
    a. Your career plans in the military? (*SHOW OF HANDS*) If so, in what ways?
    b. Your military career advancement opportunities? (*SHOW OF HANDS*) If so, how?

EXPERIENCES OF JUNIOR WOMEN

I'd now like you to think about the deployment experiences of the junior women with whom you served. By junior women, I am referring primarily to E1 to E4 female Service members.

12. What jobs did *junior women* fill while deployed?
    a. Approximately what percentage worked outside of their MOS (your best estimate is fine)?

As a reminder, we are defining combat as:

Combat - When one is physically in a combat theater of operation where one is exposed, on a *regular or irregular* basis, to the possibility of hostile action from a threat, either to self or unit, requiring *defensive or offensive* measures, which *may* involve the use of arms to keep from harm.

13. Considering this definition of combat, were *any of the junior females with whom you served* involved in any combat situations during your deployment(s) in support of OIF/OEF? (*SHOW OF HANDS*)

14. If *junior females you served with* were involved in combat situations, please tell me a little bit about the circumstances and their role.

PERSPECTIVES ON WOMEN IN COMBAT

I'd like to get your thoughts on utilizing female Service members in combat roles. Everyone can answer these questions, regardless of whether you or the junior women with whom you served have been involved in combat. For those of you who have had

combat experience or led female Service members who were in combat, please answer these questions considering your own personal experiences.

15. How does using women in combat impact:
    a. Mission accomplishment?
    b. Unit casualties?
    c. Unit morale?

16. When you're assigning junior Service members to jobs or missions that might involve combat, how does the person's gender figure into your decision process?

WRAP-UP

We have just a few final questions before we are done with our discussion.

17. What is your understanding of the current policy relating to women serving in combat?
    a. In practical terms, how well are you able to implement this policy in theatre?
18. In what roles do *you* think women *should* be utilized in theatre?
19. What are legitimate reasons for *not* allowing women to serve in combat roles?
20. (Moderator - *Ask only if time permits*): What more would you like to say regarding women in combat that we have not yet covered?

21. Reinforce confidentiality.

This concludes our discussion. Thank you for taking the time to share your opinions and experiences with us. Your thoughts are valuable to our efforts to inform the Office of the Secretary of Defense on these matters.

Once again, thank you very much.

APPENDIX D-2:
DACOWITS 2009 WOMEN IN COMBAT FOCUS GROUP PROTOCOL – FEMALE SERVICE MEMBERS

SESSION INFORMATION

FEMALE SERVICE MEMBERS

Location:

Date:

Time:

Facilitator:

Recorder:

# of Participants present for entire session:

# of Participants excused:

Reason(s) they were excused:

_____

_____

THE FOCUS GROUP KICK-OFF: KEY POINTS TO COVER

- **Distribute and gather mini-surveys (can occur before or after introductions)**

- **Welcome attendees**
  - Thank you for taking the time to join our discussion today.
  - I am ___ (insert name) and I am a member of the Department of Defense Advisory Committee on Women in the Services (DACOWITS), and this is ___ (introduce partner), also a member of DACOWITS.

- **Introduce/define DACOWITS**
  - "Department of Defense Advisory Committee on Women in the Services"
  - DACOWITS is responsible for advising the Department of Defense on issues relating to integration of women in the Armed Forces and military family matters.
  - Every year, with input from the Office of the Secretary of Defense, DACOWITS selects specific topics on which to prepare a report for the Secretary of Defense.
  - Current topic under examination:
    - Women in combat: the utilization of women in the OIF/OEF theatre of operations

- **Explain DACOWITS data collection process**
  - Committee members visit sites across the military.
  - Hold focus groups with Service members and their family members to tap their experiences/perspectives.

- **Describe how the focus group session will work**
  - This session is intended for participants who are female Service members.
  - We have scripted questions.
  - The session will last approximately 90 minutes, and we will not take a formal break.
  - Each of us has a role to play.
    - I serve as an impartial data gatherer and discussion regulator, with help from my co-moderator.
    - Our scribe serves as recorder—note s/he is taking no names.
    - You serve as subject matter experts.

- **Emphasize that participation is voluntary**
  - Your participation in this session is voluntary.
  - While we would like to hear from everyone, feel free to answer as many or as few questions as you prefer.
  - If you would prefer to excuse yourself from the focus group at this time, you are free to do so.
  - You may also excuse yourself at any point during the focus group if you so wish.

- **Address confidentiality**
  - Information you share is confidential to the maximum extent permitted by law; in fact, my colleagues and I sign a confidentiality agreement pledging to safeguard the confidentiality of the information we gather in these sessions.
  - No information will be attributed to you by name.
  - You should likewise treat what you hear in this room with confidentiality.

- **Explain ground rules**
  - Speak clearly and one at a time.
  - There are no right or wrong answers.
  - We want to hear the good and the bad.
  - We respect and value differences of opinion.
  - Please avoid sidebar conversations.

- **Conduct introductions**
  - Our scribe, ___ (insert name), is with ICF International, a research firm hired to record these sessions.

WARM-UP/INTRODUCTIONS

We are here today to hear about your experiences relating to your deployment in support of Operations Iraqi and Enduring Freedom (OIF/OEF). Before we get started, let's go around the room and please tell us:

1. How many years you have served in (branch of service).

2. Your career field or MOS.

3. Where and when you have deployed *most recently* to support OIF/OEF, and whether this was your first deployment.

DEPLOYMENT EXPERIENCES

Let's now talk about your deployment experiences.

4. What was your job while you were deployed?
    a. Is it what you expected?
    b. Did you work outside of your MOS while in theatre? If so, please explain.

We're interested in learning more about any experiences you a may have had in combat situations. Before we begin to discuss combat experiences, I'd like to first discuss what combat means.

5. When you hear the word "combat", what are the first words that come to mind? (*Moderator – please go around the room and ask each participant to share two or three words)*

I will read a general definition of combat that I'd like everyone to consider as you answer the remaining questions relating to combat. Please let me know if at any time during the discussion you'd like for me to re-read this definition.

Combat - When one is physically in a combat theater of operation where one is exposed, on a *regular or irregular* basis, to the possibility of hostile action from a threat, either to self or unit, requiring *defensive or offensive* measures, which *may* involve the use of arms to keep from harm.

6. Considering this definition of combat, were *you* involved in any combat situations during your deployment(s) in support of OIF/OEF? (*SHOW OF HANDS*)

7. If involved in any combat situations while deployed for OIF/OEF, please tell me a little bit about the circumstances and your role.

8. What kind of training did you receive in preparation for your deployment to a combat theatre? Was it adequate?

9. What kind of equipment did you receive for your deployment to a combat theatre? Was it adequate?

10. How do you feel about having served in a combat role?

11. Did your combat experiences impact…
    a. Your career plans in the military? (*SHOW OF HANDS*) If so, in what ways?
    b. Your military career advancement opportunities? (*SHOW OF HANDS*) If so, how?

PERSPECTIVES ON WOMEN IN COMBAT

I'd like to get your thoughts on utilizing female Service members in combat roles. Everyone can answer these questions, regardless of whether you've been involved in combat. For those of you who have had combat experience, please answer these questions considering your own personal experiences.

12. How does using women in combat impact:
    a. Mission accomplishment?
    b. Unit casualties?
    c. Unit morale?

WRAP-UP

We have just a few final questions before we are done with our discussion.

13. In what roles do *you* think women *should* be utilized in theatre?

14. What are legitimate reasons for *not* allowing women to serve in combat roles?

15. (Moderator - *Ask only if time permits*): What more would you like to say regarding women in combat that we have not yet covered?

16. Reinforce confidentiality.

This concludes our discussion. Thank you for taking the time to share your opinions and experiences with us. Your thoughts are valuable to our efforts to inform the Office of the Secretary of Defense on these matters.

Once again, thank you very much.

APPENDIX D-3:
DACOWITS 2009 WOMEN IN COMBAT FOCUS GROUP PROTOCOL – MALE LEADERS

SESSION INFORMATION

MALE LEADERS

Location:

Date:

Time:

Facilitator:

Recorder:

# of Participants present for entire session:

# of Participants excused:

Reason(s) they were excused:

_____
_____

THE FOCUS GROUP KICK-OFF: KEY POINTS TO COVER

- **Distribute and gather mini-surveys (can occur before or after introductions)**

- **Welcome attendees**
  - Thank you for taking the time to join our discussion today.
  - I am ___ (insert name) and I am a member of the Department of Defense Advisory Committee on Women in the Services (DACOWITS), and this is ___ (introduce partner), also a member of DACOWITS.

- **Introduce/define DACOWITS**
  - "Department of Defense Advisory Committee on Women in the Services"
  - DACOWITS is responsible for advising the Department of Defense on issues relating to integration of women in the Armed Forces and military family matters.
  - Every year, with input from the Office of the Secretary of Defense, DACOWITS selects specific topics on which to prepare a report for the Secretary of Defense.
  - Current topic under examination:
    - Women in combat: the utilization of women in the OIF/OEF theatre of operations

- **Explain DACOWITS data collection process**
  - Committee members visit sites across the military.
  - Hold focus groups with Service members and their family members to tap their experiences/perspectives.

- **Describe how the focus group session will work**
  - This session is intended for participants who are male Service member leaders.
  - We have scripted questions.
  - The session will last approximately 90 minutes, and we will not take a formal break.
  - Each of us has a role to play.
    - I serve as an impartial data gatherer and discussion regulator, with help from my co-moderator.
    - Our scribe serves as recorder—note s/he is taking no names.
    - You serve as subject matter experts.

- **Emphasize that participation is voluntary**
  - Your participation in this session is voluntary.
  - While we would like to hear from everyone, feel free to answer as many or as few questions as you prefer.
  - If you would prefer to excuse yourself from the focus group at this time, you are free to do so.
  - You may also excuse yourself at any point during the focus group if you so wish.

- **Address confidentiality**
  - Information you share is confidential to the maximum extent permitted by law; in fact, my colleagues and I sign a confidentiality agreement pledging to safeguard the confidentiality of the information we gather in these sessions.
  - No information will be attributed to you by name.
  - You should likewise treat what you hear in this room with confidentiality.

- **Explain ground rules**
  - Speak clearly and one at a time.
  - There are no right or wrong answers.
  - We want to hear the good and the bad.
  - We respect and value differences of opinion.
  - Please avoid sidebar conversations.

- **Conduct introductions**
  - Our scribe, ___ (insert name), is with ICF International, a research firm hired to record these sessions.

WARM-UP/INTRODUCTIONS

We are here today to hear about your experiences relating to the deployment of women in support of Operations Iraqi and Enduring Freedom (OIF/OEF). Before we get started, let's go around the room and please tell us:

1. How many years you have served in (branch of service).

2. Your career field or MOS.

3. Where and when you have deployed *most recently* to support OIF/OEF, and whether this was your first deployment.

DEPLOYMENT EXPERIENCES

Let's now talk about your deployment experiences.

4. What jobs did *junior women* fill while deployed? By junior women, I am referring primarily to E1 to E4 female Service members.
    a. Approximately what percentage worked outside of their MOS (your best estimate is fine)?

We're interested in learning more about any experiences junior females may have had in combat situations. Before we begin to discuss combat experiences, I'd like to first discuss what combat means.

5. When you hear the word "combat", what are the first words that come to mind? (*Moderator – please go around the room and ask each participant to share two or three words)*

I will read a general definition of combat that I'd like everyone to consider as you answer the remaining questions relating to combat. Please let me know if at any time during the discussion you'd like for me to re-read this definition.

Combat - When one is physically in a combat theater of operation where one is exposed, on a *regular or irregular* basis, to the possibility of hostile action from a threat, either to self or unit, requiring *defensive or offensive* measures, which *may* involve the use of arms to keep from harm.

6. Considering this definition of combat, were *any of the junior females with whom you served* involved in any combat situations during your deployment(s) in support of OIF/OEF? (*SHOW OF HANDS*)

7. If *junior females you served with* were involved in combat situations, please tell me a little bit about the circumstances and their role.

8. What kind of training did these junior females receive in preparation for their deployment to a combat theatre?
    a. Was it adequate?
    b. How did this training differ from that received by junior males?

9. What kind of equipment did these junior females receive for their deployment to a combat theatre? Was it adequate?

10. How effectively do you think these junior females served in this combat role? Please explain.

PERSPECTIVES ON WOMEN IN COMBAT

I'd like to get your thoughts on utilizing female Service members in combat roles. Everyone can answer these questions, regardless of whether junior females with whom you served have been involved in combat. For those of you who have led female Service members who were in combat, please answer these questions considering your own personal experiences.

11. How does using women in combat impact:
    a. Mission accomplishment?
    b. Unit casualties?
    c. Unit morale?

12. When you're assigning junior Service members to jobs or missions that might involve combat, how does the person's gender figure into your decision process?

WRAP-UP

We have just a few final questions before we are done with our discussion.

13. What is your understanding of the current policy relating to women serving in combat?
    a. In practical terms, how well are you able to implement this policy in theatre?

14. In what roles do *you* think women *should* be utilized in theatre?

15. What are legitimate reasons for *not* allowing women to serve in combat roles?

16. (Moderator - *Ask only if time permits*): What more would you like to say regarding women in combat that we have not yet covered?

17. ***Reinforce confidentiality.***

This concludes our discussion. Thank you for taking the time to share your opinions and experiences with us. Your thoughts are valuable to our efforts to inform the Office of the Secretary of Defense on these matters.

Once again, thank you very much.

APPENDIX D-4:
DACOWITS 2009 WOMEN IN COMBAT FOCUS GROUP PROTOCOL – MALE SERVICE MEMBERS

SESSION INFORMATION

MALE SERVICE MEMBERS

Location:

Date:

Time:

Facilitator:

Recorder:

# of Participants present for entire session:

# of Participants excused:

Reason(s) they were excused:

_____

_____

THE FOCUS GROUP KICK-OFF: KEY POINTS TO COVER

- **Distribute and gather mini-surveys (can occur before or after introductions)**

- **Welcome attendees**
  - Thank you for taking the time to join our discussion today.
  - I am ___ (insert name) and I am a member of the Department of Defense Advisory Committee on Women in the Services (DACOWITS), and this is ___ (introduce partner), also a member of DACOWITS.

- **Introduce/define DACOWITS**
  - "Department of Defense Advisory Committee on Women in the Services"
  - DACOWITS is responsible for advising the Department of Defense on issues relating to integration of women in the Armed Forces and military family matters.
  - Every year, with input from the Office of the Secretary of Defense, DACOWITS selects specific topics on which to prepare a report for the Secretary of Defense.
  - Current topic under examination:
    - Women in combat: the utilization of women in the OIF/OEF theatre of operations

- **Explain DACOWITS data collection process**

- Committee members visit sites across the military.
- Hold focus groups with Service members and their family members to tap their experiences/perspectives.

- **Describe how the focus group session will work**
  - This session is intended for participants who are male Service members.
  - We have scripted questions.
  - The session will last approximately 90 minutes, and we will not take a formal break.
  - Each of us has a role to play.
    - I serve as an impartial data gatherer and discussion regulator, with help from my co-moderator.
    - Our scribe serves as recorder—note s/he is taking no names.
    - You serve as subject matter experts.

- **Emphasize that participation is voluntary**
  - Your participation in this session is voluntary.
  - While we would like to hear from everyone, feel free to answer as many or as few questions as you prefer.
  - If you would prefer to excuse yourself from the focus group at this time, you are free to do so.
  - You may also excuse yourself at any point during the focus group if you so wish.

- **Address confidentiality**
  - Information you share is confidential to the maximum extent permitted by law; in fact, my colleagues and I sign a confidentiality agreement pledging to safeguard the confidentiality of the information we gather in these sessions.
  - No information will be attributed to you by name.
  - You should likewise treat what you hear in this room with confidentiality.

- **Explain ground rules**
  - Speak clearly and one at a time.
  - There are no right or wrong answers.
  - We want to hear the good and the bad.
  - We respect and value differences of opinion.
  - Please avoid sidebar conversations.

- **Conduct introductions**
  - Our scribe, ___ (insert name), is with ICF International, a research firm hired to record these sessions.

WARM-UP/INTRODUCTIONS

We are here today to hear about your experiences relating to your deployment in support of Operations Iraqi and Enduring Freedom (OIF/OEF). Before we get started, let's go around the room and please tell us:

1. How many years you have served in (branch of service).

2. Your career field or MOS.

3. Where and when you have deployed *most recently* to support OIF/OEF, and whether this was your first deployment.

PERSONAL EXPERIENCES

Let's now talk about your deployment experiences.

4. What was your job while you were deployed?
   a. Is it what you expected?
   b. Did you work outside of your MOS while in theatre? If so, please explain.

We're interested in learning more about any experiences you and your female peers may have had in combat situations. Before we begin to discuss combat experiences, I'd like to first discuss what combat means.

5. When you hear the word "combat", what are the first words that come to mind? (*Moderator – please go around the room and ask each participant to share two or three words)*

I will read a general definition of combat that I'd like everyone to consider as you answer the remaining questions relating to combat. Please let me know if at any time during the discussion you'd like for me to re-read this definition.

Combat - When one is physically in a combat theater of operation where one is exposed, on a *regular or irregular* basis, to the possibility of hostile action from a threat, either to self or unit, requiring *defensive or offensive* measures, which *may* involve the use of arms to keep from harm.

We'll begin by discussing your own experiences.

6. Considering this definition of combat, were *you* involved in any combat situations during your deployment(s) in support of OIF/OEF? (*SHOW OF HANDS*)

7. If involved in any combat situations while deployed for OIF/OEF, please tell me a little bit about the circumstances and your role.

8. What kind of training did you receive in preparation for your deployment to a combat theatre? Was it adequate?

9. What kind of equipment did you receive for your deployment to a combat theatre? Was it adequate?

10. How do you feel about having served in a combat role?

11. Did your combat experiences impact…
    a. Your career plans in the military? (*SHOW OF HANDS*) If so, in what ways?
    b. Your military career advancement opportunities? (*SHOW OF HANDS*) If so, how?

EXPERIENCES OF FEMALE PEERS

I'd now like you to think about the combat experiences of your female peers. As a reminder, we are defining combat as:

Combat - When one is physically in a combat theater of operation where one is exposed, on a *regular or irregular* basis, to the possibility of hostile action from a threat, either to self or unit, requiring *defensive or offensive* measures, which *may* involve the use of arms to keep from harm.

12. Considering this definition of combat, were *any of your female peers* involved in any combat situations during your deployment(s) in support of OIF/OEF? (*SHOW OF HANDS*)

13. If *any of your female peers* were involved in combat situations, please tell me a little bit about the circumstances and their role.

14. What kind of training did your female peers receive in preparation for their deployment to a combat theatre? Was it adequate?

15. What kind of equipment did your female peers receive for their deployment to a combat theatre? Was it adequate?

16. How effectively do you think your female peers served in this combat role? Please explain.

PERSPECTIVES ON WOMEN IN COMBAT

I'd like to get your thoughts on utilizing female Service members in combat roles. Everyone can answer these questions, regardless of whether you have been involved in combat. For those of you who have had combat experience with female peers, please answer these questions considering your own personal experiences.

17. How does using women in combat impact:
    a. Mission accomplishment?
    b. Unit casualties?
    c. Unit morale?

WRAP-UP

We have just a few final questions before we are done with our discussion.

18. In what roles do *you* think women *should* be utilized in theatre?

19. What are legitimate reasons for *not* allowing women to serve in combat roles?

20. (Moderator - *Ask only if time permits*): What more would you like to say regarding women in combat that we have not yet covered?

21. Reinforce confidentiality.

This concludes our discussion. Thank you for taking the time to share your opinions and experiences with us. Your thoughts are valuable to our efforts to inform the Office of the Secretary of Defense on these matters.

Once again, thank you very much.

APPENDIX D-5:
DACOWITS 2009 WOUNDED WARRIOR PROVIDER FOCUS GROUP PROTOCOL – PROVIDERS

SESSION INFORMATION

PROVIDERS

Location:

Date:

Time:

Facilitator:

Recorder:

# of Participants present for entire session:

# of Participants excused:

Reason(s) they were excused:

_____
_____

THE FOCUS GROUP KICK-OFF: KEY POINTS TO COVER

- **Distribute and gather mini-surveys (can occur before or after introductions)**

- **Welcome attendees**
  - Thank you for taking the time to join our discussion today.
  - I am ___ (insert name) and I am a member of the Department of Defense Advisory Committee on Women in the Services (DACOWITS), and this is ___ (introduce partner), also a member of DACOWITS.

- **Introduce/define DACOWITS**
  - "Department of Defense Advisory Committee on Women in the Services"
  - DACOWITS is responsible for advising the Department of Defense on issues relating to integration of women in the Armed Forces and military family matters.
  - Every year, with input from the Office of the Secretary of Defense, DACOWITS selects specific topics on which to prepare a report for the Secretary of Defense.
  - Current topic under examination:
    - Support for Families of Wounded Warriors

- **Explain DACOWITS data collection process**

- Committee members visit sites across the military.
- Hold focus groups with Service members and their family members to tap their experiences/perspectives.

- **Describe how the focus group session will work**
  - This session is intended for participants who are medical and non-medical providers of care to wounded warriors and their Families.
  - We have scripted questions.
  - The session will last approximately 90 minutes, and we will not take a formal break.
  - Each of us has a role to play.
    - I serve as an impartial data gatherer and discussion regulator, with help from my co-moderator.
    - Our scribe serves as recorder—note s/he is taking no names.
    - You serve as subject matter experts.

- **Emphasize that participation is voluntary**
  - Your participation in this session is voluntary.
  - While we would like to hear from everyone, feel free to answer as many or as few questions as you prefer.
  - If you would prefer to excuse yourself from the focus group at this time, you are free to do so.
  - You may also excuse yourself at any point during the focus group if you so wish.

- **Address confidentiality**
  - Information you share is confidential to the maximum extent permitted by law; in fact, my colleagues and I sign a confidentiality agreement pledging to safeguard the confidentiality of the information we gather in these sessions.
  - No information will be attributed to you by name.
  - You should likewise treat what you hear in this room with confidentiality.

- **Explain ground rules**
  - Speak clearly and one at a time.
  - There are no right or wrong answers.
  - We want to hear the good and the bad.
  - We respect and value differences of opinion.
  - Please avoid sidebar conversations.

- **Conduct introductions**
  - Our scribe, ___ (insert name), is with ICF International, a research firm hired to record these sessions.

WARM-UP/INTRODUCTIONS

To begin I'd like to go around the room and ask each of you to introduce yourselves (your first name is sufficient) and to share some brief background on your work with the wounded warrior community. Specifically please tell us:

1. Your job title and the Service branch and organization for which you work (e.g., Marine Corps, Army, hospital, SFAC, WTU)

2. How long you've worked with the wounded warrior community (including current and previous positions)

MILITARY SUPPORT OF THE NEEDS OF WOUNDED WARRIOR FAMILY MEMBERS (WHAT IS)

We are interested in understanding how wounded warrior family members are faring.

3. Apart from support for getting to the bedside and lodging during the inpatient and outpatient periods—which we understand works fairly well—what else is working well for family members of wounded warriors?

4. What is working less well for family members of wounded warriors?

5. How well do the following initiatives address the needs of family members of wounded warriors? [MODERATOR—no need to ask "a" thru "c" below if responses to earlier questions already addressed these areas]

    a. The Service-specific wounded warrior Programs (e.g., Army Wounded Warrior Program [AW2], Navy Casualty and Safe Harbor Program, Marine Wounded Warrior Regiment, Air Force Wounded Warrior Program [AFW2])
    b. The Warrior Transition Unit (WTU)
    c. The Recovery Care Program

PROGRESS IN MILITARY SUPPORT OF NEEDS OF WOUNDED WARRIOR FAMILY MEMBERS (COMPARING WHAT IS WITH WHAT WAS)

We are interested in your perspective on the progress being made in efforts to support the wounded warrior community.

6. What improvements have you observed in the last 8 -10 months in the support that is available for family members of wounded warriors (e.g., services, facilities, information, etc.)?

7. What kinds of support groups are available to family members of wounded warriors (e.g., Family Readiness Group, group for family members of amputees, etc.)? (moderator: this follows up on a specific recommendation from previous study)

8. How much information do wounded warrior's medical providers give family members about his or her condition? (moderator: this follows up on a specific recommendation from previous study)

9. How does the support that family members' receive vary as a function of whether their wounded warrior has a diagnosis of PTSD/TBI as opposed to a physical condition? (moderator: this follows up on a specific recommendation from previous study)

10. What training have you received about the role of family members in the recovery process? [MODERATOR—ask separately of medical versus non-medical providers] (moderator: this follows up on a specific recommendation from previous study)

11. In some settings, wounded warriors families are partnered with advocates who are former military or current Reserve Component members. To what extent is this being done here?

12. In what ways are the needs of wounded warrior families and the effectiveness of support programs being systematically assessed?

PROVIDERS OF SUPPORT FOR WOUNDED WARRIOR FAMILY MEMBERS (WHAT IS)

We are interested in your experiences and perceptions as care-givers for the wounded warrior community.

13. What are the barriers that prevent you from supporting wounded warrior family members as you would like?

    a. Prompts:
        i. Funding
        ii. Other physical resources (e.g., space, vehicles)
        iii. Legislation
        iv. Guidance
        v. Training
        vi. Size of caseload

14. What are the barriers that prevent other providers from adequately supporting wounded warrior family members?

15. What other types of providers, if any, could meaningfully improve the level of support provided to family members?

16. How effectively do you providers coordinate with each other on families' behalf?

WRAP UP (WHAT COULD BE)

In closing we'd like to ask you to "put on a few hats":

17. If you were in charge of all services and programs for wounded warriors and family members across the military, what aspect of family support would you change?

18. If you were a trainer of family support providers, what more would you teach them?

19. **Reinforce confidentiality.**

This concludes our discussion. Thank you for taking the time to share your opinions and experiences with us. Your thoughts are valuable to our efforts to inform the Office of the Secretary of Defense on these matters.

Once again, thank you very much.

APPENDIX D-6:
DACOWITS 2009 WOUNDED WARRIOR FAMILY MEMBER GROUP PROTOCOL – FAMILY MEMBERS

SESSION INFORMATION

FAMILY MEMBERS

Location:

Date:

Time:

Facilitator:

Recorder:

# of Participants present for entire session:

# of Participants excused:

Reason(s) they were excused:

_____

_____

THE FOCUS GROUP KICK-OFF: KEY POINTS TO COVER

- **Distribute and gather mini-surveys (can occur before or after introductions)**

- **Welcome attendees**
  - Thank you for taking the time to join our discussion today.
  - I am ___ (insert name) and I am a member of the Department of Defense Advisory Committee on Women in the Services (DACOWITS), and this is ___ (introduce partner), also a member of DACOWITS.

- **Introduce/define DACOWITS**
  - "Department of Defense Advisory Committee on Women in the Services"
  - DACOWITS is responsible for advising the Department of Defense on issues relating to integration of women in the Armed Forces and military family matters.
  - Every year, with input from the Office of the Secretary of Defense, DACOWITS selects specific topics on which to prepare a report for the Secretary of Defense.
  - Current topic under examination:
    - Support for families of wounded warriors

- **Explain DACOWITS data collection process**

- Committee members visit sites across the military.
- Hold focus groups with Service members and their family members to tap their experiences/perspectives.

- **Describe how the focus group session will work**
  - This session is intended for participants who are family members of Wounded Service members.
  - We have scripted questions.
  - The session will last approximately 90 minutes, and we will not take a formal break.
  - Each of us has a role to play.
    - I serve as an impartial data gatherer and discussion regulator, with help from my co-moderator.
    - Our scribe serves as recorder—note s/he is taking no names.
    - You serve as subject matter experts.

- **Emphasize that participation is voluntary**
  - Your participation in this session is voluntary.
  - While we would like to hear from everyone, feel free to answer as many or as few questions as you prefer.
  - If you would prefer to excuse yourself from the focus group at this time, you are free to do so.
  - You may also excuse yourself at any point during the focus group if you so wish.

- **Address confidentiality**
  - Information you share is confidential to the maximum extent permitted by law; in fact, my colleagues and I sign a confidentiality agreement pledging to safeguard the confidentiality of the information we gather in these sessions.
  - No information will be attributed to you by name.
  - You should likewise treat what you hear in this room with confidentiality.

- **Explain ground rules**
  - Speak clearly and one at a time.
  - There are no right or wrong answers.
  - We want to hear the good and the bad.
  - We respect and value differences of opinion.
  - Please avoid sidebar conversations.

- **Conduct introductions**
  - Our scribe, ___ (insert name), is with ICF International, a research firm hired to record these sessions.

WARM-UP/INTRODUCTIONS

To begin I'd like to go around the room and ask each of you to introduce yourselves (your first name is sufficient) and to share some brief background on your Service member and his/her injury. Specifically please tell us:

1. Your Service member's branch of Service (e.g., Marine Corps, Army) and your relationship to him or her (e.g., Are you a spouse? A parent?)

2. Length of time since your Service member sustained his or her wounds/injuries

3. Where the Service member is in the recovery process: inpatient, outpatient and living near hospital, outpatient and living at home

    a. MODERATOR—follow-up to determine:
        i. Whether wounded or ill
        ii. If wounded, severity of condition and where injury was sustained

MILITARY SUPPORT OF THE NEEDS OF WOUNDED WARRIOR FAMILY MEMBERS (WHAT IS)

We are interested in understanding how wounded warrior family members are faring.

4. Apart from support for getting to the bedside and lodging during the inpatient and outpatient periods—which we understand works fairly well for families—what is currently working well for you as family members of wounded warriors?

5. What is currently working less well for you as family members of wounded warriors?

6. How well do the following initiatives address your needs as family members of wounded warriors? [MODERATOR—no need to as "a" thru "c" below if responses to earlier questions already addressed these areas]

    a. The wounded warrior Program established by your Service member's branch (e.g., Army Wounded Warrior Program [AW2], Navy Casualty and Safe Harbor Program, Marine Wounded Warrior Regiment, Air Force Wounded Warrior Program [AFW2])
    b. The Warrior Transition Unit (WTU)
    c. The Recovery Care Program

PROGRESS IN MILITARY SUPPORT OF NEEDS OF WOUNDED WARRIOR FAMILY MEMBERS (COMPARING WHAT IS WITH WHAT WAS)

We are interested in your perspective on the progress being made in efforts to support the wounded warrior community.

7. What improvements have you observed in the last 8 -10 months in the support that is available for family members of wounded warriors (e.g., services, facilities, information, etc.)?

8. Where do you turn for all the information you need as the family member of a wounded warrior? (moderator: this follows up on a specific recommendation from previous study)

    a. Prompts:
        i. Does the information cover all stages from incident thru retirement/return to service and beyond?
        ii. Is there an outreach strategy that proactively pushes information out to family members?
        iii. Is this information provided using a multimedia approach capitalizing on new media?

9. What kinds of support groups are available to you as the family member of a wounded warrior (e.g., Family Readiness Group, group for family members of amputees, etc.)? (moderator: this follows up on a specific recommendation from previous study)

10. How much information have your wounded warrior's medical providers given you about his or her condition? (moderator: this follows up on a specific recommendation from previous study)

    a. Prompts: Did they talk with you about:
        i. Symptoms?
        ii. Prognosis?
        iii. Recovery care plan?
        iv. Family role?
        v. Resources?

PROVIDERS OF SUPPORT FOR WOUNDED WARRIOR FAMILY MEMBERS (WHAT IS)

We are interested in your perceptions of the various types of care-givers with whom you interact as the family member of a wounded warrior. We are particularly interested in your experiences with those responsible for providing family support.

11. Let's start by identifying the various types of care-givers, or providers, that you are working with. [MODERATOR—start with their top of mind responses, then offer suggestions such as "a" through "j" below]

a. Chaplain
b. Soldier and Family Assistance Center (SFAC) personnel
c. Family Readiness Coordinator or Leader
d. Doctors/nurses
e. Medical case manager
f. Squad leader
g. Case manager
h. Family Liaison Officer
i. Patient advocate
j. Recovery Care Coordinator

12. Which of these types of providers stand out as particularly helpful to you?

13. Which of these types of providers stand out as particularly unhelpful to you?

14. As far as you can tell, what prevents these providers from being more helpful to you?

15. As we've discussed, there are various types of providers that can potentially assist you. What other types of providers, if any, could meaningfully improve the level of support you are receiving as the family member of a wounded warrior?

16. How effectively do providers coordinate with each other on your behalf?

WRAP UP (WHAT COULD BE)

In closing we'd like to ask you to "put on a few hats":

17. If you were in charge of all services and programs for wounded warriors and family members across the military, what aspect of family support would you change?

18. If you were a trainer of family support providers, what more would you teach them?

MODERATOR: *FOLLOWING QUESTIONS ONLY IF TIME PERMITS:*

19. What stands out for you as something the military did that was particularly helpful for you as the family member of a wounded warrior?

20. What stands out as something that you found unhelpful or frustrating as the family member of a wounded warrior?

21. Reinforce confidentiality.

This concludes our discussion. Thank you for taking the time to share your opinions and experiences with us. Your thoughts are valuable to our efforts to inform the Office of the Secretary of Defense on these matters.

Once again, thank you very much. We want to express our sincere hopes for your Service member's recovery.

APPENDIX E:
MINI-SURVEYS

APPENDIX E-1:
DACOWITS 2009 WOMEN IN COMBAT MINI-SURVEY

2009 DACOWITS Women in Combat Mini-Survey

1. What is your branch of Service?

- O Air Force
- O Army
- O Coast Guard
- O Marine Corps
- O Navy
- O Navy Reserve
- O Army Reserve
- O Air Force Reserve
- O Army National Guard
- O Air Guard
- O Marine Corps Reserve

2. How long, in total, have you served in the military? PLEASE ROUND TO THE NEAREST YEAR.

_____ **Years**

3. What is your gender?

- O Female
- O Male

4. What is your marital status?

- O Single, with no significant other
- O Single, but with a significant other (e.g., girlfriend/boyfriend, fiancé)
- O Married
- O Divorced or legally separated
- O Widowed

5. How many children do you have in each of the following age groups? MARK ALL THAT APPLY.

_____ Under 3 years
_____ 3 - 5 years
_____ 6 - 10 years
_____ 11 - 13 years
_____ 14 - 17 years
_____ 18 and over

- O Does not apply; I have no children

6. How many times have you deployed in support of OIF/OEF?

- O Once
- O Twice
- O Three times
- O Four times or more
- O Does not apply; I have not been deployed in support of OIF/OEF

7. While in theatre, did you work outside your MOS?

- O No
- O Yes, occasionally
- O Yes, frequently
- O Does not apply; I have not been deployed in support of OIF/OEF

8. While in theatre, did you perform the job assignment that you received prior to deployment?

- O Yes
- O No, my assignment changed after I deployed
- O Does not apply; I have not been deployed in support of OIF/OEF

9. While deployed in support of OIF/OEF, were you…

	No	Yes, irregularly	Yes, regularly
Physically in a combat theatre of operations?	O	O	O
Exposed to the possibility of hostile action from a threat to yourself or your unit?	O	O	O
In a situation where you fired your weapon?	O	O	O
In a situation where you received hostile fire (e.g., gunfire, rockets/mortars, IEDs, suicide bomber, ambush)?	O	O	O

- O Does not apply; I have not been deployed in support of OIF/OEF

10. If you selected "yes" to any of the above scenarios (in Q9), how did these experiences influence your military career plans? PLEASE SELECT ONE.

- O Did not influence my military career plans at all
- O Made me want to *stay in the military longer* than I had planned
- O Made me want to *leave the military earlier* than I had planned
- O Does not apply; I did not select "yes" to any of the above scenarios in Q9
- O Does not apply; I have not been deployed in support of OIF/OEF

11. Please rate the adequacy of the training you received prior to your most recent deployment in preparing you for combat. PLEASE SELECT ONE.

- O Very adequate
- O Somewhat adequate
- O Neither adequate nor inadequate
- O Somewhat inadequate
- O Very inadequate
- O I did not receive any combat-related training prior to my most recent deployment
- O Does not apply; I have not been deployed in support of OIF/OEF

12. What is your pay grade?

- O E1
- O E2
- O E3
- O E4
- O E5
- O E6
- O E7
- O E8
- O E9
- O WO1
- O CW2
- O CW3
- O CW4
- O CW5
- O O1
- O O2
- O O3
- O O4
- O O5
- O O6

DACOWITS 2009, Women in Combat Mini- Survey, ICF International, 2009

APPENDIX E-2:
DACOWITS 2009 WOUNDED WARRIOR PROVIDER MINI-SURVEY

2009 DACOWITS Family Support for Wounded Warrior Mini-Survey (Provider)

1. What is your employment status?
- O Military (please indicate pay grade:_____)
- O Civil Service (please indicate level: _____)
- O Contractor
- O Other: _____

2. With what branch of Service are you affiliated?
- O Air Force
- O Army
- O Coast Guard
- O Marine Corps
- O Navy
- O Army Reserve
- O Air Force Reserve
- O Army National Guard
- O Air Guard
- O Joint
- O Does not apply

3. Please specify your job title:

_____

4. With which wounded warrior organization are you most closely affiliated? SELECT ONE.
- O Hospital
- O Soldier and Family Assistance Center (SFAC)
- O Warrior Transition Unit (WTU)
- O Private organization: _____
- O Other: _____

5. What is the highest civilian education or degree you have received?
- O High school or equivalency
- O Some college credit but no degree
- O Associate's degree (e.g., A.A., A.S.)
- O Bachelor's degree (e.g., B.A., B.S.)
- O Graduate or professional degree (e.g., M.A., Ph.D., M.D., J.D.)

6. Please indicate your overall level of satisfaction with the military's support for Families, for each stage of a Service member's treatment/recovery.

Stages of Treatment/Recovery Process	Level of Satisfaction: Very Satisfied	Satisfied	Neither Satisfied nor Dissatisfied	Dissatisfied	Very Dissatisfied	Don't Know
A. Support getting you to the member's bedside after you were notified	O	O	O	O	O	O
B. Support while member undergoes Inpatient care	O	O	O	O	O	O
C. Support during Outpatient care or partial hospitalization	O	O	O	O	O	O
D. Support during follow up care (home, rehabilitation)	O	O	O	O	O	O

7. Please indicate your level of satisfaction with the military's support for Families, in the each of the following areas:

Areas of Support	Level of Satisfaction: Very Satisfied	Satisfied	Neither Satisfied nor Dissatisfied	Dissatisfied	Very Dissatisfied	Don't Know
A. Overall Support	O	O	O	O	O	O
B. Finances (e.g., advances, reimbursements)	O	O	O	O	O	O
C. Logistics (e.g., movement to and between treatment facilities; condition of facilities)	O	O	O	O	O	O
D. Information/education (e.g., info about available benefits and services, how to care for injuries, etc.)	O	O	O	O	O	O
E. Emotions (e.g., stress management, coping with grief/depression)	O	O	O	O	O	O
F. Assistance/advocacy (e.g., reducing red-tape, case management, respite care)	O	O	O	O	O	O
G. Support helping children cope with a Service member's injuries	O	O	O	O	O	O

DACOWITS Provider Mini-survey on Family Support for Wounded Warriors, ICF International, 2009

8. Please indicate your level of agreement or disagreement with the following statements:

Statements	Level of Agreement					Don't Know
	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	
A. There is at least one support group that I know of for Family members of wounded warriors	O	O	O	O	O	O
B. Most Families have access to an *advocate* who cares for the Family as a whole	O	O	O	O	O	O
C. Families are generally satisfied with their interactions with the *doctors* who care for their wounded warrior	O	O	O	O	O	O
D. Families are generally satisfied with their interactions with the *nurses* who care for their wounded warrior	O	O	O	O	O	O
E. The military generally provides Families the information they need as Family members of a wounded warrior	O	O	O	O	O	O

9. Please indicate whether or not the following features are part of your current wounded warrior setting. For each feature, check "Yes," "No," or "Don't know".

Features	Presence		
	Yes	No	Don't know
A. Comprehensive information for wounded warrior Family members is available	O	O	O
B. Information for wounded warrior Family members can be found at a central installation or hospital location	O	O	O
C. Information for wounded warrior Family members is available online	O	O	O
D. There are regular welcome briefings that incoming wounded warrior Family members can attend	O	O	O
E. There are town hall meetings (i.e., group meetings held by leadership to exchange information and hear concerns)	O	O	O
F. The chain of command (i.e., the leadership of the local wounded warrior program) has implemented one or more methods for learning about the needs of wounded warrior Family members	O	O	O
G. Child care is provided for wounded warrior Families	O	O	O
H. Transportation support (e.g., bus/van, gas gift card, etc.) is provided for wounded warrior Families	O	O	O
I. The Warrior Transition Unit (WTU) has a support group for WTU Families (may or may not be called Family Readiness Group [FRG])	O	O	O
J. There is a support group for Family members of wounded warriors with similar conditions (e.g., for Family members of amputees)	O	O	O
K. Family members are provided thorough information regarding their wounded warrior's condition (e.g., symptoms, prognosis, recovery plan, Family member role, resources)	O	O	O

APPENDIX E-3:
DACOWITS 2009 WOUNDED WARRIOR FAMILY MEMBER MINI-SURVEY

2009 DACOWITS Family Support for Wounded Warriors Mini Survey (Family)

ABOUT YOU

1. **What is your relationship to the wounded warrior?**
   - O Parent of wounded warrior
   - O Spouse of wounded warrior
   - O Other (Please specify):_____

2. **Please indicate which of the four stages below best describes where your wounded warrior is in the recovery process:**
   - O Initial hospitalization
   - O Outpatient care/Partial hospitalization
   - O Follow-up/Rehabilitation

3. **In what kind of lodging are you currently staying? (e.g., at home, Fisher House, etc.)**

   _____

4. **With whom are you attending this focus group?**
   - O I am attending by myself
   - O I am attending with my spouse
   - O I am attending with someone else
     (Please specify): _____

5. **What is <u>your</u> current employment status?** MARK ALL THAT APPLY.
   - O Employed full-time
   - O Employed part-time
   - O Not employed
   - O Volunteer my time
   - O In school

ABOUT YOUR WOUNDED WARRIOR

6. **Is your <u>wounded warrior</u> married?**
   - O Yes
   - O No

7. **How many dependent children in the following age groups does your <u>wounded warrior</u> have?** MARK ALL THAT APPLY.
   - _____ Under 3 years
   - _____ 3 - 5 years
   - _____ 6 - 10 years
   - _____ 11 - 13 years
   - _____ 14 - 17 years
   - _____ 18 and over
   - O Does not apply; my wounded warrior has no children

8. **What is the nature of your wounded warrior's injury?** MARK ALL THAT APPLY.
   - o Limb Loss
   - o Multiple Limb Loss
   - o Blind
   - o Traumatic Brain Injury
   - o Burn
   - o Spinal Cord Injury
   - o PTSD
   - o Other _____

9. **Does your wounded warrior have a Recovery Plan? (For example, provides an individualized long-term medical and non-medical service plan)**
   - O Yes
   - O No
   - O Not sure

10. **How satisfied are <u>you</u> with the Recovery Plan?**
    - O Very satisfied
    - O Satisfied
    - O Neither satisfied nor dissatisfied
    - O Dissatisfied
    - O Very dissatisfied
    - O Does not apply, my wounded warrior does not have a Recovery Care Plan that I'm aware of

11. **Which of the below listed programs for wounded Service Members has your wounded warrior/family used?**
    - O Army Wounded Warrior Program
    - O Navy Casualty and Safe Harbor Program
    - O Marines Wounded Warrior Regiment
    - O Air Force Palace (HART) (Helping Airmen Recover Together) Program
    - O None of the above
    - O Don't know

12. **What is your wounded warrior's branch of Service**?
    - O Army
    - O Navy
    - O Air Force
    - O Marine Corps
    - O Coast Guard
    - O Army Reserve
    - O Air Force Reserve
    - O Army National Guard
    - O Air Guard
    - O Marine Corps Reserve

13. **What is your wounded warrior's pay grade?**

O E1	O E6	O WO1	O O1
O E2	O E7	O CW2	O O2
O E3	O E8	O CW3	O O3
O E4	O E9	O CW4	O O4
O E5		O CW5	O O5
			O O6

SUPPORT YOU HAVE RECEIVED SINCE YOUR SERVICE MEMBER'S INJURIES

14. **How well informed are you about military support for wounded warriors and their families?**
    - O Very well informed
    - O Moderately well informed
    - O Not very well informed
    - O Not at all informed

DACOWITS Family member Mini-survey on Family Support for Wounded Warriors, ICF International, 2009

15. <u>For each stage</u> of your wounded warrior's treatment/recovery, please indicate your overall level of satisfaction with the military's support for your Family.

Stages of Treatment/Recovery Process	Level of Satisfaction: Very Satisfied	Satisfied	Neither Satisfied nor Dissatisfied	Dissatisfied	Very Dissatisfied	Does not apply (not at this stage yet)
A. Support getting you to the member's bedside after you were notified	O	O	O	O	O	O
B. Support while member undergoes Inpatient care	O	O	O	O	O	O
C. Support during Outpatient care or partial hospitalization	O	O	O	O	O	O
D. Support during follow up care (home, rehabilitation)	O	O	O	O	O	O

16. Please indicate your level of agreement or disagreement with the following statements:

Areas of Support	Level of Satisfaction: Very Satisfied	Satisfied	Neither Satisfied nor Dissatisfied	Dissatisfied	Very Dissatisfied	Does not apply/ Have not needed support in this area
A. Overall Support	O	O	O	O	O	O
B. Finances (e.g., advances, reimbursements)	O	O	O	O	O	O
C. Logistics (e.g., movement to and between treatment facilities; condition of facilities)	O	O	O	O	O	O
D. Information/education (e.g., info about available benefits and services, how to care for injuries, etc.)	O	O	O	O	O	O
E. Emotions (e.g., stress management, coping with grief/depression)	O	O	O	O	O	O
F. Assistance/advocacy (e.g., reducing red-tape, case management, respite care)	O	O	O	O	O	O
G. Support helping children cope with a Service member's injuries	O	O	O	O	O	O

17. Please indicate your level of satisfaction with the military's support of your Family in the <u>each of the following areas</u>:

Statements	Level of Agreement: Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Does not apply
A. There is at least one support group that I know of for Family members of wounded warriors	O	O	O	O	O	O
B. Most Families have access to an *advocate* who cares for the Family as a whole	O	O	O	O	O	O
C. Families are generally satisfied with their interactions with the *doctors* who care for their wounded warrior	O	O	O	O	O	O
D. Families are generally satisfied with their interactions with the *nurses* who care for their wounded warrior	O	O	O	O	O	O
E. The military generally provides Families the information they need as Family members of a wounded warrior	O	O	O	O	O	O

18. Please indicate whether or not the following features are part of your current wounded warrior setting. For each feature, check "Yes," "No," or "Don't know".

Features	Presence: Yes	No	Don't know
A. Comprehensive information for wounded warrior Family members is available	O	O	O
B. Information for wounded warrior Family members can be found at a central installation or hospital location	O	O	O
C. Information for wounded warrior Family members is available online	O	O	O
D. There are regular welcome briefings that incoming wounded warrior Family members can attend	O	O	O
E. There are town hall meetings (i.e., group meetings held by leadership to exchange information and hear concerns)	O	O	O
F. The chain of command (i.e., the leadership of the local wounded warrior program) has implemented one or more methods for learning about the needs of wounded warrior Family members	O	O	O
G. Child care is provided for wounded warrior Families	O	O	O
H. Transportation support (e.g., bus/van, gas gift card, etc.) is provided for wounded warrior Families	O	O	O
I. The Warrior Transition Unit (WTU) has a support group for WTU Families (may or may not be called Family Readiness Group [FRG])	O	O	O
J. There is a support group for Family members of wounded warriors with similar conditions (e.g., for Family members of amputees)	O	O	O
K. Family members are provided thorough information regarding their wounded warrior's condition (e.g., symptoms, prognosis, recovery plan, Family member role, resources)	O	O	O

APPENDIX F:
MINI-SURVEY RESULTS

APPENDIX F-1:
DACOWITS 2009 WOMEN IN COMBAT MINI-SURVEY RESULTS

Demographic Profile of Focus Group Participants (N=339)		
Variable/Response	**N**	**Percent***
Gender:		
Female	238	70%
Male	101	29%
Total	**339**	**100%**
Service:		
Air Force	45	13%
Army	93	28%
Coast Guard	30	9%
Marine Corps	49	15%
Navy	48	14%
Army Reserve	35	10%
Air Force Reserve	2	1%
Army National Guard	27	8%
Air Guard	1	0.3%
Marine Corps Reserve	6	2%
Total	**336**	**100%**
Pay Grade:		
E2	3	1%
E3	10	3%
E4	39	12%
E5	47	14%
E6	45	13%
E7	59	17%
E8	20	6%
E9	15	4%
CW2	3	1%
O1	2	1%
O2	15	4%
O3	42	12%
O4	21	6%
O5	15	4%
O6	3	1%
Total	**339**	**100%**
Marital Status:		
Single, with no significant other	54	16%
Single, but with a significant other	58	17%
Married	184	55%
Divorced or legally separated	40	12%

Demographic Profile of Focus Group Participants (N=339)		
Variable/Response	**N**	**Percent***
Widowed	1	0.3%
Total	**337**	**100%**
Respondents with Children:		
Children	138	41%
No Children	199	60%
Total	**337**	**100%**
Number of Children in Family (of respondents with children):		
1	70	35%
2	68	34%
3 or more	61	31%
Total	**199**	**100%**

* Not every participant answered each question. Percentages may not sum to 100% due to rounding.

How long in total, have you served in the military?		
Response	**N**	**Percent***
Under 3 years	20	6%
3-5 years	61	18%
6-10 years	61	18%
11-15 years	64	19%
16-20 years	68	20%
More than 20 years	62	19%
Total	**336**	**100%**

* Not every participant answered each question. Percentages may not sum to 100% due to rounding.

How many times have you deployed in support of OIF/OEF?		
Response	**N**	**Percent***
Once	179	58%
Twice	102	33%
Three times	15	5%
Four times or more	11	4%
Total	**307**	**100%**
Does not apply; I have not been deployed in support of OIF/OEF	32	-

* Not every participant answered each question. Percentages may not sum to 100% due to rounding.

While in theatre, did you work outside your MOS?		
Response	**N**	**Percent***
No	142	46%
Yes, occasionally	71	23%
Yes, frequently	96	31%
Total	**310**	**100%**
Does not apply; I have not been deployed in support of OIF/OEF	26	-

* Not every participant answered each question. Percentages may not sum to 100% due to rounding.

While in theatre, did you perform the job assignment that you received prior to deployment?		
Response	**N**	**Percent***
Yes	240	78%
No, my assignment changed after I deployed	66	22%
Total	**306**	**100%**
Does not apply; I have not been deployed in support of OIF/OEF	29	-

* Not every participant answered each question. Percentages may not sum to 100% due to rounding.

While deployed in support of OIF/OEF, were you…*								
	No		**Yes, Irregularly**		**Yes, Regularly**		**Total**	
Response	**N**	**%**	**N**	**%**	**N**	**%**	**N**	**%**
Physically in combat theatre of operations	92	30%	50	16%	164	54%	**306**	**100%**
Exposed to the possibility of hostile action from a threat to yourself or your unit?	70	23%	110	36%	126	41%	**306**	**100%**
In a situation where you fired your weapon?	272	90%	20	7%	12	4%	**304**	**100%**
In a situation where you received hostile fire (e.g., gunfire, rockets/mortars, IEDs, suicide bomber, ambush)?	137	45%	98	32%	73	24%	**308**	**100%**

* Not every participant answered each question. Percentages may not sum to 100% due to rounding.

If you selected "yes" to any of the above scenarios (in Q9), how did these experiences influence your military career plans?		
Response	**N**	**Percent***
Did not influence my military career plans at all	187	73%
Made me want to stay in the military longer than I had planned	39	15%
Made me want to leave the military earlier than I had planned	30	12%
Total	**256**	**100%**
Does not apply; I did not select "yes" to any of the above scenarios in Q9	24	-
Does not apply; I have not been deployed in support of OIF/OEF	29	-

* Not every participant answered each question. Percentages may not sum to 100% due to rounding.

Please rate the adequacy of the training you received prior to your most recent deployment in preparing you for combat.		
Response	**N**	**Percent***
Very adequate	97	32%
Somewhat adequate	127	42%
Neither adequate nor inadequate	31	10%
Somewhat inadequate	35	12%
Very inadequate	11	4%
Total	**301**	**100%**
I did not receive any combat-related training prior to my most recent deployment	9	-
Does not apply; I have not been deployed in support of OIF/OEF	28	-

* Not every participant answered each question. Percentages may not sum to 100% due to rounding.

APPENDIX F-2:
DACOWITS 2009 WOUNDED WARRIOR PROVIDER MINI-SURVEY RESULTS

Demographic Profile of Focus Group Participants (N=339)		
Variable/Response	**N**	**Percent***
Employment Status		
Military	35	39%
Civil Service	27	30%
Contractor	25	28%
Other	3	3%
Total	**90**	**100%**
Branch of Service		
Army	26	31%
Navy	25	30%
Marine Corps	14	17%
Army National Guard	6	7%
Joint	6	7%
Air Force	5	6%
Army Reserve	1	1%
Air Force Reserve	0	0%
Air Guard	0	0%
Marine Corps Reserve	0	0%
Total	**83**	**100%**
Does Not Apply	5	-
With which Wounded Warrior Organization are you most closely affiliated?		
Warrior Transition Unit	35	40%
Hospital	30	35%
Soldier and Family Assistance Center	7	8%
Service-Level Wounded Warrior**	6	7%
Other	6	7%
Mental Health**	2	2%
Private Organization	1	1%
Total	**87**	**100%**
Highest civilian education received		
Some college credit but no degree	7	8%
Associate's degree	9	10%
Bachelor's degree	27	30%
Graduate or professional degree?	46	52%
Total	**89**	**100%**

* Not every participant answered each question. Percentages may not sum to 100% due to rounding.

** These responses were not offered to participants on the mini-survey but were created in the analysis phase based on verbatim responses to "Private organization _____" and "Other_____"

Providers' Job Titles (N=90)		
Job Categories and Job Titles**	**N**	**Percent***
Case Manager	22	25%
Mental Health Job Title	8	9%
Military Job Title	8	9%
Family Assistance Job Title	7	8%
Nurse	5	6%
AW2 Advocate	5	6%
Therapist	4	5%
Transition Assistance Job Title	4	5%
Ombudsman	3	3%
Recovery Coordinator	3	3%
Federal Recovery Coordinator	2	2%
Trauma Coordinator	2	2%
Physician	2	2%
VA Liaison for Healthcare (Includes A "Wounded Warrior Liaison")	1	1%
Chaplain	0	0
Other	12	4%
Total	**88**	**100%**

* Not every participant answered each question. Percentages may not sum to 100% due to rounding.
** These job categories were created based on verbatim responses during the analysis phase.

Please indicate your overall level of satisfaction with the military's support for families, <u>for each stage</u> of a Service member's treatment/recovery.		
Question/Response	**N**	**Percent***
Support getting to the member's bedside after notification		
Very satisfied	32	51%
Satisfied	21	33%
Neither satisfied nor dissatisfied	7	111%
Dissatisfied	2	3%
Very dissatisfied	1	2%
Total	**63**	**100%**
Don't Know	24	-
Support while member undergoes inpatient care		
Very satisfied	35	49%
Satisfied	27	38%
Neither satisfied nor dissatisfied	5	7%
Dissatisfied	4	6%
Very dissatisfied	0	0%
Total	**71**	**100%**
Don't Know	17	-

Please indicate your overall level of satisfaction with the military's support for families, for each stage of a Service member's treatment/recovery.		
Question/Response	**N**	**Percent***
Support during outpatient care or partial hospitalization		
Very satisfied	26	36%
Satisfied	30	42%
Neither satisfied nor dissatisfied	8	11%
Dissatisfied	7	10%
Very dissatisfied	1	1%
Total	**72**	**100%**
Don't Know	16	-
Support during follow-up care		
Very satisfied	22	31%
Satisfied	29	41%
Neither satisfied nor dissatisfied	12	17%
Dissatisfied	5	7%
Very dissatisfied	2	3%
Total	**70**	**100%**
Don't Know	18	-

* Not every participant answered each question. Percentages may not sum to 100% due to rounding.

Please indicate your level of satisfaction with the military's support for Families, in each of the following areas:		
Question/Response	**N**	**Percent***
A. Overall support		
Very satisfied	24	28%
Satisfied	50	57%
Neither satisfied nor dissatisfied	12	14%
Dissatisfied	1	1%
Very dissatisfied	1	1%
Total	**88**	**100%**
Don't Know	1	-
B. Finances (e.g., advances, reimbursements)		
Very satisfied	17	22%
Satisfied	35	46%
Neither satisfied nor dissatisfied	19	25%
Dissatisfied	4	5%
Very dissatisfied	1	1%
Total	**76**	**100%**
Don't Know	11	-
C. Logistics (e.g., movement to and between treatment facilities; condition of facilities)		
Very satisfied	15	19%
Satisfied	38	48%
Neither satisfied nor dissatisfied	18	23%

Please indicate your level of satisfaction with the military's support for Families, in <u>each of the following areas:</u>		
Question/Response	**N**	**Percent***
Dissatisfied	8	10%
Very dissatisfied	0	0%
Total	**79**	**100%**
Don't Know	10	-
D. Information/education (e.g., info about available benefits and services, how to care for injuries etc.)		
Very satisfied	22	26%
Satisfied	49	58%
Neither satisfied nor dissatisfied	10	12%
Dissatisfied	3	4%
Very dissatisfied	0	0%
Total	**84**	**100%**
Don't Know	6	-
E. Emotions (e.g., stress management, coping with grief/depression)		
Very satisfied	17	20%
Satisfied	45	52%
Neither satisfied nor dissatisfied	13	15%
Dissatisfied	10	12%
Very dissatisfied	2	2%
Total	**87**	**100%**
Don't Know	3	-
F. Assistance/advocacy (e.g. reducing red-tape, case management, respite care)		
Very satisfied	20	24%
Satisfied	40	48%
Neither satisfied nor dissatisfied	14	17%
Dissatisfied	8	10%
Very dissatisfied	1	1%
Total	**83**	**100%**
Don't Know	6	-
G. Support helping children cope with a Service member's injuries		
Very satisfied	11	15%
Satisfied	21	29%
Neither satisfied nor dissatisfied	26	36%
Dissatisfied	13	18%
Very dissatisfied	1	1%
Total	**72**	**100%**
Don't Know	18	-

* Not every participant answered each question. Percentages may not sum to 100% due to rounding.

Please indicate your level of agreement or disagreement with the following statements:		
Question/Response	**N**	**Percent***
A. There is at least one support group that I know of for Family members of wounded warriors.		
Strongly agree	46	57%
Agree	32	40%
Neither agree nor disagree	1	1%
Disagree	1	1%
Strongly disagree	1	1%
Total	**81**	**100%**
Does Not Apply	6	-
B. Most families have access to an *advocate* who cares for the Family as a whole.		
Strongly agree	38	45%
Agree	34	41%
Neither agree nor disagree	8	10%
Disagree	3	4%
Strongly disagree	1	1%
Total	**84**	**100%**
Does Not Apply	5	-
C. Families are generally satisfied with their interactions with the *doctors* who care for their wounded warrior.		
Strongly agree	22	26%
Agree	32	37%
Neither agree nor disagree	17	20%
Disagree	13	15%
Strongly disagree	2	2%
Total	**86**	**100%**
Does Not Apply	2	-
D. Families are generally satisfied with their interactions with the *nurses* who care for their wounded warrior.		
Strongly agree	27	32%
Agree	42	50%
Neither agree nor disagree	11	13%
Disagree	3	4%
Strongly disagree	1	1%
Total	**84**	**100%**
Does Not Apply	5	-
E. The military generally provides Families the information they need as Family members of a wounded warrior.		
Strongly agree	23	28%
Agree	43	52%
Neither agree nor disagree	12	15%
Disagree	4	5%

Please indicate your level of agreement or disagreement with the following statements:		
Strongly disagree	1	1%
Total	**83**	**100%**
Does Not Apply	5	-

* Not every participant answered each question. Percentages may not sum to 100% due to rounding.

Please indicate whether or not the following features are part of your current wounded warrior setting. For each feature, check "Yes," "No," or "Don't Know".		
Feature/ Response	**N**	**Percent***
A. Comprehensive information for wounded warrior Family Members is available		
Yes	72	82%
No	5	6%
Don't Know	11	13%
Total	**88**	**100%**
B. Information for wounded warrior Family members can be found at a central installation or hospital location		
Yes	65	75%
No	9	10%
Don't Know	13	15%
Total	**87**	**100%**
C. Information for wounded warrior Family members is available online		
Yes	71	81%
No	2	2%
Don't Know	15	17%
Total	**88**	**100%**
D. There are regular welcome briefings that incoming wounded warrior Family members can attend		
Yes	62	60%
No	10	12%
Don't Know	25	29%
Total	**87**	**100%**
E. There are town hall meetings (i.e., group meetings held by leadership to exchange information and hear concerns)		
Yes	69	78%
No	6	7%
Don't Know	14	16%
Total	**89**	**100%**
F. The chain of command (i.e., the leadership of the social wounded warrior program) has implemented on or more methods for learning about the needs of wounded warrior Family members		
Yes	68	77%
No	1	1%
Don't Know	20	23%
Total	**89**	**100%**
G. Child care is provided for wounded warrior Families		

Please indicate whether or not the following features are part of your current wounded warrior setting. For each feature, check "Yes," "No," or "Don't Know".		
Feature/ Response	**N**	**Percent***
Yes	43	48%
No	16	18%
Don't Know	30	34%
Total	**89**	**100%**
H. Transportation support (e.g., bus/van, gas gift card, etc.) is provided for wounded warrior Families		
Yes	68	77%
No	4	5%
Don't Know	17	19%
Total	**89**	**100%**
I. The Warrior Transition Unit (WTU) has a support group for WTU Families (may or may not be called Family Readiness Group [FRG])		
Yes	49	55%
No	11	12%
Don't Know	29	33%
Total	**89**	**100%**
J. There is a support group for Family members of wounded warriors with similar conditions (e.g., for Family members of amputees)		
Yes	44	49%
No	15	17%
Don't Know	30	34%
Total	**89**	**100%**
K. Family members are provided thorough information regarding their wounded warrior's condition (e.g., symptoms, prognosis, recovery plan, Family member role, resources)		
Yes	67	75%
No	3	3%
Don't Know	19	21%
Total	**89**	**100%**

* Not every participant answered each question. Percentages may not sum to 100% due to rounding.

APPENDIX F-3:
DACOWITS 2009 WOUNDED WARRIOR FAMILY MEMBER MINI-SURVEY RESULTS

Demographic Profile of Focus Group Participants (N=339)		
Variable/Response	**N**	**Percent***
Relationship to wounded warrior:		
Spouse of wounded warrior	23	77%
Other	4	13%
Parent of wounded warrior	3	10%
Total	**30**	**100%**
Participant Attended the Focus Group with:		
I am attending by myself	23	77%
I am attending with my spouse	6	20%
I am attending with someone else	1	3%
Total	**30**	**100%**
Participant's Employment Status (Mark all that apply):		
Employed full-time	12	41%
Not employed	11	38%
In school	5	17%
Employed part-time	2	7%
Volunteer my time	2	7%
Total	**32**	**NA**

* Not every participant answered each question. Percentages may not sum to 100% due to rounding.

Demographic Profile of Focus Group Participants' Wounded Warriors (N=339)		
Variable/Response	**N**	**Percent***
Wounded Warrior's Marital Status:		
Yes	28	93%
No	2	7%
Total	**30**	**100%**
Wounded Warriors with Children:		
Children	23	23%
No Children	7	77%
Total	**30**	**100%**
Number of Children in Family (of respondents with children):		
1	10	44%
2	6	26%
3 or more	7	30%
Total	**23**	**100%**
Wounded Warrior's Stage of Recovery:		
Follow-up/Rehabilitation	21	72%
Outpatient Care/Partial Hospitalization	6	21%

Demographic Profile of Focus Group Participants' Wounded Warriors (N=339)		
Variable/Response	**N**	**Percent***
Initial Hospitalization	3	10%
Total	**30**	**100%**
Wounded Warrior's Injury:		
Poly-trauma**	20	67%
PTSD	15	50%
Traumatic Brain Injury	12	40%
Spinal Cord Injury	5	17%
Limb Loss	3	10%
Other	3	10%
Burn	2	7%
Multiple Limb Loss	0	0
Blind	0	0
Total***	**60**	**NA**
Wounded Warrior's Branch of Service:		
Army	18	62%
Army National Guard	6	20%
Marine Corps	3	10%
Navy	2	7%
Air Force	0	0%
Coast Guard	0	0%
Army Reserve	0	0%
Air Force Reserve	0	0%
Air Guard	0	0%
Marine Corps Reserve	0	0%
Total	**29**	**100%**
Wounded Warrior's Pay Grade:		
E1	0	0%
E2	0	0%
E3	2	7%
E4	9	32%
E5	5	18%
E6	6	21%
E7	2	7%
E8	2	7%
E9	0	0%
WO1	0	0%
CW2	0	0%
CW3	0	0%
CW4	0	0%
CW5	0	0%
O1	0	0%

Demographic Profile of Focus Group Participants' Wounded Warriors (N=339)		
Variable/Response	**N**	**Percent***
O2	0	0%
O3	1	4%
O4	0	0%
O5	1	4%
O6	0	0%
Total	**28**	**100%**

* Not every participant answered each question. Percentages may not sum to 100% due to rounding.
** Poly-trauma category was created based on verbatim responses during the analysis phase.
*** Total number of injuries exceeds the total number of respondents because some WW had multiple injuries.

Does your wounded warrior have a recovery plan? (For example, provides an individualized long-term and non-medical service plan)		
Response	**N**	**Percent***
Yes	11	39%
No	6	21%
Not Sure	11	39%
Total	**28**	**100%**

* Not every participant answered each question. Percentages may not sum to 100% due to rounding.

How satisfied are you with the recovery plan?		
Response	**N**	**Percent***
Very satisfied	4	21%
Satisfied	6	32%
Neither satisfied nor dissatisfied	3	16%
Dissatisfied	4	21%
Very dissatisfied	2	11%
Total	**19**	**100%**
Does Not Apply, my Wounded Warrior does not have a Recovery Care Plan that I'm aware of	9	-

* Not every participant answered each question. Percentages may not sum to 100% due to rounding.

Which of the below listed programs for wounded Service members has your wounded warrior/family used?		
Response	**N**	**Percent***
Army Wounded Warrior Program	16	59%
Navy Casualty and Safe Harbor	1	4%
Marines Wounded Warrior Regiment	2	7%
Air Force Palace (HART) (Helping Airmen Recover Together) Program	0	0%
None of the above	5	19%
Total	**27**	**100%**
Don't know	3	-

* Not every participant answered each question. Percentages may not sum to 100% due to rounding.

How well informed are you about military support for wounded warriors and their families?		
Response	**N**	**Percent***
Very well informed	4	14%
Moderately well informed	14	48%
Not very well informed	10	35%
Not at all informed	1	3%
Total	**29**	**100%**

*Not every participant answered each question. Percentages may not sum to 100% due to rounding.

For each stage of your wounded warrior's treatment/recovery, please indicate your overall level of satisfaction with the military's support for your Family.		
Question/Response	**N**	**Percent***
Support getting you to the member's bedside after you were notified		
Very satisfied	7	37%
Satisfied	6	32%
Neither satisfied nor dissatisfied	3	16%
Dissatisfied	0	0%
Very dissatisfied	3	16%
Total	**19**	**100%**
Does Not Apply (not at this stage yet)	8	-
Support while member undergoes inpatient care		
Very satisfied	7	30%
Satisfied	8	35%
Neither satisfied nor dissatisfied	2	9%
Dissatisfied	4	17%
Very dissatisfied	2	9%
Total	**23**	**100%**
Does Not Apply (not at this stage yet)	4	-
Support during outpatient care or partial hospitalization		
Very satisfied	4	19%
Satisfied	7	33%
Neither satisfied nor dissatisfied	4	19%
Dissatisfied	3	14%
Very dissatisfied	3	14%
Total	**21**	**100%**
Does Not Apply (not at this stage yet)	4	-
Support during follow-up care		
Very satisfied	3	15%
Satisfied	8	40%

For each stage of your wounded warrior's treatment/recovery, please indicate your overall level of satisfaction with the military's support for your Family.		
Question/Response	**N**	**Percent***
Neither satisfied nor dissatisfied	6	30%
Dissatisfied	1	5%
Very dissatisfied	2	10%
Total	**20**	**100%**
Does Not Apply (not at this stage yet)	5	-

* Not every participant answered each question. Percentages may not sum to 100% due to rounding.

Please indicate your level of satisfaction with the following statements		
Question/Response	**N**	**Percent***
A. Overall support		
Very satisfied	7	26%
Satisfied	11	41%
Neither satisfied nor dissatisfied	4	15%
Dissatisfied	5	19%
Very dissatisfied	0	0%
Total	**27**	**100%**
Does Not Apply/ Have not needed support in this area	0	**-**
B. Finances (e.g., advances, reimbursements)		
Very satisfied	8	32%
Satisfied	6	24%
Neither satisfied nor dissatisfied	5	20%
Dissatisfied	3	12%
Very dissatisfied	3	12%
Total	**25**	**100%**
Does Not Apply/ Have not needed support in this area	2	**-**
C. Logistics (e.g., movement to and between treatment facilities; condition of facilities)		
Very satisfied	7	30%
Satisfied	5	22%
Neither satisfied nor dissatisfied	6	26%
Dissatisfied	3	13%
Very dissatisfied	2	9%
Total	**23**	**100%**
Does Not Apply/ Have not needed support in this area	3	-
D. Information/education (e.g., info about available benefits and services, how to care for injuries etc.)		
Very satisfied	6	22%
Satisfied	10	37%
Neither satisfied nor dissatisfied	5	19%
Dissatisfied	4	15%
Very dissatisfied	2	7%
Total	**27**	**100%**

Please indicate your level of satisfaction with the following statements		
Question/Response	**N**	**Percent***
Does Not Apply/ Have not needed support in this area	1	-
E. Emotions (e.g., stress management, coping with grief/depression)		
Very satisfied	5	20%
Satisfied	7	28%
Neither satisfied nor dissatisfied	5	20%
Dissatisfied	6	24%
Very dissatisfied	2	8%
Total	**25**	**100%**
Does Not Apply/ Have not needed support in this area	3	-
F. Assistance/advocacy (e.g. reducing red-tape, case management, respite care)		
Very satisfied	6	24%
Satisfied	7	28%
Neither satisfied nor dissatisfied	6	24%
Dissatisfied	3	12%
Very dissatisfied	3	12%
Total	**25**	**100%**
Does Not Apply/ Have not needed support in this area	2	-
G. Support helping children cope with a Service member's injuries		
Very satisfied	3	19%
Satisfied	4	25%
Neither satisfied nor dissatisfied	3	19%
Dissatisfied	4	25%
Very dissatisfied	2	13%
Total	**16**	**100%**
Does Not Apply/ Have not needed support in this area	12	-

* Not every participant answered each question. Percentages may not sum to 100% due to rounding.

Please indicate your level of agreement or disagreement with the military's support for your Family in <u>each of the following areas</u>:		
Question/Response	**N**	**Percent***
A. There is at least one support group that I know of for Family members of Wounded Warriors.		
Strongly agree	4	15%
Agree	10	37%
Neither agree nor disagree	6	22%
Disagree	5	19%
Strongly disagree	2	7%
Total	**27**	**100%**
Does Not Apply	1	-
B. Most families have access to an *advocate* who cares for the Family as a whole.		
Strongly agree	5	19%
Agree	9	33%

Please indicate your level of agreement or disagreement with the military's support for your Family in <u>each of the following areas</u>:		
Question/Response	**N**	**Percent***
Neither agree nor disagree	4	15%
Disagree	4	15%
Strongly disagree	5	19%
Total	**27**	**100%**
Does Not Apply	1	-
C. Families are generally satisfied with their interactions with the *doctors* who care for their Wounded Warrior.		
Strongly agree	3	11%
Agree	11	41%
Neither agree nor disagree	4	15%
Disagree	6	22%
Strongly disagree	3	11%
Total	**27**	**100%**
Does Not Apply	2	-
D. Families are generally satisfied with their interactions with the *nurses* who care for their Wounded Warrior.		
Strongly agree	5	21%
Agree	10	42%
Neither agree nor disagree	6	25%
Disagree	2	8%
Strongly disagree	1	4%
Total	**24**	**100%**
Does Not Apply	4	-
E. The military generally provides Families the information they need as Family members of a wounded warrior.		
Strongly agree	2	8%
Agree	12	48%
Neither agree nor disagree	3	12%
Disagree	2	8%
Strongly disagree	6	24%
Total	**25**	**100%**
Does Not Apply	1	-

* Not every participant answered each question. Percentages may not sum to 100% due to rounding.

Please indicate whether or not the following features are part of your current wounded warrior setting. For each feature, check "Yes," "No," or "Don't Know".		
Feature/ Response	**N**	**Percent***
A. Comprehensive information for wounded warrior Family members is available		
Yes	16	57%
No	1	4%
Don't Know	11	40%
Total	**28**	**100%**

Please indicate whether or not the following features are part of your current wounded warrior setting. For each feature, check "Yes," "No," or "Don't Know".		
Feature/ Response	**N**	**Percent***
B. Information for wounded warrior Family members can be found at a central installation or hospital location		
Yes	9	32%
No	2	7%
Don't Know	17	61%
Total	**28**	**100%**
C. Information for wounded warrior Family members is available online		
Yes	16	57%
No	1	4%
Don't Know	11	39%
Total	**28**	**100%**
D. There are regular welcome briefings that incoming wounded warrior Family members can attend		
Yes	12	43%
No	3	11%
Don't Know	13	46%
Total	**28**	**100%**
E. There are town hall meetings (i.e., group meetings held by leadership to exchange information and hear concerns)		
Yes	15	54%
No	1	4%
Don't Know	12	43%
Total	**28**	**100%**
F. The chain of command (i.e., the leadership of the social wounded warrior program) has implemented on or more methods for learning about the needs of wounded warrior Family members		
Yes	9	33%
No	4	15%
Don't Know	14	52%
Total	**27**	**100%**
G. Child care is provided for wounded warrior Families		
Yes	11	39%
No	1	4%
Don't Know	16	57%
Total	**28**	**100%**
H. Transportation support (e.g., bus/van, gas gift card, etc.) is provided for wounded warrior Families		
Yes	10	36%
No	5	18%
Don't Know	13	46%
Total	**28**	**100%**

Please indicate whether or not the following features are part of your current wounded warrior setting. For each feature, check "Yes," "No," or "Don't Know".		
Feature/ Response	**N**	**Percent***
I. The Warrior Transition Unit (WTU) has a support group for WTU Families (may or may not be called Family Readiness Group [FRG])		
Yes	11	39%
No	4	14%
Don't Know	13	46%
Total	**28**	**100%**
J. There is a support group for Family members of wounded warriors with similar conditions (e.g., for Family members of amputees)		
Yes	7	25%
No	2	7%
Don't Know	19	68%
Total	**28**	**100%**
K. Family members are provided thorough information regarding their wounded warrior's condition (e.g., symptoms, prognosis, recovery plan, Family member role, resources)		
Yes	13	46%
No	5	18%
Don't Know	10	36%
Total	**28**	**100%**

* Not every participant answered each question. Percentages may not sum to 100% due to rounding.

APPENDIX G:
PROVIDER INSIGHTS ABOUT WOUNDED WARRIOR FAMILIES

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Although characterizing wounded warrior families was not an objective of the moderators' questioning, the providers occasionally shared casual observations about the wounded warrior family member population in the course of responding to the focus group moderators' questions. Their comments offer insight into potential complexities and challenges inherent in working with this population—indeed with all populations. Providers' observations are summarized below.

Patients' families vary in how they react to and process information about their loved one's condition.

> "The family gets angry if you give them bad news, or if you give them news that doesn't happen that way. Like if you tell them someone's not going to make it and they do, then they get upset! It's hard to know what's going to happen, because you can't predict."
> —Provider

> "A lot of people appreciate honesty as well. They want you to be straightforward."
> —Provider

There may be family or marital dysfunction independent of the Service member's condition.

> "You have some dysfunctional families, and it's an issue. The whole extended family can be an issue."
> —Provider

> "Function of the family is sometimes a problem. Sometimes they fight and you have to have security come in and handle the situation. And then you have families that really don't get along, and they have to have time slots for when the mom or the dad can be here so that they don't overlap. It's parents, wives, mother-in-laws, lots of drama. It gets in the way of caring for the patients."
> —Provider

Families may withhold certain information from providers until trust is established.

> "I'm a retired military wife and the mindset before was if you wanted a wife, they would issue you one (smiles). So this is a new concept to value the families. It's like anything else in life; you test it out and need to buy into it before you really believe in it. As a nurse, you see that the families don't want to tell everyone everything that's going on. They worry about the impact on the service member's career. Having a husband that is not the same is very hard and they need to adjust to this. We deal with this and trust is a major issue. Once we earn the trust, then they see us as extended family and trust us to help them."
>
> —Provider

> "I reiterate what others have said. Families are under a lot of stress. They are always smiling and have the kids with them and seem happy, but when you get down to it, it's not how it really is. Sometimes they don't want to open up or be involved with the programs here. With that barrier, it takes a long time to get that information from them [their needs]. Sometimes you go to a meeting and you never get all the information about how the recovery is going. Service members often don't want their wives involved. There are many things available to them, but we can't make them use everything we have."
>
> —Provider

> "The family members are affected by it. They don't know that they should come because they don't trust us yet. After we earn their trust then they participate more."
>
> —Provider

> "Reconciling expectations along the journey is very difficult. The family has a hard time when patients plateau. The Recovery Care Program helps with this."
>
> —Provider

The protracted separation between Service members and their spouses can create or exacerbate problems in their relationship.

> "As that intimate relationship is fostered, we can discern if there is marital conflict and give them information about the support groups. A big problem is the separations. They are here for so long and there's a big cost for dealing with this."
>
> —Provider

Young couples may be particularly vulnerable to a lack of coping skills.

> "Take a step back. The 18-year-olds don't have communication skills. They don't have life skills. I think we need to go back—every Soldier should be required to go through marriage counseling when he/she gets into the Army. We do too much crisis management."
>
> —Provider

> "Serious marital issues that impact a Soldier's ability to function in his job is seen primarily in the 18- to 23-year-old Soldiers. They marry and then immediately deploy, and we wonder why they have problems. There should be some communication building skills…"
>
> —Provider

As the recovery process continues over months and years, and demands persist upon family members caring for the wounded warrior, they are prone to burn-out.

> "I think one of the things that is difficult is further down the road is these people are getting caregiver burn out. After a couple of years, you still have a lot of physical needs, the family and patients are still angry."
>
> —Provider

The Committee categorizes these observations as insights rather than findings, since they did not emerge as salient themes across multiple providers or sites.

APPENDIX H:
BRIEFINGS PRESENTED TO DACOWITS

APPENDIX H:
BRIEFINGS PRESENTED TO DACOWITS DURING FISCAL YEAR 2009 BUSINESS MEETINGS

Assessing the Assignment Policy for Army Women – Presented by Dr. Margaret C. Harrell

Understanding the Deployment Experiences of Guard and Reserve Families – Presented by Dr. Laura Castaneda and Dr. Margaret C. Harrell

Survey of Health Related Behaviors among Military Personnel – Presented by LTC Lorraine Babeu

National Guard Bureau Warrior Support – Presented by Mr. Alex Baird

Psychological Health Program – Presented by CAPT Joan Hunter

Army Wounded Warrior Program & Support for Families of Wounded Warriors – Presented by Mr. Robert Moore

Marine Corps Wounded Warrior Report and Program – Presented by Colonel Greg Boyle

Navy Safe Harbor – Presented by CAPT Key Watkins

Navy Family Support Plans for Wounded Warriors – Presented by Zona Lewis

Air Force Wounded Warrior Program – Presented by LtCol Thomas J. Goutler, Jr.

Senior Oversight Committee Wounded Warrior Update – Presented by Mr. Joseph Materia

Marine Corps Policy on Assignment of Women – Presented by Major Paul Hilliard

U.S. Military Women in War Zones – Presented by Ms. Charlotte Brock

Women in Combat Civilian Literature Review – Presented by Ms. Amy E. Falcone

Book Review of *The Lonely Soldier – The Private War of Women Serving in Iraq* – Presented by LtCol Nate Galbreath

Sexual Assault Prevention and Response Policy – Presented by LtCol Nate Galbreath

DoD Women's Assignment Policy – Presented by Jim Schwenk and Maria Fried
Foundations of Care, Mgt, & Transition Support for Recovering Service Members and Their Families – Presented by Mrs. Lynda Davis

Transition Policy and Care Coordination Programs – Presented by Mrs. Susan Roberts

Update on Center for Women Veterans Recent Events and Initiatives – Presented by Dr. Irene Trowell-Harris, MajGen (Ret)

Real G.I. Janes: Attitudes of American Women Soldiers across Iraq, Kuwait, and Haiti; Chapter Review from book *American Soldiers in Iraq: McSoldiers or Innovative Professionals* – Presented by Mr. Morten G. Ender, Ph.D.

Veterans Health Administration Services for Women Veterans – Presented by Mrs. Patty Hayes, Ph.D.

APPENDIX I:
ACRONYMS USED IN REPORT

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ACROYNMS USED IN REPORT

AC	Active Component
AFAP	Army Family Action Plan
AMEDD	Army Medical Department (U.S. Army)
AW2	Army Wounded Warrior Program
BRAC	Base Realignment and Closure
CAT I	Category I
CAT II	Category II
CAT III	Category III
CBWTU	Community-Based Warrior Transition Unit
CNA	Center for Naval Analysis
COIN	Counterinsurgency
CONUS	Continental United States
CYA	Cover Your Ass
DACOWITS	Defense Department Advisory Committee on Women in the Services
DGCAP	Direct Ground Combat Assignment Policy
DoD	Department of Defense
FET	Female Engagement Teams
FISS	Families of Injured Soldiers and Spouses
FLO	Family Liaison Officer
FOB	Forward Operating Base
FRG	Family Readiness Group
FTE	Full-Time Equivalents
GAO	Government Accountability Office
GS	United States General Schedule Pay Scale
HART	Helping Airmen Recover Together
HIPAA	Health Insurance Portability and Accountability Act
IED	Improvised Explosive Device
MCM	Medical Case Manager
MOS	Military Occupational Specialty
MP	Military Police
MRAP	Mine Resistant Ambush Protected Vehicles
NCO	Noncommissioned Officer
NDAA	National Defense Authorization Act
NMA	Non-Medical Attendant
NMCM	Non-Medical Case Manager
OB	Obstetrics
OEF	Operation Enduring Freedom
OIF	Operation Iraqi Freedom
OSD	Office of the Secretary of Defense
PCCWW	President’s Commission on Care for America’s Wounded Warriors
PCM	Primary Care Manager
PCS	Permanent-change-of-station
PDUSD (P&R)	Principal Deputy Under Secretary of Defense (Personnel and Readiness)

PME	Professional Military Education
PT	Physical Training
PTSD	Post-Traumatic Stress Disorder
RC	Reserve Component
RCC	Recovery Care Coordinator
R&D	Research and Development
RSM	Recovering Service members
SAF/MR	Secretary of the Air Force for Manpower and Reserve Affairs
SAPI	Small Arms Protective Inserts
SFAC	Soldier and Family Assistance Center
SI	Seriously Injured
SOC	Senior Oversight Committee
SOF	Status of Forces
SOP	Standard Operating Procedure
SWII	Safe Harbor Seriously Wounded, Ill, and Injured Program
TBI	Traumatic Brain Injury
TPCC	Transition Policy and Care Coordination Office
TSGLI	Traumatic Service Members Group Life Insurance
USAID	United States Agency for International Development
VA	Veterans Affairs
VHA	Veterans Health Administration
VSI	Very Seriously Injured
VTC	Video Teleconference
WHINSEC	Western Hemisphere Institute for Security Cooperation
WIA	Wounded in Action
WRAMC	Walter Reed Army Medical Center
WTB	Warrior Transition Brigade
WTU	Warrior Transition Unit
WWBN-E	Wounded Warrior Battalion-East
WWBN-W	Wounded Warrior Battalion-West
WWR	Wounded Warrior Regiment