disability**rights** | WISCONSIN

VETERANS LITERATURE SURVEY

Prepared by Michele M. Hughes
Staff Attorney, Disability Rights Wisconsin

TODAY'S MILITARY

- Since September 11, 2001, more than 1.5 million troops have been deployed in support of the OEF and OIE. Of those deployed, a large percentage has served multiple tours of duty, with some service members experiencing as many as five deployments (American Psychological Association Presidential Task Force on Military Deployment Services for Youth, Families and Service Members [APA], 2007, p. 9).[1]
- The reserve components of the U.S. military have played an integral role in deployed operations, and they continue to be called on to augment the fighting forces (Alvarez, 2007). In 1973, the Department of Defense (DoD), which had previously relied on an active duty force, embraced a "total force" policy, demanding reliance on and mobilization of six military reserve components (Reserve Forces Policy Board, 2004). The total force policy signified a departure from the traditional military structure in which almost all military families resided on or near military installations. Instead, members were now broadly distributed throughout the United States, with significant numbers living and working in civilian communities (Knox & Price, 1999).[2]
- As of 2005, there were approximately 2.5 million active duty and reserve component military personnel, with reservists and National Guard members representing roughly 45 percent of the DoD's total military force (DoD, 2006a).[3]
- The military has also become increasingly diverse. Over 25 percent of active duty personnel are members of an ethnic minority group. Women represent 16 percent of the total force and are represented in 90 percent of all military job categories (APA, 2007). More than 160,000 female soldiers have been deployed to Iraq and Afghanistan, as compared with 7,500 who served in Vietnam and the 41,000 who were dispatched to the gulf war in the early '90s. Today one of every 10 U.S. soldiers in Iraq is female. (Corbett, 2007)[4]

---

[1] Savitisky et al, *Civilian social work: serving the military and veteran populations*, Social Work [Soc Work] 2009 Oct; Vol. 54 (4), pp. 327-39.
[2] Id.
[3] Id.
[4] Id.

Unique Mental Health Needs of Veterans

Generally

- From notification of an impending deployment to homecoming and reintegration, deployment entails physical, emotional, and mental distress in the form of physical and environmental stressors, high operating tempo, long work hours, and separation from family (Hosek, Kavanagh, & Miller, 2006). Because of overall decreases in military manpower following the end of the Cold War, multiple deployments, decreased time between deployments, and extended deployments have become typical features of military deployment, which can cause increased stress on service members and their families (Hosek et al., 2006).[5]
- Over 25,000 service members have been injured in combat since the onsets of OEF and OIF (DoD, Statistical Information Analysis Division, 2007).When nonhostile injuries (that is, vehicular and in-country training accidents) are included, this number more than doubles to nearly 53,000 (Gamboa, 2007). Many of these injuries would have been fatal in earlier combat situations, but contemporary helmets and body armor, advances in battlefield medicine, and swift evacuations to hospitals have prevented death. The 98 percent survival rate among service members injured in Iraq is higher than that in any previous war (Kilbride, 2007).This progress, however, means that more service members return home with grave injuries that often necessitate treatment of depression and PTSD.[6]

Veterans' access of services

- Early data suggest that approximately 40% of eligible OEF and OIF veterans have sought physical or mental health treatment at VA medical facilities (Veterans Health Administration, 2008).[7]

Veterans' diagnoses

- Of the first 103,788 OEF and OIF veterans seen, 25% were given mental health diagnoses and an additional 6% received diagnoses for other psychosocial problems (Seal, Bertenthal, Miner, Sen, & Marmar, 2007). [8]
- Almost half of those with mental health problems were diagnosed with posttraumatic stress disorder (PTSD).[9] Research has shown that the majority of persons in whom PTSD develops meet the criteria for the diagnosis of this illness within the first three months after the traumatic event.[10]
- However, it is unclear whether findings from largely active duty samples extrapolate to National Guard and Reserve units, as there are several reasons to suspect that the National Guard population may have different rates of treatment seeking. Of National Guard and Reserve soldiers returning from OIF combat deployments, as many as 42% screen positive for mental health disruptions (Milliken, Auchterlonie, & Hoge, 2007) The authors provide two possible reasons for the higher need for services:
    - National Guard troops tend to be older and may be more likely to have family and civilian work responsibilities than active component troops. This may lead to greater familial and occupational strain and unique reintegration challenges (Office of the Undersecretary of Defense, 2006).

---

[5] Id.
[6] Id.
[7] Kehle , et al., *Early Mental Health Treatment-Seeking Among U.S. National Guard Soldiers Deployed to Iraq*, Journal of Traumatic Stress, Vol. 23, No. 1, February 2010, pp. 33–40 (2010)
[8] Id.
[9] Id.
[10] Charles W. Hoge, M.D, et. al, *Combat Duty in Iraq and Afghanistan, Mental Health Problems, and Barriers to Care,* The New England Journal of Medicine, Vol. 351, no. 1, July 2, 2004

- Further, because they are not embedded within their military units following deployments, National Guard personnel may have low levels of postdeployment support.[11]

Relationship between exposure to combat and PTSD

- Exposure to combat was significantly greater among those who were deployed to Iraq than among those deployed to Afghanistan.[12]
- The percentage of study subjects whose responses met the screening criteria for major depression, generalized anxiety, or PTSD was significantly higher after duty in Iraq (15.6 to 17.1 percent) than after duty in Afghanistan (11.2 percent) or before deployment to Iraq (9.3 percent) The largest difference was in the rate of PTSD.[13]
- Of those whose responses were positive for a mental illness, only 23 to 40 percent sought mental health care.[14]
- Those whose responses were positive for a mental illness were twice as likely as those whose responses were negative to report concern about possible stigmatization and other barriers to seeking mental health care.[15]
- There was a strong reported relation between combat experiences, such as being shot at, handling dead bodies, knowing someone who was killed, or killing enemy combatants, and the prevalence of PTSD. For example, in one study among soldiers and Marines who had been deployed to Iraq, the prevalence of PTSD increases in a linear manner with the number of firefights during deployment: 4.5 percent for no firefights, 9.3 percent for one to two firefights, 12.7 percent for three to five firefights, and 19.3 percent for more than five firefights. Rates for those who had been deployed to Afghanistan were 4.5 percent, 8.2 percent, 8.3 percent, and 18.9 percent, respectively.[16]
- The linear relationship between the prevalence of PTSD and the number of firefights in which a soldier had been engaged was remarkably similar among soldiers returning from Iraq and Afghanistan, suggesting that differences in the prevalence according to location were largely a function of the greater frequency and intensity of combat in Iraq.[17]
- The percentage of participants who had been deployed to Iraq who reported being wounded or injured was 11.6 percent as compared with only 4.6 percent for those who had been deployed to Afghanistan.[18]

Battlemind and domestic violence

- According to the U.S. Army, Battlemind is the "soldier's inner strength to face fear and adversity with courage" (Walter Reed Army Institute of Research, 2006, p. 2), requiring targeted aggression and key skills such as discipline and cohesion. Although Battlemind is critical in a combat zone, inability to moderate aggression postdeployment may result in misplaced, inappropriate aggression and lead to family violence (Walter Reed Army Institute of Research, 2006). Social workers should be familiar with the impact of Battlemind and military culture on families, and with the policies that govern the military's response to domestic violence.[19]

---

[11] Kehle, supra.
[12] Hoge, supra.
[13] Id.
[14] Id.
[15] Id.
[16] Id.
[17] Id.
[18] Id.
[19] Savitisky, supra

TBI

- Improvised explosive devices (IEDs) are largely responsible for the signature injury of the Iraq war: TBI. In 2005, the DoD reported that approximately 65 percent of OEF and OIF service members wounded in action sustained injuries from blasts and fragments from IEDs, land mines, and other explosive devices (Bascetta, 2007). "For the first time, the U.S. military is treating more head injuries than chest or abdominal wounds" (Glasser, 2007, p. B1). Approximately 28 percent of troops medically evacuated from combat are sustaining TBIs (McIntire Peters, 2007). Moreover, "88 percent of patients who sustained traumatic brain injuries did not have penetrating head wounds, meaning their injuries were not always apparent to others or even to themselves" (McIntire Peters, 2007, p. 30).
- The complexity of treating brain-injured troops is taxing an already overburdened military and veteran health care system, and the cost of these injuries to society is staggering. Bilmes and Stiglitz (cited in McIntire Peters, 2007) have estimated the cost of treatment for brain injury at $14 billion if U.S. troops are withdrawn from Iraq by 2010.
- Military and VA health care providers are learning that significant neurological injuries should be suspected in any troops exposed to a blast, regardless of their proximity. As soldiers who walk away from IED blasts discover, they often suffer from "memory loss, short attention spans, muddled reasoning, headaches, confusion, anxiety, depression, and irritability" (Glasser, 2007, p. B5).
- As a result of TBI, symptoms of aggression, irritability, and emotional instability also frequently contribute to family turmoil, which may interfere with therapy and recovery. A strong, healthy support system, reinforced by the community, creates an environment that is conducive to healing and effective reintegration (Cantrell & Dean, 2005).[20]

Trauma (Sexual assault)

- Women who have suffered military sexual trauma (MST) are at an even greater risk of developing PTSD (Street & Stafford, 2004; Yaeger, Himmelfarb, Cammack, & Mintz, 2006), major depressive disorder, and increased substance use (Street & Stafford, 2004).
- A 2003 DoD report examining women seeking care through the VA indicated that one-third of the female veterans had experienced rape or attempted rape during their time in service (Corbett, 2007).
- Although MST is more prevalent among women, men have also reported rape (Street & Stafford, 2004). The Iraq War Clinician Guide suggested that social workers include specific questions related to MST on assessments to ensure appropriate identification and treatment (Street & Stafford, 2004).[21]

Risk of Suicide

Source: Wortzel, et al, *Suicide Among Incarcerated Veterans,* J Am Acad Psychiatry Law 37:82–91, 2009

- There remains a paucity of research literature on suicide among incarcerated veterans.
- There is a substantially increased suicide rates among male veterans, between two and three times those of the general population
- Thompson *et al.*5 performed a cause-of-death search of 1,075 veterans from VA case rolls who died in 1998 and then chart reviews to characterize those patients who had completed suicide. Prior diagnoses represented among this group of patient suicides included depression (31.6%), psychotic disorder (15.8%), and substance abuse (15.8%). The authors noted a difference between elderly and nonelderly suicides: none of the former had any listed psychiatric diagnoses in their charts, and they were less likely to have engaged mental health services, while over half of the nonelderly suicides carried a psychiatric diagnosis.
- Price *et al.*6 found that major depression, followed by drug dependence, has the largest effect on the timing of suicidality. They described a vicious cycle wherein drug dependence exacerbates PTSD and

[20] Id.
[21] Id.

suicidality, and then PTSD and suicidality promote ongoing drug dependence, indicating a need to recognize and treat PTSD and substance abuse early in their courses.

- Zivin *et al.* note the very high rate of depression among veterans—two to five times that of the general U.S. population—and the typical association with suicide and depression and substance disorders, with individuals featuring comorbid mental health disorders being at the greatest risk. In the Zivin study,
    - Male gender and white race were more frequently associated with suicide.
    - Younger veterans (age 18–44) were found to have higher rates than middle-aged and elderly patients. Substance abuse was associated with higher suicide rates, while PTSD was associated with lower rates. (The reduced risk of suicide in patients with PTSD was unexpected and warrants further investigation.)
    - Service connection (disability benefits related to military service yielding greater access to VA services and regular compensation payments) was noted to be a protective factor against suicide.
    - Individuals with bipolar disorder had the highest suicide rates, while individuals diagnoses with PTSD and anxiety were less likely to commit suicide.
    - Money spent on outpatient mental health services was associated with reduced suicide rates, with every $100 per capita increase being associated with a six percent reduction in suicide. Increased spending on inpatient services as a proportion of mental health budget also had a protective effect.

Availability of services

- All U.S. veterans of Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF), including those activated from the National Guard, are eligible for free Department of Veterans Affairs (VA) health care for 5 years following deployment.[22]
- Veterans Health Administration Directive 2002-049 delineates specific VA health care privileges for combat OIF and OEF veterans. "Many activated reserve and National Guard personnel lose routine access to military health care and assistance as soon as they leave active duty, and may require VA services immediately" (VA, Veterans Health Administration, 2002, p. 1). The window of opportunity to access these benefits is limited to two years from the date of discharge from the military.[23]
- However, symptoms of some mental health conditions such as PTSD may not always present within the period of eligibility stipulated by the VA. Veterans may also be experiencing feelings of stigma, denial, or anger toward the military that will prevent them from seeking care from government agencies (Clay, 2006). The burden of responsibility falls on the veteran to apply for benefits, and many veterans may not be aware of the eligibility requirements or the implications of enrollment rules (for example, the need to enroll within a specific period).[24]
- Military personnel are the only professionals eligible to receive SSDI benefits while still employed. Service members should submit claims as soon as possible to activate the benefit.[25]1
- Although various forms of counseling and behavioral health services are provided by military and veteran systems to service members to assist with the impact of deployment, services may not always be easily accessible. Whereas an active duty contingent typically returns to an area replete with support units, National Guards and Reservists are widely dispersed, often in areas without sufficient military infrastructure to support adequate reintegration. Often, the only military support facility available to reservists is the drill center, whose primary purpose is to provide logistical support for training and mobilization. In some cases, a reservist may not live in the state in which his or her unit drills.

---

[22] Kehle, supra.
[23] Savitisky, supra.
[24] Id.
[25] Id.

Consequently, continuity of services and ability to connect with others who have had similar experiences are compromised (DeAngelis, n.d.). Isolation is the enemy of healthy reintegration, and for many members of the National Guard and Reserves, the risk of isolation is considerable.[26]

Availability of Services – Community Based Services

- In December 2003, the Secretary of the Army approved a plan to expand medical services for National Guard and Reserve personnel to their communities. Known as Community Based Health Care Organizations (CBHCOs), the goal of this initiative is to expedite the return of service members while leveraging medical capacity within soldiers' communities. There are currently eight regional CBHCOs operating throughout the United States, providing case management to over 3,300 service members (Baker, 2007). Approximately 50 percent of service members receive care through local military and VA treatment facilities, whereas the other 50 percent receive care through military health system (TRICARE) network providers. During a service member's recovery within a CBHCO, active duty registered nurses remotely manage his or her medical care in conjunction with medical providers and social workers.[27] For more information about Tricare, see http://www.military.com/benefits/content/tricare/community-based-health-care-organization.html
- Heroes to Hometowns, a Department of Defense sponsored transition program, facilitates the reintegration of severely injured service members throughout the United States by establishing state and national networks that identify and coordinate resources before service members return to their local communities. Recently, Heroes to Hometowns established and identified charter committees for every state to mobilize local support in a more consistent manner. These charter members include the American Legion's State Adjutants, State Directors of Veterans' Affairs, and the National Guard Joint Force Headquarters' State Family Program Directors. Each charter member is uniquely able to contribute to overall support with the ability to tap into their national, state, and local support systems to provide essential links to government, corporate and nonprofit resources at all levels and to garner the all important hometown support. (Heroes to Hometowns, n.d.)[28] In Wisconsin, there are several American Legion posts which participate. You can locate these at http://www.legion.org/heroes.

---

[26] Id.
[27] Id.
[28] Id.

Homelessness

- Although veterans make up 12.6 percent of the U.S. population, they make up 18.7 percent of the homeless population, 33 percent of which served in a war zone (U.S. Department of Housing and Urban Development, Office of Community Planning and Development, 2007).[29]
- The risk of homelessness is two to four times greater for female veterans than it is for nonveteran females (Gamache, Rosenheck, & Tessler, 2003).[30]
- The VA has reported that 45 percent of homeless veterans suffer from mental illness, and 70 percent of the homeless veteran population wrestles with substance abuse problems (VA, n.d.).[31]
- The VA currently estimates that almost 200,000 veterans are homeless nightly, and approximately 400,000 will be homeless at some point during the course of a year. In addition to mental illness and substance abuse, lack of affordable housing, lack of livable income, lack of access to health care, war injuries, unemployment, and breakdown of family and social support also contribute to homelessness (Stewart, 2004;VA, n.d.)[32]
- Proactive programs that identify individuals and their families who may be at risk may help to arrest the rising rate of homelessness among veterans. Collaborative programs between the VA and local providers can help to expand the range of services available to this population.[33]

Risk of Incarceration

- As of 2000, approximately 20 percent of veterans in prison or jail have reported seeing combat duty. The Bureau of Justice Statistics (BJS) (2000) reported that veterans incarcerated in federal prisons (13.2 percent) are more than twice as likely as nonveteran federal prisoners (6.4 percent) to report mental illness problems.[34]
- Veterans are also more likely than nonveterans to report traits of alcohol abuse and dependence. The crimes committed by veterans that led to their incarceration were more violent in nature, overall, than those committed by nonveterans. About 35 percent of the veterans in state prison were convicted of homicide or sexual assault, compared with 20 percent of nonveteran offenders. Veterans (30 percent) were more likely to be first-time offenders than were nonmilitary offenders (23 percent), suggesting the possibility of combat-related triggers as a factor contributing to criminal activity (BJS, 2000).[35]

---

[29] Id.
[30] Id.
[31] Id.
[32] Id.
[33] Id.
[34] Id.
[35] Id.