

New Veterans in Illinois: A Demographic Snapshot, Picture of Need, and Utilization of Services

Brief 1: Background and Picture of Need of New Veterans

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December 2012

SOCIAL **IMPACT** RESEARCH CENTER
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Brief 1: Background and picture of need of new veterans. A short overview of the experiences of the United States' newest veterans, as well an overview of their challenges and needs.

Brief 2: New veterans. Analysis of demographic, social, and economic information.

Brief 3: Future veterans. Understanding service members' education, military training, and experience.

Brief 4: Service Utilization. Documentation and analysis of new veterans' utilization of VA services and benefits.

Acknowledgements

The research for the following briefs was conducted by the Social IMPACT Research Center for the Robert R. McCormick Foundation Veterans Initiative.

A special thanks to the providers and researchers in the Robert R. McCormick Foundation's community of practice who have helped inform this work.

Suggested Citation: Carrow, L., Rynell, A., & Terpstra, A. (2012, December). *New Veterans in Illinois: A Demographic Snapshot, Picture of Need, and Utilization of Services*. Chicago: Social IMPACT Research Center.

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Key Findings in this report:

- Over 1.9 million American troops have been deployed to Iraq and Afghanistan since October 2001; most are from the Army, junior- to mid-level enlisted soldiers, and male, though women make up a growing minority in the Armed Forces.
- Veterans face many challenges to reintegration to civilian life upon their return from military service.
 - Many face difficulty finding work and subsequent unemployment.
 - Physical wounds and mental health issues often serve as barriers to readjustment; signature wounds of these wars include Traumatic Brain Injury and Post Traumatic Stress Disorder.
 - Female veterans are particularly vulnerable to many challenges of returning from military service, as many face impacts of both combat exposure and military sexual trauma.
- Many veterans are also at risk of homelessness, which is known to be a significant barrier to work and well-being.

Introduction

The newest cohort of veterans of the United States Armed Forces is a unique population with particular needs. They face a challenging context upon return: an economy with few job openings, systems of care that have grown accustomed to serving older and predominantly male veterans, and personal reluctance to seek help. The newest veterans - military service members who have been deployed in 2001 or later - may also suffer from mental and physical injuries that act as barriers to reintegration into civilian life. These veterans require sufficient supports in order to prevent the long-term negative impacts that many previous veteran cohorts have suffered.

Operation Enduring Freedom (OEF), an invasion of Afghanistan by the United States, the United Kingdom, and other countries, began in October 2001 after the September 11th terrorist attacks on the United States. Operation Iraqi Freedom (OIF) began two years later, in March 2003. These conflicts in Afghanistan and Iraq, as well as other surrounding countries, are generally referred to as OEF/OIF, or the Global War on Terror (GWOT). Operation New Dawn (OND) began in 2010 (replacing the name OIF), when U.S. forces in Iraq shifted to more of a support role in preparation to remove all troops from Iraq by the end of 2011.¹

Conditions in OEF/OIF have been compared with the Vietnam War, in that there are no real front lines, and service members are often in hazardous situations regardless of being in a combat or a support position. Travel can be dangerous for service members due to roadside bombs, and ambushes are common. Combat military service takes a toll on all service members, but the burden is not borne evenly. The impact of military service on soldiers is largely determined by the number of times that soldier is deployed, their personal characteristics, and the experiences they have while in the military. Understanding the military experience of new veterans, as well as characteristics associated with higher vulnerability to unemployment and need for supportive services, will be valuable to service providers and employers interested in employing veterans.

Transitioning from military life to civilian life poses a multifaceted challenge to returning service members, especially those coming from combat zones. A combination of physical and mental health issues common to the OEF/OIF/OND wars (such as traumatic brain injury or post-traumatic stress) has set new veterans up for unique challenges in readjustment to civilian life, particularly in employment. These issues can act as barriers to employment, and also have bearing on the workplace accommodations and work-related support services veterans need.

In this way, the newest cohort of veterans from OEF/OIF/OND share many similarities with veterans of previous wars. They need support in their transition back to civilian life, just as earlier veterans have. However, some of the needs of new veterans are unique due to the high stress nature of the wars in the Middle East, the characteristics of the troops themselves, and because of the conditions of the communities to which they are returning. When left unmet, these unique needs can lead to serious problems for veterans and may serve as barriers to employment and self-sufficiency.

Background on Briefs and Data Sources

Background

This is the first in a series of four briefs that provide a snapshot of new and future veterans, their needs, and their service utilization in Illinois and the Chicago region. Together these indicators provide a current picture of the newest cohort of veterans and the services they are receiving relative to their anticipated needs. The briefs have a heightened focus on employment because unemployment rates are higher for veterans than non-veterans and because employment is such a crucial part of reintegration and self sufficiency. Each brief uses data from very different sources. While the descriptions of veterans in each brief are not directly comparable, each brief captures the new veteran population from a unique and valuable perspective.

The briefs were prepared for a working group of Chicago-area veteran-serving human service providers. The group was created by the Robert R. McCormick Foundation Veterans Initiative to address challenges, share successes and resources, and to network and collaborate. It includes mental health workers, employment specialists, disability advocates, and others. Their perspectives and inquiries helped drive the research for these briefs and influenced the conclusions and suggestions.

Data Sources

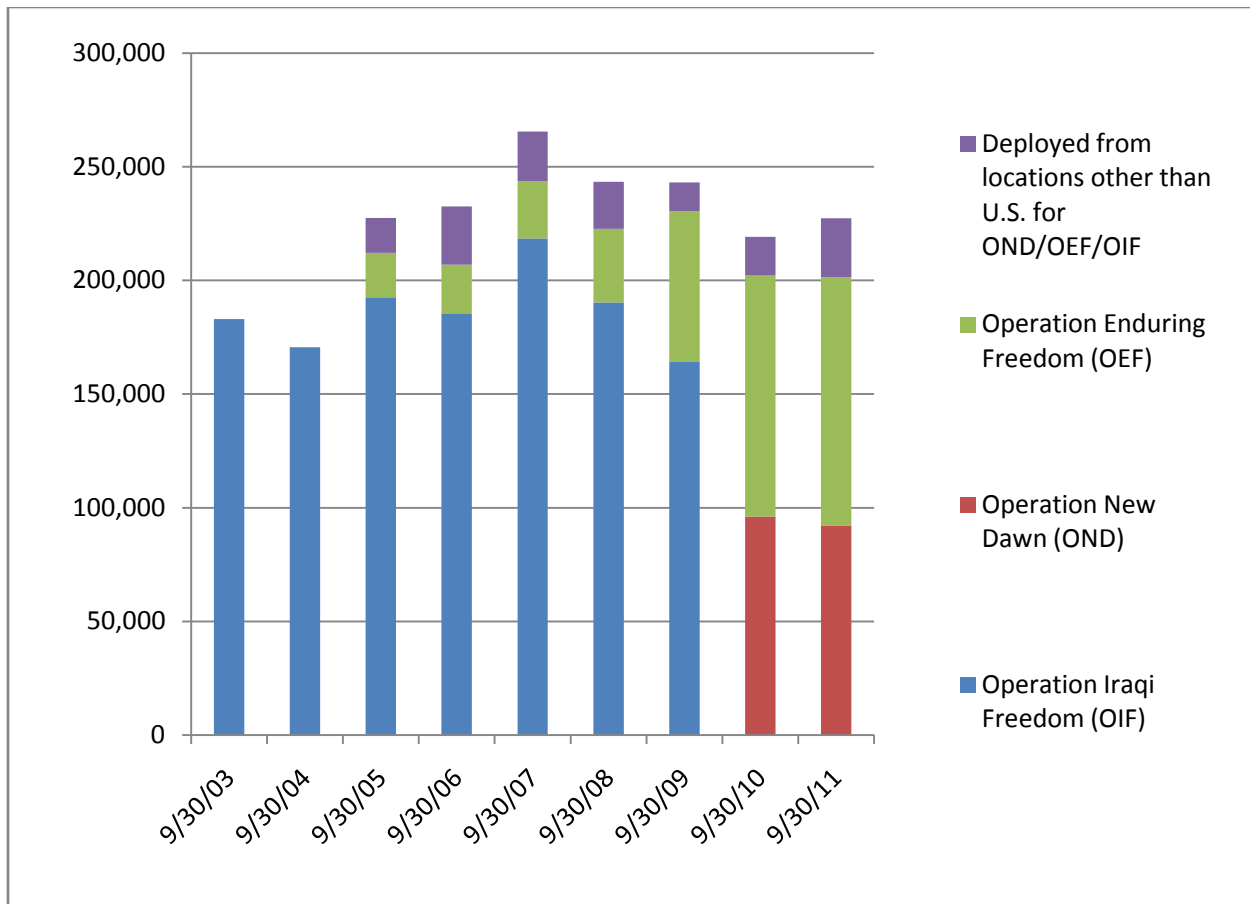
Information and data for this brief were gathered from public data sources such as the Department of Defense statistical analysis website, as well as published literature on the wars, service members and veterans, and their service needs and utilization.

Because each brief uses different data sources, data are not directly comparable among briefs. Where possible, Illinois-specific data are used, but national data are presented when Illinois-specific data are unavailable. Some data are specifically on recently deployed veterans, while other data are on all Illinois veterans. Each brief clearly explains data and information sources which should be kept in mind when using the data.

Snapshot of Recent Deployments

The last U.S. troops left Iraq on December 18, 2011.² Since October 2001, more than 1.9 million American troops have been deployed to Iraq and Afghanistan, which has been the United States' largest sustained ground operation since the Vietnam War.^{3, 4} Figures 1 and 2 show the military strength, or number deployed, between 2003 and 2011 by conflict and by military branch. Deployments peaked in 2007, with over 265,000 deployed for OEF/OIF.

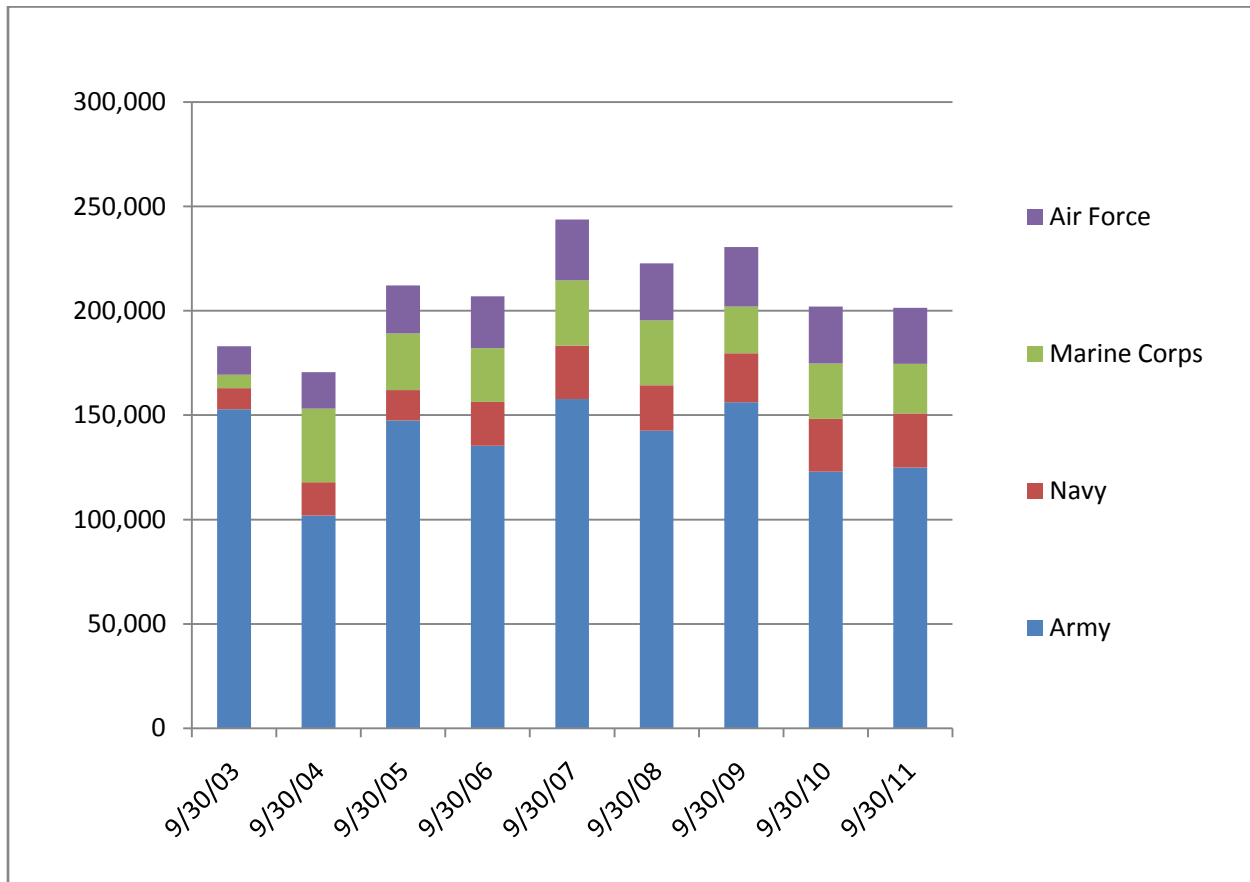
Figure 1: Military Strength (total number deployed) by Conflict, 2003-2011^{5, a, b}



^a Deployment data on OEF/OIF only began being reported separately in 2003.

^b The category of 'Deployed from locations other than the U.S. for OND/OEF/OIF' was reported by the Defense Manpower Data Center, the Department of Defense's data management center, as a separate category of service members deployed to OND/OEF/OIF but who were presumably stationed in another county previous to that deployment.

Figure 2: Military Strength (number deployed) by Military Branch, 2003-2011⁶



The largest share (52 percent) of all Active Duty OEF/OIF/OND Troop deployments are from the U.S. Army, followed by the Navy (19 percent), Marine Corps (15 percent), and Air Force (15 percent).^{7, 8} This is similar to the proportions of service members in previous recent conflicts such as the Vietnam War and the Persian Gulf War, though the Gulf War had a more even distribution across the Army, Navy and Air Force.⁹

In OEF/OIF/OND, Army soldiers have had the longest cumulative deployment times compared with service members from other branches serving in OEF/OIF/OND, meaning they are deployed for longer periods or are on more multiple deployments or both. The majority of the 'deployment burden' falls on junior and mid-grade soldiers,¹⁰ who are soldiers that began at the bottom ranks and have worked their way up, as opposed to academically trained Commissioned Officers. They have had more opportunities for deployment, have carried the most weight of deployments, and thus may have higher service needs.

The proportion of male and female service members has been shifting over the years. There are now more female service members than ever before, so there will be a growing number of female veterans as well. Women comprise 7 percent of the total veteran population, and 17 percent of the new veteran population.¹¹

Challenges Faced by New Veterans

Veterans face many challenges to reintegration to civilian life upon their return from military service. Many face difficulty finding work and subsequent unemployment. Physical wounds and mental health issues often serve as barriers to readjustment, and as this report shows, female veterans are particularly vulnerable to many challenges of returning from military service. Many veterans are also at risk of homelessness, which is known to be a significant barrier to work and well-being.

Unemployment

The overall unemployment rate for veterans is higher than that of non-veterans – roughly 15 percent versus 10 percent, respectively, in January 2011—and has risen in recent years. Young adult men (ages 18 to 24), both veterans and non-veterans, have the highest unemployment rates of any age group, which is of great concern since the newest cohort of veterans is disproportionately male and young compared to the overall adult population. Unemployment rates for veterans of OEF/OIF are also higher than rates for veterans of other veteran cohorts, which again may be connected to their age, since younger groups tend to have higher unemployment rates.¹²

While male veteran unemployment rates follow national trends, there are notable differences in unemployment rates for female veterans and non-veterans.¹³ Female veterans age 18 to 24 have twice the unemployment rate of non-veteran females of the same age.¹⁴ In many respects, female veterans face more barriers to employment than male veterans, and therefore may require more supports. Unemployment among newly discharged service members may also be due to time spent job searching or transitioning back into civilian life; for the first six months after returning from a deployment, veterans are more likely to receive unemployment benefits compared with non-veterans, after which point veterans are more likely to be employed and less likely to be out of the labor force.¹⁵

Physical Wounds

Many new veterans have sustained debilitating wounds of all types; exposure to combat (which may include anything from receiving artillery, rocket, or mortar fire, to being responsible for the death of a noncombatant) can inflict both physical and mental wounds.¹⁶ The most common types of battle wounds from OEF/OIF are similar to those inflicted on service members in previous wars; the majority are extremity injuries, particularly ankle and foot injuries.¹⁷ However, since OEF/OIF troops endure high levels of combat exposure where improvised explosive devices (IEDs) are common, Traumatic Brain Injury (TBI) has become the “signature wound” of these wars.^{18, 19} New protective technology, such as Kevlar body armor and helmets, has enabled many OEF/OIF soldiers to survive injuries that would likely have proven fatal for soldiers in prior wars, with the result that unprecedented numbers of veterans are reintegrating with certain combat wounds not previously seen in such large numbers.²⁰

OEF/OIF has seen significantly lower numbers of killed and wounded soldiers than earlier wars, with the exception of the Persian Gulf War, which only lasted about seven months.²¹ As seen in Table 1, OEF/OIF has had a lower rate of service member deaths and wounded than the Persian Gulf War, Vietnam, and Korean Wars.^{22, 23} There have also been fewer amputations as a result of OEF/OIF; however, as of September 2010, OEF/OIF service members underwent 1,033 major limb amputations and 374 partial

(hand/foot, toes/fingers) amputations.^{24, 25} These and some other combat-inflicted wounds are lifelong conditions that will most often require workplace accommodations or supports.

Table 1: Casualties by Conflict

War	Length	Total killed	Killed per year	Total wounded	Wounded per year
OEF/OIF	2001-2011 <i>10 years</i>	6,362	592	47,505	4,751
Persian Gulf War	1990-1991 <i>7 months</i>	383	657	NA	NA
Vietnam	1955-1975 <i>20 years</i>	58,220	2,911	153,303	7,665
Korea	1950-1953 <i>3 years</i>	36,574	12,191	103,284	34,428

While penetrating brain injuries (such as bullet wounds) are easily identified, closed head injuries (such as a concussion) that can be present with no visible wound are not as obvious, but happen much more frequently.²⁶ Soldiers from prior conflicts were more likely to die of brain injury than be treated and recover, so today’s survivors of TBI are facing challenges that previous veterans did not face in such great numbers. With new technology in protective gear and medical advances, service members survive what would have previously been fatal, but also embark on a new path of recovery and readjustment that is still not fully understood.

In OEF/OIF veterans, TBI is usually caused by roadside explosions. Blast waves from explosives have also been known to internally injure air-filled organs like lungs and bowels, but new armor technology also protects against this danger.²⁷ Heat waves from explosives externally wound soldiers, and flying debris or being thrown back from blasts also often cause other injuries, especially TBI.²⁸ Since most military helmets do not fully shield the face, it has also recently been found that blast waves can cause internal brain injuries similar to internal injuries they inflict on air-filled organs. These TBIs are even harder to detect than those caused by falls or flying debris; some service members who survive blasts may not have even sustained a direct head injury but still suffer TBI.²⁹

A TBI is essentially a concussion and can vary greatly in severity. Most individuals with mild TBIs recover within 1 to 3 months, but some continue to suffer postconcussive symptoms, such as headaches, dizziness, irritability, and memory problems, for months or years thereafter.^{30, 31} An estimated 300,000 returning service members have reportedly suffered mild TBI.³² As with any injury-inducing phenomena, the more explosions that a veteran has been exposed to, the more likely they are to have neurological impairments and more severe reported headaches.³³ Veterans with even the most severe TBIs can recover and be fully functional, but many survivors continue to suffer lingering effects.³⁴ Identifying more mild cases of TBI can be difficult and the injury often goes undiagnosed, so estimates of the number of veterans who are suffering from or have suffered from TBI are most likely lower than actual numbers.³⁵ As a potentially chronic and often undiagnosed condition, TBI can be a very difficult barrier to work.

Mental Health

Mental health issues are also common wounds of war. Though changes in the medical field have led Post-Traumatic Stress Disorder (PTSD) to be thought of in different ways and be called by different names, post-traumatic stress is not a new consequence of combat exposure. After the Civil War, 44 percent of veterans were diagnosed with 'nervous disease' or 'irritable heart,'³⁶ and following World War I and World War II many veterans suffered 'shell shock,' 'soldier's heart,' 'war neurosis,' or 'battle fatigue.'³⁷ About half of Vietnam Veterans have experienced PTSD at some point, and about a third endure chronic or lifetime PTSD symptoms.³⁸ PTSD is currently defined as an anxiety disorder that occurs as a result of traumatic experiences and can lead to symptoms such as numbness, hyperarousal, reliving the traumatic event, and avoiding situations that are reminders of the traumatic event.³⁹

The circumstances in OEF/OIF are particularly conducive to triggering and exacerbating mental health issues like PTSD. Veterans of OEF/OIF report incredibly stressful combat experiences in Iraq and Afghanistan. The guerilla-style ground combat that many troops are exposed to, where seeing the death of civilians is almost indistinguishable from that of enemy soldiers, is similar to the traumatic circumstances in Vietnam that left so many veterans mentally scarred and suffering from PTSD for years, or even sometimes a lifetime.⁴⁰

Threats to life and limb are also constant worries for troops in combat. The overwhelming majority (89 to 95 percent) of veterans from Iraq reported that they had been attacked or ambushed and most (86 to 87 percent) reported knowing someone seriously injured or killed.⁴¹ Rates of PTSD are strongly related to these first-hand combat experiences, and the probability of being diagnosed with PTSD is directly correlated with the number of firefights a veteran has survived.⁴² Veterans deployed to Iraq report higher levels of combat experience and higher rates of PTSD than those deployed to Afghanistan.⁴³ PTSD is also more common among those who have been injured.⁴⁴

Length of time deployed is also directly related to PTSD prevalence, which is an important factor, considering the 15-month deployment rotations that some active duty U.S. soldiers were assigned to, which was extended from traditional 12-month deployments.^{c, 45} The Army generally has longer tours of duty (usually 12 to 18 months) than other military branches (4 to 7 months).⁴⁶ Troops who have served multiple deployments in Iraq are also 50 percent more likely to suffer acute combat stress, which greatly increases the risk of chronic PTSD.^{47, 48} Personal and social variables associated with PTSD and depressive symptoms include being separated or divorced and being a junior enlisted soldier (or a lower- to mid-ranked enlisted soldier, as opposed to an officer).⁴⁹ PTSD has also been found to be slightly more prevalent among female veterans than male veterans from OEF/OIF.⁵⁰

Veterans are at high risk for other mental health issues as well. One study found that 44 percent of surveyed soldiers returning from Iraq and Afghanistan reported clinically significant depressive symptoms or post-traumatic stress symptoms, or both.⁵¹ A survey of OEF/OIF veterans enrolled in Veterans' Administration (VA) care showed that along with PTSD, they had elevated problematic drinking levels and that these issues were linked to a lower quality of life.⁵²

^c The standard Army deployment is 12 months, but can be extended when needed. At the height of the U.S. involvement in the wars in 2007, the Army extended some service members' deployments to 15 months. Some may have been deployed as long as 18 months, depending on need for particular skills. Beginning in April 2012, deployments were shortened to 9 months. (<http://www.defense.gov/Releases/Release.aspx?ReleaseID=14708>, <http://www.military.com/NewsContent/0,13319,140663,00.html>, www.washingtonpost.com/wp-dyn/content/article/2007/04/11/AR2007041100615.html).

Some service members need to be evacuated from active duty for psychiatric reasons, though this is generally rather rare, since most health issues can be stabilized and treated within the military's health care system, allowing service members to return to combat.⁵³ Psychiatric evacuees have been more likely to be young, female, minorities, and enlisted as National Guard/Reserve.⁵⁴ Female psychiatric evacuees reported that day-to-day stressors of the deployment environment contributed more to stress than combat exposure; these included: "stressful living conditions, weather extremes, interpersonal difficulties with supervisors or peers, sleep deprivation, and sexual or physical abuse."⁵⁵

Mental health issues are also incredibly important to treat in veterans because of the recent increase in suicide rates for veterans and service members.⁵⁶ While the suicide rate has historically been lower for military service members than for the general population, the gap narrowed between 2004 and 2008 as military suicide rates increased more rapidly than general population suicide rates.⁵⁷ In 2008, military suicide rates surpassed demographically comparable civilian suicide rates.⁵⁸ The Army in particular has seen a dramatic increase in its suicide rate, which doubled between 2001 and 2008.⁵⁹

The Department of Defense keeps records of cause of death of service members, but no such consistent record-keeping exists for veterans; the VA estimates that 18 veterans kill themselves every day, but this is based on very limited data.^{60, 61} It is therefore unknown how many veterans actually take their own lives, but based on correlations with risk factors of service members who commit suicide, new veterans are likely still at high risk. Risk factors that are of particular concern for military service members include prior suicide attempts, mental disorders, substance-use disorders, head trauma/TBI, triggering life events, and firearm access.⁶² It has also been found that PTSD is a predictor of suicidal ideation and suicide completion, especially when compounded with other mental health issues such as depression.⁶³ Causes of increased suicide rates are baffling military leaders because unemployment and deployment status do not appear to be predictors of suicide and because rates have lowered in active duty service members, but increased in guard and reserve members.⁶⁴ Targeted suicide prevention outreach to active duty members may account for some of the noted decrease, and give hope for further prevention efforts.⁶⁵

Female Veterans' Unique Needs

Many female veterans face significant and often unique challenges that affect their social service and employment needs. For example, 17 percent of new female veterans, compared with 3 percent of males, are single parents.⁶⁶ Female veterans are also much younger, more likely to be a racial minority, more likely to be unemployed, and have lower incomes than male veterans.⁶⁷ They may also face consequences of exposure to violence similar to those faced by men; while women in the military are still not officially deployed to the 'front lines,' many female veterans of OEF/OIF have been exposed to combat situations and have basically had the 'front line' brought to them. The majority (87 percent) of respondents in one study of female veterans from Iraq and Afghanistan reported that they had experienced at least some degree of combat exposure.⁶⁸

Additionally, female veterans report interpersonal violence in the military at an alarmingly high rate. Half of surveyed women veterans report experiencing this type of violence from within the military, during military service; one third report being raped, over one third being physically assaulted, and over half report being sexually harassed.^{69, 70} Sexual violence in the military is typically inflicted upon junior enlisted female service members by more senior servicemen.⁷¹ Specifically among female veterans from OEF/OIF utilizing VA health care, 15 percent reported sexual trauma, which was associated with a higher risk of mental health issues such as PTSD, depression, anxiety, and substance abuse.⁷² Another study of

the prevalence of military sexual assault among women utilizing VA health services found that 23 percent reported being sexually assaulted and more than 55 percent reported being sexually harassed while in the military.⁷³

Military sexual assault leaves lasting negative medical impacts on survivors such as chronic physical health problems, has been found to have a stronger impact on PTSD symptomatology than combat exposure, and is correlated with other negative life outcomes.^{74, 75, 76, 77} In fact, women who survive military sexual assault are nine times more likely to have PTSD than women veterans without sexual assault histories.⁷⁸ Sexual assault is also highly correlated with substance abuse in female veterans.⁷⁹ These traumatic events weigh heavily on survivors and can be a difficult barrier to employment. Women who report harassment are less likely to be working, and women who report assault are often not working due to physical limitations.⁸⁰ Sexual violence in the military is also committed against men, but prevalence and impact are not as well documented or understood, likely for the same reasons it so often goes unreported against women.

Though some female veterans face serious health-related consequences of their military service, only a small portion use VA health care.⁸¹ Female veterans are a very small minority in the overall veteran population, and they make up an even smaller minority within the population of veterans using VA health care.^{82, 83} Women who do use VA health care are found to be at higher economic, social, and health risks than female veterans who do not use VA health care—they are more likely to be poor, have no health insurance, and be unemployed.⁸⁴ Some female veterans report non-use of VA health care services for reasons such as alternative health insurance, more convenient opportunities for service outside the VA, as well as lack of knowledge of VA eligibility and services and belief that VA services are of lower quality than non-VA health services.⁸⁵

Furthermore, though women veterans with a history of military sexual trauma suffer more negative consequences than other women veterans, they receive fewer VA health care services than women veterans without histories of military sexual trauma.⁸⁶ Only 38 percent of female veteran sexual assault survivors utilize mental health services.⁸⁷ In a survey of women who served in Iraq or Afghanistan, 78 percent felt they needed mental health treatment, but 42 percent of those who felt that need did not seek services—some because of long wait periods at the VA and bad previous experiences.⁸⁸

Homelessness

As of 2009, 916 OEF/OIF veterans had already accessed VA homeless services, and the VA estimated that 2,986 more were at risk of becoming homeless.⁸⁹ Veterans are overrepresented in the homeless population, especially Vietnam and post-Vietnam era veterans.⁹⁰ Most Vietnam veterans, however, did not become homeless until 10 years after leaving military service, which is disconcerting since this is the most comparable cohort of veterans to the OEF/OIF/OND cohort.⁹¹ Following this trend, veteran homelessness may be a growing risk in the coming years. The VA reports that the number of homeless veterans on any given night dropped from 131,000 in 2008 to 107,000 in 2009, which is a vast improvement, but still a startling problem.^{d, 92} Housing instability and homelessness make it very difficult to find and retain employment and engagement in other needed services.

^d The United States Interagency Council on Homelessness notes that this reduction could be due to nationwide reductions in chronic homelessness at that point in time, and could be due to improved methods of counting and estimating.

Summary

The newest veterans face many challenges in their process of reintegration. These challenges can also be barriers to employment, which is a vital part of readjusting to life after military service. Physical wounds such as TBI may prevent veterans from performing at their fullest potential and make obtaining and retaining employment more difficult. New veterans may also be coping with mental and emotional issues such as PTSD, whether due to combat exposure or military sexual trauma. This can also have a detrimental impact on employment if left untreated. Due to the experiences many of our service members have endured, supportive services will likely be necessary to improve employment rates and adjustment after serving in the military. Female veterans may need extra support, as their unemployment rates and service needs tend to be disproportionately higher than those of other veterans.

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