

The Emerging Needs of Veterans: A Call to Action for the Social Work Profession

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The needs of the nation's veterans are changing, and as such, the profession of social work will need to adapt to the increasing demand for our services. The U.S. Department of Veterans Affairs (VA) is the largest employer of master's-level social workers in the nation. Social workers have been serving veterans since 1926, when the first social work program in the Veterans Bureau was established. According to Manske (2008), the VA originally hired 36 hospital social workers, with the number increasing to 97 by 1930, and they treated patients with psychiatric illness and tuberculosis. Manske (2008) further stated that "in 1989, Congress elevated the VA to Cabinet status, creating the Department of Veterans Affairs. At that time, more than 3,000 social workers were providing psychosocial and mental health services at 175 VA hospitals" (p. 255).

Today, social workers offer a variety of services to veterans and their families, including resource navigation, crisis intervention, advocacy, benefit assistance, and mental health therapy for conditions such as depression, posttraumatic stress disorder (PTSD), and drug and alcohol addiction. Social workers in the VA also ensure continuity of care through admission, evaluation, treatment, and follow-up processes, and they provide assessment, crisis intervention, high-risk screening, discharge planning, case management, advocacy, and education to veterans and their families.

THE CHANGING FACE OF WAR

The United States has been engaged in Operation Enduring Freedom (OEF) in Afghanistan since 2001 and in Operation Iraqi Freedom (OIF) in Iraq since 2003, with 1.64 million troops serving in these wars (Jaycox & Tanielian, 2008). As of May 2008, more than 4,100 American troops had died in Iraq and Afghanistan, and 31,850 troops had been physically

wounded in the two wars (Give an Hour, 2009). In past conflicts, such as World War II, people who experienced serious physical and mental trauma often did not survive long enough to deal with the repercussions of the event. With advances in medical technology and body armor, more service members are surviving experiences that would have led to death in prior wars (Jaycox & Tanielian, 2008). Nearly all U.S. soldiers wear 16-pound Interceptor body armor, and as a result, 15 out of 16 seriously wounded service members survive injuries that would have been fatal in previous wars. During the Vietnam era, only five out of eight injured soldiers survived (Stiglitz & Bilmes, 2008). New casualties are emerging in the form of veterans with mental health conditions and cognitive health impairments.

Another issue of deep concern is the length of deployments and numerous redeployments facing soldiers who may already be dealing with a mental health disorder. Deployments have become longer, redeployment to combat is common, and breaks between deployments are infrequent (Jaycox & Tanielian, 2008). Williamson and Mulhall (2009) stated that

since September 11, 2001, troops have regularly had their tours extended and as of June 2008, more than 638,000 troops have been deployed more than once. U.S. soldiers serving in Iraq have essentially spent their entire deployment engaged in round the clock combat operations.

According to the Army's Mental Health Advisory Team, soldiers deployed to Iraq for more than six months, or deployed more than once, are much more likely to be diagnosed with psychological injuries (Mental Health Advisory Team V, 2008). In surveys of troops redeploying to Iraq, 20 percent to 40 percent "still had symptoms of past concussions,

including headaches, sleep problems, depression, and memory difficulties. Even after getting home, those who had deployed for longer periods are still at higher risk for PTSD” (Williamson & Mulhall, 2009).

THE EMERGING NEEDS OF VETERANS

Because of the often traumatic experience of serving in combat, our nation’s veterans have unique mental health needs related to PTSD, traumatic brain injury (TBI), depression, and anxiety, among other issues. By March 2008, the VA reported that more than 130,000 Iraq and Afghanistan war veterans had been diagnosed with a mental disorder by their mental health services. Williamson and Mulhall (2009) stated that “no one comes home from the war unchanged. But with early screening and adequate access to counseling, the psychological and neurological effects of combat are treatable.”

According to a RAND Corporation report released in April 2008, over 18 percent of the troops who have served in Iraq and Afghanistan—nearly 300,000 service members—have symptoms of post-traumatic stress or major depression (Jaycox & Tanielian, 2008). In addition, about 19 percent of service members reported that they experienced a possible TBI. One-third of those previously deployed suffer from depression, PTSD, or TBI, and about 5 percent suffer symptoms of all three. Jaycox and Tanielian also reported that only 53 percent of service members with PTSD or depression had sought help over the past year.

Individuals suffering from these mental health and cognitive conditions are more likely to have other psychiatric diagnoses, are at increased risk for committing suicide, have higher rates of unhealthy behaviors (for example, smoking, overeating, engaging in unsafe sex), and higher rates of physical health problems (Jaycox & Tanielian, 2008). Finally, mental and brain disorders from the war could cost the U.S. economy more than \$6 billion over the next two years, and RAND predicts that \$2 billion of that could be saved if treatment is provided to the U.S. troops (Jaycox & Tanielian, 2008).

Overall, veterans make up approximately 11 percent of the general population, yet they account for 26 percent of the homeless population. Women veterans are two to four times more likely than nonveteran women to be homeless (Gamache, Rosenheck, & Tessler, 2003). According to Fairweather (2006),

approximately 600 Iraq veterans have sought homeless healthcare services from the Department of Veterans Affairs. . . . Knowing that veterans, particularly recent veterans are loath to seek help, we can safely assume that the number of Iraq veterans with unstable housing is much higher. (p. 1)

An important factor to note is that among Iraq and Afghanistan-era veterans of the active-duty military, the unemployment rate was over 8 percent in 2007, about 2 percent higher than that for their civilian peers (Williamson & Mulhall, 2009).

Those who serve in the military are also committing suicide at an alarming rate. In August 2007, the *Army Suicide Event Report* showed that suicides were at their highest point in 26 years. Rates of suicides in the Army have increased every year since 2004, and Army suicides in 2008 were on track to surpass the prior year’s record rate (Williamson & Mulhall, 2009). A CBS News investigation (Keteyian, 2007) found that veterans were twice as likely to commit suicide than nonveterans and that 120 veterans of all wars kill themselves every week—over 5,000 per year. Veterans account for 20 percent of the nation’s suicides (Williamson & Mulhall, 2009).

CHALLENGES OF WOMEN VETERANS

Officially, women have been serving in the U.S. military since 1901—since the Civil War as nurses—although for most of that time their service was limited to ancillary roles and was constrained by law and policy. In 1973, the Selective Service Act ended the draft, resulting in a slow but steady growth of women serving in the military, from about 2 percent to about 15 percent at the start of 2002 (Costello, Stone, & Wight, 2003).

Female veterans make up 10 percent of the soldiers who have served in Iraq and Afghanistan. More than 160,000 female soldiers have been deployed in these two wars, compared with the 7,500 who served in Vietnam and the 41,000 who were dispatched to the Gulf War in the early 1990s (Corbett, 2007). Female veterans have a much different demographic profile than that of male veterans. They tend to be younger and have a higher education level, and a greater percentage of them are minorities (Manning, 2008).

Women who serve in the military must also deal with the possibility of sexual harassment, sexual assault, and rape. Between November 2003 and April

2004, 83 female U.S. soldiers were raped in Iraq and Kuwait (Hackworth, 2004). The U.S. Department of Defense (2008) reported 2,085 unrestricted reports of sexual assaults involving military service members in fiscal year 2007. The Service Women's Action Network (2007) stated that "thousands of service women are harassed or sexually assaulted each year. Many don't report incidents for fear that they will be ignored, exposed or punished." A unique factor in the psychological trauma suffered by female troops is the threat of sexual harassment. A report published in *VA Research Currents* indicated that military sexual trauma leads to a 59 percent higher risk for mental health problems (VA Screenings Yield Data on Military Sexual Trauma, 2008).

As noted, women veterans are not only dealing with the repercussions of combat trauma, but many also endure the trauma associated with sexual harassment and abuse. More than one-third of the 23,635 women veterans who served in Afghanistan or Iraq and were evaluated at VA health facilities between 2002 and 2006 had a preliminary diagnosis of a mental disorder (Service Women's Action Network, 2007). Women account for 14 percent of, or a total of 27,000, recent veterans treated for PTSD (Give an Hour, 2009).

Women veterans face a host of unique challenges. Women often carry the double burden of serving in the armed forces—a stressful duty in and of itself—while simultaneously balancing marriages, motherhood, and caregiving responsibilities in their home lives. For female service members in particular, divorce rates are very high; female soldiers face an 8.8 percent annual divorce rate, more than 2.5 times the national average (Williamson & Mulhall, 2009). Women are making extraordinary strides in the military and, while creating a more inclusive armed forces, are also changing the ways in which we must address many challenges facing our service members.

SOCIAL WORK RESPONSE

Social workers employed by the VA are competent and passionate. They bring positive, sustainable change to the lives of veterans across the country. But as Meyeroff (2009) said, "Inevitably, . . . when servicemen become disabled, their first question is how soon they can get back to their unit. After a doctor has explained why they cannot return to active duty, the social worker picks up the pieces." Social workers are essential in helping veterans deal

with emotions, challenges, and navigation of new circumstances.

Social workers offer a particular skill set and knowledge base that is beneficial, if not indispensable, to veterans who may return from war with a host of challenges. Veterans are well served by social workers' person-in-environment perspective and their ability to solve multi-factor problems. For instance, in the VA, social work coordinates the Community Residential Care program, the oldest and most cost-effective of the VA's extended care programs (<http://www.socialwork.va.gov/>). Another example is the seamless transition program designed to facilitate the continuous care of injured active-duty military members moving into VA hospitals. In 2006, Manske described the difficulty veterans typically have in navigating the system: "There had to be a better way, and the VA Office of Social Work Service knew that social workers could play a key role" (p. 235). The seamless transitions program includes identification of "case managers . . . , [many] of whom are social workers, to assure the health, mental health, and psychosocial needs of . . . OIF [and] OEF veterans are addressed" (Manske, 2008, p. 256). As Manske (2006) described,

the director of social work suggested assigning a full-time VA social worker to Walter Reed to serve as a liaison in helping Army social workers and case managers transfer severely injured or ill OIF/OEF soldiers to VA medical centers. This effort was so successful that within weeks the workload had increased to the point that a second VA social worker was needed to assist." (p. 236)

As a result of this extraordinary program,

nearly 23,000 OIF/OEF service members and veterans have received information about VA benefits, and more than 5,900 have received help with VA benefits applications. VA social workers have provided assistance to more than 15,000 OIF/OEF patients in MTFs, arranging transfers for 5,399 to VA medical centers." (Manske, 2006, p. 236)

However, the current social work workforce, in almost all areas of practice, including work with veterans, cannot keep pace with demand. Our engagement in OIF and OEF has created, and will

continue to create, a need for a more robust workforce that is ready and able to tackle new challenges. This translates into a need to recruit and retain social workers with a desire to work with veterans, much as we must recruit and retain social workers to work with our aging population, in child welfare, and in other fields. “The Department of Veterans Affairs is affiliated with over 100 Graduate Schools of Social Work, and operates the largest and most comprehensive clinical training program for social work students—training 600 to 700 students per year” (VA, 2009). To continue our tradition of caring for veterans while keeping pace with the increasing demand for our services, this pipeline of educated and trained social workers must remain in place and continue to grow. Active-duty military, veterans, and their family members deserve to have access to needed information, services, resources, and equality of opportunity.

For social workers who are not employed within the VA or in a direct practice setting providing services to veterans, another key piece to this puzzle is advocacy. NASW is increasing its leadership on this complex and changing population in terms of diversity, challenges, and changing face of war and, as such, increasing organizational advocacy on behalf of those who have served our nation in a military capacity. These activities include supporting federal legislation such as the Post-Deployment Health Assessment Act of 2009, which would require mental health screenings for members of the armed forces who are deployed in connection with a contingency operation, and the Military Domestic and Sexual Violence Response Act, which is aimed at reducing sexual assault and domestic violence involving members of the armed forces and their family members and partners. On the state and federal levels, we can advocate for job training, employment, education, and housing for our nation’s veterans. Social workers are natural advocates, whether working with an individual client or on a legislative and policy level—and both approaches are critical.

If the social work profession is the social safety net, veterans should be the last group that we let fall through the cracks. Everyone deserves an equal opportunity to live a healthy, productive life, but because of the extraordinary commitment of our service men and women, social workers have an additional responsibility to this group in particular. It is unacceptable for our country to fail to provide every resource and service promised to those who

voluntarily sign up to protect our nation, and social workers must lead the charge with expertise and innovation to ensure that our veterans’ needs are being met. **HSW**

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