Wellness RFI 4

Homelessness, Unemployment, Suicide, Post-Traumatic Stress Disorder, and Military Sexual Trauma

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Contents

Wellness RFI 4: Homelessness, Unemployment, Suicide, Post-Traumatic Stress Disorder, and Military Sexual Trauma 1

A. Introduction 1

B. Overview of Literature on Homelessness, Unemployment, Suicide, Post-Traumatic Stress Disorder, and Military Sexual Trauma 1

References 9

Wellness RFI 4: Homelessness, Unemployment, Suicide, Post-Traumatic Stress Disorder, and Military Sexual Trauma

A. Introduction

The Committee requested a literature review in the form of a written response from Insight Policy Research on research related to the following:

- Homelessness statistics for female active/reserve Service members and veterans (as compared with male active/reserve Service members and veterans and civilian women)
- Suicide rate for female active/reserve Service members and veterans (as compared with male active/reserve Service members and veterans and civilian women)
- Unemployment rate for female reserve Service members and veterans (as compared with male reserve Service members and veterans and civilian women)
- Post-traumatic stress disorder (PTSD) rate for female active/reserve Service members and veterans (as compared with male active/reserve Service members and veterans) and any correlation to an increase in PTSD due to military sexual trauma (MST)

Below is Insight's response to this request.

B. Overview of Literature on Homelessness, Unemployment, Suicide, Post-Traumatic Stress Disorder, and Military Sexual Trauma

1. Homelessness

In this section, we present findings from a brief review of the literature and available statistics on homelessness. The Committee requested information on research related to statistics on female active and reserve Service member and veteran homelessness (as compared with statistics on homelessness for male active and reserve Service members and veterans as well as civilian women). While we identify relevant information on these populations, it is important to keep in mind that homeless populations are notoriously difficult to track, and information is not readily available for all categories requested.

A disproportionate number of persons experiencing homelessness are veterans. While veterans represent only 9.5 percent of the U.S. adult population,[1] they make up 11.4 percent of the population living in homeless shelters. Data from the U.S. Department of Housing and Urban Development's Annual

Homeless Assessment Report (AHAR), which provides Congress with nationwide estimates of homelessness each year, show the following for a single night in January 2014[1]:

- Of homeless adults, 49,933 out of 442,723 were veterans (11 percent of the adult homeless population); this marks a 33-percent decrease in veteran homelessness since 2009 when these data were first collected.
- Of 49,933 homeless veterans, 4,722 were women (9 percent of the total homeless veteran population). For comparison, in 2013, women also made up 9 percent of the total veteran population.[2]
- The "typical" veteran experiencing homelessness was male (91 percent); experiencing homelessness as an individual (96 percent) rather than as a member of a family with children; between the ages of 51–61 (43.5 percent); White (52.4 percent); disabled (55.9 percent); and living in a city (73.8 percent).

Despite most homeless veterans being male, female veterans are the fastest growing segment of the homeless population,[3] with their own unique set of characteristics and concerns. Research from the U.S. Centers for Disease Control and Prevention[4] found that, among female veterans, younger women (18–29 years old) and Black women were at the highest risk for experiencing homelessness. This finding suggests that women who served in more recent conflicts, such as those in Iraq and Afghanistan, are more likely than older female veterans to be homeless. The fact that younger female veterans are more likely to be homeless is also consistent with research on the general population of homeless women, which found that the period of highest vulnerability for homelessness corresponded with the period when women were heading families with young children. A brief from the National Coalition for Homeless Veterans confirms that childcare concerns have a major impact on female veterans and describes other unique challenges such as their increased exposure to MST, which in turn can lead to increased incidence of PTSD and, therefore, complicate their ability to reintegrate into civilian life. These factors help explain why female veterans are estimated to be two to four times more likely to be homeless than female nonveterans.[5]

Efforts to end homelessness among veterans have received national attention and have gained traction. For example, the White House has launched the Mayor's Challenge to End Veteran Homelessness, with more than 800 mayors and city officials supporting the initiative.[6] On Veterans Day 2015, Virginia Governor Terry McAuliffe announced that Virginia was the first state to meet the federal definition of effectively ending homelessness among veterans. Three cities—Las Vegas, NV; Syracuse, NY; and Schenectady, NY—have also met the criteria.[7]

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[1] Point-in-time estimates offer a snapshot of homelessness—both sheltered and unsheltered homeless populations—on a single night. The 1-night counts of homeless individuals for the AHAR are conducted in late January of each year.

2. Unemployment

The Committee requested additional information on the unemployment rates of female reservists and veterans as compared with male reservists and veterans as well as civilian women. In response, we present recent unemployment data from the U.S. Department of Labor.

In October 2015, the U.S. unemployment rate was comparable for adult men (4.7 percent) and adult women (4.5 percent). The unemployment rate for all adult veterans was lower than the national average at 3.9 percent; however, males in this group were less likely than females to be unemployed (3.7 percent versus 5.4 percent). Table 1 presents additional information on veteran and nonveteran unemployment rates.

Table 1. Unemployment Rate Among Veterans and Nonveterans, October 2014 and October 2015[8]

Unemployment Rate	Total		Men		Women	
	Oct. 2014	Oct. 2015	Oct. 2014	Oct. 2015	Oct. 2014	Oct. 2015
Veterans, age 18 and older	4.5%	3.9%	4.3%	3.7%	5.5%	5.4%
Nonveterans, age 18 and older	5.4%	4.7%	5.2%	4.7%	5.7%	4.7%

3. Suicide

The Committee requested a review of suicide rates for active, reserve, and National Guard Service members; veterans; and civilians. Table 2 presents this information.

Table 2. Suicide Rate Among American Adults; Active, Reserve, and National Guard Service Members; and Veterans

	U.S. Total 2013[9]	Active Component 2013[10]	Reserve Component 2013[11]	National Guard Component 2013[12]	VHA Users FY 2009[13]
Male	20.6 per 100,000	20.7 per 100,000	27.3 per 100,000	32.9 per 100,000	38.3 per 100,000
Female	5.7 per 100,000	(too few to calculate)	(too few to calculate)	(too few to calculate)	12.8 per 100,000
Total	13.0 per 100,000	18.7 per 100,000	23.4 per 100,000	28.9 per 100,000	35.9 per 100,000

VHA = Veterans Health Administration

a. Suicide Among Active, Reserve, and National Guard Component Service Members

Since 2010, suicide has been the second-leading cause of death for active duty Service members, surpassed only by war injuries. Researchers have suggested that suicides by Service members, like suicides among civilians, are often impulsive acts triggered by various stressors such as relationship, financial, or legal problems. Most of the increase in suicide rates between 2000 and 2011 has been concentrated in the Army and Marine Corps; the incidence of suicide nearly doubled between 2005 and 2009 for Army and Marine Corps personnel but remained virtually unchanged for Navy and Air Force personnel.[14]

In 2013, there were 245 suicides across all Services (active, reserve, and National Guard).[15] Among this population, suicide risk factors included behavioral health issues, psychosocial and antecedent stressors, and deployment and direct combat history.

The 245 Service members who committed suicide in 2013 had the following characteristics:

- Behavioral Health
  - 39.6 percent had at least one behavioral health diagnosis.
  - 21.2 percent had a history of substance abuse.
  - 4.9 percent had a traumatic brain injury.
  - 26.5 percent had ever taken psychotropic medications, 19.2 percent had used psychotropic medications in the 90 days prior to the suicide, 9.8 percent had used pain medication at the time of the suicide, and 9.0 percent were taking four or more medications (polypharmacy) at the time of the suicide.
  - 57.6 percent had accessed medical/support services within 90 days prior to the suicide.
- Psychosocial Stressors
  - 44.9 percent had a failed relationship within 90 days prior to the suicide.
  - 6.1 percent had experienced loss or illness of a loved one within 90 days prior to the suicide.
  - 10.2 percent had a history of suicide involving friends or family members.
  - 30.2 percent had a history of administrative/legal issues within 90 days prior to the suicide.
  - 23.7 percent had financial or workplace difficulties within 90 days prior to the suicide.
- Antecedent Stressors
  - 9.4 percent had a history of abuse victimization; of those, 34.8 percent had experienced sexual abuse and 4.3 percent had experienced sexual harassment.
  - 13.9 percent had a history of abuse perpetration; of those, 50.0 percent had perpetrated sexual abuse and 11.8 percent had perpetrated sexual harassment.
- Deployment and Direct Combat History
  - 66.5 percent had a history of deployment; of those, 50.3 percent had experienced one deployment, 26.4 percent had experienced two deployments, and 23.3 percent had experienced three or more deployments.
  - 64.9 percent were ever deployed to Operation Enduring Freedom/Operation Iraqi Freedom/Operation New Dawn (OEF/OIF/OND).
  - 14.7 percent had a history of direct combat; of those, 50.0 percent had wounded others in combat, 11.1 percent were wounded in combat, 30.6 percent had witnessed killing, 25.0 percent had seen the corpses of other soldiers, and 16.7 percent had killed others in combat.[16]

b. Suicide Among Veterans

According to data from the U.S. Department of Veteran Affairs' 2012 Suicide Data Report, more than 69 percent of veteran suicides are among those ages 50 and older. Males accounted for more than 97 percent of all suicides among those identified as veterans, compared with approximately 75 percent among nonveteran suicide decedents. Females accounted for less than 3 percent of all suicides among

reported veterans, compared with more than 26 percent among suicide decedents without a reported history of military service. [17]

c. Association Between PTSD and Suicide Risk

While there is a heightened risk of suicide among trauma survivors, there is considerable debate surrounding the reason for this heightened risk. Some studies of U.S. adults have suggested that those who have experienced trauma are at higher risk of suicide because of PTSD symptoms; other studies have claimed that those with PTSD also have related psychiatric conditions that exacerbate the risk of suicide. Some studies have suggested that highly intrusive memories, as well as anger and impulsivity, are predictive of suicide risk in those with PTSD. Certain coping mechanisms, such as using suppression to deal with stress, may be additional suicide risk predictors for this population.[18]

Research on combat-related PTSD in Vietnam-era Veterans has suggested that the most significant predictor of both suicide attempts and preoccupation with suicide in this population is combat-related guilt. Many Vietnam-era Veterans experience highly intrusive thoughts and extreme guilt about acts committed during times of war. These thoughts can often overpower the emotional coping capacities of veterans. With respect to OEF/OIF veterans, PTSD has been found to be a risk factor for suicidal ideation. A recent study found that among OEF/OIF veterans, those with subthreshold or partial PTSD were three times more likely to report hopelessness or suicidal ideation than those without PTSD.[19]

4. Post-Traumatic Stress Disorder

The Committee inquired about PTSD rates among active, reserve, and National Guard Service members; veterans; and civilians. There are several ways to identify cases of PTSD within a population, and each method varies in its validity, sensitivity, and specificity (e.g., some definitions of PTSD are broad and aim to identify all possible cases of PTSD, while others are more stringent and aim to identify only clinically validated cases). These differences in how to operationalize PTSD have led to a wide variability in prevalence estimates between studies. [20] The figures outlined in the remainder of this section should be considered with care; the rates for each population were calculated differently and may not be comparable to one another.

a. PTSD Among American Adults

Table 3 provides an estimate of the lifetime and past 12 months prevalence rates of PTSD in American adults according to data from the National Comorbidity Survey Replication conducted by Harvard Medical School between 2001 and 2003; these are the most current nationally representative data available.[21,22]

Table 3. PTSD Among American Adults

	U.S. Adults	Male	Female
Past 12 months prevalence	3.5%	1.8%	5.2%
Lifetime prevalence	6.8%	3.6%	9.7%

Gender Differences in Risk of PTSD. A recent meta-analysis reviewing 25 years of research suggested adult American women were approximately twice as likely as men to meet criteria for having PTSD and were more than four times as likely to have chronic PTSD. The reasons for these gender differences were unclear. The increased risk of PTSD does not appear to stem from a higher risk of trauma, and,

although women are more likely than men to experience sexual trauma, this alone does not appear to account for the difference.[23]

b. PTSD Among Active, Reserve, and National Guard Service Members

Active Component. Mental health disorders have significant impacts on Service member health care utilization, disability, and attrition from service. In 2011, mental health disorders accounted for more Service member hospitalizations than any other illness and more outpatient care than all illnesses except musculoskeletal injuries and routine medical care.

The reported incidence of PTSD has increased approximately 650 percent from 2000 to 2011.[24] One population-based study of active duty soldiers found that 8.5 to 14.0 percent had serious functional impairment from PTSD, and 23.2 to 31.1 percent had some functional impairment. [25]

Reserve and National Guard Components. A review of several meta-analyses examining differences in PTSD prevalence between active, reserve, and National Guard Service members found that Service component was not shown to explain variability in PTSD prevalence.[26] Several studies reviewed the prevalence of PTSD at two time points following deployments (depending on the study, the reintegration period ranged from three months to five years post deployment). The prevalence of post-deployment PTSD remained fairly stable for Active Component Service members over the reintegration period, but prevalence rates continued to rise over time for Reserve Component and National Guard Service members. [27] There are several differentiating factors between active, reserve, and National Guard Service members that may contribute to these differing rates of PTSD prevalence:

1. Military service expectations
2. Perceptions of preparedness
3. Combat exposure
4. Military unit support
5. Family support and home front stressors during deployment
6. Challenges in transitioning to civilian life
7. Post-deployment social support[28]

c. PTSD Among Veterans

This section describes the differences in PTSD rates between veterans of the Vietnam era compared with veterans from the more recent conflicts in Iraq and Afghanistan.

Vietnam Veterans. The National Vietnam Veterans Readjustment Study was conducted with a representative sample of veterans who served in the military during the Vietnam era. The estimated lifetime prevalence of PTSD among these veterans was 30.9 percent for men and 26.9 percent for women. Of Vietnam veterans, 15.2 percent of males and 8.1 percent of females were already diagnosed with PTSD at the time the study was conducted (1986–1988).[29]

OEF/OIF Veterans. In 2008, researchers at RAND published a population-based study that examined the prevalence of PTSD among previously deployed OEF/OIF Service members. Among the 1,938 participants, the prevalence of current PTSD was 13.8 percent.[30] After controlling for differential trauma

exposures and other factors, some characteristics continued to place individuals at increased risk for current PTSD; females were more likely to suffer from PTSD.[31]

RAND also conducted a review of 22 independent studies on the prevalence of PTSD among troops deployed or deploying to Iraq and/or Afghanistan. Regardless of the sample, measurement tool, or time of assessment, combat duty and being wounded were consistently associated with positive screens for PTSD. When comparisons were available, Service members deployed to Iraq appeared to be at higher risk for PTSD than Service members deployed to Afghanistan.

5. Military Sexual Trauma and Post-Traumatic Stress Disorder

The lasting effects of MST have made headlines in the past several years as female veterans continue to struggle with PTSD related to MST suffered during their active duty service. [32,33] Research shows that MST appears to be a significant source of traumatic stress among women seeking VA disability for PTSD. In a 2009 study, 71 percent of women seeking disability for PTSD reported experiencing sexual assault during their military service.[34] In three different studies,[35,36,37] researchers found a strong correlation between MST and PTSD even after controlling for prior trauma and other deployment stressors.

Health issues (including PTSD) for women veterans may be magnified because of circumstances that are unique to a military setting. Victims of MST often have to continue to work and live with their assailants on a daily basis. This not only increases the risk for continued distress but also heightens the risk of subsequent victimization.[38] In addition, military unit cohesion creates an atmosphere where women may fear retaliation and blame if they report the assault and where they believe reports will be ignored by superiors.[39] There is some debate in the literature on how MST affects PTSD in men compared with women. Kimerling and colleagues (2007) found that while both men and women suffer from MST, the association between PTSD and MST was almost three times stronger among women. [40] According to another study, Active duty men who reported sexual abuse were more likely than women to meet criteria for PTSD and had higher rates of PTSD than those who reported high combat exposure (Hourani, Bray, Williams, Wilk, & Hoge, 2015).[41] It is interesting to note that Kimerling and colleagues (2007) conducted their study among women veterans from Veterans Health Administration (VHA) data, while Hourani and colleagues (2015) studied active duty men and women. This could suggest that the effects of MST increase with time for women.

6. Challenges and Opportunities Around Transitioning From DoD to VHA Health Care

The Committee is concerned about the transition training, medical care, and mental health support women receive during and after serving in the Armed Forces. Among military personnel who served in recent years, 44 percent stated they had difficulty transitioning to civilian life.[42] These challenges can range from securing employment and housing to coping with relocation and financial changes. Veterans who need to prioritize transition concerns over mental health treatment may disengage from needed health care. Only about 55 percent of OEF/OIF/OND veterans utilize U.S. Department of Veterans Affairs (VA) services.[43] DoD and VHA have prioritized ensuring health care continuity across institutions, but the process of ensuring this continuity is not monitored nor are medical records fully integrated.[44] Service members and veterans with mental health issues often experience difficulty maintaining needed treatment after transition.[45] Researchers have identified several barriers Service members face to successfully transitioning from DoD to VA health care;[46] these include (1) lack of knowledge of VA benefits, (2) transportation/distance to VA medical centers, and (3) VA reputation. One study found that among women veterans, 19 percent had delayed or unmet health care needs; in this population,

predictors of delayed or forgone care included (1) being uninsured, (2) having knowledge gaps about VA care, (3) having the perception that VA providers are not gender sensitive, and (4) having a history of MST.[47] In their 2015 study, Villagran and colleagues found that during the process of transitioning from military to civilian life, women veterans' health care prevention service utilization decreased and, concurrently, their physical and mental health decreased through the transition.[48]

A 2012 U.S. Government Accountability Office report outlined some of the many institutional barriers that hinder collaboration between DoD and VA to meet the needs of transitioning Service members, such as IT system incompatibilities, differences in business and administrative processes, lack of military base access for care providers, and the need for additional medical facility construction.[49] Despite these challenges, there are several promising DoD/VA programs and practices in place to aid Service members in transition. The VA/DoD Federal Recovery Coordination Program and the VA Liaisons for Healthcare Program are examples of how VA and DoD are working closely to provide comprehensive care coordination and case management.[50] DoD and VHA also have used telemedicine to facilitate successful transitions between DoD health care and VA medical center care.[51] Many federal initiatives are working to study and ease the transition from VA to DoD care; for example, the Office of Interagency Collaboration and Integration exists to interface VA with other federal agencies (including DoD and the U.S. Department of Health and Human Services) to produce better outcomes in health care and benefit delivery for veterans.[52]

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