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Racial Differences in Veteran Service Connection Disability

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Racial Differences in Veteran Service Connection Disability

by

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MSW Final Research Project

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Abstract

The problem this project addresses is racial differences in veteran service connection disability, specifically for the African American Veteran community. Throughout history, African Americans have notably been underserved in the healthcare system. The literature also shows a huge disparity across races of veterans versus non-veterans when seeking mental health care. However, in some of the literature, there is conflicting research on whether non-white racial groups do in fact receive poorer quality care leading to poorer outcomes. The research question of interest is: What are the experiences of African American veterans in accessing disability resources? This research project was a qualitative study utilizing in-person interviews with five African American veterans who are currently receiving health care from the government and have a service connection disability. These respondents were chosen based on their race and ethnic background as well as their commonality of having service-connection disabilities. A content analysis was conducted on the data, where the researcher examined the data for its emerging themes. None of the participants had a disability rating below 70%, nor did anyone have a rating of 100%, and each participant was from the South. No veterans expressed concern with the VA Healthcare System or the care that they receive there. However, 4 of 5 veterans spoke of how they did not think the rating period was fair for various reasons. All veterans mentioned they felt their disability rating should be higher, and they do believe white veterans get a higher rating than black veterans. The implications for social work practice and policy as this research shows African American veterans are not receiving fair disability ratings which impacts their health and economic viability.

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Introduction

The problem this project addresses is racial differences in veteran service connection disability, specifically for the African American Veteran community. I chose this topic because I am a veteran and I work with African American veterans. I also have colleagues/friends that are African American veterans, and in our community, healthcare disparities are often discussed. In previous research, I have noticed there is very limited literature on veterans and unfair or disparaging treatment across races. I know from my previous research that, within the veteran community, the African Americans I interviewed believe they were less likely to receive similar medical benefits to their white counterparts, especially through the disability rating process. As a social worker, one of our main responsibilities is to promote human dignity, and equality for all human beings (NASW Code of Ethics 2008). For a community to not have access to basic health care, especially veterans who have fought on behalf of our country, is unethical and unjust.

The prevailing issue I have found through my previous research is African American veterans are not receiving equivalent service connection, or disability status, compared to their white counterparts. The process for receiving disability status is to go into the medical center for an initial assessment, where they complete a full physical check-up to find out what medical issues you may have from your time in the military and then give you a disability rating. For example, a white veteran may go in with a broken ankle from their military service and receive a 20% rating, whereas an African American veteran going in with the same problem might get only a 10% rating. In general, very rarely have I known an African American with 100% disability. This is an important process to consider because there is a financial stipend tied to

your disability, so at 100% status, a veteran receives several thousand dollars per month plus free health care from top to bottom. Not receiving equal disability ratings then ties back to economics and because African Americans on average do not make the same money as their white counterparts, they are being disadvantaged from several different sides.

The reason this is important to me is that I am an African American male who lived in the rural southern part of the United States in the 1970s and 80s. I grew up in a lower income family with less-than-adequate housing and two other siblings in a single parent home. I later graduated and went into the military to serve our country. Growing up in the south, some of our basic healthcare needs were not met, and there was never an opportunity to go to the doctor unless someone was dying. Some of this was because of our economic status, and some of it was also because the same treatment afforded to white people was not offered in the African American community. This personal connection makes the research even more compelling to me.

I have also learned that someone needs to give this injustice a voice. It has been my experience that, when the issue does not pertain to you nor are you directly affected by it, the issue is easily swept aside. The reason I believe this is important is that I need to be the one to give this issue a voice. If not me, then who? Being an African American man, this is an important issue that needs to be addressed and ultimately rectified. It is also very concerning that there is not a lot of research published about this problem, and it makes me wonder, why not?

The problem is that there is a prejudice that runs in the United States and is felt throughout the entire healthcare system, whether it be income, access to services, or access to medical attention. This research project focused on exploring how this problem manifests itself in the veterans' experiences and what solutions might be available to rectify the situation.

Knowing all this and being a veteran of the United States Military, I developed the following research question: What are the experiences of African American veterans in accessing disability resources?

Literature Review

Historical Racial Disparities

Throughout history, African Americans have notably been underserved in the healthcare system. When reviewing the history, there are two events which have particular relevance to this study. The Tuskegee Syphilis trials and the case of Henrietta Lacks. Henrietta Lacks was an African American woman whose cancer cells were used to form the polio vaccine without her knowledge or her understanding of what it would be used for. The vaccine, once developed, was sold to billions of people around the world without any restitution or any financial gain to her family (Zielinski 2010). To this day, her family cannot even afford basic health insurance. 1

The second case worth noting are the medical trials done at Tuskegee University went on from 1932-1972, which included over 600 African Americans that were exposed to syphilis and misled about the outcome and the real purpose of the experiments (Brandt, 1978). The participants were enrolled with this study through the U.S. Public Health Services and misled to believe they would receive free healthcare from the US government. However, the real purpose was to follow the natural process of syphilis in rural, impoverished African American men; 399 of which already had syphilis prior to enrolling, and the rest received exposure during the study.

After the funding was discontinued, the researchers continued without informing the participants they would never be treated for their disease. The participants, in fact, were never told they had the disease, but just that they had “bad blood” disease and none were given

antibiotics to treat the disease (Brandt, 1978). This was exceptionally immoral since researchers knowingly and unethically did not tell the patients about their disease nor did they treat them for it.

These two historical examples demonstrate the complete disregard for the dignity and respect of African American lives in the United States healthcare system. Unfortunately, many of the stigmas existing in history can still be found today. Research has also shown the lack of trust that the African American community, as well as other non-white groups, has for doctors and healthcare professionals in general (Gonzalez, Alegria, Prihoda, Copeland and Zeber, 2011). The disparity in seeking care between white and non-white ethnic groups is often about the quality of care and health outcomes (Burgess, Ding, Hargreaves, van Ryn and Phelan, 2008). For example, researchers used data from a large, cross-sectional telephone survey of a multi-ethnic group of people (n=10,098) in Minnesota to analyze whether perceived discrimination in everyday and health care settings lead to underutilization of medical or mental healthcare (Burgess et al., 2008). The survey used validated instruments, and researchers analyzed the data with a multivariate logistic regression model. Their findings showed both everyday discrimination as well as discrimination within the healthcare system lead to underutilization of care in all racial groups (Burgess et al., 2008).

Veteran vs non-veteran

The literature also shows a huge disparity across races of veterans versus non-veterans when seeking mental health care (De Luca, Blosnich, Hentschel, King and Amen, 2016; Payne et al., 2005). In one study, (Payne et. al, 2005) researchers conducted an additional analysis on a subsample (n=1,909) of the respondents to the Veterans Health Survey to determine if there were

any differences in healthcare utilization of VA and non-VA care or between users of VA care. The Veterans Health Survey is a large survey prospective study of almost 2,500 male veterans in the Boston area and was done to assess veteran health-related quality of life and outcomes. In Payne et al.'s (2005) study, an effect between VA and non-VA users was only seen in non-white, specifically black, populations where veterans were three times more likely than non-veterans to seek out any kind of mental health care services. When the same analysis was conducted for white veterans compared to non-veterans, there was no difference in these behaviors, even when controlling for age, gender, marital status, and certain attitudes and supports (Payne et al., 2005).

In another study using data from the CDC's Texas Behavioral Risk Factor Surveillance System (BRFSS), a random-digit dial telephone survey of 8,563 respondents in Texas regarding mental health care utilization, found younger veterans (age 22-44) had higher mental health care utilization rates than older veterans (De Luca et al., 2016). They also found that, for African Americans and Latinos, being a veteran increased the likelihood they would seek mental health care. However, in whites, there was no difference between veterans and non-veterans with regards to mental health care utilization (De Luca et al., 2016).

Race and Healthcare Outcomes

In some of the literature, there is conflicting research on whether non-white racial groups do in fact receive poorer quality care leading to poorer outcomes. For example, Eack & Newhill (2012) conducted a longitudinal study where they followed 925 severely mentally ill patients for one year after an in-patient hospitalization to see if outcomes differed. They wanted to know if there were disparities in mental health outcomes for those with severe mental illness. They created individual growth curve models and found a difference in health outcomes – there was

less improvement in various symptoms and levels of functioning in African American patients versus white patients (Eack & Newhill, 2012). Larrison et al (2004) conducted a similar study but with a sample of patients seeking outpatient treatment from a rural, community health agency and analyzed using a type of growth curve model. These researchers saw no significant difference in outcomes between white and non-white groups. However, they state in their limitations that their results were preliminary, and their sample was not sufficiently large or diverse enough to be able to generalize to the larger population (Larrison et al, 2004).

Another interesting study showed differences between the types of care racial groups may seek, noting that non-white groups of veterans may be less likely to take medications prescribed to treat mental illness due to treatment preferences (Spoont, Hodges, Murdoch and Nugent, 2009). The researchers conducted a retrospective cohort study of veterans with PTSD in the administrative database data of the veterans' healthcare system to determine if there were differences in treatment by race/ethnicity. The researchers examined the odds of receiving medication or counseling, and if those receiving either treatment received a minimal trial, defined as at least four 1-month supplies of psychotropic or antidepressant medications or at least 8 sessions of therapy. Their logistic and binomial regression models found no lower treatment rates in minorities, but differences in types of treatment for certain races/ethnicities, specifically that blacks and pacific islanders were as likely as whites to receive medication, but much less likely to receive a minimal medication trial. Additionally, blacks were more likely than whites to receive a minimal trial for counseling; so the researchers noted there may be a treatment preference in these groups (Spoont et al., 2009).

Disability status

In the Veterans Healthcare system, any veteran of any line of service is eligible to receive healthcare, at their own expense or with their personal or employer-sponsored insurance plan. However, subsidized healthcare is available to veterans who have service-connected disability status. Service-connected disability is a percentage a veteran is awarded for any injuries he may have sustained (emotional, psychological or physical) during his time in the service. The higher the rating/percentage, the less a veteran has to pay, and the more added benefits the veteran can receive (Murdoch 2002). In addition, there is a stipend awarded to the veteran monthly based on their rating, with a maximum amount being \$3,500 per month, tax free, for 100% disability. The way this process works is, a veteran goes into the VA health care system or his veterans service officer and files for compensation for whatever ailment they may have. The VSO may also refer the veteran to the eBenefits website for claims processing information. The website instructs a veteran how to start a claim as well as complete and follow-up on the claim (Department of Veteran Affairs 2016).

For example, a veteran may go in stating he broke his ankle during active duty. The VSO then contacts the VA to open a case on the veteran. First they will gather the veteran's medical records, which are kept in St Louis National Hospital. The records are reviewed to ensure the veteran did break his ankle or receive whatever injury during his time. The veteran is then set up with a doctor and a case manager. The doctor will give a full physical, focusing on the injury indicated. The doctor will also look at other associated disabilities, or what they call secondary injuries. In the example of the broken ankle, a doctor will point out the veteran may suffer from knee problems stemming from their broken ankle, so they assign a percentage of disability to

both the primary injury as well as all associated secondary injuries. Then a veteran is awarded an overall disability rating based on the doctor's recommendations and the evidence presented in her records. Once this process is complete, if a veteran does not agree with the findings/rating, they can appeal the decision. Once a decision is finalized, the veteran will begin receiving their benefits.

There is limited research about veteran's disability status once they have already been awarded compensation for their disability. However, there is one study which explored differential disability awards between white and non-white veterans. Murdoch, Hodges, Cowper, Fortier, and Van Ryn (2002) conducted a survey study of 3,337 men and women veterans, of which 17% were black, in order to find out if there were any racial disparities in service connection for veterans PTSD. The sample contained a large portion of lower income individuals - 44% of respondents' annual household income was \$20,000 or less. They found service connection for PTSD was granted for only 43% of black veterans, while 56% of others (all non-black groups) were granted service connection. These findings remained significant even after adjusting for PTSD severity and level of functioning (Murdoch et al, 2002). The fact the study only covers PTSD shows there is a need for additional research on these racial disparities in other service connection disabilities as well.

Conclusion

This literature review shows there is significant inequality concerning African American health care and specifically veterans. Wherever people suffer and are vulnerable, there will be a need for social work. The majority of the research on access to health care, especially among veterans, are quantitative. This indicates researchers have not investigated the lived experience

and perspectives of those most impacted. This leaves too much ambiguity and potential misrepresentation. The following study attempts to fill in part of this gap.

Conceptual Framework

The conceptual framework informing my research will include several theories discussed during my MSW program at the University of St Thomas. I believe that throughout my research many themes will evolve and be expounded upon during the research report. However, I will focus on Critical Race Theory as the guiding framework for my research. Critical Race Theory recognizes that, as an overarching theory, racism is essentially engrained into the fabric of our society in America, like a dark cloud floating over our country. It states that black men are not equal to white men and that white supremacy is real, at the same time marginalizing other races and ethnicities (Milner 2007). Ladson-Billings and Tate (1995) speak to educational values specifically, but it carries throughout life, saying that the racial tension can be felt by African Americans across society, including education and many other realms. Systematically, African Americans would naturally feel an inequality because they have been treated this way throughout life, almost as if a mantra being spoken over them, because they are taught they do not deserve it either (Ladson-Billings and Tate, 1995). Ladson-Billings and Tate say "...by making him (the Negro) feel that his race does not amount to much and never will measure up to the standards of other peoples" (p. 50 1995). In the military, one thing that was always spoken was that rank has its privileges. In society, we understand and know that white has its privileges just the same.

Methods

Research Design

This research project was a qualitative study utilizing in-person interviews with five African American veterans who are currently receiving health care from the government and have a service connection disability. Qualitative research is a more exploratory form of research than quantitative research, which uses numerical data and analysis. Qualitative research is used to provide insights and understanding of individual experiences and the meaning they attribute to such events. This researcher chose qualitative research, specifically using in-depth interviews, as it is the most fitting type of design for the research question so that we can better understand veterans' experiences in the healthcare system directly from them. Merely reviewing data and numbers for this research question would not be helpful as it does not describe the actual experiences of this group of people, which is the greater purpose of this study.

Sample

The sample for this research was five service-connected African American veterans receiving health care at a large metropolitan VA Medical Center. All respondents had retired from the military after serving for 19+ years. They all were originally from the Southern part of the United States. They ranged in age from 45-55. All respondents had service connection ratings between 70-80%. Their disabilities included: PTSD, ankle injury, back injury, knee injury, mental health disorders, tendinitis, sleep apnea, skin irritation, tinnitus and upper respiratory illnesses.

Participants were recruited via a posting on social media asking for volunteers who were African American veterans with a service-connection disability.

Protection of Human Subjects

When volunteers contacted me by phone/email, the researcher explained the study and reviewed consent information at that time. The researcher then set up a time for an in-person interview during the initial contact. Prior to the interviews, the respondents were emailed a consent form approved by the Institutional Review Board (IRB) at the University of St Thomas. The consent form, which can be found in Appendix A, outlines the background and purpose of the study as well as informs respondents their information will be kept confidential with no identifying information being included in the final research report. The researcher reviewed the consent form in its entirety with each respondent prior to beginning the interview and allowed for the respondent to ask any questions before signing and participating in the study. Respondents were assured at the beginning of the interview they could decline to answer any question as the research is completely voluntary, as outlined in the consent form. Additionally, the professional transcriber signed a confidentiality agreement before any transcriptions were sent to them. All signed consent forms, recorded interviews, and transcripts from all participants are stored in a locked file cabinet and on a password protected computer to protect the participants' confidential information until the study is complete. Upon completion of the study report and review/approval by all committee members, the researcher will destroy all personally identifying information and keep consent forms for the mandated 3-year limit, and then destroy them.

Data Collection

The interviews took place in a location chosen by the participant. All interviews were recorded, with the respondent's permission, and transcribed afterwards. The researcher hired a professional to transcribe all interviews to ensure high data quality and used the interview protocol found in Appendix B. The researcher drew from the literature review and consultation with the MSW research committee to develop the interview protocol. The questions developed were also based on previous experience and cultural sensitivity and consisted of 10 questions about the Respondent's receipt of healthcare, whether they are happy with their healthcare, if they notice any variations in healthcare compared to their white counterparts, and an overall rating of their healthcare satisfaction. The interviews lasted approximately 45-60 minutes per participant.

Analysis

The researcher had all interviews transcribed by a third party, and the researcher reviewed all transcriptions thoroughly to find any commonalities in their responses. A content analysis was conducted on the data, where the researcher created a list of common themes which emerged from the study (Zhang and Wildemuth, 2009). In content analysis, the researcher first reviews the literature to sensitize themselves to the major themes and findings on their topic, and makes note of them in order to create codes for application to their specific data. For this study the sensitizing concepts included: historical patterns of racial inequalities, veteran-specific inequalities, and disability status challenges. The researcher tested the coding scheme developed on a portion of the data to see if it applied to the results and still made sense. The coding scheme appeared to make sense for the data collected and therefore it was applied to the full data set,

comparing to find out what was similar as well as what was different between the literature and respondents in order to draw conclusions about the overall research question.

Research Question

The main research question for this study is: What are the experiences of African American veterans in accessing disability resources?

Results/Findings

All of the veterans spoke of their enjoyment for their time in the military for several reasons, including the travel experiences, family environment, and the people they met. One veteran said, when asked about what he enjoyed from his military time, “the travel, the different people I met, and the different experiences. Overall it was a good experience.” However, at the same time several veterans spoke about how travelling caused them to be sad because it “took time away from family” so it was a double-edged sword.

Southern roots

During the content analysis, the researcher noted all participants were African American, and all five veterans interviewed grew up in the South and have since relocated to the Midwest. They were all relocated here by the military. They discussed how in the South veterans “were looked at as a problem that was not going to get a solution.” In addition, the service connection process in the South was much less clear. A few of them had applied prior to relocating, and they felt in the South that they were filing blindly, and they were not educated nor did they understand much about the process. One veteran noted, “I had no guidance on how to do it” and that during the process, “there were a lot of things missed.” He even stated at one point, about

the veteran disability system in the South, “They don’t care.” In addition, several of the veterans thought they just had to accept the rating they were given. One was told to “take it now and appeal later” but no one explained how the appeals process worked or how to do it. However, when they moved up North, they were able to get more advisement on the options and appeals process. One veteran said he was “Connected with the American Legion in Minneapolis, something that was not available to me in the South.” Therefore, for those interviewees, their service connection ratings were lower in the South, and when they moved to Minnesota and filed their new claims to fight the rating, they were all increased substantially.

Education

One other commonality between the veterans interviewed was the lack of knowledge regarding the process for obtaining the military and government. Out of the 5 veterans interviewed, only one had a college degree. He had just received his bachelor’s degree at age 55, and said, “had I known how easy it was to get the educational benefits, I would have gotten my degree much sooner so I could have progressed through the ranks in the military.”

Time in the military

Each participant I interviewed was a retired veteran of 20+ years, which was an unexpected finding. None of the participants achieved a rank higher than Sargent First Class (SFC)/E-7. Any ranking higher than that would require at least a Bachelor’s degree, if not a Master’s degree. All participants felt retired veterans got a higher rating than those who just left the military after a period of time. One veteran stated it was “Almost like the doctors felt you deserved it since you put in your time.” However, none of the veterans interviewed had a disability rating below 70%, nor did anyone have a rating of 100%.

Access to services

The veterans interviewed are all service connected between 70-80% for a variety of disabilities from their service in the military, including PTSD, ankle injury, back injury, knee injury, mental health disorders, tendinitis, sleep apnea, skin irritation, tinnitus and upper respiratory illnesses. The veterans had no issues with the VA Healthcare System nor the care they receive there. All veterans interviewed seemed satisfied with the healthcare services obtained at the VA and all had positive experiences with their primary care physicians. As a matter of fact, each veteran spoke rather fondly of the care they received from their primary care doctor. One veteran said “primary care at the VA is good” and another said, “I have zero problems with the VA. Contrary to the public opinion and negative publicity out there, I think the VA is an outstanding facility as it pertains to care for veterans.” The researcher also inquired with participants about use of other services in the community; however, the question did not appear to be clear to respondents even with clarification, so they did not indicate use of any other types of services outside of their VA healthcare.

Rating experiences

However, despite their positive experiences with their primary care, 4 of 5 veterans spoke of how they thought the rating system and process “was unfair”. They spoke of how the process was “not very friendly if you do not have someone to actually walk you through it” and they most often did not have someone to do that. Several spoke about how there was really no guidance on how to apply – they were just “thrown in the mix”, as one veteran said, and “told to figure it out.”

The veterans also felt like the rating board was against them – they were not there to help the veteran get their approval but to discourage them from going through with it. One veteran shared a story of a negative experience he encountered during a disability rating exam. The rater was checking his range of motion for tendinitis his neck, and when he moved his head to certain point, he told the rater that it caused him pain and the rating doctor said, “Turn your head further anyway.” He noted his primary care doctor would never have had him push beyond the pain but immediately made him stop. The veteran noted that he felt the rater made him “push it further so he could say I have no range of motion troubles and deny my claim”.

Insufficient ratings

Another thing all veterans mentioned was they felt their disability rating should be higher, with several veterans stating that they are “still fighting my low rating”. One veteran spoke of how “on paper, I am service connected for 80% but my overall rating is actually 160%” and he noted he is “still fighting this decision today.”

Additionally, they all believe white veterans get a higher rating than black veterans. One veteran said he felt African Americans “felt they had to do more than the white veterans to prove their needs”. One veteran even mentioned once sitting on the rating board as his primary job, and veterans with the same disability issues that he received his 70% for “are rated higher than me” and that he thinks “race does have something to do with it”, that “to me, it almost feels like it is two systems” between the two races.

Another issue discussed was having a rating adjusted. Respondents said “once you are rated, it’s very difficult to get additional ratings.” They also noted that some injuries do not

show up right away, so “you try to apply for additional coverage for other injuries, but it is very hard to get any additional percentage at that point” after they accepted the initial rating.

Every veteran interviewed stated they “do not trust the VA rating system for disability”. Whether this is historical due to things they heard about the VA rating system or because of what they have been through thus far, the researcher is not sure. It seems they may have gone into the process hearing from other veterans hearing how difficult it may be, and then they may have experienced on their own how difficult the process is.

Discussion

All of the veterans were eager to share their experiences with me, but also expressed a feeling that no real change would result from their story sharing. However, they all said they would love to see such change. As a researcher, it seemed like they wanted someone to know their story so that someone knew what they went through, even if they doubted it would create change.

Implications for social work practice

The results of this research certainly have an impact on social work practice. Some of the core values of social work are social justice, social dignity and worth of the human, importance of the human relationship, and integrity and competency. Throughout the research, it was shown most of these values have been infringed upon. We know that in the history of the US has been one of privilege for white men and the disadvantage in the lower class of African American men. Throughout this research and the literature, the evidence is shown regarding the disadvantage of the African American community in regards to social justice and dignity and worth. During the interviews, there was a sense of this from their body language and their attitude that was not

captured on paper. All of them were eager to speak and yet unhopeful of any type of change or restitution.

As a society, based on this report, African Americans have not had social value within the community, within their healthcare system, nor within their socioeconomic realm. Social workers need to be purposeful in their purpose. One might say what does that mean? It means to go out of your way to help the less fortunate. It means not giving so much time to the privileged class but giving more time to the underprivileged groups. Social workers need to fight against stigmas in all we do and in all aspects of society. We need to move against the norm, not always taking the easy route, and stand up for what is right. That means standing with those who are less fortunate, standing by those who are less fortunate and standing for those who are less fortunate. These are just some of the ways that social workers of this generation need to work to fight these injustices.

Implications for policy

There are many policy implications in this research report, including a policy regarding African American veterans specifically. This could be addressed by hiring more African Americans in areas of decision making, including as board members for approvals for service connection claims. There could also be more understanding and education surrounding claims, as well as more empathetic physicians sensitive to the needs of African American veterans.

Implications for research

There is certainly more opportunity for further research in this area. The only hindrance there is that there has always been research. As far as I could look back, all the way back to Tuskegee, there has been research conducted showing the social injustice going on concerning African Americans. But in a society like today where there is racism and economic injustice, this continues to happen. The problem is this research is either ignored or not being shared with those who can effectively intervene to remedy the problem. I am afraid it will continue to happen as long as we have people that are different from each other. As long as we have differences, there will continue to be inequalities.

Strengths and Limitations

Qualitative research is an effective means of studying these types of research questions in order to obtain firsthand knowledge and experience from people affected by the issue by conducting in-person interviews. However, there are limitations to this type of research as well. First, qualitative research is conducted with a small sample of respondents, so generalizations to the larger population cannot be made. It is also possible the researcher did not uncover all the themes due to the limited sample size and the ability to ask the right questions to pull out all of those themes. Additionally, data cannot be triangulated by other sources such as quantitative data about their disability, healthcare or healthcare outcomes, or direct observation. Also, the researcher only interviewed African American veterans and not any white veterans, therefore, he was not able to capture firsthand experiences of white veterans in this healthcare system to compare to the data collected.

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Appendix A

CONSENT FORM

African American Veterans Study

You are invited to participate in a research study about *African American veterans' experiences with disability claims*. I invite you to participate in this research. You were selected as a possible participant because you responded to an ad for participants. You are eligible to participate in this study because you are an African American service-connected veterans. The following information is provided in order to help you make an informed decision whether or not you would like to participate. Please read this form and ask any questions you may have before agreeing to be in the study.

This study is being conducted by Jonathan Arnold, a MSW student at the University of St. Thomas. This study was approved by the Institutional Review Board at the University of St. Thomas.

Background Information

The purpose of this study is to gain information about veterans' experiences in obtaining service connection disability status, specifically African American veterans.

Procedures

If you agree to participate in this study, I will ask you to do the following things: complete a 20-30 minute recorded interview with the researcher at a location where you feel comfortable. The interview will ask about your experiences with disability claim processes

Risks and Benefits of Being in the Study

The study has risks, which include privacy issues. The researcher will ensure minimal risk by conducting the interview in a place you feel comfortable and by de-identifying all study data.

There are no direct benefits from participating in this study.

Privacy

Your privacy will be protected while you participate in this study. Participants will be able to choose the location of the interview and time of the interview. The researcher will not share any identifiable information about participants with anyone outside of the study.

Confidentiality

The records of this study will be kept confidential. In any sort of report I publish, I will not include information that will make it possible to identify you. The types of records I will create include recordings and transcripts of all interviews. Only the researcher will have access to these records, and they will be kept for a minimum of three years upon completion of the study. All signed consent forms will be kept for a minimum of three years upon completion of the study. All study records will be erased at this time. Institutional Review Board officials at the University of St. Thomas reserve the right to inspect all research records to ensure compliance.

Voluntary Nature of the Study

Your participation in this study is entirely voluntary. Your decision whether or not to participate will not affect your current or future relations with the researcher or the University of St. Thomas. There are no penalties or consequences if you choose not to participate. If you decide to participate, you are free to withdraw at any time without penalty or loss of any benefits to which you are otherwise entitled. Should you decide to withdraw, data collected about you will be erased. You can withdraw by contacting the researcher to request withdrawal. You are also free to skip any questions I may ask at any time.

Contacts and Questions

My name is Jonathan Arnold. You may ask any questions you have now and any time during or after the research procedures. If you have questions later, you may contact me at 952-607-6455 or at arno3107@stthomas.edu. You may also contact my advisor, Mary Nienow, at 651-295-3774 or at nien3538@stthomas.edu. You may also contact the University of St. Thomas Institutional Review Board at 651-962-6035 or muen0526@stthomas.edu with any questions or concerns.

Statement of Consent

I have had a conversation with the researcher about this study and have read the above information. My questions have been answered to my satisfaction. I consent to participate in the study. I am at least 18 years of age. I give permission to be audio recorded during this study.

You will be given a copy of this form to keep for your records.

Signature of Study Participant

Date

Print Name of Study Participant

Signature of Researcher

Date

Appendix B

INTERVIEW QUESTIONS

1. In what region of the US were you born?
2. What branch of the military did you serve?
3. How long did you serve in the military?
4. Tell me a bit about your military service.
 - What did you enjoy about your military experience?
 - What was the most difficult thing about your military experience?
5. Tell me a bit about the injury/injuries for which you pursued a disability claim.
6. Describe the process of pursuing your disability claim. (Potential probes: length of time, steps involved, how they felt throughout it, did they feel the process was fair, do they feel race was a factor in their disability rating?)
7. What is your rating?
 - Did you feel like this is the right rating based on your injury/injuries? Why/Why not?
8. How has this rating impacted your experience accessing health care services? How has this rating impacted any other types of support or services that you have access to (or not)?
9. Is there anything else you would like to tell me about your experience through the disability rating process as an African American Veteran?