**The Next Battle: Taking Care of Our Veterans**

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Two recent events present an appropriate opportunity to take stock of the toll of combat for returning veterans of recent and current wars – in particular, the health care needs of veterans with physical and mental wounds from Operations Enduring Freedom (Afghanistan) and Iraqi Freedom (OEF/OIF).

First, the Iraqi Parliament recently ratified a sweeping security agreement that sets out a timetable requiring US troops to withdraw from Iraqi cities and towns by June 2009 and to completely withdraw from the country by the end of 2011. While there is undoubtedly a long way to go before Iraq is stable enough for American forces to leave (and the agreement must still be approved in a national referendum), recent political events in Iraq point to an eventual withdrawal of US forces and an end to the costly war and occupation in Iraq.

Second, last week President-Elect Barack Obama selected retired General Eric Shinseki to head the Veterans Affairs Department (VA), the second largest of the 15 Cabinet departments and home to the VA health care system, which provides a broad spectrum of medical, surgical and rehabilitative care to nearly 250,000 veterans in Nevada and millions more across the US.

General Shinseki will be inheriting an agency already struggling with rapidly rising caseloads and treatment issues unique to veterans of the first gulf war and OEF/OIF. Since the onset of OEF shortly after the events of September 11, the VA has experienced unprecedented growth in the medical system workload, with the number of patients treated in VA facilities rising by 29 percent from 4.2 million in 2001 to nearly 5.5 million in 2008.

Equally important, the VA must deal with high and rising rates of mental health problems among veterans returning from war and thousands of military personnel who have suffered moderate to severe traumatic brain injury or TBI.

Mental health problems and psychological injuries are, of course, common to veterans of any military conflict. Nonetheless, according to Iraqi and Afghanistan Veterans of America (IAVA) about one in three Iraq veterans will face a serious psychological injury, such as depression, anxiety, or post-traumatic stress disorder (PTSD) – rates comparable to, if not higher than, levels of mental illness experienced by Vietnam veterans.

Where 1.6 million people have served in Iraq and Afghanistan to date, IAVA estimates that approximately half a million troops are returning with combat-related psychological wounds. Moreover, long and multiple tours – active-duty Army combat tours were increased from 12 to 15 months in 2007 and at least 450,000 troops have been deployed more than once – have increased the risk of mental health problems among those who have served in Afghanistan and Iraq.

Untreated mental health injuries, in turn, have resulted in rising levels of marital and family problems, drug and alcohol abuse, and suicide. For example, the suicide rate of active-duty soldiers in Iraq is significantly higher than soldiers in general – 16.1 suicides per 100,000 Army troops in Iraq, as compared to a rate of 11.6 Army-wide.

The IAVA contends that the Department of Defense (DOD) and VA must address three of the most pressing mental health needs faced by returning veterans – mandatory mental health screenings, access to psychiatrists and other trained mental health professionals, and assuring that military families have access to training and care – and that progress on these fronts "would be a tremendous step toward reducing the stigma attached to mental health care, building a less passive response to veterans' mental health needs, and stemming the flood of veterans with untreated mental health injuries."

Similarly, traumatic brain injury (TBI) represents a serious threat to active duty troops and returning veterans of recent and current conflicts. TBI and blast-induced injuries have become the signature wounds of the wars in Iraq and Afghanistan because of the pervasive use of explosive weaponry.

According to IAVA, ten to twenty percent of Iraq veterans or 150,000 to 300,000 of the 1.6 million Americans who have served in OIF/OEF have some degree of brain injury, while the DOD puts the figure at a much lower 5,500. Regardless, service members of these wars are experiencing higher rates of TBI and blast-induced injury than veterans of any previous conflict, leading many to refer to TBI as the signature wound of the wars in Iraq and Afghanistan.

TBI can lead to emotional problems; vision, hearing, and speech problems; dizziness; sleep disorders; and memory loss. Worse, a recently released report from the Institute of Medicine (IOM) concludes that those who suffer TBI face an increased risk for developing several long-term health problems, including Alzheimer's like dementia, aggression, depression, and symptoms similar to Parkinson's disease.

While the VA has instituted mandatory TBI screening of all returning combat veterans visiting a VA hospital, both the IAVA and the authors of the IOM report recommend that every soldier receives a pre- and post-deployment brain-function test which will allow brain injury experts to compare baseline neuropsychological function to post-deployment function.

Over the next couple of years, as the end to the conflicts in Iraq and Afghanistan become more likely, our need to address and fully respond to the unique toll of combat on returning veterans of Iraq and Afghanistan will only grow. We must insist that the new Administration and the incoming Secretary of the VA are equal to the task.

For more information on recent veterans' health issues, please visit Iraq and Afghanistan Veterans of America at www.iava.org. Information on disability and health care services programs at the Veterans Affairs Department can be found at www.va.gov. The IOM report, Gulf War and Health Volume 7: Long-Term Consequences of TBI, can be accessed at the National Academies Press at www.nap.edu.

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