BACKGROUNDER

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Care for Mind as Well as Body: The Support Our Troops Need

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While the pictures of veterans visibly lacking care at Walter Reed have garnered headlines, a less visible challenge is wreaking severe damage on our military. Post-traumatic stress disorder, a hallmark of the Iraq conflict, can devastate veterans and their families back home - and also undermines our military's performance, particularly as troops return to Iraq for multiple tours. Congress can act to ensure more and better care for the mental health problems that silently afflict our troops.

Talking Points

1 in 5 Iraq vets suffer from post-traumatic stress disorder. The Pentagon has no effective plan to address this growing crisis.

The Army and Navy face a vacancy rate for active duty psychologists of nearly 40%.

A 2006 GAO report found that 80% of soldiers who showed warning signals on a return questionnaire were not referred for treatment.

Care for these battle-scarred vets has been a scandal. Instead of getting the care they have earned, suffering servicemen and women have been discharged and denied benefits.

Clear Steps Can Be Taken

- More screening for troops deployed to battle and returning home
- High standards for mental health care across the country
- More resources for mental health practitioners and programs
- Strong statements to combat the stigma against seeking care.

Post-Traumatic Stress Disorder

There is no line between battlefield and safe haven in much of Iraq. Troops face danger in firefights, but also on patrol, training Iraqis, or on bases targeted by mortar fire. Threats can come from a taxi, trashcan, or a stroller full of explosives. Redeployment compounds the stress: nearly 500,000 of the roughly 1.5 million troops who have been deployed to Iraq are now on their second or even third deployment.

Studies estimate that nearly 20%of those who have served in Iraq suffer from post-traumatic stress disorder (PTSD). For some, PTSD is a debilitating condition that can lead to withdrawal from everyday life, substance abuse, homelessness or violence. Even milder forms can lead to hyper-vigilance, aggression, or fear of the ordinary. For those with PTSD redeployed to Iraq, it can exacerbate an already serious problem, and lead to erratic behavior, poor combat performance, criminal behavior, and even suicide.

Despite these risks, the Pentagon has no systematic process to identify PTSD. Troops deployed to Iraq face only one screening: a single inquiry on a questionnaire asking: "During the past year have you sought counseling or care for your mental health?" For troops returning home, PTSD is often buried amongst many issues in briefings and questionnaires. The burden thus falls squarely on an individual service member to come forward, or on senior officers to be proactive in seeking help for a member of their unit. Yet service members are not effectively educated to spot the signs of PTSD, and the warrior attitude discourages self-identification. Meanwhile, an attitude permeates much of the military that says that, "if it doesn't look broken, it isn't."

Those brave enough to speak up may be ignored, or even punished. **A 2006 GAO report found that 80% of soldiers who showed warning signals on a return questionnaire were not**

referred for treatment. Some have received dishonorable discharges because they failed to report for duty as they wrestled with debilitating stress. Over 22,000 service members have been diagnosed with "personality disorders" and discharged in the last six years. Those dishonorably discharged or discharged for personality disorders lose their benefits, thus providing a strong disincentive to coming forward and seeking help.

Those who receive treatment often find it wanting. Many troops deployed to Iraq are simply prescribed antidepressants like Zoloft, or sleep aids like Ambien, which are not adequately monitored. Back home, service members often have to struggle for adequate care, with mental health appointments limited to 30 minutes, long waiting lists, and a lack of psychologists trained to treat PTSD. The result may be a ticking time bomb if treatment does not improve: it can take years for PTSD to lead to destructive behavior.

What Can Be Done

We ask our troops to undertake repeated deployments on complex missions in confusing environments. Our security is compromised when we send men and women into harms way who are struggling under the weight of demons. And our commitment to the fabric of our society is threadbare if we fail to stand with our veterans when they return home, and leave them to fight their own private wars.

Mounting problems and media attention have prompted the Pentagon to move in the right direction. Acting at the behest of Congress, new mental health guidelines were issued late last year that allow for troops to be sent home from Iraq, or held back from redeployment, if they exhibit sustained warning signs. A congressionally initiated Defense Task Force on Mental Health is set to report this May. Yet more must be done.

Congress can make a difference by pressing the Pentagon - or legislating - for change in four areas:

1. More Screening: We need more screening. Voluntary questionnaires don't cut it - only 1 in 1000 soldiers who do not exhibit warning signs on a questionnaire is screened. The ideal goal is pre and post-deployment screening sessions for all troops. Short of that, widespread, random screening should be instituted: if a service member is required to see a professional, it will be easier to spot problems. Across the military, education about PTSD is required. Military general practitioners need better training to discern the different gradations of PTSD. Commanding officers need to be trained to spot warning signs within their units. Troops need to know when to seek help.

2. Standards for Care: The Pentagon and VA need to meet uniform standards for mental health care. Some bases and hospitals have sophisticated programs and highly qualified caregivers. Many don't. Returning veterans should not have to rely on the luck of the draw to get the care they need. The Pentagon should issue standards for care that apply across the services, across the country. The VA should do the same. The bar should be set high. Best practices in treatment should be identified, and used as the baseline for care.

3. More Resources: The Army and Navy face a vacancy rate for active duty psychologists of nearly 40%. Earlier this year, one marine was turned away from a VA hospital when he sought care, then was told he could be put on a waiting list - he killed himself four days later. The Pentagon and VA budget for mental health and TBI care must be increased. VA mental health benefits should be extended in duration, and counseling and outreach should be extended to include family members.

4. Reduce the Stigma: Many suffer in silence: a 2005 Army survey found that more than half viewed mental health problems as a sign of weakness. Progress will never be made unless the stigma of seeking care is reduced. This demands strong statements and institutionalized education. Our civilians and military leadership must speak out strongly about the need to seek treatment for mental wounds. We want our troops to be tough and battle-hardened. But service members struggling with PTSO are risks to themselves, their unit, and their mission. Part of the warrior ethic needs to include knowing when one is fit to fight.

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