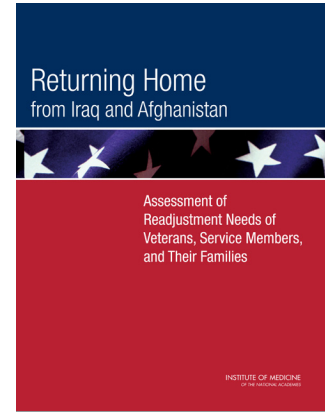


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# Returning Home from Iraq and Afghanistan

## Assessment of Readjustment Needs of Veterans, Service Members, and Their Families



**The wars in Iraq and Afghanistan** have been the longest sustained U.S. military operations since the Vietnam era, sending more than 2.2 million troops into battle, and resulting in more than 6,600 deaths and 48,000 injuries.

Many service members returning from the conflicts in Iraq and Afghanistan are relatively unscathed. Upon return, the vast majority report that their experiences were rewarding, and they readjust to life off the battlefield with few difficulties. Others, however, return with varied complex health conditions and find that readjusting to life at home, reconnecting with family, finding work, or returning to school is an ongoing struggle.

In response to the surge of Iraq and Afghanistan veterans returning with lingering problems, Congress required the Department of Defense (DoD) and the Department of Veterans Affairs (VA) to study their physical and mental health, and other readjustment needs. The Institute of Medicine (IOM) committee conducted this congressionally mandated assessment in two phases. The result of the second phase, *Returning Home from Iraq and Afghanistan: Assessment of Readjustment Needs of Veterans, Service Members, and Their Families*, presents the IOM committee's comprehensive assessment of the physical, psychological, social, and economic effects of deployment on service members, their families, and communities.

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### Multiple, Overlapping Stressors from Deployment

The all-volunteer troops engaged in these extended military operations in Iraq and Afghanistan have included more women, parents of young children, and reserve and National Guard troops than those in previous conflicts. Military

personnel often have served longer deployments with shorter intervals at home between missions.

Although the majority of returning troops have readjusted well to post-deployment life, 44 percent have reported difficulties after they returned. Significant numbers of personnel deployed to Iraq and Afghanistan have suffered traumatic brain injuries (TBI) and many have shown symptoms of posttraumatic stress disorder (PTSD), depression, and substance misuse or abuse. In the scientific literature, the estimates of the prevalence of those conditions among service members who served in these two conflicts range from 19.5 to 22.8 percent for mild TBI (commonly known as concussion), 4 to 20 percent for PTSD, 5 to 37 percent for depression, and 4.7 to 39 percent for problematic alcohol use.

These military and veteran personnel often have more than one health condition. The most common overlapping health disorders are PTSD, substance use disorders, depression, and symptoms attributed to mild TBI. In 2010, nearly 300 service members committed suicide, and about half of those suicides involved service members who had deployed to Iraq or Afghanistan.

On top of contending with lingering health problems, returning service members had other difficulties readjusting to civilian life. In 2011, the unemployment rate among all post-9/11 veterans aged 18 to 24 was 30.2 percent, compared with 16.1 percent for similarly aged nonveterans.

Further, military sexual trauma has been occurring in high rates throughout the U.S. armed forces, including the Iraq and Afghanistan theaters. Sexual harassment and assaults disproportionately affect women; they have both mental and physical ramifications, and in many cases these victims have a difficult time readjusting.

The depth and breadth of challenges faced by returning military service members varies and are the result of a complex interplay of factors. And today's challenges are just a prelude to future problems. Previous wars have demonstrated that veterans' needs peak several decades after their war service, highlighting the necessity

of managing current problems and planning for future needs. Moreover, if their readjustment is to be successful, the IOM committee concludes, the difficulties that service members and veterans face must be addressed by primary prevention, diagnostics, treatment, rehabilitation, education, outreach, and community support programs.

## **Focusing on Evidence-Based Treatment**

In many ways, the DoD and the VA are at the forefront of providing evidence-based care for service members with TBI and psychological health problems. But challenges exist in both systems. Not all service members and veterans who need treatment receive it. Recent increases in hiring may help to alleviate a shortage of clinicians; however, unrealized opportunities remain in improving clinician training and evaluation. When care departs from the scientific evidence base and varies significantly from clinician to clinician, patients may receive poor quality care.

While the DoD and the VA have assembled an array of programs and interventions to meet the needs of Iraq and Afghanistan service members, veterans, and their families, more needs to be done to evaluate their effectiveness. For example, when the DoD assesses cognitive function after a head injury, it uses a tool whose effectiveness has no clear scientific evidence base. Also, research shows that restricting access to lethal means to carry out a suicide, such as a gun, prevents suicides. Even if a service member is at risk for suicide, however, a DoD policy prohibits restricting access to privately owned weapons. The VA has included Acceptance and Commitment Therapy for depression in its national rollout of preferred mental health treatments, but the therapy lacks sufficient scientific evidence to support its use as a first-line intervention.

What's more, the committee has serious misgivings about inadequate and untimely clinical follow-up and low rates of delivery of evidence-

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based treatments, especially therapies to treat PTSD, depression, and substance use disorder. There are scant data documenting which treatments patients receive or whether those treatments were appropriate and timely.

The committee recommends that the DoD and the VA systematically and periodically evaluate clinicians after training to ensure they administer therapeutic interventions in ways that are supported by scientific evidence. Further, the two departments should align treatments with the evidence base, especially before any treatment is offered nationally.

### **Strengthening Military Families**

Strong, supportive families help with service members' resilience to the multiple stressors associated with combat and aid in troops' successful readjustment upon return. The DoD offers many programs and policies to support families as they face deployment-related health, economic, and family violence burdens. But, in general, the department largely focuses on married, heterosexual couples and their children. The IOM committee recommends that the DoD expand its definition of family to include the full constellation of military families, and provide support to all families, including nontraditional households, which include unmarried partners, same-sex couples, single parents, and stepfamilies.

Because most interventions for families have been tested on civilians, the committee endorses a greater focus on efforts to identify, develop, and test new prevention and treatment interventions

specifically designed to meet the unique challenges faced by military families. To address the data gaps, the DoD and other federal agencies should fund well-designed research studies examining the social, psychological, and economic effects of deployment for the broad spectrum of military families.

Domestic violence impairs force readiness and the well-being of military families. There has been a troubling rise in domestic violence in families of service members deployed to Iraq and Afghanistan, typically involving abuse of spouses or neglect of children. For this reason, the committee recommends that the DoD place a high priority on reducing domestic violence.

### **Sharing and Linking Vital Data**

A large array of data are captured by the DoD, the VA, and other federal government agencies that are relevant to the issues that most interest Congress—the physical, psychological, social, and economic challenges facing returning service members and veterans. If it were possible to fully link and integrate this data, it could be comprehensively analyzed to answer many of the key questions about readjustment posed by Congress. As the committee found, numerous barriers hinder sharing and linking this vital data.

The committee is unaware of any databases that fully integrate demographic and deployment data for service members with data that describes their health outcomes, treatment, access to care, or employment before and after deployment.



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The committee calls on the DoD and the VA to support comprehensive analysis of both departments' data to answer questions about readjustment that are not addressed by peer-reviewed literature. They should link and integrate their databases so they can be used more effectively. Further, the departments should work together to establish a work group to explore interagency coordination, define common goals, establish common policies, and create mechanisms to share data. Safeguarding the privacy and confidentiality of such data is paramount, and privacy experts will need to be involved prior to linking data.

**Conclusion**

The questions posed to the committee are complex and critical to the well-being of U.S. service members, veterans, their families, and the communities in which they live. Although the DoD and the VA actively seek to understand the scope of the readjustment challenges, implement appropriate policies, and provide programs and services, at many times their response is dwarfed by the magnitude of the problems.

The urgency of alleviating these health, economic, and social issues is heightened by the number of people affected, the rapid drawdown of military personnel from Iraq and Afghanistan, and the long-term effects for service members, veterans, their families, and the nation. 

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