Health Care Benefits for Veterans and Active Duty Military and Their Families through the Federal System

Chapter 4

Active duty and reserve component service members, retirees, veterans, and their families are potentially eligible for a wide array of mental health and behavioral health services available through the federal government. Active duty service members (ADSMs) and their families (ADFMs) receive health care coverage and benefits through TRICARE when on active duty, which augments military health services available through military treatment facilities (MTFs). Retired service members are also eligible for TRICARE. Generally, most other veterans are not eligible for TRICARE coverage (although they may be eligible for transitional services when they first leave the military). Instead, health care coverage for veterans falls within the purview of the Department of Veterans Affairs (VA). Both TRICARE and the VA offer a wide and robust range of health benefits to covered individuals, including mental health and substance use services.

A major goal of the Task Force was to help people access federal services to which they are entitled (whether through TRICARE or VA).

Although the federal government provides services through MTFs, TRICARE, and the VA, these services are not available to everyone who has served in the armed forces or their families. Members of the National Guard and Reserve (the reserve component) who have not been called to active duty or deployed may not be eligible for VA benefits. Also, service members who are dishonorably discharged from active duty may lose eligibility for TRICARE and VA benefits. Family members are not eligible for VA services and are generally ineligible for TRICARE unless they have a family member who is on active duty or retired from the military. As a result, some former service members, as well as many family members of active and former military members, remain without coverage.

A major goal of the Task Force was to help people access federal services to which they are entitled (whether through TRICARE or VA). In order to do so, it was necessary to understand who qualifies for the programs and services provided, as well as gaps in coverage and the rates of utilization of these services. Eligibility for TRICARE and VA benefits is described below, along with a description of mental health and substance use services that are offered through these systems. In addition, this chapter describes family counseling and behavioral health services offered by the National Guard, which are intended to fill some of the gaps for National Guard and family members who are not eligible for TRICARE or VA services.

Despite all the services available to active, former, and retired members of the military and their families, many gaps remain. This chapter includes a description of gaps in coverage, the challenges that some active duty, reserve component, or retired service members, veterans, and their families face in accessing mental health and substance use services through TRICARE or the VA, and an overview of the rates of utilization of mental health and substance use services.

Eligibility for Benefits for Active Duty Military, Reserve Component, Retirees, Veterans, and Their Families

Active duty service members who are stationed on or near a military base will generally receive health services at a military treatment facility. Active duty family members and retirees may also seek care from an MTF, but priority for services is given to the ADSMs. If services are not available through the MTF, then the ADSMs or their family members can receive care through private (civilian) providers. Health care coverage for ADSMs, ADFMs, retirees, and certain veterans is provided through TRICARE.

Eligibility for TRICARE

TRICARE is the health care program for active duty service members and their families, as well as military retirees and their families.

Active Duty Members and Retirees

TRICARE is the health care program for ADSMs and their families, as well as military retirees and their families. The term "active duty service members" includes members of all branches of the uniformed services as well as National Guard and Reserve who have been called to active duty for more than 30 consecutive days. Enrollment in TRICARE Prime or TRICARE Prime Remote (TPR), which is similar to a health maintenance organization (HMO), is mandatory for ADSMs and voluntary for their families. If ADSMs live and work *less* than 50 miles from an MTF, they enroll in TRICARE Prime and obtain their health services through MTFs (if available). If ADSMs live and work *more* than 50 miles from an MTF, they enroll in TRICARE Prime Remote and obtain their health services through civilian providers. ADSMs pay no deductibles or co-pays. ADFMs can enroll in TRICARE Prime (or Prime Remote), TRICARE Extra (similar to a preferred provider organization [PPO]), or TRICARE Standard (similar to fee-for-service but with discounts if the enrollee uses an in-network provider). TRICARE Extra and Standard both have cost sharing and deductibles.[1,2]

TRICARE is also available to retirees (veterans who served at least 20 years in the military) and their families. Retirees and their families have the option to enroll in TRICARE Prime, Standard, or Extra. However, once they become eligible for Medicare (provided they purchase Medicare Part B), retirees are enrolled in TRICARE for Life, which becomes a wrap-around insurer.[3]

After separating from active duty, service members and their families lose eligibility for TRICARE. However, there are two transitional health care programs that members and their families can receive after TRICARE eligibility ends. First, service members who are leaving active duty following service in Iraq or Afghanistan may be eligible for the Transitional Assistance Management

Program (TAMP).[a] TAMP provides an additional 180 days of premium-free health care benefits once TRICARE eligibility ends.[4] Second, former ADSMs and ADFMs are eligible for the Continued Health Care Benefit Program (CHCBP) once eligibility for TRICARE or TAMP ends. CHCBP is available to former military members and their families for 18 to 36 months upon payment of a monthly premium.[b] CHCBP covers service members, as well as their families, although premiums are higher for family coverage ($311 a month for individuals and $665.33 a month for families).[5] Service members who are separating from service after being on active duty are eligible to join CHCBP. However, service members who are dishonorably discharged are not eligible for CHCBP.[6]

Most people who are eligible for TRICARE enroll. Of the 496,628 individuals in North Carolina eligible for TRICARE, 319,823 are enrolled, the vast majority being ADSMs and ADFMs.[7]

National Guard and Reserve members become eligible for TRICARE once they are activated and called to active duty for more than 30 days.

Table 4.1
Number of TRICARE Eligibles by Enrollment Status (Nov. 18, 2009)

Beneficiary Population	Eligibles	MTF Enrolled (TRICARE Prime)	Civilian Enrolled (all other TRICARE plans)	Total Enrolled
NADSMs	115,365	105,759	2,654	108,413
ADFMs	158,299	86,044	51,326	137,370
Non-Active Duty and Non-Active Duty Family Members	142,314	21,243	51,739	72,982
TAMP	N/A	351	707	1,058
Other	80,650	N/A	N/A	N/A
TOTALS	496,628	213,397	106,426	319,823

Abbreviations: ADFM, active duty family member; ADSM, active duty service member; MTF, military treatment facility; TAMP, Transitional Assistance Management Program.

Source: Amos D. Introduction to TRICARE. Talk presented to: North Carolina Institute of Medicine Task Force on Behavioral Health Services for the Military and Their Families; November 18, 2009; Morrisville, NC.

Reserves and National Guard

National Guard and Reserve members become eligible for TRICARE once they are activated and called to active duty for more than 30 days. If eligible, National Guard and Reserve members receive the same services as regular ADSMs. As ADSMs, they are enrolled in TRICARE Prime or Prime Remote and their families can be enrolled in TRICARE Prime, Prime Remote for ADFMs, Standard, or

a Eligible service members are those:
1) Involuntarily separating from active duty under honorable conditions;
2) Separating from the National Guard or Reserves after a period of active duty that was more than 30 consecutive days in support of a contingency operation;
3) Separating from active duty following involuntary retention (stop-loss) in support of a contingency operation;
4) Separating from active duty following a voluntary agreement to stay on active duty for less than one year in support of a contingency operation.

b All former ADSMs and their families receive coverage for 18 months. Unremarried former spouses and emancipated children receive coverage for 36 months.

Extra for the duration of their tour of duty. However, family members often opt to continue to receive their previous health insurance coverage—for example, through their civilian employer—rather than switch to TRICARE coverage. When leaving active duty, the National Guard and Reserve are also eligible for TAMP or CHCBP. However, members of the National Guard and Reserve who are not on active duty and who are separating from military service are not eligible for either CHCBP or TAMP.

When not on active duty, all National Guard and Reserve members are eligible for line of duty care, which covers any injury or illness related to training or drilling. Certain members of the National Guard and Reserve are also eligible for TRICARE Reserve Select (TRS) when they are neither on active duty nor covered under TAMP. TRICARE Reserve Select is premium based, with two types of coverage available: TRS member-only and TRS member and family. National Guard and Reserve members may qualify to purchase TRS if they are members of the Selected Reserve of the Ready Reserve and are neither eligible for nor enrolled in the Federal Employees Health Benefit Program.[8-10,c] In general, members of the Selected Reserve are those who are on drilling status, who drill one weekend a month and two weeks a year. Although many National Guard and Reserve members are eligible for TRICARE, those who have not been called to active duty, are not in CHCBP or TAMP, and are not members of the Selected Reserves are not eligible to receive services through TRICARE.[1,2,4,6] Also, some National Guard and Reserve members choose not to purchase TRICARE Reserve Select, particularly those who have coverage through their civilian employer.

Although many National Guard and Reserve members are eligible for TRICARE, those who have not been called to active duty, are not in CHCBP or TAMP, and are not members of the Selected Reserves are not eligible to receive services through TRICARE.

Reserve members who have served 20 years before age 60 are eligible for the newly offered TRICARE Retired Reserve.[d] As with other retirees, at age 60 the retired reservists become eligible for TRICARE Prime or TRICARE Standard. At age 65 (or when they become Medicare eligible), they become eligible for TRICARE for Life.[11]

Eligibility for Veterans Affairs (VA) Health Benefits

The mission of the US Veterans Health Administration (VHA) is to provide comprehensive medical care and social support services to eligible veterans. It is the largest integrated health care provider in the country, with 153 medical centers and 909 outpatient clinics spread over all 50 states, the District of Columbia, American Samoa, Guam, the Philippines, Puerto Rico, and the US Virgin Islands. Currently, the VHA provides services to 5.7 million veterans (approximately 25% of all veterans).[12]

The VA has complex rules to determine eligibility for health benefits. First, the person must have been an active duty or reserve component member of the Army, Navy, Marines, Air Force, or Coast Guard and must have served for 24

c TRICARE Reserve Select premiums are $49.62 per month for individuals and $197.65 per month for families (2010).

d TRICARE Retired Reserve premiums are $408.01 per month for individuals and $1,020.05 per month for families (2011).

continuous months or have been injured while on duty.[e] Reservists and National Guard members who are called to active duty and who complete their full tour are exempt from this 24-month rule. VA health services are not available to family members. Second, the individual must not have been dishonorably discharged.[f] Third, an individual must be enrolled in the VA.[13,14]

The process for enrolling to receive services is based upon a Priority Group system. The VA's budget is fixed and is not sufficient to cover the health needs of all veterans. Thus, the VA has created a priority system that ranks veterans on the basis of whether they have a service-related disability (injury or medical condition), its severity, and the person's income. This ranking system helps to prioritize the veterans who are eligible for services.[15]

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A service-related condition is a health problem that was incurred or aggravated while in the service. These conditions need to be linked to a veteran's active duty activities. If a condition is determined to be service related, the VA then determines the severity of the disability or condition. The VA system gives greatest weight to those with severe disability resulting from service-related conditions. Those in Priority Group 1 (the highest rating) are individuals with very high disability ratings and/or individuals who are unemployable because of their disability. The first 4 ratings groups are all ranked on the basis of the level of disability.[13,15,g]

Disability determination is completed by VA-employed physicians and may be updated over time. This determination is based on a scale from 0% to 100% that reflects the impact of the disability or condition on occupational and social functioning. A 100% rating reflects a disability or condition that results in complete occupational and/or social impairment, and a 0% indicates a condition with symptoms that are not severe enough to impact daily activities. Regarding mental health conditions, disability ratings are based upon "the frequency, severity, and duration of psychiatric symptoms, the length of remissions, and the veteran's capacity for adjustment during periods of remission" [38 CFR §4.125]. This system is meant to ensure that ratings are based not only on an evaluation of the condition at the moment of examination but also on its total impact on a veteran. Recently, the VA revised the rules surrounding disability determinations for posttraumatic stress disorder (PTSD), with the intent to make it easier for veterans to receive care for PTSD.[16,h]

e There are also some exceptions to this 24-month service rule. Those who are discharged for service-related conditions or Reservists and National Guard who are called up for less than 24 months are still eligible.

f The VA does have some limited discretion when it comes to eligibility for those who are dishonorably discharged, which is discussed later in the chapter.

g The VA's definition of each Priority Group is provided in Appendix B.

h Before July 13, 2010, in order for a veteran to be able to claim that PTSD was service related, the veteran was required to provide documentation of the in-service stressor directly related to the PTSD. This made it difficult for some veterans to prove a service connection, because they lacked an event, or documentation of an event, upon which to base their claim. The new rule repeals this requirement if a veteran claims that the in-service stressor was related to the general fear of hostile activity. This is intended to reflect the inherently stressful nature of service in situations with ongoing hostile activity and to facilitate veterans' ability to claim service connection for PTSD.

For veterans without service-related conditions, income plays a large role in determining their placement in Priority Groups 5 through 8, with some notable exceptions. In assessing group placement, the VA evaluates a veteran's income against a national benchmark and a regional benchmark, which varies on the basis of the cost of living in different areas. Veterans with the lowest incomes are given higher priority to receive services than those with higher incomes. Veterans whose incomes are below both the national and regional levels are placed in Group 5.[i] Also included in this group are military retirees, those with 20 years of service. Returning combat veterans are placed in Group 6 (addressed below). Group 7 includes veterans whose incomes are below the regional level but not the national level. Lastly, veterans whose incomes are above both the national and regional benchmarks are placed in Group 8. Because of limited resources, those placed in Group 8 are not currently eligible for enrollment in the VA and thus cannot receive VA health services.[15,j]

All service members who served in combat theater in Iraq or Afghanistan are eligible for enrollment for five years.

Veterans returning from combat operations in Iraq and Afghanistan are currently exempt from the normal placement rules. All service members who served in combat theater in Iraq or Afghanistan are eligible for enrollment for five years and are placed in Group 6. This includes those in the National Guard and Reserve. After the five-year period following the most recent return and discharge from the service, these veterans are subject to the normal enrollment rules.[15] Veterans who have been enrolled in VA medical services through this program will remain enrolled after the five-year period elapses, even if they are moved to Group 8.[17] However, veterans who have not enrolled after five years may have difficulty enrolling unless they can demonstrate a service-related disability.

In summary, to be eligible for enrollment, a veteran must have served for at least two years (unless injured while on duty) and cannot have been dishonorably discharged. Veterans with service-related conditions and disabilities are eligible for, and given highest priority access to, health benefits. After this group, those with the lowest income levels are enrolled. All returning Iraq and Afghanistan veterans have access for five years. Veterans with high incomes and no service-related conditions are not being enrolled in the VA. Unlike TRICARE, VA services do not extend to family members.

Mental Health and Substance Use Services

Both TRICARE and the VA system offer comprehensive mental health and substance use services. However, the ability to access services is dependent, in large part, on where the person lives, the availability of providers, and whether the person can pay any required cost sharing. This section describes the services available through both TRICARE and the VA system.

i The national income limit for a single veteran in 2010 was $29,402. The geographic limits vary above and below this level.

j The exceptions to this are veterans who were enrolled before 2003 and in Group 8, and there has been some loosening of the income levels. In essence, they were raised by 10%, moving some who were in Group 8 up to Group 7 or Group 5.

Mental Health and Substance Use Services Available through TRICARE

The mental health and substance use services covered under the various TRICARE plans are consistent across plans (i.e., TRICARE Prime, Extra, or Standard). TRICARE covers inpatient and outpatient psychiatric and substance use services.[1-3,10] For example, TRICARE covers:

- Outpatient Services:
  - Individual therapy
  - Group therapy
  - Collateral visits
  - Play therapy
  - Psychoanalysis
  - Psychological testing
- Inpatient Services
  - Acute inpatient psychiatric care
  - Psychiatric partial hospitalization
  - Residential treatment center (RTC) care for children and adolescents
  - Substance use, including detoxification and rehabilitation

TRICARE has also recently begun the TRICARE Assistance Program (TRIAP), which uses Internet-based services to provide counseling and behavioral health information to beneficiaries. TRIAP provides free private, personalized, web-based video counseling to ADSMs, ADFMs, and Reserve Select and TAMP beneficiaries. However, the services are intended to treat only short-term problems. Serious or long-term issues will continue to require a provider visit.[18]

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Location of care: Active duty service members enrolled in TRICARE Prime, including activated National Guard and Reserve members, must first seek services at an MTF if residing in an MTF prime service area (PSA). If the ADSM is enrolled in TRICARE Prime Remote, they may go to a non-MTF (civilian provider) if they have a referral.[1] Active duty family members, retirees and their families, Reserve Select members, and those enrolled in TAMP or CHCBP may receive care at MTFs, if space is available.[10] There are five MTFs in North Carolina, located at Fort Bragg, Marine Corps Base Camp Lejeune, Pope Air Force Base, Seymour Johnson Air Force Base, and Marine Corps Air Station Cherry Point.

ADSMs have priority for receiving care at an MTF. If there is no available space at MTFs, family members and other TRICARE enrollees must seek services from civilian providers (whether in or out of network).[2,10] To help beneficiaries find non-MTF providers and schedule outpatient behavioral health appointments, TRICARE administers a behavioral health provider locator and appointment line. ADSMs, ADFMs, and TRICARE Prime enrollees can use this line to facilitate searching for private providers when services are not available at an MTF.

Utilization review: All ADSMs must receive prior authorization from their primary care provider to receive any mental health or substance use services.[k] This covers both inpatient and outpatient care and includes both mental health and substance use treatment. TRICARE members who are not ADSMs can receive up to eight outpatient behavioral health sessions without prior authorization. After eight visits, the individual must obtain prior authorization to receive care. Inpatient care requires prior authorization, except in emergency situations. This includes residential treatment for children, acute inpatient care, and partial hospitalizations.[1-3,10]

TRICARE members who are not active duty service members can receive up to eight outpatient behavioral health sessions without prior authorization.

Cost sharing: ADSMs incur no costs for any authorized health services, including mental health services and treatment for substance use disorders. They are not required to pay any cost sharing regardless of whether they receive their services from an MTF or from a civilian provider. Charges vary for others covered by TRICARE, depending on their beneficiary category, which TRICARE option they use, and the type of provider they see. For example, ADFMs enrolled in TRICARE Prime pay no charges when receiving care at an MTF, but ADFMs enrolled in TRICARE Standard or Extra must pay coinsurance or co-payments when receiving care from civilian providers. Retirees enrolled in TRICARE Prime must pay co-pays for each inpatient admission or outpatient visit if they seek services from private network providers.[l] TRICARE beneficiaries will have higher out-of-pocket costs if they seek services from providers outside the TRICARE network. Typically, ADFMs (even under TRICARE Standard) have lower cost-sharing rates than all others enrolled in TRICARE.[19,m]

Mental Health and Substance Use Services through the VA

Unlike TRICARE, which is largely an insurance system, the VA provides services directly. Health services, including mental health and substance use services, are provided at the VA medical centers (hospital medical complexes), community-based outpatient clinics (CBOCs), and vet centers. In North Carolina, there are

k Primary care providers (called primary care managers by TRICARE) may be either a provider at an MTF or a civilian network provider.

l Outpatient behavioral health visit: $25 (individual) or $17 (group). Inpatient behavioral health visit: $40 per day.

m For ADFMs, the TRICARE Standard outpatient cost share is 15% in network and 20% out of network after deductible, and inpatient care is $20 per day. For retirees, the TRICARE Standard cost share is 20% in network and 25% out of network after deductible for outpatient care. For inpatient care, they pay 20% of total charge plus 20% of separately billed services in network, and out of network they pay 25% of the per diem or $193 per day, whichever is less.

four medical centers (located in Asheville, Durham, Fayetteville, and Salisbury),[n] 12 outpatient clinics (located in Charlotte, Durham, Franklin, Greenville, Hamlet, Hickory, Midway Park, Morehead City, Raleigh, Rutherfordton, Wilmington, and Winston-Salem), and five vet centers (located in Charlotte, Fayetteville, Greensboro, Greenville, and Raleigh).[20]

The Veterans Health Administration provides an extensive range of inpatient and outpatient care and treatment for mental health and substance use disorders. For example, the VA offers:

- Diagnostic and treatment planning evaluations for the full range of mental health and substance use problems
- Treatment services using evidence-based pharmacotherapy and/or evidence-based psychotherapy for patients with mental health conditions and substance use disorders
- Consultation and treatment services for the full range of mental health conditions
- Evidence-based psychotherapy
- Referrals as needed to inpatient and residential care programs
- Consultation about special emphasis problems, including posttraumatic stress disorder (PTSD) and military sexual trauma (MST)
- PTSD teams or specialists
- MST specialty clinics
- Specialty substance use treatment services
- Mental health intensive case management
- Psychosocial rehabilitation services, including psychological rehabilitation and recovery centers (outpatient treatment centers), family psychoeducation, family education, skills training, peer support, and compensated work therapy and supported employment
- Homeless programs
- Patient education
- Family education and family counseling, when it is associated with benefits to the veterans, as adjunctive treatment[21]

The Veterans Health Administration provides an extensive range of inpatient and outpatient care and treatment for mental health and substance use disorders.

n The Naval Hospital at Camp Lejeune is currently being transitioned to become another VA hospital.

The VA is mandated to offer all of these services to enrolled veterans. However, the availability of specific services varies by type and size of facility. Medical centers are the VA hospitals; these facilities are required to provide all of the services listed above. CBOCs vary widely in size; they may provide services to fewer than 1,000 veterans to more than 10,000 veterans. The mental health and substance use services that each CBOC is required to offer vary on the basis of the size of its patient population. The largest CBOCs must provide all the outpatient mental health and substance use care. As the size of the CBOC decreases, they are required to offer a progressively smaller subset of these services. Smaller CBOCs may offer these services through telemedicine, as appropriate. If services are not available through one of these facilities in reasonable proximity to the veteran, then the VA system can refer the individual to another VA treatment facility or to outside providers. Veterans receiving care through these arrangements are not subject to additional required payments.[22] However, veterans at smaller outpatient clinics may have difficulty obtaining care because of the limited services offered at their primary location of care and/or the distance to the referral provider.

If services are not available through one of these facilities in reasonable proximity to the veteran, then the VA system can refer the individual to another VA treatment facility or to outside providers.

Vet centers are community-based counseling centers offering a broad array of outpatient readjustment counseling services for combat veterans, including:

- Individual and group counseling for veterans
- Family counseling for military-related issues
- Bereavement counseling for families who experience an active duty death
- Military sexual trauma counseling and referral
- Outreach and education, including postdeployment health reassessment (PDHRA) survey and community events
- Substance abuse assessment and referral
- Employment assessment and referral
- Veterans Benefit Administration benefits explanation and referral
- Screening and referral for medical issues, including traumatic brain injury (TBI) and depression[23]

Whenever possible, vet centers hire veterans with professional qualifications, such as social work and psychology degrees, to provide these services with peer support.[23] These centers are meant to complement VA mental health and substance use services.

Support Services Separate from TRICARE and the VA

Recognizing the unique challenges caused by multiple and longer deployments associated with OEF/OIF, the military has worked to expand the programs and

services available to members of the military and their families. In particular, many of the programs have been developed to provide additional support to National Guard and Reserve members and their families. These programs are meant to supplement mental health and support services, not to be the primary source of care or treatment.

Military OneSource

Military OneSource is a comprehensive support program for ADSMs, ADFMs, and all Reserve and National Guard members and their families. Retired service members and service members separating from service also are eligible for 180 days after leaving the service. Military OneSource provides consultants who are available by phone 24/7 and in person, to help service members with emotional, family, financial, or deployment-related issues. The services provided are confidential and free. Service members are eligible for up to 12 consultations per person per year on each individual issue. Although this program does provide some services relating to mental health and substance use disorders, they are meant to be for short-term problems only. For serious or long-term mental health or substance use issues, Military OneSource consultants refer service members to appropriate medical providers.[24-26]

National Guard Bureau Programs

Family Readiness Program

The Family Readiness Program works to provide support for service members and their families who are not located on a military facility. The Family Readiness Program primarily serves National Guard members. The services offered are available to Reserve members and their families, but Reserve members do not always know about the services offered, because the National Guard cannot advertise to them about these services. This program employs Military and Family Life Consultants (MFLCs), who are licensed clinicians with a master's degree, to provide direct assistance to service members and their families. MFLCs provide free, confidential counseling and are available by phone and to travel between communities to help facilitate access.[27]

The Family Readiness Program works to provide support for service members and their families who are not located on a military facility. The Family Readiness Program primarily serves National Guard members.

The Family Readiness Program also operates three types of Family Assistance Centers (FACs) to provide services and information to families. The FACs offer various support services that may include counseling for mental health disorders and marital problems, support groups for families, as well as financial and employment counseling.[25] The FACs are located either in the local National Guard Armory, in a separate building outside of the Armory, or out in the communities themselves. These latter two types of FACs are meant to encourage families and service members who are not comfortable seeking services in an Armory.[27]

Psychological Health Program

In 2008, the National Guard began placing Directors of Psychological Health (DPHs) in every state and territory to assist Army National Guard and Reserve

members in accessing psychological support services. In November 2010, the National Guard Bureau added DPHs to the Air National Guard at the wing level.[28] Available around the clock and 365 days a year, each DPH works to assess the clinical needs of service members and to act as a portal to care. Although the DPHs do not provide therapy or treatment themselves, they do work to guarantee that service members receive direct referrals to appropriate mental health and behavioral health services. The DPHs facilitate this by working with both the VA and TRICARE, as well as community and state providers and programs to which service members may have access.[27]

The Integrated Behavioral Health System and Reconstitution Program need additional support to expand the availability of counseling and treatment services for individuals who have served in the military through the active and reserve components and their families.

Yellow Ribbon Program

The Yellow Ribbon Program was started in 2008 to provide support services for National Guard and Reserve members and their families throughout the cycle of deployment. This program provides one-day briefing and information seminars before deployment, during deployment, and two times after deployment. To facilitate attendance, the Yellow Ribbon program provides briefings throughout the state. During each briefing, service members are provided with information regarding services and resources that are available, such as Military OneSource, the Family Readiness program and MFLCs, the Psychological Health Program, TRICARE, and the VA. The focus of post-deployment briefings is providing services regarding reintegration and health issues to returning service members. At the second post-deployment briefing, service members are administered their PDHRA survey.[o] VA providers and vet center counselors are brought in to conduct counseling for service members who are identified through the PDHRA as at risk for mental health and substance use issues. A goal of this briefing is to get service members enrolled in the VA and to seek care if necessary.[27]

North Carolina National Guard Programs

In addition to the programs instituted by the National Guard Bureau, the North Carolina National Guard (NCNG) has developed programs that serve as a national model in support of Guardsmen and women.

Integrated Behavioral Health Program

In fall 2010, the NCNG created the Integrated Behavioral Health System (IBHS) within the Psychological Services Section. The State Behavioral Health Programs Director serves as the head of the new system. The Integrated Behavioral Health System is a one-stop, telephonic portal to both clinical and support services.

o The PDHRA and the Post Deployment Health Assessment (PDHA) are discussed in Chapter 3.

The toll-free number is automatically attended 24 hours a day, 7 days a week. The system is voluntary, confidential, and professionally staffed by contracted licensed NCNG clinical staff. Although the system primarily serves National Guard and their family members, all military branches and family members have access to its services, including consultation, assessment of need and risk, referrals to internal and external resources, and follow-up.

Reconstitution Program

The North Carolina National Guard Reconstitution program, which was recently begun, embeds the National Guard support services at the demobilization centers. The State Behavioral Health Programs Director, Military and Family Life Consultants, representatives of the Yellow Ribbon program, and financial counselors are located in the service members' barracks area. The goal is to help the support service personnel build relationships with National Guard members as they return from active duty overseas, so that when they return to North Carolina, they are more familiar with available services and are willing to seek help if necessary.

These innovative programs need additional support to expand the availability of counseling and treatment services for individuals who have served in the military through the active and reserve components and their families. The North Carolina National Guard funding for these programs is a mix of both federal and state funding. The earmarked federal funding is set to expire at the end of the federal fiscal year. The state appropriation has been decreased from past years.

In order to provide additional support to expand the availability of counseling and treatment services, the Task Force recommended:

PRIORITY Recommendation 4.1

a) The General Assembly should appropriate $1,470,000[p] in recurring funds to the North Carolina Department of Crime Control and Prevention to sustain and to add to the North Carolina National Guard Integrated Behavioral Health System, currently located at four Family Assistance Centers and available to all who have served in the military through the active and reserve components and their families. Priority should be given to individuals who are not eligible for or who have difficulty accessing Department of Veterans Affairs (VA) services or TRICARE. Funding for the pilot program should be used to support:

1) Full-time behavioral health clinicians and behavioral health case managers in each of the seven North Carolina National Guard (NCNG) Family Assistance Centers (FACs).

p The Task Force recommended that the North Carolina General Assembly appropriate $210,000 for each of seven family assistance centers for a total of $1,470,000. Funding would be used to pay for one mental health and substance abuse counselor ($100,000/person including salary, equipment, travel, and training) one behavioral health case manager ($55,000/person including salary, equipment, travel, and training), and one veteran outreach peer specialist ($55,000/person including salary, equipment, travel, and training) at each Family Assistance Center.

2) **Contracts with peers who are veterans and/or family members with appropriate mental health, substance abuse, or behavioral health trainings to provide services and support for active and retired members of the active duty and reserve components, veterans, and their families.**

3) **Linkages between trained mental health, substance abuse, and behavioral health counselors and psychiatrists or other licensed professionals who can provide medication management or health services needed to address more significant health problems.**

4) **Use of telepsychiatry in rural areas to expand availability of psychiatric services for active duty and retired members of the active and reserve components, veterans, and their families.**

b) **In addition to the NCNG clinical providers, additional personnel and resources should be collocated in the FACs, including but not limited to:**

1) **Veteran services officers,**

2) **VA-trained mental health and addiction services providers, including contract behavioral health personnel through the Veterans Integrated Service Network 6 Rural Health Initiative,**

3) **Division of Mental Health, Developmental Disabilities, and Substance Abuse Services providers and other state and local agency representatives as appropriate, and**

4) **Other professional, advocacy, and support services.**

c) **The Family Assistance Centers should report annually to the House and Senate Appropriations Subcommittees on Justice and Public Safety and to the House Committee on Military and Homeland Security on:**

1) **Services provided**

2) **Number and type of active and reserve component service members, veterans, and family members served**

Reserves

The Reserve uses the same programs as the National Guard, depending on the branch of service. For example, the Psychological Health Program in the Reserve offers services similar to the National Guard program. However, the Reserve program covers service members in eight states and the territory of Puerto Rico in addition to those in the state of North Carolina.[29] There is ongoing work to make Reserve members in North Carolina aware of the resources available through the North Carolina National Guard.

Barriers That Prevent Some Active and Former Military Members and Their Families from Receiving Coverage

There are four primary barriers that prevent active and former members of the armed services and their families from receiving necessary mental health and substance use services: 1) eligibility (coverage) restrictions, 2) costs, 3) inability to access needed services due to lack of providers, and 4) fear of adverse military consequences resulting from seeking mental or behavioral health services.

Health care coverage—through TRICARE or the VA—is not guaranteed to everyone...who has a military connection.

Eligibility restrictions

As noted above, current and former members of the military and their families have two primary sources of health care coverage: TRICARE for active or retired military and their families, and the VA system for members of the armed forces once they leave the military. ADSMs automatically receive TRICARE, so there are no eligibility restrictions for ADSMs. However, health care coverage—through TRICARE or the VA—is not guaranteed to everyone else who has a military connection. The major coverage gaps are summarized below:

Veterans: Once a service member leaves active duty, they may be eligible for time-limited transition coverage through TRICARE or continuing health services through the VA system. As described previously, ADSMs leaving the service and their families are eligible for 18 to 36 months of premium-based coverage (CHCBP). Those leaving duty after service in Iraq or Afghanistan are eligible for 180 days of premium-free coverage (TAMP). Veterans who served in active duty in Iraq or Afghanistan are also eligible to enroll for five years of services through the VA system, regardless of income or disability status. Thereafter, eligibility for enrollment in the VA health care system is limited and based on whether they have a service-connected disability and the severity of the disability, as well as family income.[14]

The main disqualification for veterans from receiving TRICARE or VA benefits is a dishonorable discharge. In the rare case of dishonorable discharge, the service member is ineligible to receive care from the VA and is ineligible for the transition benefits programs through TRICARE (CHCBP or TAMP). This is particularly an issue when it comes to mental health or substance use disorders, because these conditions can lead to behavior that will end in a dishonorable discharge. However, the VA does retain some discretion in providing care to those

who are discharged under "other than honorable circumstances," including those who may have been discharged because of mental health or substance use disorders that began or were exacerbated while on active duty.[14,q] Certain categories of discharge permanently disqualify a veteran from VA benefits, but in other categories, veterans may be awarded benefits after a review of the case and the circumstances surrounding discharge.[14,r]

Because of these coverage gaps, many veterans—especially older veterans who did not serve in Iraq or Afghanistan—have no access to VA health care services. Veterans who have higher incomes and who did not have a service-related injury or serve in the current Iraq and Afghanistan operations (OEF/OIF) are another group of veterans who are not eligible for services through the VA.

Certain categories of discharge permanently disqualify a veteran from VA benefits, but in other categories, veterans may be awarded benefits after a review of the case and the circumstances surrounding discharge.

National Guard members: National Guard members are eligible for TRICARE Reserve Select while remaining in the Guard. Injuries or health problems related to training or while National Guard members are drilling are covered under line of duty care (which is similar to workers' compensation). Guard members receive free coverage through TRICARE while on active duty, as do their families, and are eligible to purchase TRICARE Reserve Select while in a drilling status (a member of the Ready Reserve). Guard members returning from active duty overseas are currently receiving five years of care through the VA, but after that point their VA eligibility will depend on their income and disability status.

Reservists: Another group of military members who are generally not covered for free healthcare through TRICARE or the VA system are reservists. Injuries or health problems related to training or while reservists are drilling are covered under line of duty care (similar to workers' compensation). Reservists receive free coverage through TRICARE while on active duty, as do their families, and are eligible to purchase TRICARE Reserve Select while in a drilling status (a member of the Selected Reserve of the Ready Reserve). Reservists returning from active

q "Under VA regulations, administrative discharges characterized by the armed services as 'Honorable' or 'General Under Honorable Conditions' are qualifying, and punitive discharges ('Dishonorable' or 'Bad Conduct') issued by ***general*** courts-martial are disqualifying. The in-between categories, administrative 'Other than Honorable' discharges, and punitive 'Bad Conduct Discharges' issued by ***special*** courts-martial, ***may or may not*** be disqualifying for purposes of general VA benefit eligibility or VA health benefits eligibility specifically. In assessing whether such discharges were issued 'under conditions other than dishonorable,' VA must apply the standards set forth in *Title 38 Code of Federal Regulations (C.F.R.) §3.12*.' An individual with an 'Other than Honorable' discharge that VA has determined to be disqualifying under application of title 38 C.F.R. §3.12 still retains eligibility for VA health care benefits for service-incurred or service-aggravated disabilities unless he or she is subject to one of the statutory bars to benefits set forth in *Title 38 United States Code §5303(a). Authority: Section 2 of Public Law 95-126 (Oct. 8, 1977)*."

r Veterans are ineligible for benefits when discharged: by reason of a bad conduct discharge, or under one of the statutory bars of 38 CFR 3.12(c)
(1) As a conscientious objector who refused to perform military duty, wear the uniform, or comply with lawful order of competent military authorities.
(2) By reason of the sentence of a general court-martial.
(3) Resignation by an officer for the good of the service.
(4) As a deserter.
(5) As an alien during a period of hostilities, where it is affirmatively shown that the former service member requested his or her release. See §3.7(b).
(6) By reason of a discharge under other than honorable conditions issued as a result of an absence without official leave (AWOL) for a continuous period of at least 180 days.
Pensions, Bonuses & Veterans' Relief. Title 38 Code of Federal Regulations §3.12.

duty overseas are currently receiving five years of care through the VA, but after that point their VA eligibility will depend on their income and disability status.

Family members are generally not eligible for VA health services.

Family members: Family members are eligible for TRICARE benefits if their spouse or parent is eligible for TRICARE. However, they may be required to pay a premium for their coverage—for example, for the time-limited CHCBP coverage or for retiree benefits.[4,6] Family members are generally not eligible for VA health services. Bereavement counseling is available through vet centers for families who experience an active duty death, and family members may participate in family or couple's counseling as part of the veteran's treatment plan at vet centers or VA facilities, as available. However, family members of veterans who are no longer receiving TRICARE are not eligible for federal military health benefits to address their own health or behavioral health needs.

Costs

The cost of care may be another barrier to eligible individuals receiving care through TRICARE or the VA. ADSMs and ADFMs are not required to pay for their TRICARE services. Retirees, reservists, and those eligible for CHCBP all face cost sharing for care through the TRICARE system.[19]

Table 4.2
TRICARE Cost Sharing (Dec. 2009)

Plan	ADSMs	ADFMs	Reserve Select and CHCBP Enrollees	Retirees and Their Families
TRICARE Prime	$0	No deductible No co-payment	N/A	No deductible Variable copayment[a]
TRICARE Extra (in-network providers)	N/A	Cost share after deductible is met: 15% of negotiated rate[b]	Cost share after deductible is met: 15% of negotiated rate	Cost share after deductible is met: 20% of allowed charges[c]
TRICARE Standard (out-of-network providers)	N/A	Cost share after deductible is met: 20% of negotiated rate	Cost share after deductible is met: 20% of negotiated rate	Cost share after deductible is met: 25% of charges

Source: TRICARE. Summary of Beneficiary Costs. Department of Defense. December 2009. http://www.triwest.com/document_library/pdf_docs/Summary_Bene_Cost_Flyer.pdf
[a]Outpatient visits: $12 co-payment per visit; Durable Medical Equipment, Prosthetic Devices, and Medical Supplies: 20% of negotiated fee; Hospitalization: $11 per day ($25 minimum); Emergency Services: $30 co-payment; Outpatient Behavioral Health: $25 (individual visit) or $17 (group visit); Inpatient Behavioral Health: $40 per day; and Inpatient Nursing: $11 per day ($25 minimum).
[b]This applies to all outpatient and emergency services. The deductible for outpatient care is $50 or $150 per individual and $100 or $300 for families, depending on the rank of the sponsor. Hospitalization is $15.65 per day, and inpatient behavioral health services are $20 per day.
[c]Retired service members also pay higher deductibles, $150 for an individual and $300 for a family. Also, inpatient care is $250 per day or 25% of institutional charges plus 20% for separately billed charges. Charges for inpatient behavioral health services are 20% of the total charge plus 20% for separately billed services.

Retirees enrolled in TRICARE Prime must pay yearly premiums of $230 for individuals or $460 for families.[6] Reservists purchasing TRICARE Select pay a monthly premium of $49.62 for an individual and $197.65 for their families (fiscal year 2010 costs).[30] The premiums to purchase CHCBP are higher, $233

per month for individuals and $499 per month for families.[6] Although the premium level and cost sharing may be "reasonable" when viewed in the context of what a similar plan would cost in the private market, these costs may still be prohibitive for families who have low incomes.

The lack of [TRICARE] provider availability has three primary reasons: 1) a lack of qualified mental health and substance use professionals, 2) TRICARE's credentialing rules, and 3) the willingness of mental health and substance use professionals to contract with TRICARE.

The VA priority system is designed to act as a safety net for low-income veterans; they are given priority to receive services. Veterans enrolled in Priority Groups 2 through 6 may have to pay co-pays for medication but generally that is all that is required. Veterans with higher incomes—those in Groups 7 or 8—are required to pay co-pays when receiving services, but few of these individuals are eligible to enroll in the VA system because they are in the lowest priority groups.[31,s] Iraq and Afghanistan veterans (OEF/OIF), although not paying co-pays while enrolled through the five-year special enrollment period, are required to pay co-pays if they are shifted to Groups 7 or 8, after the five-year period is over. If a veteran is able to enroll and has private insurance, the VA system will bill the private insurance carrier. If the payment is sufficient to cover the co-pay, then the veteran will not be subject to additional charges.

Availability of Service Providers

TRICARE

Although on paper TRICARE offers a comprehensive array of mental health and substance use services, the actual availability of these services may be limited if there is an insufficient number of providers. The lack of provider availability has three primary reasons: 1) a lack of qualified mental health and substance use professionals, 2) TRICARE's credentialing rules, and 3) the willingness of mental health and substance use professionals to contract with TRICARE.

The lack and maldistribution of mental health and substance use professionals in North Carolina is described more fully in Chapter 6. This situation is not unique to the TRICARE system; it also creates problems for people who have private or public coverage or who are seeking services through the state mental health and substance use system. However, there are problems that are unique to TRICARE. For example, North Carolina licenses certain types of mental health and substance use professionals, but TRICARE will not contract with all of the state-licensed health professionals. Under federal law, TRICARE can only "credential" and contract with health professionals who are recognized under federal Medicare laws. Currently, TRICARE cannot contract with most of the licensed substance use professionals, including Licensed Clinical Addiction Specialists. As a result, the availability of specially trained substance use professionals is severely limited in the TRICARE program.

s Veterans in Priority Group 7 pay 20% of the co-pay rates, and veterans in Priority Group 8 pay the full co-pay rate. The co-pays are as follows:
1) Outpatient Care: $15 Primary Care; $50 Specialty Care; $0 for x-rays, lab, immunizations, etc.
2) Outpatient Medication: $8 per 30-day supply. Priority Groups 2-6 Calendar Year cap - $960
3) Inpatient Care: $10/day + $1,100 for first 90 days and $550 after 90 days – based on 365-day period.
4) Extended Care Services: Institutional Nursing Home Care Unit, Respite, Geriatric Evaluation - $0-$97 per day. Noninstitutional Respite, Geriatric Evaluation, Adult Day Health Care - $15 per day.

In addition, some providers choose not to contract with TRICARE. Some providers avoid contracting with TRICARE because of concerns regarding administrative difficulties.[32] Another reason that providers state for neither contracting with TRICARE nor accepting TRICARE beneficiaries is the low reimbursement rate.[32] In North Carolina, most health professionals in the state agree to participate in Medicaid, even though Medicaid reimbursement rates are typically lower than payments from Medicare or private payers. A comparison between TRICARE and Medicaid shows that TRICARE, on average, pays higher rates than Medicaid for common psychiatric diagnostic codes. (See Table 4.3.)

Table 4.3
Reimbursement Rates for TRICARE and Medicaid

Procedures (Current Procedural Terminology 4 Codes)	Reimbursement Rate	
	TRICARE	Medicaid
Psychiatric diagnostic interview (90801)	$146.10	$128
Individual psychotherapy (90806)	$84.08	$79
Individual psychotherapy (90807)	$95.92	$95
Family and medical psychotherapy (90847)	$102.92	$92
Pharmacologic management (90862)	$53.56	$50
Psychological counseling services assessment (96101)	$79.40	$71

Source: TRICARE Reimbursement Rates (effective April 1, 2010). David Amos. Email correspondence.

This indicates that, in North Carolina, concerns about low reimbursement rates should not serve as a barrier to providers contracting with TRICARE. However, TRICARE does not cover all the procedures that Medicaid does.

A comparison between TRICARE and Medicaid shows that TRICARE, on average, pays higher rates than Medicaid for common psychiatric diagnostic codes.

The provision of mental health and substance use services to TRICARE enrollees varies considerably among services and within TRICARE. Specifically, the receipt of necessary services depends in part on the service member's location.[25] In North Carolina, mental health and substance use providers who are affiliated with TRICARE are concentrated around Ft. Bragg, Camp Lejeune, and large cities.[7] (See Table 4.4.)

Currently in North Carolina, there are efforts to overcome provider resistance to contracting with TRICARE and to overcome the geographic maldistribution of providers. The Citizen Soldier Support Program (CSSP), at the University of North Carolina at Chapel Hill, Odum Institute for Research in Social Science, works with mental health and substance use providers and encourages them to contract with TRICARE (CSSP is discussed in more detail in Chapter 6). CSSP maintains an online, searchable database of all the providers who contract with TRICARE in order to help TRICARE enrollees find providers in their geographic area.

Veterans Affairs

Provider availability within the VA is largely determined by geographic proximity of veterans to VA facilities. Because mental health and substance use services available in the VA vary by the type of facility, as discussed above, veterans may

Table 4.4
TRICARE Network Behavioral Health Providers

Prime Service Area (PSA)	Number of Network Behavioral Health Providers
Charlotte PSA	69
Ft. Bragg PSA	237
Greenville PSA	22
NH Camp Lejeune PSA	90
NH Cherry Point PSA	44
NMC Portsmouth PSA	9
Raleigh-Durham PSA	259
Seymour Johnson PSA	151
Wilmington PSA	86
Winston-Salem/Greensboro PSA	115
Non-PSA	127
Total	1,209
Ft. Bragg, Raleigh-Durham, Seymour Johnson PSAs	647

Key: NH – Navy Hospital, NMC – Navy Medical Center. Source: Amos D. Introduction to TRICARE. Talk presented to: North Carolina Institute of Medicine Task Force on Behavioral Health Services for the Military and Their Families; November 18, 2009; Morrisville, NC.

More than 50% of the approximately 800,000 veterans in North Carolina live in rural or highly rural areas.

have to travel to reach services, particularly specialty care. This is particularly an issue for the large number of veterans who live in rural areas far from VA facilities. More than 50% of the approximately 800,000 veterans in North Carolina live in rural or highly rural areas, as defined by the US Census Bureau. The Veterans Integrated Service Network 6 (VISN 6), responsible for providing VA health services in North Carolina, is currently launching an innovative Rural Health Initiative to improve access for those living in rural areas. As part of its Rural Health Initiative, VISN 6 has developed multidisciplinary traveling teams at each of its four North Carolina medical centers. Each team is committed to community outreach to veterans in rural communities. Although direct care is not currently offered, these teams serve as health educators for rural veterans, their family members, their community leaders, and their local providers. They work at all levels of the rural community to increase understanding of the special health issues facing veterans (including postdeployment health and mental health issues facing newly returned combat veterans and reserve component members) and to increase understanding of ways to identify and to access the many services available through VA. These Rural Health Teams understand that they are in the rural community to complement local health care services rather than to compete with them. They are partnering with the NC Office of Rural Health and Community Care to ensure full coordination of their often overlapping outreach efforts. By raising awareness of veteran health issues and of the range and accessibility of VA services, the VISN 6 Rural Health Initiative

is building a vital connection between VA and rural veterans. However, distance from VA health centers is still a significant barrier to care for these veterans.

Fear of the Potential for Adverse Professional Consequences by Seeking Mental or Behavioral Health Services

The stigma that some service members and veterans feel in seeking behavioral health services is a significant barrier to care for those who need treatment. Many service members fear that they could jeopardize or harm their careers by seeking care. This fear is particularly acute among service members who need care. The evidence of this stigma is significant: 59% of soldiers and 48% of Marines surveyed reported that they felt they would be treated differently by leadership if they sought mental health or substance use services.[25] Service members returning from Iraq or Afghanistan whose postdeployment health screenings identified mental health issues were twice as likely to be concerned about stigmatization if they sought care.[33] A similar study found that 43% of service members with an identified need for PTSD or depression treatment thought seeking care would harm their career or result in a denial of security clearance.[34,35] However, there is evidence that this perception is changing. Between 2002 and 2008, the percentage of service members reporting that seeking care would *definitely* damage their career fell from 18% to 13% and the percentage reporting it *probably would* damage their career fell from 30% to 23%.[36]

59% of soldiers and 48% of Marines surveyed reported that they felt they would be treated differently by leadership if they sought mental health or substance use services.

These fears about the consequences of seeking care are in part motivated by the military's policies surrounding mental health and substance use treatment. For instance, command leaders must be notified if a military member reports substance use problems or enters into treatment. Failure to complete treatment for alcohol abuse can lead to immediate separation from the service, and reporting other drug abuse issues can lead to immediate separation from the service.[37,38] However, there are a number of policies in place surrounding mental health treatment that protect, to a degree, service members' confidentiality.[39,40] Official policy is that seeking mental health treatment will not lead to revocation of security clearances and that commanding officers are not to treat service members differently.[27] Confidentiality surrounding treatment is still seen as a way to increase the number of service members who need care who actually seek it.[41] Many of the supplementary support services, such as the NC National Guard's Integrated Behavioral Health System and Military OneSource, provide confidential counseling, allowing service members to seek care without their commanders being notified.

The military has tried to overcome fears surrounding seeking and receiving treatment by increasing the number of mental health professionals embedded in units and by integrating behavioral health providers into the primary care setting.[25] For example, the Army has recently instituted the RESPECT-Mil (Re-Engineering Systems for the Primary Care Treatment of Depression and PTSD in the Military) program, which aims to leverage primary care visits to detect and

to facilitate treatment of depression and PTSD in service members. RESPECT-Mil trains primary care providers to screen for depression and PTSD during every outpatient visit and to diagnose it when present. During visits in the pilot test of this program, approximately 75% of service members were screened for depression, compared with only 5% at comparison clinics. Additionally, only 28% of those identified as having these conditions through the screenings declined referrals or were not already receiving care.[41,42]

Utilization of TRICARE and VA Mental Health and Substance Use Services

Although service members and their families have potential access to a wide array of mental health and substance use services, there is still a gap between the number of individuals needing care and the number who receive care. Chapter 3 discussed the prevalence of mental health and substance use problems among service members, veterans, and their families. In surveys of service members returning from deployment, approximately one-third (between 23% and 40%) of those with an identified need for treatment sought treatment within a year of returning from deployment.[43] Additionally, not only are service members who seek needed treatment in the minority, but also most of these seekers receive treatment that is not minimally adequate.[34,t] Both the rate of utilization of services and the rate of receiving minimally adequate treatment mirror the rates in the general civilian population.[34,44] However, in recent years, there has been a concerted effort to decrease the stigma and to increase access to mental health and substance use services. As a result, there has been a general increase in the proportion of active duty service members receiving mental health or substance use counseling, increasing from 14.6% in 2005 to 17.5% in 2008.[36]

There has been a general increase in the proportion of active duty service members receiving mental health or substance use counseling, increasing from 14.6% in 2005 to 17.5% in 2008.

Studies of utilization of services by veterans in the VA system have found similar rates of utilization and similar increases in the numbers receiving services. Approximately 35% of OEF/OIF veterans have received a mental health diagnosis, and of these veterans, two-thirds received treatment.[26] However, a majority with new PTSD diagnoses did not receive minimally adequate treatment.[26] As a whole, the VA has seen an increase in the numbers of veterans using specialty mental health services, although the majority of the increase has been among Vietnam era veterans.[45] However, the intensity of treatment (number of visits per veteran) has decreased, indicating that fewer veterans are receiving adequate treatment.[45]

As a whole, there does appear to be a significant gap between the need for mental health services among service members and the number who receive adequate treatment. In addition, little is known about the use of mental health services by family members, National Guard and Reserve members, and those who have

t Participants were judged to have had a *minimally adequate trial of a psychotropic drug* if they (1) had taken a prescribed medication as long as the doctor wanted, and (2) had at least four visits with a doctor or therapist in the past 12 months. *Minimally adequate exposure to psychotherapy* was defined as having had at least eight visits with a "mental health professional such as a psychiatrist, psychologist, or counselor" in the previous 12 months, with visits averaging at least 30 minutes.

separated from the service but do not use the VA, because most studies have focused on active duty service members and veterans using the VA.

More federal support is needed to ensure that active and former members of the military and their families have access to mental health and substance abuse professionals in the military health system. In order to provide federal support for behavioral health access, the Task Force recommended:

Recommendation 4.2

The North Carolina Congressional delegation should work with Congress to:

a) **Increase funding for behavioral health services for members of the active and reserve components, veteran members of the military, and their families. Special emphasis must be made on meeting the behavioral health needs of the Reserve and National Guard.**

b) **Direct the Department of Defense (DoD) to change policies to allow licensed substance abuse professionals and other licensed behavioral health professionals to be credentialed as a participating provider in TRICARE.**

c) **Direct the Department of Veterans Affairs (VA) to designate staff time to provide family and couple's counseling and psychoeducation as a part of mental and behavioral health services provided to veterans with behavioral health problems in the VA health care system.**

d) **Direct the VA and DoD to work with the North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, and other state TBI service organizations, to support efforts to integrate services for both civilian and military personnel for community-based reintegration day programs.**

Conclusion

The federal system currently provides active duty service members, their families, retirees, and some veterans a wide array of mental health and substance use services. Although there are gaps in access to services for some groups of service members or family members, improvements are being made to ensure access to mental health and substance use services for all active and former service members and their families who are eligible for health care through the federal system and linkage to the system. When individuals are not able to access services through the federal system, because of barriers including eligibility restrictions, stigma, and provider shortages, it is important to link them to state resources. The following Chapter 5 discusses state-funded mental health and substance use services that may be available to service members and their families.

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