# Coverage, and Availability of Mental Health and Substance Abuse Services

Although TRICARE, the US Department of Veterans Affairs (VA), and the National Guard provide very comprehensive health, mental health, substance abuse, and other behavioral health services for many current and former members of the active duty and reserve components, there are barriers that prevent many people who are, or who have been, connected to the military from accessing needed services. As noted in Chapter 4, some people who served in the armed forces are ineligible for continuing coverage once they leave active duty and reserve components. Others are eligible but choose not to obtain mental health or substance abuse services because of the potential for adverse consequences—whether real or perceived—on their military careers. Family members may not have their previous coverage options, once their service member leave active service. Some active duty and reserve components, retired military personnel, veterans, and their families may seek mental health or substance abuse services from civilian health professionals.

**Private and public insurance coverage, state-funded mental health and substance abuse services, the informal system of peer support, and counseling through faith leaders—can provide needed mental health and substance abuse services.**

Service members who have been discharged from active duty and reserve components may have access to private third-party health insurance coverage, through either their civilian employer, their spouse, or their private purchase of such insurance. In addition, others have publicly subsidized coverage through Medicaid, Children's Health Insurance Program, or Medicare. Many individuals first seek services through their primary care providers. Others obtain mental health and substance abuse services through civilian mental health and substance abuse professionals. However, many of the former members of the active duty and reserve components, as well as their family members, are uninsured. These individuals often rely on state-funded mental health and substance abuse services for treatment. Others turn to peer support groups, faith leaders, or other community organizations for help. All of these—private and public insurance coverage, state-funded mental health and substance abuse services, the informal system of peer support, and counseling through faith leaders—can provide needed mental health and substance abuse services. Yet there are still barriers that former members of the active duty and reserve components, veterans, or their families can experience in accessing needed services. Each of these systems is described in more detail below.

## Private Group and Nongroup Coverage

Most of the non-elderly in North Carolina and in the United States receive their health insurance coverage through their employer (NC: 53.5%; US: 55.8%). Others purchase private nongroup coverage (NC: 8.8%; US: 8.9%) in 2009.[1] Until relatively recently, many people with private health insurance coverage had more limited coverage for mental health or substance abuse services than for other health conditions. However, changes in state and federal laws expanded coverage for mental health and substance abuse services. In 2007, the North Carolina General Assembly enacted a law that required insurers to provide the same coverage for certain mental health disorders as

provided for other physical illnesses. Mental health parity was extended to people who had received a diagnosis of bipolar disorder, other major depressive disorder, obsessive-compulsive disorder, paranoid and other psychotic disorder, schizoaffective disorder, schizophrenia, posttraumatic stress disorder, anorexia nervosa, and bulimia. In addition, insurers were required to provide at least 30 days of inpatient and outpatient treatment, and at least 30 days of office visits, for other mental health disorders (Session Law 2007-268, Section 6). This law applies to all state-regulated insurance policies sold through the group or nongroup market. However, the state law does not apply to self-funded plans governed by the Employee Retirement and Income Security Act (ERISA).[a] Furthermore, the state law did not provide parity in insurance coverage to people with substance use disorders.

**Patient Protection and Affordable Care Act (ACA) requires qualified health plans to provide mental health or substance abuse parity in plans offered to small employers or individuals through the Health Benefits Exchange. However, this expanded mental health and substance abuse parity provision does not go into effect until 2014.**

This gap in coverage was partially ameliorated with the passage of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act (Wellstone-Domenici Act), as part of the Emergency Economic Stabilization Act of 2008. Under the Wellstone-Domenici Act, group health plans with 50 or more employees must provide mental health and substance abuse coverage in parity with medical and surgical benefits, if the employer offers health insurance with any coverage of mental health disorders.[b] In these instances, the coverage of mental health and addiction disorders may not have higher cost sharing (including deductibles, coinsurance, or co-payments), lower annual or lifetime limits, or more restrictive treatment limitations for mental health and substance abuse disorders than is provided for coverage of medical or surgical health problems. Unlike the state law, this Wellstone-Domenici legislation covers employer groups whether or not they are self-funded (if they meet the other statutory requirements). In addition, Wellstone-Domenici provides parity in coverage for substance use disorders, as well as for all mental health disorders. However, the federal law does not extend to employer groups with fewer than 50 employees or to nongroup plans.

The combination of these two laws expands coverage for mental health and substance abuse to many people who have private employer-based coverage. However, gaps still remain—particularly for coverage of substance abuse services for individuals who work for small businesses (with 50 or fewer employees) or

a ERISA is a federal law that governs employer-sponsored welfare plans, including employer-sponsored health benefits. The federal ERISA law preempts state laws that would have the effect of mandating that employer-sponsored plans cover certain health benefits, such as mental health parity. States can regulate or mandate what insurers cover in their health plans. If an employer purchases health insurance through a regulated insurance plan, then the enrollees would be covered by the state-mandated benefits. However, when employers pay directly for health services (self-funded or self-insured plans), these self-funded plans are not required to provide the state-mandated benefits. Approximately 62% of the employed population in North Carolina who are enrolled in employer-sponsored insurance are enrolled in ERISA self-funded plans (as of 2009). Agency for Healthcare Research and Quality. Medical Expenditure Panel Survey. Table II.B.2.b.(1)(2009). 2009.

b Group health plans that would otherwise be covered through the Wellstone-Domenici law can be exempt from the requirements for mental health and substance abuse parity if a licensed actuary demonstrates that the costs of coverage will increase more than 2% in the first plan year or 1% for each subsequent year as a result of this new coverage. Subtitle B—Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008. Public Law 110-343, codified at 29 USC §1185a, 42 USC §300gg-5.

for those who purchase health insurance in the nongroup market. Additionally, some individuals with mental health problems who work for small businesses or who purchase nongroup coverage also lack complete parity, if they have a mental health condition that is not specifically protected by state statute. The Patient Protection and Affordable Care Act (ACA) requires qualified health plans to provide mental health or substance abuse parity in plans offered to small employers or individuals through the Health Benefits Exchange (Sec. 1311(j)). However, this expanded mental health and substance abuse parity provision does not go into effect until 2014.

Individuals with health insurance coverage of mental health and substance abuse services can obtain mental health or substance abuse services directly from private providers. However, access may be limited because of the shortage and maldistribution of trained licensed mental health and substance abuse providers. (See Chapter 6.) Additionally, even if insured, some people may still not be able to afford services because of cost-sharing requirements (deductibles, coinsurance, or co-payments).

**Some low-income members of the active duty, reserve component, and their family members may be eligible for either Medicaid or NC Health Choice (available for children only).**

## Publicly Subsidized Insurance Coverage (Medicaid, NC Health Choice, or Medicare)

Medicaid, NC Health Choice, and Medicare are publicly subsidized health insurance programs that cover some people in the state. Medicaid and NC Health Choice are jointly administered between the federal and state governments. The federal government sets broad program rules, giving the states some flexibility in how the programs are designed. Both Medicaid and NC Health Choice are targeted to low-income people. In contrast, Medicare is a federal health insurance program that is available to certain people who are older (age 65 or older) or disabled. The programs are described more fully below.

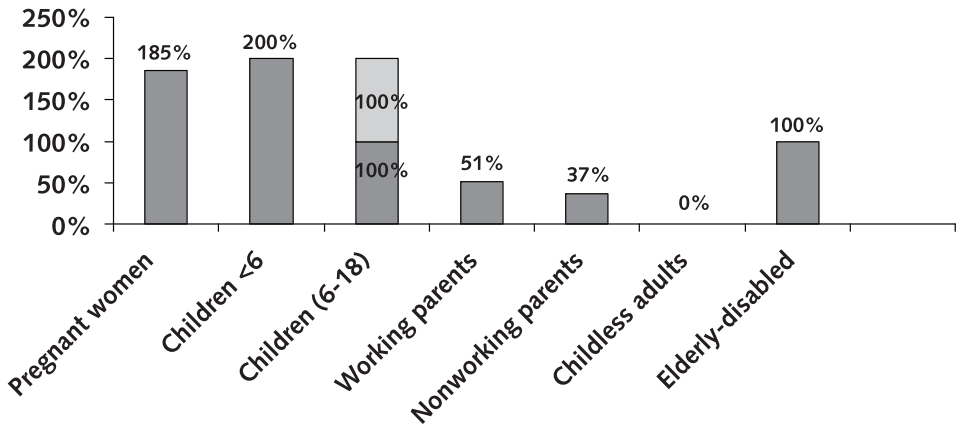
### *Medicaid or NC Health Choice*

Some low-income members of the active duty, reserve component, and their family members may be eligible for either Medicaid or NC Health Choice (available for children only). Medicaid and NC Health Choice provide health coverage to certain low-income individuals who meet program eligibility rules. Under current rules, an individual or family must meet three eligibility tests before qualifying.

- First, the person or family must be in a group of people who are potentially eligible. Only certain "categories" of people are eligible for Medicaid or NC Health Choice. For example, NC Health Choice is the state's Child Health Insurance Program (CHIP) and only available to low-income children under the age of 19. Medicaid covers children under age 21, pregnant women, parents of dependent children under age 19, people with disabilities (meeting the Social Security disability definition), or older adults age 65 or older. Under current Medicaid rules, childless, non-elderly adults who do not meet the Social Security disability standards will not qualify for Medicaid, regardless of how poor they are.

- Second, the individual or family must have income below the income limits. Income eligibility is generally higher for children than for other categories of eligibles (meaning more children can qualify than other groups). (See Figure 5.1.)
- Third, some groups of eligibles must also meet a "resource" or "asset" test. That is, they cannot have countable resources that exceed a state-established resource limit. Children and pregnant women do not have to meet a resource test, but all other groups of eligibles must meet a resource test.

**Table 5.1**
**Medicaid and NC Health Choice Income Limits (2009)**




Source: Kaiser Family Foundation. State Health Facts (2009). Calculations for parents and medically needy based on a family of three.

**Beginning January 2014, Medicaid will be expanded to cover most individuals with incomes below 133% of the federal poverty guidelines.**

The Medicaid rules will change significantly once the federal health reform law, the Affordable Care Act (ACA), is fully implemented. Beginning January 2014, Medicaid will be expanded to cover most individuals with incomes below 133% of the federal poverty guidelines.[c] The ACA eliminates the "categorical" eligibility restrictions and eliminates the asset test for most eligibles.

If a person does qualify for either Medicaid or NC Health Choice, the program provides relatively comprehensive coverage of mental health and substance abuse disorders, with one major exception. Medicaid will not pay for services provided in an institution for mental diseases (IMD) for eligible individuals who are between the ages of 18 and 64. IMDs include the state psychiatric institutions and state-operated alcohol and drug treatment centers. Aside from that one exception, both programs provide comprehensive coverage of inpatient and outpatient services for people with mental health, substance abuse, or

c The Affordable Care Act expands Medicaid to most people with incomes no greater than 133% of the federal poverty guidelines, beginning in January 2014. However, to qualify, a person must be a citizen or lawfully present in the United States for at least five years. In other words, the Affordable Care Act does not expand Medicaid to cover low-income undocumented immigrants.

traumatic brain injury (TBI). Furthermore, because these programs are targeted to low-income individuals, Medicaid and NC Health Choice enrollees pay little (if any) cost sharing. However, as with individuals who have private health insurance coverage, those with Medicaid or NC Health Choice experience barriers accessing services because of workforce shortages in many areas of the state.

### *Medicare*

Medicare is available to any individual who meets the program rules, regardless of his or her income or assets. To qualify, an individual must be age 65 or older or be disabled,[d] and the individual must have sufficient quarters of earnings. Eligibility for Medicare and Social Security is tied to a person's work history. In general, a person must have 40 "credits" (i.e., quarters of earnings) in which they paid Social Security and Medicare taxes, although younger people with disabilities may be able to qualify for benefits with fewer quarters of earning.

**By 2014, Medicare will provide parity of coverage for mental health and substance abuse disorders.**

If a person is 65 or older, or disabled (meeting the strict Social Security disability definition), and they have sufficient quarters of coverage, then they will receive Medicare.[e] Medicare Part A covers hospital services and is provided automatically to individuals who meet the eligibility criteria. Part B generally covers outpatient services, including physician services, as well as outpatient mental and substance abuse services. Part D is prescription drug coverage. Individuals must pay a monthly premium to receive Parts B or D services.

Unlike Medicaid or NC Health Choice, Medicare does not provide mental and substance abuse services in parity with treatment of other medical conditions. Under current law, Medicare recipients have to pay 45% of the cost of outpatient mental health and substance abuse services. In contrast, they have to pay only 20% for treatment of physical health problems.[2] However, this cost-sharing differential (between treatments for mental and substance abuse disorders and treatments for other physical health problems) is being phased out during the next four years. By 2014, Medicare will provide parity of coverage for mental health and substance abuse disorders.

## Publicly Funded Mental and Substance Abuse Services through the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services

People who do not have private or public health insurance coverage may turn to public programs for mental health and substance abuse services. The North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMHDDSAS) is the state agency charged with coordinating the

d To qualify as "disabled," a person must have a physical or mental condition that both precludes the person from obtaining a job that pays and is expected to last 12 months or end in death.

e Medicare is provided automatically to people once they turn 65; however, people are generally not eligible for Medicare on the basis of a disability until they have been receiving Social Security or Railroad disability payments for 24 months.

**The North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMHDDSAS) is the state agency charged with coordinating the prevention, treatment, and recovery supports for people with mental health, intellectual, and other developmental disabilities (including traumatic brain injury) or substance abuse problems in North Carolina.**

prevention, treatment, and recovery supports for people with mental health, intellectual, and other developmental disabilities (including traumatic brain injury) or substance abuse problems in North Carolina. Services are typically provided through private providers under contract with Local Management Entities (LMEs). There are currently 24 LMEs that oversee and manage services provided at the community level. Most LMEs cover multiple counties, although a few of the larger counties have a single-county LME.

### *Eligibility for Services through the DMHDDSAS System*

Individuals with public or private health insurance coverage can seek services directly with private providers. However, those who are uninsured or otherwise need help paying for mental and substance abuse services must first seek assistance through their LME. There is generally a five-step process to obtain mental health and substance abuse services[3]:

1) ***24/7 Initial contact.*** An individual who seeks services may contact the LME by telephone or in person. LMEs must be available 24 hours a day, 7 days a week, to help screen and triage those who seek services to determine whether the person is in need of emergency services.

2) ***Screening, triage, and referral (STR).*** The LME first will determine whether the person needs mental and substance abuse services or should be referred to another community provider. If the person does need mental health or substance abuse services, the LME will collect basic information, establish a timeframe for how quickly the person needs services, and then refer the person to needed services. Specifically, the LME will determine whether the situation is an emergency (crisis services will be provided within 2 hours), urgent (necessitating services within 48 hours), or routine (services provided within 14 days). Individuals who need emergency services will be referred immediately into care.

3) ***Determining eligibility for services.*** Anyone who needs emergency mental health or substance abuse services can receive those services. However, services are more limited once a person has been stabilized. DMHDDSAS does not have funding to provide all the needed services and supports for people with mental health, developmental disability, and substance abuse problems. Thus, the state has identified target populations to ensure that services are targeted to people most in need. ***Veterans and members of their families are part of the target population***.

4) ***Comprehensive clinical assessment and person-centered plan.*** Individuals who are part of the target population will be referred to a qualified mental health, substance abuse, or developmental disability professional to conduct an assessment. This is used to gather clinical and diagnostic information to determine a person-centered plan. The person-centered plan is an individualized plan, developed in conjunction with the client, that identifies needed services, supports, and treatment.

5) ***Referral for services and prior authorization.*** If authorized as part of the person-centered plan, adults can receive up to eight outpatient mental health or substance abuse visits and children can receive up to 26 outpatient visits, without first obtaining prior authorization. Prior authorization is needed for additional outpatient visits or more intensive inpatient services.

Although veterans and their families are target populations, state data show that only 2,828 people who self-identified as veterans received services through an LME during state fiscal year (SFY) 2009. During the last nine months of SFY 2009, 1,842 active and reserve components members and 3,584 family members were screened (which may or may not have led to an admission for services). This may be an undercount of the total number of active or former members of the military and their families who are receiving services, because LMEs starting collecting these data only in September 2008. Nonetheless, these data suggest that few active or former members of the military or their families are seeking services through the DMHDDSAS system.

**Although veterans and their families are target populations, state data show that only 2,828 people who self-identified as veterans received services through a local management entity during state fiscal year (SFY) 2009.**

### *Services Offered*

Most services are provided by local or regional private providers under contract with the LMEs. The types of services that can be authorized as part of the person-centered plan will vary, depending on the person's mental health or substance abuse problem, level of need, and individual preferences for treatment choices.

Generally, LMEs offer access to comprehensive services. However, different LMEs may offer different arrays of services on the basis of the availability of local or regional service providers. The types of services that may be available include outpatient treatment, medication-assisted treatment, intensive outpatient and partial hospitalization, clinically managed low-intensity residential services, clinically managed medium- and high-intensity residential treatment, medically monitored high-intensity treatment, detoxification, crisis, and recovery supports.[4] Most of these services are available to people with mental illness, substance abuse disorders, or traumatic brain injury, although some services (such as detoxification) are limited to individuals with specific types of mental health or substance abuse problems.

- ***Outpatient treatment services.*** Outpatient services include therapy, medication management, and supportive services needed to help consumers manage their mental health or substance abuse problems. These services are limited to people who do not need more intensive residential treatment.
- ***Medication-assisted treatment.*** Medication is available to treat many people with mental illness and substance abuse. Appropriately prescribed medications can improve treatment outcomes as well as improve the person's quality of life. Medications may be used to treat people with

psychiatric conditions, opioid addiction, alcohol or nicotine dependence, pain, sleep disorders, depression, or comorbid medical conditions.

- ***Intensive outpatient and partial hospitalization.*** These services include day treatment programs, intensive outpatient programs, and comprehensive outpatient programs.
- ***Clinically managed low-intensity residential treatment.*** This includes mental health and substance abuse services provided in a residential setting 24 hours a day, 7 days a week. There are separate residential treatment facilities for children, adolescents, and adults, because different facilities focus on people with substance use disorders, mental illness, or intellectual and other developmental disorders.
- ***Clinically managed medium- and high-intensity residential treatment.*** These services are similar to clinically managed low-intensity residential treatment facilities but target individuals with more significant needs.
- ***Inpatient treatment.*** This includes care provided in general hospitals, psychiatric hospitals, and psychiatric residential treatment facilities (for adolescents).
- ***Crisis services (including detoxification for people with substance abuse disorders).*** Crisis stabilization includes the supports, services, and treatment necessary to stabilize the individual's acute mental health, substance abuse, or TBI disorder. Crisis service are available on a 24-hour, 7-days-a-week basis.
- ***Recovery supports.*** Recovery supports include services that help people remain sober (for people with substance abuse problems) or manage mental health or TBI. These services include but are not limited to telephone follow-up, group housing, care management, employment coaching, and family services.

**Local management entities offer access to comprehensive services. However, different local management entities may offer different arrays of services on the basis of the availability of local or regional service providers.**

Critical Access Behavioral Health Agencies (CABHAs) are a new model of service delivery in DMHDDSAS. They are designed to reduce clinical fragmentation, to increase provider capacity, to embed case management within comprehensive clinical providers, to ensure that consumers have access to an array of appropriate clinical services, to increase accountability, and to provide a competent clinical platform on which to implement best practice service models. They must provide the core services of comprehensive clinical assessment, medication management, and outpatient therapy. They are also required to deliver at least two enhanced services in the same location where they provide the three core services to create a continuum of care.[5,f]

f Services that must be delivered within the CABHA structure include Community Support Team (CST), Intensive In-Home (IIH), Day Treatment, Mental Health/Substance Abuse (MH/SA) Case Management, and a new service: Peer Support – pending implementation. The proposed implementation date is January 1, 2011. The transition from other providers to CABHAs for these services will be complete in December 2010.

In addition to the outpatient and inpatient services that are available through the LMEs and CABHAs, the state operates certain residential treatment facilities directly.[6] DMHDDSAS operates:

- ***State psychiatric hospitals:*** DMHDDSAS operates four psychiatric hospitals, located in Morganton (Broughton Hospital), Goldsboro (Cherry Hospital), Butner (Central Regional Hospital and John Umstead Hospital), and Raleigh (Central Regional Hospital Raleigh Campus). The state psychiatric hospitals provide inpatient mental health services, including services for people who are dually diagnosed with mental health and substance abuse disorders.
- ***Alcohol and Drug Abuse Treatment Centers (ADATCs):*** DMHDDSAS operates three ADATCs, located in Black Mountain (Julian F. Keith ADATC), Greenville (Walter B. Jones ADATC), and Butner (R. J. Blackley ADATC). The ADATCs provide comprehensive detoxification services, including mental health and substance abuse crisis stabilization and intensive inpatient treatment.[4]
- ***State developmental centers:*** DMHDDSAS operates three developmental centers, located in Kinston (Caswell Developmental Center), Morganton (J. Iverson Riddle Developmental Center), and Butner (Murdoch Developmental Center). The state developmental centers provide residential services and supports for people with significant intellectual and other developmental disabilities. There are no specific units for traumatic brain injury, but these patients may be housed in other units.[7]
- ***Neuro-medical treatment centers:*** DMHDDSAS operates three neuro-medical treatment centers, located in Black Mountain (Black Mountain Neuro-Medical Center), Goldsboro (O'Berry Neuro-Medical Center), and Wilson (Longleaf Neuro-Medical Center). The neuro-medical treatment centers provide a nursing home level of care for people with severe and persistent mental illness, those with intellectual and other developmental disabilities, and those with a diagnosis of Alzheimer disease or other related dementia who are aggressive and who cannot be appropriately cared for in a traditional nursing facility.

**Although veterans and their family members have been identified as a target population for services through the DMHDDSAS system, they do not always receive all the services they need.**

### *Barriers*

Although veterans and their family members have been identified as a target population for services through the DMHDDSAS system, they do not always receive all the services they need. There are at least four problems that hinder effective treatment through the DMHDDSAS system. First, many individuals with mental health and/or substance abuse disorders fail to recognize that they have a problem. Denial of their behavioral health problems is a common characteristic of both diseases. Thus, many individuals fail to seek care because they do not believe they have a problem. These individuals may not confront their problems unless they are faced with an immediate crisis, such as marital

or family problems, interaction with the criminal justice system, or loss of a job.

Second, some of those who know they have a problem still choose not to seek care because of the stigma associated with the receipt of mental health or substance abuse services. This potential stigma can be compounded for active military members, who are afraid that the receipt of mental health or substance abuse services could adversely affect their military careers. Although the Department of Defense has made concerted efforts to reduce this fear and stigma (see Chapter 4), some people in the armed forces still forgo care because of the fear that they may be perceived as "weak" or that seeking care for services could negatively affect their chances for career advancement. Although military members may have greater confidentiality protection by seeking services in the civilian health system,[g] some people still fail to seek services because of the stigma.[8,9] Studies show that military members who have more significant mental health or substance abuse disorders were more likely to report concerns about being stigmatized or to report other barriers to receiving care than were others with less severe conditions.[10,11]

**Some of those who know they have a problem still choose not to seek care because of the stigma associated with the receipt of mental health or substance abuse services.**

Third, the state DMHDDSAS and LME system do not have sufficient funding to meet all the needs of the different target populations.

Finally, there are insufficient numbers of mental health and substance abuse providers across the state. Some communities—particularly rural and underserved communities—experience significant provider shortages. (See Chapter 6.)

More outreach is needed to ensure that active and former members of the military and their families are linked to federally funded mental health and substance abuse services and treatment for traumatic brain injury, when appropriate and available. As discussed in Recommendation 4.1, there should be expansion of the availability of counseling and treatment services for individuals who have served in the military through the active and reserve components and for their families. This expansion will operate in the North Carolina National Guard Family Assistance Centers and provide a central location for access to a variety of resources and programs. In addition, our Congressional delegation should advocate for expansion of services available to active and former members of the military and to their families, as discussed in Recommendation 4.2. In addition, the Task Force recommended new training for key staff within the Local Management Entities (Recommendation 5.7), crisis workers, veterans

g Individuals who seek behavioral health services through the civilian health system are afforded greater confidentiality protection. The Health Insurance Portability and Accountability Act (HIPAA) prohibits health care providers from disclosing protected health information to others (including the military) without the person's consent. In addition, federal mental health and substance abuse laws provide additional confidentiality protections.

**Table 5.1**
**State and Federal Expenditures for Community-Based Services**

| Community-Based Services[a] | Mental Health (MH) Disorders | Substance Abuse (SA) Disorders | Brain Injury Traumatic | Cross-Disability Crisis Services[b] |
|---|---|---|---|---|
| **2001** | | | | |
| Number of people in need of services (2001)[e] | 534,033 | 362,038 | | |
| Persons served (2001)[c] | 231,054 | 75,219 | 851 | 306,273 |
| Federal funds expended (2001)[d] | $14,313,245 | $33,719,053 | $0 | $0 |
| State funds expended (2001)[d] | $95,915,838 | $28,769,969 | $781,550 | $0 |
| Total federal and state funds expended (2001) | $110,229,083 | $62,489,022 | $781,550 | $0 |
| Combined state and federal funds expended per person served (2001) | $477 | $831 | $918 | N/A |
| **2009** | | | | |
| Number of people in need of services (2009)[e] | 560,970 | 606,867 | | |
| Persons served (2009)[c] | 232,178 | 74,546 | 816 | 306,724 |
| Federal funds expended (2009) | $11,390,452 | $41,215,319 | $0 | $0 |
| State funds expended (2009) | $79,025,238 | $47,577,898 | $1,844,000 | $21,218,863 |
| Total federal and state funds expended (2009) | $90,415,690 | $88,793,217 | $1,844,000 | $21,218,863 |
| Inflation-adjusted state and federal funds expended[f] | $74,638,028 | $73,298,679 | $1,522,219 | $17,516,142 |
| Inflation-adjusted state and federal funds expended per person served (2009) | $321 | $983 | $1,865 | $57 |

[a]The information in this table includes services provided in community settings, including community hospitals. It does not include services or expenditures for state-operated facilities.
[b]Cross-Disability Crisis Services includes expenditures for legislated community psychiatric hospitalization for all LMEs and crisis services for non-Single Stream LMEs only. Crisis services for Single Stream LMEs are included in the MH Disorders and SA Disorders columns. Crisis services are available to all MH and SA consumers but are accessed primarily by persons with mental health disorders.
[c]The numbers of persons served are based on the Annual Statistical Reports of Persons (Child and Adult) Served in Community Settings by LMEs (Area Programs in 2001). A person admitted to more than one LME is counted more than once (about 4% of persons served in SFY 2009). Individuals not registered with an LME are not included.
[d]Expenditures include funds appropriated by the North Carolina Legislature and federal block grant funds for MH and SA services. Expenditures for SFY 2001 may be understated. The maximum allowable amount (13%) for Area Program administrative costs have been removed from the total SFY 2001 expenditures to make the comparison to SFY 2009 more accurate. Administrative funds for LMEs are paid separately and are not included in state funds for SFY 2009.
[e]These calculations were made and described in the North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services' Community Systems Progress Report Fourth Quarter SFY 2009-2010. http://www.ncdhhs.gov/mhddsas/statspublications/reports/sfy10communitysystemsprogressrptq4appendices.pdf
[f]The 2009 total federal and state funds were reduced to 2001 funds using the Consumer Price Index (CPI). Calculations were made using the following formula. Formula:$2001 = $2009 x (CPI-2001/CPI-2009) = $2009 x (177.1/214.537). Source for CPI values: ftp://ftp.bls.gov/pub/special.requests/cpi/cpiai.txt These are conservative estimates using the general rather than medical CPI because the medical CPI did not include all the measures reported in the state data.

service organizations and veterans service officers, advocacy and peer support groups, and the faith community (Recommendation 6.2), to help them identify people with behavioral health problems and to know what federal and state resources are available to serve them.

When federal behavioral health services are not available or accessible to active and former members of the military and to their families, the state resources should be made available to meet their needs. The Task Force made two recommendations to address some of the gaps or problems in our currently state-funded system, both aimed at improving the care of people with traumatic brain injury.

As noted in Chapter 3, individuals with TBI may have residual impairments affecting a wide range of brain functions, such as cognition, communication, emotion, memory, social behavior, and/or motor function.[12] Whether civilian, military, or veteran with TBI, individuals who no longer need inpatient treatment should be reintegrated back into the community. A neurobehavioral system of care focuses on attaining an individual's goals through the use of various services and supports as needed throughout the individual's life. Community rehabilitation should include neurobehavioral programs, residential programs, comprehensive holistic day-treatment programs, and home-based programs. With small target populations and the resources required to support these programs, collaboration and integration of services will be required at the levels of active and reserve military components, veteran, state, and community.[13]

In order to move forward with the development of an accessible community-based neurobehavioral system of care, the Task Force recommended:

## Recommendation 5.1

**The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services and military partners should collaborate to determine gaps in order to develop an accessible community-based neurobehavioral system of care for service members with traumatic brain injury. These military/civilian services should be available to service members, veterans, and their families. A fully realized system of care would consist of neurobehavioral programs, residential programs, comprehensive day programs, and home-based programs.**

As state and federal partners collaborate to provide a continuum of care for active and former service members and their families, it is important to share knowledge of best practices and relevant research. Recent studies have suggested more detailed information on diagnostic screening and testing for TBI.[14] Health professionals with the Department of Veterans Affairs have begun communication with state partners, including the Division of Medical Assistance, to ensure that they are aware of the most recent evidence-based practices.

In order to provide the most up-to-date diagnostic screening and testing for TBI, the Task Force recommended:

## Recommendation 5.2

**The North Carolina Division of Medical Assistance, MedSolutions, and appropriate health professionals at the Department of Veterans Affairs should continue to work together to ensure that MedSolutions is using the appropriate evidence-based diagnostic testing (including imaging, biomarker testing, or other tests) for screening and assessment of traumatic brain injury.**

Although it is important to strengthen the DMHDDSAS system in order to expand access to treatment services, the Task Force also recognized that many people with mental health or substance abuse problems or traumatic brain injury may first seek services through other systems of care. For example, some people may access services only through their primary care providers. Others may seek help through pastoral counselors or community-based self-help organizations. Still others may be "coerced" into treatment as part of the criminal justice system (e.g., as a condition of probation) or to keep custody of children in a child protective services case.

**One way to improve access is to offer mental health, substance abuse, and other behavioral health services directly from primary care providers.**

### Primary Care

Most people access primary care services at least once per year. In 2009, 70.8% of North Carolina adults reported going to a doctor for a routine checkup within the past year.[15] Thus, one way to improve access is to offer mental health, substance abuse, and other behavioral health services directly from primary care providers.

Primary care providers should be trained to understand the potential medical, mental health, or substance abuse disorders of returning veterans and their families. With this understanding, they consistently should screen individuals connected to the military, using evidence-based screening instruments, to identify potential mental health or substance abuse problems. With appropriate training, primary care providers can also provide effective treatment and medication management for people who have mild to moderate cases of depression or who have abused, but not yet become dependent on, the use of alcohol or other drugs. Those with more significant problems should be referred to more specialized treatment services.

The US Preventive Services Task Force recommends screening adolescents and adults in a primary care practice for depression if support is available to assure accurate diagnoses, treatment, and follow-up. The Task Force found evidence that screening people for depression in a primary care practice, if followed up with antidepressants, psychotherapy, or both, can help reduce clinical depression.[16,17] There is also strong evidence to offer screening, brief intervention (counseling),

and referral into treatment (SBIRT) to reduce misuse of alcohol or other illegal drugs.[18,19,h] Data have shown that SBIRT is effective in reducing the use of alcohol by people who consume five or more alcoholic beverages in one setting (alcohol "abuse") or those who use illegal substances. This model has been studied for more than 20 years and has been shown to be effective in different outpatient settings, including primary care provider offices, Federally Qualified Health Centers, health departments, and school-based clinics.[20-22] Moreover, studies have shown that implementation of SBIRT reduces emergency department and hospital costs.[23] For every one dollar spent on SBIRT, there is a corresponding decrease in health care costs of between four and seven dollars.

**Primary care providers should be trained to understand the potential medical, mental health, or substance abuse disorders of returning veterans and their families.**

The state and federal governments, community agencies, and other partners have been working together as part of the North Carolina Governor's Focus on Servicemembers, Veterans, and Their Families to develop broader systems of care for returning veterans and their families. (See Chapter 6.) This group has been working since 2006 to improve the capacity of state and local agencies and organizations to improve systems of care, including primary care, mental health services, and substance abuse services, for returning veterans and their families. As part of this larger effort, the Citizen Soldier Support Program, the Governors Institute on Substance Abuse, the Area Health Education Center (AHEC) program, and the Durham VA Medical Center developed a statewide training initiative to increase the skills and awareness of primary care providers, as well as mental health and substance abuse professionals, about the medical and behavioral health needs of active and former military members and their families. Since 2006, this training has been provided to 622 licensed clinical social workers and licensed clinical addiction specialists and 105 physicians, nurse practitioners, and physician assistants.[i]

Additionally, AHEC, the Governor's Institute on Substance Abuse, DMHDDSAS, and the Integrated, Collaborative, Accessible, Respectful and Evidence-Based care project (ICARE) have been working together to provide training and technical assistance to primary care providers to encourage them to implement SBIRT in their practices. (ICARE is described more fully below.) As part of the partnership with ICARE, AHEC and partnership organizations also help train primary care providers to provide evidence-based screening and treatment for depression.

h More information on SBIRT is available on the Substance Abuse and Mental Health Services Administration website: http://sbirt.samhsa.gov/about.htm

i The DMHDDSAS and the Behavioral Healthcare Resource Program of the Jordan Institute for Families at the University of North Carolina School of Social Work have cosponsored the workshop *PTSD, Substance Abuse, and Returning OEF/OIF NC Guard and Reserve Veterans*. This workshop addresses issues faced by returning combat veterans that substance abuse professionals need to know. A total of 583 substance abuse professionals attended 14 full-day training events from 2006 to 2009, with three workshops scheduled for fall 2010. An advanced 20-hour course was offered at the North Carolina School for Alcohol and Drug Studies for the past two summers, with 14 substance abuse professionals attending in 2009 and 25 substance abuse professionals attending in 2010. *Postdeployment Mental Health Issues: Working with Veterans of Iraq and Afghanistan and their Families* provides evidence-based practices in the assessment of PTSD. A total of 105 physicians, nurse practitioners, and physician assistants attended the nine 2-hour workshops.

Although AHEC and other partners offer different trainings that cover the medical, mental health, and substance abuse needs of military and their families, as well as screening, counseling, and treatment for depression and substance abuse, it has been difficult to get primary care providers and other physicians to participate in these trainings. More must be done to train and encourage physicians to provide appropriate mental health and substance abuse screening and treatment services to members of the military and their families. Furthermore, the state should continue to offer on-going trainings to other health, mental health, and substance abuse professionals.

In order to continue to support ongoing trainings for health, mental health, and substance abuse professionals, the Task Force recommended:

## PRIORITY Recommendation 5.3

**a) The Area Health Education Centers (AHECs), in collaboration with the Citizen Soldier Support Program; North Carolina health professional training programs; Department of Veterans Affairs; University of North Carolina system; Operation Re-entry North Carolina; North Carolina Community College System; health care professional associations; DMHDDSAS; Governor's Focus on Servicemembers, Veterans, and Their Families; and academic health programs, should facilitate and continue to provide health education and skills training for health professional students; primary care, mental health, and substance abuse providers; and hospital administrators about the health, mental health, and substance abuse needs of the military and their families. Trainings should include but not be limited to:**

**1) Information about the number of North Carolinians who are serving or who have served in the active and reserve components and their families.**

**2) Information about military culture.**

**3) Information about the average number of deployments, length of time in conflict zones, and potential injuries these members may have faced, particularly those who have served recently in Iraq or Afghanistan.**

**4) The types of health, mental health, and substance abuse disorders that these service personnel may have experienced, including but not limited to traumatic brain injury (TBI), posttraumatic stress disorder (PTSD), military sexual trauma (MST), depression, substance use disorders, potential suicide risks, or domestic violence.**

**5) The potential impact of the deployment cycle (before, during, and after) on family members and children, including but not limited to resiliency skills, intervention skills, resources, and community supports.**

6) **Evidence-based screening and assessment instruments.**

7) **Evidence-based case management, treatment, and medication management for different mental health and substance abuse problems, and potential adverse effects of prescribed medications, particularly for people with comorbidities.**

8) **Information about the TRICARE system, payment, and enrollment procedures.**

9) **Available referral sources through the TRICARE, Department of Veterans Affairs, Military One Source, Army One Source, Defense Center of Excellence Deployment Health Clinical Center, North Carolina National Guard's Integrated Behavioral Health System, Local Management Entities, North Carolina Department of Health and Human Services (DHHS) Office of Citizen Services, North Carolina Health Info, Federally Qualified Health Centers, professional advocacy and support services, and other community resources.**

b) **The North Carolina General Assembly should appropriate $250,000 in one-time funds to the Area Health Education Centers program to develop additional continuing education conferences, workshops, and online courses that address the remaining topics 6, 7, 8 and 9 (above). Existing curricula that address clinical care and evidence-based treatments for brain injury, behavioral health, and substance abuse problems may also be adapted to reflect the special needs of service personnel.**

Enhanced training for primary care and other providers is important, but training by itself—without appropriate reimbursement to support the additional work—is unlikely to change provider practices. It is already difficult for primary care physicians to provide all the recommended care. An average physician with a panel of 2,000 patients would need to spend 17.4 hours per day to provide all the recommended acute, chronic, and preventive services to his or her patients.[24] Furthermore, primary care, mental health, and substance abuse professionals should be encouraged to participate in TRICARE—to expand the availability of civilian providers to active and retired members of the military and their families. Additional reimbursements may help change provider practices and support additional work. Incentive payments reward professionals for providing evidence-based treatment services and achieving desired health outcomes. The North Carolina Department of Health and Human Services can explore both cost-neutral as well as incentive payments that increase overall payments to providers.

In order to encourage additional provider reimbursement, the Task Force recommended:

## Recommendation 5.4

**a) The North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services should work with the North Carolina Division of Medical Assistance to explore value-based purchasing or grants, which would provide additional reimbursement to providers who:**

**1) Complete approved training programs that focus on the identification, treatment, and referral of service members, veterans, and their families who may have experienced depression, traumatic brain injury, posttraumatic stress disorder, military sexual trauma, substance use disorders, potential suicide risks, or domestic violence.**

**2) Consistently use state-approved evidence-based screening and assessment instruments to identify people with one or more of these conditions.**

**3) Consistently offer evidence-based treatment, including medication management and psychotherapy.**

**4) Report process and outcome measures, as defined in subsection b) below.**

**5) Actively participate in TRICARE, Department of Veterans Affairs (VA) fee-for-service system, DMHDDSAS, and Medicaid.**

**b) DMHDDSAS, North Carolina Division of Medical Assistance (DMA), and VA should work collaboratively to define appropriate behavioral health process and outcome measures on which to tie performance-based incentive payments.**

It is not sufficient to train primary care providers to screen and to offer brief counseling if there are not strong linkages into treatment services. Approximately one-third to one-half of the people who are referred into mental health specialty care do not follow through with the referral.[25] Instead, North Carolina should encourage the development of integrated or collaborative care models in which primary care providers work collaboratively with mental health and substance abuse specialists and care managers to provide appropriate treatment. The Department of Veterans Affairs is also implementing primary care integrated mental health care nationally, to bridge the same gap in the VA health care system.

**Collaborative care models have two components: 1) care management to ensure that the person is receiving appropriate care and 2) closer collaborative relationships between the mental health or substance abuse specialist, care manager, and primary care provider.**

Generally, collaborative care models have two components: 1) care management to ensure that the person is receiving appropriate care and 2) closer collaborative relationships between the mental health or substance abuse specialist, care manager, and primary care provider.[26] The North Carolina Foundation for Advanced Health Programs (NCFAHP) has been working with the DMHDDSAS, DMA, AHEC, the North Carolina Psychiatric Association, the North Carolina Academy of Family Physicians, the North Carolina Pediatric Society, the North Carolina Medical Society, the Governor's Institute on Substance Abuse, the North Carolina Psychological Association, the National Association of Social Workers, and others to develop ICARE, a similar collaborative care model in North Carolina. ICARE was created to improve collaboration and communication between primary care and mental health, developmental disabilities, and substance abuse providers, and to increase the capacity of primary care physicians to provide appropriate, evidence-based behavioral health services.[j] ICARE has developed and tested several models of collaboration and integration. Initially, primary care providers in pilot sites were trained to provide better mental health services (particularly aimed at depression) and then to develop stronger linkages with the local LME for other more specialized mental health, developmental disabilities, or substance abuse services. Later, ICARE staff worked with the North Carolina Office of Rural Health and Community Care (ORHCC) to develop collocation models, funded initially through the North Carolina General Assembly. In this model, mental health professionals are collocated in the primary care practices (often in pediatric practices). Individuals in need of mental health services can be referred "down the hall" to a mental health provider.[27-31] The Army has also implemented a mental health and substance abuse collocation model at Ft. Bragg (Re-Engineering Systems of Primary Care Treatment in the Military [RESPECT-Mil]).

In SFYs 2007 and 2008, the North Carolina General Assembly provided nonrecurring funds to the North Carolina Office of Rural Health and Community Care to support the development of services for the Aged, Blind, and Disabled. One of the models tested was collocation of behavioral health and primary care professionals in practices serving the Medicaid population. These funds were used to support the development of collocation models in 60 different practices across the state. The DMA worked closely with the partnership called ICARE, operated by the North Carolina Foundation for Advanced Health Programs, which was developing protocols, provider tools, and training for primary care providers around the state not only to collocate behavioral health providers in primary care practices but also to fully integrate the behavioral health provider into the practice. ICARE was testing models of integration for

j ICARE is funded by the Kate B. Reynolds Charitable Trust, The Duke Endowment, AstraZeneca, North Carolina Area Health Education Centers Program, the North Carolina Department of Health and Human Services, and the North Carolina Foundation for Advanced Health Programs. Information about ICARE is available at www.icarenc.org.

different populations by funding pilot projects in practices across the state, with the support of Kate B. Reynolds and Duke Endowment funding. To date, most of the behavioral health specialists in primary care practices are licensed mental health providers, including licensed clinical social workers or clinical psychologists. These professionals do not necessarily have specific training to address substance abuse issues. North Carolina has not had much experience with collocation of substance abuse professionals in primary care practices. Furthermore, most of the existing collocation models are in pediatric practices.[k] Most children in the state have insurance coverage (or are eligible for publicly subsidized insurance) and have coverage for mental health and substance abuse services. Thus, the behavioral health professionals have a source of reimbursement to support their practices. In contrast, many adults—particularly low-income adults—are uninsured. This includes many of the National Guard or Reserve before they are deployed or after they return from deployment, as well as other members of the armed forces who leave active duty but who do not qualify for VA services. Thus, it is more difficult to financially support the collocation of mental health and substance abuse professionals in practices geared to an adult population.[l]

In order to expand collocation and integration of behavioral health and primary care services, the Task Force recommended:

## Recommendation 5.5

**a) The North Carolina Foundation for Advanced Health Programs through the Center of Excellence in Integrated Care should work in collaboration with the North Carolina Office of Rural Health and Community Care (NCORHCC); Division of Mental Health, Developmental Disabilities, and Substance Abuse Services; the Governor's Institute on Substance Abuse; North Carolina Community Care Networks, Inc.; the North Carolina Community Health Center Association; and other professional associations to support and to expand collocation in primary care practices of licensed health professionals trained in providing substance abuse services, and to expand the availability of mental health and substance abuse professionals in primary care practices serving an adult population.**

k The North Carolina Division of Medical Assistance received a 5-year Children's Health Insurance Reauthorization Act grant from the US Department of Health and Human Services in February, 2010. It will be administered through NCORHCC, to be implemented through North Carolina Community Care Networks, Inc. The $9,277,361 grant award will be used to support quality improvement in pediatric care for the Medicaid and North Carolina Health Choice populations. The Center of Excellence in Integrated Care has a subcontract of this grant to help primary care practices and health departments integrate behavioral health care and better connect to community mental health resources and family support services.

l Collocation of behavioral health specialists with primary care providers may be more viable financially after implementation of the ACA, because the ACA mandates mental health and substance abuse parity and expands coverage to more of the adult population.

**b) The North Carolina General Assembly should appropriate $500,000[m] in recurring funds to the NCORHCC to support this effort. Funding can be used to help support the start-up costs of collocation of licensed substance abuse and mental health professionals in primary care practices, or to support continuing education of mental health and substance abuse professionals who are already collocated in an existing primary care practice in order to cross-train these professionals to provide mental health and/or substance abuse services to TRICARE, Medicaid, and uninsured patients with substance abuse disorders. Funding should be targeted to private practices, Federally Qualified Health Centers, local health departments, and rural health clinics that are located in counties with or that serve a substantial number of active or former members of the military and their families, that are enrolled providers in TRICARE, and that participate in Community Care of North Carolina.**

## Other Publicly Funded Mental Health and Substance Abuse Treatment Programs

In addition to the services offered through DMHDDSAS, there are other publicly funded programs available to certain subpopulations, including youth involved in the Juvenile Justice system, welfare recipients, those involved with Child Protective Services, and adults in the prison system or community corrections.[4] Many of the individuals served through these systems are either members of the military themselves or family members of the military.

One major difference between the mental health and substance abuse services offered through traditional channels (e.g., TRICARE, VA, or DMHDDSAS system) and those offered through one of these other publicly funded treatment programs is that the latter systems are more coercive in nature. As noted earlier, some people who have mental health or substance abuse problems choose not to seek services because of the stigma or because they do not believe they have a problem. For some of these individuals, the only time they may seek mental health or substance abuse services is if they are required to do so. A youth may be required to obtain services through the Juvenile Justice system. Adults may be required to undergo substance abuse or mental health screening, assessment, or treatment in order to receive welfare benefits (Work First), to keep their children (child welfare system), to restore their driver's license (driving while impaired), or to maintain or restore their freedom (as a condition of probation or parole).[4]

m This estimate is based on supporting 20 new practices in their collocation efforts at a cost of $25,000 over two years and training 40 new providers (at a cost to be determined) to function in these settings. The total could change on the basis of the number of practices and providers. This is the maximum number that the Office of Rural Health and Community Care estimates it could support each year.

These systems are described briefly below:

- ***Juvenile Justice:*** The North Carolina Department of Juvenile Justice and Delinquency Prevention (DJJDP) provides prevention and treatment services to reduce delinquency and to treat juvenile offenders. Juveniles involved with DJJDP are assessed to determine their risks and needs. In 2007, 43% of juveniles involved in DJJDP were determined to need further assessments or treatment for substance abuse, and 75% were determined to have mental health needs. DMHDDSAS offers substance abuse screening, assessment, and treatment and supports 71 counties through Juvenile Justice/Substance Abuse/Mental Health Partnerships (formerly known as the Managing Access for Juvenile Offender Resources and Services [MAJORS] program).

- ***Work First/Child Protective Services (CPS):*** The North Carolina Division of Social Services (DSS), within the North Carolina Department of Health and Human Services, administers Work First and the CPS system. Work First provides time-limited cash assistance to families with dependent children to help them move into employment and self-sufficiency. Mental health and substance abuse disorders are major barriers that prevent many families from moving to self-sufficiency. All Work First applicants and recipients are screened for possible substance abuse problems and offered a voluntary mental health screening. If the individual is determined to be at high risk for having a substance abuse disorder, then he or she is referred to a Qualified Professional in Substance Abuse for additional assessment and treatment. Adults must participate in the screening and recommended treatment in order to receive Work First benefits.

  The CPS system is designed to help protect children who have been victims of abuse or neglect. There have been two studies in North Carolina that suggest that child maltreatment may be more prevalent in military families than in the civilian population[32,33]; however, most of the published literature is more mixed.[34] Regardless, child maltreatment is a problem for some children of military personnel just as it is for some children of civilian parents. In the approximately nine-month period between July 1, 2009, and March 15, 2010, there were 216 cases of substantiated child abuse and neglect cases in North Carolina involving parents or caretaker relatives who were connected to the military (North Carolina Central Child Protective Services Registry. Special data run, March 23, 2010). Furthermore, this problem is exacerbated by the use of alcohol or other drugs. Nationally, studies by the Child Welfare League of America showed that alcohol and/or drug abuse contributed to at least 75% of the cases when children enter foster care.[35]

  The DSS and DMHDDSAS developed the Work First/CPS Substance Abuse Initiative to help with early identification of Work First recipients

**For some of these individuals, the only time they may seek mental health or substance abuse services is if they are required to do so.**

with substance abuse problems severe enough to affect their ability to find and maintain employment, and to help parents involved with CPS who have substance abuse problems. The program operates out of LMEs. Each LME receives funding from DMHDDSAS to hire Qualified Professionals in Substance Abuse (QPSAs). The QPSAs are outstationed, when possible, at the local Departments of Social Services to provide screening, assessment, care coordination, and referral into treatment. The QPSAs make a referral to the appropriate level of care, and the substance abuse provider, consumer, and Work First caseworker (if applicable) develop a person-centered plan to meet the consumer's treatment needs. Although these services do exist through many local DSS offices, there are neither sufficient QPSAs nor sufficient treatment services to serve all in need. In 2007, the federal government determined that the lack of substance abuse services—both in terms of accessibility and the array of services—was a concern.[36]

**Military personnel aged 18 to 25 and those aged 26 to 35 were significantly more likely to report rates of heavy drinking than were corresponding groups in the civilian population.**

- ***Driving While Impaired:*** As noted in Chapter 3, between 1998 and 2008, the percentage of active duty service personnel who reported engaging in binge drinking increased significantly in all branches of the military.[37] In addition, military personnel aged 18 to 25 and those aged 26 to 35 were significantly more likely to report rates of heavy drinking than were corresponding groups in the civilian population.[n] Active duty service personnel who are heavy drinkers are more likely to engage in risk-taking behaviors, including drinking while driving. Motor vehicle crashes are a leading cause of injury and death for active duty military personnel.[38]

  North Carolina has a specialized substance abuse intervention system for people convicted of driving while impaired (DWI). Individuals convicted of this criminal offense have their driver's licenses revoked, must undergo a substance abuse assessment, and must complete an educational or treatment program to have their licenses restored.[4] These services are typically provided by private agencies.

- ***Criminal Justice System: Community Corrections:*** There are numerous points in the criminal justice process at which a person with mental health or substance abuse services can be coerced into treatment. Most adults who have been convicted remain in the community, where they are supervised and referred to services and supports. Individuals who have substance abuse or mental health disorders may be required to seek treatment as a condition of their probation or parole. There are different programs available to individuals, depending on where they live and the nature of their underlying health problem. For example, DMHDDSAS administers the Treatment Accountability for Safer Communities (TASC)

n Binge drinking is defined as having consumed five or more drinks (four or more for women) on at least one occasion in the past 30 days. Heavy drinking is defined as having consumed five or more drinks on the same occasion at least once a week during the past 30 days.

program. TASC provides screening, assessment, and care management services to people with substance abuse and mental health disorders. TASC services are available in all 100 counties across the state. The Division of Community Corrections, North Carolina Department of Corrections, funds the Criminal Justice Partnership Program (CJPP). CJPP provides grants to support community-based programs, including some programs targeted to both individuals with mental health disorders and those with substance abuse disorders. In addition, the Administrative Office of the Courts operates mental health treatment courts, adult and youth drug treatment courts, and family courts in various district courts throughout the state.[o] The drug and mental health treatment courts are targeted to individuals with substance abuse disorders or mental health needs who have been convicted but who could remain in the community with appropriate supervision, treatment, and support services.

- ***Prison system:*** Most prisoners receive an assessment upon entering North Carolina prisons. Approximately 90% of the criminals who enter the prison system have a substance abuse disorder, and 27.6% have a mental health problem.[39]

**Approximately 90% of the criminals who enter the prison system have a substance abuse disorder, and 27.6% have a mental health problem.**

Service members, veterans, and their families affected by traumatic brain injury and other disabling mental health disorders may need additional types of support. The Division of Vocational Rehabilitation (DVR) within the North Carolina Department of Health and Human Services is the lead agency that helps people with disabilities obtain jobs. Specifically, DVR helps people with disabilities with job development, placement, and training. DVR has 77 local offices. DVR and its partner agencies provide services that support people in their efforts to obtain meaningful work, with the goal of supporting people in competitive employment. Some of the services that DVR, local offices, or partner agencies provide include evaluation and counseling, benefit counseling, employment services, services to employers, rehabilitation engineering and assistive technology, community rehabilitation, and supported employment.

Some service members, veterans, and their families can benefit from the use of assistive technology (AT). Assistive technology—for example, ambulatory aids, speech-generating devices, modified tools, educational software, and modified vehicles—is used to increase the independence of individuals with disabilities. Use of AT can help individuals to participate in school, work, and their community

o Mental health treatment courts are currently operating in Guilford, Orange, and Mecklenburg district courts. Adult drug treatment courts are available in 20 counties including Avery, Watauga, Brunswick, Buncombe, Carteret, Catawba and Burke, Craven, Cumberland, Durham, Forsyth, Guilford/Greensboro, Guilford/High Point, McDowell, Mecklenburg, New Hanover, Orange, Person and Caswell, Pitt, Randolph and Wake. Youth drug treatment courts are available in four counties: Durham, Forsyth, Mecklenburg, and Wake. Family courts are operating in Durham; Anson, Richmond, Stanly, and Union; Mecklenburg; New Hanover and Pender counties; Halifax; Cumberland; Greene, Lenoir and Wayne; Burke, Caldwell and Catawba; Buncombe; Wake; Pitt; and Montgomery, Moore and Randolph counties. Family Dependency/ Drug Treatment Courts operate in the counties of Alamance, Buncombe, Chatham, Cumberland, Durham, Halifax, Lenoir, Mecklenburg, New Hanover, Orange, Robeson, Union, and Wayne. Information available at: http://www.nccourts.org/Courts/Default.asp

with a few modifications or adaptations.[40] The North Carolina Assistive Technology Program (NCATP) provides assistive technology services, including device demonstrations, device loans, technical assistance, assessments, and training through workshops and seminars.

In addition to state-funded mental health and substance abuse treatment programs, North Carolina operates CARE-LINE, which is the North Carolina Department of Health and Human Services toll-free information and referral telephone service. Specialists provide information and referrals regarding human services in government and nonprofit agencies. In FY 2010, the funding was decreased so that CARE-LINE no longer operates 24 hours a day, 7 days a week. Crisis calls are redirected to the National Suicide Prevention Lifeline after hours. CARE-LINE is an important resource and should have well-trained staff who are available and competent to handle a variety of behavioral health referrals 24 hours a day, 7 days a week.

In order to expand CARE-LINE, the Task Force recommended:

## Recommendation 5.6

**The North Carolina General Assembly should appropriate an additional $128,502 in recurring funds to the North Carolina Department of Health and Human Services to expand CARE-LINE, in order to ensure the competency and capacity to handle crisis calls, including potential suicides, in a timely manner, and to ensure that telephone counselors are available 24 hours/day, 7 days/week, 365 days/year.**

### Coordination of Federal and State Behavioral Health Services

Although many service members and their families seek behavioral health services in either the federal or the state system, many service members, veterans, and their families transition between these systems. To better serve their behavioral health needs, it is necessary to have improved transition services between military health, veterans, and state-funded Mental Health, Developmental Disabilities, and Substance Abuse Systems.

In order to improve transition and integration of services between military health, veterans, and state-funded systems, the Task Force recommended:

## PRIORITY Recommendation 5.7

**The North Carolina Division of Mental Health, Developmental Disabilities and Substance Abuse Services should:**

**a) Continue the work of the Governor's Focus on Servicemembers, Veterans, and Their Families.**

**b) Continue to ensure that each Local Management Entity (LME) has at least one trained care coordination staff member to serve as the point of contact for TRICARE, the North Carolina National Guard's Integrated Behavioral Health System (e.g., Behavioral Health Clinicians and Military and Family Life Consultants), the Army Reserve Department of Psychological Health, the Department of Veterans Affairs (VA), and the North Carolina Department of Corrections to enable active duty and reserve components, veterans, and their families to access state-funded services when they are not eligible for federally funded mental health or substance abuse services.**

**c) Develop a required training curriculum for LME staff members who provide screening, treatment, and referral services. The training should be available in person and online and should include but not be limited to information about:**

**1) The numbers of North Carolinians who are serving or who have served in the active duty and reserve components living in their catchment areas.**

**2) The types of mental health and substance abuse disorders that these service personnel and their families may have experienced, including but not limited to traumatic brain injury, posttraumatic stress disorder, depression, substance use disorders, potential suicide risks, military sexual trauma, and domestic violence.**

**3) Available referral sources through TRICARE, VA, Military One Source, Army One Source, Defense Center of Excellence Deployment Health Clinical Center, North Carolina National Guard's Integrated Behavioral Health System, Army Reserve Department of Behavioral Health, North Carolina DHHS Office of Citizen Services (e.g., CARE-LINE and CARE-LINK), North Carolina Health Info, Federally Qualified Health Centers, professional advocacy and support services, and other community resources.**

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