Executive Summary

Our military men and women and their families are heroes who risk their lives in their mission to protect our freedom. There is a strong commitment to ensuring they have the resources they need to complete the mission and return home safely, but a safe return home does not always ensure that they have the services and support they need once they get home. The two most common health issues diagnosed in service members of the wars in Iraq and Afghanistan who seek care at the US Department of Veterans Affairs are musculoskeletal and mental health problems.[1] There are excellent systems in place to treat the physical wounds, but treating behavioral health problems is often complicated by several barriers including stigma, lack of behavioral health providers, and lack of coordination between the federal, state, and local systems of health care.

The North Carolina Institute of Medicine (NCIOM) Task Force on Behavioral Health Services for the Military and Their Families

The North Carolina General Assembly (NCGA) recognized the need to provide services and supports to meet the behavioral health needs of the service men and women in North Carolina when federal resources are not available. The NCGA asked the NCIOM to study the adequacy of mental health, developmental disabilities, and substance abuse services funded with Medicaid and state funds that are currently available to active and reserve component members of the military, veterans, and their families and to determine any gaps in services.[a] Funding support for the Task Force was provided by the North Carolina Department of Health and Human Services Division of Mental Health, Developmental Disabilities, and Substance Abuse Services through the North Carolina Substance Abuse Prevention and Treatment Block Grant from the Substance Abuse and Mental Health Services Administration.

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The Task Force was co-chaired by Representative Grier Martin, JD, LLM, North Carolina House of Representatives, an Afghanistan war veteran; Senator William R. Purcell, MD, North Carolina Senate, a veteran; and Michael Watson, Deputy Secretary for Health Services, North Carolina Department of Health and Human Services, a Vietnam war veteran. They were joined by 43 other Task Force and Steering Committee members, including active duty service members, veterans, family members, legislators, behavioral health personnel, federal and state agency representatives, and other community members. The Task Force met 11 times between November 2009 and December 2010. The Task Force made 13 recommendations, four of which were priority recommendations. The recommendations are summarized in this executive summary. A full listing of the recommendations is included in Appendix A of the report.

a Section 10.78(ff) of Session Law 2009-451; Sections 16, 19 of Session Law 2009-574

Service Members and Their Families in North Carolina

North Carolina is home to the fourth largest military population in the country. Our military personnel are represented in each branch of the military: Army, Marines, Navy, Air Force, and Coast Guard. There are currently 120,000 active duty personnel based at one of the seven military bases or deployed overseas. In addition, our state is likely to receive 15,000 additional active duty members by 2013 as military installations close in other states. Another 45,000 soldiers, marines and airmen live in all 100 counties of North Carolina and serve in the National Guard or Reserve. There are nearly 800,000 veterans who live in our state, which places North Carolina fifth in military retiree population and ninth in veteran population in the country.[2] More than 103,000 children and adolescents of active and reserve components live in North Carolina.[b] There are also 9,300 surviving spouses of deceased veterans in the state.[2] Approximately one-third (35%) of the state's population is in the military, a veteran, spouse, surviving spouse, parent, or dependent of someone connected to the military. These families live, work, study and play in every county of the state.

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Since September 2001, more than two million troops have been deployed in support of Operation Iraqi Freedom (OIF), Operation Enduring Freedom (OEF) and Operation New Dawn (OND).[1] These wars are very different than previous wars and have lasted longer. The military is an all volunteer force. Rather than drafting additional service members, the United States deploys current service members multiple times, for longer lengths of time, and with less time at home between deployments. There is also an increased use of Reserve and National Guard service members and increased numbers of deployed women and parents of young children. The physical environment in Iraq and Afghanistan exposes service members to more direct involvement, both in traditional combat theater and support roles. Although there is more exposure to violence, service members are now surviving more than 90% of injuries that in previous wars would have resulted in death.[1,3] In consequence, North Carolina has welcomed home a higher percentage of active and reserve service members with traumatic brain injury (TBI), post traumatic stress disorder (PTSD), other mental health problems, or substance use disorders than in past conflicts.

Military service members and their families face unique challenges, including deployments and transitions. Military families move an average of every two to three years.[3]These frequent relocations disrupt systems of support and interfere with careers and school for military families. In addition to these challenges, these service members and families have languages, traditions, perspectives and values that represent a distinct culture. Aspects of the military culture, including honor, resilience, and self sacrifice, help service members achieve their mission in stressful conditions. However, the self-sacrifice and "just deal with it" attitude can create a significant barrier to seeking care when problems

b Fang WL. Director for Research and Evaluation, Governor's Institute on Alcohol and Substance Abuse. Written (email) communication. September 21, 2009.

arise. Service members may overestimate their abilities to cope and may not seek care when it is needed.

TBI, Mental Health and Substance Use Disorders

The stress of combat and military service has lasting psychological and behavioral effects on our service members and their families. For example, there are estimates that as many as 19% of active and returning veterans have experienced a TBI, 12% to 25% have PTSD, and 20% to 45% have problems with alcohol use.[4-7]

TBI is an injury that "is caused by a bump, blow, or jolt to the head or a penetrating head injury that disrupts the normal function of the brain." Similar to civilians, military personnel can sustain TBI from falls, assaults, and motor vehicle crashes. In combat settings, these injuries may also be caused by firearms and by blasts.[8] The manifestations and consequences of traumatic brain injury vary widely. Patients with moderate or severe TBIs may have residual impairments affecting a wide range of brain functions, such as cognition, communication, emotion, memory, social behavior, and/or motor function.[9] Both the Departments of Defense and Veterans Affairs have issued treatment protocols to help practitioners treat service members with TBI. In order to provide the most up to date TBI service in a coordinated system, the Task Force recommends:

Recommendation 5.1: Expand the System of Care for Traumatic Brain Injury (TBI)

The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services and military partners should collaborate to determine gaps in current TBI treatment system. They should develop an accessible community-based neurobehavioral system of care for service members with traumatic brain injury and services should be available to service members, veterans, and their families.

Recommendation 5.2: Expand TBI Diagnostic Testing

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 appropriate evidence-based diagnostic testing for screening and assessment of traumatic brain injury is used.

Combat environments can also lead to PTSD among some service members. PTSD is a type of anxiety disorder that develops following an extreme event in which one either directly experiences or observes circumstances that threaten or lead to grave harm. This traumatic event is experienced with a profound sense of fear, helplessness, and/or horror.[10,11] People who have PTSD may experience

symptoms such as intrusive recollections, avoidant/numbing behavior, and hyperarousal. The degree of combat experience seems to increase the risk and severity of PTSD symptoms.[12] Data show that between 12% to 17% of active duty members and 13% to 25% of reserve component personnel meet screening criteria for PTSD upon return from deployment and a higher prevalence is seen six months later.[6] The Departments of Defense and Veterans Affairs recently updated Clinical Practice Guidelines for providers caring for patients with PTSD.[13]

In addition to TBI and PTSD, many service members experience other behavioral health problems such as depression, panic attacks, phobias, and generalized anxiety. Some have suicide ideation, and too many other service members commit suicide. Service members are at heightened risk for interpersonal conflict when they return home, including domestic violence or child abuse.[6,14] In addition, some service members suffer from military sexual trauma.

Service personnel often experience multiple overlapping behavioral health problems which further complicate diagnosis and treatment for service members, veterans, and their families.

Alcohol use continues to pose a significant problem for the armed services, with 20% of surveyed active duty service members reporting heavy drinking. Compared with the use of tobacco and alcohol, the use of illicit nonprescription drugs, such as marijuana, cocaine, and heroin, appears to be a less common problem among active duty military personnel. However, an increase in reported prescription drug misuse has been observed during the past six years.[4] Even when service members are identified as needing substance abuse counseling and treatment, very few actually receive the needed services.[6]

Service personnel often experience multiple overlapping behavioral health problems which further complicate diagnosis and treatment for service members, veterans, and their families. Federal, state, and public health care systems need to not only be aware of these disorders in the military population, but work together to ensure that all the needs of the population is met.

Federal Health System

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 through TRICARE and the Department of Veterans Affairs (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. However, gaps remain.

TRICARE and Military Treatment Facilities: Active duty service members who are stationed on or near a military base will generally receive health services at a military treatment facility (MTF). If services are not available through the MTF, then the active duty service members or their family members can receive care through private (civilian) providers. TRICARE insurance programs are available to active duty service members, their families, retirees, and certain veterans. While TRICARE offers coverage for comprehensive behavioral health services,

barriers remain which make it difficult for active duty, family members, and retirees to access services. First, TRICARE is not available to all National Guard or Reservists. Additionally, TRICARE may not have sufficient numbers of behavioral health professionals in their networks and some providers are unfamiliar with military culture or the potential effects of deployment stress on military members, veterans, and their families.

Department of Veterans Affairs (VA): Health care coverage for veterans falls within the purview of the Department of Veterans Affairs (VA). To be eligible for enrollment in VA, a veteran must have served for at least two years (unless injured while on duty) and cannot have been dishonorably discharged. All returning Iraq and Afghanistan veterans have access to VA services for five years. After the initial period, enrollment in VA is limited to veterans in one of the priority populations. Although VA has made significant strides in involving family members in the care of the veteran, it does not provide direct health services for family members.[15]

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

VA offers comprehensive behavioral health services to veterans enrolled into the VA system. In North Carolina, VA provides direct health services at four VA medical centers (hospital medical complexes), 12 community-based outpatient clinics (CBOCs), and five vet centers.[16] However, only 50% of eligible OEF/OIF veterans have enrolled into the VA system, and of these, fewer of the people who are expected to need behavioral health services actually seek care.[1] Further, despite significant growth in the number and distribution of VA facilities across North Carolina, the geography of our state and its significant rurality continue to comprise important barriers to access.

Programs for National Guard and Reserves: One of the major gaps in the TRICARE program is for National Guard and Reserves. The National Guard/ Reserves are only eligible for TRICARE once they are activated and called to active duty for more than 30 days. At that time, their family members also become eligible. Further, the distance between National Guard and Reserve members and their commands and comrades may not afford the same level of support system that is available to other members of the armed forces who are attached to a military unit once they return to civilian life. To address these gaps, the National Guard and Reserves have developed programs to provide additional support to National Guard and Reserve members and their families.

The North Carolina National Guard (NCNG) has developed programs that serve as a national model in support of Guard members. The NCNG Integrated Behavioral Health System is one-stop, telephonic portal to both clinical and support services that is available 24 hours a day, 7 days a week. The NCNG Reconstitution program, which also began recently, embeds the National Guard support services at the demobilization centers. 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.[17] In support of the innovative North Carolina National Guard programs, the Task Force recommends:

Recommendation 4.1: 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 (PRIORITY RECOMMENDATION)

The North Carolina General Assembly should appropriate $1,470,000 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. Funding for this program should be used to support full-time behavioral health clinicians and behavioral health case managers, peer support services, linkages with behavioral health treatment providers, and telepsychiatry in rural areas. Additional personnel and resources should also be collocated within the Family Assistance Centers.

A major goal of the Task Force was to help people access federal services to which they are entitled (whether through TRICARE or VA). Federal programs and insurance coverage should be the primary source of coverage for behavioral health services for our men and women who have served our country in the military. However, there are significant barriers that prevent active and former members of the armed services and their families from receiving necessary mental health and substance use services including eligibility (coverage) restrictions, costs, inability to access needed services due to lack of providers, and fear of adverse military consequences resulting from seeking mental or behavioral health services. Even when behavioral health issues are diagnosed, there is a gap between those who need services and those who receive them. In order to better meet the behavioral health needs of our service members and their families, the Task Force recommends:

Recommendation 4.2: Expand Access to Mental Health and Substance Abuse Professionals in the Military Health System

Congress should increase funding for behavioral health services with a special focus on Reserve and National Guard personnel. They should change TRICARE policies to allow licensed substance abuse and other mental health professionals to be credentialed through TRICARE. In addition, Congress should authorize VA staff time to provide family counseling, and should direct VA and the Department of Defense to work to integrate TBI community based day services for military and civilian personnel.

State Public Health System

Despite the laudatory efforts to expand the availability and accessibility of federal behavioral health resources, there are gaps and other barriers which make it difficult for active duty and reserve components, veterans, and their families to access these services. The Task Force examined how the state behavioral health system and other state-funded systems of care could help address some of these gaps.

Service members who have been discharged from active duty and reserve components may have access to private or public insurance coverage. However, many of the former members of the active duty, reserve components, and 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. Yet there are still barriers that the active duty, reserve components, veterans, or their families can experience in accessing needed services.

The Task Force examined how the state behavioral health system and other state-funded systems of care could help address some of these gaps that make it difficult to access services.

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. Services are typically provided through private providers under contract with Local Management Entities (LMEs).[18] 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.*

The Task Force also recognized the importance of improving the availability of behavioral health services and appropriate referrals into treatment in a primary care setting. Most people access primary care services at least once per year.[19] Thus, one way to improve access is to expand the provision of mental health, substance abuse, and other behavioral health services from primary care professionals. Primary care professionals should be trained to understand the potential medical, mental health, or substance abuse disorders of returning veterans and their families. Thus, the Task Force recommends:

Recommendation 5.3: Provide Training for Health Professionals and Hospital Administrators (PRIORITY RECOMMENDATION)

AHEC, along with state and federal partners, should provide additional outreach and training for health professionals and hospital administrators. These trainings should the number of active and reserve component members and veterans in their catchment area, military culture and deployment, behavioral health needs they may

have, evidence-based assessment and treatment tools, TRICARE, and available referral resources. The North Carolina General Assembly should appropriate $250,000 in one-time funds to the Area Health Education Centers program to develop new training resources for the topics they not yet developed.

As part of the partnership with Integrated, Collaborative, Accessible, Respectful and Evidence-Based care project (ICARE), AHEC and partner organizations also help train primary care professionals to provide evidence-based screening and treatment for depression. 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. In order to incentivize providers to incorporate best practices for the military into their practices, the Task Force recommends:

Recommendation 5.4: Improve Reimbursement to Behavioral Health Providers who Meet Certain Standards

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 that would provide additional reimbursement to behavioral health providers who meet certain quality of care standards. They should also work collaboratively with VA 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. 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. In order to expand collocation and integration of behavioral health and primary care services, the Task Force recommends:

Recommendation 5.5: Expand Collocation and Integration of Behavioral Health and Primary Care Services

The North Carolina Foundation for Advanced Health Programs through the Center of Excellence in Integrated Care should work in collaboration with partner organizations 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. The North Carolina General Assembly should appropriate $500,000 in recurring funds to the North Carolina Office of Rural Health and Community Care to help support the start-up or continuing education costs of collocation of licensed substance abuse and mental health professionals in primary care practices.

In addition to the services offered through DMHDDSAS, there are other publicly funded programs available to service members and their families. For example, the Department of Health and Human Services (DHHS) operates CARE-LINE, which is the DHHS toll-free information and referral telephone service. In 2009, CARELINE expanded its capacity to provide suicide prevention crisis services, as well as appropriate resources for service members and their families. However, the funding was decreased in FY 2010 so that it can no longer provide round the clock crisis services in addition to its information and referral. Thus the Task Force recommends:

Recommendation 5.6: Expand CARE-LINE

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 funding to support return to 24-hours/day, 7-days/week.

Although many service members and their families seek behavioral health services in either the federal or the state systems, 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 Services systems. Thus, the Task Force recommends:

Recommendation 5.7: Improve Transition and Integration of Services between Military Health, Veterans, and State-Funded Mental Health, Developmental Disabilities, and Substance Abuse Services Systems (PRIORITY RECOMMENDATION)

The North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMHDDSAS), other state and federal partners should improve transition and integration services between military and public systems by continuing the work of the Governor's Focus on Servicemembers, Veterans, and Their Families. DMHDDSAS should 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 military organizations. DMHDDSAS should develop a mandatory 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 information about the number of active and reserve component members and veterans in their catchment area, behavioral health needs they may have, and available referral resources.

Workforce, Outreach, and Research

A coordinated system of care for the military and their families needs sufficient providers and support to operate effectively. North Carolina, like the nation, has a shortage of trained mental health and substance abuse professionals. Between 1999 and 2004, 19 counties in the state had no or only one psychiatrist. During that same time, more than half of the counties in the state experienced a decrease in the number of psychiatrists.[20] In 2009, there were five North Carolina counties—Camden, Graham, Hyde, Tyrrell, and Warren—that did not have psychiatrists, psychologists, psychological associates, or nurse practitioners or physician assistants with mental health specialties.[21]

In addition to the shortage of substance abuse professionals, there are six counties with behavioral health providers who are eligible to participate in TRICARE, but these counties have no participating behavioral health providers who accept TRICARE. These counties are Alexander, Anson, Bertie, Clay, Greene, and Northampton. In addition, there are some licensed behavioral health providers in most of the other counties who choose not to participate in TRICARE, even though most would be eligible to do so. Of the more than 3,000 behavioral health providers in North Carolina who are currently eligible to participate in TRICARE, just more than 1,300 are participating.[21]

The shortage and maldistribution of behavioral health providers affects the entire state. The North Carolina Office of Rural Health and Community Care (NCORHCC) operates the National Health Service Corps and state funded loan forgiveness programs, which can be used to recruit certain types of mental health and substance abuse professionals into Health Professional Shortage Areas. However, these loan forgiveness programs are unlikely to be able to address all the behavioral health provider shortages in our state. Thus the Task Force recommends:

Recommendation 6.1: Expand the Supply of Trained Mental Health and Substance Abuse Professionals

The University of North Carolina (UNC) System, North Carolina Community College System, and other independent colleges and universities in the state should monitor and apply for any federal grant opportunities to expand training funds to increase the number of mental health and substance abuse professionals in the state. If efforts to obtain federal funding are unsuccessful or insufficient, the North Carolina General Assembly should appropriate $1.9 million beginning in FY 2011. This funding should be appropriated to the Governor's Institute on Substance Abuse to create a scholarship program to increase the number of qualified professionals in the field of substance abuse and mental health, and to the Area Health Education Center (AHEC) program to establish clinical training sites for additional behavioral health providers.

Because of the stigma in seeking behavioral health services, active and former service members and their families often turn to other veteran service organizations, community-based organizations and/or the faith community when they need help. North Carolina has many organizations with a direct mission to provide support and programs to the military population. The Citizen Soldier Support Program helps facilitate the development and sustainment of effective military and community partnerships in support of our reserve component members and families. Veteran service organizations provide a variety of support and links to key resources for veterans from many different military eras. The faith community is an important part of North Carolina culture as well as that of many military families.

As one of the most military-friendly states, North Carolina has a myriad of outreach organizations. In recognition of the services and commitments to our service members of these varied organizations, the Task Force recommends:

Recommendation 6.2: Provide Training for Crisis Workers, Veteran Service Organizations and Veteran Service Officers, Professional Advocacy and Support Organizations, and the Faith Community (PRIORITY RECOMMENDATION)

The Citizen Soldier Support Program, along with state and federal partners, should provide training for local crisis service providers, veteran service organizations and veteran service officers, professional advocacy and support organizations, and the faith community on behavioral health conditions that affect the military, eligibility for federal programs, and referral resources.

The Task Force also recognized the unique circumstances of children connected to military families in its recommendation to improve support for military children in the North Carolina school system including training for local educators on military children in their area, behavioral health issues that might affect them, and referral resources. The Task Force recommends:

Recommendation 6.3: Improve Support for Military Children in the North Carolina School System

The North Carolina State Board of Education should require Local Education Agencies (LEAs) to collect information on military children in their area. Each LEA should have a staff member trained on military children and the behavioral health issues that might affect them, as well as appropriate referral resources. The trained LEA staff member should provide similar trainings to school administrators, nurses, nurse aides, counselors, and social workers in the LEAs.

While there are many resources at the national, state and community level to support service members and their families, these services are not always well-coordinated. The Governor's Focus on Servicemembers, Veterans, and their Families is a Department of Defense, VA, state, and community partnership that works to ensure that service members and their families receive the best and most updated services available. In fact, North Carolina has received national recognition from the United States Substance Abuse and Mental Health Services Agency because of the work of the Governor's Focus group.[c]

c Substance Abuse and Mental Health Services Agency. Written (letter) communication. January 2001.

There is still much to learn about the military population and the ways to best serve them. North Carolina is home to world renowned research facilities that are studying these problems and their solutions. In recognition of this ongoing work, the Task Force recommended:

Recommendation 6.4: Expand Research to Improve the Effectiveness of Behavioral Health Services Provided to Active Duty and Reserve Component Service Members, Veterans, and their Families

The University of North Carolina, General Administration, in collaboration with other college and university partners should collaborate on research to address the behavioral health problems and challenges facing military personnel, veterans, and family members. Collaborative teams and faculty investigators should aggressively pursue federal funding from pertinent agencies to conduct this work.

Conclusion

Our service members, veterans and their families make tremendous sacrifices in their service to our state and nation. When they come home and face difficulties adjusting to their communities and family lives, it is our responsibility to honor their service by making sure they have access to quality behavioral health services. In order to meet that commitment, partners at the federal, state, and community level must work together to strengthen our military families.[22]

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