



Honoring Their Service:

A Report of the
North Carolina
Institute of Medicine
Task Force on
Behavioral Health
Services for the
Military and Their
Families

January 2011

North Carolina Institute of Medicine

Supported by funding from 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





North Carolina Institute of Medicine

shaping policy for a healthier state

The North Carolina Institute of Medicine (NCIOM) is a nonpolitical source of analysis and advice on important health issues facing the state. The NCIOM convenes stakeholders and other interested people from across the state to study these complex issues and develop workable solutions to improve health, health care access, and quality of health care in North Carolina.

The full text of this report is available online at <http://www.nciom.org>

North Carolina Institute of Medicine

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Acknowledgements

The North Carolina Institute of Medicine (NCIOM) created the Task Force on Behavioral Health Services for the Military and Their Families at the request of the North Carolina General Assembly in 2009. The North Carolina General Assembly directed 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. The NCIOM was also asked to determine any gaps in services (Section 10.78(ff) of Session Law 2009-451; Sections 16, 19 of Session Law 2009-574). 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 members committed one day a month from November 2009 until December 2010 to study these important issues. The Steering Committee members helped shape the meeting agendas and identify speakers and gave important input into the report and recommendations. The accomplishments of this Task Force would not have been possible without the combined effort of the Task Force and Steering Committee members. For a complete list of Task Force and Steering Committee members, please see pages 9-11 of this report.



The Task Force was supported by funding from 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.

The NCIOM Task Force on Behavioral Health Services for the Military and Their Families heard presentations from state and national experts on issues related to behavioral health, federal behavioral health programs, state funded behavioral health programs, military service members in North Carolina, and state and professional advocacy and support organizations. We would like to thank the following people for sharing their expertise and experiences with the Task Force: David Amos, TRICARE Field Operations Director, Health Net Federal Services; L. Worth Bolton, MSW, LCAS, CCS, Clinical Assistant Professor, Behavioral Healthcare Resource Program, School of Social Work, University of North Carolina at Chapel Hill; Gary L. Bowen, PhD, MSW, Kenan Distinguished Professor, School of Social Work, University of North Carolina at Chapel Hill, Chief Scientist, Jordan Institute for Families Faculty Group for Military Members, Veterans, and their Families; Major Robert Boyette, Casualty Operations Officer, North Carolina National Guard (NCNG); Colonel Jeffrey

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MAOM, VISN 6 Lead Women Veteran Program Manager, Department of Veterans Affairs; and Laura Yates, MSW, LCSW, Social Work Program Director, Division of Prisons, North Carolina Department of Corrections.

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Education Coalition, provided valuable information on resources for children of military families.

The Task Force would like to thank the members of a small group that was convened to address diagnostic testing and imaging issues for traumatic brain injury. The members of that group were Task Force member Robin Hurley, MD; Jennifer Meko, MD, Medical Director; Cindy Crandall, Senior Account Executive; and Deidra Cook, Director of Account Management, all with MedSolutions; and Diane Holder, RN, Nurse Consultant, Division of Medical Assistance, Practitioner and Clinical Services.

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In addition to the above individuals, the staff of the North Carolina Institute of Medicine contributed to the Task Force’s study and the development of this report. Pam Silberman, JD, DrPH, President and CEO, guided the work of the Task Force. Sharon Schiro, PhD, Vice President, provided behavioral health data analyses for the Task Force. Kimberly M. Alexander-Bratcher, MPH, Project Director, served as project director for the Task Force and greatly contributed to the report. Suzanne Bertollo, MD, MPH, former Research Assistant and Intern, served as a content expert and drafted the behavioral health section of the report. Paul Mandsager, Research Assistant and Intern, provided research skills and drafted the federal programs chapter of the report. Thalia Fuller, Administrative Assistant, assisted in coordination of Task Force meetings. Rachel Williams, MPH, Research Assistant, assisted in coordination of the Task Force meetings. Scott O’Brien, MA, MPH, Managing Editor, *North Carolina Medical Journal*, helped share the work of the Task Force through social media and an upcoming issue of the *Journal*. Adrienne Parker, Director of Administrative Operations, handled the business operations of the Task Force. Mark Holmes, PhD, former Vice President; Catherine Liao, MPH, former Project Director; Christine Nielsen Seed, former Managing Editor, *North Carolina Medical Journal*; and Jordan Parker, former Assistant, also contributed to the work of the Task Force and report.

Finally, the Task Force would like to dedicate this report to all current and former service members and their families of North Carolina. Their service and sacrifice deserves the appreciation of our state and the nation. We hope this report helps strengthen the systems of care that provide their behavioral health and other support needs.

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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.

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.



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

**Approximately
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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.

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

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

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.

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,

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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

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

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

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 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

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.

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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Our military men and women and their families are heroic, risking their lives or the lives of their loved ones for our safety and freedom. North Carolina has a strong connection to these courageous men and women, with the fourth largest number of military personnel 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. 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.

North Carolina is home to many veterans. 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.¹ Chapter 2 discusses the military members and their impact on North Carolina in more detail.

During the past 100 years, the United States has been involved in armed conflicts from World War I through the current conflicts in Iraq and Afghanistan. By its very nature, armed conflicts increase the risk of both physical and psychological harm. The likelihood of harm is increased when combatants are subject to multiple deployments. Our current engagements in Iraq (Operation Iraqi Freedom/OIF [now Operation New Dawn/OND]), and Afghanistan (Operation Enduring Freedom/OEF) have been particularly challenging. The United States has been engaged in these wars for more than nine years, longer than World War II. More than 2 million men and women have fought in Iraq or Afghanistan.^{2,3} These wars are being fought by an all-volunteer fighting force. This puts additional strain on the military, because they cannot draft more troops when needed. As a result, service members are subject to multiple deployments with much less time at home between deployments (dwell time).

Historically, battle lines were well-defined, and military service members deployed into theater were in less danger than those in combat. In OEF/OIF, there are no distinct battle lines. As the amount of time spent in armed conflict and in theater increases, so does the chance of physical or psychological injury. In the past, many people who experienced combat injuries would not survive. However, with our recent advances in medicine, we have been able to save a great majority of our injured service members. Thus, we have increasing numbers of active and returning service members and veterans living with significant injuries, including physical, mental health, and other behavioral health problems. The two most common health issues diagnosed among OEF/OIF veterans seeking US Department of Veterans Affairs (VA) health care are musculoskeletal and



By its very nature, armed conflicts increase the risk of both physical and psychological harm. The likelihood of harm is increased when combatants are subject to multiple deployments.

mental health problems.² More than half (50.2%) of all OEF/OIF veterans who have presented for VA health care report symptoms of possible behavioral health problems, including posttraumatic stress disorder (PTSD), traumatic brain injury (TBI), depression, affective psychoses, neurotic disorders, suicidal ideation, and drug and alcohol dependence. More information about substance abuse, mental health disorders, traumatic brain injury, and other needed services is discussed in Chapter 3.

Not only does active service in the armed forces affect the service member but also military service affects their families before, during, and after deployment. More than 100,000 children and adolescents of active and reserve components live in North Carolina. Children of military families in which one or more parents are deployed experience emotional and behavioral difficulties more often than other children. The longer the deployment, the more likely that a child will suffer social and emotional difficulty.⁴ Similarly, longer deployments are associated with increased mental health diagnoses in spouses.⁵ The effects of military service on family members are discussed further in Chapter 2.

Addressing the physical health needs of veterans can be challenging. However, it is often even more difficult to address the complex *behavioral health* needs of active and former members of the armed forces and their families. Behavioral health includes mental health, substance use disorders, and traumatic brain injury. Understanding the nature of the military culture, combat, and the stresses of living and working in a war zone is critical for behavioral health providers to establish credibility with clients. Nonetheless, many active and former service members and veterans choose not to seek behavioral health services because of the stigma attached to these conditions. Furthermore, active duty personnel are sometimes concerned that seeking mental health or substance abuse services may jeopardize their military careers.

Active duty service members and their families can receive medical and behavioral health services through military treatment facilities and TRICARE, the health benefit program for services mainly offered by civilian providers. TRICARE is available to service members and their families while on active duty or for a short transition period after leaving the military. However, TRICARE is generally not available to people once they leave the armed forces unless they have retired with 20 or more years of service. VA provides health care services to eligible veterans through four VA medical centers and eight community-based outpatient clinics (CBOCs) across the state. But, only 50% of those who are eligible use VA health services.³ Unlike TRICARE, the VA system does *not* provide direct services to family members except for care involving the well-being of the veteran (e.g., couple's counseling). However, individual, group, and family counseling is available to any combat veteran or bereaved spouse through any of the five storefront vet centers located in North Carolina. Thus, although the United States offers health services to active and former military

Addressing the physical health needs of veterans can be challenging. However, it is often even more difficult to address the complex behavioral health needs of active and former members of the armed forces and their families.

personnel, there are gaps in coverage for both the service member and his or her family. Eligibility for military health and behavioral health services is described in Chapter 4. Furthermore, as noted above, some people who do have access choose not to seek services within the military, TRICARE, or VA systems. State-funded services can help fill in some of the gaps.

The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMHDDSAS) is charged with providing state-funded behavioral health services in North Carolina. The resources vary by region. Behavioral health services are managed by Local Management Entities (LMEs) across the state. However, because of limits in state funding, mental health and substance abuse services are not available to serve all the current and former military members who need services. Chapter 5 discusses service availability among the civilian population.

The needs of military families are unique and need to be understood by those who provide services to them. When service members and families seek behavioral health services and other support, they need providers who understand military culture and other aspects of military service. The North Carolina Area Health Education Centers, the Citizen Soldier Support Program, and other partners have developed a series of trainings to help a variety of service providers understand more about the military in North Carolina. Chapter 6 will discuss more about military outreach, training for providers of services, and research.

Task Force on Behavioral Health Services for the Military and their Families

The North Carolina General Assembly directed the North Carolina Institute of Medicine (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. The NCIOM was also asked to determine any gaps in services (Section 10.78(ff) of Session Law 2009-451; Sections 16, 19 of Session Law 2009-574). The Task Force was co-chaired by Representative Grier Martin, JD, LLM, North Carolina House of Representatives; Senator William R. Purcell, MD, North Carolina Senate; and Michael Watson, Deputy Secretary for Health Services, North Carolina Department of Health and Human Services. It included 43 other Task Force and Steering Committee members. (See pages 9-11 for a complete list of Task Force and Steering Committee members.) The Task Force was asked to provide an interim report to the 2010 Session of the North Carolina General Assembly and a final report to the 2011 Session. The Task Force was supported by funding from 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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Work of the Task Force

The Task Force met a total of 11 times between November 2009 and December 2010.

The report includes 7 chapters, the first being this brief introduction. Chapter 2 describes the various components of the military population in North Carolina and their families. Chapter 3 reviews behavioral health needs of the military, including posttraumatic stress disorder, depression, suicidal ideation, substance abuse, and traumatic brain injury. Chapter 4 summarizes eligibility for military health and behavioral health services. Chapter 5 describes the availability of services in the civilian population, including those services provided by the North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services. Chapter 6 describes the behavioral health workforce; outreach to active and former service members, veterans, and their families; and research. Finally, Chapter 7 summarizes the Task Force recommendations.

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Impact of Military Members and Their Families on North Carolina

Chapter 2

North Carolina has a proud, strong connection to the military. Currently, approximately 35% of the state's population is a military service member, veteran, spouse, surviving spouse, parent, or dependent of a current or former military service member. These service members and their families work to protect our freedom and keep us safe. Given the tremendous sacrifices these service members and families have made for our country, it is incumbent upon our nation and state to ensure they receive the support and services they need. The federal health system generally does a good job treating the physical wounds of war. However, there are gaps in meeting the behavioral health needs of the military service members, veterans, and family members. For the purposes of this report, behavioral health problems comprise mental health conditions (such as posttraumatic stress disorder [PTSD], depression, and anxiety-related conditions), military sexual trauma (MST), traumatic brain injury (TBI), and substance use disorders (SUD) that are caused by, or exacerbated through, the military experience of the service member or a family member.

This report refers to the military as a single population. In reality, the military consists of three distinct types of service:

1. Active duty service members (ADSMs) are enlisted and officer, full-time employees of the United States Armed Forces.
2. National Guard and Reserve personnel constitute the reserve component of the military and usually work part-time for the United States Armed Forces. There are distinctions between the two types of service but also many similarities in their experiences.
3. Veterans are former members of the active duty or reserve components who, depending on their type and length of service, may continue to be connected to the military.

The United States Armed Forces are composed of the Army, Marines, Navy, Air Force, and Coast Guard. All five of the branches were originally under the direction of the United States Department of Defense, but the Coast Guard was transferred to the Department of Homeland Security in 2001. The military services are composed of both active and reserve components. Each branch of the military has a reserve component; these reserve forces augment the forces on active duty.

Active Component

Active duty service members are full-time employees of their respective military branches. Most ADSMs are assigned to a unit located on a specific military installation. They have access to a variety of services and supports provided on those military installations. In addition, they have the support of other service members with a similar set of experiences.



Approximately 35% of the state's population is a military service member, veteran, spouse, surviving spouse, parent, or dependent of a current or former military service member.

The state has the fifth highest number of total military personnel per capita and ranks fourth nationally in active duty military personnel per capita.

Reserve service members of all five branches total 22,517 Selected Reservists and 8,375 Individual Ready Reservists.

Nearly 10% of all United States ADSMs live in North Carolina. The state has the fifth highest number of total military personnel per capita and ranks fourth nationally in active duty military personnel per capita. There are currently 120,000 ADSMs based at one of the seven military installations or deployed overseas. North Carolina is likely to receive 15,000 additional active duty members by 2013 as military installations close in other states.^{1,2}

Reserve Component

The reserve component comprises both the Reserve and the National Guard. Although there are many similarities between these two reserve components, there are also key differences. Thus, the two reserve components are described separately to clarify their structure, function, and impact on North Carolina.

Reserve

The Reserve is a diverse group. Each of the five military branches has Reserve units; this discussion will focus on the Army Reserve. The Army is the largest and longest-established branch of the military in the nation and in North Carolina. Reserve units include both Selected and Individual Ready Reserves. The Selected Reserve is made up of:

Troop Program Unit (TPU): The Troop Program Unit is an Army Reserve soldier assigned to an Army Reserve unit and required to perform training one weekend each month and 14 days active duty training (ADT) per year. The TPU soldier is commonly referred to as a “Drilling Reservist.” There are 5,784 TPU soldiers in North Carolina.

Active Guard Reserve (AGR): The Active Guard Reserve soldier supports and enhances the mobilization readiness of the Army Reserve. AGR soldiers serve full time and enjoy the same benefits and entitlements as an active duty soldier, including medical care for themselves and their immediate family and the opportunity for immediate retirement after 20 years of active service. Soldiers serving within the AGR program are stationed worldwide in positions that directly support the Army Reserve. There are 568 AGR soldiers in North Carolina.

Individual Mobilization Augmentee (IMA): The Individual Mobilization Augmentee program’s overall objective is to facilitate the rapid expansion of the Active Army wartime structure of the Department of Defense and/or other departments or agencies of the US Government to meet military manpower requirements. The IMA soldiers are subject to immediate, involuntary order to active duty whenever there is a presidential reserve call-up (PRC)^a and in time of war or national emergency when declared by the President or Congress.^b Drilling IMA (DIMA) positions are identified as critical elements for mobilization during PRC, requiring an incumbent to maintain an even higher level of proficiency than a regular IMA soldier. Soldiers assigned to DIMA positions are authorized

a 10 USC 12304

b 10 USC 12301, 12302, or 12303

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to perform training up to two weekends each month. There are 121 IMA soldiers in North Carolina.

The “Ready Reserve” consists of the Selected Reserve, mentioned above, as well as the Individual Ready Reserve (IRR). IRR soldiers do not belong to an Army Reserve unit but still have a military service obligation (MSO) to fulfill. Many IRR soldiers have served several years on active duty and have been transferred to the IRR to fulfill the remainder of their eight-year MSO. Each IRR soldier is required annually to meet minimum requirements that include updating personal contact information, attending muster duty, updating a readiness screening questionnaire online, and responding to official military correspondence. IRR soldiers may also be involuntarily mobilized in time of national crisis.^c There are 2,244 IRR soldiers in North Carolina.

In total, the Army Reserve operates 43 facilities across North Carolina. Reserve service members of all five branches total 22,517 Selected Reservists and 8,375 Individual Ready Reservists.^d These Reserve service members may be commanded by a number of headquarters across the southeast and the nation.

National Guard

In addition to the Reserve, North Carolina—like all states—is home to the National Guard. The National Guard has the dual mission of serving their state and the nation. The National Guard provides for the defense of their respective states and can be called upon for military service by order of the President of the United States. Because of this dual mission, the North Carolina National Guard is under the authority of the Governor of North Carolina but is also part of the reserve component of the Department of Defense.³ Both the Army and the Air Force have a National Guard structure. There is no National Guard structure for the Marines, Navy, or Coast Guard.

The North Carolina National Guard (NCNG) includes 11,792 traditional service members, who serve part-time, and 2,076 full-time employees.^e The average age of the NCNG members is 34. Service members of the NCNG are demographically different from their active duty counterparts, with a higher proportion of women, married members, and people with dependent children serving in the NCNG. The NCNG have 101 Army locations and 3 Air Force locations in 75 North Carolina counties.^{3,4}

Veterans

The proportion of the population in North Carolina that is veterans is higher than the proportion of the population in the nation that is veterans. Veterans constitute more than 13% of the adult population in North Carolina, compared

The North Carolina National Guard is under the authority of the Governor of North Carolina but is also part of the reserve component of the Department of Defense.

The North Carolina National Guard (NCNG) includes 11,792 traditional service members, who serve part-time, and 2,076 full-time employees.

^c Bukaweski T. Army Reserve Legislative Liaison (South-East). Written (email) communication. September 21, 2010.

^d Meed J. Research Associate, Citizen Soldier Support Program. Written (email) communication. March 24, 2009.

^e Personal communication with North Carolina National Guard. The Adjutant General Command Brief, October 15, 2010.

with 10% nationally.^f There are nearly 800,000 veterans who live in the state. More than 90% of them are men, but the proportion of women is growing. There are also 83,000 military retirees.^g That places North Carolina fifth in military retiree population and ninth in veteran population in the country.^{1,5}

Families

Along with a strong military member presence, North Carolina is home to many military families. Almost 35% of the North Carolina population is in the military or is a veteran, a spouse, a parent, or a dependent of a military member. More than one-third (37%) of active duty service members are married with children, and 6% are single parents. Active component service members with children have an average of two children. In the North Carolina National Guard, 57% are married and 52% have at least one child. More than 103,000 children and adolescents of active and reserve components live in North Carolina. Almost 45,000 of these children are younger than six years old, 37,000 are between the ages of 6 and 12 years, and almost 21,000 are between the ages of 13 and 18 years.^h There are also 9,300 surviving spouses of deceased veterans in the state. These families live, work, study, and play in every county of the state.^{1,3,5,6}

Distribution across the State

North Carolina is home to military installations for each of the branches. The Army base, Fort Bragg, is located in Fayetteville. There is a Marine Corps Air Station (MCAS) at Cherry Point and one at New River, and a Marine Corps Base (MCB), Camp LeJeune, near Jacksonville. The Navy also operates through the Marine Corps Base. Air Force Bases (AFBs) include Seymour Johnson, near Goldsboro, and Pope, near Fayetteville. The Coast Guard has a Sector near Morehead City and a Support Center near Elizabeth City. The Reserve members are typically assigned to units all across the country but have 43 facilities across

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Table 2.1
Military and Family Members in North Carolina

Variable	Active Duty	Reserves	National Guard
No. of service members	110,286	22,749	13,868
Percentage of service members who are married	55.8% [^]	n/a	57%
Percentage of service members who have children	43.7% [^]	n/a	52%
No. of children	138,714 [*]	n/a	8,731

n/a - Data are not available. *Number of dependents on military installations. Represent national percentages. Active Duty and Reserve data source: US Department of Defense. 2009 Demographics Profile of the Military Community. Available at http://cs.mhf.dod.mil/content/dav/mhf/QOL-Library/PDF/MHF/QOL%20Resources/Reports/2009_Demographics_Report.pdf. National Guard data source: Personal communication with North Carolina National Guard. The Adjutant General Command Brief. October 15, 2010.

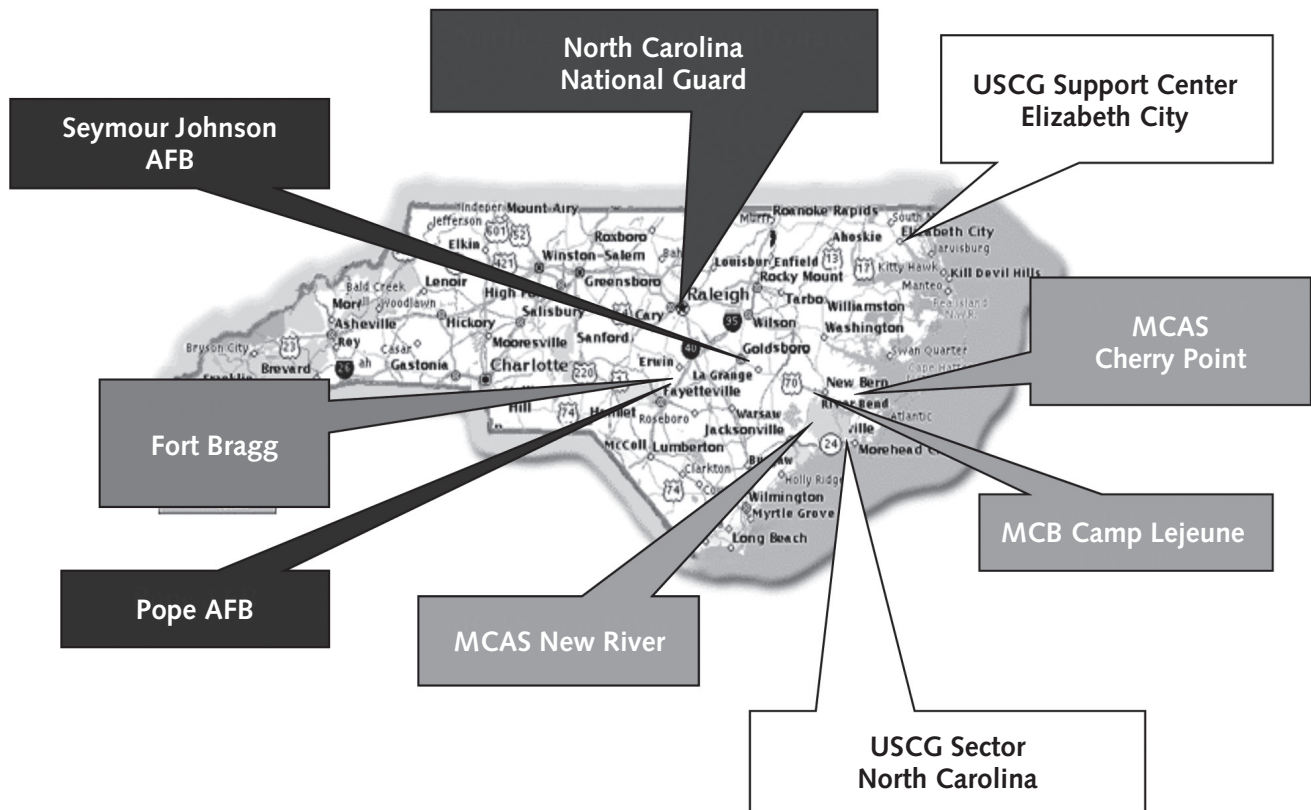
f The term veteran is defined various ways. In this report, it will be used to describe people who have served in any branch of the military.

g A military retiree is defined as a former service member who completed a career of service in the military and who receives special recognition in the form of pension and/or other benefits.

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

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Figure 2.1
North Carolina Military Installations



Source: Adapted from Smith CF. NC Department of Administration NC Division of Veteran Affairs. Talk presented to: North Carolina Institute of Medicine Task Force on Behavioral Health Services for the Military and Their Families; November 18, 2009; Morrisville, NC.

the state. The National Guard members are directed by the North Carolina National Guard Joint Forces Headquarters located in Raleigh.¹

Military members and families are likely to live near these installations. However, the reserve component and active duty recruiters live and work in all 100 counties. Those who live further from military installations have less access to federal resources. They also may be in a community without knowledge of other military members who share their experiences.

Risk Factors and Barriers

The needs of the military population are different than the needs of North Carolina in general. Service members and their families encounter stress that many North Carolinians will never know. As described more fully in Chapter 3, many ADSMs and veterans suffer from mental health problems, cognitive disorders, or substance use problems that were developed during or exacerbated by their military experience. Family members also can experience psychological consequences from the multiple deployments and attempts at reintegration or

Service members and their families encounter stress that many North Carolinians will never know.

from the emotional stress of caring for loved family members who have behavioral health problems. The federal government has the primary responsibility to meet the behavioral health needs of ADSMs as well as those of veterans. However, North Carolina can augment federal behavioral health services, particularly for ADSMs, veterans, or family members who either are not eligible for or cannot easily access federally supported services. However, to do so, the state needs to understand the unique behavioral health challenges that ADSMs, veterans, and their families face, from the length and number of deployments, to the military culture that encourages resiliency among service members and their families but also makes it difficult for individuals to seek needed behavioral health services, and to the gaps in the current federally funded services available to ADSMs, veterans, and their families.

Active Deployments

During war time, it is expected that many service members will be deployed to serve in combat. After the attack on September 11, 2001, combat operations began in Afghanistan on October 7, 2001. This conflict is officially titled Operation Enduring Freedom (OEF). The war in Iraq, officially titled Operation Iraqi Freedom (OIF), began in March 2003 and ended on August 19, 2010. Since 2001, more than 2 million United States service members have been deployed in support of OEF/OIF missions at least once. More than 218,000 women have been deployed to Iraq and Afghanistan, making up greater than 10% of the deployed service members. More than 7,500 Reserve members have been deployed at least once.ⁱ The North Carolina National Guard has deployed 10,800 soldiers to Iraq since 2003.^j Since 2001, they have also deployed 700 soldiers to Afghanistan, 1,400 soldiers to other parts of the world in support of OEF/OIF missions, and 5,100 airmen and women in support of OEF/OIF missions.^{1,3}

Approximately 40% of current service members have been deployed more than once.

Deployment to OEF/OIF is very different than deployment to previous conflicts. Operation Enduring Freedom and Operation Iraqi Freedom have continued longer than World War II. The military is now an entirely 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 (known as dwell time). There is also an increased use of Reserve and National Guard service members and increased numbers of deployed women and parents of young children. Service members have been deployed for more than three million tours of duty lasting 30 or more days. Approximately 40% of current service members have been deployed more than once. More than 25% of service members have been deployed more than twice.^{6,7}

i Meed J. Research Associate, Citizen Soldier Support Program. Written (email) communication. March 24, 2009.

j Personal communication with North Carolina National Guard. The Adjutant General Command Brief October 15, 2010.

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The physical environment in Iraq and Afghanistan exposes service members to more direct involvement, both those in traditional combat theater and those in support roles. Although there is more exposure to violence, more than 90% of injuries that in previous wars would have resulted in death are now survived.^{6,8}

Deployment is well described as a process or cycle from training and preparation to postdeployment and reconstitution. The service member receives special training and preparation for deployment. The service member or group is then mobilized to begin deployment. The deployment or employment phase involves performing a specific mission. The cycle then progresses to postdeployment and reconstitution, in which the service member leaves the war zone and readjusts to rejoin his or her community. This period varies, and many service members then progress to redeployment. The cycle of deployment elicits various responses in service members. Most service members transition through the cycle and completely reintegrate into their lives. However, some service members encounter challenges with readjustment and reintegration.⁹ Chapter 3 will discuss the challenges and problems of readjustment and reintegration.

Deployment also affects families at every stage of the deployment cycle. There are emotional, health-related, and social adjustments for the families left at home. Family members must adjust to the absence of the service member and take on new responsibilities. Children in military families with one or more deployed parents experience emotional and behavioral difficulties more often than other children. Longer deployments increase the likelihood that a child will suffer social and emotional difficulty. Similarly, longer deployments are associated with increased mental health diagnoses in spouses.^{6,10,11} These issues are also discussed in Chapter 3.

Military Culture

Military service members and their families have language, perceptions, traditions, and values that represent a distinct culture. Bravery, courage, honor, resilience, and respect for authority are expected and entrenched values. They are reflected in the slogans for each of the branches. The Army encourages soldiers to “be all you can be” and reminds them to “be Army strong” and that they are “an Army of one.” The Marines are “the few, the proud” and are reminded to be always faithful in their motto “*semper fidelis*.” The Navy is described as a “global force for good.” The Air Force teaches airmen and women to “aim high,” “do something amazing,” and be “above all.” The Coast Guard is “always ready” and describes their careers as “jobs that matter.” The North Carolina National Guard is “always ready, always there.”

Aspects of the military culture, including honor, resilience, and self sacrifice, help service members achieve their mission in stressful conditions. This inward culture is a benefit that provides a ready group of peers that share experiences. Resilience is the positive capacity to cope with stress and adversity and is valuable both in combat and at home. However, the self-sacrifice and “just deal with it” attitude can create a significant barrier to seeking care when a problem

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

Transitions are another shared experience of service members and their families. Relocation is not only a possibility but also a guarantee for most military families. One-third of military families are relocated every year. The average military family moves every two to three years. This may be related to the service member's specialty training or career advancement. Families are required to leave the communities where they have become entrenched. Children have to change schools, and spouses have to leave jobs and support networks. The new assignment may be in a different part of the country or another part of the world. Often there is little choice in the location of the relocation. It is simply a fact of military life.⁶

**One-third of
military families
are relocated every
year.**

For some military families, the impact of deployment and military culture, including transitions, is doubled. Almost 7% of military marriages are between two active duty service members. These dual-military marriages are highest in the Air Force (12.8% of marriages). More than 26% of women in the Marine Corps and 30% of women in the Air Force are in dual-military marriages.^{1,5,6}

Gaps in the Federal System

The military does not have a single, comprehensive system of care for all its service members and their families. Depending on the type and length of service, a service member may get health coverage through a variety of sources. TRICARE is a federal program that generally provides coverage to active duty service members, eligible reserve component service members, retirees, and their families. The Veterans Affairs system provides care to eligible veterans. There are also state-funded services, private insurance, and other options for healthcare coverage. Chapter 4 will discuss some of the differences in eligibility for federal programs between active and reserve components. Chapter 5 will discuss state-funded services that cover more reserve component service members.

Conclusion

The military and their families provide a valuable service to the state of North Carolina. In response to their sacrifices, the nation and state should take extra care to provide services and supports for their well-being. Most active duty service members have access to federal services, either through services on military bases or through TRICARE. Many—but not all veterans—can access behavioral health services through a VA provider. The National Guard and Reserve also have systems to help link service members to federal or state-subsidized behavioral health services. However, these services are not available to everyone, as described more fully in Chapter 4. Thus, the state can help by augmenting and filling gaps in behavioral health services for active and retired members of the military and their families.

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Introduction

Military service has long been associated with honor and sacrifice. The same is true for our troops who have served and who continue to serve our country in Iraq and Afghanistan. For many of these men and women, a safe return home does not bring an end to the challenges of the armed conflicts. Instead, they may confront pervasive mental health issues, such as depression and posttraumatic stress disorder and the aftermath of traumatic brain injury. These conditions can go undetected and untreated and have been described as “invisible wounds.”¹ In addition, many of our service members struggle with the misuse of substances such as tobacco, alcohol, and other drugs. Difficulties when service members return to daily life within their family and community environments are commonly encountered.^{1,2}

All of these issues can profoundly affect the quality of life for military personnel and their families, who share in the sacrifice of military service. In order to ensure that our military and their families receive proper care and are supported in their readjustment to life after deployment, it is helpful to learn more about the challenges they may face. This chapter will define these conditions and explore their scope and potential impact.

Traumatic Brain Injury

According to the Centers for Disease Control and Prevention (CDC) and the Defense and Veterans Brain Injury Center (DVBIC), traumatic brain injury (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.”^{3,4} *Penetrating head injuries* are those in which an object breaks through the skull and into underlying brain tissues. Gunshot wounds are an example of this type of injury. In contrast, *closed head injuries* leave the skull intact.⁵ 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, in the current conflicts, even more commonly by blasts.⁴

Blasts are a regular occurrence in the combat zones of Afghanistan and Iraq and are caused by several types of weapons, such as improvised explosive devices (IEDs), grenades, and land mines.⁶ According to the latest summary of Operation Enduring Freedom (OEF) and Operation Iraqi Freedom (OIF) casualties, blasts account for nearly three-quarters (73%) of overall injuries and fatalities.⁷ In addition to causing a broad spectrum of injuries, blasts cause TBI by means of several mechanisms. Pressure waves created by the blast may directly injure the brain without visible evidence of head trauma.⁸ Blasts also generate wind that may thrust the victim, explosive fragments, and debris into the air. Brain injury may result if the victim’s head strikes an object or is struck by airborne material during the explosion.^{6,8} These mechanisms may occur in combination, adding to the complexity of TBI.^{6,9}



For many of these men and women, a safe return home does not bring an end to the challenges of the armed conflicts.

According to the Defense and Veterans Brain Injury Center (DVBIC), more than 178,000 service members have been diagnosed with TBI during the past 10 years.

The manifestations and consequences of traumatic brain injury vary widely, with injury severity and location being important factors. There are three categories of TBI—mild, moderate, and severe, based on acute injury characteristics. This categorical classification system is based on clinical presentation immediately following the injury. It does not change over time as a person’s condition changes.¹ Injuries are categorized on the basis of the degree of resulting impairment in consciousness, memory, and cognitive function, and on the presence of neurological symptoms or deficits.^{10,11} According to the Defense and Veterans Brain Injury Center (DVBIC), more than 178,000 service members have been diagnosed with TBI during the past 10 years. Of these injuries, approximately 77% have been classified as mild, 17% as moderate, and only 1% as severe. Fewer than 2% of TBIs have resulted from penetrating trauma. Therefore, the majority of TBI cases diagnosed among service members have been mild TBI, presumably due to blunt head trauma or blast.¹¹

Mild TBI or *concussion* is a closed head injury that may occur when the head is impacted by or impacts an object. It can also be caused by blast exposure with or without direct head trauma.^{8,10} Research indicates that blast may be the more common cause of mild TBI in OEF/OIF.^{12,a} According to established clinical guidelines, mild TBI is an initial injury that is followed by a brief period of unconsciousness or decreased consciousness, transient periods of posttraumatic confusion, or amnesia. For TBI to be considered mild, clinical imaging studies must also be normal.¹⁰ Although considered the least severe form of TBI, concussion can produce a wide variety of symptoms. Headache is the most frequent symptom, but other problems include fatigue, vision changes, dizziness, and balance difficulties.^{4,10} Those with concussion may also experience problems with sleep, memory, and/or concentration. They may also find themselves feeling irritable, anxious, or depressed. Although symptoms may be unpleasant and distressing for some, the majority of cases resolve in time without lasting effects.^{4,10} Recovery for service members who incur a combat-related concussion may be more difficult than for civilians who incur a TBI, because of the traumatic circumstances in which the initial combat-related concussion occurred.¹³

In addition, service members may incur multiple concussions during their tour (or multiple tours) of combat duty. It is possible that multiple concussions may have a cumulative effect that impairs long-term recovery and prognosis. Studies in athletes call this “second injury syndrome.” Many service members with TBI may also have co-occurring mental health problems, such as posttraumatic stress disorder (PTSD), depression, anxiety, mood disorders, addiction disorders, and/or suicide ideation.¹ Individuals with co-occurring disorders have more severe symptoms, and the recovery process may be more complicated. Many service members with mild TBI report that symptoms persist and that their mild TBI

a In a survey of more than 2,500 Army soldiers returning from deployment to Iraq, approximately three-quarters (73%-79%) of those with a self-reported history of mild TBI identified blast as the injury mechanism.¹²

has also contributed to problems with employment, school, family relations, and social interaction.¹⁴ Individuals who have symptoms that do not respond to initial treatment should receive further evaluation and referrals to specialists.¹⁰

Researchers have begun to evaluate the prevalence of mild TBI among military personnel serving in Iraq and Afghanistan. In surveys of returning service members, approximately 15% to 19% reported screening criteria consistent with having sustained a mild TBI during deployment.^{1,12} On the basis of screening surveys, it has been suggested that as many as 320,000 service members may have sustained a mild TBI during these conflicts.¹ The number of clinically confirmed cases within the military healthcare system is much lower, with approximately 137,000 mild TBIs recorded since 2000.¹¹

According to the DVBIC, various factors make the identification of TBI a potentially challenging process, particularly when injuries are the result of blast exposure. For example, mild TBI may be the sole injury sustained in a blast. Those who are injured in this manner may lack visible evidence of physical trauma. In these instances, the service member may be unaware of the injury. In the absence of very obvious impairment, the mild TBI may not be detected by others. In other circumstances, TBI may be only one of a number of injuries sustained, and diagnosis may be deferred as more serious injuries are identified and stabilized. Given the prevalence of mild TBI and blast exposure in combat settings, injured service members may not perceive this injury as concerning and may forgo or postpone medical evaluation.⁶ Research has shown that more than half (57%) of those sustaining probable mild TBI while deployed to Iraq or Afghanistan did not pursue medical evaluation for this condition.¹ Beyond the acute setting, diagnosis of mild TBI may remain challenging. Symptoms subsequent to a concussion are similar to those experienced with several common psychiatric conditions, such as PTSD and depression, thus further complicating diagnosis.^{6,9}

In an effort to better detect those with mild TBI, the Department of Defense (DoD) and Department of Veterans Affairs (VA) have instituted screening protocols to be used at the time of initial injury and at various times thereafter. Furthermore, OEF/OIF veterans are screened as part of their initial evaluation when first receiving care within the Veterans Health Administration system.¹⁵ With education and supportive care, the majority of those sustaining mild TBI make a complete recovery.¹⁰ Of the total number of diagnosed cases of TBI reported by the DVBIC since 2000, approximately 20% were moderate or severe.¹¹ Although these cases occur less frequently than mild TBI, their impact should not be underestimated. Treatment of moderate to severe TBI begins with stabilization followed by continued supportive care, interventions, and medical evacuation from the field as indicated by the underlying injury and condition. Early treatment is often multidisciplinary and may require a variety of medical specialists.¹⁶ As recovery continues, rehabilitation becomes the focus of treatment, drawing upon the expertise of various health professionals who

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can assist the patient in optimizing functional abilities. 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.⁵

Psychological Issues and Military Service

Military service is potentially stressful with many contributing factors. In a 2008 survey of more than 28,000 active duty service members, 27% reported high levels of work-related stress during the previous year. Deployment and separation from family were the most frequently identified stressors. Other major stressors were increasing work responsibilities and the challenge of balancing these demands with family needs. Approximately one-quarter of nondeployed (24.6%) and deployed (28.7%) service members experienced high levels of work stress.^{17,18} However, those who experience combat are at increased risk for mental health issues.¹⁷⁻¹⁹

Combat exposure has been associated with several mental health conditions, such as depression, anxiety, and PTSD. Among Army and Marine Corps personnel, the prevalence of screening positive for one of these three mental health conditions was higher for those who had been deployed to Afghanistan or Iraq, compared with the corresponding prevalence for those who were not deployed. The prevalence for those deployed to Iraq (up to 17%) was greater than the prevalence for those deployed to Afghanistan (11%), consistent with the higher degree of combat exposure experienced by troops in Iraq. In contrast, the prevalence of these mental health disorders was lowest in those who were screened at baseline before deployment (9%).¹⁹

Shortly after the start of OIF in 2003, the DoD initiated the Post-Deployment Health Assessment (PDHA), a process designed to evaluate a service member's overall health, to address health concerns, and to arrange appropriate referrals following deployment. The PDHA is administered either immediately before return to the United States or within 30 days after return. The PDHA is conducted using a questionnaire in conjunction with a provider interview. Among the questions in the PDHA are items used to screen for mental health conditions, such as PTSD and depression.^{20,21} Of Army soldiers and Marines screened during the first year of PDHA implementation, mental health concerns were identified in 19% of those returning from Iraq and in 11% of those who had been deployed to Afghanistan.²⁰ These findings are consistent with previous research showing a relationship between combat exposure and postdeployment mental health problems.¹⁹

In 2005, the DoD expanded its postdeployment assessment process to include a second evaluation. This Post-Deployment Health Reassessment (PDHRA) is administered to service members three to six months after their return home and is designed to screen for problems that may have developed since the PDHA was completed. This survey is generally similar to the PDHA and is again teamed with an interview by a health care provider. The PDHRA offers

In 2003, the DoD initiated the Post-Deployment Health Assessment (PDHA), a process designed to evaluate a service member's overall health, to address health concerns, and to arrange appropriate referrals following deployment.

another opportunity to identify mental health issues and to connect affected service members with appropriate referrals and resources.²² Research assessing the utility of this second assessment has shown that it does indeed identify a large number of individuals at risk for mental health conditions who were not identified at the time of the PDHA. Among active duty soldiers returning from Iraq, the prevalence of mental health risk increased from 17% on the PDHA to 27% at the time of the PDHRA. The increase was even more significant for reserve personnel, among whom the prevalence of mental health risk doubled over the same period, from 18% to 36%. Although this marked increase in the prevalence of mental health risk among reserve personnel may be in part due to increased reporting in this population, these findings do suggest that the postdeployment period may pose special challenges for reserve personnel as they return to civilian life.²³

Despite the frequency with which service members experience symptoms of mental health disorders, a minority pursue evaluation or treatment for these concerns, even when they are severe enough to impair function. Of combat troops identified as having possible depression, generalized anxiety, or PTSD, only 23% to 40% received professional help. Furthermore, fewer than half were interested in mental health care. Several reasons were offered for their reluctance; however, the most commonly cited concerns centered on the possibility of career damage or stigma.¹⁹ Overall, these findings suggest that a sizeable number of service members go without needed treatment. Instead, they live with the daily struggle of such conditions as PTSD, anxiety, and depression. There is evidence that service members are interested in reintegration services and information to help them adjust to civilian and community life.²⁴

Posttraumatic Stress Disorder

Posttraumatic stress disorder (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.^{25,26}

Persons who develop PTSD may experience a number of different symptoms that generally fall into three categories. The first group of symptoms is *intrusive recollections*. Within this category are symptoms in which the individual re-lives the traumatic event, often in the form of recurrent thoughts, memories, dreams, or flashbacks. Also, he or she may feel emotional and/or physical distress when facing reminders of the event. The category of *avoidant/numbing* symptoms includes efforts to avoid reminders of the traumatic event, feelings of detachment from activities and relationships, and difficulties with emotional expression. The third category includes *hyperarousal* symptoms, such as sleep difficulties, anger or irritability, and hypervigilance.^{25,26}

During combat, military personnel may encounter a number of traumatic events, such as being fired upon, being attacked, or witnessing death.¹⁹ Therefore, it would be expected that those deployed to combat zones would be more likely

Despite the frequency with which service members experience symptoms of mental health disorders, a minority pursue evaluation or treatment for these concerns, even when they are severe enough to impair function.

Following OIF deployment, 12% to 13% of Army soldiers and Marines reported symptoms of PTSD that were significant enough to impair daily function.

to experience PTSD than people in civilian settings. Less than 4% of adults under the age of 54 years experience PTSD in a given year in the United States.²⁷ The baseline pre-deployment prevalence of PTSD among military members is similar to this figure. However, research has confirmed that deployment and combat exposure are associated with a higher prevalence of PTSD symptoms.¹⁹ The majority of soldiers serving in Iraq are involved in combat events that could cause significant trauma.²³ Following OIF deployment, 12% to 13% of Army soldiers and Marines reported symptoms of PTSD that were significant enough to impair daily function.¹⁹

Not only has combat experience been associated with PTSD, but also there appears to be a relationship between degree of combat experience and PTSD symptoms. Among troops serving in Iraq and Afghanistan, the prevalence of PTSD symptoms was positively associated with the number of firefights experienced during combat. Furthermore, being wounded also increased one's odds of reporting PTSD symptoms after deployment.¹⁹ Even more than combat experience, killing someone or being responsible for killing someone was a significant predictor of PTSD symptoms.²⁸

Symptoms of PTSD may develop or worsen over time and affect members of military components in varying proportions. Studies of PDHA/PDHRA data have shown that 12% to 17% of active duty members and 13% to 25% of reserve component personnel meet screening criteria for PTSD, with higher prevalence seen at the time of the PDHRA.²³ Given these findings, it is wise to be mindful of this mental health disorder and to consider it as a potential problem for military personnel beyond the immediate postdeployment period, so that appropriate treatment can begin.

VA and the DoD have developed a Clinical Practice Guideline to be used by providers caring for patients with PTSD. This guideline highlights the importance of PTSD prevention, diagnosis, and treatment and recommends steps to be considered during each of these phases of care to optimize outcomes. There are several types of treatment available for the management of PTSD, such as psychotherapy and medication. This guideline reviews the evidence related to these various treatments, with recommendations made on the basis of this evidence and expert consensus.²⁹

Association between PTSD and TBI

In addition to the physical and cognitive impairments attributed to mild TBI, research has suggested a potential link between this injury and PTSD. In one study, prevalence of PTSD among soldiers returning from Iraq was markedly higher for those reporting mild TBI during deployment, compared with the corresponding prevalence for those who did not report this injury. Of soldiers who sustained mild TBI with loss of consciousness, 44% screened positive for postdeployment PTSD symptoms. Of those whose injury caused mental status changes such as confusion, 27% met these same PTSD screening criteria. PTSD symptoms were less common among those who sustained injuries other than

mild TBI (16%) or who were uninjured during deployment (9%).¹² Although these findings support an association between mild TBI and PTSD, further research is needed to clarify this potential relationship.

Depression

According to the American Psychiatric Association, major depression is a condition in which one experiences at least two weeks of sadness, depressed mood, or loss of interest or pleasure in daily activities.²⁵ Depression may result in a number of physical symptoms, such as appetite or weight changes, sleep disturbances, and/or decreased energy. Cognitive disturbances may also be present, such as a diminished ability to think or concentrate and indecisiveness. Depressed persons may also have feelings of worthlessness or inappropriate guilt and/or recurrent thoughts of death. At its most severe, depression may culminate in suicidal ideation and attempted or completed suicide.^{25,30}

In the United States, approximately 5% of adults have major depressive disorder in a given year.³¹ Depression may be even more common in the military, with 21% of active duty service members reporting feelings of depression that warranted further evaluation in a 2008 survey.¹⁷ Among those deployed in OEF or OIF, 14% met screening criteria suggestive of depression.¹

Recent research suggests a relationship between combat exposure and the subsequent development of depression. In a large longitudinal study, the proportion of service members who were exposed to combat in OEF/OIF and who developed depression was greater than the proportion of those who were not deployed and who developed depression. In this study, deployment in and of itself did not appear to be the contributing factor, because the prevalence of new-onset depression was lowest among those who were deployed but who did not experience combat.³²

Like the symptoms of other mental health conditions, symptoms of depression may take time to develop and may not fully manifest or be reported until months after deployment. Of routinely screened personnel returning from Iraq, the prevalence of depression among active duty members more than doubled from the time of the PDHA to the PDHRA administered several months later. The prevalence of screening positive for depression nearly tripled during this same time period for reserve component personnel.^{23,b} This once again illustrates the need to consider the possibility of depression well beyond the immediate postdeployment period.

The Department of Veterans Affairs and the Department of Defense have developed a Clinical Practice Guideline for Management of Major Depressive Disorder. This guideline is intended to provide clinicians with the latest

Symptoms of depression may take time to develop and may not fully manifest or be reported until months after deployment.

^b Among active duty personnel, the prevalence of screening positive for depression on the PDHA was 4.7%, compared with 10.3% several months later on the PDHRA. A similar trend was seen among reserve component personnel, in whom prevalence increased from 3.8% to 13% during a similar postdeployment period.

information so that they may make informed treatment decisions. It also outlines the various available treatment options for those with depression and reviews the evidence and/or consensus supporting each approach.³⁰

Suicide

More people die by suicide across the world than in war, terrorist activities, and homicides combined.³³ In 2000, in the United States alone, suicide was the 11th leading cause of death. Historically, the suicide rate has been lower in the military than among civilians, but in 2008 the suicide rate in the Army (20.2 suicides per 100,000 population) exceeded the age-adjusted rate of 19.2 suicides per 100,000 population.³³

American troops are taking their own lives in the largest numbers since records began to be kept in 1980. From January through November 2009, the Army reported 102 confirmed suicides and 45 suspected suicides among its active forces. Another 71 suicides were reported among the reserve component not on active duty, 41 of those confirmed and 30 still under investigation. This is a sharp rise from the same period in 2008, which saw 127 suicides among the active forces and 50 in the reserve component. Later in November 2009, 47 suicides in the Navy, 34 in the Air Force, and 42 in the Marine Corps were reported. More troubling is comparing this trend to that of the civilian population in the United States; suicide is the fourth leading cause of death among people aged 25 to 44 years but is the third leading cause of death among Marines.³⁴

The high rate of suicides and suicidal behavior in the services needs to be seen in the larger context of mental health throughout the entire force. The challenge is to address the whole mental health landscape, both in theater and at home, and not just exclusively with PTSD and TBI. That is a challenge further exacerbated for the reserve component by its geographic dispersal, its barriers to health care delivery, and its members' dual-role lives as warriors and civilian employees.

Although the stresses of the current war, including long and repeated deployments and posttraumatic stress, may be potential contributors, suicide behavior is a complex phenomenon. Several aspects make understanding suicide and preventing suicide particularly challenging, but one of the most challenging aspects is the multitude of factors that underlie and precede the event. Suicide is the visible manifestation of a much larger set of physical, mental, and spiritual stressors.

Males are four times more likely to die from suicide than females. Females reported attempting suicide three times more often than males. Suicide rivals the battlefield in its toll on US military. The average age of soldiers dying by suicide is 21; most of them are white males. Of these service members, 35% have never been deployed. The predominant factors reflected in suicidal behavior among service members are relationships, employment, and substance abuse.³³

Suicide is the fourth leading cause of death among people aged 25 to 44 years but is the third leading cause of death among Marines.

A strategy for fighting suicidal behavior is the DoD's attempt to build psychological resilience in individuals. The Mental Health Advisory Team (MHAT) is composed of senior Army behavioral health professionals who monitor the Army's suicide rate and who study the reasons that soldiers engage in suicide. In 2004, the MHAT's report indicated that among soldiers who screened positive for depression, anxiety, or PTSD, 53% reported that their unit leadership might treat them differently, and 54% reported that they would be seen as weak. The perception of stigma acts as a deterrent to seeking care for many soldiers. When soldiers fail to seek help when it is necessary, the general outcome is emotional degeneration leading to poor work performance and possibly to suicidal behavior.³³

Substance Abuse

As discussed in earlier sections, military deployment is associated with significant stress. Recent research suggests that some personnel use substances such as alcohol and tobacco to help manage the stressors associated with deployment and military service.^{18,c} Among active duty service members with high levels of combat exposure, as many as 45% reported drinking for relaxation, 24% drank to forget problems, and 21% drank to cheer up. Likewise, as many as 31% began a smoking habit to relieve stress, 33% to help relax, and 29% to relieve boredom. Since 1980, progress has been made toward decreasing substance use among active duty personnel.¹⁸ However, substance abuse remains a concern for the military.^{17,18}

Alcohol

Alcohol use continues to pose a significant problem for the armed services, with 20% of surveyed active duty service members reporting heavy drinking.^{17,18} Compared with civilians aged 18 to 35 years, active duty military in the same age group reported heavy drinking in a greater proportion.^d Binge drinking was also a serious problem, with nearly half (47%) of all active duty personnel engaging in this behavior.¹⁸

Research suggests a link between combat deployment and drinking behavior. Combat experience has been associated with an increased risk of developing alcohol misuse and its associated problems, such as impaired driving, compromised work performance, or difficulties with social interaction.^{35,36} In a large prospective study, this was found to be true particularly for members of the reserve component and for the youngest service members, such as those born after 1980.³⁵ The same characteristics of alcohol misuse and associated problems are true for service members returning from deployment.³⁷ Among

c According to the 2008 DoD Survey of Health-Related Behaviors among Active Duty Personnel, 25% of women and 37% of men reported having a drink to cope with stress. Similarly, 28% of men and 21% of women used cigarettes for this purpose.¹⁶

d According to the 2008 DoD Survey of Health-Related Behaviors among Active Duty Personnel, 26% of active duty personnel aged 18 to 25 years reported heavy drinking, compared with 16% of civilians in the same age group. Among personnel aged 26 to 35 years, 18% reported heavy drinking, compared with 11% of age-contemporary civilians.

Combat experience has been associated with an increased risk of developing alcohol misuse and its associated problems, such as impaired driving, compromised work performance, or difficulties with social interaction.

Although post-deployment screening may help detect alcohol misuse among military personnel, data suggest a need to improve the referral process used to connect those with alcohol problems to needed services.

soldiers returning from Iraq, those with greater degrees of combat exposure were more likely to report alcohol misuse on a routinely used screening instrument.³⁶ Furthermore, certain types of combat experiences were more strongly related to alcohol misuse and related problems. For example, personnel exposed to combat events in which they feared being killed or injured were more likely to report alcohol misuse after deployment. Those who witnessed atrocities, such as brutal treatment of noncombatants, were more likely to report post-deployment behavioral problems related to alcohol misuse.³⁶ Given these findings, it is important to be especially mindful of the risk of alcohol misuse among those who return from combat deployment to better identify those in need of evaluation and treatment.³⁶

Although post-deployment screening may help detect alcohol misuse among military personnel, data suggest a need to improve the referral process used to connect those with alcohol problems to needed services. In a routine post-deployment assessment of more than 80,000 troops returning from Iraq, 12% of active duty members and 15% of reserve component members met screening criteria suggestive of alcohol misuse on the PDHRA. However, only 0.2% of those active duty members who were identified and only 0.6% of those National Guard/Reserve personnel who were identified were referred for further substance abuse evaluation and treatment.²³

Drugs

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. Approximately 2% of those surveyed in 2008 reported such use within the past month. This prevalence remained essentially unchanged from the prior six-year period.^{17,18} Military drug testing may in part account for this lower observed prevalence of illicit substance misuse.¹⁷ Nonprescription drug misuse (illicit drug use) is less prevalent among military personnel than among civilians (2% vs 12%). However, the misuse of prescription drugs (legal drug use) is three times as common among service members than among civilians (12% vs. 4%).¹⁸

Misuse of prescription drugs includes such behaviors as taking drugs that have not been prescribed or taking prescribed medications in an intentionally inappropriate manner.^{17,18} Among active duty military personnel, the most commonly misused prescription drugs are pain relievers, tranquilizers, and muscle relaxants.¹⁸ An increase in reported prescription drug misuse has been observed during the past six years. On the basis of 2008 survey results, 11% of active duty military members reported engaging in this behavior within the previous month, in contrast to nearly 4% in 2005.^{17,18} Given that survey questions regarding drug use were modified and refined during the 2005 and 2008 surveys, it is uncertain how much of this observed increase in prevalence is due to actual misuse of prescription drugs rather than to differences in reporting.^{17,18} Nonetheless, this is an important finding. Furthermore, unlike

the relationship between combat and alcohol misuse, combat deployment does not appear to be related to the prevalence of drug use.^{17,35,36}

Tobacco

Cigarette smoking continues to damage health and shorten lives. It has been estimated that annually more than 443,000 deaths in the United States are due to direct and indirect exposure to cigarette smoking. The estimated economic costs to our country are equally astounding, with more than \$193 billion spent each year in direct medical care costs and lost productivity.³⁸

The prevalence of smoking within the military has decreased during nearly three decades. However, it is still a common problem, with 31% of active duty service members reporting cigarette use in 2008. Furthermore, nearly one-third (30%) of personnel who smoked began their habit after beginning their military careers.¹⁸

Research has examined the relationship between smoking behavior and deployment in OEF or OIF. In one large study, deployment was associated with an increased risk of new-onset smoking as well as recidivism among former smokers. Although the prevalence of new-onset smoking was low for both deployed (2.3%) and nondeployed (1.3%) groups, recidivism was a more common occurrence. Nearly 40% of former smokers who were deployed resumed their smoking habit, in contrast to 29% of former smokers who were not deployed. Furthermore, the odds of resuming smoking were increased for those who were deployed more than once or for longer than nine months. Beyond deployment, this study also found that those service members who were exposed to combat were more likely to begin a new smoking habit or to resume a previous one, compared with the likelihood of those who did not experience combat.³⁹ Overall, the number of service members who begin smoking or who return to smoking after entering the military is larger than the number of civilians, and the risk of these service members doing so may be increased by deployment and combat.^{18,39}

Despite the continued problem of smoking in the armed services, it is encouraging that the percentage of military members smoking greater than one pack per day has decreased since 1980 from 34% to 10%.¹⁸ Furthermore, in 2008, smoking cessation was on the agenda for many active duty service members, with nearly two-thirds (62%) reporting plans to stop smoking in the near future.¹⁸ Although deployment has been linked with new and resumed smoking, it is important to note that during a three-year period, 8% of those deployed to Iraq or Afghanistan still managed to quit smoking, as did 10% of those who did not deploy.³⁹

Women's Issues

As of 2007, approximately 14% of all active duty military personnel were women, as were nearly 18% of reserve component personnel.⁴⁰ Although men and women contend with some of the same stressors during and after military

Nearly one-third (30%) of personnel who smoked began their habit after beginning their military careers.

service, women who serve in the current conflicts may experience a number of additional stressors attributable to their gender.⁴¹ In a 2008 survey, 39% of female active duty military personnel attributed high levels of stress to being a female service member.¹⁸

Women serving in OEF and OIF are encountering greater degrees of combat exposure.^{41,42} The increase in the professional scope of female personnel broadens their range of work settings and increases their risk of being in a location that is subject to attack.^{41,42} Also, with blurred battle lines and unconventional attacks, women are more frequently in the line of fire.^{41,42} DoD statistics as of July 2010 reveal that in the OEF/OIF conflicts, 129 female military members have died and 707 have been wounded in action.⁷

Research has revealed an association between several mental health conditions and military sexual trauma.

As more women experience greater degrees of combat, research is being conducted to study the effects of deployment on subsequent mental health issues. On the basis of data from the PDHA and from the VA patient population, similar proportions of male and female service members experience mental health concerns after deployment.^{20,43} Although overall prevalence of mental health conditions may be similar, in caring for female military members and veterans it is important to consider the impact of gender on the experience and manifestation of specific issues and disorders, such as military sexual trauma, depression, and PTSD.

Military sexual trauma (MST) includes “severe or threatening forms of sexual harassment and sexual assault sustained in military service.”⁴⁴ MST has been more commonly identified among women than men.⁴⁴⁻⁴⁶ For example, in a 2002 survey, 8% of female active duty service members reported sexual coercion in the previous year, and 3% experienced sexual assault, compared with 1% of men who reported each of these types of MST. Although the reported prevalence of these offenses had decreased since a previous survey in 1995, this issue remains of concern.⁴⁵ The prevalence of MST is an important consideration in the provision of clinical care to female veterans. Approximately 15% of female OEF/OIF veterans cared for under the Veterans Health Administration (VHA) have met screening criteria for MST, in contrast to less than 1% of males.⁴⁶

Recent research has revealed an association between several mental health conditions and MST. Among male and female OEF/OIF veterans cared for within the VHA, those with a history of MST were more likely to have mental health conditions than were those without MST. Furthermore, women with MST had nearly twice the prevalence of PTSD, depression, and anxiety disorders, compared with the corresponding prevalence for women without MST. The most striking difference was seen in the occurrence of alcohol and substance abuse, which was nearly three times as prevalent among female veterans with MST,

compared with the prevalence for those without MST.^{46,e} Given the prevalence of MST and its associated mental health problems, it is an important factor to consider in the psychological well-being of female OEF/OIF veterans.

With regard to the general occurrence of postdeployment psychological conditions, male and female OEF/OIF veterans may experience depression and PTSD in differing degrees.^{32,44} Research has shown that deployed female service members have a greater prevalence of depression than do males. Of those experiencing combat in Afghanistan or Iraq, women were nearly three times as likely to meet screening criteria for new-onset depression, compared with the likelihood of men (16% vs. 6%).³² Among OEF/OIF veterans receiving care within the VA healthcare system, nearly half (48%) of female veterans were identified as having possible depression by standard screening procedures, compared with 39% of men. In contrast, these female OEF/OIF veterans were found to have a lower prevalence of PTSD than their male counterparts (21% vs. 33%). It is unclear, however, if this difference in PTSD prevalence is due to differing degrees of combat exposure.⁴⁴ In female OEF/OIF veterans, older age was associated with greater prevalence of PTSD and depression.⁴⁷ Much remains to be learned about the mental health needs of female OEF/OIF veterans. This is an area of increasing concern as the number of women returning from Iraq and Afghanistan continues to grow.⁴⁴

Family Issues

Psychological Needs of Military Spouses

The families of our service members share in the stress of military service and deployment. Studies of military spouses suggest that these spouses endure some of the same mental health conditions experienced by service members.^{48,49} In a 2003 study, emotional issues and stress posed a challenge for nearly one-quarter (22%) of surveyed spouses. Depression and anxiety were commonly identified conditions, with 12% to 17% of spouses meeting standard screening criteria for these mental health conditions. For many of these spouses, mental health issues interfered with their ability to function in relationships and to perform daily activities.⁴⁸ On the basis of this study, the prevalence of depression and generalized anxiety among military spouses is comparable with that observed among similarly screened service members who have experienced combat duty in Afghanistan or Iraq.^{19,48} Additional research has found deployment duration to be associated with the diagnosis of several mental health conditions among military spouses. The greatest number of cases of conditions such as anxiety, acute stress reaction, depressive disorders, and sleep disorders were diagnosed among wives whose spouses were deployed for longer than 11 months, in comparison to the corresponding number of cases among spouses of those deployed for shorter periods or not at all.⁴⁹

The prevalence of depression and generalized anxiety among military spouses is comparable with that observed among similarly screened service members who have experienced combat duty in Afghanistan or Iraq.

^e Among female veterans who reported experiencing MST, the prevalence of PTSD was 51% , compared with 22% in those without MST. The prevalence of depression was 56% for those with MST and 30% for those without MST. The prevalence of anxiety disorders was 29% in those with MST and 17% in those without MST. Finally, 14% of women with MST experienced alcohol and/or substance abuse, in contrast to 5% of those without MST.

Children aged 11 to 17 years from military families with a deployed parent were more likely to have emotional problems than were average US children.

Although a similar proportion of service members and spouses experience common mental health problems, spouses may be more apt to pursue mental health treatment. In the previously described study of military spouses, more than two-thirds (68%) of those whose anxiety or depression was severe enough to impair daily functioning obtained help from a health care professional.⁴⁸ This is in contrast to 23% to 40% of similarly affected service members, among whom stigma was identified as a formidable barrier to seeking care.^{19,48} Although stigma was still a concern for nearly one-quarter of military spouses (21% to 22%), other issues such as financial concerns, limited time, and scheduling difficulties were more commonly cited as obstacles to treatment.⁴⁸ It is important to note that many of these spouses received all of their mental health care from primary care practitioners rather than mental health specialists. This may be due in part to the limitations of the current military system that requires spouses to seek this specialty care within the civilian sector rather than on base.⁴⁸

Psychological Needs of Military Children

A large proportion of service members are parents who leave behind children when deployed. Approximately 43% of active duty members and nearly 42% of reserve component personnel have children. According to a 2007 report, nearly 2 million children had a parent serving in the military.⁴⁰

Recent studies have explored how deployment of a parent affects the functioning of children in a variety of contexts, including family, school, and social settings.^{50,51} From these studies, several key findings have emerged. First, children aged 11 to 17 years from military families with a deployed parent were more likely to have emotional problems than were average US children.⁵⁰ Of these children, nearly one-third (30%) experienced anxiety symptoms. Children older than three years were more likely to have attention difficulties and aggressive behaviors when parents were deployed.⁵² Furthermore, as total time of parental deployment increased, the number of difficulties experienced by children during and after deployment increased as well.^{50,53}

Gender and age may play a role in how children experience and adjust to parental deployment.^{50,51} Compared with boys, girls aged 11 to 17 years reportedly encounter more difficulties adjusting to both the deployment and the return of a deployed parent.⁵⁰ Furthermore, boys and girls may express deployment-related problems differently. On the basis of observations of teachers and staff, girls tended to exhibit more physical symptoms and signs of depression. However, boys had a more external focus with more frequent anger and aggressive behavior.⁵¹ In addition to gender, age appears to affect children's functioning during the deployment and the return of a parent, with the most difficulties encountered by those in adolescence.⁵⁰

Children's abilities to function in academic and other settings have been found to be related to the mental health of their nondeployed caregivers.^{50,51} Poor caregiver mental health has been linked to greater problems among their children.^{50,51} Recent studies show that parenting stress is the most significant

predictor of child psychosocial functioning during parental deployment.⁵⁴ These findings underscore the importance of ensuring adequate mental health care for military spouses and families as well as for military personnel.

Interpersonal Conflict and Domestic Violence

Research has shown that interpersonal conflict is an important issue for service members returning from deployment. Furthermore, concern for conflict becomes more prevalent with time.²³ During several months following return from deployment to Iraq, the percentage of troops affected by interpersonal conflict quadrupled among active duty members (from 3.5% to 14%) and increased more than five-fold among reserve personnel (from 4.2% to 21.1%). These military members reported concerns with conflict in their relationships with friends and co-workers as well as with spouses and family.²³

Family stress is commonly experienced by active duty members of the armed services. In 2008, nearly one in five service members (18%) reported large amounts of stress within their families or relationships with significant others.¹⁸ Furthermore, high family stress was nearly twice as prevalent among those who had high cumulative levels of combat exposure, compared with the prevalence among those with the lowest levels of combat experience (23% vs. 14%). In a recent study of OEF/OIF veterans, three-fourths of those who were married or living with a partner reported some type of family problem within the previous week.⁵⁵ Although family stress may be experienced by all service members, these data suggest that those who are deployed with combat exposure may be at even greater risk for high levels of family stress.¹⁸

One of the most severe manifestations of interpersonal conflict and/or family stress is intimate partner violence. According to the Centers for Disease Control and Prevention, intimate partner violence (IPV) is defined as “physical, sexual, or psychological harm by a current or former partner or spouse.”⁵⁶ In addition to physical injury, victims of intimate partner violence report poorer overall health status and numerous physical and mental health problems.^{57,58}

In 2003, nearly 16% of soldiers screened before deployment were identified by self-report as having been engaged in IPV during the preceding 12 months. A number of factors were associated with an increased risk of IPV in this group. These factors included greater degrees of stress, less relationship satisfaction, younger age, and less education. A strong association was also observed between reported alcohol misuse and IPV.⁵⁹

On the basis of a 2005 literature review, studies examining IPV perpetration by male veterans and active duty service members have produced a broad range of prevalence estimates (13% to 58%).⁶⁰ The variability in these estimates is due in part to differences in measures of IPV, sources of data, period studied, and characteristics of the study population, such as the presence of concurrent substance abuse or psychological conditions.⁶⁰ At this point in time, little is known about the issue of IPV among military personnel returning from Iraq

In 2008, nearly one in five service members (18%) reported large amounts of stress within their families or relationships with significant others.

and Afghanistan. However, one small study that included OEF/OIF veterans suggested those with PTSD are at increased risk for perpetrating and experiencing IPV, compared with the risk for those without PTSD.⁶¹ Further research in this area is needed.

Intimate partner violence is an important issue in and of itself. However, its presence in a family has also been found to be a risk factor for child abuse. During a six-year period ending in 1995, Army families with a documented occurrence of spouse abuse had two times the risk of subsequent confirmed child abuse, compared with the risk of families without spouse abuse.⁶² Therefore, it is important to consider intimate partner violence and child maltreatment within the larger context of family stress and violence.

Studies have suggested a relationship between parental deployment and child maltreatment.^{63,64} Among Army families with a confirmed history of child maltreatment, maltreatment rates were greater during periods of deployment, compared with rates during nondeployment.⁶³ During parental deployment periods, maltreatment rates were 42% higher and rates of more severe degrees of maltreatment were more than 60% higher, compared with the corresponding rates in periods in which the enlisted parent remained home. Furthermore, during times of deployment, female nonmilitary spouses perpetrated child maltreatment at a rate more than three times greater than when the military spouse was home.⁶³ Population-level data have shown an increase in child maltreatment rates not only during periods of increased deployments but also during times in which greater numbers of personnel return home.⁶⁴ These studies illustrate the potentially far-reaching and serious effects of military service on family members and suggest a greater need for family support during these potentially stressful times.^{63,64}

Conclusion

This chapter has provided an overview of issues faced by many military members who have been deployed to Iraq and Afghanistan. Although these issues have been described as individual topics, it is important to note that these conditions may occur together. For example, in a postdeployment survey of service members and veterans of OEF/OIF, approximately 5% experienced symptoms of depression, PTSD, and TBI concurrently.¹ Likewise, individuals may be challenged by more than one mental health condition at the same time. Of OEF and OIF veterans first receiving care within the VA system, 25% had at least one mental health diagnosis. Of this group, 29% had two separate mental health diagnoses, and 27% had three or more—meaning greater than half of those with diagnosed mental health conditions had more than one disorder.⁴³ Furthermore, because mental health problems may take time to develop and to manifest, it is important to consider their presence beyond the immediate postdeployment period and to ensure that service members have adequate follow-up and access to mental health care.²³

Population-level data have shown an increase in child maltreatment rates not only during periods of increased deployments but also during times in which greater numbers of personnel return home.

There are many indications that the demands on our health care system are likely to increase as more service men and women return home and require care. For example, of more than 220,000 OIF veterans, 31% received outpatient care for a mental health concern during the first year after their return home from Iraq.²⁰ This is coupled with an overall steady increase in mental health service use among Army and Marine personnel.²⁰ This amplifies the importance of ensuring that effective services are available to keep pace with these growing demands.²⁰

Our service members and their families have made sacrifices to serve us in the current conflicts. As they return home, it is important that these men and women have the resources and support that they need to heal both the physical and the “invisible” wounds that have resulted from their brave service. In order to provide for the health needs of our military, it is important to first understand more about the system that drives and delivers this care. The chapter that follows will serve as a guide as we learn about the workings of the military health care system.

As they return home, it is important that these men and women have the resources and support that they need to heal both the physical and the “invisible” wounds that have resulted from their brave service.

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

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

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

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



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

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

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

Eligibility for TRICARE**Active Duty Members and Retirees**

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

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

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

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

Military and Their Families through the Federal System

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

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

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

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

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

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

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

Reserves and National Guard

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

a Eligible service members are those:
 1) Involuntarily separating from active duty under honorable conditions;
 2) Separating from the National Guard or Reserves after a period of active duty that was more than 30 consecutive days in support of a contingency operation;
 3) Separating from active duty following involuntary retention (stop-loss) in support of a contingency operation;
 4) Separating from active duty following a voluntary agreement to stay on active duty for less than one year in support of a contingency operation.
 b All former ADSMs and their families receive coverage for 18 months. Unremarried former spouses and emancipated children receive coverage for 36 months.

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

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

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

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

Eligibility for Veterans Affairs (VA) Health Benefits

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

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

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

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

Military and Their Families through the Federal System

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

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

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

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

The VA has created a priority system that ranks veterans on the basis of whether they have a service-related disability (injury or medical condition), its severity, and the person's income. This ranking system helps to prioritize the veterans who are eligible for services.

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

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

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

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

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

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

Veterans returning from combat operations in Iraq and Afghanistan are currently exempt from the normal placement rules. All service members who served in combat theater in Iraq or Afghanistan are eligible for enrollment for five years and are placed in Group 6. This includes those in the National Guard and Reserve. After the five-year period following the most recent return and discharge from the service, these veterans are subject to the normal enrollment rules.¹⁵ Veterans who have been enrolled in VA medical services through this program will remain enrolled after the five-year period elapses, even if they are moved to Group 8.¹⁷ However, veterans who have not enrolled after five years may have difficulty enrolling unless they can demonstrate a service-related disability.

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

Mental Health and Substance Use Services

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

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

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

Military and Their Families through the Federal System***Mental Health and Substance Use Services Available through TRICARE***

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

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

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

Although the array of services covered through TRICARE is the same for different enrollees, the place to receive care, the utilization review requirements, or the cost sharing can be different.

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

Although the array of services covered through TRICARE is the same for different enrollees, the place to receive care, the utilization review requirements, or the cost sharing can be different.

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

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

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

Cost sharing: ADSMs incur no costs for any authorized health services, including mental health services and treatment for substance use disorders. They are not required to pay any cost sharing regardless of whether they receive their services from an MTF or from a civilian provider. Charges vary for others covered by TRICARE, depending on their beneficiary category, which TRICARE option they use, and the type of provider they see. For example, ADFMs enrolled in TRICARE Prime pay no charges when receiving care at an MTF, but ADFMs enrolled in TRICARE Standard or Extra must pay coinsurance or co-payments when receiving care from civilian providers. Retirees enrolled in TRICARE Prime must pay co-pays for each inpatient admission or outpatient visit if they seek services from private network providers.¹ TRICARE beneficiaries will have higher out-of-pocket costs if they seek services from providers outside the TRICARE network. Typically, ADFMs (even under TRICARE Standard) have lower cost-sharing rates than all others enrolled in TRICARE.^{19,m}

Mental Health and Substance Use Services through the VA

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

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

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

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

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

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

- Diagnostic and treatment planning evaluations for the full range of mental health and substance use problems
- Treatment services using evidence-based pharmacotherapy and/or evidence-based psychotherapy for patients with mental health conditions and substance use disorders
- Consultation and treatment services for the full range of mental health conditions
- Evidence-based psychotherapy
- Referrals as needed to inpatient and residential care programs
- Consultation about special emphasis problems, including posttraumatic stress disorder (PTSD) and military sexual trauma (MST)
- PTSD teams or specialists
- MST specialty clinics
- Specialty substance use treatment services
- Mental health intensive case management
- Psychosocial rehabilitation services, including psychological rehabilitation and recovery centers (outpatient treatment centers), family psycho-education, family education, skills training, peer support, and compensated work therapy and supported employment
- Homeless programs
- Patient education
- Family education and family counseling, when it is associated with benefits to the veterans, as adjunctive treatment²¹

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

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

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

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

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

- Individual and group counseling for veterans
- Family counseling for military-related issues
- Bereavement counseling for families who experience an active duty death
- Military sexual trauma counseling and referral
- Outreach and education, including postdeployment health reassessment (PDHRA) survey and community events
- Substance abuse assessment and referral
- Employment assessment and referral
- Veterans Benefit Administration benefits explanation and referral
- Screening and referral for medical issues, including traumatic brain injury (TBI) and depression²³

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

Support Services Separate from TRICARE and the VA

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

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

Military OneSource

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

National Guard Bureau Programs

Family Readiness Program

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

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

Psychological Health Program

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

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

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

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

Yellow Ribbon Program

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

North Carolina National Guard Programs

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

Integrated Behavioral Health Program

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

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

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

Reconstitution Program

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

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

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

PRIORITY Recommendation 4.1

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

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

- 2) Contracts with peers who are veterans and/or family members with appropriate mental health, substance abuse, or behavioral health trainings to provide services and support for active and retired members of the active duty and reserve components, veterans, and their families.
 - 3) Linkages between trained mental health, substance abuse, and behavioral health counselors and psychiatrists or other licensed professionals who can provide medication management or health services needed to address more significant health problems.
 - 4) Use of telepsychiatry in rural areas to expand availability of psychiatric services for active duty and retired members of the active and reserve components, veterans, and their families.
- b) In addition to the NCNG clinical providers, additional personnel and resources should be collocated in the FACs, including but not limited to:
- 1) Veteran services officers,
 - 2) VA-trained mental health and addiction services providers, including contract behavioral health personnel through the Veterans Integrated Service Network 6 Rural Health Initiative,
 - 3) Division of Mental Health, Developmental Disabilities, and Substance Abuse Services providers and other state and local agency representatives as appropriate, and
 - 4) Other professional, advocacy, and support services.
- c) The Family Assistance Centers should report annually to the House and Senate Appropriations Subcommittees on Justice and Public Safety and to the House Committee on Military and Homeland Security on:
- 1) Services provided
 - 2) Number and type of active and reserve component service members, veterans, and family members served

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Reserves

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

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

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

Eligibility restrictions

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

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

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

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

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

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

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

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

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

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

r Veterans are ineligible for benefits when discharged: by reason of a bad conduct discharge, or under one of the statutory bars of 38 CFR 3.12(c)

- (1) As a conscientious objector who refused to perform military duty, wear the uniform, or comply with lawful order of competent military authorities.
- (2) By reason of the sentence of a general court-martial.
- (3) Resignation by an officer for the good of the service.
- (4) As a deserter.
- (5) As an alien during a period of hostilities, where it is affirmatively shown that the former service member requested his or her release. See §3.7(b).
- (6) By reason of a discharge under other than honorable conditions issued as a result of an absence without official leave (AWOL) for a continuous period of at least 180 days.

Pensions, Bonuses & Veterans’ Relief. Title 38 Code of Federal Regulations §3.12.

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

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

Family members are generally not eligible for VA health services.

Costs

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

Table 4.2
TRICARE Cost Sharing (Dec. 2009)

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

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

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

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

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

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

Availability of Service Providers

TRICARE

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

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

^s Veterans in Priority Group 7 pay 20% of the co-pay rates, and veterans in Priority Group 8 pay the full co-pay rate. The co-pays are as follows:

- 1) Outpatient Care: \$15 Primary Care; \$50 Specialty Care; \$0 for x-rays, lab, immunizations, etc.
- 2) Outpatient Medication: \$8 per 30-day supply. Priority Groups 2-6 Calendar Year cap - \$960
- 3) Inpatient Care: \$10/day + \$1,100 for first 90 days and \$550 after 90 days - based on 365-day period.
- 4) Extended Care Services: Institutional Nursing Home Care Unit, Respite, Geriatric Evaluation - \$0-\$97 per day. Noninstitutional Respite, Geriatric Evaluation, Adult Day Health Care - \$15 per day.

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

Table 4.3
Reimbursement Rates for TRICARE and Medicaid

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

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

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

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

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

Veterans Affairs

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

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

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

Table 4.4
TRICARE Network Behavioral Health Providers

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

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

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

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

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

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

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

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

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

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

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

Utilization of TRICARE and VA Mental Health and Substance Use Services

Although service members and their families have potential access to a wide array of mental health and substance use services, there is still a gap between the number of individuals needing care and the number who receive care. Chapter 3 discussed the prevalence of mental health and substance use problems among service members, veterans, and their families. In surveys of service members returning from deployment, approximately one-third (between 23% and 40%) of those with an identified need for treatment sought treatment within a year of returning from deployment.⁴³ Additionally, not only are service members who seek needed treatment in the minority, but also most of these seekers receive treatment that is not minimally adequate.^{34,t} Both the rate of utilization of services and the rate of receiving minimally adequate treatment mirror the rates in the general civilian population.^{34,44} However, in recent years, there has been a concerted effort to decrease the stigma and to increase access to mental health and substance use services. As a result, there has been a general increase in the proportion of active duty service members receiving mental health or substance use counseling, increasing from 14.6% in 2005 to 17.5% in 2008.³⁶

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

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

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

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

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

Recommendation 4.2

The North Carolina Congressional delegation should work with Congress to:

- a) Increase funding for behavioral health services for members of the active and reserve components, veteran members of the military, and their families. Special emphasis must be made on meeting the behavioral health needs of the Reserve and National Guard.
- b) Direct the Department of Defense (DoD) to change policies to allow licensed substance abuse professionals and other licensed behavioral health professionals to be credentialed as a participating provider in TRICARE.
- c) Direct the Department of Veterans Affairs (VA) to designate staff time to provide family and couple's counseling and psychoeducation as a part of mental and behavioral health services provided to veterans with behavioral health problems in the VA health care system.
- d) Direct the VA and DoD to work with the North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, and other state TBI service organizations, to support efforts to integrate services for both civilian and military personnel for community-based reintegration day programs.

Conclusion

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

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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.

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



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.

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.

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.

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).

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.

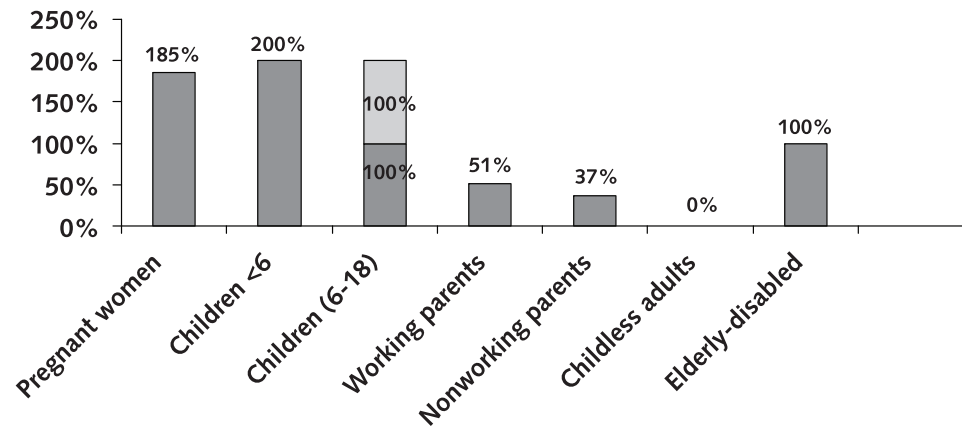
- First, the person or family must be in a group of people who are potentially eligible. Only certain “categories” of people are eligible for Medicaid or NC Health Choice. For example, NC Health Choice is the state’s Child Health Insurance Program (CHIP) and only available to low-income children under 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.

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).

- 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.

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

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.

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.

Availability of Mental Health and Substance Abuse Services

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.

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 (DMHDDAS) 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.

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

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 services³:

- 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.

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

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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.

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.

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

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.

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.

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,⁸ 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}

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

^aThe information in this table includes services provided in community settings, including community hospitals. It does not include services or expenditures for state-operated facilities.

^bCross-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.

^cThe 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.

^dExpenditures 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.

^eThese 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>

^fThe 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/cpiait.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.

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),

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

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.

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.

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.

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

- **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.

Availability of Mental Health and Substance Abuse Services

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

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

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

^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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A coordinated system of care for the military and their families needs sufficient providers and support to operate effectively. As noted in Chapter 5, having access to health coverage of behavioral health services, including mental health, substance abuse, and traumatic brain injury services, does not guarantee that individuals will receive the services they need. One of the major barriers service members and their families face is the shortage and maldistribution of providers. This chapter provides information on the number of behavioral health providers in North Carolina and specific areas of need. Many service members may choose not to seek services directly from military, the US Department of Veterans Affairs (VA), or civilian behavioral health specialists because of the stigma. Although they may not initially seek services from behavioral health professionals, they may seek help from veterans service organizations, community organizations, or faith leaders. Thus, the Task Force recognized the importance of working closely with these trusted community resources. However, better training is needed to ensure that these organizations have the capacity to identify families in need and to refer them to appropriate resources.

Behavioral Health Workforce

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.¹ The behavioral health workforce in North Carolina includes not only psychiatrists but also psychiatric nurses, psychoanalysts, psychologists, psychological associates, licensed clinical social workers, nurse practitioners, and physician assistants who specialize in mental health, alcohol and drug abuse, or addiction; child, adolescent, marriage, and family therapists; substance abuse counselors; licensed clinical addiction specialists; and certified peer support specialists. In 2009, there were five North Carolina counties—Camden, Graham, Hyde, Tyrrell, and Warren—that did not have any of these behavioral health providers.^a It is not clear if people in these counties have access to behavioral health providers in neighboring counties.^{2,b}



North Carolina, like the nation, has a shortage of trained mental health and substance abuse professionals.

a The North Carolina Institute of Medicine (NCIOM) examined the practice location for psychiatrists, physician assistants, nurse practitioners, psychologists, and psychology associates. However, the NCIOM was not able to obtain data on practicing licensed clinical social workers because their licensing agency does not maintain records of specialty area. Therefore, these data do not include licensed clinical social workers. Sources: Personal (email) communication with Jessica Carpenter. North Carolina Health Professions Data System, Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill. November 3, 2010. Personal (email) communication with Brian Corlett and Karen Ledsky. Health Net Federal Services. November 30, 2010.

b Current data provide information on the county where the provider's main office is located. If a provider also works in other counties, there is no standard way to account for the additional counties across the data sets.

TRICARE Gap Analysis

As noted in Chapter 4, TRICARE covers behavioral health services and supports for many service members and their families. Under federal law, TRICARE must follow Medicare provider credentialing rules. Medicare and thus TRICARE neither recognize nor pay for services provided by substance abuse counselors, licensed clinical addiction specialists, and certified peer support specialists. We recommended in Chapter 4 that Congress change the TRICARE payment policies to allow TRICARE to pay for substance abuse services provided by licensed clinical addiction specialists. (See Recommendation 4.2.) This would expand the availability of professionals with the training and competence to address the addiction disorders of active and returning service members and their families.

In addition to the shortage of substance abuse professionals, there are 6 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.

Table 6.1
TRICARE Eligible Providers in North Carolina

No. of TRICARE Eligible Behavioral Health Professionals ^a	No. of TRICARE Participating Behavioral Health Professionals ^b	No. of Behavioral Health Professionals Who Could, But Currently Do Not, Participate in TRICARE
3023	1309	1714

^aThe number of TRICARE eligible behavioral health professionals includes psychiatrists, psychiatric nurses, psychoanalysts, psychologists, psychological associates, nurse practitioners, and physician assistants who specialize in mental health, child, adolescent, marriage, and family therapy. Professionals were assigned to the county where they provided the most care. These data do not include substance abuse counselors, licensed clinical addition specialists, and certified peer support specialists, because these professionals are not currently eligible to participate in TRICARE. Furthermore, these data do not include licensed clinical social workers, who are eligible to participate in TRICARE, because the state social work licensure board does not maintain data on specialty area. Sources: Personal (email) communication with Jessica Carpenter. North Carolina Health Professions Data System, Cecil G. Sheps Center for Health Services Research, University of North Carolina at Chapel Hill. November 3, 2010. Personal (email) communication with Brian Corlett and Karen Ledsky. Health Net Federal Services. November 30, 2010.

^bThis column includes the number of behavioral health professionals who participate in TRICARE, either as a network provider or as a non-network provider.

Note: These data do include licensed clinical social workers who participate in TRICARE. Professionals were assigned to the county where they saw the most TRICARE patients.

These data suggest the need to recruit more behavioral health providers into TRICARE. There are efforts underway that are discussed below. However, it is important to note that the shortage of behavioral health providers is not unique to the TRICARE population. In general, there is a greater number of participating TRICARE behavioral health professionals per population than of behavioral health providers per general population. Recent analyses show an average of more than 30 behavioral health providers per 10,000 TRICARE population, while there are fewer than four behavioral health providers per 10,000 population. This is not surprising, because the number of TRICARE enrollees is smaller than the general population, and many behavioral health

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professionals do participate in TRICARE. Nonetheless, the Task Force recognized that the need for behavioral health services may be greater in the military population than in the civilian population because of all the stresses from deployment and reintegration discussed in Chapter 3. Furthermore, Task Force members reported barriers in being able to access behavioral health services in a timely manner in some communities.³ Thus, more needs to be done both to increase the supply of behavioral health professionals and to recruit eligible professionals into TRICARE.²

Provider Recruitment Initiatives

The shortage and maldistribution of behavioral health providers affects the entire state. In 2006, the North Carolina General Assembly directed the North Carolina Office of Rural Health and Community Care (NCORHCC) to help recruit psychiatrists into underserved areas. Since that time, NCORHCC has been able to recruit 52 psychiatrists into counties that are designated as behavioral health professional shortage areas. This designation is important because health professionals who agree to practice in a health professional shortage area can qualify for National Health Service Corps loan forgiveness to offset their educational loans. The Affordable Care Act increased funding for the National Health Service Corps by \$1.5 billion over six years with annual adjustments to help combat provider shortages. Behavioral health providers eligible for National Health Service Corps loan repayment include psychiatrists (physician and nurse specialists) plus psychologists, licensed clinical social workers (LCSWs), marriage and family therapists, and licensed professional counselors (LPCs).^{4,c} There are also loan repayment programs specific to North Carolina operated through the ORHCC and the North Carolina Medical Society Foundation.

Loan repayment is a great opportunity to recruit behavioral health providers, but it does not directly increase the pipeline for new behavioral health providers. To combat the shortage and maldistribution and to expand the supply of trained behavioral health providers, the Task Force recommended:

Recommendation 6.1

- a) **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 providers in the state.**
- 1) **North Carolina institutions of higher education should ensure that the curriculum includes information that educates health professionals about the unique behavioral**

More needs to be done both to increase the supply of behavioral health professionals and to recruit eligible professionals into TRICARE.

c Personal (telephone) communication with Michael Taylor. Special data run. North Carolina Office of Rural Health and Community Care. December 1, 2010.

health needs of the active duty and reserve components and their families, as specified in more detail in Recommendation 5.3.

- 2) Funding should be used to help support people seeking training through the community colleges, undergraduate education, master's or doctoral degree programs or those who are seeking to pay for the hours of supervised training needed for their license. Priority for enrollment should be given to individuals who have served in the military through active duty and reserve components and those who are willing to work with military members and their families.
- b) If efforts to obtain federal funding are unsuccessful or insufficient, the North Carolina General Assembly should appropriate \$1.9 million beginning in FY 2011. Of this:
- 1) \$750,000 in recurring funds in SFY 2011, \$1.5 million in recurring funds in SFY 2012, and \$2.0 million in recurring funds in SFY 2012 and thereafter 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 training. Funding should be provided to help support people seeking training through the community colleges, undergraduate education, master's or doctoral degree programs or those who are seeking to pay for the hours of supervised training needed for their license. Priority for enrollment should be given to individuals who have served in the military through active duty and reserve components. Individuals who receive state funds must agree to work for one year in a public or private not-for-profit substance abuse treatment program for every \$4,000 in scholarship funds, and must agree to serve the active duty and reserve components and their families.
 - 2) \$750,000 to increase the number of qualified mental health professionals who are seeking training through community colleges, undergraduate programs, and graduate education programs or who are seeking to pay for the hours of supervised training needed for their licensure (i.e., psychiatrist, psychologist, LPC, LCSW). Priority should be given to individuals who have served in the military through the active duty and reserve components. Individuals who receive state funds must participate in training on military culture, military benefits, and military resiliency and agree to work for a year accepting individuals with TRICARE insurance for every \$4,000 in scholarship funds.
 - 3) \$400,000 in recurring funds to the Area Health Education Center (AHEC) program to establish clinical training sites for people seeking their substance abuse professional credentials, and to develop and support new

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residency training rotations for psychiatrists, family physicians, emergency medicine physicians, or other physicians likely to enter the addiction field. AHEC shall give priority to clinical training sites or residency training rotations that expose health professionals to working with active duty and reserve components, veterans, and their families.

Provider recruitment incentives, scholarships for behavioral health provider training, and additional clinical training sites are useful tools to combat the behavioral health workforce shortage and maldistribution. However, stigma is still a barrier to the military and their families seeking and receiving behavioral health services and supports. Organizations that provide outreach and other services to the military and their families have a unique opportunity to help combat stigma. As trusted resources, outreach organizations have developed a rapport that can help connect active and former service members and their families with behavioral health and other resources.

Outreach to the Military and their Families

Active and former service members and their families need a variety of services and supports that outreach organizations may provide. North Carolina has many organizations with a direct mission to provide support and programs to the military population. The Citizen Soldier Support Program (CSSP) helps facilitate the development and sustainment of effective military and community partnerships in support of our reserve component members and families. The Governor's Focus on Servicemembers, Veterans, and their Families is a military, federal, state, and community partnership that works to ensure that service members and their families receive the best and most updated services available. Veterans 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. Furthermore, there are many nonprofit advocacy and peer support groups, such as the National Alliance on Mental Illness North Carolina Chapter (NAMI-NC), Brain Injury Association of North Carolina, and the Alcohol and Drug Council of North Carolina, that can provide information and counseling to people with specific behavioral health conditions. As one of the most military-friendly states, North Carolina has too many outreach organizations to list here. See Appendix C for information on other resources.

Citizen Soldier Support Program (CSSP)

The Citizen Soldier Support Program is funded through a federal Department of Defense (DoD) grant administered through the Odum Institute for Research and Social Science at the University of North Carolina at Chapel Hill. CSSP is a capacity-building initiative designed to strengthen community support for National Guard and Reserve members and their families. CSSP focuses on

The Citizen Soldier Support Program is a capacity-building initiative designed to strengthen community support for National Guard and Reserve members and their families.

To prepare civilian providers to address postdeployment issues facing OEF/OIF veterans and their families, CSSP has partnered...to create on-site and online courses for post traumatic stress disorder (PTSD), traumatic brain injury (TBI), and issues of women in combat.

increasing geographic and financial access to deployment- and postdeployment-related behavioral health services, especially for those living in rural areas.⁵ The CSSP goals for reserve component members and their families are:

- To identify gaps in health coverage (including TRICARE) and underserved areas requiring civilian health services,
- To increase civilian health providers' knowledge of and sensitivity to deployment-related issues,
- To improve civilian health providers' identification and treatment of behavioral health issues,
- To build capacity of civilian health providers and services, and
- To expand access to knowledgeable civilian health providers.

To prepare civilian providers to address postdeployment issues facing OEF/OIF veterans and their families, CSSP has partnered with Area Health Education Centers (AHECs) and medical providers and researchers from the Department of Veterans Affairs, United States Navy, and United States Public Health Service, to create on-site and online courses for post traumatic stress disorder (PTSD), traumatic brain injury (TBI), and issues of women in combat. VA's Mid-Atlantic Health Care Network (also known as Veterans Integrated Service Network 6 or VISN 6) has been a major contributor to this training program through the efforts of its Mental Illness Research, Education, and Clinical Center (MIRECC), which is a translational research center focused on deployment mental health. In fall 2010, new courses identifying signs of head trauma in military veterans during routine dental visits and routine optometry visits were added. More than 2,500 providers have received these day-long trainings in North Carolina, Virginia, Missouri, Florida, and Arizona and at several national conferences. Live courses are presented at any of the nine AHEC sites. CSSP online training is also available at no cost.⁵ As discussed in Recommendation 5.3, the Task Force recommended that the trainings be expanded and financially supported for primary care providers.

The NC AHEC Program, in partnership with CSSP and the VISN 6 MIRECC, has recently developed two face-to-face training tool kits on PTSD and TBI. More than 2,000 providers in North Carolina have received these day-long trainings, and many states are interested in duplicating these trainings. This program has already been shared in live trainings in Arizona, Florida, Missouri, Oklahoma, and Virginia. Free, accredited, web-based versions of the live trainings have now been mounted at www.aheconnect.com/citizensoldier. More than 9,000 clinicians and stakeholders have participated in either live or online trainings nationwide.⁵

Another CSSP tool is the www.warwithin.org database that enables veterans and family members to find local civilian health providers who understand

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the challenges of deployment-related issues, such as PTSD, TBI, depression, substance use disorder, and suicide. To address the concern that a reservist might have a lapse in care during the deployment cycle as they switch from civilian to military health insurance, www.warwithin.org allows users to search for providers who accept patients with different types of insurance or with no insurance at all. As discussed in Chapter 5, CSSP also works with mental health and substance use providers and encourages them to contract with TRICARE and to join the <http://www.warwithin.org> database.⁵

Governor's Focus on Servicemembers, Veterans, and Their Families

The mission of the Governor's Focus on Servicemembers, Veterans, and Their Families is to promote evidence-based and best practices in the screening, assessment, and treatment of active duty and reserve components, veterans who served in the military, and their families. This effort includes the articulation and implementation of an integrated continuum of care that emphasizes access, quality, effectiveness, efficiency, and compassion. Principles of resilience, prevention, and recovery are emphasized along with state-of-the-art clinical services as part of a balanced public health and behavioral health approach. The Governor's Focus envisions a referral network of services that will comprise a system through which service members, veterans, and their families will have access to assistance during all stages of the deployment cycle in North Carolina.⁶

On September 27, 2006, leaders of the North Carolina state government, VA, and DoD met with community providers and consumer groups at the Governor's Summit on Returning Veterans and Their Families. The initial summit meeting led to an ongoing effort called the Governor's Focus on Servicemembers, Veterans, and Their Families, whose mission is to promote best practices in the service of veterans who served in Operation Iraqi Freedom and Operation Enduring Freedom and their families, while envisioning a referral network of services through which North Carolina residents will have access to postdeployment readjustment assistance.⁶

In response to the recommendations made in the report at the Governor's Summit, the North Carolina General Assembly allocated more than \$2 million in SFY 2008 state funds to support new initiatives on behalf of returning service members, veterans, and their families. Issues addressed by the North Carolina Governor's Focus include stress in the workplace (military or civilian), health and behavioral health needs, educational and training needs (discussed in Chapter 5), housing needs, educational and employment needs of veterans, financial and/or legal issues, and reintegration challenges facing the service members and their families.⁶

A key component of the Governor's Focus involves a three-pronged public health intervention consisting of an outreach letter from the Governor's office, the CARE-LINE, and the delivery of a variety of outreach and education seminars in each of the state's nine Area Health Education Centers (AHECs).

The mission of the Governor's Focus on Servicemembers, Veterans, and Their Families is to promote evidence-based and best practices in the screening, assessment, and treatment of active duty and reserve components, veterans who served in the military, and their families.

The Governor's Focus is working to develop partnerships with professional organizations at the state level.

- **Governor's Letter:** A personalized letter is sent by the North Carolina Governor's Office to every OEF/OIF veteran in the state, thanking them for their service and expressing the Governor's desire to serve each new veteran and his or her family. Veterans are provided the toll-free number for CARE-LINE, which is offered by the Office of Citizen Services in the North Carolina Department of Health and Human Services.
- **CARE-LINE:** CARE-LINE is a toll-free number, available from 8 am to 5 pm, Monday through Friday, except holidays, in English and Spanish, linking callers to services in government, faith-based organizations, and for-profit and nonprofit agencies. Staff is trained and data are reviewed by members of the Governor's Focus. As discussed in Recommendation 5.6, the Task Force has recommended expanding the service to 24/7/365 availability because services were decreased by budget cuts.
- **Outreach and Education to Providers:** Training provided by CSSP explores a model curriculum for educating and forming bridges between mental health, primary care, chaplain services/congregations, and family support services across the DoD, VA, and state. As discussed previously, the program is designed to increase understanding of deployment-related stressors and health issues among community providers and leaders and to increase community capacity by educating local clinicians about TRICARE.

The Governor's Focus is working to develop partnerships with professional organizations at the state level. Partnering organizations include the North Carolina Medical Society, North Carolina Academy of Family Physicians, North Carolina Pediatric Society, North Carolina Psychiatric Association, North Carolina Psychological Association, and the North Carolina Association of Social Workers. The North Carolina Governor's Focus is a model that can be adapted to the specific needs of each state.⁶

Veterans Service Organizations

There is a wide variety of veterans service organizations, with each of the 13 in North Carolina having a unique mission. Overall their goal is to advocate for veterans on many different levels and topics. As examples, Disabled American Veterans concentrates its efforts on issues pertaining to veterans with a VA-recognized disability, and Veterans of Foreign Wars concentrates its efforts on issues pertaining to having served in combat on foreign soil.^d

Veterans service organizations have service officers who assist with individual benefits claims.^e The service officer helps the veteran navigate the complex benefits system. They have legislative and advocacy departments that work closely with

^d Personal (email) communication with Jean Reaves. North Carolina Office of Senator Kay Hagan. November 29, 2010.

^e There are also veterans service officers (VSOs) employed by the North Carolina Division of Veterans Affairs (DVA). There are 35 DVA VSOs who operate in 15 DVA District Offices that provide services across the state. There are also 66 full-time county VSOs. The remaining counties without their own county VSOs are served by those from DVA. (Personal communication with Wayne Peedin, December 9, 2010.)

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elected officials on all levels to bring attention to issues that pertain to veterans and their families. Veterans service organizations also have a charitable arm that supports scholarships, special research, purchase of handicapped vans, and a wide array of special projects that support veterans and their families. Most veteran service organizations have subsidiary organizations, such as a Ladies Auxiliary, Sons of American Legion, AMVETS Riders, and others. Membership in these subsidiaries is open to family members of veterans who perhaps did not serve themselves but who want to actively support the work of the organization and to pay honor to their veteran and veterans in general. See Appendix D for a listing of veterans service organizations in North Carolina.^d

Veterans service organizations also promote patriotism through a variety of programs within our schools and through public community services such as on Veterans Day and on Memorial Day. They also honor and recognize America's veterans through their work with homeless veterans, constant vigil for full accountability of Prisoners of War and those Missing in Action (POW/MIAs), and a variety of community service efforts, ranging from Special Olympics and Reserve Officers Training Corps (ROTC) to scouting and organ donations. Finally, veterans service organizations offer a substantial list of benefits to their membership, from discount drug programs to long-term care insurance and travel discounts.^d

Faith Community

The faith community is another important outreach group that helps support the military and their families. In addition to military chaplains and other military faith leaders, most communities in North Carolina have diverse representation of faith communities. Churches, synagogues, mosques, and other places of worship offer a variety of services to their members and communities. Some offer professional counseling and support groups, while others help link community members to resources. Recent evidence shows that having faith and prayer helps people cope with difficult situations.⁷ The role of faith can be described as a type of resiliency. Although there are few evidence-based programs for successful collaboration between the faith community and military, it is important to include faith leaders and communities in discussions about outreach and support.

Other Professional, Advocacy, and Support Services

In addition to CSSP, the Governor's Focus, veterans service organizations, and the faith community, there are a number of organizations across North Carolina that provide professional, advocacy, or other support services. (See Appendix C for a listing of other resources.) When service members and their families go to these outreach organizations, it is important for the organizations to be able to link those with needs beyond their scope of work to appropriate resources. To ensure that outreach organizations are prepared to provide linkages to other resources, the Task Force recommended:

There is a wide variety of veterans service organizations, with each of the 13 in North Carolina having a unique mission. Overall their goal is to advocate for veterans on many different levels and topics.

Recent evidence shows that having faith and prayer helps people cope with difficult situations.

PRIORITY Recommendation 6.2

- a) The Citizen Soldier Support Program; the Governor’s Focus on Servicemembers, Veterans, and Their Families; the North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMHDDSAS); the North Carolina Division of Veterans Affairs; the Department of Veterans Affairs; and other military-related organizations should offer trainings to:
 - 1) Crisis workers, including but not limited to mental health and addiction services staff on mobile crisis teams; screening, triage, and referral (STR) teams; public safety officers; crisis intervention teams (CITs); emergency management technicians (EMTs); disaster and emergency response teams; local sheriff’s offices; and local Red Cross chapters.
 - 2) Veterans service organizations and veterans service officers.
 - 3) Professional advocacy and support organizations, including but not limited to the National Alliance on Mental Illness North Carolina, the Traumatic Brain Injury Association of North Carolina, and other nonprofit organizations that have a mission to serve members of the active duty and reserve components, veteran members of the military, and their families.
- b) Training for all of the groups should cover certain core information, including:
 - 1) 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 (TBI), posttraumatic stress disorder (PTSD), military sexual trauma (MST), depression, substance use disorder (SUD), potential suicide risks, or domestic violence.
 - 2) Strategies to encourage eligible veterans to enroll in and access services through the VA system, including opportunities to enroll former military members with previously undiagnosed PTSD, MST, TBI, or SUD, and those who left under less-than-honorable discharges into the VA system, if the reason for the discharge was due to behavioral health problems that arose or were exacerbated through military service.
 - 3) Available referral sources through 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, Army Reserve Department of Psychological Health, Local Management Entities, North Carolina

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Department of Health and Human Services Office of Citizen Services (e.g., CARE-LINE and CARE-LINK), North Carolina Health Info, Federally Qualified Health Centers, professional advocacy and support services, or other community resources.

- c) In addition to the content listed above, training for crisis workers, professional advocacy and support organizations, and the faith communities should include the following:
- 1) Information about the number of North Carolinians who are serving or who have served in the active duty and reserve components and their families living in North Carolina.
 - 2) Information on 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 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, with a focus on the critical role of the faith community in the provision of assistance with needed service, personal support, and when necessary, grief counseling.
 - 5) Early identification of individual or family members with mental health or substance abuse disorders and appropriate referral sources.
- d) Military chaplains should be involved in the training of the faith community. This training should include information on the important role of faith leaders in providing spiritual support, counseling, and referral into treatment services for active and former members of the military and their families.

Resources for Children in Military Families

Children in military families have unique concerns and needs. As discussed in Chapter 2, there are more than 103,000 children and adolescents of active and reserve components living in North Carolina. Almost 45,000 of these children are under the age of six, 37,000 are between the ages of 6 and 12, and almost 21,000 are between the ages of 13 and 18. Most children spend the majority of their time at school or daycare away from their families. The staff of the schools and other places where children spend their time should be aware of the special characteristics of children in military families.

Military Child Education Coalition

The Military Child Education Coalition (MCEC) is a nonprofit organization focused on ensuring quality educational opportunities for all military-connected children affected by mobility, family separation, and transition. The MCEC performs research, develops resources, conducts professional institutes and conferences, and publishes resources for all constituencies.⁸

Military children generally move from six to nine times during their kindergarten to 12th grade school years. There is great variety among states and even from school to school on academic standards, courses, access to programs, promotion and graduation requirements, programs for children with special needs, and transfer and acceptance of records. These frustrations, in addition to giving up friends and associates with whom a rapport has been established, and separation from a deployed parent (or parents), can create major challenges for the children and family. MCEC's role is to help families, schools, and communities to be better prepared to support children during these frequent moves and this difficult-and sometimes traumatic-time in the life of military families.⁸

MCEC is working to solve the challenge of helping schools and military installations deliver accurate, timely information to meet transitioning parent and student needs, and MCEC seeks to enhance the development and education of children from military families. Their mission is to ensure inclusive, quality educational experiences for all military children affected by mobility, family separation, and transition.⁸

Interstate Compact on Educational Opportunity for Military Children

The Interstate Compact on Education Opportunity for Military Children is an agreement between and among states to use the same set of education policies for children in military families. It was designed to replace the widely varying policies affecting transitioning military students. The compact uses a comprehensive approach that provides a consistent policy in every school district and in every state that chooses to join. The compact addresses key educational transition issues encountered by military families, including enrollment, placement, attendance, eligibility, and graduation. Children of active and reserve component members or of veterans who are medically discharged or retired

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for one year are eligible for assistance under the compact. It was developed by the Council of State Governments' National Center for Interstate Compacts, the Department of Defense, national associations, federal and state officials, departments of education, school administrators, and military families. As of July 2010, there are 35 states that have joined the compact. North Carolina joined the compact in August 2008.⁹ Membership in the compact not only provides benefits to military children in the state but also places some requirements on the state. One of those requirements is to collect data on military children in schools. The Military Child Education Coalition proposes that states add a single field to the state data system that could be populated from information obtained at school enrollment.^f The MCEC notes that there is currently no reliable, consistent, and sustainable data system that collects information on military children. These data would benefit school districts and the state by broadening the possibilities of funding from the US Department of Education, US Department of Defense, and other potential sources. These data would also provide a baseline of information to better understand the impact of military families on local communities.

In order to improve the emotional and psychological well-being of children and families and their impact on North Carolina communities, the Task Force recommended:

Recommendation 6.3

a) The North Carolina State Board of Education (SBE) should require:

- 1) Local Education Agencies (LEAs) to collect information, on an annual basis, about whether a child has an immediate family member who has served in the US military since September 11, 2001, as required in the rules adopted as part of the Interstate Compact on Educational Opportunity for Military Children (NCGS §115C-407.5 et seq.).
- 2) Each LEA to have at least one staff person who is trained on the needs of children of service members. Training should include but not be limited to:
 - a. The numbers of children of current members of the active and reserve components living in their LEA.
 - b. Available curricula on military families.
 - c. The impact of deployments on the emotional and psychological well-being of the children and families.

^f Personal (email) communication with Mary M. Keller, EdD. President and CEO, Military Child Education Coalition. December 1, 2010.

- d. Potential warning signs of emotional and mental health disorders, substance use disorders, suicide risks, child maltreatment, or domestic violence.
 - e. Available referral sources through TRICARE, Department of Veterans Affairs, Military OneSource, Army OneSource, Defense Center of Excellence Deployment Health Clinical Center, North Carolina National Guard's Integrated Behavioral Health System, Army Reserve Department of Psychological Health, Local Management Entities, North Carolina Department of Health and Human Services Office of Citizen Services, North Carolina Health Info, Federally Qualified Health Centers, professional advocacy and support services, or other community resources.
 - f. Scholarships for after-school and enrichment activities available through the Department of Defense, National Guard, or Reserve for children of parents who are actively deployed.
- 3) The trained LEA staff member to provide similar trainings to school administrators, nurses, nurse aides, counselors, and social workers in the LEAs.
- b) The North Carolina General Assembly should require the SBE to report annually on the number of children served through North Carolina public schools who have immediate family members who have served in the US military since September 11, 2001, as well as the number of LEA staff members who have received the specified training. The SBE should submit the report annually to the Appropriations Subcommittee on Education and the Legislative Oversight Committee on Education.

As discussed in Chapter 4, there are programs, such as the North Carolina National Guard Family Assistance Centers and Family Assistance Program, that provide outreach and support for children in military families. There are additional resources across communities in North Carolina. These programs were not a focus of the Task Force but deserve attention and support to help provide the best care for children in military families.

Research

In order to provide effective medical and behavioral health interventions to service members, veterans, and their families, it is necessary to develop an understanding of the types of clinical problems facing this population, the prevalence of the clinical and behavioral problems they experience, and the clinical and policy interventions needed to address them. North Carolina is home to a number of federal, military, academic, and private sector research

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resources. These research institutions are in a unique position to provide the knowledge required to develop and implement evidence-based interventions to address the gaps between the military and civilian systems in the area of behavioral health. It is important that a research agenda be sensitive to all populations impacted by the wars, including active and reserve components, veterans, and their families.

At the population level, surveillance studies are needed to determine the scale and scope of behavioral health problems for veterans, military members, and members of military families living in the state of North Carolina. Such studies should consider barriers that prevent members of the different groups from accessing care as well as identify factors that facilitate care. Without knowledge about the prevalence of behavioral health problems, particularly for service members and families attached to Reserve and National Guard units, it is difficult to measure the impact of new programs in addressing behavioral health issues in this population. In addition, more scientific knowledge is needed to develop evidence-based treatments for individuals. Ongoing research is needed to further understand the nature of behavioral health problems and which treatments are effective in combating them. Two programs uniquely positioned to help lead the effort to provide evidence on which to base behavioral health treatments and policy are Operation Re-entry North Carolina and the VISN 6 MIRECC.

Operation Re-entry North Carolina

Operation Re-entry North Carolina (ORNC) is a research initiative in support of military service personnel, veterans, and their families. This initiative is led by East Carolina University and provisionally funded through a \$2.4M federal appropriation in the FY 2010 Defense Appropriations Act. Through unique university-military partnerships, ORNC addresses the resilience and reintegration concerns of returning combat veterans and the challenges facing the DoD and VA providers who care for them. It was developed as a research support organization to mobilize university expertise and to address gaps within the current military, VA, and TRICARE health systems.^g

The research focus of ORNC lies at the intersection of rehabilitation, behavioral health, and telemedicine. Year 1 pilot research projects focus on innovative applications of biofeedback and virtual reality, balance and hearing analyses, marriage and social resiliency programs, new blood tests for TBI and blast exposure, novel substance abuse and e-mental health interventions, and civilian readiness training utilizing telemedicine networks. The research support activities of ORNC are centered around five cores and their corresponding specific aims:

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^g Personal (email) communication with David Cistola. Operation Re-entry North Carolina. December 5, 2010.

Two programs uniquely positioned to help lead the effort to provide evidence on which to base behavioral health treatments and policy are Operation Re-entry North Carolina and the VISN 6 MIRECC.

- 1) Core A, Research Projects: stimulate innovation and collaboration through faculty-initiated pilot projects,
- 2) Core B, Research Infrastructure: build the technical capabilities and organizational infrastructure needed to conduct collaborative projects of military relevance,
- 3) Core C, Research Training: in collaboration with CSSP, train civilian faculty and students to work effectively with military/veteran populations and DoD/VA collaborators,
- 4) Core D, Research Dissemination: share the latest advances through affiliate faculty appointments for military/VA providers, joint seminar series, and an annual symposium, and
- 5) Core E, Research Leadership: coordinate/participate in UNC system- and state-wide activities in order to build effective high-level research partnerships with regional and national military organizations/VA organizations, including the Naval Hospital Camp Lejeune and the Durham VA Medical Center.⁸

In addition to the ORNC, which has a broad military health research focus, the Department of Veterans Affairs has funded research in VISN 6 (including North Carolina) to study postdeployment mental health in returning veterans.

VISN 6 MIRECC

In 2005, the Office of Mental Health of the Department of Veterans Affairs awarded the Mid-Atlantic Mental Illness Research, Education, and Clinical Center (MIRECC) to a multidisciplinary team of clinicians, educators, and researchers at VA medical centers and community-based outpatient clinics in VISN 6. This VISN 6 MIRECC, along with others in the VA system, is charged with the goal of bringing best practices in mental health care into veteran-serving systems. The Mid-Atlantic MIRECC pursues methodologically rigorous basic, clinical, epidemiologic, and health services research; produces clinical educational programs and products for health care providers, veterans, and their families; and conducts outreach information dissemination projects that seek to advance mental health care in the VA.¹⁰

The Mid-Atlantic MIRECC is organized as a translational medicine center in which the overarching goal is the clinical assessment and treatment of postdeployment mental illness and related problems, and the development of novel mental health interventions through basic and clinical research. This MIRECC aims:

- 1) To determine whether early intervention in postdeployment mental health is effective in decreasing the severity of postdeployment mental illness,
- 2) To determine what neuroimaging, genetic, neurocognitive, or other characteristics predict the development of postdeployment mental illness,

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and

- 3) To assess the longitudinal course of postdeployment mental illness.¹⁰

The MIRECC's organizational structure includes three major components: clinical, research, and education.

The research component is composed of six core areas: intervention, health services, genetics, neuroimaging, neurocognitive, and neuroscience. The platform for much of the MIRECC's research is the recruitment of a large registry of veterans from Operation Enduring Freedom and Operation Iraqi Freedom (OEF/OIF). These cores are tightly integrated so that knowledge gained from one area can be applied in another area—for example, a patient's therapeutic response to a novel drug therapy.¹⁰

The clinical component seeks to define, model, champion, and refine the continuum of care for OEF/OIF mental health needs by means of the public health model. In support of this goal, the clinical component serves as a key driver for the dissemination of evidence-based, actionable quality of care elements across the Mid-Atlantic Healthcare Network and the Veterans Health Administration, in close collaboration with Readjustment Counseling Service; DoD; local, state, and regional community systems of care; and informal community care networks.¹⁰

The education component develops educational materials and experiences to positively impact the mental health of OEF/OIF veterans. These projects target health care providers (both VA and non-VA), veterans, families, clergy, and community members both within VISN 6 and nationally. Methods of delivery include live presentations, print materials, recordings, and the web. The education component seeks to translate best practices and challenging research concepts for other audiences in order to bridge the gap between research and clinical care.¹⁰

Collaboration between research agencies, colleges, universities, and organizations in North Carolina could lead to improvements in many areas of behavioral health for the military and their families. In order to expand research to improve the effectiveness of the behavioral health services provided to active duty and reserve components, veterans, and their families, the Task Force recommended:

Recommendation 6.4

- a) **The University of North Carolina, General Administration, in collaboration with Operation Re-entry North Carolina at East Carolina University, North Carolina Translational and Clinical Sciences Institute, other North Carolina colleges and universities, North Carolina National Guard, military health, and VA should collaborate on research to address the behavioral health problems and challenges facing military personnel, veterans, and family members.**

- 1) The collaborative research teams should include civilian investigators from North Carolina colleges and universities and private research organizations, health providers in regional and national military health system institutions, and providers and investigators in VISN 6 in the VA system. The research should:
 - a. Define the behavioral health problems facing service members, veterans, and their families, with a special emphasis on the behavioral health needs of the Reserve and National Guard.
 - b. Develop, implement, and evaluate innovative pilot programs to improve the quality, accessibility, and delivery of behavioral health services provided to this population.
 - c. Evaluate the effectiveness of new programs put into place by the National Guard and other military organizations to address the behavioral health challenges facing military service personnel, veterans, and family members.
 - d. Conduct research that will help contribute to the knowledge for evidence-based behavioral health screening, diagnosis, treatment, and recovery supports for military service personnel, veterans, and their families.
 - e. Study other issues as requested by the different branches of the military, Reserve and National Guard, and VA to improve behavioral health services for service members, veterans, and their families.
- 2) Collaborative teams and faculty investigators should aggressively pursue federal funding from pertinent agencies to conduct this work.
 - b) The North Carolina General Assembly should direct the University of North Carolina, General Administration, to provide an annual report to the Health Care Oversight Committee and the Legislative Appropriations Subcommittee on Health and Human Services on the research findings generated as part of this initiative.
 - c) The North Carolina National Guard should cooperate in providing information to assess the effectiveness of behavioral health services provided to the North Carolina National Guard.

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Military service has long been associated with honor and sacrifice, but a safe return home does not bring an end to the challenges associated with deployment to a combat area of operations. Instead, returning members of the military may confront pervasive mental health issues, such as depression, suicidal ideation, posttraumatic stress disorder, and the aftermath of traumatic brain injury. Individuals may face more than one mental health condition at the same time. These conditions can go undetected and untreated and have been described as “invisible wounds.” In addition, many of our service members struggle with the misuse of substances such as tobacco, alcohol, and other drugs. As service members return to daily life within their family and community environments, difficulties are commonly encountered.¹

The challenges that confront members of the military and their families are especially relevant to North Carolina. Approximately one-third (35%) of state’s population is in the military, a veteran, a spouse, a surviving spouse, a parent, or a dependent of someone connected to the military. 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 Reserves. There are nearly 800,000 veterans who live in North Carolina, which places North Carolina fifth in military retiree population and ninth in veteran population in the country. More than 100,000 children and adolescents of active duty and reserve components live in North Carolina.²

Active duty and reserve component service members, retirees, veterans, and their families are potentially eligible for a wide array of mental health and behavioral health services available through the federal government. Although the federal government provides services through military treatment facilities, TRICARE, and the VA, these services are not available to everyone who has served in the armed forces or to all their families. A major goal of the Task Force was to help people access federal services to which they are entitled. In order to do so, it was necessary to understand who qualifies for these programs and services, as well as gaps in coverage and the rates of utilization of these services. Although there are gaps in access to services for some groups of service members or family members, improvements are being made to ensure access to mental health and substance use services for all active and former service members and their families who are eligible for health care through the federal system. When individuals are not able to access services through the federal system because of barriers, including eligibility restrictions, stigma, and provider shortages, it is important to link them to state resources.



The challenges that confront members of the military and their families are especially relevant to North Carolina.

This final report provides 13 recommendations to help ensure that the mental health, substance abuse, and brain injury services that are available to active and reserve component members of the military, veterans, and their families are adequate to meet the needs today and in the future.

Service members who have been discharged from active or reserve components may have access to private third-party health insurance coverage, either through their civilian employer, a spouse, or private purchase. In addition, others have publicly subsidized coverage through Medicaid, the Children’s Health Insurance Program, or Medicare. Many individuals seek services first 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 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, and the informal system of peer support or counseling through faith leaders—can provide needed mental health and substance abuse services. Yet there are still barriers that former members of the active and reserve components, veterans, and their families can experience in accessing needed services.

Although both federally funded and state-funded systems provide services to service members and their families, the transition between the systems may present more difficulty in receiving behavioral health services. Collaboration between the systems and helping civilian providers understand the unique circumstances of military families can help bridge those gaps. Outreach organizations, including research centers, veterans service organizations, the faith community, and other professional, advocacy, and support services, can help connect service members and their families with the most appropriate resources.

The North Carolina General Assembly directed the North Carolina Institute of Medicine (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 components of the military, veterans, and their families. The NCIOM was also asked to determine any gaps in services.^a The Task Force focused on examining state services that can help address gaps in behavioral health services available through the military or Veterans Affairs. This final report provides 13 recommendations to help ensure that the mental health, substance abuse, and brain injury services that are available to active and reserve component members of the military, veterans, and their families are adequate to meet the needs today and in the future.

Below is an abridged list of the Task Force recommendations, along with the agencies or organizations charged with addressing the recommendation. The grid also includes the costs of implementing the recommendations, when known. A list of the complete Task Force recommendations can be found in Appendix A. Four of the 13 recommendations were considered by the Task Force

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

Conclusion

to be priority recommendations. Given the state’s limited budget, the Task Force included only two priority recommendations that would need additional state appropriations. However, all of the recommendations should be implemented to ensure that service members, veterans, and their families have access to the behavioral health services and other supports to meet their unique needs.

RECOMMENDATION	NCGA	State Agencies	Federal Agencies	Others
<p>PRIORITY 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</p> <p>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 the pilot 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.</p>	\$1.47M (R)	✓ (DCCP, NCNG)	✓ (NCNG)	
<p>Recommendation 4.2: Expand access to mental health and substance abuse professionals in the military health system</p> <p>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 DoD to work to integrate TBI community based day services for military and civilian personnel.</p>		✓ (DMHDDSAS)	✓ (NCCD, DoD, VA)	
<p>Recommendation 5.1: Expand the system of care for traumatic brain injury (TBI)</p> <p>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.</p>		✓ (DMHDDSAS)	✓ (DoD, VA)	

RECOMMENDATION	NCGA	State Agencies	Federal Agencies	Others
<p>Recommendation 5.2: Expand TBI diagnostic testing</p> <p>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.</p>		<p>✓ (DMA)</p>	<p>✓ (VA)</p>	<p>✓ (MS)</p>
<p>PRIORITY Recommendation 5.3: Provide training for health professionals and hospital administrators</p> <p>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.</p>	<p>\$250K (NR)</p>	<p>✓ (AHEC, UNC, NCCCS, DMHDDSAS)</p>	<p>✓</p>	<p>✓ (CSSP, GF)</p>
<p>Recommendation 5.4: Improve reimbursement to behavioral health providers who meet certain standards</p> <p>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.</p>	<p>\$ n/a#</p>	<p>✓ (DMA, DMHDDSAS)</p>		
<p>Recommendation 5.5: Expand collocation and integration of behavioral health and primary care services</p> <p>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</p>	<p>\$500K (R)</p>	<p>✓ (NCORHCC, DMHDDSAS)</p>		<p>✓ (NCFAHP, NCCHCA, NCCCN)</p>

RECOMMENDATION	NCGA	State Agencies	Federal Agencies	Others
<p>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.</p>				
<p>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.</p>	\$128.5K (R)	✓ (DHHS)		
<p>PRIORITY 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 The North Carolina Division of Metal Health, Developmental Disabilities, and Substance Abuse Services (DMHDDSAS), and 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. DHMDDSAS 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 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 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.</p>		✓ (DMHDDSAS)		
<p>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 providers in the state. If efforts to obtain federal funding are unsuccessful or insufficient, the North Carolina General Assembly should appropriate \$1.9 million</p>	\$1.9M SFY12* (R)	✓ (UNC, NCCCS, GISA)		

RECOMMENDATION	NCGA	State Agencies	Federal Agencies	Others
<p>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.</p>				
<p>PRIORITY Recommendation 6.2: Provide training for crisis workers, veteran service organizations and veteran service officers, professional advocacy and support organizations, and the faith community</p> <p>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.</p>		<p>✓ (DMHDDSAS, DVA)</p>	<p>✓ (VA)</p>	<p>✓ (CSSP, GF)</p>
<p>Recommendation 6.3: Improve support for military children in the North Carolina school system</p> <p>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.</p>	<p>✓ (no cost)</p>	<p>✓ (DPI, SBE)</p>		
<p>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.</p> <p>The University of North Carolina, General Administration, in collaboration 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.</p>		<p>✓ (NCNG, UNC)</p>	<p>✓ (DoD, NCNG, VA)</p>	<p>✓ (Colleges & Universities)</p>

*Funding changes over time - \$1.9M in recurring funds in SFY 2012, \$2.6M in recurring funds in SFY 2013, and \$3.15M in recurring funds in SFY 2013 and thereafter.

#Funding will depend on the methods DMA and DMHDDSAS use to improve reimbursement.

Key:

AHEC	Area Health Education Center program
CSSP	Citizen Soldier Support Program
DoD	US Department of Defense
DCCP	Department of Crime Control and Prevention
DHHS	Department of Health and Human Services
DMA	Division of Medical Assistance
DMHDDSAS	Division of Mental Health, Developmental Disabilities, and Substance Abuse Services
DPI	Department of Public Instruction
DVA	North Carolina Division of Veterans Affairs
GF	Governor's Focus on Service Members, Veterans, and Their Families
GISA	Governor's Institute of Substance Abuse
LEA	Local Education Agency
LME	Local Management Entity
MS	MedSolutions
NCCCN	North Carolina Community Care Networks
NCCCS	North Carolina Community College System
NCCD	North Carolina Congressional Delegation
NCCHCA	North Carolina Community Health Center Association
NCFAHP	North Carolina Foundation for Advanced Health Programs
NCGA	North Carolina General Assembly
NCNG	North Carolina National Guard
NCORHCC	Office of Rural Health and Community Care
n/a	not applicable
NR	non recurring
R	recurring
SBE	State Board of Education
UNC	University of North Carolina System
VA	US Department of Veterans Affairs

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Chapter 4: Health Care Benefits for Veterans and Active Duty Military and Their Families through the Federal System

PRIORITY Recommendation 4.1

- a) The General Assembly should appropriate \$1,470,000^a in recurring funds to the North Carolina Department of Crime Control and Prevention to sustain and to add to the North Carolina National Guard Integrated Behavioral Health System, currently located at four Family Assistance Centers and available to all who have served in the military through the active and reserve components and their families. Priority should be given to individuals who are not eligible for or who have difficulty accessing Department of Veterans Affairs (VA) services or TRICARE. Funding for the pilot program should be used to support:
 - 1) Full-time behavioral health clinicians and behavioral health case managers in each of the seven North Carolina National Guard (NCNG) Family Assistance Centers (FACs).
 - 2) Contracts with peers who are veterans and/or family members with appropriate mental health, substance abuse, or behavioral health trainings to provide services and support for active and retired members of the active duty and reserve components, veterans, and their families.
 - 3) Linkages between trained mental health, substance abuse, and behavioral health counselors and psychiatrists or other licensed professionals who can provide medication management or health services needed to address more significant health problems.
 - 4) Use of telepsychiatry in rural areas to expand availability of psychiatric services for active duty and retired members of the active and reserve components, veterans, and their families.
- b) In addition to the NCNG clinical providers, additional personnel and resources should be collocated in the FACs, including but not limited to:
 - 1) Veteran services officers,

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

- 2) VA-trained mental health and addiction services providers, including contract behavioral health personnel through the Veterans Integrated Service Network 6 Rural Health Initiative,
 - 3) Division of Mental Health, Developmental Disabilities, and Substance Abuse Services providers and other state and local agency representatives as appropriate, and
 - 4) Other professional, advocacy, and support services.
- c) The Family Assistance Centers should report annually to the House and Senate Appropriations Subcommittees on Justice and Public Safety and to the House Committee on Military and Homeland Security on:
- 1) Services provided
 - 2) Number and type of active and reserve component service members, veterans, and family members served

Recommendation 4.2

The North Carolina Congressional delegation should work with Congress to :

- a) Increase funding for behavioral health services for members of the active and reserve components, veteran members of the military, and their families. Special emphasis must be made on meeting the behavioral health needs of the Reserve and National Guard.
- b) Direct the Department of Defense (DoD) to change policies to allow licensed substance abuse professionals and other licensed behavioral health professionals to be credentialed as a participating provider in TRICARE.
- c) Direct the Department of Veterans Affairs (VA) to designate staff time to provide family and couple's counseling and psychoeducation as a part of mental and behavioral health services provided to veterans with behavioral health problems in the VA health care system.
- d) Direct the VA and DoD to work with the North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, and other state TBI service organizations, to support efforts to integrate services for both civilian and military personnel for community-based reintegration day programs.

Chapter 5: Nonmilitary Public and Private Insurance Coverage, and Availability of Mental Health and Substance Abuse Services

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.

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.

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.

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.

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.

- b) The North Carolina General Assembly should appropriate \$500,000^b 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.

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.

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

^b 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.

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.

Chapter 6: Workforce and Outreach for the Military and Their Families

Pecommendation 6.1

- a) 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 providers in the state.
 - 1) North Carolina institutions of higher education should ensure that the curriculum includes information that educates health professionals about the unique behavioral health needs of the active duty and reserve components and their families, as specified in more detail in Recommendation 5.3.
 - 2) Funding should be used to help support people seeking training through the community colleges, undergraduate education, master's or doctoral degree programs or those who are seeking to pay for the hours of supervised training needed for their license. Priority for enrollment should be given to individuals who have served in the military through active duty and reserve components and those who are willing to work with military members and their families.
- b) If efforts to obtain federal funding are unsuccessful or insufficient, the North Carolina General Assembly should appropriate \$1.9 million beginning in FY 2011. Of this:
 - 1) \$750,000 in recurring funds in SFY 2011, \$1.5 million in recurring funds in SFY 2012, and \$2.0 million in recurring funds in SFY 2012 and thereafter 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 training. Funding should be provided to help support people seeking training through the community colleges, undergraduate education, master's or doctoral degree programs or those who are seeking to pay for the hours of supervised training needed for their license. Priority for enrollment should be given to individuals who have served in the military through active duty and reserve components. Individuals who receive state funds must agree to work for one year in a public or private not-for-profit substance abuse treatment program for every \$4,000 in scholarship funds, and must agree to serve the active duty and reserve components and their families.

- 2) \$750,000 to increase the number of qualified mental health professionals who are seeking training through community colleges, undergraduate programs, and graduate education programs or who are seeking to pay for the hours of supervised training needed for their licensure (i.e., psychiatrist, psychologist, LPC, LCSW). Priority should be given to individuals who have served in the military through the active duty and reserve components. Individuals who receive state funds must participate in training on military culture, military benefits, and military resiliency and agree to work for a year accepting individuals with TRICARE insurance for every \$4,000 in scholarship funds.
- 3) \$400,000 in recurring funds to the Area Health Education Center (AHEC) program to establish clinical training sites for people seeking their substance abuse professional credentials, and to develop and support new residency training rotations for psychiatrists, family physicians, emergency medicine physicians, or other physicians likely to enter the addiction field. AHEC shall give priority to clinical training sites or residency training rotations that expose health professionals to working with active duty and reserve components, veterans, and their families.

PRIORITY Recommendation 6.2

- a) The Citizen Soldier Support Program; the Governor's Focus on Servicemembers, Veterans, and Their Families; the North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMHDDDSAS); the North Carolina Division of Veterans Affairs; the Department of Veterans Affairs; and other military-related organizations should offer trainings to:
 - 1) Crisis workers, including but not limited to mental health and addiction services staff on mobile crisis teams; screening, triage, and referral (STR) teams; public safety officers; crisis intervention teams (CITs); emergency management technicians (EMTs); disaster and emergency response teams; local sheriff's offices; and local Red Cross chapters.
 - 2) Veterans service organizations and veterans service officers.
 - 3) Professional advocacy and support organizations, including but not limited to the National Alliance on Mental Illness North Carolina, the Traumatic Brain Injury Association of North Carolina, and other nonprofit organizations that have a mission to serve members of the active duty and reserve components, veteran members of the military, and their families.

- b) Training for all of the groups should cover certain core information, including:
- 1) 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 (TBI), posttraumatic stress disorder (PTSD), military sexual trauma (MST), depression, substance use disorder (SUD), potential suicide risks, or domestic violence.
 - 2) Strategies to encourage eligible veterans to enroll in and access services through the VA system, including opportunities to enroll former military members with previously undiagnosed PTSD, MST, TBI, or SUD, and those who left under less-than-honorable discharges into the VA system, if the reason for the discharge was due to behavioral health problems that arose or were exacerbated through military service.
 - 3) Available referral sources through 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, Army Reserve Department of Psychological Health, Local Management Entities, North Carolina Department of Health and Human Services Office of Citizen Services (e.g., CARE-LINE and CARE-LINK), North Carolina Health Info, Federally Qualified Health Centers, professional advocacy and support services, or other community resources.
- c) In addition to the content listed above, training for crisis workers, professional advocacy and support organizations, and the faith communities should include the following:
- 1) Information about the number of North Carolinians who are serving or who have served in the active duty and reserve components and their families living in North Carolina.
 - 2) Information on 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 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, with a focus on the critical role of the faith community in the provision of assistance with needed service, personal support, and when necessary, grief counseling.

- 5) Early identification of individual or family members with mental health or substance abuse disorders and appropriate referral sources.
- d) Military chaplains should be involved in the training of the faith community. This training should include information on the important role of faith leaders in providing spiritual support, counseling, and referral into treatment services for active and former members of the military and their families.

Recommendation 6.3

- a) The North Carolina State Board of Education (SBE) should require:
 - 1) Local Education Agencies (LEAs) to collect information, on an annual basis, about whether a child has an immediate family member who has served in the US military since September 11, 2001, as required in the rules adopted as part of the Interstate Compact on Educational Opportunity for Military Children (NCGS §115C-407.5 et seq.).
 - 2) Each LEA to have at least one staff person who is trained on the needs of children of service members. Training should include but not be limited to:
 - a. The numbers of children of current members of the active and reserve components living in their LEA.
 - b. Available curricula on military families.
 - c. The impact of deployments on the emotional and psychological well-being of the children and families.
 - d. Potential warning signs of emotional and mental health disorders, substance use disorders, suicide risks, child maltreatment, or domestic violence.
 - e. Available referral sources through TRICARE, Department of Veterans Affairs, Military OneSource, Army OneSource, Defense Center of Excellence Deployment Health Clinical Center, North Carolina National Guard's Integrated Behavioral Health System, Army Reserve Department of Psychological Health, Local Management Entities, North Carolina Department of Health and Human Services Office of Citizen Services, North Carolina Health Info, Federally Qualified Health Centers, professional advocacy and support services, or other community resources.

- f. Scholarships for after-school and enrichment activities available through the Department of Defense, National Guard, or Reserve for children of parents who are actively deployed.
- 3) The trained LEA staff member to provide similar trainings to school administrators, nurses, nurse aides, counselors, and social workers in the LEAs.
- b) The North Carolina General Assembly should require the SBE to report annually on the number of children served through North Carolina public schools who have immediate family members who have served in the US military since September 11, 2001, as well as the number of LEA staff members who have received the specified training. The SBE should submit the report annually to the Appropriations Subcommittee on Education and the Legislative Oversight Committee on Education.

Recommendation 6.4

- a) The University of North Carolina, General Administration, in collaboration with Operation Re-entry North Carolina at East Carolina University, North Carolina Translational and Clinical Sciences Institute, other North Carolina colleges and universities, North Carolina National Guard, military health, and VA should collaborate on research to address the behavioral health problems and challenges facing military personnel, veterans, and family members.
- 1) The collaborative research teams should include civilian investigators from North Carolina colleges and universities and private research organizations, health providers in regional and national military health system institutions, and providers and investigators in VISN 6 in the VA system. The research should:
- a. Define the behavioral health problems facing service members, veterans, and their families, with a special emphasis on the behavioral health needs of the Reserve and National Guard.
 - b. Develop, implement, and evaluate innovative pilot programs to improve the quality, accessibility, and delivery of behavioral health services provided to this population.
 - c. Evaluate the effectiveness of new programs put into place by the National Guard and other military organizations to address the behavioral health challenges facing military service personnel, veterans, and family members.

- d. Conduct research that will help contribute to the knowledge for evidence-based behavioral health screening, diagnosis, treatment, and recovery supports for military service personnel, veterans, and their families.
 - e. Study other issues as requested by the different branches of the military, Reserve and National Guard, and VA to improve behavioral health services for service members, veterans, and their families.
- 2) Collaborative teams and faculty investigators should aggressively pursue federal funding from pertinent agencies to conduct this work.
- b) The North Carolina General Assembly should direct the University of North Carolina, General Administration, to provide an annual report to the Health Care Oversight Committee and the Legislative Appropriations Subcommittee on Health and Human Services on the research findings generated as part of this initiative.
 - c) The North Carolina National Guard should cooperate in providing information to assess the effectiveness of behavioral health services provided to the North Carolina National Guard.

Priority 1:

- Veterans with VA-rated service-connected disabilities 50% or more disabling
- Veterans determined by VA to be unemployable because of service-connected conditions

Priority 2:

- Veterans with VA-rated service-connected disabilities 30% or 40% disabling

Priority 3:

- Veterans who are Former Prisoners of War (POWs)
- Veterans awarded a Purple Heart medal
- Veterans whose discharge was for a disability that was incurred or aggravated in the line of duty
- Veterans with VA-rated service-connected disabilities 10% or 20% disabling
- Veterans awarded special eligibility classification under Title 38, U.S.C., § 1151, “*benefits for individuals disabled by treatment or vocational rehabilitation*”

Priority 4:

- Veterans who are receiving aid and attendance or housebound benefits from VA
- Veterans who have been determined by VA to be catastrophically disabled

Priority 5:

- Nonservice-connected veterans and noncompensable service-connected veterans rated 0% disabled by VA with annual income and net worth below the VA National Income Thresholds
- Veterans receiving VA pension benefits
- Veterans eligible for Medicaid programs

Priority 6:

- World War I veterans
- Compensable 0% service-connected veterans
- Veterans exposed to Ionizing Radiation during atmospheric testing or during the occupation of Hiroshima and Nagasaki
- Project 112/SHAD participants
- Veterans who served in a theater of combat operations after November 11, 1998, as follows:
 - Currently enrolled veterans and new enrollees who were discharged from active duty on or after January 28, 2003, are eligible for the enhanced benefits for five years after discharge
 - Veterans discharged from active duty before January 28, 2003, who apply for enrollment on or after January 28, 2008, are eligible for this enhanced enrollment benefit through January 27, 2011

NOTE: At the end of this enhanced enrollment priority group placement period, veterans will be assigned to the highest Priority Group for which their unique eligibility status at that time qualifies them.

Priority 7:

- Veterans with income and/or net worth above the VA national income threshold and income below the VA National Geographic Income Thresholds who agree to pay copays

Priority 8:

- Veterans with income and/or net worth above the VA National Income Thresholds and the VA National Geographic Income Thresholds who agree to pay copays

Veterans eligible for enrollment: Noncompensable 0% service-connected and:

- **Subpriority a:** Enrolled as of January 16, 2003, and who have remained enrolled since that date and/or have been placed in this subpriority because of changed eligibility status
- **Subpriority b:** Enrolled on or after June 15, 2009, and whose income exceeds the current VA National Income Thresholds or VA National Geographic Income Thresholds by 10% or less

Veterans eligible for enrollment: Nonservice-connected and:

- **Subpriority c:** Enrolled as of January 16, 2003, and who have remained enrolled since that date and/or have been placed in this subpriority because of changed eligibility status
- **Subpriority d:** Enrolled on or after June 15, 2009, and whose income exceeds the current VA National Income Thresholds or VA National Geographic Income Thresholds by 10% or less

Veterans not eligible for enrollment: Veterans not meeting the criteria above:

- **Subpriority e:** Noncompensable 0% service-connected
- **Subpriority g:** Nonservice-connected

Source: VA Health Care. Fact Sheet 164-2. Enrollment Priority Groups. June 2010. Available at <http://www.va.gov/healtheligibility/Library/pubs/EPG/EnrollmentPriorityGroups.pdf>

Carolina Military Personnel and their Families

National Guard Programs and Services:

The North Carolina National Guard has developed a number of support services to increase soldier resiliency, prevent suicide, support psychological fitness for operational readiness, re-integrate service members back into civilian society and reassure Survivors that they are continually linked to the Military Family for as long as they desire. The Guard works collaboratively with many military and community partners to create a safety net that provides confidential referrals for soldiers and educates front line and senior leadership about behavioral health issues.

North Carolina National Guard Family Programs

(800) 621-4136

<http://www.nc.ngb.army.mil/index.php/fp/fac>

Family Assistance Centers are located throughout North Carolina. Representatives are subject-matter specialists on health care issues, personal and financial matters, ID cards, DEERS Enrollment, TRICARE and other matters of importance to military families.

North Carolina National Guard (NCNG) Integrated Behavioral Health System

(800) 621-4136

The NCNG Integrated Behavioral Health System has been created to assist service and family members using an 800 number to access timely assessment of risk and needs (clinical and other). Leaders, service members, and families can call the auto-attendant number 24-hours a day, 7 days a week, to gain access into the System for consultation, assessment of need and risk, and to receive immediate and appropriate referrals to internal and external resources. All cases are then followed up by the NCNG case management team. The System is manned and facilitated by contracted licensed NCNG clinical staff. While the 800 # is not a hot line, answered live, all calls are returned in time sensitive fashion.

North Carolina National Guard (NCNG) Family Readiness Program

<http://www.guardfamily.org/FP/Readiness.aspx>

The NCNG Family Readiness Program provides support for service members and their families who are not located on a military facility. The Program strives to ensure the more than 11,700 National Guard service members and their families are prepared for whatever deployment phase they may be facing. The Program provides training and education to prepare families for the call to state or federal active duty. This program employs Military and Family Life Consultants (MFLCs), to provide free, direct, and confidential assistance and counseling to soldiers and their families. The Program also operates three types of Family Assistance Centers (FACs) to provide various support services such as counseling for mental health disorders and marital problems, support groups for families, and financial and employment counseling.

Yellow Ribbon

<http://www.yellowribbon.mil>

The Yellow Ribbon Program provides support services for National Guard and Reserve members and their families throughout the deployment cycle. This program provides one-day briefing seminars before deployment, during deployment, and two times after deployment. During each briefing, service members are provided with information regarding services, entitlements, benefits and resources that are available such as Military OneSource, the Family Readiness program and MFLCs, Psychological Health Program, TRICARE and the VA. The focus of post-deployment briefings is to provide services regarding reintegration and health issues to returning service members.

Statewide Services and Programs:**Alcohol and Drug Council of North Carolina National Guard Project**

3500 Westgate Drive, Suite 204, Durham, NC 27707

(800) 688-4232

<http://www.alcoholdrughelp.org/national-guard-project>

The Alcohol and Drug Council of North Carolina's (ADCNC) National Guard Veteran's Project's mission is to improve the ability of the State to provide appropriate clinical substance abuse interventions, assessments and treatment referrals to service members who are at risk for substance abuse disorders. The primary goals of this project are to improve service member's access to quality drug assessments in order to help military organizations determine a soldier's fitness for duty and to coordinate the assessments with additional services as needed.

Brain Injury Association of North Carolina (BIANC)

Family Helpline (800) 377-1464

<http://www.bianc.net/index.htm>

BIANC provides a forum for state, military, veteran and local agencies to work together on military, veteran and family needs. BIANC develops, supports, and/or administers programs, services, and activities that make a difference to those that have been affected by the trauma of brain injury including military and veterans. BIANC's mission is to offer help, hope, and a voice for people with brain injury, and their families by prevention, education, research and advocacy. BIANC currently has Family and Community Support Centers in Raleigh, Charlotte, Greenville, and Asheville, and a volunteer resource center in Winston-Salem. BIANC participates in the statewide Governor's Focus on Servicemembers, Veterans and Families.

Military Personnel and their Families

CARE-LINE and NC careLINK

North Carolina Department of Health and Human Services
Office of Citizen Services
(800) 662-7030
<https://www.nccarelink.gov>

CARE-LINE is a toll free number, available from 8 am to 5 pm, Monday through Friday, except holidays, in English and Spanish, linking callers to services in government, faith-based organizations, and for-profit and non-profit agencies. Staff is trained and data are reviewed by members of the Governor's Focus group. The website [NC careLINK.gov](http://NC.careLINK.gov) maintains a section of the site to assist veterans and their families find benefits and financial assistance programs, hospital and medical services, and counseling services.

CitizenSoldierSupport.org

<http://www.citizensoldiersupport.org>

The Citizen Soldier Support Program (CSSP) is a congressionally authorized, federally funded grant administered through the Odum Institute for Research and Social Science at the University of North Carolina at Chapel Hill. CSSP is a capacity-building initiative designed to strengthen community support for National Guard and Reserve members and their families. CSSP focuses on increasing geographic and financial access to deployment and post-deployment related behavioral health services, especially for those living in rural areas. CSSP efforts center around training civilian behavioral health providers and enrolling them into a web-based provider database at www.warwithin.org.

Families at Ease

(866) 947-8018
<http://www.mirecc.va.gov/FamiliesAtEase>

The Families at Ease program works with family members who become aware of their veteran's post-deployment difficulties and supports their efforts to find help for the veteran. Families at Ease also helps veterans having difficulty transitioning from combat to home life by suggesting, providing, and referring resources to help veterans get the treatment and support they need.

Governor's Focus on Servicemembers, Veterans, and Their Families

<http://www.veteransfocus.org>

The mission of the Governor's Focus on Servicemembers, Veterans, and their Families is to promote evidence-based and best practices in the screening, assessment, and treatment of active and reserve components and veterans who served in the military and their families. This effort includes the articulation and implementation of an integrated continuum of care that emphasizes access, quality, effectiveness, efficiency, and compassion. Principles of resilience, prevention, and recovery are emphasized along with state-of-the-art clinical services as part of a balanced public health and behavioral health approach. The Governor's Focus envisions a referral network of services that will comprise a system through which servicemembers, veterans, and their families will have access to assistance during all stages of the deployment cycle in North Carolina.

Military and Veterans Rural Network Initiative (MVRNI)

John Harris, MSW QMHP

North Carolina Department of Health and Human Services

Division of Mental Health, Developmental Disabilities, and Substance Abuse Services

john.w.harris@dhhs.nc.gov

The MVRNI is a planned initiative which will develop and utilize a caregiver and veteran centered service model to create collaborative, targeted rural wellness services designed to bridge gaps and create vital connections to the VA at the rural community service level. MVRNI will connect caregivers and rural veterans with needed support services that are available but not fully accessible to them.

The National Alliance on Mental Illness (NAMI) North Carolina

(800) 451-9682, Monday - Friday 8:30 am to 5 pm

mail@naminc.org

<http://www.naminc.org>

NAMI NC provides support, education and advocacy for individuals who have been diagnosed with a mental illness, their families and friends. Free, psycho-educational classes and support groups are available for family members, parents of diagnosed children or adolescents, and peers. Please see the web site for a full description of classes and support groups. NAMI NC currently offers a growing program for veterans in 5 VA hospitals around the state. For online resources for veterans, visit NAMI's Veterans Resources Center at <http://www.nami.org/veterans>.

North Carolina Department of Administration

Division of Veterans Affairs (NCDVA)

1315 Mail Service Center, Raleigh, NC 27699

(919) 733-3851

<http://www.ncveterans.net>

The NCDVA offers assistance through a network of District and County Veterans Service Offices available on the web site and at no charge to the citizen. NCDVA assists veterans and their families in the presentation, processing, proof and establishment of claims, privileges, rights and benefits as they may be entitled to under Federal, State or local laws.

NC Division of Mental Health, Developmental Disabilities and Substance Abuse Services (NC MH/DD/SAS)

3007 Mail Service Center, Raleigh, NC 27699

(919) 733-4670

Contact DMH@dhhs.nc.gov

Services include a range of prevention, treatment, recovery and supports for those experiencing problems related to mental illness, intellectual and developmental disabilities including TBI (IDD), and substance use disorders. Services are delivered locally by critical access behavioral health agencies and many other providers managed by 24 Local Management Entities (LMEs). The system of care includes inpatient, residential and outpatient care as well as waiver and other supports for those with IDD needs.

Military Personnel and their Families

NC Traumatic Brain Injury Program

(919) 715-5989

<http://www.ncdhhs.gov/mhddsas/tbi/index.htm>

The NC Traumatic Brain Injury Program is housed within the NC Division of Mental Health, Developmental Disabilities and Substance Abuse Services. Its roles include advocating for survivors of traumatic brain injuries and their families and overseeing and supporting services/supports statewide. The Program supports day programs; residential programs; Brain Injury Association of North Carolina Family & Community Assistance Centers and support groups; and services to individuals through local mental health, developmental disabilities and substance abuse programs; and education and training. The program works with the division's military liaison to collaborate with military and veteran groups in North Carolina and with the statewide Governor's Focus on Servicemembers, Veterans and Families.

NC Health Info

Health Sciences Library, CB 7585

University of North Carolina at Chapel Hill, Chapel Hill, NC 27599

(919) 843-6236

<http://www.nchealthinfo.org>

NC Health Info features a Military Health section that provides easy-to-use, reliable information on military-related health conditions, PTSD, TBI, trauma and grief, depression, substance use, deployment issues, TRICARE and issues related to military children. The Go Local section is a comprehensive listing of NC based veteran and military related programs, providers and services on a statewide or county by county basis. Service members and their families can find information on veterans' benefits and services, health facilities, referral services, and other services related to military health.

Operation Re-Entry NC

Mail Stop 668, CAHS Dean's Office

East Carolina University, Greenville, NC 27834

(252)744.6012

<http://www.ecu.edu/ornc>

Operation Re-entry North Carolina (ORNC) is a research initiative in support of military service personnel, veterans and their families. Through innovative projects and partnerships, ORNC addresses the resilience and reintegration concerns of combat veterans returning from deployment and the challenges facing the Department of Defense and VA health providers who care for them. It is a research support organization designed to address critical gaps in behavioral health and rehabilitation, and to apply telemedicine and advanced technology to improve quality and access to services. This research initiative is led by East Carolina University and provisionally funded through the U.S. Department of Defense.

Public Schools of North Carolina

<http://www.ncpublicschools.org/militarysupport>

To help North Carolina educators identify and assist children who are dealing with the stress and other problems caused by deployment, the North Carolina Department of Public Instruction and the North Carolina National Guard Family Readiness Program developed the North Carolina Supports Military Children web site of resources to help teachers and public schools provide stability and a normal routine for military families.

Strengthening Military Families with Children Who Have Developmental Disabilities: OneStop for Family Support

School of Social Work, CB #3550

University of North Carolina at Chapel Hill, Chapel Hill, NC 27599

Phone: (919) 962-6542

This project implements an evidence-based model of peer support, develops an integrated military-civilian family support system in the Camp Lejeune area, and raises public awareness of the issues facing military families across the state. The project aims to increase access to needed support for both active and reserve component military families living off base across North Carolina and to promote the development of an integrated military-civilian family support system for military families with children who have developmental disabilities across North Carolina.

United for Health

PO Box 1717, New Bern, NC 28563

(252) 808-5978

<http://www.united4health.org>

United for Health is a collaboration of groups in eastern North Carolina that is committed to improving the health, safety and well being of individuals and families by reducing substance abuse problems. The current focus of The United for Health collaborative is to reduce alcohol-related motor vehicle crashes and fatalities in Onslow County and on Marine Corp Base Camp Lejeune, as well as the surrounding communities of Craven, Carteret, Jones and Pamlico counties. United for Health utilizes The Domino Strategy™, a national social marketing campaign that introduces responsible drinking guidelines. The Domino Strategy™ is the first social marketing collaboration of its kind between military installations in eastern North Carolina and the local communities surrounding those installations.

Military Personnel and their Families

Department of Veterans Affairs (VA) Health Care

<http://www.va.gov/health/default.asp>

In North Carolina, the VA provides mental health and substance use services through four VA Medical Centers, twelve community based outpatient clinics and five vet centers. The VA provides diagnostic and treatment planning evaluations, treatment services, consultation, evidence-based psychotherapy, referrals to inpatient and residential care programs, PTSD specialists, military sexual trauma clinics, mental health intensive case management, psychosocial rehabilitation services, individual and group counseling to veterans and their families, as well as homeless programs, patient education and family education. The five vet centers in North Carolina provide readjustment counseling and outreach services to all veterans who served in any combat zone and to their family members.

Veterans Integrated Service Network (VISN) 6 Mental Illness Research, Education and Clinical Center (MIRECC)

Durham VA Medical Center, Durham, NC

<http://www.mirecc.va.gov/visn6>

MIRECC is focused on post deployment mental health issues. MIRECC's goals are to improve clinical assessment and treatment and develop novel interventions through basic and clinical research. The MIRECC site points veterans and their families to information and resources to assist during the phases of deployment and the readjustment process. MIRECC also serves providers needing further education on the topics of post-deployment mental health and/or brain injury. There are also clinical resources that include how to enroll in VA health care, information on symptom management, and good healthy living strategies.

WarWithin.org

<http://www.warwithin.org>

WarWithin.org provides a directory of primary health care and behavioral health providers who are trained in, or who have expressed an interest in serving the specific needs of military members and their families. With more than 1200 providers in NC representing 96% of the counties, this database enables veterans and family members to find local civilian health providers who understand the challenges of deployment-related issues such as PTSD, TBI, depression, substance use disorder and suicide and to address the concern that a reservist might have a lapse in care during the deployment cycle as they switch from civilian to military health insurance. WarWithin.org was created by the Citizen Soldier Support Program (CSSP) and is hosted through the Odum Institute at the University of North Carolina at Chapel Hill.

North Carolina Department of Correction Programs

The North Carolina Department of Correction is working with the Health Care for Reentry Veterans (HCRV) Program of the VA to identify inmates who are veterans. It is estimated that 20% of the 42,000 NC inmates may be veterans. To date, over 2,000 veterans have self-identified. The prison staff is trying to help veterans obtain their benefits before they are discharged. A HCRV Specialist provides pre-release assessment services; referrals to medical, psychiatric, and social services; and short term case management upon release with a goal to prevent homelessness, reduce the impact of medical and mental health problems upon the community and reduce the recidivism rate.

Jail Diversion and Trauma Recovery Program

<http://www.ncoperationrecovery.org>

This is a Substance Abuse and Mental Health Services Administration funded program developed to support local implementation and statewide expansion of trauma-integrated jail diversion programs to reach individuals with PTSD, TBI and other trauma related disorders involved in the justice system with priority eligibility for veterans. A pilot program in Mecklenburg County screens all inmates for trauma and veteran status, completes trauma assessments on all inmates screened positive for trauma, and refers veterans with criminal justice involvement to mental health court, jail diversion and other services. The program also developed support groups for families of veterans with PTSD.

North Carolina Treatment Accountability for Safer Communities (TASC) Network

<http://www.ncdhhs.gov/mhddsas/tasc/index.htm>

The NC TASC Network provides care management services to people with substance abuse or mental illness who are involved in the justice system. TASC was developed to divert individuals to community based services and away from institutional settings. TASC combines the influence of legal sanctions with treatment and support services to interrupt the cycle of addiction and crime. 88% of TASC Care managers are serving veterans and 45% are serving immediate family members of current armed service members.

Regional Programs and Services:**81st Regional Support Command, Command Surgeon's Office,
Department of Psychological Health, United States Army Reserve**

81st, RSC, Command Surgeon
9810 Lee Rd Room 156
Fort Jackson, SC 29207
(803)751-4071

The Department of Psychological Health is responsible for over 54,000 service members and their families in 9 southeastern states including North Carolina and Puerto Rico. The

Military Personnel and their Families

Department provides outreach, surveillance resilience promotion, intervention and care coordination and caregiver support. The Department also conducts suicide prevention, PTSD and domestic violence prevention, depression, anxiety, combat stress, TBI, substance abuse and other behavioral health education programs.

National Programs and Services:

American Red Cross

<http://tinyurl.com/mvqu78>

The American Red Cross links members of the United States Armed Forces with their families during a crisis, briefs departing service members and their families regarding available support services, and provides information and referral assistance to veterans. Red Cross chapters are listed in local telephone books.

Lash and Associates Publishing/Training, Inc.

100 Boardwalk Drive, Ste 150, Youngsville, NC 27596

(919) 556-0300

<http://lapublishing.com>

Lash and Associates publish books, manuals, tip cards and tool kits that describe the symptoms, treatment, cognitive rehabilitation and recovery of individuals with brain injuries acquired due to trauma, blast injuries and concussion.

TRICARE

(877) TRI-CARE

<http://www.healthnetfederalservices.com>

<http://www.tricare.mil>

<http://www.mytricare.com>

TRICARE is an entitlement program under the Department of Defense which provides health care to eligible beneficiaries. These include active duty service members, retirees, and eligible members of the National Guard and Reserves. TRICARE also covers family members of beneficiaries. Care is provided in military treatment facilities including hospitals and clinics, and also by network and non network providers and facilities. TRICARE offers many behavioral health care services including private personalized Web-based video counseling, telemental behavioral health treatment, an online behavioral health resource center, a behavioral health provider locator and appointment assistance line and access to military and family life consultants.

National Hotlines:**Army OneSource**

(800) 464-8107

This number connects callers to MilitaryOneSource. Active duty and reserve component service members, and their family members may call Army OneSource for private counseling for short term problems such as grief counseling, deployment readjustment, marital and family issues.

Army Human Resource Command Center

(800) 833-6622

This hotline provides families and loved ones support in the form of information, resources, and referrals related to family issues. The hotline is a “safety net” for those who have exhausted all other information resources.

Army Long Term Family Case Management (ALTFCM)

(866) 272-5841

<https://www.hrc.army.mil/site/Active/tagd/CMAOC/ALTFCM/programs.htm>

ALTFCM provides long-term case management for survivors of deceased service members.

Army Reserve Warrior and Family Assistance Center

(866) 436-6290

This helpline provides referrals and information for family members of soldiers who are deployed or about to be deployed.

Defense Centers of Excellence for Psychological Health Outreach Center (DCoE)

(866) 966-1020

resources@dcoeoutreach.org

<http://www.dcoe.health.mil/24-7help.aspx>

DCoE is staffed by trained, professional health resource consultants with expertise in psychological health and traumatic brain injury who provide information and referral services to anyone.

Deployment Health Clinic Helpline at Walter Reed

(800) 796-9699

The core mission of the Deployment Health Clinic is to improve deployment-related health by providing caring assistance and medical advocacy for military personnel and families with deployment-related health concerns.

Military Personnel and their Families

Military OneSource 24/7 Help Center

(800) 342-9647

<http://www.militaryonesource.com>

Military OneSource provides free, non-clinical counseling sessions in person or by phone, for eligible military personnel and their families for short term issues such as bereavement, deployment adjustment, work/life management and combat stress. Service members are eligible for 12 consultations per person per year on each individual issue. Services related to mental health and substance use disorders are for short term problems only.

National Call Center for Homeless Veterans, Department of Veterans Affairs

(877) 424-3838

<http://www.va.gov/homeless/nationalcallcenter.asp>

The VA has founded a National Call Center for Homeless Veterans hotline to ensure that homeless veterans or veterans at-risk for homelessness have free, 24/7 access to trained counselors. The hotline is intended to assist homeless veterans and their families, VA Medical Centers, federal, state and local partners, community agencies, service providers and others in the community.

National Veterans Suicide Prevention Hotline

(800) 273-TALK, Veterans Press 1

<http://www.suicidepreventionlifeline.org/Veterans>

The Veterans Health Administration (VHA) founded a national suicide prevention hotline to ensure veterans in emotional crisis have free, 24/7 access to trained counselors. The hotline is operated in partnership with the Substance Abuse and Mental Health Services Administration (SAMHSA) and the National Suicide Prevention Lifeline.

Sexual Assault Prevention and Response Office

(800) 342-9647

<http://www.myduty.mil>

This MilitaryOneSource number will connect callers to local sexual assault response coordinators or VA points of contact, and established Department of Defense sexual assault services restricted or unrestricted reporting.

US Coast Guard Office of Work-Life Programs - Suicide Prevention Program

(800) 222-0364

http://www.uscg.mil/worklife/suicide_prevention.asp

This Program applies to all Coast Guard active duty and reserve personnel and appropriated civilian and non-appropriated fund employees and their families. It also applies to other Uniformed Services members and their families while either serving with the Coast Guard or using Coast Guard facilities. Emergency suicide crisis services may also be accessed using this number.

Veterans Hotline, National Veterans Foundation

(888) 777-4443

Callers may speak directly with a trained veteran about challenges or questions concerning services and benefits. Hotline staff can also help with combat trauma or post-traumatic stress or suicidal thoughts. Online chat with a counselor is also available at: <http://www.nvf.org/pages/resource-center>.

Wounded Warrior Resource Center Call Center

(800) 342-9647

<https://www.militaryonesource.com/Portals/0/Content/Flyers/WWRC%20Flyer.pdf>

This call center is a service of MilitaryOneSource. The center provides service members who have become wounded, ill, or injured as well as their family members and caregivers with a single point of contact for assistance with reporting deficiencies in covered military facilities, obtaining health care services, and receiving benefits information.

Wounded Soldier and Family Hotline

(800) 984-8523

This hotline offers wounded and injured soldiers and family members a way to seek help to resolve medical issues and to provide an information channel of soldier medically related issues directly to Army leadership so they can improve Army provided medical services to soldiers and their families.

NC Veterans Council

The North Carolina Veterans Council is a nonprofit cooperation whose purpose is to promote legislation at the state level to advance the interests of veterans in the state of North Carolina. Voting membership in the North Carolina Veterans Council is limited to representation of those military veterans' service organizations, which have been duly recognized and chartered by the Congress of the United States of America; and those veterans' service organizations without a Congressional Charter, but are nationally recognized and have controlling subordinate units located in this state. The Council has a combined membership of more than 140,000 members in North Carolina.

Veterans of Foreign Wars

<http://www.vfw.org/>

Veterans of Foreign Wars (VFW) is for American citizens who served honorably that received a campaign medal for overseas service, served 30 consecutive or 60 non-consecutive days in Korea, or received hostile fire or imminent danger pay. VFW offers services to veterans, raises awareness through community service, and advocates for veteran causes such as the new GI Bill, improvement of VA medical centers, and the construction of foreign war memorials. Members of VFW receive services such as troop support and family assistance, post-military assistance, and transitioning to civilian life assistance. Programs VFW has to deliver services include Unmet Needs (financial assistance for emergencies), Operation Uplink (free phone time to deployed and disabled veterans), Military Assistance Program (support before, during and after deployments), and Benefits Delivery at Discharge (assistance for returning veterans seeking VA benefits). One program, The National Veteran's Service (NVS) is available to all veterans, not only VFW members. Veteran Service Officers assist veterans and their families with claims to the VA including filing for disability benefits, rehabilitation and education programs, pension and death benefits, and employment and training programs.

Disabled American Veterans

<http://www.dav.org/>

Disabled American Veterans (DAV) is for men and women who have either retired or been honorably discharged from service who were injured or disabled in any degree during their service. There are 88 offices throughout the US and Puerto Rico, including one in Winston-Salem, North Carolina. DAV provides assistance to disabled veterans and their families through obtaining benefits and services, outreach, advocacy for veteran interests and volunteer programs. DAV outreach programs include Mobile Service Offices, Informational Seminars, Homeless Veterans Initiative (housing and help transitioning back into society), VA Hospital transportation, and Disaster Relief Grants (natural disaster relief for veterans and their spouses). The National Service Program, offered through the DAV, is available to all veterans and their families, not only DAV members. National Service Officers (NSOs) represent veterans and their families with claims for benefits from the VA and other government organizations including disability compensation, rehabilitation and employment, education, home loans, life insurance, death benefits and health care. NSOs also assist active military and veterans with paperwork and establishing evidence for Discharge Review Boards, Boards for Correction of Military Records, Physical Evaluation Boards, and others.

Family and extended family of DAV members, or any person (living or deceased) that served with the United States or with a United States ally who became an American citizen, can become a member of the DAV Auxiliary (DAVA). DAVA has over 1,000 local units throughout the United States, including 61 in North Carolina. DAVA offers community service programs, Junior Activities (for members 17 and younger), disabled veteran advocacy programs, Service Support (financial assistance for emergencies), and the National Disabled American Veterans Auxiliary Education Scholarship Program (scholarships for continuing education).

<http://www.davanc.org/>

<http://auxiliary.dav.org/>

The American Legion

<http://www.legion.org/>

The American Legion is the largest VSO in the United States and has numerous posts in North Carolina with a state headquarters office in Raleigh. The Legion is for current active-duty military or veterans who served honorably during eligible war eras. The Legion was founded in 1919 based on four pillars: Veterans Affairs and Rehabilitation, National Security, Americanism, and Children & Youth. All the programs and services of the Legion fall under the pillars. Veterans Affairs and Rehabilitation programs advocate for proper health care, economic opportunities and legal benefits for veterans and active-duty military. These programs include Heroes to Hometowns (assists severely injured OEF/OIF veterans transition to civilian life), department service officers (DSOs), and the Veterans Career Center. National Security programs support the Legion's position on strong national defense, homeland security and good quality of life for service members and their families. Programs include Operation Comfort Warriors (to support injured veterans), Family Support Network (to support families of OEF/OIF service members and veterans), and POW/MIA advocacy. Americanism programs support patriotism, morality and citizenship. These programs include flag advocacy, Get Out the Vote, and scholarships for education. The Legion's Children and Youth programs aim to strengthen the family unit, support quality organizations that provide services to children, and support well-rounded community programs. Programs for Children and Youth include American Legion Baseball, the Child Welfare Foundation, and Junior Shooting Sports.

AMVETS

<http://www.amvets.org/>

American Veterans (AMVETS) is for anyone currently serving or who has honorably served in the Armed Forces anytime from World War II to present including those who serve or served in the National Guard or Reserves. AMVETS has over 1,400 posts nationwide including many throughout North Carolina and a state headquarters office in Lexington. AMVETS advocates for public policy related to national defense, homeless veterans, funding for VA, veterans' benefits, veteran employment and training, POW/MIA accountability, and flag protection. The organization also supports national monuments, quality of life programs (such as the Special Olympics and ROTC), and volunteer programs. Programs through AMVETS include National Service Officers (NSOs) to help veterans with compensation claims, Warrior Transition

Workshops to assist those returning from deployment, AMVETS Against Drug and Alcohol Abuse to educate children on drug and alcohol abuse, and the Americanism program to educate children on American heritage, civics and citizenship.

Military Order of Purple Heart

<http://www.purpleheart.org/>

The Military Order of the Purple Heart (MOPH) is for veterans who have been awarded the Purple Heart Medal and have not been dishonorably discharged. The Purple Heart Medal is awarded to those wounded by an instrument of war in the hands of the enemy in the line of duty. A majority of MOPH funding goes towards the National Service Program. This program has National Service Officers (NSOs) that assist veterans and dependents claim benefits from the VA. NSOs also represent veterans at Board of Veteran Appeals and Court of Appeals for Veterans Claims no matter a service member's affiliation or membership status. MOPH programs also include Veteran Affairs Voluntary Services (VAVS) to assist veterans living in VA facilities, the Americanism program to educate children on veteran experiences, a National Scholarship Program, and a First Responders Program for policemen and firemen injured or killed in the line of duty. The organization also advocates for legislation related to veteran affairs.

Vietnam Veterans of America

<http://www.vva.org/>

Vietnam Veterans of America (VVA) is for any veteran who served on active duty, other than training, in the Republic of Vietnam during specific dates of the Vietnam War and for those who served in any duty location between August 5, 1964, and May 7, 1975. There are 630 local chapters including 19 in North Carolina. North Carolina's VVA State Council is based in West End. The organization's programs advocate for issues important to veterans, seek full access to health care for veterans, identify injuries and illnesses related to service, create a positive perception of Vietnam veterans, account for POW/MIAs, serve communities, and support future generations of veterans.

Marine Corps League

<http://www.mcleague.com>

The Marine Corps League has over 1,100 detachments worldwide. The League is for currently serving or those that honorably served in the United States Marine Corps, Marine Corps Reserves or the United States Navy Corpsman who trained with Marine FMF Units. The League supports active duty and veteran Marines through advocacy, scholarship, youth and volunteer programs. Programs include Marines Helping Marines (supports wounded Marines in various hospitals), Veterans Service Officer Program (assists Marines with benefit claims to the federal government), Military Order of Devil Dogs (a Marine honor society), and Toys-for-Tots (raises money and takes toy donations for needy children).

American EX-POW

<http://www.axpow.org/>

American EX-POW (AXPOW) is for all former prisoners of war, military and civilian, and their family members over the age of 18. There are ten chapters in North Carolina with a state headquarters in Charlotte. The organization maintains historical records of POWs, fosters fraternal relationships to support POWs, educates the public and youth on the experiences of POWs, and assists POWs apply for VA POW benefits through National Service Officers.

Fleet Reserve Association

<http://www.fra.org/>

The Fleet Reserve Association (FRA) is for current and former active duty and reserve Sea Service personnel including those in the United States Navy, United States Marine Corps, and the United States Coast Guard. The FRA advocates members of the Navy, Marines and Coast Guard through assistance with career problems, such as receiving benefits, and lobbying Congress. The organization works to preserve and enhance benefits, improve health care options, and ensure adequate funding to the Department of Defense and the VA. FRA also gives scholarships to members and their children through the FRA Education Foundation.

MOAA

<http://www.moaa.org/>

The Military Officers Association of America (MOAA) is for all active duty or retired officers of the uniformed services including the Army, Navy, Air Force, Marines, Coast Guard, Public Health Service and the National Oceanic and Atmospheric Administration (NOAA). National Guard and Reserve officers are also eligible for membership. MOAA advocates for officers in issues concerning military personnel such as the career force, retired community, and veterans. Members have access to career transition services, benefits counseling, and educational assistance. The Scholarship Fund assists children of military families to pay for university education. The MOAA Education Foundation (MEF) is a program that ensures financial literacy, offers assistance with employment transition, and provides information, assistance and planning related to military benefits. There are 18 chapters in North Carolina and a state Council of Chapters located in Chapel Hill.

ACA	Patient Protection and Affordable Care Act
AHEC	Area Health Education Center
ADATC	Alcohol and Drug Treatment Center
ADFM	active duty family member
ADSM	active duty service member
AGR	Active Guard Reserve
AT	assistive technologies
CABHA	critical access behavioral health agency
CBOC	community-based outpatient clinic
CDC	Centers for Disease Control and Prevention
CHCBP	Continued Health Care Benefit Program
CHIP	Child Health Insurance Program
CIT	crisis intervention team
CJPP	Criminal Justice Partnership Program
CPI	Consumer Price Index
CPS	Child Protective Services
CSSP	Citizen Soldier Support Program
CST	community support team
DCCP	North Carolina Department of Crime Control and Prevention
DHHS	Department of Health and Human Services
DIMA	Drilling Individual Mobilization Augmentee
DJJDP	North Carolina Department of Juvenile Justice and Delinquency Prevention
DMA	North Carolina Division of Medical Assistance
DMHDDSAS	North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services
DoD	US Department of Defense
DPH	Director of Psychological Health
DPI	North Carolina Department of Public Instruction
DSS	North Carolina Division of Social Services
DVA	North Carolina Division of Veterans Affairs
DVBIC	Defense and Veterans Brain Injury Center
DVR	North Carolina Division of Vocational Rehabilitation
DWI	driving while impaired
EMT	emergency management technician
ERISA	Employee Retirement and Income Security Act
FAC	family assistance center

FY	fiscal year
GF	Governor’s Focus on Servicemembers, Veterans, and Their Families
GISA	Governor’s Institute of Substance Abuse
HIPAA	Health Insurance Portability and Accountability Act
HMO	health maintenance organization
IBHS	Integrated Behavioral Health System
ICARE	Integrated, Collaborative, Accessible, Respectful, and Evidence-Based Care Project
IED	improvised explosive device
IIH	Intensive In-Home
IMA	Individual Mobilization Augmentee
IMD	institution for mental diseases
IPV	intimate partner violence
IRR	Individual Ready Reserve
LCSW	licensed clinical social worker
LEA	local education agency
LME	local management entity
LPC	licensed professional counselor
MAJORS	Managing Access for Juvenile Offender Resources and Services program
MCAS	Marine Corps Air Station
MCB	Marine Corps Base
MCEC	Military Child Education Coalition
MFLC	Military and Family Life Consultants
MHAT	Mental Health Advisory Team
MIA	missing in action
MIRECC	Mental Illness Research, Education, and Clinical Center
MS	MedSolutions
MSO	military service obligation
MST	military sexual trauma
MTF	military treatment facility
NAMI-NC	National Alliance on Mental Illness—North Carolina chapter
NCATP	North Carolina Assistive Technology Program
NCCCN	North Carolina Community Care Networks, Inc.
NCCCS	North Carolina Community College System
NCCD	North Carolina Congressional Delegation
NCCHCA	North Carolina Community Health Center Association

NCFAHP	North Carolina Foundation for Advanced Health Programs
NCGA	North Carolina General Assembly
NCIOM	North Carolina Institute of Medicine
NCNG	North Carolina National Guard
OEF	Operation Enduring Freedom
OIF	Operation Iraqi Freedom
ORHCC	North Carolina Office of Rural Health and Community Care
ORNC	Operation Re-entry North Carolina
PDHA	post deployment health assessment
PDHRA	post deployment health reassessment
POW	prisoner of war
PPO	preferred provider organization
PRC	presidential reserve call-up
PSA	prime service area
PTSD	posttraumatic stress disorder
QPSA	Qualified Professional in Substance Abuse
RESPECT-Mil	Re-Engineering Systems of Primary Care Treatment in the Military
RTC	residential treatment center
SBE	North Carolina State Board of Education
SBIRT	screening, brief intervention, and referral into treatment
SFY	state fiscal year
STR	screening, triage, and referral
SUD	substance use disorder
TAMP	Transitional Assistance Management Program
TASC	Treatment Accountability for Safer Communities
TBI	traumatic brain injury
TPR	TRICARE Prime Remote
TPU	Troop Program Unit
TRIAP	TRICARE Assistance Program
TRS	TRICARE Reserve Select
UNC	University of North Carolina System
USCG	United States Coast Guard
VA	US Department of Veterans Affairs
VHA	US Veterans Health Administration
VISN 6	Veterans Integrated Service Network 6
VSO	veterans service organizations or veterans service officers

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