NORTH CAROLINA INSTITUTE OF MEDICINE
2011 TASK FORCE ON BEHAVIORAL HEALTH SERVICES FOR THE MILITARY AND THEIR FAMILIES
2018 UPDATE ON RECOMMENDATIONS

INTRODUCTION

Since September 2001, more than two million troops have been deployed in support of Operation Iraqi Freedom (OIF), Operation Enduring Freedom (OEF), Operation New Dawn (OND), Operation Inherent Resolve (OIR), and Operation Freedom's Sentinel (OFS).[1] Due to the changing nature of war, these conflicts have lasted longer than those before the turn of the century. The transition to an all-volunteer military, with service members deployed multiple times, for longer periods of time, has increased exposure to violence. Advances in medicine and technology have increased the likelihood of surviving an injury.[2] As a consequence, a higher percentage of active and reserve service members have experienced traumatic brain injury (TBI), post-traumatic stress disorder (PTSD), other mental health problems, or substance use disorders.

North Carolina is home to the fourth-largest population of active duty, National Guard and reserve, and appropriated funds Department of Defense (APF DOD) civilians, as well as the seventh-largest veteran population, in the country.[3,4] Over 100,000 active duty service members reside in North Carolina.[3] The state also has over 21,000 National Guard and reserve members and over 21,000 APF DOD civilians.[3] Over 730,000 veterans live in North Carolina.[4]

Military operations and activities have an estimated $66 billion impact on state's economy.[5] Six major military installations operate within the state's borders, contributing to the state's nearly 600,000 defense-related jobs.[5]

In 2009, to address the behavioral and mental health needs of service members and their families, the North Carolina General Assembly requested that the North Carolina Institute of Medicine (NCIOM) study the mental health, developmental disabilities, and substance abuse services currently available to active, reserve, and National Guard members of the military, veterans of the military, and their families.[a] NCIOM convened a Task Force to study the availability of these services, the extent of their use, and any gaps in services.

Representative Grier Martin, JD, LLM of the North Carolina House of Representatives and an Afghanistan war veteran, former Senator William R. Purcell, MD, and Michael Watson, former Deputy Secretary of Health Services at the North Carolina Department of Health and Human Services, co-chaired the Task Force. 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 once a month from November 2009 through December 2010.

[a] Per Section 10.78(ff) of North Carolina General Assembly Session Law 2009-451 and Parts 16 and 19 of North Carolina General Assembly Session Law 2009-574.

In January 2011, NCIOM published a final report highlighting the Task Force's 13 recommendations, four of which were priority recommendations. Later that year, the North Carolina General Assembly passed legislation (Session Law 2011-185) addressing many of the Task Force's recommendations. This document details the progress, or lack thereof, North Carolina has made regarding the recommendations of the Task Force on Behavioral Health Services for the Military and Their Families.[b] Progress has been made implementing all of the Task Force's 13 recommendations.

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[b] The report includes the original recommendations in bold, along with descriptions of the progress, to date, on the implementation of the recommendations.

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TOTAL RECOMMENDATIONS: 13

- **FULLY IMPLEMENTED: 7**
- **PARTIALLY IMPLEMENTED: 6**
- **NOT IMPLEMENTED: 0**

Recommendation 4.1 (Priority Recommendation) PARTIALLY IMPLEMENTED

a) The General Assembly should appropriate $1,470,000[c] 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 co-located in the FACs, including but not limited to:

1) **Veteran services officers,**

[c] 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**

The North Carolina General Assembly (NCGA) did not appropriate any funding in response to this recommendation. However, Session Law (SL) 2011-185 directed state and local agencies, to the extent feasible and practical, to make personnel and other resources available to the National Guard Family Assistance Centers (NGFACs). NCGA did not identify specific personnel or resources.

SL 2011-185 also called for the Department of Crime Control and Public Safety to report annually to the Chairs of the House of Representatives and Senate Appropriations Subcommittees on Justice and Public Safety and to the House of Representatives Committee on Homeland Security, Military, and Veterans Affairs on the activities of NGFACs, including what services are being provided, how many members are being served, and what type of members (active, reserve, etc.) are being served.

Three NGFACs and eight family contact centers currently operate throughout North Carolina, in Charlotte, East Flat Rock, Greenville, Greensboro, Lenoir, Raleigh, Morrisville, Smithfield, Southern Pines, Wilmington, and Winston-Salem.[6] Full-time behavioral health clinicians and behavioral health case managers now work in all the NGFACs.[7] NGFACs have specialists who are **"**contract employees who provide confidential assistance to Service Members and their Families on an individual basis regardless of deployment status or branch of service."[6]

In addition to NGFACs and the VA, the North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services offers support for veterans' behavioral health issues through the state's local management entities/managed care organizations (LME/MCOs).[5] LME/MCOs contract with networks of community agencies and organizations to behavioral health services, including TBI and substance use services. To access these services, veterans contact the LME/MCO covering their counties. Each LME/MCO has a

trained Veteran Point of Contact and a TBI Point of Contact who provide guidance and assistance to those who contact the LME/MCOs.[5]

The North Carolina Division of Veteran's Affairs and Duke University's Medical Center's Evidence-Based Practice Implementation Center (EPIC), in collaboration with the University of North Carolina, Chapel Hill, also offer peer support services through the Veteran Support Specialist Training Program, held twice a year.[8] A Veteran Support Specialist (VSS) is a "veteran who has successfully completed specialized training in veteran peer support, crisis management, and VA resource navigation to promote quality of life and well-being for veterans and their family members."[9]

The program's curriculum consists of modules on topics such as *Understanding Military and Veteran Services, The Role of a Peer Support Specialist, The Role of the VSS, Understanding Trauma and PTSD, Traumatic Brain Injury, Military Sexual Trauma, Co-occurring Disorders, Homelessness, Suicide, Treatment and Mental Health Issues, Military Culture,* and *De-escalation and Planning for Anger*.[8]

Program participants receive eight hours of in-person training, followed by 20 hours of training via online videos and a final four hours of in-person training. Each "class" has a cap of 30 participants. Over 80 VSSs have completed the program. GlaxoSmithKline funded the program through 2017.[8] The program's organizers plan to continue the program every two years moving forward.

Recommendation 4.2 PARTIALLY IMPLEMENTED

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.**

The General Assembly provided no specific language in SL 2011-185 regarding these recommendations.

However, the Office of the Secretary of the Department of Defense published a rule, which went into effect on August 18, 2014, implementing "the TRICARE Certified Mental Health Counselor (TCMHC) provider type as a qualified mental health provider authorized to independently diagnose and treat TRICARE beneficiaries and receive reimbursement for services."[10]

Multiple organizations throughout the state offer family and couple's counseling and psychoeducation.[7] North Carolina's seven Vet Centers provide counseling services to combat veterans and their families.[11] USO, a nonprofit providing services at Camp Lejeune and Fort Bragg, offers the Warrior Reset Program and the Spouse Reset Program.[12,13] The Steven A. Cohen Military Family Clinic, located in Fayetteville, also provides services for relationship and family difficulties.[14]

North Carolina Department of Health and Human Services's Division of Vocational Rehabilitation Services (DVRS) provides support to veterans with disabilities transitioning back into the community. DVRS offers services to individuals with the following types of disabilities: physical, psychiatric, intellectual and/or developmental, substance abuse, deaf or hard of hearing, and any other disability that affects an individual's ability to work or live independently.[5] More information on DVRS's services can be found at https://www.ncdhhs.gov/divisions/dvrs.

Recommendation 5.1 **FULLY IMPLEMENTED**

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.

In Session Law 2011-85, the NCGA directed The Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMHDDSAS) to collaborate with military agencies and other appropriate organizations to determine gaps in care for veterans and service members with TBI. The legislation specified DMHDDSAS develop recommendations for an "accessible, community-based neurobehavioral system of care for those service members." This system of care would consist of neurobehavioral programs, residential programs, comprehensive day programs, and home-based programs. NCGA required the DMHDDSAS to report recommendations, by July 1, 2012, to the Chairs of the House of Representatives and Senate Appropriations Subcommittees on Health and Human services and Justice and Public Safety, Chairs of the House of Representatives, Committee on Homeland Security, Military, and Veterans Affairs, and the Joint Legislative Oversight Committee on Mental Health.

In December of 2012, the DMHDDSAS issued a report to the House of Representatives and Senate Appropriations Subcommittee on Health and Human Services, House of Representatives

Committee on Homeland Security, Military and Veterans Affairs, Joint Legislative Oversight Committee on Justice and Public Safety, and Joint Legislative Oversight Committee on Health and Human Services.[15]

The report outlines the scope of the problem with TBI, as it relates to service members and veterans, identifying TBI as one of the "signature wounds" of war. TBI can cause emotional issues, cognitive and behavioral problems, and substance abuse, as well as financial problems. The DMHDDSAS recognizes that the state systems to care for service members, veterans, and their families have issues. Without cohesion and integration, these systems are "confusing" and can "create barriers to obtaining help."[15]

To conduct the gap analysis, the DMHDDSAS brought together a team of veterans and representatives from the Division of Veterans Affairs, the Division of Medical Assistance (DMA), the Brain Injury Association of North Carolina (BIANC), the NC Brain Injury Advisory Council, the VA, and the DMHDDSAS. The gap analysis consisted of a review of North Carolina's care delivery system for TBI services, identified gaps in the system, and developed recommendations to address the gaps and create a framework for a community-based neurobehavioral system of care.

Resources for Service Members and Veterans with TBI

The gap analysis team identified a number of resources and programs available in North Carolina for individuals with TBI, including a State TBI Program, various community-based services, and services available specifically to members and veterans of the National Guard.

DMHDDSAS provides resources for, and coordinates, statewide services for individuals with TBI. Services for TBI are provided as part of North Carolina's community-based mental health, developmental disabilities, and substance abuse service system. LME/MCOs offer these services to North Carolinians.

Each LME/MCO has a point of contact who coordinates TBI services with a network of providers. Each month, the State TBI Program engages with the TBI points of contact through phone calls and meetings.

Funding for TBI services is provided to LME/MCOs at the beginning of each fiscal year, and then as needed. As the LME/MCO system has limited funds, if TBI funds are not being "used appropriately," they can be reallocated.

The Brain Injury Association of North Carolina (BIANC) is another statewide resource that provides "specialized outreach and support for people with brain injuries and their families." At the time of the report, BIANC had four Family Resource Offices, in Greenville, Charlotte, Asheville, and Raleigh, and one volunteer center in Winston-Salem. There are now five resource centers, located in Asheville, Charlotte, Triad, Raleigh, and Greenville.[16] These offices offer brain injury education, training on group leadership, self-advocacy, and health and wellness programs, and training and coordination of resources for community agencies. BIANC also offers a helpline and resource guide for individuals with TBI and their families.

Other community-based TBI programs in North Carolina include Lifetime Connections (offered by First in Families of North Carolina), the Gateway Clubhouse, the Hinds' Feet Farm Day Programs, and group homes supported by the State TBI Program.[17]
Individuals with TBI also can receive care from three psychiatric hospitals, three Alcohol and Drug Abuse Treatment Centers, three developmental centers, and three neuro-medical treatment centers throughout the state. However, these facilities do not have specific TBI programs.

Trainings regarding TBI are available through BIANC and Project STAR. A limited number of trainers can provide in-person training, but a training course is also available online. These trainings are targeted toward substance abuse and mental health professionals, vocational rehabilitation or independent living staff, educations, care coordinators, social security or social services professionals, advocacy or support agencies, and other providing services to those with TBI.

Issues Facing Service Members and Veterans with TBI

The report outlines a complex system of service providers and payers that can hinder access to care for service members and veterans. Service members and veterans qualify for care through different programs, including TRICARE, Medicaid, Medicare, and the Veterans Administration (VA). Determining what benefits are available and under which programs service members and veterans may qualify can be difficult. In addition, individuals with TBIs applying for benefits can face issues if their TBIs are not documented properly.

Cost can also be a barrier to care for veterans with TBIs. Uninsured individuals with few financial resources may not be able to pay for services. Although some low-income veterans qualify for Medicaid, others, such as those without children, may not qualify.
Service members and veterans may choose not to seek care because of a stigma associated with injuries, including TBI. Some members of the military view injuries and other health issues as weaknesses, and believe admitting a weakness will harm their careers.

Recommendations of the Gap Analysis Team

The gap analysis team identified gaps in service for individuals with TBI and made the following general recommendations:

1. *Existing services need to be expanded to accommodate the influx of individuals with service-related TBI;*
2. *Services array should be expanded and incorporate improved intervention developed by the military; and*
3. *Service providers should begin to screen routinely for service-related TBI.*

The report also includes seven specific recommendations, highlighting collaboration, community development, care management, screening, and education.

Recommendation 5.2 **FULLY IMPLEMENTED**

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.

In Session Law 2011-185, NCGA directed the Division of Medical Assistance (DMA) to work with MedSolutions Inc. and appropriate health professionals at the Department of Veterans Affairs to ensure that appropriate testing was used in the screening and assessment of traumatic brain injury.

Recommendation 5.3 (Priority Recommendation) **FULLY IMPLEMENTED**

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.

NCGA did not appropriate any funds to the Area Health Education Centers (AHECs). However, Session Law 2011-185 states that AHEC trainings should include the recommendations made by NCIOM's Task Force listed above. The NCGA also instructed AHECs to collaborate with the Citizen Soldier Support Program, North Carolina health professional training programs, the U.S. Department of Veterans Affairs, the University of North Carolina, Operation Re-Entry North Carolina, the North Carolina Community College System, health care professional associations, DMHDDSAS, Governor's Focus on Servicemembers, Veterans, and Their Families (whose work is now being done through the Governor's Working Group), and academic health programs.

The AHEC Program and the Citizen-Soldier Support Program (CSSP) currently offer a training program called "Treating the Invisible Wounds of War" (TTIWW). The main course is meant to "help behavioral health providers and clinicians in all disciplines…develop a better understanding of the culture in which veterans and their families live and work, and provide best practices for identifying, assessing and treating mental health disorders that result from the trauma of war."[18]

Over 7,500 practitioners have enrolled in TTIWW.[d] Through the training, more than 300 primary care and behavioral health practitioners became enrolled as TRICARE providers.[15] In addition to the online courses, the CSSP offers on-site trainings. Almost 3,000 providers across the nation have taken these day-long on-site trainings.[19]

[d] Data provided by Karen Stallings, Associate Director of the North Carolina Area Health Education Centers Program.

DMHDDSAS's December 2012 report indicates providers can also submit an online form signaling they have completed the required trainings to have their contact information posted online in a list of providers who have completed trainings on military issues.[15]

In addition to TTIWW, VA Mid-Atlantic Mental Illness Research, Education and Clinical Center (MIRECC) professionals give lectures for AHEC on topics such as traumatic brain injury.[20] The VA Mid-Atlantic MIRECC has given six trainings on post-deployment mental health.[21] Training on cognitive processing therapy (CPT), a cognitive-behavioral treatment for PTSD, also has been offered in North Carolina.[22,23]

Recommendation 5.4 PARTIALLIY IMPLEMENTED

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.

NCGA included these recommendations in SL 2011-185.

In its December 2012 report, DMHDDSAS recommended LME/MCOs, as purchasers of mental health services, introduce a value-based purchasing (VBP) system.[15] However, the report gives no details regarding the structure and implementation of a value-based purchasing framework.

The North Carolina Practice Improvement Collaborative (NCPIC) meets three times a year to provide evidence-based guidance on behavioral health services and supports.[24] Funding for the

NCPIC is provided through a block grant from the U.S. Substance Abuse and Mental Health Services Administration through the North Carolina DMHDDSAS.

These recommendations were made at the beginning of a statewide shift toward managed care for mental health, intellectual and developmental disability, and substance abuse services (MH/DD/SA). Local Management Entities (LMEs) that provided MH/DD/SA services transitioned to managed care, becoming Managed Care Organizations. Managed care is meant to encourage the use of value-based purchasing.[15]

In 2017, the Department of Health and Human Services's proposed a plan for the integration of physical and behavioral health care for the state's Medicaid population.[25] The plan outlines a broad strategy for implementing value-based payment arrangements for Medicaid managed care, but does not specifically address the recommendations above.

Recommendation 5.5 **FULLY IMPLEMENTED**

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 colocation 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[e] in recurring funds to the NCORHCC to support this effort. Funding can be used to help support the start-up costs of colocation 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 colocated 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.

NCGA included part "a" of these recommendations in SL 2011-185. However, no funding was appropriated to the NCORHCC in support of collocation.

[e] This estimate is based on supporting 20 new practices in their colocation 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.

In 2011, the North Carolina Department of Health and Human Services received a five-year, $8.33 million grant from SAMHSA to co-locate substance abuse professionals in primary care practices.[26] As part of the grant, co-located substance abuse professionals would use the Screening, Brief Intervention and Referral to Treatment (SBIRT) model. The SBIRT model is a "comprehensive, integrated, public health approach to the delivery of early intervention and treatment services for persons with substance use disorders, as well as those who are at risk of developing these disorders."[27]

DHHS worked with the Governor's Institute of Substance Abuse and Community Care of North Carolina Networks (CCNC) to implement the grant project, called NC SBIRT. NC SBIRT placed eight full-time Care Ambassadors and eight substance abuse professionals across six primary care clinics, affiliated with CCNC, and two sites of a Federally-Qualified Health Center. As part of the grant, Care Coordinators and clinicians received SBIRT training.

Organizations throughout North Carolina, such as the Center for Excellence for Integrated Care, a program of the Foundation for Health Leadership & Innovation, are also working to integrate primary care and behavioral health care.

The Center for Excellence for Integrated Care has worked with 15 co-location sites, primary care practices with a minimum of one behavioral health person at the site one day per week. The organization also has worked with 65 fully integrated sites[f], 5 bi-directional sites[g], and 14 school-based health centers[h] throughout the state.[i]

Between 2009 and 2017, the Kate B. Reynolds Charitable Trust has provided over $17 million in grants for projects related to integrating behavioral health care throughout North Carolina.[j]

Recommendation 5.6 **FULLY IMPLEMENTED**

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.

The General Assembly did not appropriate any funding for CARE-LINE in SL 2011-185. CARE-LINE has not been expanded.[7]

However, in 2011, the US Department of Veterans Affairs' Veterans Suicide Prevention Hotline was renamed Veterans Crisis Line; this crisis hotline, 1-800-273-8255, is available 24 hours a

[f] Fully integrated sites are currently at or working toward full integration of behavioral health.
[g] Bi-directional sites are mental health clinics with integrated primary care.
[h] School-based health centers employ, or contract with, a behavioral health agency to have a behavioral health person on site.
[i] Data provided by Monica Harrison, Associate Director, and Lisa Tyndall, Integration Consultant, at the Center for Excellence for Integrated Care.
[j] Data provided by Jason Baisden, Program Officer at Kate B. Reynolds Charitable Trust.

day, seven days a week, 365 days a year by phone or text.[28] Additionally, there are other national military behavioral health crisis lines.

Recommendation 5.7 (Priority Recommendation) FULLY IMPLEMENTED

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 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, Reserves 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.

The DMHDDSAS continues to work with North Carolina Governor's Working Group on Veterans to address the needs of service members, veterans, and their families.[29] The Working Group continues to meet once a month for presentations and discussions on various topics.

NCGA Session Law 2011-185 amended G.S. 122C-115.4 to require each LME/MCO to have:

at least one trained care coordination person on staff to serve as a point of contact for TRICARE, the North Carolina National Guard's Integrated Behavioral Health System, the Army Reserve Department of Psychological Health, the United State Department of Veterans Affairs, the North Carolina Department of Correction, and related organizations to ensure that members of the active and reserve components of the Armed Forces of the United States, veterans, and their family members have access to State-funded services when they are not eligible for federally funded mental health or substance abuse services.

The DMHDDSAS's December 2012 report lists the following requirements and optional activities of care coordination staff:

Requirements:

- *Provide information and assistance to Military/Veterans National Guard/Reserves members and their families in understanding and obtaining services through LME/MCO and DMHDDSAS that meets their specific needs.*
- *Act as the LME/MCO subject matter expert on staff and the "point of contact" for TRICARE, the NCNG's Integrated Behavioral Health System, the Army Reserve Department of Psychological Health, and the US Department of Veterans Affairs.*
- *Ensure that the LME/MCO and the provider network are collecting data regarding military status and history on all current consumers and those applying for services.*
- *Review data on active and reserve military members, including the NC National Guard and their families to ensure that services are being met.*
- *2009 Session law designated Military members as a target population for IPRS services. This ensure that all crisis services are available to military members, veterans and their families.*
- *Ensure the coordination of benefits and eligibility determination for military members and their families including referral to VA services and TRICARE providers.*
- *Contact the NC Division of Veterans Affairs Service Officers in each county to assist with coordination and access to benefits.*
- *Ensure that all appropriate staff in the LME/MCO and provider network obtains necessary training outlined in the legislation.*

Optional Activities:

- *Attend Monthly Meetings with the Governor's Focus Group for Returning Combat Veterans to stay updated on critical collaborative service information and assistance located in other counties.*
- *Coordinate with appropriate VA, Veteran Service Organizations, Veteran Service Officers and other federal, state and community resources to provide critical information and assistance to meet the service member's needs.*
- *Participate in the National Guard and Reserves mobilization and demobilization process. to brief/advise Guard/Reserve members and their families on available county community resources.*
- *Support the Guard and Reserves Yellow Ribbon activities for gathering critical service information and assistance needs.*

- *Research and resolve issues associated with entitlements when Military/Veterans or Guard/Reserves members and their family members encounter problems.*
- *Provide information to the LME/MCO Leadership Staff and coordinate with sections and unit, regarding veterans' entitlements available through NC Department of VA, Department of Labor, The United States Department of Housing and Urban Development (HUD) and other veterans' entitlement and benefit programs.*
- *Monthly contact with the local community, National Guard and Reserves Military facilities. (Family Centers, Amory Centers, Reserve Units).*

LME/MCO care coordination staff, as well as Mobile Crisis Teams, were trained, by DMHDDSAS and personnel from the North Carolina National Guard, on the partnership to reduce crisis-related trauma and to prevent and intervene in potential suicide risk.[15] Care coordination staff, serving as points of contact, continue to collaborate and learn, holding monthly meetings prior to Governor's Working Group meetings.

Initial trainings to enhance the services provided to members of the active or reserve components of the Armed Forces of the United States, veterans, and their families were provided to LME/MCO staff or their providers of screening, triage, or referral services.[15] Additional trainings are being planned.

Recommendation 6.1 PARTIALLY IMPLEMENTED

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.**

NCGA did not appropriate any funding in response to these recommendations.

However, educational institutions in North Carolina have received funding for behavioral health training initiatives. In 2017, NC State received two grants, totaling $3.1 million, from the federal Department of Health and Human Services.[30] The money will fund the Behavioral Health Scholars program, which will train 20 graduate social work students over 4 years, and a professional training program preparing students for certification and/or licensure to increase the availability of behavioral health providers in primary care settings.[31]

In 2016, the University of North Carolina-Chapel Hill's Behavioral Healthcare Resource Program received a federal grant to offer Mental Health First Aid training to faculty and staff over a three-year period.[32]

As of the end of September 2017, the federal Health Resources & Services Administration (HRSA) had 10 active grants with universities throughout North Carolina, including Appalachian State University and East Carolina University, funding behavioral health workforce education and training.[33] While many of these programs address the integration of behavioral health in

primary care, they focus on care of the youth population and do not specifically mention veterans or service members.

Recommendation 6.2 (Priority Recommendation) PARTIALLY IMPLEMENTED

a) The Citizen Soldier Support Program; the Governor's Focus on Service members, 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, 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.

See Recommendation 5.3 for information regarding the Citizen Soldier Support Program's trainings.

The U.S. Department of Veterans Affairs Mental Health and Chaplaincy Program offers trainings to faith leaders regarding the military, veterans, and mental health. Seven chaplains that are, or were, located in North Carolina received training on strategies to treat veterans mental health through a year-long training program.[34] The Mental Health and Chaplaincy Program also offers online training videos for the faith community a clergy. These videos can be accessed at https://www.mirecc.va.gov/mentalhealthandchaplaincy/community.asp.

Recommendation 6.3 **PARTIALLY IMPLEMENTED**

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.

Session Law 2011-185 requires local boards of education to collect and report annually to the State Board of Education all the information in part b of Recommendation 6.3. In 2012, in response to Session Law 2011-185, the North Carolina State Board of Education submitted a report to the Joint Legislative Education Oversight Committee. The report includes data on the number of children with immediate family members who have served in the military since September 1, 2001. The State Board of Education also reported on the training available to staff in each Local Education Agency (LEA) and the number of staff supporting students with military family members who receive training.

The State Board of Education reported approximately 11% of the state's students had immediate family members who have served in the military.[35] The five districts with the highest percentage of students with family members who have served in the military are the Onslow County School District (47%), the Cumberland County School District (35%), the Craven County School District (32%), the Harnett County School District (31%), and the Camden County School District (26%).[35]

Four of those five districts provided trainings that meet the General Assembly's criteria for staff members who support military-connected students. Statewide, 12 districts provided a total of 75 trainings.[35] 103 school districts either did not provide training or did not provide training that met the General Assembly's criteria.

The North Carolina Department of Public Instruction provided one two-day workshop, called Military Careers Pathways 101, for school counselors and Career Development Coordinators.[35] Most of the workshop took place at Fort Bragg, where participants learned about the "military lifestyle," military careers, and transitioning to civilian life. The 30 participants were expected to share the information they learned with their school communities.

Recommendation 6.4 **FULLY IMPLEMENTED**

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.**

The NCGA included the Task Force's recommendations in SL 2011-185. The legislation requires the General Administration of the University of North Carolina to report its findings on July 1, 2012 and each subsequent year.

The VA Mid-Atlantic (MIRECC) collaborates with universities and researchers throughout North Carolina on the clinical assessment and treatment of post-deployment mental illness and related problems, as well as the development of mental health interventions.[36] The VA Mid-Atlantic MIRECC works with Duke University, University of North Carolina, and Wake Forest. Faculty at the VA Mid-Atlantic MIRECC have joint appoints at these universities.[37] The VA Mid-Atlantic MIRECC has offices in both North Carolina and Virginia.

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