

Honoring Their Service: Behavioral Health Services in North Carolina for Military Service Members, Veterans, and Their Families

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The North Carolina Institute of Medicine Task Force on Behavioral Health Services for the Military and Their Families examined the adequacy of Medicaid- and state-funded services for mental health conditions, developmental disabilities (including traumatic brain injury), and substance abuse that are currently available in North Carolina to military service members, veterans, and their families. The task force determined that there are several gaps in services and made 13 recommendations related to federal, state, and local community resources. This article reviews the work of the task force and current efforts to improve services in North Carolina.

As commander in chief, I am determined to do whatever it takes to make sure that our service members have the resources, leadership, and support necessary to accomplish their mission and return home safely.

President Barack Obama [1]

Our military men and women and their families are heroes who sacrifice daily in their mission to protect our freedom. While the Department of Defense (DoD) makes a strong commitment to ensure that war fighters have the resources they need to complete their assigned mission and return home safely, this does not guarantee that health care services and supports will be available or easily accessible once they return home. The 2 most common diagnoses among service members and veterans of the wars in Iraq and Afghanistan who seek care at Department of Veterans Affairs (VA) facilities are musculoskeletal injuries and mental health problems [2]. There are excellent systems in place to treat the physical wounds of war, but accessing comprehensive behavioral health care is complicated by several barriers, including stigma, lack of behavioral health professionals, and lack of coordination between the federal, state, and local systems of health care.

Service Members and Their Families in North Carolina

North Carolina is home to the fourth-largest military population in the nation, representing every branch of the mili-

tary. Active-duty service members—enlisted personnel and officers—are full-time employees of the US armed forces. There are currently 120,000 active-duty personnel based at the 7 military installations in North Carolina who are serving in our state or deployed overseas. In addition, another 15,000 active-duty members are expected to move to North Carolina by 2013, as military installations close in other states [3]. National Guard and reserve personnel constitute the reserve component of the military and usually serve part-time in one of the branches of the armed forces. More than 45,000 reserve-component members are distributed across all 100 North Carolina counties [4]. North Carolina is also home to nearly 800,000 veterans, which places the state fifth in military-retiree population and ninth in veteran population [3]. Approximately one-third of the state's population is either in the military, a veteran, or a 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 2 million troops have deployed in support of Operation Iraqi Freedom (OIF), Operation Enduring Freedom (OEF), and Operation New Dawn [2]. These wars differ markedly from previous wars in how they are fought and in their extended length. Our current military is an all-volunteer force. Rather than drafting additional service members, the United States deploys current service members multiple times, for longer periods, and with less time at home between deployments. There is also an increased use of reserve-component service members and increased numbers of deployed women and parents of young children. The physical environment in Iraq and Afghanistan exposes service members to an increased risk of injury, whether they are in traditional combat-theater roles or support roles. Although many injuries in these theaters would have resulted in death had they occurred in previous

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wars, more than 90% of service members who are injured now survive their injuries [2, 5]. As a consequence, North Carolina welcomes home a higher percentage of active- and reserve-component service members with traumatic brain injury (TBI), posttraumatic stress disorder (PTSD), other mental health problems, and/or substance use disorders, compared with past conflicts.

Service members and their families face unique challenges, including multiple deployments and repeated transitions. Military families move, on average, every 2-3 years [5]. These frequent relocations disrupt systems of support and interfere with careers and school attendance. In addition to these challenges, service members and their 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 under stressful conditions. However, their self-sacrifice and resilience pose a significant barrier to seeking care when problems arise. Service members may overestimate their abilities to cope and may not seek care when it is needed.

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

The North Carolina General Assembly recognizes that, when federal resources are not available to meet the behavioral health needs of service members in North Carolina, the state must provide the necessary services and supports. The General Assembly asked the NCIOM to study the adequacy of Medicaid- and state-funded services for mental health conditions, developmental disabilities, and substance abuse that are currently available to active- and reserve-component members of the military, veterans, and the families of these groups, and to identify any gaps in services [6, 7]. The task force was cochaired by Representative Grier Martin, JD, LLM, North Carolina General Assembly; Senator William R. Purcell, MD, North Carolina General Assembly; and Michael Watson, deputy secretary for health services, North Carolina Department of Health and Human Services. The 3 cochairs are veterans themselves and were joined by 43 members of the task force and steering committee, including individuals in the active and reserve components of the military, veterans, family members of these groups, legislators, behavioral health personnel, representatives from federal and state agencies, and other members of the community. The task force met 11 times between November 2009 and December 2010 and made 13 recommendations in its report, 4 of which were priority recommendations (presented here in bold) [4].

TBI and 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. It is estimated that 19% of active-duty

members and returning veterans have experienced a TBI, 12%-25% have PTSD, and 20%-45% have problems with alcohol use [8-11].

TBI is a blunt or penetrating injury that disrupts the normal function of the brain. Military personnel sustain TBI from falls, assaults, and motor-vehicle crashes and, in combat settings, from firearms and blasts [12]. The manifestations and consequences of TBI vary widely. Patients with moderate or severe TBI may have residual impairments affecting a wide range of brain functions, such as perception, cognition, communication, emotion, memory, social behavior, and regulation of motor activity. In some cases, multiple head injuries have cumulative effects [13]. The DoD and the VA issued joint clinical practice guidelines to help practitioners treat service members with TBI [14]. The task force recommended continued communication between the VA and the North Carolina Division of Medical Assistance, to ensure that service members have access to the latest technologies for TBI screening and diagnosis, and creation of a community-based neurobehavioral system of care for TBI. In the policy forum, Lash and colleagues [15] discuss some of the challenges to providing TBI-associated services in North Carolina.

Combat environments can also lead to PTSD among some service members. PTSD is a type of anxiety disorder that develops after an extreme event in which one either directly experiences or observes circumstances that are threatening or lead to grave harm. This traumatic event is experienced with a profound sense of fear, helplessness, and/or horror [16, 17]. People who have PTSD may experience symptoms such as intrusive recollections, avoidant/numbing behavior, and hyperarousal. The degree of combat experience seems to increase the risk and severity of PTSD symptoms [18]. Symptoms of PTSD may develop or worsen over time. Data show that 12%-17% of active-component members and 13%-25% of reserve-component personnel meet screening criteria for PTSD on return from deployment and that a higher prevalence is seen 6 months later [10]. The DoD and the VA recently updated clinical practice guidelines for providers caring for patients with PTSD [19].

In addition to TBI and PTSD, many service members experience other behavioral health problems, such as depression, panic attacks, phobias, and generalized anxiety. Some service members have suicide ideation, and some commit suicide. Service members are at heightened risk for interpersonal conflict, including domestic violence and child abuse, when they return home [10, 20]. In addition, some service members experience military sexual trauma.

Alcohol use continues to be a significant problem in the armed services, with 20% of surveyed active-duty service members reporting heavy drinking [8]. 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 military personnel. However, an increase in reported misuse of prescription

drugs has been observed during the past 6 years [8]. Even when service members are identified as needing substance abuse counseling and treatment, very few actually receive the necessary services [10]. In the policy forum, Bolton [21] discusses some of the pressing issues associated with substance use disorders in the military.

Service personnel often experience multiple overlapping behavioral health problems, which further complicate diagnosis and treatment. A 2007 study of OEF/OIF veterans receiving care within the VA health system found that 25% had at least 1 mental health diagnosis. Of these individuals, 29% had 2 separate mental health diagnoses, and 27% had 3 or more—meaning that more than half of veterans with diagnosed mental health conditions had more than 1 such disorder [22]. As of September 2010, 50.2% of OEF/OIF veterans presenting to a VA health center met criteria for a mental health disorder [23]. Federal, state, and public systems of care need to be aware of the prevalence of these disorders in the military population and must work together to ensure that all needs of this population are met. Brancu and colleagues [24] describe best practices for treatment of behavioral health conditions in the military in the policy forum.

Military and VA Health Systems

Active- and reserve-component service members, retirees, veterans, and their families are potentially eligible for a wide array of mental health and behavioral health services provided through the federal government. Active-duty service members and their families receive health care coverage and benefits through TRICARE, which augments services available through military treatment facilities. Retired service members are also eligible for TRICARE. Health care coverage for veterans falls within the purview of the VA. Both TRICARE and the VA offer a wide and robust range of health benefits, including mental health and substance use services, to covered individuals. In recognition of 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.

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. If services are not available through the facility, the active-duty personnel or their family members can receive care through private (ie, civilian) providers. TRICARE insurance programs are available to active-duty service members, their families, retirees, and certain veterans. The covered services are the same across programs, but the cost of a premium (if any), the required cost sharing, utilization requirements, and source of care may differ [25].

TRICARE covers inpatient and outpatient psychiatric and substance use services [25]. It has also recently begun the TRICARE Assistance Program (TRIAP), which uses Internet-based services to provide counseling and behavioral health

information to beneficiaries. TRIAP is intended to treat only short-term problems and provides free private, personalized, Web-based video counseling to TRICARE enrollees. Individuals with more-serious or long-term behavioral health problems must obtain services directly through qualified health professionals, rather than through TRIAP [26].

Although TRICARE offers coverage for comprehensive behavioral health services, barriers remain that make it difficult for active-duty members, family members, and retirees to access services. First, TRICARE is not available to all National Guard members or reservists. Reserve-component members become eligible for TRICARE only after they have been on active duty for 30 days. Another problem is that some service members and their families do not seek treatment because of the stigma associated with behavioral health conditions and, among service members specifically, because of concern that seeking care will adversely affect their military careers. Additionally, TRICARE may not have sufficient numbers of behavioral health professionals in its networks, and those providers may be unfamiliar with military culture or the potential effects of deployment-related stress on military members, veterans, and their families.

VA health system. To be eligible for enrollment in the VA health system, a veteran must have served for at least 2 years (unless injured while on duty) and cannot have been dishonorably discharged. All returning Iraq and Afghanistan veterans have access to VA services for 5 years. After the initial period, enrollment in the VA health system is limited to priority populations, namely, veterans with service-related conditions and disabilities and/or low incomes. Although the 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 [27].

In North Carolina, the VA provides direct health services at 4 VA medical centers (hospital medical complexes), 12 community-based outpatient clinics, and 5 Vet Centers [28]. The VA provides an extensive range of inpatient and outpatient care and treatment for mental health and substance use disorders, but the availability of specific services varies by type and size of facility. Later in this issue, Kudler and colleagues [29] discuss recent efforts to improve access to behavioral health services in the VA health system.

The VA offers comprehensive behavioral health services to veterans enrolled in the VA system. However, only 50% of eligible OEF/OIF veterans have enrolled in the VA system, and of these, few who are expected to need behavioral health services actually seek care [2]. Less is known about the 50% of eligible OEF/OIF veterans who have not yet sought VA care, but on the basis of findings of the National Vietnam Veterans Readjustment Study [2], there is reason to believe that a significant number of these veterans may also be dealing with behavioral health issues that they do not feel ready to discuss. Although the VA and the armed forces have tried to remove the stigma attached to seeking behavioral health services, this stigma still exists.

Despite significant growth in the number and distribution of VA facilities across North Carolina, the geography of the state continues to present important barriers to access. The VA Mid-Atlantic Health Care Network, with funding from VA Office of Rural Health, recently created the Rural Health Mental Health Contract Program to help rural veterans access behavioral health services in a number of North Carolina communities. This time-limited program may be expanded if it is successful. The VA is also taking assertive action by reframing the rules by which service connection is established for PTSD, by focusing clinical and administrative resources on eliminating the backlog in disability assessments, and by launching an unprecedented effort to eliminate homelessness among veterans, but these efforts may not be known to providers and systems outside of the VA health system. Thus, the task force recommended that the VA, along with state and community partners, should offer training to professional advocacy and support organizations about coverage eligibility and the recent changes.

Programs for National Guard and reserve personnel. One of the major gaps in the TRICARE program affects the reserve component. The reserve component and their families are only eligible for TRICARE after the service member has been on active duty for more than 30 days. Furthermore, the distances that separate most National Guard and reserve members from their commands and comrades may not afford the same levels of social and instrumental support systems available to service members and families who live on or near a military base. To address these gaps, new programs are being developed to provide additional support to North Carolina service members and their families.

The NCNG has developed programs that serve as a national model for supporting National Guard personnel. The NCNG Integrated Behavioral Health System is a one-stop, telephonic portal to clinical and support services and is available 24/7. The system is voluntary, confidential, and professionally staffed by contracted, licensed NCNG clinical professionals. It began operations on November 1, 2010. The NCNG Reconstitution Program, which also began recently, embeds National Guard support services at demobilization centers. The goal is to help National Guard members become aware of support services, so that they are more willing to seek help [30]. In support of the innovative NCNG programs, the task force recommended that **the North Carolina General Assembly should expand the availability of counseling and treatment services for individuals who have served in the military, whether in active or reserve components, and their families.** Later in this issue, Nissen and colleagues [31] discuss further the NCNG programs and how they evolved in response to particular issues in North Carolina.

There are significant barriers, including eligibility (ie, coverage) restrictions, costs, inability to access diagnostic services and care because of a lack of providers, and fear of adverse military consequences, that prevent active and

former military members and their families from receiving necessary behavioral health services. To better meet the behavioral health needs of service members and their families, the task force recommended that Congress should increase funding for behavioral health services and make other changes, such as allowing licensed substance abuse and other mental health professionals to be credentialed through TRICARE. In the policy forum, US Senators Burr and Hagan [32] offer their perspectives on postdeployment behavioral health care.

A major goal of the task force was to help people access federal services they are entitled to, whether through TRICARE or the VA. Federal programs and health insurance should be the primary source of coverage for behavioral health services for the men and women who have served our country in the military. Thus, the task force recommended that the VA and state partners should provide additional outreach and training to veterans service groups, the faith community, and other community organizations, to help them understand the needs of the military, the array of services available, and how to link service members and their families to various resources.

State-Funded Health Systems

Despite efforts to expand the availability and accessibility of federal behavioral health resources, there are gaps and other barriers that make it difficult for active 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 and reserve components may have access to private or public insurance coverage. However, many reserve-component members, veterans, and their families are uninsured. These individuals often rely on state-funded mental health and substance abuse services for treatment. Other individuals turn to peer-support groups, faith leaders, or other community organizations for help. Yet there are still barriers that reserve-component members, veterans, and their families experience when accessing needed services.

The North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMHDDSAS) is the state agency charged with coordinating prevention, treatment, and recovery support services for people with mental health, intellectual, and other developmental disabilities (including those associated with TBI) and substance abuse problems in North Carolina. Services are typically accessed through private providers under contract with local management entities (LMEs) [33]. There are currently 24 LMEs that oversee and manage services provided at the community level across the state. The DMHDDSAS does not have sufficient funding to provide all the needed services and supports for people with mental health problems, developmental disabilities, and substance abuse problems. Thus,

the state has identified a target population—which includes veterans and members of their families—to ensure that services are targeted to the people most in need.

Although many service members and their families seek behavioral health services in either the federal or the state system, many of these people transition between these systems. Thus, the task force recommended that **the DMHDDSAS, along with other state and federal partners, should improve transition and integration services between military and public systems.** As a result of the task force discussions, the DMHDDSAS has already begun to implement this recommendation. The DMHDDSAS requires each LME to designate 1 person to serve as the primary contact for reserve-component and TRICARE staff working to help service members or their families with referrals to civilian behavioral health providers. In addition, the task force recommended that LME staff, as well as local crisis service providers (such as first responders or emergency medical technicians), should receive additional training about the number of active- and reserve-component members and veterans in their catchment areas, the behavioral health needs they may have, and the available referral resources.

The task force also recognized the importance of improving the availability and readiness of behavioral health and primary care services, as part of the state's response to the needs of military members, veterans, and their families. Most people access primary care services at least once per year [34]. Thus, one way to improve access is to encourage primary care providers to offer mental health, substance abuse, and other behavioral health services. Primary care providers should be trained to understand the potential medical, mental health, and substance abuse issues facing returning veterans and their families. The Integrated, Collaborative, Accessible, Respectful, and Evidence-Based Care (ICARE) project, the Area Health Education Centers (AHEC) program, and their partner organizations already help train primary care providers to provide evidence-based screening and treatment for depression. Stein and colleagues [35] discuss state-funded behavioral health initiatives, including ICARE, later in this issue. Although AHEC and other partners offer different trainings that cover the medical, mental health, and substance abuse needs of military members 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. Thus, the task force recommended that **the AHEC program, along with state and federal partners, should provide additional outreach and training for health professionals and hospital administrators.** The task force also recommended improvement of Medicaid and DMHDDSAS reimbursement to behavioral health providers who meet certain quality-of-care standards, as well encouragement of co-location and integration of behavioral health and primary care.

In addition to the services offered through the DMHDDSAS, there are other publicly funded programs available to service members and their families. For example, the Department of Health and Human Services operates CARE-LINE, a toll-free information and referral telephone service. In 2009, CARE-LINE expanded its capacity to provide suicide-prevention crisis services and its resources for service members and their families; however, its funding was decreased in fiscal year 2010, and it can no longer provide round-the-clock crisis services. To ensure that telephone information, referral, and crisis counseling are available, the task force recommended that CARE-LINE funding should be increased to support a return to 24/7 availability.

Workforce, Outreach, and Research

A coordinated system of care for military members 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 1 or fewer psychiatrists. During that period, more than half of the counties in the state experienced a decrease in the number of psychiatrists [36]. In 2009, there were 5 North Carolina counties—Camden, Graham, Hyde, Tyrrell, and Warren—without any psychiatrists, psychologists, psychological associates, or either nurse practitioners or physician assistants with mental health specialties [37].

In addition to the shortage of substance abuse professionals, there are 6 counties—Alexander, Anson, Bertie, Clay, Greene, and Northampton—with behavioral health providers who are eligible to participate in TRICARE but do not participate. In addition, there are licensed behavioral health providers in most of the other counties who are eligible but who choose to not participate in TRICARE. Of the more than 3,000 behavioral health providers in North Carolina who are currently eligible to participate in TRICARE, approximately 1,300 are participating [37].

This shortage and maldistribution of behavioral health providers affects the entire state. The North Carolina Office of Rural Health and Community Care 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 to areas where there are shortages of health professionals. However, these loan-forgiveness programs are unlikely to address all the behavioral health provider shortages in our state. Accordingly, the task force recommended that North Carolina should expand behavioral health training programs, to increase the supply of trained mental health and substance abuse professionals.

Because of the stigma associated with seeking behavioral health services, active-duty and former service members and their families may turn to veterans service organizations, community-based organizations, and/or the faith community when they need help. North Carolina has many organi-

zations with a 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 reserve-component members and their families. In the policy forum, Goodale and colleagues [38] discuss the CSSP in more detail. Veterans service organizations and the faith community provide a variety of supports and links to key resources for military families.

As one of the most military-friendly states, North Carolina has many outreach organizations. Silbajoris [39] describes the state's behavioral health resources. In recognition of the services and commitments to our service members from these varied organizations, the task force recommended that **the CSSP, along with state and federal partners, should provide training for veterans service organizations and veterans 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 public school system, including increased training for local educators on military children and the behavioral health issues that might affect them, as well as appropriate referral resources.

Although there are many resources at the national, state, and community levels to support service members, veterans, and their families, these services are not always well coordinated. The Governor's Focus on Servicemembers, Veterans, and Their Families is a DoD, VA, state, and community partnership that works to ensure that service members, veterans, and their families receive the best services available. North Carolina has received national recognition from the US Substance Abuse and Mental Health Services Administration because of the work of the Governor's Focus group; Fang [40] discusses this initiative in the policy forum.

There is still much to learn about the military/veteran population and the ways to best serve it. North Carolina is home to world-renowned research facilities that are studying and seeking solutions to these problems, and their efforts are setting a national standard for the integration of DoD, VA, state, and private health research programs. In recognition of this ongoing work, the task force recommended expanding research to improve the effectiveness of behavioral health services provided to active- and reserve-component service members, veterans, and their families.

Conclusion

Our service members, veterans, and their families make tremendous sacrifices in their service to North Carolina and the nation. When service members and veterans face difficulties adjusting to their communities and family lives, it

is our responsibility to honor their service by making sure that they and their families have access to quality behavioral health services. To meet this commitment, agencies and organizations at the federal, state, and community levels must work together. **NCMJ**

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