

North Carolina Institute of Medicine
Task Force on Behavioral Health Services for the Military and their Families
Wednesday November 18, 2009
Meeting Summary

ATTENDEES

Task Force/Steering Committee Members: Rep. Grier Martin, Sen. William Purcell, Michael Watson, Linda Alcove, David Amos, Sen. Bob Atwater, Sen. Peter Brunstetter, David Cistola, Gracye Crockett, Debra Dihoff, Catharine Goldsmith, Bob Goodale, Lil Ingram, M. Victoria Ingram, Rep. Verla Insko, Andy Jackson, Harold Kudler, Mike Lancaster, Sara McEwen, Sen. Martin Nesbitt, Stephanie Nissen, Sheryl Pacelli, Christie Silbajoris, Karen Stallings, John Wagnitz, Edmund Watts, John Harris, Charlie Smith

Interested Persons: Elizabeth Bishop, Holly Danford, Becky Ebron, Joan Kaye, Marilyn Lash, Lou Murray, Tanya Roberts, Kristy Termina, David Zell

NCIOM Staff and Intern: Pam Silberman, Mark Holmes, Kimberly Alexander-Bratcher, Thalia Fuller, Berkeley Yorkery, Catherine Liao

WELCOME AND INTRODUCTIONS

Sen. Purcell welcomed members of the Task Force and asked them to introduce themselves. He also asked for a moment of silence for those soldiers killed at Ft. Hood.

CHARGE TO THE TASK FORCE & NCIOM OVERVIEW

Pam Silberman, JD, DrPH, President & CEO, North Carolina Institute of Medicine

The North Carolina Institute of Medicine (NCIOM) is a quasi-state agency chartered in 1983 by the North Carolina General Assembly to be concerned with the health of the people of North Carolina; to monitor and study health matters; to respond authoritatively when found advisable; and to respond to requests from outside sources for analysis and advice when this will aid in forming a basis for health policy decisions (NCGS §90-470). The NCIOM studies issues at the request of the NC General Assembly, state agencies, health professional organizations, and the NCIOM Board. The NCIOM often works in partnership with other organizations to study health issues.

The NCIOM also publishes the *NC Medical Journal*. Each issue contains a special focus area with articles and commentaries discussing specific health issues. After the completion of this Task Force's work on behavioral health of the military and their families, the *Journal* will most likely publish an issue on the Task Force's findings. The *Journal* is widely distributed to over 30,000 subscribers across the state.

The North Carolina General Assembly has charged the NCIOM to convene a Task Force to study the adequacy of state-funded mental health, developmental disabilities, and substance abuse services available to active, reserve, National Guard members of the military, veterans, and their families, what services are currently available, and the need for increased state services. The Task Force is to report interim findings to the 2010 session of the North Carolina General Assembly and the final report to the 2011 session. The Task Force is funded through the Center for Substance Abuse Treatment (CSAT) Substance Abuse Prevention and Treatment Block Grant (SAPTBG), which flows to the Division of Mental Health, Developmental Disabilities and Substance Abuse Services.

North Carolina has the fourth largest number of military personnel in the country. Currently, 120,000 active duty personnel are based at one of the state's seven military bases or deployed overseas. North Carolina is likely to receive an additional 25,000 active duty members by 2011. Another 25,000 soldiers,

marines and airmen from North Carolina serve in the National Guard or Reserves. There are more than 100,000 children and adolescents of active members, National Guard and Reserves. There also are more than 770,000 veterans who live in North Carolina.

Many of the active and returning veterans report alcohol abuse or other substance abuse disorders; experience post-traumatic stress disorder (PTSD) or other mental health problems; or have traumatic brain injury (TBI). The high number of repeat deployments has exacerbated these problems, and deployment and service in the military can also cause stress or behavioral health problems for the spouses, children, and other supportive people at home.

OVERVIEW OF THE MILITARY AND VETERANS IN NORTH CAROLINA

Charlie Smith, Assistant Secretary for Veterans Affairs, Director, NC Division of Veteran Affairs and VA System

The North Carolina Division of Veterans Affairs (NCDVA) was first established as a part of the Commission of Labor in 1925 to “aid veterans of the World War.” In 1945, the NCDVA became a separate agency to assist veterans and their families in securing benefits earned through military service. The NCDVA is comprised of the NC Veterans Affairs Commission, Assistant Secretary’s Office, State Service Office, fifteen District Field Offices, Affiliated County Service Offices, State Veterans Cemeteries, State Veterans Homes, and Scholarship Program.

The function of this agency is to assist veterans and their families in the presentations, processing, proof and establishment of claims, privileges, rights, and benefits to which they may be entitled to under federal, state, or local laws. More than 792,000 veterans currently reside in the state, which ranks 9th in the country in veterans population. Over 13% of the state’s population is a veteran, while 35% of the state’s population is military, veteran, spouse, parent, or a dependent.

The US Department of Veterans (USDVA) provided \$2.9 billion in direct benefits to North Carolina veterans in 2008. This federal funding ranks North Carolina 6th in the nation for these expenditures, although the state does not rank that high for funding for medical care. (Nearly 172,000 North Carolina veterans receive health care from the USDVA). Roughly 120,000 North Carolina veterans receive veteran disability compensation. Moreover, 83,000 military retirees and 9,300 surviving spouses reside in the state.

North Carolina ranks sixth in the nation in military retiree population. They received \$1.97 billion in retirement benefits in 2008. Fifteen district offices are strategically located from Elizabeth City to Murphy and staffed by one or more service officers with clerical staff. The affiliated County Veterans Service Officers are hired by each respective county. Sixty-six counties have full time county service office programs; 26 counties have part-time service officers; 8 counties are served by the NCDVA; and the state pays \$2,000 to each county that has a program.

North Carolina provides additional benefits to veterans living in North Carolina, including:

- 366 scholarships were awarded to the children of disabled or deceased North Carolina war veterans in 2008. Since 1945, more than 20,000 children have been awarded these scholarships. The annual cost to the state for these scholarships is about \$9 million.
- The NCDVA provides hometown service for veterans in all of North Carolina’s 100 counties through a network of state and county Veterans Service Offices.
- The NCDVA provides two state veterans nursing homes, located in Fayetteville and Salisbury, and has received state and federal funding to build two additional 100-bed homes near Kinston and near Black Mountain.

- The NCDVA also operates three state veterans cemeteries located in Black Mountain, Spring Lake, and Jacksonville.

Active military service members and their families are a significant population in North Carolina. There are nine military installations across North Carolina, most of which are east of I-95. The military population is growing: Ft. Bragg and Pope Air Force Base will see a significant increase in their populations over the next two to three years. All Marines who deploy for the reserves come through Camp Lejeune. The state has the third largest concentration of active duty military in the country (currently 120,000 personnel). Roughly 37% are married with children, and 6% are single parents. Most of the personnel in the Marine Corps are unmarried because they are younger, unlike the Army or Air Force, whose population is generally a little older. Nearly 15% of active duty personnel currently serving in the US are female. (15 years ago, this number was less than 5%.) Almost half of those currently serving in the Armed Forces are under the age of 30 years. More than \$20 billion comes into the state's economy from the US Department of Defense each year.

HEALTH SERVICES FOR ACTIVE MILITARY: TRICARE

David Amos, TRICARE Field Operations Director, Health Net Federal Services

TRICARE is the US Department of Defense's integrated health care delivery system, which provides health benefits and services to 9.2 million active duty and retired members of the uniformed services, their families, survivors, and other eligible beneficiaries worldwide. The uniformed services include the U.S. Army, U.S. Air Force, U.S. Navy, U.S. Marine Corps, U.S. Coast Guard, U.S. Public Health Service, and National Oceanic & Atmospheric Administration.

TRICARE combines an individual's current access to military hospitals and clinics, known as military treatment facilities (MTFs), with resources from a network of civilian health care providers. For example, an Army, Navy, or Air Force hospital or clinic is considered an MTF.

Individuals may choose from TRICARE Prime, TRICARE Standard, and TRICARE Extra. There are three TRICARE regions: North, South, and West. North Carolina is located in the North region. Just like one's medical coverage, an individual's financial responsibility for behavioral health care services is dependent upon which TRICARE option is selected. Active duty service members never pay anything. Their family members and retirees have varying copayments and cost sharing depending on their selected plan. Being eligible for TRICARE is not the same as being a veteran. A service member can use TRICARE by being on active duty for 30 days or more, retired, or remaining in the reserves. TRICARE for life is the plan that has coinsurance paid by Medicare.

A Prime Service Area (PSA) is defined as the area within a 40-mile radius around a military hospital. Each commander has a PSA for which they are responsible. In the western part of the state, there is a need for a PSA, but the federal government elected not to establish one there. The number of behavioral health providers varies across PSAs in North Carolina. The Raleigh-Durham PSA includes 259 behavioral health providers, while the Ft. Bragg PSA includes 237; the Seymour Johnson PSA includes 151; the Camp Lejeune PSA includes 90; and the Cherry Point PSA includes 44.

TRICARE Prime is a managed care option offering the most affordable and comprehensive health care. TRICARE Prime is available in areas near an MTF and where regional contractors have established TRICARE Prime networks. To use TRICARE Prime, you must enroll and choose a provider, who acts as a gatekeeper to other services. The government requires no more than 30 minutes driving time for primary care and no more than 60 minutes for specialty care. Active duty service members are required to enroll in TRICARE Prime. TRICARE Prime is portable and easy to transfer when a service member moves. If an individual has family members living in separate locations (i.e. college students, children

living with a custodial parent, etc.), he or she can all enroll in TRICARE Prime with a single enrollment fee (when applicable) with TRICARE Prime's split enrollment feature. Beneficiaries eligible for TRICARE Prime include active duty service members and their families, retired service members and their families, National Guard or Reserve members called to active duty on federal orders for more than 30 consecutive days and their families, survivors, certain former spouses and other eligible beneficiaries such as Medal of Honor recipients and their families. The rates paid to providers are pre-negotiated rates (less than Medicare) and it can be challenging enroll new providers depending on the level of competition.

TRICARE Standard is available to active duty family members, retired service members and their families, and others who choose not to enroll or who are not able to enroll in TRICARE Prime. (An individual may not be able to enroll in TRICARE Prime if he or she lives in an area where it is not offered.) Enrollment in TRICARE Standard is not required. An individual may make appointments and receive care from any non-network provider, without referral, but that provider must be TRICARE-authorized. Some services will require prior authorization. TRICARE Standard may be the best option if the individual has other primary health insurance such as employer-sponsored health insurance, travels frequently, or if the preferred provider is not a TRICARE network provider. An individual will not have priority access to MTF care if enrolled in TRICARE Standard. An individual pays \$150/year, then pay 20-25% of government's rate. Catastrophic cap is \$1,000/year (\$3,000/year for retirees).

TRICARE Extra functions like a preferred provider organization and is essentially the same program as TRICARE Standard except one may get care from TRICARE network providers instead of non-network providers. Everything else is the same including no enrollment, self-management of own care (no referrals necessary, but some services require prior authorization), and MTF care on a space-available basis. Because TRICARE Extra beneficiaries visit TRICARE network providers, they will pay less out-of-pocket for the same care. Under this plan, network providers agree to accept a lower negotiated rate for services. The catastrophic cap is \$1,000/year (\$3,000/year for retirees) and the deductible is also the same as TRICARE Standard.

TRICARE offers prescription drug coverage to all eligible beneficiaries, regardless of which program option is selected. TRICARE has a uniform formulary process that establishes three separate categories of medication: Tier 1 includes generic medication from a formulary, Tier 2 includes brand name medication from a formulary, and Tier 3 includes medication not on the formulary. Costs for prescriptions are based on the category of drug and the location where the prescription is filled. In general, there is a \$3 copayment for a 90-day supply.

TRICARE offers comprehensive behavioral health care coverage for services that are considered medically necessary. In order to be cost-saving, an individual is encouraged to seek behavioral health care from an MTF, when available, or from a TRICARE network provider. Special referral and authorization requirements are in place for behavioral health care services. TRICARE Prime beneficiaries may be seen for up to eight initial visits of outpatient behavioral health care per fiscal year without an authorization. It is unnecessary to obtain a referral from a primary care manager (PCM) for behavioral health care services unless an active duty service member (who always requires a referral and authorization). In most cases, an individual can self-refer to a TRICARE network behavioral health provider. Seeking care from a network provider will considerably reduce out-of-pocket costs. Prior authorization is required after the eighth visit. TRICARE Standard and Extra beneficiaries do not have to obtain a referral for any outpatient visit and also are entitled to eight initial outpatient visits per fiscal year without authorization. Prior authorization is required after the eighth visit, and seeking care from a TRICARE network provider will reduce the out-of-pocket costs.

TRICARE Reserve Select (TRS), which began 18 months ago, is a premium-based health plan. National Guard and Reserve members may qualify to purchase enhanced TRS coverage if they are a member of the

Selected Reserve of the Ready Reserve and not eligible for or enrolled in the Federal Employees Health Benefits program. TRS offers similar coverage to TRICARE Standard and TRICARE Extra, with a monthly premium payment of \$47.51 for member or \$180.17 for family. Coverage for survivors may continue six months after member's death.

There are several types of behavioral health services and support resources available through TRICARE. The following types of providers are authorized to provide behavioral health care services: psychiatrists (M.D., D.O.), clinical psychologists (Ph.D.), certified psychiatric nurse specialists (PNS), master's-level clinical social workers (LCSW), certified marriage and family therapists (MFT), and licensed professional counselors (LPC's) with physician referral and supervision. Federal restrictions set the licensure standards because not all states license some of the providers. A physician referral is needed if a beneficiary seeks care with a pastoral counselor or a mental health counselor. It is a Department of Defense/TRICARE Policy requirement that a referral indicating ongoing communication between the beneficiary's physician and these types of behavioral health providers be obtained. It also is necessary for the counselor to have a referral for claims payment purposes. This referral is necessary before being seen by the pastoral or mental health counselor. TRICARE covered outpatient services includes individual therapy, family therapy, collateral visits, play therapy, psychoanalysis, and psychological testing (max. 6 unit benefit/yr), with the last two service requiring prior authorization. Outpatient psychotherapy is limited to a maximum of two sessions per week in any combination of individual, family, collateral, or group sessions and is not covered when the patient is an inpatient in an institution. TRICARE covered inpatient services include acute inpatient psychiatric care, psychiatric partial hospitalization, care in a residential treatment center, and substance abuse detoxification and rehabilitation. Inpatient psychotherapy is limited to five sessions per week in any combination of individual, family, collateral, or group sessions. The duration and frequency of additional care is dependent upon medical necessity.

The TRICARE Assistance Program (TRIAP) is Web-based video counseling, providing private, personalized service with a licensed behavioral health clinician. This counseling is a short-term, solution-focused, problem-solving approach that provides for private, non-reportable discussions of personal issues related to family, relationships, work and stress on a one-to-one basis in the context of a confidential relationship with a licensed professional. Video counseling is confidential and not documented in an individual's military record. This service is available to active duty service members, their spouses and family members, as well as beneficiaries in the Transitional Assistance Management Program (TAMP) and TRICARE Reserve Select. There are no costs for this service and reimbursed as an office visit.

The TRICARE Telemental Health benefit provides outpatient behavioral health treatment through secure, audio/video conferencing via Web cam. This benefit is useful when a behavioral health provider appointment within TRICARE access standards is difficult to obtain (e.g., a local behavioral health provider is not available). Telemental Health is not available in all geographical areas and is not considered a substitute for face-to-face therapy when it is available. This benefit is available for all TRICARE beneficiaries, and Telemental Health services are considered outpatient behavioral health visits. Current TRICARE rules regarding behavioral health care (e.g., prior authorization and out-of-pocket costs, if applicable) also apply to Telemental Health services. Copayments and cost-shares may apply and could be higher than a regular behavioral health office visit because both the TRICARE-authorized provider office and the TRICARE-authorized behavioral health provider will charge a copayment or cost-share for services.

The Behavioral Health Care Provider Locator and Appointment Assistance Line helps beneficiaries locate civilian behavioral health care providers and schedule routine and urgent outpatient behavioral health appointments in the TRICARE network. This service is available to all active duty service members, TRICARE Prime active duty family members and TRICARE Prime Remote for Active Duty Family

Members beneficiaries, and TRICARE Overseas Program Prime active duty family members who have temporarily returned to the United States. The dedicated toll-free number 1-877-747-9579 is available from 8 a.m. to 6 p.m. Eastern Time/7 a.m. to 5 p.m. Central Time, Monday through Friday, excluding holidays. It was noted that this appointment assistance line is not a crisis intervention line. If the beneficiary's situation is critical, he or she will immediately be connected with a suicide prevention representative at the National Suicide Prevention Lifeline (1-800-273-TALK). There is no cost for this service; however applicable copayments and cost-shares will apply for behavioral health care. Non-enrolled ADFMs, retired service members, their families and others should call Health Net's normal TRICARE toll-free telephone line at 1-877-TRICARE (1-877-874-2273) for behavioral health care assistance.

The Online Behavioral Health Resource Center is an online center provided by Health Net's behavioral health division, MHN, and is designed to help beneficiaries learn how to balance work, family and other aspects of life. This service is available to all TRICARE beneficiaries, 24 hours a day, 7 days a week, 365 days per year. There is no cost for this service.

Military & Family Life Consultants (MFLCs) provides direct, face-to-face non-medical counseling and education regarding daily life stressors related to deployment and reintegration. The counselors address concerns of stress, relationships, family problems, financial issues, grief and loss, conflict resolution, and the emotional challenges of transitioning from combat back to civilian life and family. MFLC services are confidential and not documented on an individual's military record. MFLCs support active duty, National Guard and Reserve members and their families stationed around the world. MFLC services may not be available in all geographical areas. There are no costs for MFLC services.

Military OneSource offers cost-free, non-clinical confidential counseling sessions to eligible military personnel and their family members. Counseling is available in person or by phone and addresses short-term issues, such as grief and loss, deployment adjustment, work/life management, and combat stress. Seeking care through Military OneSource for short-term counseling is helpful if the situation does not warrant long-term treatment. There are no costs for Military OneSource services.

In conclusion, TRICARE is an insurance provider for a large cadre of the patient population – the entire military community and families. TRICARE may be the only health insurance for a whole population component, dependent on their military service status. TRICARE is mandated to provide coverage to the military community and is dependent on civilian providers to do so.

Discussion focused on myths and perceptions about TRICARE, provider and workforce issues, and detailed information about the plans and available services.

OVERVIEW OF ACTIVE AND RETIRED MILITARY, NATIONAL GUARD AND RESERVES

Harold Kudler, MD, Co-Director, Clinical Core, VISN 6 Mental Illness Research, Education and Clinical Center (MIRECC), VISN 6 Mental Health Coordinator

Certain aspects of the current wars may create increased stressors and risk of psychological injury. The United States has been in Afghanistan since October 2001 (8 years) and in Iraq since March 2003 (almost 7 years). As of November 27, 2006, the war in Iraq has been going on longer than World War II, and an all-volunteer force has resulted in multiple deployments. The landscaping is changing as 90% of returning service members survive their injuries. As a society, we don't have traditions to fall back on given the length of current operations. As of December 2007, the number of Active Reserves totals 94,487. The numbers of Americans who have served in Iraq – military and civilian – are significant. The population to be served is huge and growing, and it is disbursed throughout the nation in very small concentrations.

More than 1.5 million people have served in Iraq and Afghanistan, and a vast majority of them have satisfied the criterion for post-traumatic stress disorder (PTSD). From the Report of the President's Commission on Care for America's Returning Wounded Warriors (July 2007), the number of deployments total 2.2 million, and the number of service members deployed total 1.5 million. The majority of these service members have either been in situations where they could be seriously injured or killed, knew someone seriously injured or killed, or experienced an event that caused them intense fear, helplessness or horror. Over a million children under the age of 11 have had at least one parent deployed. More than 6,000 children live on base at Camp Lejeune. To date, 52,375 returnees have been seen in the VA for PTSD symptoms.

As of the second quarter of Fiscal Year 2009, over one million Operation Enduring Freedom (OEF) veterans are eligible for VA services. Roughly 45% of those who are eligible have already had at least one episode of VA care (i.e., seen for at least one clinical service). Electronic medical records provide information regarding what services and diagnoses they received and what their current health status is. Only 3% of service members returned home by way of emergency medical transportation; the rest come home in their own time. The three most common health issues among them include musculoskeletal (e.g., back and knee pain), mental health (includes substance abuse), and symptoms, signs, and ill-defined conditions (may include traumatic brain injury). The possible mental health problems reported among 46.4% (210,527) of the **454,121** eligible OEF/Operation Iraqi Freedom (OIF) veterans who have presented to VA include PTSD, depressive disorder, affective psychoses, neurotic disorders (including phobias, general anxiety, etc.) nondependent abuse of drugs and tobacco use disorder, and alcohol dependence. The first two provisional mental health diagnoses combined are greater than the rate of PTSD diagnosis. A dual-diagnosis is possible. The VA doesn't ask about dependence on other drugs, only tobacco and alcohol.

Beyond the DoD/VA continuum of care, only 20% who are eligible for VA care use it. There is a "silent majority" of OEF/OIF veterans not coming to the VA. In comparison, a large majority of the Vietnam veterans with PTSD in the National Vietnam Veterans Readjustment Study (NVVRS) had never come to VA for any mental health problem. Only 20% of the Vietnam Veterans with PTSD at the time of the study had ever gone to the VA for mental health care, yet 62% of all Vietnam Veterans with PTSD had sought mental health care at some point. Although this does not mean that all OEF/OIF veterans who have (so far) chosen not to use VA services have PTSD, it suggests a need to make sure that appropriate care will be available for those of them that do.

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 establishing credibility with clients. Of the 23.4 million veterans currently alive, nearly three-quarters of them served during a war or an official period of conflict. Women account for 8% of all veterans (roughly 1.8 million women veterans), and about a quarter of the nation's population is potentially eligible for VA benefits and services because they are veterans or family members. The VA currently provides health care to 5.5 million veterans (roughly 1 in 5 veterans), and roughly 10% of VA users are women veterans.

Of the care access points provided by the VA, 153 are medical centers, with at least one in each state, Puerto Rico, and the District of Columbia. Ambulatory care and community-based outpatient clinics, which total 909 nationwide, are like hospitals without beds and typically small that offer both primary care and mental health services. These clinics complement big medical centers by rotating trainees and conducting their own research programs. Residential rehabilitation treatment programs can be specialized, and very few of the 47 nationally are currently looking at TBI. Veteran centers were established in 1979 as a way to get veterans who didn't see the VA as an access point. The VA hired combat veterans with degrees in social work and psychology to offer counseling to anyone seeking care. Although they were originally intended for Vietnam veterans, the country's 232 centers now provide outreach and link new

veterans and their families with appropriate services and benefits. Other care access points include 88 comprehensive home-care programs, 4 DoD/VA Polytrauma Centers, the website My HealthVet (<http://www.myhealth.va.gov/>), and 21 Veterans Integrated Service Networks (VISNs).

The focus of the VA has been reframed as deployment mental health. According to Capt. Bill Nash in Combat Stress Injury, a combat stress injury happens *to* a person; involves a loss of normal integrity; causes a loss of function at least temporarily; provokes predictable self-protective or healing symptoms; and cannot be undone (though it usually heals). A participant in or witness to event(s) involving horror may have feelings that he or she, or someone close to them will die, leaving them feeling helpless and powerless. Cumulative stress and grief, which can be debilitating, also are related issues. Loss can take the form of casualties within a unit, death or relationship breakup back home, or spiritual. Many problems faced by returning combat veterans and their families are more functional than clinical. They can include work stress and unemployment, educational and training needs, housing needs, financial and/or legal problems, family issues, lack of social support, estrangement, family breakup, and trouble for children. Perceived support from family is the best indicator that an individual won't have PTSD.

The VA/DOD Clinical Practice Guideline for the Management of Post-traumatic stress was created by a working group of VA and DoD clinicians and researchers. Separate algorithms were defined for primary care providers and mental health professionals, and evidence tables were provided for each recommendation. More information is available at www.oqp.med.va.gov/cpg/PTSD/PTSD_Base.htm.

On September 27, 2006, key leaders of North Carolina State Government, VA, and DoD met with representatives of state and community provider and consumer groups as part of the North Carolina Governor's Summit on Returning Veterans and their Families. Governor Michael Easley charged Summit participants to develop new ideas that would help veterans succeed in getting back to their families, their jobs, and their communities. The Summit was only the start of a process, and interested persons since have been meeting monthly.

Dr. Kudler concluded noting the need for a system where there is *No Wrong Door* to which OEF/OIF veterans or their families can come for help.

Discussion focused on family member ineligibility for VA services, barriers to determining VA eligibility, the effects of repeated deployments on service members and their families, TBI, and North Carolina ranking low nationwide on continuum of services for neurobehavioral health.

NORTH CAROLINA BEHAVIORAL HEALTH SERVICES AVAILABLE TO SERVE ACTIVE AND RETIRED MILITARY AND THEIR FAMILIES

Mike Lancaster, MD, Chief of Clinical Policy, Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, North Carolina Department of Health and Human Services

While National Guard and Reserve families are not adequately covered by behavioral health services offered across the state, the Division of Mental Health, Developmental Disabilities, and Substance Abuse Services has been able to work with the VA to improve access to services. Stigma associated with behavioral health services and geography are large problems. The state is working to serve people across the state, and it may be impossible to get a routine service for someone living in a rural part of state. Part of the educational programming done through the NC Department of Health and Human Services (DHHS) is to educate primary care providers and faith-based initiative organization on symptoms and resources available to active and retired military and their families.

Dr. Lancaster presented background information pertaining to serving military and veterans. Several veterans laws enacted on the federal and state levels are pertinent:

- P.L. 96-22: The Veterans Health Care Amendments of 1979 established the Veterans Centers.
- P.L. 105-277: The Persian Gulf War Veterans Act of 1998
- P.L. 110-181: The National Defense Authorization Act of 2008, Section 582, which required DOD to establish a national combat veterans reintegration program.
- P.L. 105-368: The Veterans Programs Enhancement Act of 1998
- S.B. 2162: The Mental Health Improvement Act of 2007, which provided mental health services and readjustment and transition assistance to families of veterans.
- Session Law 2008-107, House Bill 2436: The establishment of Veterans and Family as a Target Population in North Carolina.

State funding is becoming scarcer, which is making it more difficult for behavioral health providers to provide services. However, it is important that they have the ability to do so under Session Law 2008-107. Dr. Lancaster gave an overview of the military in NC, including the 792,646 veterans in the state. The North Carolina Department of Health and Human Services deals primarily with the National Guard and Reserve population.

The nature of military communities across North Carolina is changing. In the past, the National Guard and Reserve did not expect to fight in war with three to four deployments. Also, the military has shifted towards a home-based operation, as opposed to maintaining large numbers of active duty members and their families overseas in foreign countries. Families are able to Skype in order to keep in touch with family much more constantly. As a result, active service members deployed abroad are engaged with problems at home with which they are unable to handle.

This transitional nature of military life has increased the demands for support services for service members and their families, especially those in the National Guard and Reserve components. The demand for support for services also has caused the military to embrace a community capacity building model of service delivery. As a result, this shift places more responsibility on families to use community support systems that have increased funding from DoD, the service departments and individual states for family support.

The resources in the state vary across regions. Behavioral health services are managed by local management entities across the state. Current services available to veterans in the state's current mental health infrastructure include 30 regional mobile crisis teams trained in response to military issues, 6 START teams located statewide to address developmental disability issues, and total 3-way contract community hospital beds for additional inpatient capacity. A reintegration initiative involves a number of factors, including establishing agreements and contracts with federal, state, and local government and developing partnerships with the military and civilians communities; continuing a veteran-centered process in which mental health, suicide prevention, substance abuse and TBI service needs of all military service members will be identified and addressed through concrete plans and seamless timelines; producing a final product that will be an informational, training, educational and support service system; and, the identification of stakeholders and local service providers in North Carolina who will have access to transition, readjustment and reintegration assistance for veterans and their families. An outreach and faith-based initiative also involves a number of factors, including community collaborative networks in civilian settings; an interagency planning group to increase the overall amount of communication between agencies in local communities; active participation of agencies in planning and coordination functions; an increasing number of external agency referrals as the number of agencies who actively participate also increases; in- services for targeted military personnel and their families; recognition that communities with active collaborating partners work together effectively, and developing diverse faith-based collaborative support. There are also a number of health-related web sites including NC Health Info.

Discussion focused on the need for veteran classification and identification, homelessness, confidentiality, and conflicts in sharing data among national databases.

NEXT STEPS AND QUESTIONS FROM TASK FORCE MEMBERS

Dr. Silberman asked the group how we might target our work, particularly geographically. Mark Holmes presented several maps of North Carolina, which displayed information on the number of children in military families; veterans across the state; and selected Reserves as of 2007 (which included an overlay of locations of VA facilities across the state). These maps will be updated.

In Dr. Silberman's view, the five common issues discussed today include workforce issues (e.g. provider availability, participation, credentialing, training, and provider-to-population ratios); eligibility for federal services (i.e. who qualifies for what services and who's left out, including families, prisoners, individuals without service-connection); what services are needed (e.g. for someone with TBI or PTSD); how do we work with non-traditional providers like the faith-based community to identify individuals in need of services, and family support.

Dr. Silberman asked the group of other issues we should be thinking of for future meetings. Some of the ideas for further study suggested include coordination of federal funding for housing and other federal resources, services for families (children, school system), stigma and the culture of the military (assertive outreach), coordination of care – active duty people going off base and coordination with military personnel, behavioral health definitions, delivery systems, resiliency, stigma, infrastructure, suicide, incarcerated prisoners who were veterans, outreach, neurobehavioral services, women veterans, care for the caregivers, the perception of availability of services for veterans, Gold Star families, the duration of services needed for people with different disabilities need services, impact of brain injuries on people at different ages, TBI waiver and Medicaid eligibility. These ideas will be grouped into thematic categories for discussion in upcoming meetings.

The next meeting is scheduled for December 16, 2009.

Sen. Purcell remarked that he was pleased with the background and experience of the Task Force and asked that everyone keep it up. He then adjourned the meeting.