Workforce and Outreach for the Military and Their Families

Chapter 6

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

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

Behavioral Health Workforce

North Carolina, like the nation, has a shortage of trained mental health and substance abuse professionals. Between 1999 and 2004, 19 counties in the state had no or only one psychiatrist. During that same time, more than half of the counties in the state experienced a decrease in the number of psychiatrists.[1] The behavioral health workforce in North Carolina includes not only psychiatrists but also psychiatric nurses, psychoanalysts, psychologists, psychological associates, licensed clinical social workers, nurse practitioners, and physician assistants who specialize in mental health, alcohol and drug abuse, or addiction; child, adolescent, marriage, and family therapists; substance abuse counselors; licensed clinical addiction specialists; and certified peer support specialists. In 2009, there were five North Carolina counties—Camden, Graham, Hyde, Tyrrell, and Warren—that did not have any of these behavioral health providers.[a] It is not clear if people in these counties have access to behavioral health providers in neighboring counties.[2,b]

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

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

TRICARE Gap Analysis

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

In addition to the shortage of substance abuse professionals, there are 6 counties with behavioral health providers who are eligible to participate in TRICARE, but these counties have *no* participating behavioral health providers who accept TRICARE. These counties are Alexander, Anson, Bertie, Clay, Greene, and Northampton. In addition, there are some licensed behavioral health providers in most of the other counties who choose not to participate in TRICARE.

Table 6.1
TRICARE Eligible Providers in North Carolina

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

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

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

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

Provider Recruitment Initiatives

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

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

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

Recommendation 6.1

a) The University of North Carolina (UNC) System, North Carolina Community College System, and other independent colleges and universities in the state should monitor and apply for any federal grant opportunities to expand training funds to increase the number of mental health and substance abuse providers in the state.

1) North Carolina institutions of higher education should ensure that the curriculum includes information that educates health professionals about the unique behavioral

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

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

2) Funding should be used to help support people seeking training through the community colleges, undergraduate education, master's or doctoral degree programs or those who are seeking to pay for the hours of supervised training needed for their license. Priority for enrollment should be given to individuals who have served in the military through active duty and reserve components and those who are willing to work with military members and their families.

b) If efforts to obtain federal funding are unsuccessful or insufficient, the North Carolina General Assembly should appropriate $1.9 million beginning in FY 2011. Of this:

1) $750,000 in recurring funds in SFY 2011, $1.5 million in recurring funds in SFY 2012, and $2.0 million in recurring funds in SFY 2012 and thereafter to the Governor's Institute on Substance Abuse to create a scholarship program to increase the number of qualified professionals in the field of substance abuse training. Funding should be provided to help support people seeking training through the community colleges, undergraduate education, master's or doctoral degree programs or those who are seeking to pay for the hours of supervised training needed for their license. Priority for enrollment should be given to individuals who have served in the military through active duty and reserve components. Individuals who receive state funds must agree to work for one year in a public or private not-for-profit substance abuse treatment program for every $4,000 in scholarship funds, and must agree to serve the active duty and reserve components and their families.

2) $750,000 to increase the number of qualified mental health professionals who are seeking training through community colleges, undergraduate programs, and graduate education programs or who are seeking to pay for the hours of supervised training needed for their licensure (i.e., psychiatrist, psychologist, LPC, LCSW). Priority should be given to individuals who have served in the military through the active duty and reserve components. Individuals who receive state funds must participate in training on military culture, military benefits, and military resiliency and agree to work for a year accepting individuals with TRICARE insurance for every $4,000 in scholarship funds.

3) $400,000 in recurring funds to the Area Health Education Center (AHEC) program to establish clinical training sites for people seeking their substance abuse professional credentials, and to develop and support new

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

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

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

Outreach to the Military and their Families

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

Citizen Soldier Support Program (CSSP)

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Veterans Service Organizations

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

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

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

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

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

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

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

Faith Community

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

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

Other Professional, Advocacy, and Support Services

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

PRIORITY Recommendation 6.2

a) **The Citizen Soldier Support Program; the Governor's Focus on Servicemembers, Veterans, and Their Families; the North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services (DMHDDSAS); the North Carolina Division of Veterans Affairs; the Department of Veterans Affairs; and other military-related organizations should offer trainings to:**

   1) **Crisis workers, including but not limited to mental health and addiction services staff on mobile crisis teams; screening, triage, and referral (STR) teams; public safety officers; crisis intervention teams (CITs); emergency management technicians (EMTs); disaster and emergency response teams; local sheriff's offices; and local Red Cross chapters.**

   2) **Veterans service organizations and veterans service officers.**

   3) **Professional advocacy and support organizations, including but not limited to the National Alliance on Mental Illness North Carolina, the Traumatic Brain Injury Association of North Carolina, and other nonprofit organizations that have a mission to serve members of the active duty and reserve components, veteran members of the military, and their families.**

b) **Training for all of the groups should cover certain core information, including:**

   1) **The types of mental health and substance abuse disorders that these service personnel and their families may have experienced, including but not limited to traumatic brain injury (TBI), posttraumatic stress disorder (PTSD), military sexual trauma (MST), depression, substance use disorder (SUD), potential suicide risks, or domestic violence.**

   2) **Strategies to encourage eligible veterans to enroll in and access services through the VA system, including opportunities to enroll former military members with previously undiagnosed PTSD, MST, TBI, or SUD, and those who left under less-than-honorable discharges into the VA system, if the reason for the discharge was due to behavioral health problems that arose or were exacerbated through military service.**

   3) **Available referral sources through TRICARE, Department of Veterans Affairs, Military One Source, Army One Source, Defense Center of Excellence Deployment Health Clinical Center, North Carolina National Guard's Integrated Behavioral Health System, Army Reserve Department of Psychological Health, Local Management Entities, North Carolina**

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

c) In addition to the content listed above, training for crisis workers, professional advocacy and support organizations, and the faith communities should include the following:

1) Information about the number of North Carolinians who are serving or who have served in the active duty and reserve components and their families living in North Carolina.

2) Information on military culture.

3) Information about the average number of deployments, length of time in conflict zones, and potential injuries these members may have faced, particularly those who have served recently in Iraq or Afghanistan.

4) The potential impact of the deployment cycle (before, during, and after) on family members and children, including but not limited to resiliency skills, intervention skills, resources, and community supports, with a focus on the critical role of the faith community in the provision of assistance with needed service, personal support, and when necessary, grief counseling.

5) Early identification of individual or family members with mental health or substance abuse disorders and appropriate referral sources.

d) Military chaplains should be involved in the training of the faith community. This training should include information on the important role of faith leaders in providing spiritual support, counseling, and referral into treatment services for active and former members of the military and their families.

Resources for Children in Military Families

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

Military Child Education Coalition

Military children generally move from six to nine times during their kindergarten to 12th grade school years.

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

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

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

Interstate Compact on Educational Opportunity for Military Children

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

for one year are eligible for assistance under the compact. It was developed by the Council of State Governments' National Center for Interstate Compacts, the Department of Defense, national associations, federal and state officials, departments of education, school administrators, and military families. As of July 2010, there are 35 states that have joined the compact. North Carolina joined the compact in August 2008.[9] Membership in the compact not only provides benefits to military children in the state but also places some requirements on the state. One of those requirements is to collect data on military children in schools. The Military Child Education Coalition proposes that states add a single field to the state data system that could be populated from information obtained at school enrollment.[f] The MCEC notes that there is currently no reliable, consistent, and sustainable data system that collects information on military children. These data would benefit school districts and the state by broadening the possibilities of funding from the US Department of Education, US Department of Defense, and other potential sources. These data would also provide a baseline of information to better understand the impact of military families on local communities.

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

Recommendation 6.3

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

1) Local Education Agencies (LEAs) to collect information, on an annual basis, about whether a child has an immediate family member who has served in the US military since September 11, 2001, as required in the rules adopted as part of the Interstate Compact on Educational Opportunity for Military Children (NCGS §115C-407.5 et seq.).

2) Each LEA to have at least one staff person who is trained on the needs of children of service members. Training should include but not be limited to:

a. The numbers of children of current members of the active and reserve components living in their LEA.

b. Available curricula on military families.

c. The impact of deployments on the emotional and psychological well-being of the children and families.

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

d. Potential warning signs of emotional and mental health disorders, substance use disorders, suicide risks, child maltreatment, or domestic violence.

e. Available referral sources through TRICARE, Department of Veterans Affairs, Military OneSource, Army OneSource, Defense Center of Excellence Deployment Health Clinical Center, North Carolina National Guard's Integrated Behavioral Health System, Army Reserve Department of Psychological Health, Local Management Entities, North Carolina Department of Health and Human Services Office of Citizen Services, North Carolina Health Info, Federally Qualified Health Centers, professional advocacy and support services, or other community resources.

f. Scholarships for after-school and enrichment activities available through the Department of Defense, National Guard, or Reserve for children of parents who are actively deployed.

3) The trained LEA staff member to provide similar trainings to school administrators, nurses, nurse aides, counselors, and social workers in the LEAs.

b) The North Carolina General Assembly should require the SBE to report annually on the number of children served through North Carolina public schools who have immediate family members who have served in the US military since September 11, 2001, as well as the number of LEA staff members who have received the specified training. The SBE should submit the report annually to the Appropriations Subcommittee on Education and the Legislative Oversight Committee on Education.

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

Research

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

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

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

In order to provide effective medical and behavioral health interventions to service members, veterans, and their families, it is necessary to develop an understanding of the types of clinical problems facing this population, the prevalence of the clinical and behavioral problems they experience, and the clinical and policy interventions needed to address them.

Operation Re-entry North Carolina

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

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

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

1) Core A, Research Projects: stimulate innovation and collaboration through faculty-initiated pilot projects,

2) Core B, Research Infrastructure: build the technical capabilities and organizational infrastructure needed to conduct collaborative projects of military relevance,

3) Core C, Research Training: in collaboration with CSSP, train civilian faculty and students to work effectively with military/veteran populations and DoD/VA collaborators,

4) Core D, Research Dissemination: share the latest advances through affiliate faculty appointments for military/VA providers, joint seminar series, and an annual symposium, and

5) Core E, Research Leadership: coordinate/participate in UNC system- and state-wide activities in order to build effective high-level research partnerships with regional and national military organizations/VA organizations, including the Naval Hospital Camp Lejeune and the Durham VA Medical Center.[g]

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

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

VISN 6 MIRECC

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

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

1) To determine whether early intervention in postdeployment mental health is effective in decreasing the severity of postdeployment mental illness,

2) To determine what neuroimaging, genetic, neurocognitive, or other characteristics predict the development of postdeployment mental illness,

and

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

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

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

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

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

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

Recommendation 6.4

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

1) **The collaborative research teams should include civilian investigators from North Carolina colleges and universities and private research organizations, health providers in regional and national military health system institutions, and providers and investigators in VISN 6 in the VA system. The research should:**

   a. **Define the behavioral health problems facing service members, veterans, and their families, with a special emphasis on the behavioral health needs of the Reserve and National Guard.**

   b. **Develop, implement, and evaluate innovative pilot programs to improve the quality, accessibility, and delivery of behavioral health services provided to this population.**

   c. **Evaluate the effectiveness of new programs put into place by the National Guard and other military organizations to address the behavioral health challenges facing military service personnel, veterans, and family members.**

   d. **Conduct research that will help contribute to the knowledge for evidence-based behavioral health screening, diagnosis, treatment, and recovery supports for military service personnel, veterans, and their families.**

   e. **Study other issues as requested by the different branches of the military, Reserve and National Guard, and VA to improve behavioral health services for service members, veterans, and their families.**

2) **Collaborative teams and faculty investigators should aggressively pursue federal funding from pertinent agencies to conduct this work.**

b) **The North Carolina General Assembly should direct the University of North Carolina, General Administration, to provide an annual report to the Health Care Oversight Committee and the Legislative Appropriations Subcommittee on Health and Human Services on the research findings generated as part of this initiative.**

c) **The North Carolina National Guard should cooperate in providing information to assess the effectiveness of behavioral health services provided to the North Carolina National Guard.**

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