Building Communities of Care for Military Children and Families

Harold Kudler and Colonel Rebecca I. Porter (U.S. Army)

Summary
Military children don't exist in a vacuum; rather, they are embedded in and deeply influenced by their families, neighborhoods, schools, the military itself, and many other interacting systems. To minimize the risks that military children face and maximize their resilience, write Harold Kudler and Colonel Rebecca Porter, we must go beyond clinical models that focus on military children as individuals and develop a public health approach that harnesses the strengths of the communities that surround them. In short, we must build communities of care.

One obstacle to building communities of care is that at many times and in many places, military children and their families are essentially invisible. Most schools, for example, do not routinely assess the military status of new students' parents. Thus Kudler and Porter's strongest recommendation is that public and private institutions of all sorts—from schools to clinics to religious institutions to law enforcement—should determine which children and families they serve are connected to the military as a first step toward meeting military children's unique needs. Next, they say, we need policies that help teachers, doctors, pastors, and others who work with children learn more about military culture and the hardships, such as a parent's deployment, that military children often face.

Kudler and Porter review a broad spectrum of programs that may help build communities of care, developed by the military, by nonprofits, and by academia. Many of these appear promising, but the authors emphasize that almost none are backed by strong scientific evidence of their effectiveness. They also describe new initiatives at the state and federal levels that aim to break down barriers among agencies and promote collaboration in the service of military children and families.

www.futureofchildren.org

Harold Kudler is an associate professor of psychiatry and behavioral sciences at Duke University and associate director of the Mental Illness Research, Education, and Clinical Center for the Department of Veterans Affairs' Mid-Atlantic Health Care Network (VISN 6). Colonel Rebecca I. Porter is the commander of the Dunham Army Health Clinic at Carlisle Barracks in Pennsylvania and the former chief of the Behavioral Health Division in the U.S. Army's Office of the Surgeon General. The authors wish to thank Patricia Lester for contributing to this article.

Pediatrician-turned-child psychoanalyst Donald Woods Winnicott once said that "there is no such thing as a baby."[1] In other words, no child exists in isolation. Each develops biologically, psychologically, and socially through give-and-take with others. By the same token, military children develop through their relations with their military parents, other family members, caretakers, schools, communities, and the culture and operational tempo of the armed forces. That's what makes them military children. And many such children are, themselves, intergenerational links in long family histories of military service, which they will pass on to their own children. The U.S. Department of Defense (DoD) estimated that 57 percent of active-duty troops serving in 2011 were the children of current or former active-duty or reserve service members.[2] To understand and promote the growth and health of military children, for their own sake and for the sake of our nation, we must consider interactions that extend across families, communities, culture, and time. In practical terms, we need a public health model that looks beyond the clinical care of individual military children to define broader interactions that either promote or threaten their wellbeing. We must also pose a fundamental question: How does a nation develop communities of care that maximize resilience and minimize the health risks that military children and their families face?

In this article, we define communities of care as complex systems that work across individual, parent/child, family, community, military, national, and even international levels of organization to promote the health and development of military children. Relatively few elements of these communities are clinical. Some elements focus directly on military children, while others support military children (or, at least, minimize their vulnerabilities) through interaction with parents, schools, youth organizations, law enforcement and judicial systems, educational and vocational programs, and veterans' organizations, among others. Communities of care often evolve around military children in a particular geographic area and/or period of history (for example, wartime life on a military base in a foreign country). Such communities are shaped by explicit care and planning, but they also reflect implicit principles and practices embedded in military culture.

We know a great deal about the links between the health of individual children and that of their family and community, but less research has focused on military children specifically. We are also hampered by longstanding tension between clinical models (for example, diagnosing depression in a military child and instituting an evidence-based course of treatment) and public health models (such as encouraging community schools to identify and support military children to better promote their wellbeing). People trained in one camp or the other may not be comfortable working outside their own paradigm. But to build effective communities of care, clinicians and public health professionals must work together.

From a systems perspective, any attempt to isolate interventions (whether clinical or public health) and their effects within any single dimension is futile: each dimension inevitably resonates across the entire system. For example, a program designed to ensure that Guard and Reserve members have stable housing when they return from deployment may enhance their children's academic performance and mental health. As we review programs that support military children,

it would be appealing to organize them in clearly defined categories. For example, do they focus on direct interaction with children, the military parents, the parents as a couple, the family as a whole, the school, the children's broader social network, the military community, or society at large? Some interventions focus primarily on clinical care, while others enhance resilience, cohesion, safety, education, or economic security in families, military units, and their surrounding communities. Many programs are still in the early stages. Even those that have been well received and seem to help often lack the strong evidence base that planners would need to make informed decisions about whether they should be replicated. Our goal is to define common principles across existing community approaches, assess the strength of current evidence, and suggest next steps to develop effective communities of care.

In practical terms, we need a public health model that looks beyond the clinical care of individual military children to define broader interactions that either promote or threaten their wellbeing.

A Historical Precedent

Military medical history demonstrated long ago that merging clinical and public health approaches can effectively help service members cope with the stress of deployment. An outstanding example is the work of Thomas Salmon, a doctor who served as chief consultant in psychiatry for General Pershing's American Expeditionary Force during World War I.[3] When U.S. forces entered the war in 1917, they had to prepare for the same mental health problems that had stymied the English, French, Germans, and Russians since the war began in 1914. Chief among them was "shell shock," a common response to the psychological trauma that troops experienced in combat. Symptoms of shell shock included nightmares, psychosomatic complaints, or the inability to eat or sleep. European military medical experts approached shell shock through a clinical model. Soldiers stayed in the trenches until they developed all the signs and symptoms of that devastating disorder. Then the warrior was summarily "demoted" to the rank of patient, evacuated to his home country, and hospitalized. Though doctors applied every standard (and many experimental) treatments of the day, these patients proved very hard to put back together again. Consequently, the fighting force was significantly diminished, and hospitals on the home front overflowed with fresh cases from the trenches.

Salmon developed a different strategy.[4] Rather than wait for warfighters to develop the full clinical picture of shell shock, he arranged for anyone who displayed significant signs of stress (including marked irritability, anxiety, insomnia, social withdrawal, tics, or confusion) to be immediately identified by his buddies, noncommissioned officers, or command and, as quickly as possible, sent just behind the front lines. The entire American force was trained to be alert to such changes, understand the need to spot them as early as possible, and know how to report them. Crucially, they were taught that paying attention and taking prompt action were instrumental to helping their buddies, helping their units, and accomplishing their mission. Because military culture sees the health and success of the individual as inseparable from

the health and success of the group, the military is fertile ground for merging clinical and public health models of care.

Warfighters with signs of shell shock (which we might now call combat stress) remained in uniform and worked in noncombat roles.[5] Their treatment emphasized regular meals and sleep ("three hots and a cot") and maintaining their military identity. The psychologically injured warfighter was treated as a worthy soldier making a meaningful contribution to the mission. Program leaders consistently expressed their clear and confident expectation that these troops would soon return to regular duty with their units. Salmon's combat stress doctrine of proximity, immediacy, and high expectations of success came to be known as the PIE model. It remains a central principle of combat medicine today. For example, Combat Stress Control Teams in Iraq and Afghanistan, using this approach, have had a 97 percent return-to-duty rate.[6] Salmon's model has been adopted around the world as a fundamental principle of military mental health.[7]

Public health has been defined as "the science and art of preventing disease, prolonging life and promoting health through the organized efforts and informed choices of society, organizations public and private, communities and individuals."[8] While the clinical model focuses on diagnosing and treating a specific disorder in an individual patient, a public health perspective aims to increase resilience to health problems at the population level. In practice, health interventions often involve a mixture of clinical and public health practices. For example, clinicians and public health leaders collaborate to tell patients about the coming flu season, inoculate those at risk, and monitor the disease across the population.

Salmon's PIE model sprang from his experience as the first director of the National Committee for Mental Hygiene. Mental hygiene was an early-twentieth-century social movement that brought those we would now call "mental health consumers," including psychiatric patients and their families, into partnership with medical professionals, academics, and leaders in government and public opinion across multiple levels of society. The National Committee hired Salmon to put its vision into practice. Under Salmon's leadership, the mental hygiene movement cultivated an informed community, replaced

An enlightened, well-organized community plays the decisive role in recognizing, managing, and, whenever possible, preventing mental illness.

stereotypes and stigma with understanding and hope for the mentally ill, created community organizations to advocate for and assist the mentally ill and their families, and always paired community efforts with those of mental health clinicians and researchers. Salmon's PIE model directly extended the mental hygiene movement's key principle on behalf of service members: although any population (civilian or military) needs well-trained clinical professionals and excellent clinical facilities, an enlightened, well-organized community plays the decisive role in recognizing, managing, and, whenever possible, preventing mental illness. You might well say that the mental hygiene movement's

primary goal was to create communities of care. Decades after Salmon's death, the programs described in this article extend his time-tested principles of battlefield medicine to improve the health of military children and their families on the home front.

Communities of Care for Military Children

To apply Salmon's principles to military children, we must first determine where their "front lines" are, identify the clinical and public health supports available to them, and apply a few basic tenets. One key tenet of deployment mental health is that all warfighters and all of their family members (including children) face difficult readjustments in the course of the deployment cycle. This population-based approach is less about diagnosing individual patients than about helping children, families, military units, and entire communities retain or regain a healthy balance despite the stress of deployment. In the life of the family and the child, each developmental step builds on the relative success of previous steps. Thus we should remember that children and their families are dynamic rather than static. Military parents' resilience and vulnerability affects the resilience and vulnerability of their children. Clinical experience suggests that children may be the most sensitive barometers of their families' adaptation, and military children are no different. Each family brings its own capacities and liabilities to the coping process, and each has successive opportunities to adapt over the course of the deployment cycle and in the years after.

Unfortunately, the family's efforts to adapt may miscarry. For example, a military child might learn (without ever having been told) to remain quiet and even aloof in the face of a parent's volatile emotions and violent outbursts. Though this tactic might help the child adjust to a parent's deployment-related problems, it could cause trouble over time. But even when children's attempts to protect themselves are maladaptive in the long run, they are nonetheless efforts to cope and adapt rather than inherent weaknesses or failures. This is the basis for treating veterans and their family members with respect and high expectations that they will successfully adapt over time.

Communities of care extend the responsibility for developing that environment of respect and positive expectations from the clinic to the community. They must work steadily and incrementally to improve access to information, support and, when necessary, clinical care. Their efforts must be integrated across clinical and public health domains, and their services must be timely and appropriate. The services that warfighters or their children need as they prepare for deployment are different from those they need during deployment or in the days, weeks, months, and years after the service member returns home. And communities of care must reach out rather than wait for military families to find their way to the right mix of services and support.

To build successful communities of care for deployment mental health, we need two things: policy (building community competence by bringing end-users, health providers, community leaders, and policy makers together to identify military populations, understand military culture, and tackle the broader implications of deployment stress) and practice (building community capacity to identify those who need clinical care and deliver that care effectively). Policy and practice require separate but related structures

and partnerships that converge to establish and enhance outreach, education, and integration of systems.

A Developing Relationship

Our approach to military children must be multipronged because, like their military parents, these children are highly mobile and intimately adapted to a wide range of communities and social support systems. Some are born in military facilities and raised in base housing, live in a succession of military installations, and attend on-base schools. Others grow up many miles from a parent's military base and are immersed in civilian culture and civilian schools. Still others are born and raised overseas.

Children of Guard and Reserve members face their own challenges. They usually live far from military bases and military treatment facilities, and they may be strangers to the institutions of military life. Their parents were once called "weekend warriors" because they drilled only one weekend a month (plus an additional two weeks a year). Many of these families did not even think of themselves as military until they were plunged into the deployment cycle of our recent wars. Their children are less likely to have the steady companionship of other military children or reliable access to military family programs.

Military children don't wear uniforms, and they may be hard to recognize in their communities. Yet they serve and sacrifice alongside their parents in ways that often go unappreciated. Teachers, guidance counselors, coaches, and even their own pediatricians may not know that they are military children, even though this core component of their identity may be critical to their academic success, behavior, and health. These children have to manage frequent moves that repeatedly separate them from friends, support systems, and school curricula. Even when they don't move, a parent's deployment disrupts routines and family dynamics. Military children live with constant concern for the safety of their deployed mother or father. Depending in part on their families' health, stability, and resilience, they may fall behind in school, regress in their development, or display emotional or behavioral problems. This is not to say that military children are doomed to troubles or permanent damage. Many thrive in the face of challenges. But these challenges are significant, and we must help military children cope with them.

Military Children at the Community Level

Most Americans today are comfortably isolated from the military deployment cycle. Fewer than 1 percent of Americans have served in our recent wars. Still, service members and their families are not a rare species. There are more than 22 million living U.S. veterans, and more than 60 million Americans are either veterans or dependents of veterans eligible for benefits and services from the Department of Veterans Affairs (VA).[9] Three-quarters of these veterans served during a war or other official conflict. Military and veteran families are one of the largest U.S. subcultures, and they live in every community. The effects of war on military families and their communities extend from predeployment through return and reintegration, and they are often repeated through cycles of further deployments. Veterans and their families may require years of readjustment to psychological and physical stress and/or injuries. When a nation goes to war, it makes a long-term investment in

military families, whether it acknowledges this explicitly or not.

Given this long-term investment in military families, what are the requisites of resilient development? The Positive Youth Development model holds that young people thrive in the context of community-based, youth-serving programs that foster five attributes: competence, connection, character, confidence, and contribution to society.[10] In this issue of the *Future of Children*, M. Ann Easterbrooks, Kenneth Ginsburg, and Richard M. Lerner add two more attributes—coping and control—for a total of "Seven C's" that promote resilience.[11] So, for military children to thrive, we should give them opportunities to develop a strong sense of competence, experience a profound connection to family and community, maintain character despite adversity and ambiguity, build confidence in themselves, contribute to society, cope with stress, and exercise self-control.

Clinical Services

Communities of care can't be reduced to clinical services. But informed, accessible clinical services are an important component. People often assume that the health burden of going to war is fully met and managed by the DoD and the VA. But the DoD and VA health-care systems focus primarily on service members rather than their families. The nation needs clinical systems for military families that understand military culture, ask about military histories, and consider the health implications of deployment as a routine component of care.

Before the wars in Iraq and Afghanistan, military medical facilities were brimming with military spouses and children who received care from military clinicians in military settings. It was easy for military children to feel at home in these settings and for their providers to understand them in the context of their military community (of course, this was less true for the spouses and children of Guard and Reserve members). Like their military parents, military children had a military medical home.

Military children … serve and sacrifice alongside their parents in ways that often go unappreciated.

The accelerated operational tempo in Afghanistan and Iraq, however, meant that service members used more health-care services, including comprehensive pre- and post-deployment medical screening. This drove a shift of military children out of military facilities and into civilian clinical practices, paid for through TRICARE, the national health-care program for service members, veterans, and their families. Unfortunately, TRICARE doesn't mandate any special training for providers, and there is no guarantee that community health-care professionals who enroll in TRICARE have the understanding of military culture or the training about deployment's effects that they need to treat military children. They are simply licensed health professionals willing to accept the terms of coverage. Nor is there any guarantee that enough pediatricians, child mental health professionals or family therapists will be available to meet the needs of military children wherever they reside. Guard and Reserve members, whose TRICARE benefits

are often limited to the period immediately before, during, and after deployment, may also face the difficult decision of whether to change pediatricians if their current doctor doesn't accept TRICARE.

Even in military facilities, where service members receive state-of-the-art care, a wounded service member's children may remain beyond the focus of that care. One of the authors of this article, Harold Kudler, first recognized this in 2004, while touring Walter Reed Army Medical Center with an editor of this issue, Stephen J. Cozza. As we stepped aside to allow a young child to push a wheelchair bearing his disfigured father toward the physical therapy room, Cozza quietly asked, "Who talks with these children?" This is still an important question, though recent years have seen some gains.

Beginning in 2007, for example, Congress appropriated additional funding to the DoD to support psychological health and treatment of traumatic brain injury. The Army Medical Command used these funds to develop a Comprehensive Behavioral Health System of Care, which includes Child and Family Assistance Centers and a School Behavioral Health interface with military children's parents and teachers. Unfortunately, fiscal realities may constrain this effort in the future.

Service members and their children are twice as likely as the average American to live in rural communities, where accessing DoD health care is more difficult. Guard and Reserve members and their families also tend to live in rural areas. Compared with other Americans, rural Americans in general face significant disparities in access to health care.[12] Unfortunately, in the mistaken belief that service members and their families live only on or near military bases, rural health-care professionals often assume that there is no point in becoming TRICARE providers. This misunderstanding is a major obstacle to ready access to health care for military children.

DoD data tell a very different story: all but 27 counties across the continental United States had sent Guard and Reserve members to Iraq or Afghanistan as of October 2011.[13] Given that Guard and Reserve members make up about one-third of the force in Iraq and Afghanistan, and that active duty service members and their families are also scattered across the nation, it is fair to say that virtually every county and community in the United States is home to military children. Data from the Department of Health and Human Services bring home another key point: most communities across the United States face a shortage of mental health professionals.[14] And mental health professionals are particularly hard to find in rural areas.

All but 27 counties across the continental United States had sent Guard and Reserve members to Iraq or Afghanistan as of October 2011.

The DoD and VA have made great strides in reaching geographically dispersed populations through online and mobile technologies, or telehealth. Legislation passed at the end of 2012 allows certain health-care providers to work across state lines, so that telehealth

services can reach more service members in remote areas.[15] But limited broadband access, especially in rural areas, continues to hamper remote access to health services in many parts of the nation.

Testing Access to Clinical Care

Given that service members, veterans, and their families are distributed across the nation and tend to seek care within their own communities, are community providers and programs prepared to recognize, assess, treat, or triage deployment-related mental health problems? A recent survey of community providers (mental and primary care combined) found that 56 percent don't routinely ask patients about military service or military family status.[16] Even more worrisome, the survey was circulated primarily in North Carolina and Virginia, states that host some of the nation's largest military bases and, together, are home to more than 198,000 active-duty service members, 44,000 Guard and Reserve members, and more than 1.5 million veterans.

Failure to screen for military service or military family status may reflect the community providers' lack of experience with the military or with military health issues. In fact, only one of six respondents had served in the military. And although the VA is a national leader in training health-care providers, only one in three providers reported past training in VA settings and only one in eight had ever worked as a VA health professional.

The survey also found that rural providers were significantly less likely to have ever been employed by the VA. And even though rural Americans are overrepresented in the military, a significantly smaller percentage of rural providers routinely screen for military history (37 percent of rural providers versus 47 percent of others). Further, rural providers were significantly more likely to report that they didn't know enough about managing depression, substance abuse and dependence, and suicide. Rural providers also reported significantly less confidence in treating posttraumatic stress disorder (PTSD) (46 percent of rural providers reported low confidence, versus 35 percent of others). Finally, the survey found that only 29 percent of community providers felt that they knew how to refer a veteran to VA care. Taken together, these findings indicate a yawning disconnect between community providers and the DoD and VA systems of care.

Envisioning Communities of Care

The DoD has tremendous capacity to support service members and their children through its clinical and family services, but there are limits to what it can accomplish without the help of clinical and public health programs in the civilian communities where military families live. The community response must be flexible enough to track military families and their children as they change over time, both over the course of a military career and in the transition from military to veteran status. It must appreciate that military children often grow into the next generation of service members, and that they carry a complex legacy of stress and resilience into the future. Individual military careers, like wars, have a beginning and an end, but the dynamics of military children go on across generations. These children cannot go unrecognized and unsupported in their communities.

Among the greatest challenges to building communities of care is the stigma in military culture associated with deployment-related

mental health problems, which seems to apply whether the problem is experienced by a parent or a child. Military families may be unwilling to report a child's problem because they fear that the service member will be held responsible. If a military child is missing school, getting drunk, or having run-ins with the police, for example, the local military command is likely to find out; if it does, it is certain to bring the issue to the military parent. The service member and even the child are likely to fear implications for the parent's performance review, security clearance, or future promotion, and this fear can hinder communication and dissuade families from seeking appropriate help. Even Guard and Reserve members who live hundreds of miles from the nearest base may experience this stigma. If we are to develop a proactive approach to deployment-related problems among military children, people at all levels of the military must understand that identifying such problems early is much more likely to support both the child and the service member.

Health-care providers trained and employed in traditional clinical programs often have problems of their own when they try to incorporate public health principles into their practices. Most of them have been taught to focus on discrete diseases that have known causes, diagnostic criteria, treatments, and outcomes. Communities of care for warfighters and their families require a broader picture. For example, PTSD may be the single most common mental health disorder associated with deployment, but a nation's medical response to going to war can't be reduced to screening for and treating PTSD. After all, PTSD is just one of many conditions associated with deployment. It often coexists with major depression, substance abuse, and/or traumatic brain injury, and any of these can affect families and children, creating a wide array of clinical and nonclinical needs.

Moreover, PTSD and other deployment health problems coexist with and are strongly affected by other issues not traditionally considered clinical. For example, one of the most important predictors of whether Vietnam veterans developed PTSD was the level of social support that they believed they were getting from their families.[17] This is likely just as true of today's veterans. And when service members come home to a nation in recession and have trouble finding or keeping a job, their work problems are likely to exacerbate the severity of their PTSD, depression, substance abuse, or chronic pain. Moreover, PTSD or traumatic brain injury may contribute to homelessness among veterans and their families. Even the best clinical practice guidelines for deployment health problems need to incorporate public health perspectives, and the best place for intervention is often the community rather than the clinic.

To advance the wellbeing of military children along with that of their military parents, then, we need to integrate clinical systems with community systems, including schools, youth organizations, employee assistance programs, child and family services, child protective services, local law enforcement, family courts, and more. Community programs must be able to identify military children and families, and they must understand how military culture and deployment can affect health and resilience. The question is, How can we ensure that there is no wrong door in the community to which service members and their families can turn for help?

PTSD may be the single most common mental health disorder associated with deployment, but a nation's medical response to going to war can't be reduced to screening for and treating PTSD.

Military Programs that Support Communities of Care

The military has worked to optimize support for military children, and many programs already in place follow the principles of communities of care.

Family Readiness Groups (FRGs), as they are known in the Army, connect families with their service member's unit and with one another. Each of the services has an FRG-like organization, and each unit customizes its FRG to match its mission, membership, deployment cycle, and home community. At one level, the FRG is the commanders' tool to communicate through the ranks to individual service members and their families. But it also lets family members share information (much of which has been gained through personal experience rather than institutional indoctrination) and support one another, and to share questions and concerns with commanders. When units and families are geographically dispersed, online virtual FRGs promote community support and continuity.[18] Unfortunately, the open door that is a key strength of the FRG can sometimes be its greatest weakness: As one military spouse said, "Why would I want to talk about my family's troubles when his commander's wife might be listening?"[19]

Military OneSource functions much like a national employee assistance program for service members and their families. It offers practical information and reliable support through free online, telephone, and face-to-face counseling, for everything from managing a checkbook to changing a tire. Military OneSource can help with effective parenting, health problems (including those related to deployment), special educational needs, and coping with frequent moves and long separations. Other online resources, such as RealWarriors.Net and AfterDeployment.Org, also offer links to information, support, and clinical resources.

RESPECT-Mil, based at Walter Reed National Military Medical Center's Deployment Health Clinical Center, trains military and civilian clinicians about the deployment cycle and how to manage stress and illness among service members and their families. The program, which uses a systems approach to get better results by disseminating the military's guidelines for treating depression and PTSD, has been implemented at more than 100 military facilities around the world.[20] RESPECT-Mil provides systematic, evidenced-based care to service members with symptoms of depression and PTSD in primary care settings. Primary care providers are trained to routinely screen for depression and PTSD and communicate effectively about behavioral health. Routine screening leads to early identification and treatment of these problems in easy-to-access primary care settings, where the stigma of seeking mental health services is reduced. Early, effective support for military members translates to meaningful support for their children.

One of RESPECT-Mil's goals is to improve the continuity of care for personal or family problems that require coordinated or sustained intervention. Such problems may not be clinical (at least, not yet), but they are still critical to bolstering resilience among service members and their families. With better continuity of care, people in the RESPECT-Mil program are less likely to fall through the cracks of a complex health services delivery system.

Military Kids Connect is an online community of military children (aged 6–17) created by the DoD's National Center for Telehealth and Technology. This website supports military children from predeployment through a parent's return home, offering informative activities, games, videos, and surveys that promote understanding, resilience, and coping skills. In monitored online forums, children share their ideas, experiences, and suggestions with other military children, letting them know they are not alone. Military Kids Connect also helps parents and educators understand what it takes to support military children at home and in school. Parents can control and monitor their children's access and activity on the website.

Not all interventions for military children and their families that use community-of-care principles have begun as in-house DoD programs. For example, the University of California, Los Angeles (UCLA), and the Harvard School of Medicine collaborated to adapt and pilot a family-centered, evidence-based program for military families at the Marines' Camp Pendleton.[21] Families OverComing Under Stress (FOCUS) is a preventive intervention that teaches children and families to cope with hardships such as long separations, changes in family routines, worries about deployed parents' safety, and the effects of combat stress or injuries.[22] The Navy's Bureau of Medicine and Surgery adopted FOCUS through a contract with UCLA in 2008, and the program has since expanded to 23 Navy and Marine Corps facilities and served more than 400,000 people.[23]

FOCUS teaches practical, empirically tested resilience skills that help military children from infancy through the teen years, along with their families, meet the challenges of deployment and reintegration, communicate and solve problems effectively, and successfully set goals together. Each family creates a shared family narrative about their deployment cycle experiences, thereby increasing mutual understanding and enhancing family cohesion and support. Evaluations have shown that the program improves psychological health and family adjustment for service members, spouses, and children alike.[24] FOCUS also provides ready access to a select set of resources for parents, providers, military commanders, and community leaders. By detecting stress early and beginning intervention in culturally acceptable ways within the family rather than in clinical settings, FOCUS effectively promotes family and community resilience.

Recently, to better serve military families who live far from large military communities, the developers of FOCUS have worked to employ the same principles in civilian communities (and sometimes through online resources). FOCUS is scalable and portable, and it can be tailored to the dramatically different needs of individual communities and military children.

Each National Guard unit offers a variety of programs to support military children, including local National Guard Family Assistance Centers, which any military family

may use. The centers are supported jointly by the Guard and by the unit's home state or territory. Their staff includes Military and Family Life Consultant Counselors, who must have a minimum of five years' experience and a master's degree in counseling, social work, or a related discipline. Counseling is private, confidential, and free for service members and their families.

National Guard programs across the nation have been progressively incorporating behavioral health support programs into everyday operations and at family gatherings and events. Guard children can take part in the innovative Operation: Military Kids (OMK), the Army's collaboration with communities to support children and teens affected by deployment. Through OMK, they meet other children whose parents are deployed, and they learn about community resources. In 2011, more than 103,000 military children participated in OMK activities in 49 states and the District of Columbia. Through OMK's recreational, social, and educational programs, military children, many of whom live far apart from one another, can become friends and develop personal and leadership skills. OMK also helps military children and their families with problems that crop up at school.[25]

The military also supports children through partnerships with national youth programs at the community level. The 4-H Club, itself a program of the U.S. Department of Agriculture, has formal partnerships with the Army, Air Force, and Navy. These 4-H Military Partnerships harness the resources of land grant universities across the nation (including youth development professionals and targeted programing) to establish 4-H Clubs for military children living on and off base. 4-H seeks out children whose parents serve in the Guard and Reserve and live in communities with little or no military presence. Given that military families move frequently and experience lengthy and frequent deployments, 4-H provides continuity through predictable programming and a safe, dependable, and nurturing environment for military kids.

In a similar partnership with the military, the Boy Scouts of America serves about 20,000 military children annually on bases around the world. Scouts conduct service projects such as clothing drives for children in Afghanistan, painting military facilities, base-wide cleanups, and book drives for military libraries. Like 4-H, Scouting is a "portable culture" of shared values, knowledge, and skills that can help sustain a military child through frequent moves and long separations.[26]

The departments of Defense, Veterans Affairs, and Labor have developed the National Resource Directory (NRD), a website that connects wounded warriors, service members, veterans, and their families and caregivers with helpful programs and services. The NRD is an ambitious effort to build a virtual community. It connects service members and their families to national, state, and local resources that can help them with benefits and compensation, education and training, employment, family and caregiver support, mental and physical health, homelessness and housing, transportation, and travel and volunteer opportunities.

Perhaps the NRD's greatest weakness derives from its vast ambition. Military family members and providers trying to make the right referral depend on comprehensive, accurate, constantly updated information, but constant updating is hard to sustain across the entire

United States. One practical solution is modeled by War Within, a demonstration project of the Citizen Soldier Support Program that has recruited health professionals for a state-by-state database. Searching by county on the War Within website, military families can find descriptions of practitioners, what insurance they accept (including TRICARE), whether they offer sliding-scale fees, whether they have expertise in deployment health, and how to get to their offices. The data are reviewed and validated every six months and can easily be uploaded to the NRD. Thus War Within is an effective model of how to develop and maintain state-by-state processes to make the NRD more timely, accurate, and useful.

Those who have seen [Talk Listen Connect] programs will never think about military families without deep appreciation for their resilience and their sacrifices.

Civilian Programs that Support Communities of Care

The military has put considerable thought, energy, and investment into helping military children become resilient and thrive. But much of this work can be accomplished only in and by the communities where military children live. National advocacy organizations such as the National Military Family Association (NMFA) and the Military Child Education Coalition (MCEC) are excellent examples of civilian organizations that effectively mobilize civilian communities. Both organizations work to ensure quality opportunities for all military children affected by frequent moves, deployment, family separations, and the transition to civilian life.

A closer examination of the MCEC illustrates how such civilian programs can work. As they move from school to school, from state to state, and even to other nations, military children must give up friends and routines, deal with changing academic standards and curricula, and fulfill disparate requirements for promotion and graduation. The MCEC helps families, schools, and communities support military children as they cope with these transitions. The organization recommends that schools ask every new student, "Has someone in your household served in the armed forces?" This basic step would go a long way toward ensuring that military children and their families are recognized wherever they go. Knowing children's military status would help schools understand the academic and social problems they face.

One of the MCEC's innovations is the Living in the New Normal Institute (LINN-I), which encourages military families to enhance their children's resilience, fosters community support for military children and their families, and provides concerned adults with information about helping military children cope with uncertainty, stress, trauma, and loss.[27] The LINN-I's core tenet is that military children's inherent attributes of courage and resilience can be strengthened through deliberate encouragement at the community level. The target audience includes school guidance counselors and other professional educators, school nurses, community social workers, military installation leaders, military and VA transition specialists, military and veteran parents, and other caring adults who want to improve the education of military children. The LINN-I provides accredited training for

such people in communities across the nation. For example, the MCEC Health Professionals Institute deepens the capacity of community providers to serve military children, and the MCEC Special Education Leaders Institute prepares education and health professionals to work with military children who have special needs.[28]

Give an Hour, another nonprofit organization, develops national networks of health professionals and other community members who volunteer their services to meet the mental health needs of service members and their families. At this writing, Give an Hour's network of licensed mental health professionals includes nearly 6,500 psychologists, social workers, psychiatrists, marriage and family therapists, drug and alcohol counselors, pastoral counselors, and others. Through free services for individuals, couples, families, and children, these counselors help with depression, anxiety, PTSD, traumatic brain injury, substance abuse, sexual health and intimacy, and grief. Give an Hour volunteers also work to reduce the stigma associated with seeking mental health care through training and outreach in schools and communities on and around military bases.

Recently, the organizers of Give an Hour developed Community Blueprint, a road map that lets local communities across the United States effectively tackle common problems that military families face.[29] This network brings together local leaders, government agencies (including representatives from local DoD and VA programs), nonprofits, and others to develop community-based collaborative solutions for problems ranging from unemployment to education to behavioral health to housing. Volunteers, including service members, veterans, and their family members, are integral to this process.

Many well-established organizations have used their talents and resources to help military families and children. Prominent among them is Sesame Workshop, which produces Sesame Street's Talk Listen Connect series.[30] This multimedia program, in English and Spanish, helps military families with children between the ages of two and five cope with the stress of deployment or combat injuries. A separate program helps military children and their families deal with a parent's death in combat or by suicide. A broad yet fully integrated set of Sesame Street products includes videos for children, teaching materials for parents and providers, magazines, postcards, and posters. Talk Listen Connect has reached hundreds of thousands of households around the world through free DVDs and related materials as well as direct downloads from the Sesame Street website. Few public health interventions are as likely to be taken home and enthusiastically put to use by military children and their families.

An essential strength of Talk Listen Connect is its ability to sensitize health professionals, teachers, school administrators, and others in the community to the way deployment stress can affect military families and their children. Those who have seen these programs will never think about military families without deep appreciation for their resilience and their sacrifices. They will also be more likely to recognize and engage military children and their families in the future and more likely to advocate for military children with their colleagues and across their communities.

Many more civilian organizations work independently and together to weave a patchwork quilt of clinical, supportive, or other services that champion military families and children. They represent community responses from

the grassroots level to the needs of military families, and to the gaps that the government cannot and should not be fully expected to fill. In this way, they exemplify communities of care.

New Partnerships to Build Communities of Care

In recent years, millions of service members returned home from war to a nation in recession. This "double whammy" galvanized the development of new government-community partnerships to serve them. Military children may not always be the primary focus of these partnerships, but, as with many of the programs described above, children are often their beneficiaries. Unfortunately, the recession constrained not only families' resources but also those of communities and governments at every level. When funds are short, it's even more important to collaborate, both formally and informally, to support military children. The national recession has been a powerful incentive to develop communities of care.

One key initiative is Paving the Road Home, a program of the U.S. Substance Abuse and Mental Health Services Administration (SAMHSA).[31] Since 2007, Paving the Road Home has coordinated a series of National Behavioral Health Conferences on Returning Veterans and Their Families. The conferences bring together state-level teams of community mental health and substance abuse service leaders, DoD and VA representatives, and veterans' service organizations for Policy Academies, where they make recommendations about (1) how national programs can best support the behavioral health of returning warfighters, their families, and their children at the community, state, and regional levels and (2) how to foster enduring state-level partnerships geared to local and regional needs. At this writing, virtually all U.S. states and territories have attended at least one SAMHSA Policy Academy, and many of these state-level partnerships continue to work together.

Among the advantages of working at the state level is that each state has its own National Guard and state office of veterans services. Each state offers services and benefits for service members, veterans, and their families that are geared to local needs and resources, and these are best promoted at the state level. Many state benefits and services further enhance those available through the federal government. North Carolina, a mentor state in Paving the Road Home, has been developing its model since 2005. The North Carolina program illustrates what can be accomplished at the state level.

First, a small working group partnered with the governor to host a summit that brought together key leaders of state and local government, senior representatives of DoD and VA facilities, leaders of the North Carolina National Guard, and representatives of state and community provider and consumer groups. The governor asked summit participants to develop new ideas to help returning warfighters get back to their families, their jobs, and their communities. The North Carolina Governor's Focus on Returning Veterans and Their Families has met monthly ever since.[32] Its mission is to continuously expand a network of services through which service members and their families can get effective assistance throughout the deployment cycle and beyond. Military children have been a central interest from the start.

Surveying access to needed services, the Governor's Focus found that only 76 of

North Carolina's 100 counties had an identified TRICARE mental health professional. Members of the group then produced "Treating the Invisible Wounds of War," a training series, conducted in person and online, for health professionals and others.[33] For example, these free, accredited training programs can teach doctors to recognize symptoms of traumatic brain injury during routine eye exams, or train employers to help workers with problems related to deployment and combat. More than 14,000 people have completed at least one of these training programs. Since 2011, the U.S. Health Resources and Services Administration has collaborated with the National Area Health Education Center (AHEC) Organization to field a train-the-trainer version of North Carolina's series, aimed at training another 10,000 health-care providers through 112 participating AHECs across the nation.[34]

Members of the North Carolina Governor's Focus recently joined forces with the North Carolina Institute of Medicine to produce a comprehensive report laying out key medical and community assets and needs in the effort to support service members and their families across the state.[35] The report's recommendations, which went well beyond traditional clinical perspectives to outline services for military children in state and community programs—including public schools, colleges, and religious communities—were then established in state law.[36] The Governor's Focus is monitoring compliance with that law on behalf of the North Carolina General Assembly.

Replicating the steps that established the North Carolina Governor's Focus, Virginia developed the Virginia Wounded Warrior Program, which has created high-level partnerships within the state's leadership while simultaneously building local capacity and coordinated outreach in communities across the commonwealth.[37] These same steps could be applied to develop community competence and capacity in any state or territory, but it's essential to recognize that each state has its own culture and needs to build its system in its own way. There are no cookie cutters for this process.

The next great push in establishing a national system that builds community-level competence and capacity is the White House Joining Forces Initiative.[38] Joining Forces is a comprehensive effort that seeks action on behalf of military families from all sectors of society, including individual citizens, communities, businesses, nonprofits, religious institutions, schools, colleges and other educational programs, philanthropic organizations, and government. In the clinical realm, Joining Forces is challenging professionals to integrate evidence-based practices and licensing and credentialing processes across disciplines and national professional organizations, aiming to ensure that knowledge of military culture and training in deployment mental health are ubiquitous.

To support Joining Forces, a presidential order of August 2012 calls for a national public health approach that "must encompass the practices of disease prevention and the promotion of good health for all military populations throughout their life-spans, both within the health-care systems of the departments of Defense and Veterans Affairs and in local communities," adding that "our efforts also must focus on both outreach to veterans and their families and the provision of high-quality mental health treatment to those in need."[39] This mission, which can best be accomplished through partnerships among the military, states, and communities, must

focus on military children to be truly effective. At this writing, each of the nation's 152 VA Medical Centers was planning to hold a community mental health summit in response to the presidential order. These summits should create new opportunities for communities of care.

Evidence-Based, Effective Communities of Care

Based on our review of military and community programs that serve military children, what have we learned about building communities of care? The first lesson is that we must identify military children so that we can make community resources available to them. Too often, military children remain invisible. The second lesson is that there can be no single approach to serving our nation's military children. They come in all ages, live in all sorts of communities (rural and urban, on and off military bases), have parents at different phases of the deployment cycle, and have many different levels of need and access to resources. When more than one program for military children is available in a community, it is to everyone's advantage to look for synergy rather than to choose between competing approaches and services. William Beardslee, writing about FOCUS, spoke of the value of having a "suite of services" available.[40] We might go further and suggest that military children require an entire symphony of services—health care, educational, spiritual, legal, business, and more—across their communities and across time.

The programs we've reviewed have been evaluated in many ways. Some programs, like FOCUS, have established a solid evidence base. Other programs can point only to positive evaluations from participant surveys, and still others lack any formal evaluations, though they "seem like the right thing to do." Participant surveys and "do-gooding" do not constitute valid evidence that a program has met its goals. We are still a long way from having the needed menu of evidence-based services for military children, and further still from anything approaching a practice guideline to steer clinical or public health services across the nation. As we wait for data that will eventually tell us which programs and approaches work best, we should remember that much if not most of the support military children need is in areas that are already well understood. If military children have access to good schools, safe and stable housing, and, when necessary, clinical and social services—and if their parents have stable jobs, opportunities for advancement, and quality health care—military children will be better off.

Recommendations

Based on these considerations, we recommend the following steps to recognize military children and their family members and respond to their needs when they seek help in clinical settings:

- Every clinical program (including those associated with local schools, child protection agencies, law enforcement, and the courts) should routinely ask everyone who enters its system, "Have you or has someone close to you served in the military?"
- Military membership and military family status should be flagged in each person's medical record so that it is noted at each encounter. Appropriate data fields should be required as a meaningful part of all electronic health records.[41]
- Government health-care programs and private-sector insurance companies should

offer incentives to providers to take military history as a way to improve health outcomes and potentially reduce healthcare costs through more effective treatment and better-coordinated care across DoD, VA, and private systems.

- All clinical program staff members should be taught about military culture and basic deployment mental health.

- Every clinical program that agrees to routinely apply these steps should register its name and basic information in the National Resource Directory (following the strategies of War Within described in this article) so that it is easily accessible to military families as well as to providers, employers, college officials, religious leaders, and others.

Taken together, these five practical steps will go a long way toward building communities of care in clinical settings.

Similar recommendations apply in educational, occupational, religious, local governmental, and other community settings:

- Military-connected status (whether active duty or Guard and Reserve) should be annotated in children's education records, as the MCEC has advocated.

- Employers should record which of their employees are service members, or have service members in their family, so that they can better understand military-related work/family issues and offer optimal support at times of stress. Employee assistance programs should routinely address military family issues and raise awareness of these issues among supervisors.

- Religious leaders should likewise be aware of the presence and contributions of military families and remain alert to opportunities to support them.

- State and local governments, including law enforcement, child protection services, and local courts and judiciary officials, should take advantage of programs that teach civilians about military life, culture, and deployment stress.

- Local, state, and federal governments, as well as community organizations, should commit to fully populating and continuously updating the National Resource Directory so that community resources are fully represented and accessible. Further, librarians in communities, schools, universities, hospitals, professional schools, businesses, penal institutions, and government agencies of all kinds should be trained to post and promote information about the NRD and help users access the services available through it.

Conclusions

The greatest irony and most exciting opportunity is that the same principles Thomas Salmon developed to control combat stress in World War I provide a strong foundation on which to build communities of care for military children today. We ought to focus on recognizing military children and addressing their problems in close proximity to their homes, schools, community organizations, and doctor's offices. We need to identify their needs early by watching for warning signs of stress rather than waiting for them to develop clear clinical disorders and find their way to clinical settings. Finally, we should always have high expectations that, despite their sacrifice and stress, military children will continue to cope,

grow, and succeed as valued citizens of their communities and their nation.

Military children and their families constitute one of the largest American subcultures, but they are also one of the least visible. Thinking back to Winnicott, there is, after all, such a thing as a military child. But military children are always embedded in families and communities, and in a military culture that values humility and self-sufficiency. Precisely because they are military children, they strive to put the needs of others (including their military parents) above their own. This is perhaps the real secret of their invisibility. An effective community of care can be measured by its public awareness of military children, its ability to recognize military children in community settings, and the ease with which military children and their family members can access its resources and services. Again, there should be no wrong door to which military children or their families can turn for help at the right time.

The distinguished physician and medical educator Francis Peabody once said that "the secret of the care of the patient is caring about the patient."[42] Summarizing the clinical and public health models reviewed in this article, we might well say that the secret of creating communities of care for military children is creating communities that care about military children. This will require effort and time, but we believe it is a highly achievable goal.

ENDNOTES

1. Donald Woods Winnicott, "The Theory of the Parent-Infant Relationship," *International Journal of Psycho-Analysis* 41 (1960): 585–95.
2. Human Resources Strategic Assessment Program, *January 2011 Status of Forces Survey of Active Duty Members: Leading Indicators* (Arlington, VA: Defense Manpower Data Center, 2011).
3. Françoise Davoine and Jean-Max Gaudillière, *History Beyond Trauma*, trans. Susan Fairfield (New York: Other Press, 2004).
4. Thomas William Salmon, "The Care and Treatment of Mental Diseases and War Neuroses ('Shell Shock') in the British Army," *Mental Hygiene* 1 (1917): 509–47.
5. Charles R. Figley and William P. Nash, *Combat Stress Injury: Theory, Research, and Management* (New York: Routledge, 2007).
6. Joint Mental Health Advisory Team 7 (J-MHAT 7), *Operation Enduring Freedom 2010 Afghanistan* (Washington: Office of the Surgeon General United States Army Medical Command and Office of the Command Surgeon HQ, USCENTCOM, and Office of the Command Surgeon U.S. Forces Afghanistan (USFOR-A), 2011).
7. Zahava Solomon, Rami Shklar, and Mario Mikulincer, "Frontline Treatment of Combat Stress Reaction: A 20-year Longitudinal Evaluation Study," *American Journal of Psychiatry* 162 (2005): 2309–14, doi: 10.1176/appi.ajp.162.12.2309.
8. Charles-Edward Amory Winslow, "The Untilled Fields of Public Health," *Science* 51 (1920): 23–33.
9. VA National Center for Statistics and Analysis, U.S. Department of Veterans Affairs, "Veteran Population," accessed March 9, 2013, http://www.va.gov/vetdata/Veteran_Population.asp.
10. Richard M. Lerner, Elizabeth M. Dowling, and Pamela M. Anderson, "Positive Youth Development: Thriving as the Basis of Personhood and Civil Society," *Applied Developmental Science* 7 (2003): 172–80, doi: 10.1002/yd.14.
11. M. Ann Easterbrooks, Kenneth Ginsburg and Richard M. Lerner, "Resilience among Military Youth," *Future of Children* 23, no. 2 (2013): 99–120.
12. David Hartley, "Rural Health Disparities, Population Health, and Rural Culture," *American Journal of Public Health* 94 (2004): 1675–78, doi: 10.2105/AJPH.94.10.1675.
13. Citizen Soldier Support Program, "Citizen Soldier Support Program Mapping and Data Center," accessed March 9, 2013, http://www.unc.edu/cssp/datacenter/.
14. Health Resources and Services Administration, U.S. Department of Health and Human Service, "Health Professional Shortage Areas—Mental Health," http://datawarehouse.hrsa.gov/exportedmaps/HPSAs/HGDWMapGallery_BHPR_HPSAs_MH.pdf.
15. National Defense Authorization Act for Fiscal Year 2012, Section 713, H.R. 1540, 112th Congress, http://www.gpo.gov/fdsys/pkg/BILLS-112hr1540enr/pdf/BILLS-112hr1540enr.pdf.
16. Dean G. Kilpatrick et al., *Serving Those Who Have Served: Educational Needs of Health Care Providers Working with Military Members, Veterans, and Their Families* (Charleston, SC: Medical University of South Carolina Department of Psychiatry, National Crime Victims Research & Treatment Center, 2011).
17. Daniel W. King et al., "Resilience-Recovery Factors in Posttraumatic Stress Disorder Among Female and Male Vietnam Veterans: Hardiness, Postwar Social Support, and Additional Stressful Life Events," *Journal of Personality and Social Psychology* 74 (1998): 420–34.

18. U.S. Army, "Army FRG: Family Readiness Group," accessed April 15, 2013, https://www.armyfrg.org/skins/frg/home.aspx; U.S. Navy, *Family Readiness Groups Handbook 2011*, http://www.nsfamilyline.org/publications/NavyFRGHandbook.pdf; U.S. Air Force, *Air Force Family Readiness Edge*, http://www.afcrossroads.com/famseparation/pdf/ReadinessFAmily.pdf; U.S. Marines, "Unit, Personal and Family Readiness Program (UPFRP)," accessed April 15, 2013, http://www.marcorsyscom.marines.mil/CommandStaff/FamilyReadinessOfficer(FRO).aspx.

19. Military wife, focus group, October 10, 2006.

20. Deployment Health Clinical Center, accessed March 9, 2013, http://www.pdhealth.mil/main.asp; U.S. Department of Veterans Affairs, "VA/DoD Clinical Practice Guidelines," accessed March 9, 2013, www.healthquality.va.gov/.

21. William Saltzman et al., "Mechanisms of Risk and Resilience in Military Families: Theoretical and Empirical Basis of a Family-Focused Resilience Enhancement Program," *Clinical Child and Family Psychological Review* 14 (2011): 213–30.

22. Patricia Lester et al., "Families Overcoming Under Stress: Implementing Family-Centered Prevention for Military Families Facing Wartime Deployments and Combat Operational Stress" *Military Medicine* 176 (2011): 19–25.

23. William Beardslee et al., "Family-Centered Preventive Intervention for Military Families: Implications for Implementation Science," *Prevention Science* 12 (2011): 339–48, doi: 10.1007/s11121-011-0234-5.

24. Patricia Lester et al., "Evaluation of a Family-Centered Prevention Intervention for Military Children and Families Facing Wartime Deployments," *American Journal of Public Health* 102 (2012): S48–54, doi: 10.2105/AJPH.2010.300088.

25. Operation: Military Kids, accessed March 9, 2013, www.operationmilitarykids.org/public/home.aspx.

26. "2011 Report to the Nation," Boy Scouts of America, accessed March 9, 2013, http://www.scouting.org/about/annualreports/2011rtn.aspx.

27. "Living in the New Normal," Military Child Education Coalition, accessed March 9, 2013, http://www.militarychild.org/professionals/programs/living-in-the-new-normal-linn.

28. "Programs," Military Child Education Coalition, accessed March 9, 2013, http://www.militarychild.org/professionals/programs.

29. "The Community Blueprint," Give an Hour, accessed March 9, 2013, http://www.giveanhour.org/CommunityBlueprint.aspx.

30. "Talk, Listen, Connect," Sesame Workshop, accessed March 9, 2013, http://www.sesamestreet.org/parents/topicsandactivities/toolkits/tlc.

31. "Paving the Road Home: Returning Veterans and Behavioral Health," *SAMHSA News* 16, no. 5 (September/October 2008), http://www.samhsa.gov/samhsaNewsletter/Volume_16_Number_5/SeptemberOctober2008.pdf.

32. North Carolina Division of Mental Health, Developmental Disabilities, and Substance Abuse Services, "North Carolina Focus on Service Members, Veterans, and Their Families," accessed March 9, 2013, http://www.veteransfocus.org/our-mission/.

33. "Treating the Invisible Wounds of War," AHEConnect, accessed March 9, 2013, http://aheconnect.com/citizensoldier/cdetail.asp?courseid=citizensoldier1.

34. "A-TrACC Project for the Behavioral/Mental Health of Veterans/Service Members & Families," Health Resources and Services Administration, accessed March 9, 2013, http://bhpr.hrsa.gov/grants/areahealtheducationcenters/ta/trainings/veterans/tttworkshopsummary.pdf.

35. North Carolina Institute of Medicine, *Honoring Their Service: A Report of the North Carolina Institute of Medicine Task Force on Behavioral Health Services for the Military and Their Families* (Morrisville, NC: North Carolina Institute of Medicine, 2011), http://www.nciom.org/wp-content/uploads/2011/03/MH_FullReport.pdf.

36. An Act to Ensure that the Behavioral Health Needs of Members of the Military, Veterans, and Their Families Are Met, Sess. L. No. 2011-185, General Assembly of North Carolina Session 2011, www.ncga.state.nc.us/EnactedLegislation/SessionLaws/PDF/2011-2012/SL2011-185.pdf.

37. "We Are Virginia Veterans," Virginia Wounded Warrior Program, accessed March 9, 2013, http://www.wearevirginiaveterans.org.

38. "Joining Forces: Taking Action to Serve America's Military Families," White House, accessed February 27, 2013, http://www.whitehouse.gov/joiningforces.

39. Office of the Press Secretary, White House, "Executive Order—Improving Access to Mental Health Services for Veterans, Service Members, and Military Families," news release, August 31, 2012, http://www.whitehouse.gov/the-press-office/2012/08/31/executive-order-improving-access-mental-health-services-veterans-service.

40. Beardslee et al., "Family-Centered Preventive Intervention," 341.

41. Centers for Medicare and Medicaid Services (CMS), "An Introduction to the Medicaid EHR Incentive Program for Eligible Professionals," accessed May 26, 2013, http://www.cms.gov/Regulations-and-Guidance/Legislation/EHRIncentivePrograms/Downloads/EHR_Medicaid_Guide_Remediated_2012.pdf.

42. Francis W. Peabody, "The Care of the Patient," *Journal of the American Medical Association*, 88 (1927): 877–82.