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Training needs among nonmental health professionals working with service members: A qualitative investigation

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Abstract

Though many service members will not directly seek mental health care due to stigma and other factors, they may interact with the healthcare system in other ways including contact with first responders, nurses and allied health care professionals. However, little attention has been spent in this regard on the educational needs of these professionals whose contact with service members and veterans may provide the opportunity to assist veterans in need with overcoming barriers to accessing mental health care. This qualitative study investigates the educational training needs of first responders and health care professionals in contact with military families and trauma survivors to determine whether, and what type, of additional training is needed. A sample of 42 first responders and health care professionals including emergency medical technicians, police officers, fire fighters, speech language pathologists, occupational therapists, physical therapists, and nurses, were recruited to participate in one of six focus groups. Sessions were audio-taped and transcribed verbatim. Data analysis was guided by a thematic analysis approach. Thematic analyses suggest there is a significant knowledge gap with unmet educational needs of these professionals such as information on the invisible wounds of war, military culture, and screening and referring patients who present symptoms falling outside professionals' scope of practice. Findings point to a need and desire for more robust education for first responders and health care providers around mental health concerns of military populations, including topics such as trauma, military culture, and screening tools. Efforts to develop curricula addressing these concerns are warranted.

Keywords

education; first responders; health professionals; military

Over two million service members have deployed at least once in support of the post 9/11 conflicts and have been exposed to experiences that can negatively impact their physical and psychological health throughout the deployment cycle (Sayer, Carlson, & Frazier, 2014). On returning home, up to 44% of service members have difficulties, with some reports suggesting 20% suffer from posttraumatic stress disorder (PTSD) and/or traumatic brain injury (TBI), 37% experience depression, and 39% struggle with problematic alcohol use (IOM, 2013). Furthermore, the nation has seen a dramatic rise in suicide rates (Hester, 2017), resulting in more deaths to suicide than combat in these conflicts. Despite these prevalence rates, as many as 50% of veterans meeting criteria for a mental health concern (Tanielian et al., 2008) do not access mental health treatment due to a confluence of factors including systemic (e.g., stigma, access to care) and personal (e.g., transportation costs to treatment, obtaining childcare, time) barriers (Bauer, Williford, McBride, McBride, & Shea, 2005). Such barriers may be more pronounced for members of the National Guard and Reserve who may not live near military installations, but in communities where healthcare providers may have little knowledge of the military, deployment cycles, and the unique reintegration challenges service members and their families face (Murphy & Fairbank, 2013). Efforts are needed to reduce stigma, enhance awareness, and support treatment seeking early enough to intervene effectively in this at-risk population who may not present directly in mental health settings. While much of the research literature has focused on educating mental health providers about the unique needs of service members, other professionals—specifically first responders and allied health providers—may be well-positioned to help break down barriers and aid in the provision of mental health services for this population.

Stigma and negative beliefs about mental health treatment amongst the veteran and service member community have been well-documented (Vogt, Fox, & Di Leone, 2014) and may present a barrier to independently seeking out mental health care services. Furthermore, many mental health conditions—particularly PTSD—are characterized by inherent avoidance that make treatment seeking behavior unlikely, or at the very least, more challenging (Sayer et al., 2009). As of April 2017, the U.S. Department of Defense reported an aggregate of over 52,500 service members wounded in action in support of the post 9/11 conflicts (DeBruyne, 2017) with recent congressional publications reporting over 36,000 moderate or severe traumatic brain injuries and 1,645 major limb amputations (Fischer, 2015). Orthopedic and other physical injuries result in many service members receiving medical care during or after deployment, offering a window of opportunity for the identification of mental health and TBI concerns by patient care and rehabilitation professionals such as speech language pathologists (SLP), occupational therapists (OT), physical therapists (PT), and nursing professionals. These healthcare professionals often provide longitudinal care for patients, which frequently leads to the formation of trust (Langer, 1999), strengthening their ability to help identify those in need of additional mental health or TBI related services and facilitate needed referrals. Additionally, many service

members will come in contact with those in the emergency services (emergency medical service (EMS), firefighters, and police) either through post-service occupation or, through misconduct as alcohol and drug abuse have become serious problems facing our military service members upon return (Wagner et al., 2007).

Though service members may be in contact with a variety of healthcare providers, such professionals may not be well trained to identify mental health concerns or adequately equipped with how to provide referral resources. Much of the limited research on adult trauma education of non-mental health providers has been focused on primary care settings, finding a need for greater mental health education (Greene, Neria, & Gross, 2016). To our knowledge, no research on this topic has been conducted examining service member specific trauma educational needs of these non-mental health (SLP, OT, PT, Nurse) professionals and first responders (EMS, Police, Fire). While specific trauma educational needs have not been firmly identified for these professionals, many educational programs about trauma have emerged. In the published peer-reviewed literature, we are only aware of one military specific trauma-focused training known as Military Mental Health First Aid (M-MHFA), designed to train laypeople about mental illness among service members (Mohatt, Boeckmann, Winkel, Mohatt, & Shore, 2017). Such programs are inherently well-intentioned and likely beneficial; however, prior to the development of trainings is a necessity to understand specifically what and for whom training is needed. Better knowledge of training gaps could allow these professionals to serve as gateways for the provision of mental health treatment by identifying individuals with unmet needs and assisting in transitioning them into appropriate care.

Without education, there is risk of unintentionally further compounding trauma (Courtois & Gold, 2009) by reinforcing avoidance or minimizing the effects of trauma. For instance, after listening to a soldier's disclosure of persistent nightmares, a care provider may unintentionally (or intentionally due to discomfort) suggest that the soldier is simply fatigued or stressed, and will feel better soon. While those attributions could certainly be true, a trained provider could have a more comprehensive conversation with the soldier about how nightmares are common amongst individuals who have experienced trauma, opening the door to screening and providing referral resources. Thus, there is a need to develop educational materials that can impact healthcare professionals' ease and comfort identifying, screening, and connecting veterans and military families to appropriate services. Though quantitative methods are useful in helping to identify needs, qualitative methods are most useful in helping to identify *what* and *where* needs specifically lie. While some programs have been developed to raise awareness, decrease stigma, and aid the layperson in referring people in need (Mohatt et al., 2017), a better understanding of specific training needs among first responders and health professionals will make such educational programs more effective by directly targeting gaps in the curricula and past training experiences. This qualitative study investigates the trauma-focused educational needs of both non-mental health providers and first responders to better understand the current training gaps in order to allow for formalized curricula to be developed to increase provider competency working with veterans impacted by the invisible wounds of war.

Methods

Sample

We conducted a pilot with two focus groups ($N=16$) consisting of leaders (e.g. director, president, senior manager) in the various stakeholder professions of interest (i.e., EMS, police officers, fire fighters, SLP, OT, PT, and nurses) to assure relevant and pointed questions were being asked. We used a convenience sample and recruited participants within the greater Boston community. Participants of these two leadership focus groups (mean age (SD) = 52.8 (9.8)) had been in their respective professions for an average of 24.4 years ($SD=8.6$). One third (37.5%) were military connected (i.e., had a loved one serve) and two individuals (12.5%) were veterans. This pilot work (described in more detail below) helped inform the remainder of the project.

The main project consisted of six stakeholder/profession specific focus groups of 6 to 10 participants for a total of 42 first responders and health professionals. Participants were recruited utilizing snowball sampling from the leadership focus groups' contacts of friends and colleagues (Noy, 2008). Recruitment criteria included: (a) being certified or licensed in one of six stakeholder professions of interest including EMS, fire service, police force, OT/SLP, PT, or nursing, and (b) over 18 years of age. Identified participants were eligible for \$100 reimbursement to compensate for their time participating and city parking.

Procedures

The study was granted institutional review board exemption by the Partners Healthcare Institutional Review Board. Six stakeholder specific focus groups were conducted to promote open sharing and comparison of multiple participant perspectives. Participants were informed that the focus group would last approximately 90 minutes and would be audio taped to ensure systematic and verifiable data analysis. Recordings and transcripts were kept on an encrypted drive accessible only to project staff. Before the focus group, participants completed surveys assessing demographics, military connection, and training related questions. The rationale for the group was described in detail, the moderators (second and last author) and supporting staff (first author) were introduced, and informed consent was verbally obtained.

Development of Interview Guide

The initial interview guide was developed by the first and second authors and informed by a literature review and the project aims. The preliminary guide was piloted with the two leadership focus groups. The following areas were revised based upon what we learned in the pilot: (1) The focus groups needed to be profession specific to assure time was not spent explaining terminology of one profession to another, (2) The focus groups needed participants of relatively equal rank to allow all participants to feel comfortable talking honestly in an open and permissive atmosphere, and (3) The focus group interview guide should incorporate questions regarding military experience and knowledge, whether personally or professionally obtained. The final semi-structured focus group interview guide was organized to facilitate discussion of trauma knowledge, military knowledge, prior training experiences, and educational needs to augment quality care of post 9/11 veterans.

Data Analysis

Stakeholder focus groups were audio-taped and transcribed verbatim by the first author. All transcriptions were anonymously coded with ID numbers known only to the first author. NVivo10 software was used for data management (International, 2014) and thematic analysis was used for coding (Braun & Clarke, 2006). After becoming familiar with the data by actively reading the transcripts, the coders (first and fourth authors) independently organized the content of the data and overarching topics (repetitive ideas) by identifying potential themes and patterns. After discussing the identified broad patterns, the coders independently defined specific codes, and collated them into overarching themes in a hierarchical fashion (e.g., main overarching themes and subthemes within them). The coders then met a second time to discuss the themes and definitions. Discrepancies (such as theme names) were resolved through reflection back to the data and mutual agreement on word choice. Next, the coders read and coded the two transcripts independently to reflect the agreed upon codebook, to assure that the themes were indeed reflected in the data and were internally coherent, consistent, and distinctive, and to identify any missed codes. Coders then met to review and refine the code hierarchy and revise definitions to address coding discrepancies. The coders repeated the process of independent coding and meeting to revise two more times to reach inter-coder reliability on the first two transcripts.

Next, the coders used this revised codebook to independently code the third focus group and met again to discuss and modify codes and definitions. This process of generating codes, re-defining, expanding, and collapsing codes was continuous throughout the coding process and overarching themes and subthemes were generated and iterated with the remaining focus groups, one transcript at a time. A consensus of the coding of each transcript and codebook revisions had to be reached and previous transcripts had to be re-coded with the most recent codebook before coders proceeded to the subsequent transcript to ensure sound inter-coder reliability. Revisions to codes ceased after theoretical saturation was reached, which occurred with the fourth transcript. All data from all six transcripts were double-coded, resulting in an overall inter-coder reliability of 93.3% agreement between coders.

Results

Full sample demographics are presented in Table 1. The six facilitated focus groups shed light on four main content areas for future training including mental health knowledge, military knowledge, screening and referral knowledge, as well as understanding the need for a holistic approach to healthcare (Please see Table 2 for main themes and subthemes).

Lack of Mental Health Knowledge as a Barrier to Providing Competent Care

Participants overall described having a moderate to low level of knowledge themselves and/or within their professions about PTSD, TBI, depression and suicidality, as well as concerns regarding staying within their scope of practice, suggesting a need for greater training.

Posttraumatic stress disorder.

Most participants in both the first responder and health professions indicated that any knowledge of PTSD was obtained through experience and not through more formalized trainings, leading to some misconceptualizations and false beliefs about the disorder (e.g., an individual with PTSD will never fully recover). Though some participants self-identified higher levels of knowledge, they reported that within their general professions, there is a low level of knowledge. One OT described,

“The PTSD aspect for me is something that, in my own practice, I would like to be more familiar with. I’ve had experiences this past year, even in the evaluation diagnostic setting where I see that this patient has a history of PTSD and I’m not sure how this patient might respond to this long period of testing or this particular type of testing or this particular type of question that I’m asking and, that seems to be a gap for me ...to better understand how to manage that.”

Further, though some participants noted knowledge of PTSD, they were not using or educated about evidence-based treatments and first line approaches. For example, there was discussion regarding the importance of utilizing “grounding techniques” and identifying ways to mitigate anxiety in the moment such as through avoidance of difficult situations and distraction from trauma reminders. While grounding techniques are sometimes used to titrate treatment response in evidence-based psychotherapies for PTSD (e.g., if a patient is dissociating), the techniques noted by participants were unhelpful and collude with avoidance inherent in PTSD.

Traumatic brain injury.

Though some participants described a general knowledge of severe TBI, most expressed greater unfamiliarity with mild-TBI, the range of brain injury severity, and the subsequent consequences and impact on quality of life. Participants further expressed confusion over how to differentiate the two “signature wounds of war”- TBI and PTSD. One PT stated,

“I didn’t realize how much overlap there was in the symptoms as well. I mean, I’ve always looked at it from the PT side obviously, but, a lot of those symptoms could be a result of posttraumatic stress so I guess education in that arena, just kind of teasing out exactly what is causing it and who’s the best person for them to see really.”

Depression and suicide.

Some participants described much less familiarity with depression and suicidality, stating that it fell outside their scope of practice and thus they attend very little training in that arena. As one SLP described,

“When it’s depression... I certainly don’t feel comfortable and I’ve never been trained in assessing that--it’s not really part of our scope of practice. We’re careful not to comment on that, and the same with suicide ideation... just sort of, ‘don’t ask those questions,’ and try and steer clear of that because I wouldn’t know how to manage that.”

Additionally, likely due to inadequate training and avoidance of sensitive topics, some professionals described either themselves or others in their field, as very uncomfortable with affect leading of feelings of anxiety working with patients in distress and anxiety. Though some participants shared that they screen for depression, many reported that they do not necessarily ask follow-up questions if a patient does describe feelings of depression and so the question becomes a “check-the-box” routine rather than an effective tool to identify, guide and direct patients to appropriate care.

Practicing within the scope of one’s profession.

Many participants, primarily healthcare providers, identified the challenges of working with mental health concerns within their profession. Professionals identified that they end up acting in the role of counselor (whether they want to or not) and asked for guidance and clarification with regard to how they can help support patients while still acting within their professional role. As one OT articulated,

“... when patients come in and they say, ‘Oh, you know I didn’t sleep at all last night because I was up with really bad nightmares.’ That- what would be a good response that we could be an active listener but not dismissing that this was a really horrible thing that happened... Is there something we could say that would be more supportive but still staying within our scope of practice?”

Some First Responders shared similar concerns regarding remaining within their scope of practice and questioned what training would be most important for their professions. Specifically, some first responders felt that due to entering a situation at a time of crisis, knowledge that someone is a veteran or may be exhibiting symptoms of PTSD would not affect their course of action. As one firefighter put it, “Awareness is good but... at that moment, for us, it’s not our priority.” Thus, these providers did not initially consider that such identification might influence other caregivers when bringing patients to medical care settings.

Military Knowledge

Knowledge of military culture was reported as a major facilitator for communicating with, and caring for, veterans, and participants described a need for military competence education.

Military culture knowledge as a facilitator.

Many participants spoke of how a military connection was important in communicating effectively with veterans. These participants felt that it gave them the credibility to be heard by the veteran and gave the veteran assurance that they, the provider, cared for and respected them. One police officer credits this communication as instrumental for mollifying tension when on the job, stating:

“I think when you’re dealing with veterans, you need to know what the culture is. You need to know the vernacular, the jargon... If I can go up to a guy and say, ‘What unit were you with? What branch of service were you with? Are you service connected?’... [Then] you’re connecting [and] not rolling around on the street.”

Lack of military culture knowledge as a barrier.

Participants who did not have adequate military culture knowledge felt that their lack of understanding created a barrier between the patient and themselves, thus unintentionally preventing them from being able to communicate effectively and provide/direct care. Veterans in the focus group offered an explanation for the barrier, citing that lack of provider education about their culture and lifestyle was yet one more barrier to receiving care, leading veterans to likely see the appointment as meaningless and thus discontinue care. As an OT put it:

“It’s interesting ‘cause we get taught about cultural sensitivity and being sensitive to people of different groups but I don’t know that people always consider military a culture... that would be really important for people to understand.”

Knowledge of reintegration challenges.

All participants described the various reintegration challenges they faced with themselves, their peers, or out in their respective fields including high standards not met in civilian life, substance use, emotion regulation, emotional numbing/detachment, depression/anxiety, and familial and interpersonal difficulties. Participants emphasized the need for heightened awareness of these challenges in an educational campaign. One firefighter described saying something as simple as, “It’s tough coming home.” Knowledge of such topics equated with greater levels of confidence and comfort interacting with this population, citing their cultural competence as instrumental to their ability to provide competent care.

Understanding that each military experience is unique.

In addition to military culture and reintegration issues, participants asked that the cultural competency component of an educational curriculum acknowledge that not all veterans feel the same way about the military. Some veterans view the military favorably whereas others leave the military with no intention of staying connected to it. This sensitivity to perceptions of the military by veterans was described as important information to remind learners to be careful about broad generalizations as each military experience is unique and different. Further, participants asked for knowledge on how to react and work with a patient who expresses their feelings about the military. As one SLP noted:

“I found that, most of the veterans that I’ve worked with fall into one of two sort of dramatic categories: Either, they hated the military... or, they really are grieving being out of the military... they’re going back to whatever their feelings are about the military and, I don’t know how to manage... how to sort of diffuse that being the center of what they want to talk about.”

Lack of Screening and Referral Knowledge

Participants discussed the need for screening resources such as tools and questionnaires in addition to referral resources such as websites and pamphlets with information about clinics and trauma centers.

Lack of simple screening tools.

Participants described a significant level of apprehension when screening and communicating with patients on matters outside of their certified profession due to fear of overstepping professional qualifications and potentially saying, or doing, something that could be more harm to the patient rather than of use or value. Central to this apprehension was that no simple screening tools exist and thus providers find themselves talking at length with patients about PTSD and related issues with no guidance and knowledge about what to do with the patient if further action is required (e.g., referring, handling the difficult conversation and moving forward to a different topic of conversation). An OT described confusion and thoughts about what would help in such a situation:

“We’re trying to screen patients for PTSD and we really don’t know anything about it...I don’t know a tool, maybe there is—but, if there was some kind of tool... [that] we could re-do it and see if it’s improving, ‘cause it’s, it’s a little unclear to me, like, how much is the PTSD is interfering with their other recovery...I don’t think we have any standardized tests or, or, screening forms, or anything like that to use on patients. So, that would be helpful.”

Challenge of screening tools.

Participants further identified a challenge in knowing when to screen citing that most patients do not self-identify as a veteran and thus the provider doesn’t necessarily think to screen or ask subsequent questions. In addition, veteran participants felt that a questionnaire screen may not actually be beneficial. One firefighter noted the stigma inherent,

“It says you know, PTSD questionnaire, and I’m like, ‘Don’t have it.’ ...I didn’t even read one of them. No, no, no... So that’s the reality of the questionnaire thing that I just wanted to share, catch-22. As much as it could be helpful... [it] reminds them, like, ‘I took this thing in the service: no, no, no, no, no.’ You know?”

Another participant acknowledged that the biggest problem with questionnaires was that there pervades the belief that they have the potential to be career-stoppers; for example, some believe that a diagnosis of PTSD may affect their security clearance. Navigating the stigma associated with mental health and PTSD was perceived as being extremely difficult among participants and a large barrier to referring patients to mental health care.

Lack of referral resources.

Many participants spoke to the need for referral resources. Though screening for mental health challenges is important, participants emphasized that it was useless unless the provider knew what to do with that information and knew how to make referrals including who to make such referrals to. As one PT described,

“Giving us tools for the toolbox and then, I think most PTs will tell you, it’s not a crime not to know what to do—it’s a crime not to know where to look it up. You know reference material- you can have it simple. You know, a simple algorithm, that kind of thing. And, you can go, ‘Okay, I’m seeing this... What do I do about it?’”

Understanding of the Bio-Psycho-Social Approach to Health Care

Professionals all spoke to the importance of a well-rounded, multi-disciplinary, approach to health care. There was recognition that healing from a physical wound or psychological wound does not occur in isolation and that the whole person must be addressed and cared for, not simply the identified concern germane to the provider's specialty. Noted in particular as important were validation, psychoeducation, and the inclusion of the family.

Participants spoke of the need to validate their patients' experiences, thoughts, feelings, and actions. Validation helps form trust between provider and patient, and can thereby be an instrumental tool in developing the relationship necessary to ascertain the appropriate information from the patient in order to provide adequate health care, including screening and referring for other problems. As one nurse described,

"It's about validation... When you meet that social worker that's just not getting it, it's a sense of not having your person validated...for your experience and for who you are and for your connection to the military."

Participants also emphasized the importance of psychoeducation for patients as a first step to treatment of any ailment. Psychoeducation may also validate patients' experiences, providing assurance they are not alone in their suffering together with knowledge that others have similar experiences and meaningful treatment is available. Finally, professionals cited the importance of including the family in care to provide adequate social support and guidance, thereby helping patients stay on track during treatment and stay engaged in care; however, participants shared that they were not always comfortable engaging with family members or managing their involvement in a patient's care plan.

Discussion

Findings from this qualitative study highlight the gaps in knowledge among non-mental health professionals regarding working with and treating military populations impacted by service related mental health concerns or traumatic brain injury, leading to an understanding of the educational needs of the first responder, nursing and rehabilitation professional communities. The results suggest that of primary concern, education regarding mental health, military culture, and screening and referring would be important to these healthcare workers and first responders. With regards to mental health, professionals asked for training in trauma, PTSD, TBI, suicide and depression. Many participants described low knowledge or, displayed via comments, inaccurate or misguided knowledge of the above conditions indicating a need for more comprehensive training. Apprehensive feelings shared about mental health were of particular concern. Since mental health is integral to overall wellbeing, it is imperative that professionals with the first opportunity to intervene develop basic comfort and competency levels working with vulnerable populations while remaining within the limitations of their professional training and licensure.

Military culture also emerged as a sought after educational need among these professionals. Military connected participants with greater military knowledge expressed the advantage of such knowledge in facilitating communication, care, and referral of patients whereas participants with more limited knowledge identified their lack of knowledge as a barrier.

When working with diverse groups, knowledge of different cultural values and norms and a willingness to develop a multicultural perspective enables providers to adapt their services and care to be consistent with the identified culture of the client (Bussema & Nemec, 2006). Previous research has documented the need and the importance of military cultural competence (Strom et al., 2012); however, studies have predominantly focused on the need in mental health professions (Canfield & Weiss, 2015).

Screening military personnel for mental health concerns has increasingly become a priority within the Department of Veteran Affairs (Bloeser et al., 2014) as well as in community mental health care settings (Tiet, Schutte, & Leyva, 2013). Participants overall expressed desire for more education around how to screen and refer patients/clients. Some participants in the first responder professions, however, expressed concerns regarding the relevance of such information, indicating a need to also provide education supporting the benefits of screening such as better provision of services.

There are a plethora of validated screening measures in the psychological literature for mental health (e.g., PTSD Checklist for DSM-5; Bovin et al., 2016). However, according to our data and despite an uptick in screening in primary care settings (Greene et al., 2016), such screening tools have failed to be applied uniformly by other professionals. Knowledge of these measures and education on their administration would enable non-mental health professionals to assess for mental health challenges so they could guide and direct patients into more specialized care when warranted. Given the identified need for greater knowledge of referral resources, trainings must not only include screeners, but listings of where these professionals can direct patients for further evaluation and care.

Participants acknowledged the influence biological, psychological, and social factors play in the health and wellbeing of an individual (Engel, 1977). It is evident that providers frequently become inadvertent sources of emotional support, often hearing of service members' experiences overseas and challenges coming back home. These care providers' experiences working with veterans have clearly helped form a basic understanding of the potentially negative impact of trauma on service members as well as on the family unit and greater community. Such recognition is a critical first step in raising awareness and provides a sound framework from which educational programs can build upon.

The findings of this qualitative study must be considered with respect to several limitations. As is true for all personal recollections, these professionals' suggestions and opinions may not reflect those of all professionals and as such, the data should be interpreted with caution. This study sample was drawn from a single urban area and combined a range of professionals with variable roles and level of contact with veterans that likely contributed to diversity in responses. The majority of our sample had some experience working with veterans and thus it is possible that professionals who chose to participate in our focus groups differ in meaningful ways from professionals who chose not to participate. However, our goal was to explore the educational experiences of a sample of professionals and work settings; future research should examine the generalizability of our results. It is important to note that this study did not explore modality preferences; the extent to which material can be delivered in similar ways (e.g., webinars) across professions is worthy of additional study.

State licensing boards may also differ with regard to training requirements for first responders and health professionals across the nation which may influence opportunities for continuing education and thus specific training needs. Finally, future studies should examine what veterans and service members would like to see from providers to ensure an alignment between perceived and actual cultural competency needs. Such information would provide a more comprehensive training needs assessment (Surface, 2012).

Findings indicate that an important area has yet to be comprehensively covered by licensure and renewal requirements of first responders and health professionals; future educational curricula should address the invisible wounds of war including PTSD, TBI, depression and suicide, in addition to basic mental health education. Further, curricula should also address military life, cultural beliefs and reintegration challenges to encourage cultural competency and increase quality of care. Educational programs encompassing these domains alongside tools to help support identification and referral of these mental health and TBI concerns are warranted. While such curricula may take time to formally develop, test, and incorporate into licensure and renewal requirements, our center (*omitted for masked review*), has begun this process and we encourage readers to proactively seek out trainings offered at (*name and hyperlink omitted for masked review*). Additionally, the National Center for PTSD has developed a number of mobile applications for individuals or families affected by PTSD and related conditions that readers may find helpful when providing patients with resources (NCPTSD, 2017).

In conclusion, this qualitative study illustrates important gaps in mental health and military competency training. Furthermore, such training has the potential to prepare providers working with anyone experiencing mental health difficulties or who have been affected by trauma. By qualifying what areas need to be covered in trainings and curricula, leaders in education, healthcare, and policy can be better equipped to meet this need and appropriately allocate resources to this important training initiative.

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Public Significance Statement

This study suggests there are profound gaps in the mental health training of allied health professionals and first responders regarding how to identify, screen, and refer service members and veterans who may be suffering from posttraumatic stress disorder, traumatic brain injury, depression, and suicidal ideation. These professionals are in a unique position to serve as gateways for the provision of mental health treatment by identifying individuals with unmet needs and assisting in transitioning them into appropriate care; however, more training is warranted.

Table 1.**Participant Characteristics**

	Focus Group						Total (<i>N</i> =42)
	EMS (<i>N</i> =8)	Police (<i>N</i> =4)	Fire (<i>N</i> =6)	OT/SLP (<i>N</i> =10)	PT (<i>N</i> =7)	Nurses (<i>N</i> =7)	
Age, <i>M</i> (<i>SD</i>), years	44.38 (10.58)	54 (13.44)	42.2 (9.96)	45 (12.46)	43.14 (10.17)	51.57 (9.43)	46.22 (11.08)
Gender, <i>n</i>							
Female	2	0	1	10	6	5	24
Male	6	4	5	0	1	2	18
Race, <i>n</i>							
White	5	3	4	10	7	7	36
Not-white	3	1	1	0	0	0	5
Trainings, <i>n</i>							
Participated in military culture training	1	2	3	4	2	4	16
Have not participated in military culture training	7	2	2	6	5	3	25
Interested in receiving military culture training	6	4	5	9	6	7	37
Not interested in receiving training	2	0	0	1	1	0	4
Years in Profession, <i>n</i>							
1–9	1	1	2	3	2	0	9
10–19	3	1	1	2	1	2	10
20–29	3	1	1	2	3	2	12
< 30	1	1	1	3	1	3	10
Ever Served in US Armed Forces in a war zone? <i>n</i>							
Yes	1	2	3	0	1	2	9
No	7	2	3	10	6	4	32
Served during peacetime	0	0	0	0	0	1	1
Family Served in US Armed Forces in a war zone? <i>n</i>							
Yes	3	3	4	3	1	5	19
No	5	1	1	7	6	2	22

Note. *N* = Sample size; *M* = mean; *SD* = standard deviation; *n* = number; EMS = emergency medical services; OT = occupational therapy; SLP = speech language pathology; PT = physical therapy; US = United States

* Some participants chose not to answer all questions explaining the variability in numbers

Table 2.**Barriers and Facilitators to Working with Service Members: Educational Needs**

Theme	Subtheme	FR		HP		Participant Description
		N	n	N	n	
Lack of Mental Health Knowledge as a Barrier to Providing Competent Care	Posttraumatic stress disorder	3	66	3	63	"PTSD... is something that... I would like to be more familiar with"
	Traumatic brain injury	3	23	3	44	"I didn't realize how much overlap there was in the symptoms [of PTSD and TBI]"
	Depression and suicide	3	46	3	36	"I don't feel comfortable and I've never been trained"
	Practicing within the scope of one's profession	2	4	2	7	"Is there something we could say that would be more supportive but still staying in our scope of practice?"
Military Knowledge	Military culture knowledge as a facilitator	3	48	3	41	"You need to know what the culture is"
	Lack of military culture knowledge as a barrier	3	28	3	24	"I don't know that people always consider military a culture... be important for people to understand"
	Knowledge of reintegration challenges	3	74	3	33	"It's tough coming home"
	Understanding that each military experience is unique	3	22	3	20	"I don't know how to manage that [feelings about the military] and how to diffuse that"
Lack of Screening Knowledge	Lack of simple screening tools	3	23	3	39	"We're trying to screen...and we don't know anything about it"
	Challenge of screening tools	3	34	3	37	"It says... PTSD Questionnaire, and I'm like, '[I] don't have it'"
	Lack of Referral Resources	3	16	3	18	"[Give] us tools for the toolbox"
Understanding of the Bio-Psycho-Social Approach to Health Care		2	5	3	22	"It's about validation... When you meet that social worker that's just not getting it, it's a sense of not having your person validated...for your experience and for who you are and for your connection to the military"

Note. FR = first responders; HP = healthcare professionals; N= number of focus groups a theme was present in (range: 0 – 3); n = number of utterances of a given theme