

Bridging the Gap: Delivering Culturally Sensitive Care for Military-connected Patients in Community Settings

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Service Members, particularly members of the Reserve Component, seek medical and mental health care in their civilian communities. To the extent that providers communicate respect and value for military culture, they can better engage and enhance outcomes.

Introduction

As we seek to better understand and address the mental health needs of the military population, it is crucial to consider the unique challenges faced by Veterans and members of the military's Reserve Component (RC). Whereas full-time members of the military's active component (AC) can typically seek mental health care from a uniformed provider in a military treatment facility (MTF), the RC relies heavily on community resources for medical services and is increasingly seeking mental health care from civilian providers [1]. As a result, there is a need among civilian providers for greater familiarization with the uniqueness of this population.

Every state has a National Guard element that can be called to active duty by either the state or federal government. These Service Members, along with those serving in the Reserves, comprise the RC and fulfill a minimum service commitment of one weekend a month and two weeks a year. Though their training and organization is similar to that of active-duty components, members of the RC face distinct challenges in receiving health care. Varying eligibility for care due to different duty statuses, the number of uninsured members, limited availability of care in rural areas, and continuity of care challenges all contribute to the complexities faced by the RC in accessing care.

These Service Members often experience unique mobilizations and deployments, further influencing their mental health needs. Furthermore, the overarching military culture—defined by a combination of knowledge, beliefs, morals, customs, habits, and capabilities—shapes the experiences of these Service Members. This culture, with its emphasis on selflessness, stoicism, and excellence, can bolster strength in military contexts while also posing potential vulnerabilities in the realm of medical and behavioral health care. Recognizing these unique factors, developing cultural sensitivity to military ethos, and learning about spe-

cific evidence-based treatment modalities that have been shown to be effective within this population can contribute to improved clinical engagement, positive outcomes, and reduced liability in the provision of mental health care [2].

Strategies for Engaging With Military-connected Patients

While important differences exist between civilian and military patients, best practices for patient-centered care remain foundational: asking open-ended questions, showing respectful curiosity and empathy, and tracking both verbal and non-verbal cues are key skills. Initial guardedness and stoicism that may stem from military culture underscore the need for significant focus on rapport-building and the clarification of roles and expectations. However, caution is advised against the assumption that military culture reflects the patient's only relevant identity, as the intersectionality of race, ethnicity, socioeconomic status, sexual orientation, gender, religion, and other values and beliefs may also have significant influence on the patient's presentation and perception of their time in the military. Additionally, it is important to acknowledge that the patient's physical or behavioral health concerns may not stem solely or even partially from combat or other military experiences [3].

Translating an understanding of military culture into enhanced clinical care involves three main areas: a provider's own beliefs and approach, assessment of the presenting concern, and the provision of treatment and support [4, 5].

Recognizing the Role of Provider Beliefs and Communication Style

An ability to convey care, understanding, and respect for military experiences is influenced by a provider's personal beliefs and attitudes, as well as their communication style. A provider who holds strong beliefs about the personality traits a military-connected patient may display, the value

Electronically published November 6, 2023.

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N C Med J. 2023;84(6):387-393. ©2023 by the North Carolina Institute of Medicine and The Duke Endowment. All rights reserved. 0029-2559/2023/84614

of military service, or the resiliency of this population will convey these themes in their interactions with military-connected patients. Importantly, to the extent that providers explore their own biases regarding military service prior to providing care, they can better connect with military-connected patients to bridge the gap between military culture and behavioral health treatment. One recommended strategy for examining such internal biases is to use a self-rating assessment, such as the Self Awareness Exercise on the Center for Deployment Psychology's website (see <https://deploymentpsych.org/self-awareness-exercise>).

A provider's communication style during appointments can convey an openness to balancing any biases or assumptions through asking culturally informed questions. Expressing an interest in and asking questions about the patient's military background serves as an entry point for building credibility and trust. Providers can directly ask about military service and keep an open dialogue with

regard to military experience. Sample questions include whether a patient has served or is currently serving in the AC or RC, in what branch and at what rank, preferred term of address, and assigned duties. More in-depth questions that can elicit helpful information include asking why the patient chose to join the military and what the impact of military service has been on their physical and mental health. Of note, a patient who did not serve may be a spouse or child of a Service Member and may have been impacted by military experiences as well. Military families often experience frequent moves or extended separations due to training or deployments, and RC families in particular are not always geographically close to military resources and support due to living in civilian communities. It is therefore relevant to inquire with every patient about military affiliation, as family members of military-connected patients may have unique concerns due to these experiences. They may also adopt military cultural norms, which can shape their value

and belief systems. After rapport is built and a patient is established in care, continuing to ask open-ended questions acknowledging military service and tying clinical recommendations and summaries to these experiences serves to further strengthen rapport.

Providers should also attempt to learn and use language consistent with military culture, including appropriate titles, preferred terms of address, acronyms, and common definitions. Using language that highlights shared values and is consistent with military contexts can indicate to the patient that their individual history matters; for example, focusing on a patient's strengths, describing treatment recommendations as "optimizing individual performance," and framing the therapeutic process as a way to enhance holistic fitness (i.e., taking care of one's mind, body, and spirit) could all be helpful ways to successfully leverage the military ethos of excellence and better engage with a military-connected patient.

An additional approach to conveying respect and consid-

eration for military experience is for providers to make available materials and resources relevant to military-connected patients. As there are a number of resources and programs available, specific guidance on which to choose and how to implement these can make next steps less overwhelming for patients to navigate. For example, if a couples' counselor is needed, there are many military and civilian programs at national, state, and local levels, such that guiding patients to a few specific programs would enable them to more readily locate care that meets their unique needs. It is recommended that providers familiarize themselves with TriCare, how to refer to US Department of Veterans Affairs (VA) and Vet Center care, and what services exist that are low- or no-cost for Service Members who are uninsured or underinsured. Military OneSource, Give An Hour, and the Cohen Veterans Network are examples of such resources to which providers can guide military-connected patients in their pursuit of behavioral health care.

Incorporating Military Cultural Contexts Into Assessment

It is of critical importance that providers conduct a culturally aware clinical assessment in order to develop an in-depth understanding of the needs of the patient [4]. Of note, Service Members have a responsibility to maintain “readiness” for duty at all times, therefore certain disqualifying or duty-limiting conditions—such as bipolar disorder, psychotic disorders, inpatient psychiatric admissions, and suicidal ideation, among other conditions—need to be reported up the chain of command. This responsibility ultimately falls on the Service Member, although providers are encouraged to engage in informed consent prior to beginning their assessment to ensure Service Members have a clear understanding of the provider’s role, limitations of confidentiality, and potential impact should a disclosure be necessary. Informed consent can also offer a segue for providers to remind members of the advantages of seeking help early as opposed to waiting until a minor issue becomes more severe.

While conducting an initial assessment, providers may learn of many factors that influence a Service Member’s medical history. RC members primarily seek care in their civilian communities, and their eligibility for medical benefits, including TriCare, can abruptly change, as eligibility of care is tied specifically to duty status and how they are activated for military service.^a Not all members of the RC are on TriCare. Those on federal orders receive this benefit just like their active-duty counterparts, however, traditional Guard and Reservists are given the opportunity to purchase TriCare at a reduced rate. Many opt out and choose to use their civilian employer’s or spouse’s health plan, pay out of pocket for a different plan, or may be uninsured. When members change duty statuses, their insurance coverage may change as well, often creating continuity-of-care challenges. For example, when in federal active-duty status, they are eligible for TriCare Prime, which provides free medical insurance and access to care at MTFs.

^a Duty statuses may include: Active Duty Federal (Title 10), Federally Funded but under control of State Governor (Title 32), State Active Duty (response to State missions), and Inactive Duty Training/Reserve (Drill Status).

However, as RC members shift back to civilian jobs, those benefits are no longer available, and they once again become responsible for covering their own insurance. This often means having to change providers in the middle of a course of treatment. During the COVID-19 pandemic, the thousands of National Guard and Reserve members who were activated to provide support across the nation experienced continuity-of-care challenges when their health care benefits shifted as they came on and off active-duty orders. These shifts in coverage can have significant impacts on Service Members and their families, resulting in temporary lapses in coverage due to issues transitioning from one insurance type to the next, which for some with significant medical needs—such as receiving high-cost medications—can be financially devastating. In addition, not all providers accept all types of TriCare or other insurance, leaving Service Members scrambling to find new providers for themselves and their families, sometimes several times a year. All of these challenges contribute to the great need for health care providers to conduct a thorough medical and behavioral health history to ensure changes in providers do not result in lack of access to clinically indicated care.

In addition to continuity-of-care challenges, Service Members may also delay seeking care for fear, whether warranted or not, of negative repercussions on their military career due to physical or behavioral health conditions. In such cases, Service Members may have experienced presenting symptoms over a long period of time, leading to advanced progression of diseases and comorbidities. They may also minimize the severity of symptoms or hesitate to volunteer concerns. For these reasons, providers should gain comfort in directly asking during assessment about common military-related issues, such as exposure to potentially traumatic experiences, the occurrence of mild traumatic brain injury (TBI), or family separation and reintegration concerns [5]. With new military-connected patients who seem reluctant to engage in the therapeutic process, providers could initially focus their efforts on issues that are less stigmatizing, such as sleep problems. Some important questions to ask this population are how long they've been experiencing the presenting concerns, whether they are concerned these presenting issues may impact their military service, and if their visit is related to their military service. Providers can also assess the patient's perception of the problems they are facing. It is

important not to assume the intent behind the visit, particularly for behavioral health providers assessing the presence of mental health symptoms and establishing a plan of care.

Leveraging Military-related Strengths Into Treatment

After conducting a thorough clinical and military history assessment, it is critical for providers to engage in evidence-based care to provide the highest quality of care for Service Members and their families [3, 4]. Providers can ensure the provision of this type of care by understanding their own professional limitations and seeking out professional development opportunities to expand their competence with both military culture and the unique clinical needs of Service Members and their families. One program whose mission is to expand this knowledge for civilian providers is the Star Behavioral Health Providers (SBHP) Program. SBHP is a National Guard Bureau-funded program that trains civilian medical and behavioral health care providers on military culture, the deployment cycle, and behavioral health needs of Service Members and families, and offers training in evidence-based treatments (EBTs) for independently licensed behavioral health providers [6]. Some EBT models recommended by VA/US Department of Defense (DoD) Clinical Practice Guidelines include Cognitive Processing Therapy

for PTSD, Prolonged Exposure Therapy for PTSD, and cognitive behavioral therapy for insomnia and suicide prevention, among many others [7-9]. SBHP and other such programs encourage providers to engage in culturally competent care with military-connected patients while maintaining a registry of trained behavioral health providers in order to expand access to treatments tailored to their unique clinical needs. Providers are also encouraged to connect with the military community in their area. The Air and Army National Guard in each state and territory have Directors of Psychological Health who serve as connection points between the military community and civilian providers. By engaging with these individuals, providers will expand their depth of understanding of the unique needs of this population and strengthen a critical access point between Service Members who need care and providers who can provide such care.

When making recommendations for care, such as initiating an EBT or following up on a specialty referral if needed, providers should incorporate military roles and language. For example, ask military-connected patients in what ways taking care of their health is consistent with maintaining the high standards and values associated with military service. Treatment can be described as a “health mission.” Providers can also ask what barriers, military-related or otherwise,

might prevent their return for continued appointments. Consider the language used to recommend a referral, particularly for behavioral health care, which may be seen as a sign of weakness or source of guilt or stigma. Framing diagnoses as resolvable “injuries” or care as a return to optimal function and readiness may increase the likelihood that the patient makes the connection. Where military-related support and resources exist, consider including these in the treatment plan. For example, community behavioral health providers trained in military culture can be found on the SBHP registry (see www.starproviders.org). RC members, who not only are impacted by military culture but many of whom also experience unique stressors (e.g., uninsured and underinsured individuals, geographic dispersion vis a vis military resources and associated limits in availability of care, increased financial stress) compared to members of the AC, seek care in their communities; accordingly, civilian providers share a responsibility to offer culturally sensitive and appropriate care.

Concluding Remarks

While addressing medical and behavioral health concerns inevitably involves a focus on deficits, it is worthwhile to recognize the strengths inherent in military culture. Service often fosters camaraderie, resilience, a sense of purpose and security, and is a source of values. Conveying respect for military-related strengths and awareness of military culture builds on patient-centered care expectations by emphasizing a team approach to care while engaging in cultural humility, and by recognizing your patient as the expert in their own lived experience. In return for incorporating military awareness into assessment and providing military-sensitive care, providers not only achieve best practices but enhance patient engagement and outcomes. NCMJ

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Acknowledgments

The authors have no conflicts of interest to disclose. The views expressed are those of the authors and do not necessarily reflect the opinions of the Henry M. Jackson Foundation for the Advancement of Military Medicine, Inc., the Uniformed Services University of the Health Sciences, the Department of Defense, the Department of Health and Human Services, or the US Government. The identification of specific products, scientific instrumentation, or organizations is considered an integral part of the scientific endeavor and does not constitute endorsement or implied endorsement on the part of the authors, DoD, DHHS, or any component agency.

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