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Self-reported clinical competencies and expertise within the Massachusetts Department of Veterans' Services

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ABSTRACT

This exploratory study collected data via the Massachusetts Department of Veterans' Services (DVS) network from mental health providers and site administrators to examine current views on existing resources, challenges, opportunities, and attitudes towards treatment guidelines. Unlicensed providers, predominantly peer support specialists, were the largest professional group that responded to the state-wide survey. Results demonstrated significant differences between providers with and without military experience as it pertains to knowledge of military topics, ambivalence towards clients, ability to work with military families, and the use of standardized screening tools.

Military veterans within the United States represent a culture that is often characterized as resistant to typical mental health treatment (Burnam et al., 2009). Though numerous theoretical works cite the power of the culture of military service for soldiers, sailors, marines, and airmen (Murray, 1999; Strom et al., 2012), very few mental health service-providing organizations identify veterans or military service members as representing a distinct culture (Monroe, 2012). A recent counseling textbook, for example, only describes a veteran's military identity relevant in terms of disability (Robinson-Wood, 2016). While many interventions and treatment modalities that focus on warrior culture have been developed for military service emembers (Lunasco et al., 2010), clinical training in the community at large, or during a provider's education, remain limited (Forgey and Young, 2014). Martial culture may even obscure or prevent understanding what a client may be saying in session, and this basic knowledge is integral to differential diagnosis and informed treatment (Strom et al., 2012). A civilian mental health provider's lack of familiarity with military rituals and rites of passage also compounds the sense many veterans have that they cannot be understood by civilians and that their experiences have set them dramatically apart (Davenport, 1994). There is even a great deal of difference within each branch of the military - differences of terminology, language, and of course, acronyms (Zwiebelson, 2013). These findings suggest the need for warrior-inspired and battlefield-informed care to best treat these individuals and their greater community (Anetis and Green, 2015).

Peer support specialists, mental health professionals who share the common bond of military service, offer a firsthand knowledge of martial culture and often meet with veterans before, after, or concurrently with treatment. Through support, advocacy, and an empowering approach to care, effective peers act as a liaison between the veteran and their community of care. Additionally, peer support practitioners within the Department of Veterans Affairs (VA) have been identified as also engaging in their own treatment and recovery process, ideally reducing the stigma associated with seeking mental health care (Salzer et al., 2010). As licensed providers within the VA report challenges and difficulties in understanding the veterans they are charged to serve (Signoracci et al., 2014), peer specialists can help provide one of the essential components of high-standard mental health care: cultural competency. Peer specialists may be the only member of a treatment team that has served in the military – as few as 6% of licensed providers within the VA self-identify as veterans (Tanielian et al., 2014a, b,).

Outside of the VA context, civilian mental health care providers report even lower levels of both clinical and cultural competencies in treating veterans (Tanielian et al., 2014a, b). This research does not include the dearth of community-based interventions that may not rely on credentialed providers, and often have different reporting structures for service utilization. Community service collectives are venues where veterans, particularly those of the recent conflicts, may congregate (Klein, 2013). Distance to a VA medical center or provider, distrust of the VA system or government at large, or even the condition or nature of separation from military service may all lead a veteran to seek services in the community.

By considering the aspects of warrior and martial culture, as well as the contemporary systems in place to provide care for veterans, it is easy to see the hurdles and obstacles in place to provide competent care. The

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National Center for Veterans Analysis and Statistics (NCVAS) identified 379,772 veterans residing in Massachusetts in 2014: 273,956 are wartime veterans and 26,151 are women (VA, 2014). Of this number, only 137,592 members were reported as enrolled in the federal VA heaalthcare system, and 83,919 of these were treated in 2014 (VA, 2014). This accounts for only 36% of veterans who reside within the Commonwealth – the remaining 64% percent may receive healthcare through other means. This discrepancy may account for a large load on state agencies, charitable organizations, and non-profit groups that provide both outreach and care to veterans who may not be enrolled in the federal network.

The state-level Massachusetts Department of Veterans' Services (DVS) network represents agencies and centers with diverse missions, client demographics, and geography within Massachusetts. While DVS provides support through grant funding and financial support, sites are not controlled or managed by DVS, nor is there shared data on agency capabilities, clinical staff, or service utilization. The only commonalities between sites are financial support from the state government, as well as the shared mission to support veterans. The goal of this study is to share knowledge of best practices, lessons learned, and current trends in both civilian and veteran providers. A statewide survey was conducted to provide an opportunity to examine current views on existing resources, challenges, opportunities, and attitudes towards treatment guidelines.

1. Method

1.1. Study design

This study was approved by the Institutional Review Board (IRB) at William James College. The study collected data via an online survey on agency capabilities within the Massachusetts DVS. In addition to agency capabilities and demographics, the survey targeted mental health professionals at these agencies on the following domains: self-reported clinical competencies, cultural awareness, and knowledge of military and veteran-related topics. Letters of solicitation from both William James College and the DVS secretary were distributed across the DVS workforce encouraging participation. As there was no listing of current staffing or services offered, this survey provided a census of those agencies and providers that responded.

1.2. Subjects

Inclusion criteria. Inclusion in the study varied based on the user's self-reported role within the veteran services workforce – both mental health professionals and management/administrators were included. Peer specialists, clinical social workers, psychologists, and psychiatrists were all included. Veteran status was not required for inclusion in this study but was identified during demographic data collection.

Exclusion criteria. Subjects were excluded if they were not a member of management or leadership at a DVS funded site, or did not work professionally with veterans, at any level, as a provider. As no archival data exists for agencies that receive DVS funding, responses to the survey were intended to act as a snapshot of current staffing akin to a census. Self-report measures were only administered to direct service providers and were analyzed across question clusters, professional credential possessed, and history of military service. These question clusters represent similar survey questions and include the following: attitudes towards clinical practice guidelines, comfort working with military-specific topics, implementation of clinical best practices, military contextual knowledge, and finally self-reported cultural competencies.

1.3. Measurements

The measures included two surveys. The first was an internally developed web-based survey that consists of likert scales, check boxes, and binary responses to gather organizational information from DVS sites. This second survey was developed by the RAND Corporation (RR806). This second measure is an aggregate of existing surveys that have been vetted for validity and reliability. Portions of these surveys were used to provide questions and relevant material for each assessed domain. This second survey instrument features questions that aim to tease apart the following: knowledge of the branches of the military, level of exposure to military treatment settings, attitudes towards clinical practice guidelines, self-reported competency on clinical issues often seen in veterans and military service members, use of nuanced screening measures for clinical issues that often occur within the veteran population, and attitudes towards treating veteran versus civilian clients.

1.4. Statistical analysis

Data analysis was conducted using both Qualtrics' native back-end software, as well as IBM's Statistical Package for the Social Sciences (SPSS). Data gathered was also used to identify demographic information about the sample, trends in response categories regarding clinical competency, attitudes towards clinical practice, and knowledge of military culture. Specifically, demographics were analyzed for central tendency, and to determine the distribution of administrators versus clinicians. As both the number of practicing clinicians within the DVS system and distribution of professional credentials within DVS was unknown, these data were assumed to not be normally distributed and nonparametric analysis was utilized. To account for a relatively low projected sample size, confidence intervals around a mean based on t-distribution was used to compare between-group variables.

2. Results

2.1. Study population descriptive statistics

Survey respondents ($N=62$) represented site administrators, senior management, and mental health clinicians working at the time of the survey administration. Due to the unknown number of providers at the agencies that receive DVS funding, there was no way to determine an accurate response rate. Of these administrators, senior management, and clinicians, a smaller portion identified themselves as direct service providers ($n=25$). This group reported beginning their careers in mental health from as early as 1971 and as recently as 2014 ($m=2000$ $sd=10.98$, $Mo=1995$). Direct providers identified predominantly as female ($n=17$), and nearly half were military veterans ($n=11$). Of these veteran providers, the majority served in the United States Army ($n=9$) and the remainder in the United States Air Force ($n=2$). These veterans reported serving an average of 11 years (or 132 months) in uniform ($m=139.8$ $sd=105$) with the largest group reporting 20 years or more of service ($n=5$). Most respondents reported a close family member currently serving in the military ($n=23$), and nearly a quarter of mental health providers had worked within a military treatment facility (MTF) at some point during their career ($n=5$). Unexpectedly, peer specialists were the largest professional group that responded to the provider portion of the survey ($n=6$).

2.2. Provider responses

Site administrators and senior managers were not given the provider-specific survey unless they reported giving direct care *in addition* to their organizational role. Mental health clinicians survey results ($n = 25$) were analyzed using nonparametric statistics as the data did not have a normal distribution. As the groups of respondents were relatively small and characterized by a high degree of professional and demographic variability, results are presented by topic cluster for clarity of presentation. Professional identities, as well as reported veteran status, were considered as separate groups for analysis when stated. Sample size within each cluster varied due to response rate and is identified specifically to each.

Attitudes towards clinical practice guidelines. Providers' attitudes towards the use of clinical practice guidelines were generally positive. Providers' attitudes towards clinical practice guidelines differed significantly in only two instances. Analysis of the mean scores of civilian clinicians (*n=10)* and clinicians who self-identified as military veterans (*n=11)* were compared using Mann-Whitney testing. Clinicians with prior military experience were significantly more likely than their civilian counterparts to view clinical practice guidelines as unbiased science ($U = 22.5, p = .014$), and additionally felt that these were used even in instances when their own existing clinical skills were strong ($U = 22, p = .025$).

Comfort working with military-specific topics. Provider attitudes towards working with veterans, military personnel, and their families around topics that are commonly found within the military were generally positive. This was true of both civilian clinicians, clinicians with prior military service, and clinicians who had been trained or worked in a MTF. Analysis using Pearson correlations within this score cluster shows strong positive correlations between comfort in working with veterans with depression and the following: post-traumatic stress disorder [$n(23) = .980, p = .0002$], currently serving military [$n(23)=.614, p=.002$], and military and war stressors [$n(23) = .959, p=.0001$]. Working with military families was moderately correlated, in a positive direction, with comfort working with currently serving military members [$n(23)= .463, p=.026$]. Despite numerous provisions for families identified by administrators, clinicians who self-identified as above average in working with individuals or with specific pathology did not have a similar report on their ability to serve families.

Implementation of clinical best practices. The provider cohort (*n=22)* reported varied utilization of identified best practices in mental health care. Providers' average endorsement of attitudes towards the use of best practices was below expected levels. Use of validated tools to screen for substance abuse, such as the CAGE Assessment of Alcohol Use or Alcohol Use Disorders Identification Test (AUDIT) was endorsed on average below "sometimes" ($M=2.23$ sd$=1.47$). Similar endorsement results were found with screening methods for post-traumatic stress disorder ($M=2.62$ sd$=1.56$), depression ($M=2.35$ sd$=1.55$), sleep problems ($M=2.76$ sd$=1.60$), and chronic pain ($M=2.82$ sd$=1.53$). These results did not significantly differ between veteran and civilian mental health providers.

Military contextual knowledge. Providers included in the final sample *(n=24)* endorsed higher than average knowledge as it pertains to a myriad of military topics. However, there were significant differences between mean scores for civilian (*n=14)* and veteran (*n=10)* clinicians across this cluster of questions (see Table 1). Analysis using Mann-Whitney U testing identified significant differences across knowledge domains: rank structure, the cultures of military branches, programs available, and behaviors learned from war being maladaptive at home (see Table 2). When the groups were separated, contextual knowledge and cultural awareness for civilians was below average, a finding that is consistent with previous studies of civilian providers outside of the VA healthcare system (Tanielian et al., 2014a, b).

Self-reported cultural competencies. Providers reported generally higher than average abilities and competencies as these pertain to mental health. Results of Mann-Whitney U analyses comparing veteran and civilian clinicians revealed statistically significant differences of clinician self-perceptions in the drive to understand each client's values and beliefs as well as the ability to teach and guide colleagues on important features of military culture. Clinicians with military experience endorsed that they were more likely to be ambivalent about their ability to understand veterans' values and beliefs ($U = 27.5, p = .011$), but more confident in their ability to teach others about the military context ($U = 39.5, p = 0.70$).

Table 1
Clinician self-reported knowledge and cultural awareness.

	Civilian		Prior Military	
	M	*SD*	*M*	*SD*
Rank Structure	3.17	1.31	4.20	1.23
Subculture of branches	3.13	1.33	4.10	.99
Active Vs Reserve Component	3.25	1.19	4.20	.92
Deployment Slang	3.17	1.31	4.00	1.56
Deployment Stress	3.42	1.21	4.20	1.03
Family Stress	3.52	1.28	4.20	1.03
Adjustment Services	3.75	1.23	4.50	.53
Behaviors learned while at war	3.87	1.25	4.40	.97

Table 2
Knowledge and cultural awareness of civilian vs. Prior military service clinicians.

	Rank Structure	Subculture	Active/ Reserves	Slang
Mann-Whitney U	20.000	19.000	16.000	25.000
Wilcoxon W	125.000	124.000	121.000	130.000
Z	-3.032	-3.060	-3.348	-2.700
Asymp. Sig. (2-tailed)	.002	.002	.001	.007
	Deployment Stress	**Family Stress**	**Adjustment Services**	**Behaviors Learned**
Mann-Whitney U	24.000	28.500	27.500	38.000
Wilcoxon W	129.000	119.500	132.500	129.000
Z	-2.777	-2.331	-2.621	-1.763
Asymp. Sig. (2-tailed)	.005	.020	.009	.078

3. Discussion

This study examined the capabilities and attitudes possessed by mental health providers in DVS. Nearly 73% of respondents identified that they did not hold current licensure within the Commonwealth of Massachusetts. This number is likely to have been inflated due to the high concentration of peer specialists that responded to the survey, and currently working within in the DVS system. While the VA requires a state certified qualification for employment, this is not a requirement for agencies or charities outside of the federal system.

There are many benefits of employing peer specialists. As lived experience is their training, and the fact that peer specialists may be the only veterans on clinical staff, peer specialists may provide differential knowledge and additional capacities that their counterparts with more exposure to education are less likely to possess. Peers also offer significant cost savings to agencies over other mental health providers. The United States Bureau of Labor Statistics indicates that the average salary for a clinical psychologist in 2015 was $72,580 (Bureau of Labor Statistics, 2016a) while the average salary for a peer counselor that same year was reported as $39,980 (Bureau of Labor Statistics, 2016b).

As even robust clinical interventions have been shown to be more effective when tailored to the culture that they are treating (Kohn et al., 2002), peers may assist in the translation of the values and concepts of traditional psychotherapy into a more syntonic language for veterans. While the number of clinicians who identified as veterans is high within this sample, it is likely an outlier based on the relatively small sample, as well as the previously unknown high concentration of peer providers.

While attitudes towards clinical practice guidelines are generally similar for civilian and veteran clinicians, clinicians with military experience reported higher positive regard for these guidelines as unbiased science and as useful even when existing clinical skills were strong. Military-specific topics were reported with similar levels of comfort between both providers with and without military experience, but relative comfort working with families was only correlated with working with active duty service members. There was no significant difference between civilian and prior military clinicians in this regard. This finding contrasts with the correlation of relative comfort working with

depression, post-traumatic stress disorder, sleep problems, and chronic pain. Civilian providers were significantly less informed than their counterparts with military experience in both military culture and knowledge around military topics. Finally, clinicians who have served in the military endorsed more ambivalence about their ability to accurately comprehend the unique experiences of the veterans they treat but identified confidence in their ability to teach and train others about the military significantly more than civilians.

Clinicians' self-reported levels of cultural awareness were generally above average. However, this effect was driven primarily by peer specialists. Aside from being consistent with previous studies (Tanielian et al., 2014a; Tanielian et al., 2014a; Tanielian et al., 2016), this finding is also consistent with the perception of a civilian/military divide. Providers also differed in their overall self-reported clinical competencies in the various sections of the survey. There was additional variation in their reported use of clinical best practices and use of guidelines that are considered aspects of optimal care. Survey respondents identified more resources, competencies, and opportunities for individual veterans and less for family members than was expected at the outset of the study. Despite this focus on the individual client, programs that support veteran or military-connected families existed at the time of the study. Additionally, supporting families was identified as the primary mission for many DVS programs that participated.

Facilitating culturally-informed communication between healthcare professionals and service members requires attunement to the values of military service (Koenig et al., 2014). Mental health providers engaging with veterans may observe a clash of values due to the espoused values of martial cultures. Civilians may believe veterans to be emotionless, overly stoic, and rigid, and traditional therapy may have to be adjusted to accommodate a warrior culture - treatment that prematurely highlights veteran vulnerability or advocates high levels of expressed emotion might lack resonance with the warrior ethos of the armed forces (Everson and Figley, 2011).

The additional capacity to be inoculated to the challenges of working with clients who have been exposed to conflict and battle is a unique and potent resource, but this may struggle to fit within the culture of traditional mental health delivery. A hard-nosed and more stoic approach to compassion may appear as callousness to fellow clinicians, and potentially the families of clients whom they serve. Counterintuitively, this same stoicism may be experienced as meaningful and welcomed attunement by the veteran him or herself. Clinicians without military service will be able to provide more informed care if they are more versed in military culture, as well as understanding the aspects of martial culture that may clash with the culture around mental health care in the United States. Clinicians *with* military service may need to consider their role beyond that of instructor and comrade in arms, as they are likely to be between the two worlds of client and counselor.

Overall, the use of clinical best practices and attitudes regarding their use was consistent in this study with previous findings within larger healthcare systems, to include the VA and DOD. Moving clinical practice guidelines into mandatory procedure and practice remain crucial to improving care for veterans within the Commonwealth. For providers who facilitate a large volume of direct care, clinical guidelines need to be identified as critical to better care. Training that focuses on the positive aspects of what may appear initially as an external mandate for more work instead should focus on the practical improvements towards outcomes. As an example, requiring that all mental health staff administer a patient health questionnaire on a regular basis, or administering a gold-standard post-traumatic stress disorder checklist, may be seen as an added burden *unless* it is identified as essential to delivering the best care possible.

3.1. Limitations

While there were observed differences between clinicians with and without military experience, the results of this survey are modest at best, and there are a number of limitations that suggest directions for future research. First, a small sample size restricts the large-scale generalizability of this study's findings. A larger sample would also allow for both the potential confirmation of the findings, as well as more exploration of the practices and attitudes held by providers across disciplines. Future research that crosses state lines and instead focuses on regions of the United States may be able to have more representation across disciplines, as peer support specialists were the largest group in this study. Another limitation is the population of this survey, which was comprised of individuals who self-identified as a member of a DVS funded agency, however the census and staffing of these organization was unknown. Future research optimally would cross reference a known employee or volunteer register which was not available at the time of this study. Additionally, collateral observation would be useful in demonstrating concordance between clinical practice and self-report survey measures.

4. Conclusion

In summary, the data presented on self-reported mental health competencies and attitudes that were conducted at sites within the DVS network in Massachusetts share many similarities to national studies that have been conducted during the Global War on Terror (Tanielian et al., 2016). Despite a modest number of responses, the responses are representative of the providers outside of either a MTF or VA. DVS sites may consider deepening their connections with other sites within the state through partnerships and training.

Providers with military experience have identified possessing the ability and interest to train other workers - agencies and teams have an opportunity to harness an existing strength within their workforce. For mental health, interventions may need to be shaped to pay attention the transformative power of martial culture. Veteran clients may prefer a hardened and direct approach to mental health care and often see this as a preferred expression of compassion. Clinicians *without* military experience may need to explore their own biases around emotional expression while also challenging clients that are unwilling to let go of the aspects of martial culture that are deleterious in civilian life. Agencies are encouraged to move beyond a "check the box" mentality regarding cultural competency. Leveraging the leadership competencies in clinicians with military experience to not just provide knowledge of the past, but also champion the care of the present and future, is a potent tool for agencies that have veterans on staff.

Finally, it is important to consider that even in a sample where 40% of mental health providers had military service, the majority still did not. With similar surveys of the VA identifying as low as 6% of direct care providers having military experience, the task of responsible and compassionate care for veterans *cannot* be solely a perspective of "we care for our own."

Declarations

Author contribution statement

Adam Freed: Conceived and designed the experiments; Performed the experiments; Analyzed and interpreted the data; Contributed reagents, materials, analysis tools or data; Wrote the paper.

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Competing interest statement

The authors declare no conflict of interest.

Additional information

No additional information is available for this paper.

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