Ready to Serve

Community-Based Provider Capacity to Deliver Culturally Competent, Quality Mental Health Care to Veterans and Their Families

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RAND CORPORATION

For more information on this publication, visit www.rand.org/t/rr806

Library of Congress Cataloging-in-Publication Data is available for this publication.

ISBN: 978-0-8330-8768-3

Published by the RAND Corporation, Santa Monica, Calif.

Cover design by Pete Soriano

OVERVIEW

Addressing the mental health needs of military service members, veterans, and their families is a national priority and the focus of many efforts at the federal, state, and local levels.[1] Over the past decade, several studies have documented the extent of the need for mental health treatment among this population, and billions of dollars have been invested to expand the capacity of the systems designed to support veterans and their families at multiple levels and across sectors.[2] The White House and Congress have been working directly with the Department of Defense (DoD) and and the Department of Veterans Affairs (VA) to ensure that mental health providers are hired and programs are disseminated to address mental health needs within the veteran community,[3] but concerns remain about whether the capacity of these systems is sufficient to meet the demand.[4] Recently, new federal legislation was enacted to increase VA beneficiary access to private, civilian-sector care.[5] Although the opportunity to receive care in the community existed in the past, the new law will likely greatly expand the rate at which eligible veterans seek care outside of the VA. This raises a new concern about the capacity of the civilian mental health service sector to meet the needs of veterans and their families.

While many veterans already receive care from private providers and community-based organizations,[6] little is known about the extent to which veterans and their families receiving such care are getting high-quality care, are benefiting from that care, and are satisfied with their providers. There have been multiple efforts at the national, state, and community levels to promote awareness of military and veteran-related issues among community-based mental health providers, including the development of specialized training curricula and certification programs. With the intent of improving providers' understanding of and skills for addressing needs in the population, these training opportunities vary from short webinars to weeklong courses to intense, certificate- or degree-awarding programs.[7]

In addition, nongovernmental organizations have pursued the formation of specialized networks, such as Give An Hour and the Star Behavioral Health Provider network,[8] and the opening of new community-based clinics dedicated to treating military service members, veterans, and their families.[9] To date, however, little is known about the capacity and performance of these networks and specialized clinics.

Monitoring access to and quality of mental health care for service members, veterans, and their families is important for ensuring that their needs are met effectively. A recent Institute of Medicine (IOM) study highlighted the challenges that both DoD and the VA face in monitoring such issues within their own systems—including the facilities they own and operate—and noted that their visibility into the "outside" systems where the population also receives care is even more limited.[10]

RAND's study was designed to assess the potential performance of the system of care for service members, veterans, and their families, with a particular focus on community-based, civilian providers. This study specifically addresses the potential readiness of mental health providers working in community settings to deliver culturally competent, high-quality care to service members, veterans, and their families. This study builds upon previous studies examining similar issues for providers working within VA and DoD settings, as well as two studies of civilian providers.[11] We explore provider capabilities, attitudes, and behaviors as they relate to providing high-quality and culturally appropriate care, and we examine what factors may predict their readiness to deliver such care. Understanding the skills and training of mental health providers from non-DoD and non-VA settings who are potentially delivering care to service members, veterans, and families will help inform expectations about what types of care these beneficiaries may experience within civilian settings and the extent to which that care is of a high quality. Such information can also help direct future training efforts designed to ensure that providers are ready, capable, and willing to address the mental health needs of our nations' veterans and their families. The following sections provide additional information about our approach, findings, and the implications from this research.

SURVEY OF MENTAL HEALTH PROVIDERS

Improving mental health outcomes for veterans and their families requires both *access to care* and receipt of *high-quality care*.[12] The overall goal of this study was to understand the readiness of community-based providers to deliver high-quality mental health care to veterans and their families once they access such care. The IOM has defined *high-quality care* as care that has been demonstrated as effective (i.e., evidence-based), safe, patient-centered, timely, efficient, and equitable.[13] Using this definition as a reference point for our study, we conceptualize the readiness of providers to deliver veteran-friendly, high-quality mental health care as having two main components (see Figure 1). The first is *cultural competency,* or the degree to which providers are sensitive to the unique needs and relevant issues of concern within the veteran population. This cultural sensitivity and competency can facilitate providers' ability to deliver patient-centered care and develop an effective therapeutic rapport.[14] The second main component of our provider readiness definition is the degree to which community-based providers have the *capacity and inclination to deliver clinically appropriate, evidence-based care*. In particular, the survey focused on evidence-based care related to major depressive disorder (MDD) and posttraumatic stress disorder (PTSD). These conditions were highlighted because of their prevalence among the recently returned veteran population and their association with experiences common to military deployments. Each concept is defined in further detail in subsequent sections.

To assess provider readiness to deliver high-quality, culturally competent care to service members, veterans, and their families, we employed a web-based survey of mental health providers. The sections below outline the methods used to sample providers and describe the survey measures used to assess the relevant components of readiness. We also gathered data on the characteristics of responding providers, their clinical caseloads, and their practice settings to explore how these factors relate to overall readiness.

Sampling

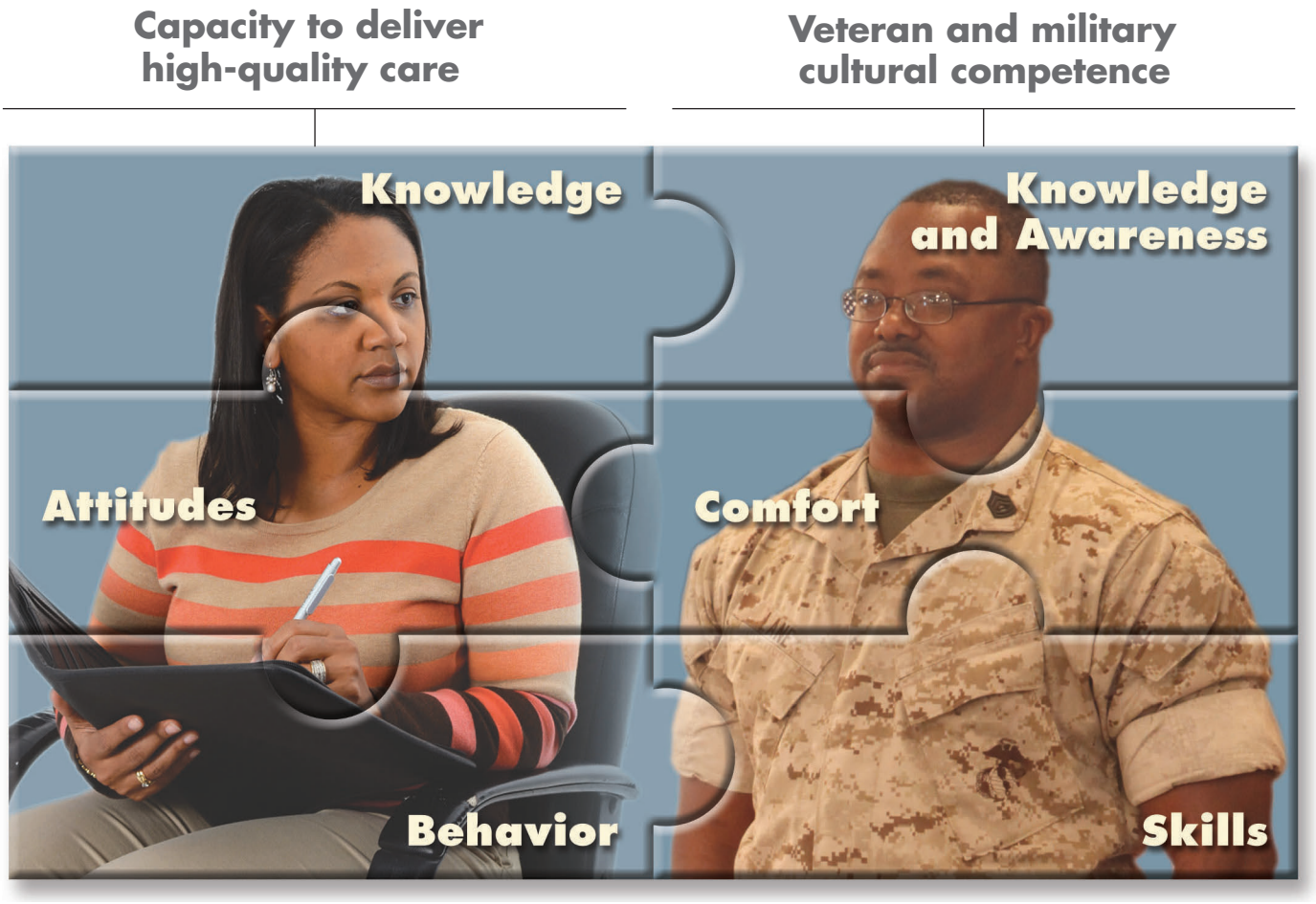
To identify and survey mental health providers working in community-based settings, we relied upon existing panels of health care providers maintained through GfK Custom Research and two of their vendors. Practicing mental health professionals in the panels were sent emails inviting them to participate, and participants were provided with tokens of appreciation through the traditional means of providing incentives in their host panels (i.e., awarded points based on the anticipated respondent burden). Specifically, psychiatrists were recruited from an existing GfK provider panel originally drawn from the American Medical Association membership list and later augmented to refresh and expand the panel. Psychologists were recruited from an existing allied health care provider panel maintained by Research Now. Social workers and licensed professional counselors were recruited from existing panels maintained by Research Now and a separate panel maintained by EMI. The demographic and practice characteristics of all mental health providers within these panels were not available and the degree to which their panel membership is representative of each provider population is unknown. GfK emailed potentially eligible participants a standard recruitment email asking for their participation in a 30-minute survey about their mental health practice.

The web-based survey was fielded only for the period of time required to reach the target numbers of each provider

Abbreviations

CBT	Cognitive Behavioral Therapy
CPG	clinical practice guideline
CPT	Cognitive Processing Therapy
DO	doctor of osteopathic medicine
DoD	Department of Defense
EAP	Employee Assistance Program
EBP	evidence-based psychotherapy
EMDR	Eye Movement Desensitization and Reprocessing
IPT	Interpersonal Therapy
IOM	Institute of Medicine
LCSW	licensed clinical social worker
LMHC	licensed mental health counselor
LPC	licensed professional counselor
MD	doctor of medicine
MDD	major depressive disorder
MCSW	master's of clinical social work
ns	not significant
PE	Prolonged Exposure Therapy
PhD	doctor of philosophy
PsyD	doctor of psychology
PTSD	posttraumatic stress disorder
SIT	Stress Inoculation Therapy
VA	Department of Veterans Affairs
WRAIR	Walter Reed Army Institute for Research

Figure 1: Readiness for Veteran-Friendly, High-Quality Mental Health Care



type (target goal was 125 respondents in each provider group, to ensure sufficient sample size for detecting differences between provider groups). All target numbers were reached within three weeks. Responding providers were screened to ensure that they were

- trained and licensed as a professional provider of mental health services in their state
- working directly with patients/clients as part of their professional responsibilities
- one of the four provider types of interest
  - psychiatrist—doctor of medicine (MD) or doctor of osteopathic medicine (DO)
  - clinical psychologist—doctor of philosophy (PhD) or doctor of psychology (PsyD)
  - licensed clinical social worker (LCSW) or master's in clinical social work (MCSW)
  - master's-level licensed professional counselor (LPC) or licensed mental health counselor (LMHC).

Participants who indicated later in the survey that they were fully retired or not currently in practice were excluded. The study was determined to be exempt from human subjects review by the RAND Human Subjects Protection Committee. The topics of military and veteran mental health care, cultural competency, and evidence-based practice were not specifically identified in the recruitment email sent by GfK or in the introductory page of the survey; thus, the topic was not likely to influence the choice to participate or complete the full survey. As with all surveys conducted among convenience samples, it is difficult to understand the potential bias introduced by those choosing to participate in such panels and surveys compared to the full population of providers.

Measures

RAND researchers designed a web-based survey to collect information from mental health providers across several domains. For each of the two components of our

readiness concept, providers were asked about their knowledge, attitudes, and behaviors relevant to the concept. Where possible, survey items come from or were adapted from prior surveys of mental health professionals. Where necessary, RAND researchers developed new items for domains without published survey instruments. Table 1 provides an overview of the survey domains, their corresponding items, and information about how the items were used to characterize providers and inform the analysis. The following section briefly describes the measures used across the domains of interest. Readers interested in additional details about specific items, including psychometric properties and scoring criteria, where available, can reference the Appendix at http://www.rand.org/pubs/research_reports/RR806.html.

Provider Characteristics

In addition to asking respondents to indicate their provider type (e.g., social worker, psychologist), we gathered information on provider gender, years since most recent degree, whether they ever served in the armed forces,[15] whether they had any close family members who served in the military, and if they ever worked in a military setting or in the VA (including training or fellowships).[16] We also asked how providers spent their time across a series of activities, including conducting assessments, providing direct patient care (psychotherapy and medication management), receiving supervision or consultation from others, providing supervision to others, and other professional or administrative responsibilities such as research or teaching.[17] In addition, we asked a series of questions about enrollment in provider networks that typically serve military and veteran populations, including TRICARE (the DoD insurance program for active component service members and their families, retirees and their families, as well as some eligible Guard and Reserve Component personnel and their families), Military OneSource (an Employee Assistance Program [EAP]–like program that employs some mental health providers to support DoD beneficiaries), and the new VA Patient Centered Community Care Contract (established for specialty providers).

Practice and Clinical Caseload Characteristics

To understand the context in which respondents practice, we assessed a number of features of their practice settings and their clinical caseloads. All questions in this section were structured to assess caseloads, hours, and setting characteristics of the most recent typical work week.

We asked providers to report the size of their patient caseload in the most recent typical week, including patients seen in individual or family format as well as those seen in group settings. We gathered information about the proportion of patients by the locus of care, by age group, and by current diagnosis using categories from the Diagnostic and Statistical Manual—Version 5. We also asked respondents to estimate the proportion of their current caseload that: were current members of the military, were former members of the military (veterans), or were family members of current or former members of the military.

To understand the types of settings and facilities our respondents were working within, we assessed the percentage of patient care hours that were spent in different physical locations (e.g., solo office practice, VA facility). Using responses to the setting and insurance items, we classified providers into one of three groups: DoD/VA providers (those providers spending any patient care time in a DoD or VA health care setting), non-DoD/VA providers who accept TRICARE, and all other providers (i.e., those that do not spend any time in a DoD or VA facility or accept TRICARE).

We also gathered the ZIP code of the facility in which the provider saw the greatest number of patients in the most recent typical work week. Using the ZIP code information for the provider's setting, we calculated the distance between their setting and the nearest DoD or VA health care facility to create a proximity to DoD/VA variable. With this continuous variable, we also created a categorical variable for analyses: within ten miles or 11 or more miles away.[18] Similarly, we used the ZIP code of the provider's setting to determine if they worked in an urban or rural setting.[19]

Assessment Behaviors

To understand the frequency of routine screening practices employed by respondents, we asked providers to report how often, using a 5-point scale (never, seldom, occasionally, often, and always), they screened patients: (1) to determine if they are current or former members of the Armed Forces or a family member of such a person; (2) for history of any traumatic events, including those experienced during military service, and (3) about stressors related to military life or being a veteran.

Table 1: Overview of Mental Health Provider Survey Domains

Domain	Types of Items	Source and Use
Provider characteristics	• Training (MD, DO, PhD, LCSW, MCSW, LMHC, LPC) • Gender • Years in practice/experience • Primary therapeutic orientation • DoD or VA work experience • Relationships with current/former members of Armed Forces	These items were adapted from prior VA, U.S. Army, and American Psychiatric Association studies. They are used to characterize the respondents and examine predictors of practice behaviors and provider attitudes.
Practice and caseload characteristics	• Caseload size • Distribution of caseload by age, diagnosis, insurance type, and military status • Setting (outpatient/inpatient/partial, solo/group, public/private) • Participation in networks that serve military members and veterans	These items were adapted from prior American Psychiatric Association and U.S. Army surveys of mental health providers. They are included to help describe the practice setting and typical patient caseload served by respondents. The data are used to characterize the respondents and examine predictors of high-quality mental health care.
Assessment behaviors	• Employment of routine screening approaches, including taking a military history and assessing suicide risk and comorbid problems such pain and sleep disturbances • Use of validated screening or interview instruments • Frequency of engaging other clinicians and family members	These items were adapted from prior surveys used by the Center for Deployment Psychology and the U.S. Army. The data are used to understand provider assessment practices.
Military cultural competency	• Knowledge of military and veteran culture • Comfort working with military service members and veterans • Self-reported proficiency in treating military service members and veterans • Participation in military/veteran culture training	These items were adapted from prior surveys used by the Center for Deployment Psychology and the VA. The data will describe respondents' knowledge military and veteran culture. The data are also used to define analytic groups of providers with respect to their military cultural competency.
Training to deliver evidence-based care	• Training and supervision in evidence-based psychotherapies (EBPs)	These items were adapted from other surveys used by the U.S. Army and assess receipt of training and supervision in EBPs for PTSD and MDD.
Comfort with treatment approaches and military/veteran populations	• Comfort treating depression • Comfort treating PTSD • Comfort treating military members and veterans • Comfort addressing war-related stress • Comfort treating military family members	These items were developed by RAND researchers for this study. The items provide descriptive information about the level of "comfort" among respondents in these areas. Some items are also used in the derivation of the military cultural competency variable.
Use of guideline-concordant care for PTSD and MDD	• Self-reported proportion of caseload treated with EBPs • Use of psychotherapeutic techniques consistent with EBPs	These items were adapted from other surveys used by the U.S. Army, U.S. Air Force and RAND and assess use of EBPs recommended in civilian and DoD/VA practice guidelines
Attitudes toward practice guidelines	• Attitudes toward clinical practice guidelines (CPGs) and evidence-based medicine	These items were adapted from an instrument developed for the New York State Psychiatric Association. The items ask providers to rate their attitudes toward using clinical guidelines and may help explain variation observed in use of guideline-concordant care for PTSD and MDD.
Prescribing practices	• Most common medications prescribed for PTSD and MDD	This item was adapted from an Army study titled "Steps Up" and is a measure of guideline-concordant pharmacological treatment for PTSD and MDD. We examine the percentage of providers who prescribe appropriate medications for PTSD and MDD.

SOURCES: We used several instruments as references in developing this survey. All of these prior surveys were developed for other purposes, but provided relevant information and suggestions for items that would help us to assess use of guideline-concordant care, evidenced-based approaches, and routine practice behaviors. We also drew on items in other surveys used to assess the impact of military and veteran cultural awareness training on participants through the Center for Deployment Psychology (for example, the Star Behavioral Health Providers) programs to inform our items on knowledge/attitudes/awareness of military and veteran culture. It should be noted that the overwhelming majority of the items have been modified in some manner from our original references; that is, we changed scales, reference points (all patients versus "this" patient), and response items in an effort to tailor this survey to the specific issues and population for this study. More information about the surveys reviewed can be found in the Appendix.

Military Cultural Competency

To understand the degree to which providers were sensitive to military and veteran culture, we asked a series of questions designed to assess providers' knowledge and awareness of, and attitudes toward, military culture. We also assessed their perceived proficiency in working with military and veteran populations and exposure to prior training in military cultural competency. Figure 2 provides an overview of the concepts we used to define cultural competency for this study.

To assess knowledge and awareness of military and veteran culture, we asked providers to rate their level of familiarity (on a 5-point Likert scale) with U.S. military culture and practices. Similarly, we asked providers to indicate their level of comfort with respect to working with military service members and veterans, working with patients/clients with military or war-related stress, and working with family members of military service members or veterans.

Respondent proficiency in military and veteran culture was assessed via ten items that tapped self-reported perceptions of cultural competency in three different domains, cultural knowledge (three items), cultural sensitivity (one item), and cultural skill (six items). These items, modified from items on the Nurse Cultural Competence Scale,[20] asked respondents to read statements and agree or disagree on a 5-point scale. Training in military culture was assessed via one yes/no item that asked about receipt of formal training in military and veteran culture.

Using all of these items described above, we derived a military cultural competency score by scoring each item as described in Table 2. This overall measure of military cultural competency summed the continuous variables for a range of 0–22, and a cut-score of 15 or more points was defined as "high military cultural competency."

Capacity to Deliver Evidence-Based Care

As highlighted earlier, provider capacity to deliver evidence-based care to patients may depend on several factors. For example, prior training in the delivery of evidence-based approaches may be one indicator that a provider has capacity to deliver high-quality care; however, it is also important to understand the degree to which they have or will use these techniques to address the mental health needs of veterans and their families when they access providers. Other factors, such as their beliefs or attitudes about such approaches, may affect their willingness to use the techniques. Thus, to understand provider capacity to deliver evidence-based care, we assessed several domains:

Figure 2: Concepts Related to Provider Military Cultural Competency

training in evidence-based approaches, use of such treatment in routine practice, attitudes toward practice guidelines, and other routine behaviors. These are described in Figure 3 and in the following sections.

Training in Evidence-Based Psychotherapies for PTSD and MDD

To assess provider capacity to deliver evidence-based psychotherapies (EBPs) for PTSD and MDD, we assessed whether providers: (a) held formal certification or intensive/advanced training and (b) had supervised professional practice in any of five psychotherapies specified as first-line therapies for PTSD and depression in VA/DoD CPGs (2009, 2010).[21] Providers who had received training and supervision in at least one type of EBP were classified as "capable" of delivering evidence-based treatment for the given condition.

Use of Evidence-Based Treatment Approaches

A dichotomous variable was used to summarize providers' reliance on evidence-based treatment modalities. Each provider estimated the percentage of patients that they treated in the most recent typical work week with 16 different treatment approaches. Treatments ranged from well-validated approaches for treating PTSD (e.g., Prolonged Exposure Therapy [PE]) to general therapeutic techniques without strong efficacy find-

Table 2: Measures of Military Cultural Competency

Concept	Measure	Response Scale	# of Items	Operationalization
Knowledge and awareness	Level of familiarity with military and veteran culture	1–5 Likert scale *(Completely unfamiliar– Extremely familiar)*	8	1=*Very familiar* or *Extremely familiar*; 0 otherwise (0–8 range)
Comfort	Comfort level working with military veterans and their families	1–5 Likert scale *(Not at all comfortable– Extremely comfortable)*	3	1=*Mostly comfortable* or *Extremely comfortable*; 0 otherwise (0–3 range)
Skills	Self-reported proficiency	1–5 Likert scale *(Strongly disagree–Strongly agree)*	10	1=*Agree* or *Strongly agree*; 0 otherwise (0–10 range)
	Prior training in military culture	*Yes/No*	1	1=*Yes*; 0=*No* (0–1 range)

ings (e.g., supportive psychotherapy). Approaches categorized as evidence-based treatments included those for PTSD (PE, Cognitive Processing Therapy [CPT], Eye Movement Desensitization and Reprocessing [EMDR], and Stress Inoculation Training [SIT]), depression treatments (Cognitive Behavioral Therapy [CBT], Interpersonal Therapy [IPT], and Acceptance and Commitment Therapy), and two additional treatments with support for use with patients who had substance use disorders or borderline personality disorder (i.e., Motivational Interviewing, Dialectical Behavioral Therapy).[22] Past-week evidence-based practice was dichotomized between providers who reported treating 75 percent or more of their patients with EBPs and those who did not meet this threshold. This threshold creates an easily summarized estimate of the proportion of providers from which patients are reasonably certain to receive an evidence-based treatment.

Practice Behaviors Related to Use of Psychotherapy for PTSD

To assess providers' adherence to therapeutic techniques associated with three validated PTSD psychotherapies (PE, EMDR, CPT), we used a modified version of a session behavior scale used in a Walter Reed Army Institute for Research (WRAIR) study in 2013.[23] Two items assessed treatment techniques representative of PE, two items assessed techniques associated with CPT, and one item assessed a technique unique to EMDR. For this report, we summarize the proportion of providers who reported that they "often" or "always" use therapeutic techniques associated with at least one EBP approach for PTSD. Note that providers who do not see patients with PTSD reported instead on their likelihood of using each technique if they "were to treat patients with PTSD."

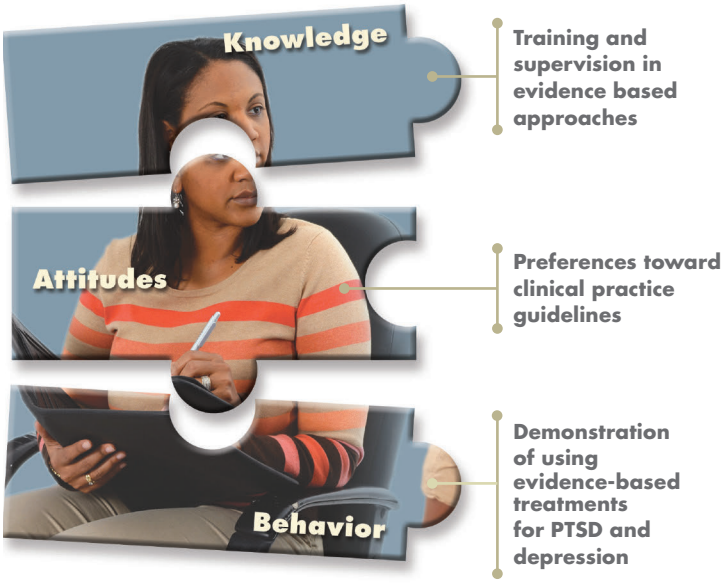
Practice Behaviors Related to Use of Psychotherapy for Depression

We used a modified version of the Psychotherapy Practice Scale to assess providers' adherence to the therapeutic techniques associated with two evidence-based approaches to depression treatment (CBT and IPT). The original scale prompted providers to consider a specific, randomly selected patient from their caseload with MDD. For ease of administration, these instructions were modified to ask providers who treat patients with depression to estimate the frequency with which they use nine distinct therapeutic techniques. Providers who do not see depressed patients were asked to estimate the likelihood that they would use each technique if they were to treat a patient with depression. Three items assessed treatment techniques representative of CBT, three assessed techniques associated with IPT, and three assessed common, but less well-supported, psychodynamic techniques. For this study, the full, 16-item Psychotherapy Practice Scale was reduced to nine items to reduce respondent burden.[24] For this report, we summarize the proportion of providers who reported that they "often" or "always" use the therapeutic techniques associated with either CBT or IPT with depressed patients. Note that providers who do not see patients with depression reported instead on their likelihood of using each technique if they "were to treat patients with depression."

Medication Management for PTSD and Depression

To assess adherence to evidence-based guidelines for psychopharmacologic treatment of PTSD and MDD,[25] prescribing providers listed the "two most common first-line psychopharmacologic treatments" they prescribe for patients with each condition. A list of 90 common psychoactive medications—including antidepressants, anxiolytics, sedative-hypnotics, psychostimulants, and opioid analgesics—was provided for

Figure 3: Concepts Related to Provider Capacity to Deliver Evidence-Based Care



respondents to select from. To meet our criteria for "evidence-based prescriptive practice," respondents had to select at least one antidepressant from the list for depression *and* one selective serotonin reuptake inhibitor or prazosin for PTSD.

Attitudes Toward CPGs

CPGs provide recommendations designed to improve patient care. They are developed after a systematic review of the evidence and consideration of the harm and benefit associated with a given approach.[26] Although the intent is to ease provider burden by succinctly recommending best practices for a given condition, some providers see CPGs as overly rigid, oversimplified, and as a threat to their clinical independence. For this study, we included the 11-item CPG Attitudes Scale from a New York State Psychiatric Association study as a proxy for provider attitudes toward evidence-based medicine and validated treatments for PTSD and MDD.[27] In the descriptive analyses below, scale scores are dichotomized into those who, on average, "agree" or "strongly agree" with CPG supportive statements (labeled "above threshold") and those who fall below this threshold. Attitudes toward CPGs are entered as a continuous variable in the regression analysis, that is, the mean of all 11 items.

Analysis

We performed analyses to describe the provider sample that generally fall into three types: (1) basic univariate analyses, (2) bivariate comparisons across pairs of variables, and (3) logistic or linear regressions to assess the contribution of sets of predictors to key dependent variables. First, univariate statistics were calculated to provide an introductory understanding of the pattern responses. For instance, the mean and standard deviation of the CPG Attitude Scale were calculated.

To assess relationships across pairs of dichotomous and continuous variables, we used independent-sample t-tests. To assess relationships across pairs of categorical variables, we used chi-square analyses. Finally, logistic and linear regressions were used to assess the relationship between a binary outcome and multiple predictor variables simultaneously. These regressions identify which predictors (if any) are most influential with respect to a specific outcome variable after controlling for the effect of all other predictor variables in the model.

RESPONDENT CHARACTERISTICS

We recruited a total of 522 mental health care professionals to participate in the survey (Table 3). Respondents included roughly equal groups (by design) of psychiatrists (n=128), psychologists (n=127), social workers (n=132), and licensed counselors (n=135). The majority of participants across professions were female (60 percent) with some variation by profession (the majority of psychiatrists—77 percent—were male).[28] Respondents generally worked full time. In addition, participants reported seeing the majority of their patients (77 percent on average) in outpatient settings in the most recent typical work week, and smaller percentages of patients (17 percent on average) were seen in inpatient and other settings (5 percent), such as schools, correctional facilities, or partial day programs. On average, providers reported spending the majority of their professional hours (19 percent) in a solo office setting, followed by a group office setting (15 percent). The percentage of professional hours spent by setting did vary by provider type.

As described earlier, we created an indicator of provider affiliation relative to military and VA settings, as well as the TRICARE provider network. The first group included any provider who indicated seeing patients (any number of patients) currently in a DoD or VA setting (n=61). The second group included those providers who did not see any current patients in a DoD or VA setting, but who reported being affiliated with the TRICARE network (n=135). The final group reported neither of these military affiliations (n=326).

Prior Experience in the Military or in VA Settings

On average, 6 percent of respondents reported that they had served in the military.[29] Participating psychiatrists had the highest rates of military service, at 10 percent. More than one-third of respondents reported having family members in the armed forces. We note that it is not clear from our survey whether time spent in service was as a mental health provider or if individuals pursued their mental health care licensing following their military service.

Military and VA treatment settings each provide professional training opportunities for health care providers in the United States.[30] The VA in particular offers several clinical internship and fellowship opportunities for health care providers, including mental health professionals. We found that, overall, about one-third of respondents reported some experience working in some capacity (during training or in other roles) in either a military setting or in the Veterans Health Administration. There was some variation by provider type with regard to experience in military and VA settings, with more psychiatrists reporting having worked in a military or VA setting (62.5 percent) compared to one-third of psychologists and one-fifth of social workers and licensed counselors. The average time that providers worked in military or VA settings was 4.5 years (*SD*=6.06). It should be noted that we asked about time spent in either a military or VA setting; however, these settings may differ in important ways with respect to the nature of the experience and training offered. In addition, for providers reporting having served or working in military or VA settings, their time spent in service or working in these facilities may have been in a different capacity than as a mental health provider. This is particularly true for licensed counselors who are traditionally not employed with VA health settings as mental health providers. Thus, some of these providers may have worked within military or VA settings as nonmedical counselors or in other capacities either before or after their licensing. Regardless of their professional designation within these settings; however, the providers are reporting having worked in such settings and as such likely had exposure to military and/or veteran patients and families.

Table 3: Respondent Demographic and Practice Characteristics

Respondents	All (*n*=522)	Psychiatrists (*n*=128)	Psychologists (*n*=127)	Social Workers (*n*=132)	Licensed Counselors (*n*=135)
Female	59.8%	22.7%	74%	80.3%	61.5%
Works full time	95.7%	98.4%	97.6%	94.7%	92.3%
Setting in which greatest number of patients seen	Solo office practice	Solo office practice	Solo office practice	"Other" setting	Group office practice
Solo office practice	18.4%	31.3%	22.8%	6.8%	13.3%
Group office practice	16.5%	15.6%	13.4%	9.8%	2.7%
Ever served in Armed Forces	6.1%	10.2%	4.7%	1.5%	8.2%
Has family in Armed Forces	38.1%	29.7%	44.9%	42.4%	35.6%
Ever worked in DoD or VA setting	34.9%	62.5%	34.7%	21.1%	22.2%
Primary setting is within ten miles of either VA or DoD	55.5%	53.9%	56.7%	59.4%	51.9%
Registered in TRICARE network	29.5%	37.5%	28.3%	27.2%	25.1%
Part of Military OneSource	5.2%	3.2%	3.2%	5.3%	8.9%
Registered in VA Veterans Patient Centered Community Care network	6.1%	5.5%	3.9%	6.8%	8.1%
Average number of years since completing training	18.0 years	26.2 years	17.0 years	16.6 years	13.9 years

Practice Settings and Proximity to Military or VA Facilities

Respondents reported working and seeing patients in a number of different settings. Figure 4 displays the percentage of professional hours that respondents reported spending in the most recent typical work week by clinical practice setting; Table 4 summarizes the percentage of patients seen by the locus of care (outpatient versus inpatient). Geographically, respondents reported working in practice locations across the continental United States and in Hawaii, Alaska, and Puerto Rico. A little more than one-half of participating providers practiced within ten miles of either a VA or DoD facility. Figure 5 displays a map of respondents' practice locations, military treatment facility locations, and VA hospital or clinic locations. The map also includes a state-by-state indication of the veteran population as a proportion of the overall population.

Provider Activity

Across all provider types, respondents reported working an average of 48 hours per week (*SD*=22.87). They indicated spending the largest percentage of their time in direct patient care doing either medication management or psychotherapy and assessment (Table 5). Participating social workers, psychologists, and licensed counselors reported spending about half their time on psychotherapy and assessment. Participating psychiatrists reported spending a majority of their time (59 percent) on medication management and only about 30 percent of their time on psychotherapy and assessment. Amount of participants' time spent on professional and administrative activities—such as committees, Continuing Medical Education, research, writing, training, and forensic activities—varied by provider type. For example, psychiatrists reported that they spend about 8 percent of their time on professional and administrative activities, whereas psychologists reported spending about 31 percent of their time on those activities.

Therapeutic Orientation

The primary therapeutic orientation reported by respondents also varied by provider type (Table 6). The majority of social worker and licensed counselor respondents reported that their primary therapeutic orientation was cognitive and/or behavioral. A large proportion of psychologists also identified cognitive and/or behavioral as their primary therapeutic orientation (41 percent), and others identified with integrative or eclectic approaches (30 percent). Psychiatrists generally identified biological/psychopharmacologic as their primary orientation.

Certification, Training, and Supervision in Therapeutic Techniques

Respondents indicated being certified or trained in an array of EBPs for PTSD and MDD and have been supervised by others

Figure 4: Percentage of Total Professional Hours Reported, by Clinical Setting

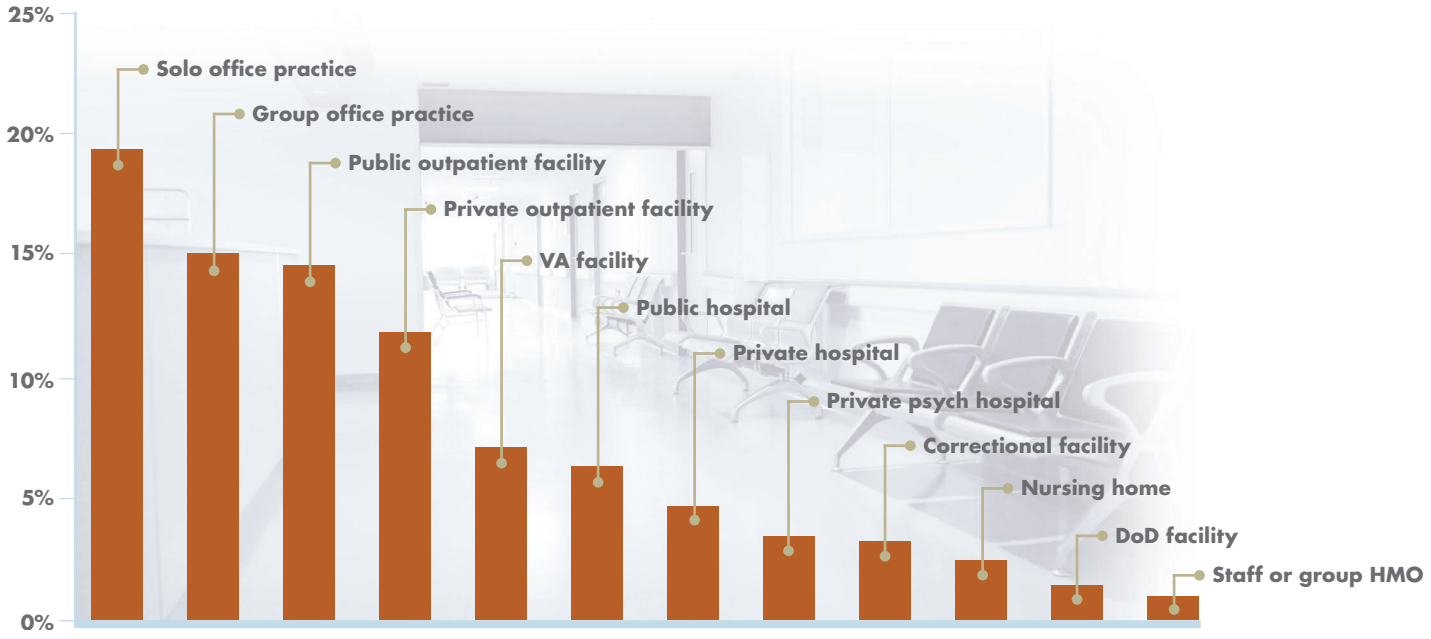


Table 4: Percentage of Patients Seen, by Respondents by Setting

	All (*n*=522)	Psychiatrists (*n*=128)	Psychologists (*n*=127)	Social Workers (*n*=132)	Licensed Counselors (*n*=135)
Outpatient setting	77.4	84.2	81.9	69.4	74.4
Inpatient setting	17.0	14.3	9.8	24.0	24.0
Other settings (school, prison, etc.)	5.0	1.5	8.3	6.6	5.6

in these methods. As Table 7 shows, CBT was the most common therapeutic technique respondents reported being trained to deliver, followed by IPT and CPT. Relatively fewer respondents had training and supervision in PE, EMDR, and SIT.

Assessment Behaviors

To understand the usual practice behaviors of participating providers, we asked them how often they implement a series of practices related to screening and assessment. While these screening behaviors are not necessarily linked specifically to quality or cultural competency, they do inform whether providers routinely adopt recommended approaches in their clinical settings. Figure 6 shows that the majority of respondents report often or always screening for a history of trauma, suicide risk, physical health problems, sleep issues, and pain. Only one-half reported screening for military affiliation and less than one-half report assessing stressors associated with military life. Less than one-half of the respondents reported often or always using validated screening tools to assess for such conditions as depression, PTSD, or alcohol and drug use.

MILITARY CULTURAL COMPETENCY

In this section, we report our findings on the military cultural competency of survey respondents. Cultural competency includes their knowledge and comfort related to military culture, self-reported proficiency working with veteran and military-affiliated patients, and prior training in military culture. We also report how individual and practice characteristics are associated with these aspects of military cultural competency. Understanding which factors are related to being more "veteran friendly" can help direct military cultural competency training to the set of providers most in need. We hypothesized that military cultural competency would be low among those providers who do not already treat veteran or military-affiliated patients.

Respondents reported being either "very familiar" or "extremely familiar" on an average of 1.84 (*SD*=2.7) of the eight military knowledge items presented and reported being "mostly comfortable" or "extremely comfortable" with an average of 1.62 (*SD*=1.3) of the three comfort items. A breakdown of knowledge items can be seen in Table 8, and indicates a wide range of self-reported knowledge on different aspects of military culture, with only 15 percent reporting being very or extremely familiar with military deployment and slang terms, but 38 percent saying they were very or extremely familiar with the way behaviors learned at war can be maladaptive at home. In terms of self-reported proficiency working with veteran or military-affiliated patients, respondents reported "agree" or "strongly agree" on an average of 4.52 (*SD*=3.2) of the ten proficiency items presented. A breakdown of self-reporting proficiency can be seen in Table 9, again with some differences across the items. Of the respondents, 18 percent agreed or strongly agreed that diagnosing and treating military personnel and veterans with mental health problems is no different than diagnosing and treating civilians with mental health problems, whereas 75 percent reported they usually actively strive to understand each military and veteran client's values and beliefs. Thirty-four percent reported receiving prior training in military culture. When these items were compiled into the overall military cultural competency score, total scores averaged 8.32 (SD=6.4) out of a possible 22 points. Overall, 19 percent were categorized as having "high military cultural competency" (with a total score of 15 or greater).

Although 70 percent of those working in a military or VA setting had high military cultural competency, only 24 percent of those participating in the TRICARE network and 8 percent of those without military or TRICARE affiliation met this threshold ($p<0.001$; see Table 7). Nearly one-quarter (23 percent) of those practicing within ten miles of a VA or military treatment facility met the threshold for high military cultural competency, whereas only 15 percent of those practicing more distantly from these facilities met the thresh-

Figure 5: Map of Survey Respondents' Practice Locations, Military Treatment Facility Locations, and VA Hospitals or Clinics

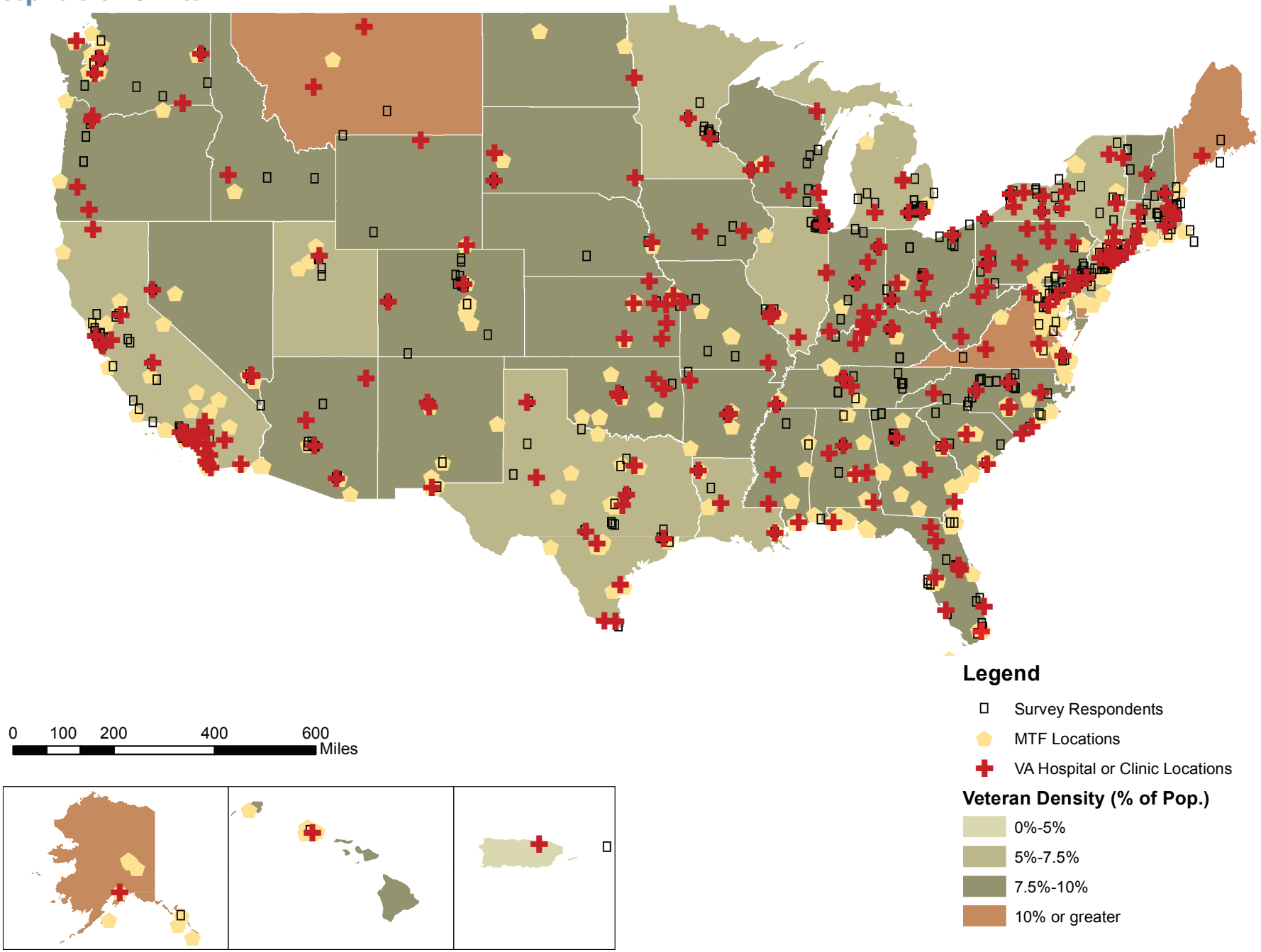


Table 5: Time Spent in Typical Week, by Activity (percentage)

	All	Psychiatrists	Psychologists	Social Workers	Licensed Counselors
Psychotherapy or assessment	49.7	29.7	54.6	58.6	54.9
Medication management	21.7	58.5	2.8	4.1	15.8
Professional/administrative activities	20.8	7.6	31.4	23.0	20.1
Receiving supervision/consultation	7.3	4.2	5.9	9.5	9.0
Supervising others	6.6	3.7	8.8	8.7	5.1

Table 6: Provider Primary Therapeutic Orientation (percentage)

	All	Psychiatrists	Psychologists	Social Workers	Licensed Counselors
Cognitive and/or behavioral	41.2	7.8	44.1	58.3	53.3
Biological/psychopharmacologic	21.8	71.8	0.8	1.5	14.1
Integrative or eclectic	17.8	12.5	29.9	16.7	12.6
Psychodynamic/relational	10.2	5.5	11.8	9.8	13.3
Interpersonal	4.8	0.0	6.3	10.6	2.2
Acceptance and commitment	1.1	0.0	1.6	0.7	2.2
Other	3.1	2.3	5.5	2.3	2.2

Table 7: Provider-Reported Psychotherapy Training and Supervision (percentage)

	All		Psychiatrists		Psychologists		Social Workers		Licensed Counselors	
	Trained	Supervised	Trained	Supervised	Trained	Supervised	Trained	Supervised	Trained	Supervised
CBT	69.4	68.6	57.0	63.3	71.6	68.5	67.4	61.4	80.7	80.7
IPT	37.0	37.4	40.6	50.0	37.0	35.4	25.8	21.2	45.2	42.9
CPT	33.0	27.6	18.0	17.2	35.4	23.6	28.8	25.0	50.4	43.7
EMDR	18.6	17.2	12.0	14.1	20.5	15.8	13.6	12.1	28.2	26.7
PE	18.0	16.9	14.0	15.6	24.4	25.2	11.4	5.3	22.9	21.5
SIT	13.6	10.9	6.3	6.3	15.8	11.0	9.1	6.1	22.9	20.0

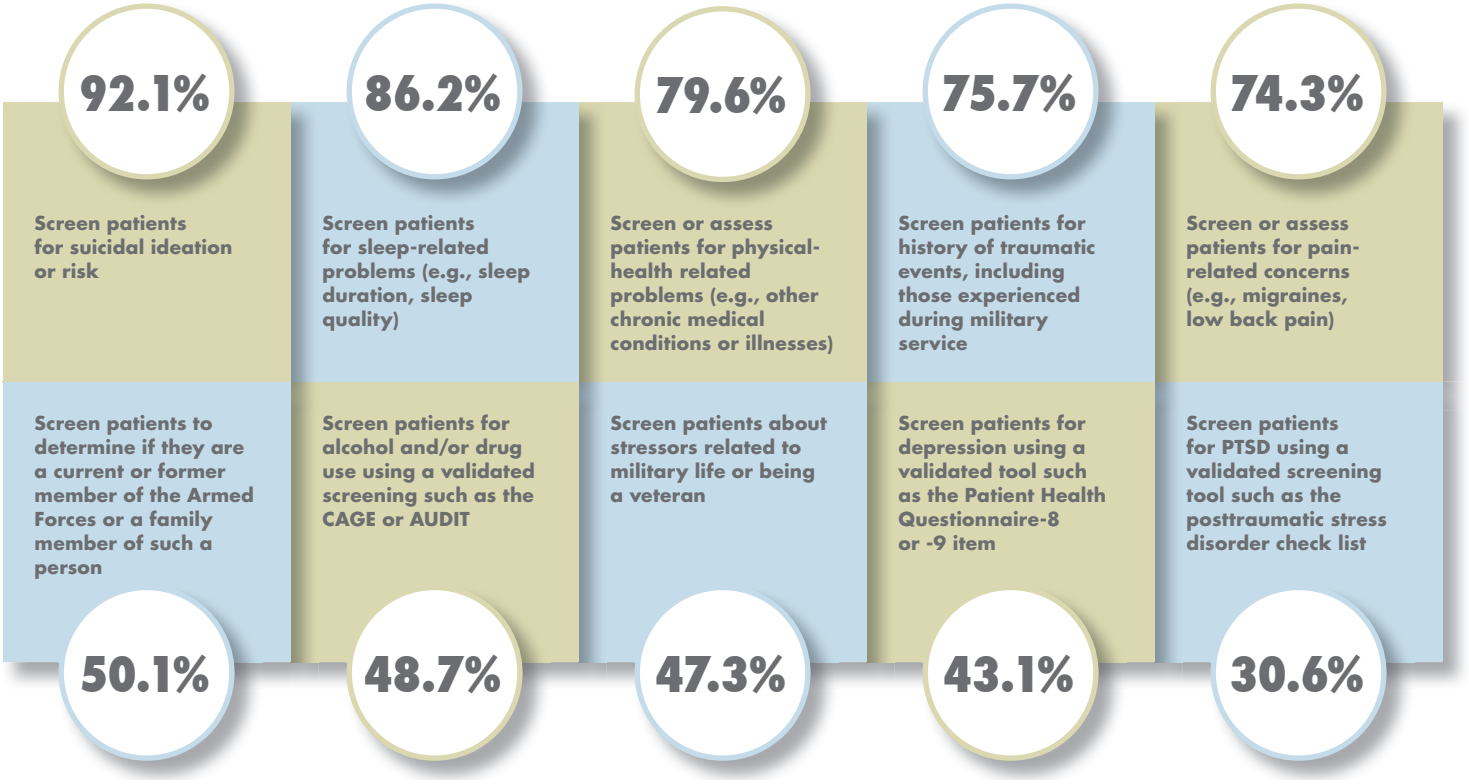
old (p<0.05). Neither provider type nor years in practice were related to overall military cultural competency.

Consistent with the bivariate analyses (shown in Table 10), a logistic regression model confirmed that, relative to those working outside military or VA settings who are part of the TRICARE network, those working in military or VA settings are more likely to meet the threshold for high cultural competency, and those working outside such settings who are not part of TRICARE are less likely to meet the threshold. The remaining independent variables failed to reach significance. A linear regression predicting the continuous variable for military cultural competency showed similar results.[31]

USE OF EVIDENCE-BASED PRACTICES FOR PTSD AND MDD

In this section, we explore respondents' reported capability of delivering evidence-based care for PTSD and MDD. We report on whether participating providers were trained and inclined to implement guideline-concordant care for PTSD and MDD, and whether these providers reported using such care in their usual practice. The success of efforts to outsource mental health care for service members and veterans to civilian providers will depend, in part, on whether providers in the community are able and willing to deliver the high-quality care outlined in the VA/DoD CPGs for MDD and PTSD.[32] Based on previous reviews of provider practices,[33] we expected that a substantial proportion of civilian providers would *not* be prepared to deliver high-quality mental health care.

Figure 6: Percentage of Providers Who Endorse Performing Each Assessment Behavior



We explored the relationships between training in and use of evidence-based care and psychotherapist type (social worker, licensed professional counselor, or clinical psychologist), military affiliation (employed in a military setting, TRICARE affiliated, or non-TRICARE affiliated), number of years since graduate training, and attitudes toward CPGs. Understanding the practice and provider characteristics associated with provision of high-quality mental health care may allow policymakers to better direct care for service members seeking services outside the military and veteran health systems.

The types of services specified as "evidence-based" differ substantially between mental health specialists (hereafter referred to as "psychotherapists") and psychiatrists. Although psychiatrists are licensed to provide both medication management and "talk" therapies for mental health conditions, most deliver more medication management than psychotherapy (see also Table 3). Psychotherapists are not licensed to provide medications and are more likely than psychiatrists to deliver "talk" therapies, including EBPs such as CBT or PE. This divergence in practice motivates our analytic structure. Below, we report first on psychotherapists' training in and delivery of EBPs for PTSD and MDD. Second, we report findings on psychiatrists' delivery of evidence-based medication management for PTSD and MDD.

Evidence-Based Practices Among Psychotherapists

Training in Evidence-Based Psychotherapies for PTSD and MDD

Only one-third (35 percent) of psychotherapists reported that they had been trained and received supervision to deliver at least one EBP for PTSD and at least one for depression (see Figure 6). Licensed counselors (LPC/LMHCs) were most likely to report having training in EBPs ($p<.001$). Nearly one-half (48 percent) reported being trained to deliver an EBP for PTSD and depression. One-third of clinical psychologists reported receiving training (34 percent), and only one-fourth of licensed clinical social workers (LCSW/MCSWs) indicated they were trained (23 percent). Neither attitudes toward CPGs nor years since clinical training were significantly associated with EBP training. A logistic regression model predicting EBP training confirmed the bivariate relationships described above.[34]

Table 8: Providers Reported Knowledge of Military and Veteran Culture (percentage)

Reported Being Very Familiar or Extremely Familiar With	All	Psychiatrists	Psychologists	Social Workers	Licensed Counselors
Military rank structure	21.6	25.0	25.2	15.9	20.7
Subculture of military branches	16.5	16.4	17.3	13.6	18.5
Differences and similarities between active and reserve components of the military	23.6	30.5	14.4	18.9	20.7
General and deployment-related military slang and terms	14.6	14.8	15.7	12.9	14.8
General and deployment-related stressors for service members and veterans	25.1	21.9	32.3	23.5	23.0
General and deployment-related stressors for military families	27.2	23.4	32.3	27.3	25.9
Programs and services available to support healthy adjustment for military-affiliated clients	17.8	13.3	19.7	19.7	18.5
How behaviors learned in war can be maladaptive at home	37.5	29.7	48.0	37.9	34.8

Table 9: Self-Reported Proficiency (percentage)

Reported Agree or Strongly Agree	All	Psychiatrists	Psychologists	Social Workers	Licensed Counselors
I can list methods or ways of collecting a military history and related mental health information (e.g., military and veteran benefits, options or eligibility for care)	40.4	39.1	43.3	42.4	37.0
I can explain how the perceptions of mental health beliefs are influenced by military and veteran culture	54.6	46.9	61.4	56.1	54.1
I usually actively strive to understand each military and veteran client's values and beliefs	74.5	75.8	77.2	77.3	68.1
I can teach and guide colleagues on the important features of military culture	25.1	22.7	26.0	25.0	26.7
I can teach and guide colleagues on planning mental health care for military and veteran clients	28.7	26.6	30.7	27.3	30.4
I can teach and guide colleagues on effective communication skills with military and veteran clients	39.5	31.3	44.1	40.2	42.2
Collecting information on a military or veteran client's mental health is easy for me	47.3	46.9	50.4	45.5	46.7
When implementing care, I can fulfill the mental health needs of military and veteran clients	54.2	56.3	57.5	48.5	54.8
I have the skills to communicate effectively with military and veteran clients	69.3	74.2	71.7	65.2	66.7
Diagnosing and treating military personnel and veterans with mental health problems is no different than diagnosing and treating civilians with mental health problems	18.4	21.9	16.5	12.1	23.0

Table 10: Relationship Between Cultural Competency and Provider Characteristics

Provider	Military Culturally Competent ≥ 15 (%)
All respondents	19.2
Provider type	
LPC or LMHC	17.8
LCSW or MCSW	18.2
Clinical Psychologist	21.3
Psychiatrist	19.5
	χ^2=0.621, *p*=not significant (ns)
Affiliation	
Works in military or VA setting	70.5
TRICARE affiliated	23.7
Not TRICARE affiliated	7.7
	χ^2=133.38, *p*<.001
Years since graduate training	
Ten years or less	20.7
More than ten years	18.4
	χ^2=0.389, *p*=ns
Geographic proximity	
Within ten miles	14.7
More than ten miles	22.8
	χ^2=5.555, *p*<.05

Delivery of Evidence-Based Psychotherapy to at Least Three-Quarters of Patients in the Most Recent Typical Work Week

One-third of psychotherapists (33 percent) self-reported that, in the most recent typical work week, they treated a substantial majority of their patients (≥75 percent) with an EBP (see Figure 6). Providers who had been trained to deliver at least one evidence-based PTSD and MDD psychotherapy (41 percent) were more likely than those without training (29 percent) to report delivering EBPs to most of their patients in the most recent typical week (*p*<.05). Providers with positive attitudes toward CPGs (45 percent) were also more likely than those with negative opinions about CPGs (31 percent) to report delivering EBPs to their patients. Among providers who self-reported delivering EBPs to most of their patients in the most recent typical week, fewer years had elapsed since their graduate training relative to providers who did not deliver EBPs to the majority of their patients (13.9 years and 16.7 years, respectively). A logistic regression model predicting self-reported delivery of EBP confirmed the bivariate relationships.[35]

Consistent Use of Evidence-Based Psychotherapy Techniques in Session

About 30 percent of psychotherapists reported that they "often" or "always" used the psychotherapy techniques associated with at least one EBP for PTSD and MDD (see Table 11). Provider type was not related significantly to use of EBP techniques. Perhaps not surprisingly, positive attitudes toward CPGs and training in EBPs for PTSD and MDD significantly predicted frequent use of EBP techniques. Neither affiliation nor years since graduate training were significant predictors of EBP techniques. A logistic regression, conducted to estimate the independent contributions of the predictor variables, confirmed the bivariate relationships described above.[36]

Evidence-Based Practices Among Psychiatrists

When asked to report the most common first-line medications that they would prescribe to a patient with PTSD or MDD, 89 percent of psychiatrists specified a medication that the VA/

Table 11: Relationship Between Provider Characteristics, and Training and Delivery of EBPs for PTSD and MDD

	Trained in 1+ EBPs for PTSD and MDD (%)	Reported Treating ≥75% of Patients with an EBP in the Last Typical Work Week (%)	Reported Often/Always Using EBP Techniques for PTSD and MDD (%)
All Respondents	35.0	33.0	29.4
Provider Type			
LPC or LMHC	48.2	36.3	32.6
LCSW or MCSW	22.7	31.1	22.0
Clinical Psychologist	33.9	31.5	33.9
	$\chi^2(2)=19.06$, p<.001	$\chi^2(2)=1.02$, p=ns	$\chi^2(2)=5.39$, p=ns
Affiliation			
Works in a VA or military setting	48.1	26.9	40.4
TRICARE affiliated	37.4	40.7	34.1
Not TRICARE affiliated	31.5	31.5	25.5
	$\chi^2(2)=5.50$, p=ns	$\chi^2(2)=3.56$, p=ns	$\chi^2(2)=5.81$, p=ns
Supportive of CPGs			
Below threshold	34.1	30.8	25.8
Above threshold	40.0	45.0	50.0
	$\chi^2(1)=0.77$, p=ns	$\chi^2(1)=4.61$, p<.05	$\chi^2(1)=14.40$, p<.001
Years since graduate training	t(392)=0.64, p=ns	t(392)=2.36, p<.05	t(392)=1.59, p=ns
Trained in 1+ EBP			
No	—	28.9	22.7
Yes	—	40.6	42.0
	—	$\chi^2(1)=5.53$, p<.05	$\chi^2(1)=16.20$, p<.0001

> Providers who meet one threshold, such as culturally sensitive or competent, may not meet the other (trained in or report using evidence-based care).

DoD CPGs include as appropriate, evidence-based psychopharmacological treatments for these conditions. Psychiatrists' practice affiliation was not significantly related to their likelihood of prescribing an evidence-based medication ($\chi^2(2)=1.20$, p=ns). Evidence-based prescribing was also unrelated to attitudes toward CPGs ($\chi^2(2) = 2.09$, p=ns). However, years since graduate training were related to self-reported practices. Psychiatrists who adhered to practice guidelines for medication management of PTSD and MDD had been practicing for about five fewer years (M=25.6, SD=7.93) than those who reported not providing guideline-concordant care (M=31.0, SD=9.02; $t(126)=2.37$, p<.05).

Given that very few psychiatrists indicated that they would use a nonevidence-based medication management strategy (n=14), there was insufficient power to conduct a logistic regression predicting psychiatrist prescribing patterns with multiple independent variables.

OVERALL PROVIDER READINESS FOR VETERAN-FRIENDLY, QUALITY CARE

In this section, we explore the extent to which providers are "ready" to deliver culturally competent, high-quality care to veterans and their families. As we outlined in earlier sections, cultural competency can facilitate the development of therapeutic rapport and improve treatment receptivity, and the definition of *high-quality care* includes the use of treatments demonstrated to be effective (i.e., evidence-based). Thus, our concept of provider readiness in this study combines the domains of cultural competency and capacity to deliver high-quality care. We are particularly interested in understanding not only the proportion of providers that meet our definition of readiness, but also in examining the factors that may be associated with such readiness. As we outlined in the previous sections, different factors have been shown to be associated with cultural competency and the use of evidence-based approaches. And, providers who meet one threshold, such as culturally sensitive or competent, may not meet the other (trained in or report using evidence-based care).

We operationalized our concept of readiness by building upon and combining the two outcomes described in the prior sections. We include providers we defined to be culturally competent (having scored 15 or greater out of a total of 22 possible on our cultural competency scale), who indicated they had been trained in an evidenced-based therapy for PTSD and MDD, and who self-reported using evidence-based treatments for PTSD and MDD. For each variable, the criteria for inclusion differed across MD and non-MD provider types due to the low numbers of psychiatrists who deliver nonmedication-based approaches. As we outlined in earlier sections, the focus for psychotherapists (non-MD providers) was on use of specific psychotherapies demonstrated to be effective for PTSD and MDD. For psychiatrists, evidence-based treatment meant selecting appropriate medications for PTSD and MDD. The previous section provides more detail on how providers perform separately on these two outcomes.

As shown in Table 12, only 13 percent of respondents met our readiness criteria. We examined associations between providers' years in practice (years since training in two categories: less than ten years, or ten years or greater), practice affiliation, proximity to military or veteran treatment facilities (within ten miles versus more than ten miles away), region (primary practice setting is in a metropolitan statistical area–defined urban or rural region), and insurance status (greater than 50 percent of patient care is not compensated through insurance). As shown, and as was confirmed in a multivariate model, we find that only providers' practice affiliation is significantly associated with readiness: Providers who work primarily in a military or VA setting were significantly more likely to meet our criteria for being culturally competent and delivering evidenced-based care for PTSD or MDD than providers who do not work in a military or VA facility, but those who indicated they were a registered provider within the TRICARE provider network were more likely to meet criteria than those who were not registered with a TRICARE provider network.

Table 12: Relationship Between Provider Characteristics and Readiness

	Culturally Competent and Reported Being Trained in 1+ EBP and Reported Often/Always Using Evidence-Based Treatment for PTSD and/or MDD (%)
All respondents	13.4
Provider type	
LPC or LMHC	13.3
LCSW or MCSW	9.8
Clinical psychologist	12.6
Psychiatrist	18.0
	χ^2=3.806, *p*=ns
Affiliation	
Works in military or VA setting	45.9
TRICARE affiliated	17.8
Not TRICARE affiliated	5.5
	χ^2=75.149, *p*<.001
Supportive of CPGs	
Not CPG friendly	13.2
CPG friendly	14.7
	χ^2=0.119, *p*=ns
Years since graduate training	
Ten years or less	16.0
More than ten years	12.2
	χ^2 =1.418, *p*=ns
Geographic proximity	
Within ten miles of DoD or VA facility	15.9
More than ten miles	10.3
	χ^2=3.436, *p*=ns

NOTE: Value and statistical tests are not shown for the associations between readiness and having greater than 50 percent of uncompensated/self-pay care because the number of providers in some cells were fewer than ten, making such tests unreliable.

As veterans and their families seek care to address mental health concerns, they will be turning to providers working across multiple sectors.

IMPLICATIONS FOR THE FUTURE

As veterans and their families seek care to address mental health concerns, they will be turning to providers working across multiple sectors. This study aimed to assess the readiness of those mental health providers working in community settings. While multiple factors may facilitate or inhibit a provider's ability to deliver high-quality care—including the system-level incentives and treatment models employed within their settings—we focused on those related to the characteristics of the providers themselves. To do so, we examined the characteristics of a convenience-based sample of mental health professionals and assessed their knowledge, attitudes, and behaviors with respect to military and veteran culture, as well as evidence-based practices for mental health problems common in veteran populations.

We find that providers vary in whether they report being knowledgable in and comfortable with treating military- and veteran-affiliated patients. We also observe variation in the extent to which participating providers were trained in and demonstrated use of evidence-based treatments for PTSD and MDD. We found that, across our outcomes of interest, the characteristics of the provider are related to the setting in which they work.

With respect to cultural competency, respondents endorsed a high degree of knowledge on less than one-quarter of knowledge items, a high degree of comfort on about two-thirds of comfort items, and a high degree of proficiency on fewer than one-half of self-reported proficiency items. Fewer than one-fifth of respondents exceeded the threshold for a high degree of cultural competency, and as expected, those respondents were more likely to be working in DoD or VA work settings or to have reported being in the TRICARE network than not.

The majority of psychotherapists (65 percent) reported that they had not received the training and supervision necessary to deliver at least one EBP for PTSD and MDD. In other words, a psychotherapist selected from the community is unlikely to have the skills necessary to deliver high-quality mental health care to service members or veterans with these conditions. Licensed counselors (LPC/LMHC) were more likely than other psychotherapists to report adequate training in EBPs. Further examination of differences across graduate training models may provide policy recommendations to improve training for the next generation of psychotherapists.

Training in EBPs, in turn, predicts implementation of these practices with the majority of patients. Increasing community-based psychotherapists' incentives to complete training in EBPs may improve patient access to these behavioral treatments for their conditions. At the same time, even among psychotherapists with training, only 41 percent reported delivering evidence-based care to most of their patients. Thus, training alone does not ensure delivery of high-quality care; other barriers to CPG adherence must be explored. Providers who delivered EBPs to most of their patients were comparatively recent graduates, having completed their training about three years after those who were not consistently implementing evidence-based care. This may reflect a trend among graduate programs toward an increasing emphasis on evidence-based strategies for care, or it may be that younger clinicians are more likely to pursue training and supervision in treatments that have been demonstrated through research to reduce clinical symptoms.

Among psychiatrists, the majority of respondents reported prescribing appropriate medication for MDD and PTSD. In general, most reported using specific psychotropic medications that are considered generally acceptable for these conditions. However, we were unable to assess the appropriateness of specific dosages and length of use.

When we combined responses for cultural competency and use of evidence-based approaches to examine the level of overall readiness to deliver culturally competent, evidence-based care, we found very few respondents (13 percent) met our threshold. Similar to our findings on cultural competency, providers who met this threshold were more likely to be affiliated with a DoD or VA facility than not, and more likely to be a part of the TRICARE network than not if working outside DoD or the VA. Although actual knowledge and practice behaviors were not assessed in this study, the data

gathered on respondents' perceptions of their own knowledge, attitudes, and behaviors offer important insights into how ready they are to work with veterans and service members, as well as their families.

These findings suggest that when service members, veterans, or family members seek care from providers not affiliated with DoD or the VA, they may encounter providers who are not as well prepared to deliver culturally sensitive care. However, the degree to which providers deliver evidence-based care for PTSD and MDD appears equivalent across settings, with those providers who have received training in evidence-based approaches more likely to deliver such care routinely to their patients.

Study Limitations

While this study provides important insight into the characteristics of community mental health professionals, several limitations should be noted. First, we relied upon a convenience sample. Thus, the results are not necessarily representative of all mental health professionals. While the topics of military and veteran mental health care, cultural competency, and evidence-based practice were not specifically identified in the recruitment email sent by GfK or in the introductory page of the survey, it is possible that providers more interested in these topics of military and veteran populations completed the survey. As with all surveys conducted among convenience samples, it is difficult to understand the potential bias introduced by those choosing to participate in such panels and surveys as compared to the full population of providers.

Further, while we compare providers across different types of characteristics, care should be taken in making inferences about differences across provider groups because we did not sample systematically. Future work should be designed to implement similar assessments in larger samples, ideally those that are designed to represent provider groups (defined within provider networks, professional categories, settings, etc.). Another limitation is that we rely on self-report methods to assess practice behaviors. As with all self-report surveys, there is the potential for socially desirable responses. We tried to minimize this bias by including anchor/reference periods or referring to specific types of patients (e.g., those with PTSD or MDD); however, the potential for selecting socially desirable responses may still remain.

In addition, we measured some aspects of potential care experiences for veterans and their families within this survey, such as self-reported knowledge about military culture and proficiency with various treatment approaches, but did not include others, such as actual knowledge on how to apply specific techniques and practice behaviors for these populations. Thus, many important aspects of knowledge, attitudes, and behavior among community-based mental health providers remain to be explored. Further, other techniques—such as gathering patient-level data on symptom levels, functioning, and experiences with care (which could be implemented within rigorous performance monitoring approaches)—would help to inform the extent to which providers' techniques are actually helping patients to improve.

Recommendations and Next Steps

Despite the exploratory nature of this study, there are several implications for informing future efforts to improve the capacity of community-based providers to deliver culturally competent, high-quality care to veterans and their families.

Conduct Better Assessments of Civilian Provider Capacity

With continued emphasis on hiring more providers into the VA,[37] workforce development and evaluation efforts are critically needed to understand more about the size and characteristics of the mental health workforce in the United States, and

These findings suggest that when service members, veterans, or family members seek care from providers not affiliated with DoD or VA, they may encounter providers who are not as well prepared to deliver culturally sensitive care.

While provider cultural competency may be important for engaging the population and thereby increasing access to care, other specific efforts may be needed to increase providers' use of quality therapeutic approaches.

in particular, whether the civilian sector can meet expectations regarding timeliness and quality of care. Unfortunately, at this time, there are no recent representative data on any of the specific professions within the mental health workforce.

Until such population-based data can be generated, organizations that maintain registries or provider networks of mental health professionals should conduct assessments related to their own networks, with a special focus on examining access and quality of care among those providers. Even registries or networks established specifically for military and veteran populations would benefit from an assessment of which providers have availability and appropriate capacity to render timely, culturally appropriate, high-quality care to veterans and their families. For example, while being part of such registries or networks may indicate a provider's willingness to accept military-affiliated patients, providers often place limits on the number of patients they accept under those arrangements. In this study, about 30 percent of providers reported they were part of the TRICARE network; however, TRICARE represented the primary payment source for only a small proportion (2.5 percent) of the patients treated by our participating providers in a typical week.

A related issue has to do with efforts to hire and train more providers working within DoD and the VA over the past several years. These efforts have been hampered by the ability to ensure an adequate pipeline of mental health providers, both in terms of numbers and quality, particularly in remote or rural areas. Several have pointed to the concerns about a national shortage in mental health,[38] and efforts to draw more providers into DoD and the VA may further deplete the civilian workforce. Again, careful study of the existing workforce may help to identify strengths and gaps and provide more information about how and where to enhance the pipeline of new professionals entering the workforce.

Assess the Impact of Trainings in Cultural Competency on Provider Capacity

In the President's 2012 Executive Order (and reinforced in new Executive Actions announced in August 2014), he called upon DoD, the VA, and the Department of Health and Human Services to collaborate in an effort to educate community-based providers about the unique needs of service members, veterans, and their families. In response to the most recent Call to Action, DoD and the VA announced an intent to disseminate their cultural competency course to civilian mental health providers. While this new initiative may help increase community-based providers' awareness of the unique issues of veterans and their families, training by itself it will not necessarily increase cultural competency or expand access or quality of care for veterans. While training may be an important underpinning for developing awareness and skills, seeing and interacting with the patient population was a significant predictor of overall competency, with providers' affiliation with DoD and VA settings and TRICARE affiliation significantly related to high military cultural competency scores in our scale.

Further, while provider cultural competency may be important for engaging the population and thereby increasing access to care, other specific efforts may be needed to increase providers' use of quality therapeutic approaches. DoD and the VA have a long history of requiring training for their providers on evidence-based approaches, as well as promulgating CPGs for the care of patients with specific conditions (including PTSD and depression), but there are few such requirements in the civilian setting. Large-scale dissemination and training efforts can be resource-intensive and require significant investment of staff time and leadership to promote participation and adherence to guidelines. Different models have been employed and many engage champions, train-the-trainer, or supportive implementation models to help disseminate information

broadly and encourage uptake. Often, these efforts also involve the development and distribution of provider resource guides, pocket tools, and other decisionmaking aids to facilitate utilization of the skills and practice recommendations. Studies that have evaluated the impact of these efforts have demonstrated success,[39] yet few programs that implement trainings of this nature evaluate their efficacy and long-term effectiveness. Many training and dissemination programs may show early success but adherence and use of new skills may wane as the support and infrastructure subsides.

DoD utilizes the Center for Deployment Psychology to train military mental health professionals in the evidence-based modalities. Recently, the Center began collaborating with academic organizations to bring training to civilian providers as well. Their approach includes specific focus on cultural competency, as well as evidence-based therapies, organized across three training tiers reflecting different topics and levels of intensity. Other promising programs have also begun designing and implementing more rigorous curricula on both the topics of cultural competency and specific evidence-based modalities using models shown to facilitate provider practice change.[40] Understanding the extent to which participating in such training affects providers' capability to serve this population will require well-designed evaluations of the training programs themselves, as well as rigorous studies to explore how providers implement the material in practice settings in the short and long terms.

Expand Access to Effective Trainings in Evidence-Based Approaches for PTSD and MDD

This study clearly points to the need for additional training on evidence-based approaches among the civilian mental health workforce, particularly for practitioners who completed their formal professional training some time ago. Recent graduates in certain professions appear to be getting training in these models more often; thus, expansion to all professional training programs as well as to more mature professionals is needed. Over the past several years, numerous organizations have sought to implement training programs for practicing providers in evidence-based approaches in mental health, with varying success based upon the particular model adopted.[41] As we outlined earlier, the type of training programs in military cultural competency and evidence-based approaches for PTSD and MDD currently available varies greatly—from short online courses, to lengthier in-person opportunities. Participation in these varying continuing education opportunities may help to expand provider skills and ability to implement these models; however, providers may need some additional motivation for attaining such training and then applying their new skills in routine practice.

While some of these training opportunities are available at little or no cost (such as web downloads), others may impose specific costs related to access and participation (including travel expenses). Beyond these participation fees, the participation time itself may be a cost for providers, as the time spent in training may detract from their time providing compensated patient care (particularly for providers working in independent, fee-for-service settings). Thus, strategies for facilitating low-cost access may be needed to increase provider willingness to participate. While some courses offer continuing education credits, not all provider groups and states have specific requirements for these credits and it may not be enough motivation to facilitate providers becoming trained. It should be noted that while we recommend greater access to training in evidence-based approaches for PTSD and MDD, we acknowledge that not all training may be equivalent in terms of quality and effectiveness in providing the appro-

This study clearly points to the need for additional training on evidence-based approaches among the civilian mental health workforce, particularly for practitioners who completed their formal professional training some time ago.

Improving the mental health of service members, veterans, and their families will require that the providers who treat them adopt and routinely use appropriate and effective approaches for addressing their conditions.

priate instruction and supervision in specific, evidence-based approaches. As such, rigorous evaluations will be needed to assess the extent to which training is effective in improving providers' skills and changing their practice behaviors.

Facilitate Providers' Use of Evidence-Based Approaches

Improving the mental health of service members, veterans, and their families will require that the providers who treat them adopt and routinely use appropriate and effective approaches for addressing their conditions. We found that prior training is associated with the use of evidence-based approaches; however, adoption of such techniques was not universal among those who received such training. Thus, providers may need additional motivation to use appropriate techniques in their usual practices. Supportive implementation models of training have shown success in increasing clinical skill acquisition and spreading evidence-based treatments among community providers, but other barriers to regular use may remain.[42]

System- or practice-level performance-monitoring approaches and quality improvement techniques have been shown to improve providers' use of specific evidence-based approaches.[43] These monitoring and improvement strategies may be applied more often within closely managed settings that prioritize quality—therefore, providers working in independent office practices may not be part of any such oversight other than what is provided through reimbursement mechanisms (e.g., claims adjudication processes). As such, motivating providers in private, independent settings within the civilian sector may require that health payers begin to monitor the quality of care provided more closely and consider strategies for incentivizing use of evidence-based approaches, either through altering reimbursement rates or providing preferred referral authorizations (particularly for those providers who choose not to accept any health insurance).[44]

Prior research has demonstrated that there is a business case for providing access to high-quality care for all veterans with PTSD and MDD.[45] Thus, strategies for facilitating providers' use of evidence-based approaches have the potential to reduce the overall costs of such care and the burden on society associated with undertreated mental health conditions. Based on our findings, it is reasonable to expect that increasing training in and incentivizing providers' use of such techniques will begin to facilitate the delivery of high-quality care to veterans and their families.

Notes

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[31] A logistic regression model was used to predict high cultural competency. Compared to the constant-only model, the full logistic regression model improved discrimination between those with high cultural competency and those that did not meet the threshold (Wald $\chi^2(6)=73.58$, $p<.0001$). Consistent with the bivariate analyses above, the Wald criterion confirmed that, relative to those working outside military or VA settings who are part of the TRICARE network, those working in military or VA settings are more likely to meet the threshold for high cultural competency (*OR*=9.62, p<.0001), and those working outside those settings who are not part of TRICARE are less likely to meet the threshold (*OR*=0.36, p<.01). The remaining independent variables failed to reach significance. A linear regression predicting the continuous variable for military cultural competency showed similar results.

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[35] A logistic regression, in which all variables were entered simultaneously, examined the independent contribution of provider type, affiliation, attitudes toward CPGs, years since graduate training, and training in EBPs to the prediction of whether the provider used EBPs with most of their PTSD and MDD patients. The full model improved discrimination relative to the intercept-only model (Wald $\chi^2(7)=28.5$, $p<.001$). Consistent with the bivariate analyses, positive attitudes toward CPGs increased the likelihood that the provider would deliver EBPs to their patients (*OR*=1.08, p<.0001). As the length of time since a provider's clinical education increased, the likelihood that they would deliver EBPs to their patients with PTSD and MDD declined (*OR* =0.97, p<.01). Finally, providers who were trained in at least one MDD and one PTSD EBP were 1.6 times more likely to deliver EBPs to the majority of their patients (*OR*=1.62, p<.05). Provider type and affiliation were not significantly related to self-reported delivery of EBPs in the model.

[36] A logistic regression was conducted to estimate the independent contributions of provider type, affiliation, attitudes toward CPGs, years since graduate training, and training in EBPs to a prediction of likelihood of "often" or "always" implementing EBP techniques. Compared to the constant-only model, the full model improved discrimination between therapists who consistently versus inconsistently implement evidence-based techniques (Wald $\chi^2(7)=35.10$, $p<.0001$). Providers with positive attitudes toward CPGs were more likely to consistently implement EBP techniques (*OR*=1.08, p<.001). Providers who had been trained to deliver EBP were twice as likely to do so relative to those without training (*OR*=2.16, p<.01). The remaining model variables failed to reach significance.

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About This Report

Ensuring that military veterans and their families have access to high-quality mental health care is a national priority. Over the past several years, the Departments of Defense and Veterans Affairs have increased the number of mental health professionals working within their facilities and have rolled out training and quality improvement initiatives designed to promote the use of evidence-based treatments. Despite these important efforts, research continues to demonstrate that many veterans prefer to seek services outside the Department of Defense and/or the Department of Veterans Affairs. Thus, providers working in the civilian sector are an increasingly important part of the overall mental health workforce addressing veterans' mental health needs.

To better understand a key aspect of our nation's ability to provide veterans and their families with access to high-quality mental health care, RAND conducted a survey of civilian mental health providers to gather information about their knowledge, attitudes, and preferences for delivering services to veterans and their families. This report provides the results of that survey. The findings and recommendations from this study should be relevant to individuals, organizations, and policy officials concerned about the capacity of the civilian health care sector to deliver culturally competent, high-quality services to veterans and their families.

The authors wish to thank several individuals who helped make this study a success. First, we thank Shelly Espinosa, Tracy Malone, and Kathy Beasley for their guidance and support with this project. We thank the mental health professionals who took the time to participate in our survey, as well as Carolyn Chu and Michael Lawrence from GfK Custom Research, who facilitated the implementation of the survey.

We thank our quality assurance reviewers, Lisa Meredith and David Riggs, for their constructive reviews. Collectively, their comments and feedback greatly enhanced the report. We also thank our report production team of editors and designers, including Arwen Bicknell, Steve Oshiro, and Tanya Maiboroda.

This research was sponsored by the United Health Foundation in collaboration with the Military Officers Association of America and conducted within RAND Health. A profile of RAND Health, abstracts of its publications, and ordering information can be found at www.rand.org/health. This research was co-led by Terri Tanielian and Lisa H. Jaycox. Questions about the report may be directed to Terri_Tanielian@rand.org.

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Ensuring that military veterans and their families have access to high-quality mental health care is a national priority. Over the past several years, the Departments of Defense and Veterans Affairs have increased the number of mental health professionals working within their facilities and have rolled out training and quality improvement initiatives designed to promote the use of evidence-based treatments. Despite these important efforts, research continues to demonstrate that many veterans prefer to seek services outside the Department of Defense and/or the Department of Veterans Affairs. Thus, providers working in the civilian sector are an increasingly important part of the overall workforce addressing veterans' mental health needs. To better understand a key aspect of our nation's ability to provide veterans and their families with access to high-quality mental health care, RAND conducted a survey of civilian mental health providers to gather information about their competency with military and veteran culture and their training and experience treating posttraumatic stress disorder and depression. This report provides the results of that survey. The findings and recommendations from this study should be relevant to individuals, organizations, and policy officials concerned about the capacity of the civilian health care sector to deliver culturally competent, high-quality services to veterans and their families.

$17.50

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ISBN-10 0-8330-8768-1
ISBN-13 978-0-8330-8768-3

9 780833 087683 51750

RR-806-UNHF