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Behavioral Health Competence: An Exploration of Army Reserve Occupational Therapists

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Abstract

The behavioral health competence of Army Reserve Occupational Therapists (OT) was examined by electronic survey to determine current levels of competence and highlight pre-deployment training needs. Results indicated that while Army Reserve OTs report high levels of behavioral health competence, many questions regarding diagnosis, assessment, evaluation, treatment planning, intervention, and progress arose throughout deployment. OT's often relied on skills from Level II fieldwork education and entry-level didactic education for competency. Perceived competencies may be compromised by curriculum changes in entry-level education, available fieldwork settings, and a lack of adequate training currently available prior to deployment.

Keywords

Army Reserve; behavioral health care; mental health; competence; fieldwork

Military engagements have occurred throughout the history of the United States. Current military engagements within the Middle East have lasted beyond eleven years and have generally not neared a foreseeable endpoint. In a speech at the Landon Lecture series at Kansas State University, former Defense Secretary Donald H. Rumsfeld compared the war on terror to the long-duration Cold War, rather than that of the high-intensity conflict of World War II (Rumsfeld, 2006). Occupational Therapists (OTs) are regularly deployed in support of combat and logistic forces. Despite the continued drawdown of troops, Army Reserve OTs will continue to serve in the Middle East and elsewhere for the next decade and beyond (Lopez, 2010). Army Reserve OTs have an extensive role in providing skilled therapy services to soldiers with psychological injuries resulting from wartime deployments. This study seeks to identify Army Reservist OTs current behavioral health care competence to determine future training needs and directions in OT education and competence.

Psychological injury is classified as a Disease Non Battle Injury (DNBI) within the military (Belmont, et al., 2010). A study performed on a U.S. Army Brigade Combat Team (BCT) deployed in a counterinsurgency campaign in Iraq, found that over 25% of its Soldiers had

experienced a DNBI (Belmont, et al., 2010). Psychiatric disorders were the second most common cause of DNBI at over 23 percent (or slightly over 5% for the particular unit studied). The study also found that females had a significantly higher likelihood of being classified as DNBI than did men. The BCT identified a suicide rate of 1 per 2000 soldiers. Every case of diagnosed psychiatric disorders is managed within the behavioral healthcare environment where OTs are employed.

Army Reserve OT's can be found throughout the battlefield. When assigned to behavioral healthcare units, they are most often active in restorative clinics or on prevention teams. Restorative clinics provide inpatient and outpatient care. This care generally includes group programming for smoking cessation, anger management, stress management, and relationship and grief counseling. These are generally outpatient services, though can be offered as part of an inpatient stay. One-to-three-day inpatient stays are sometimes necessary to assist deployed soldiers in regaining routines such as hygiene and renewing occupational performance including soldiering skills and specific military competencies necessary to perform their job. This is particularly necessary when soldiers are no longer performing in their regular occupational capacity, for instance when infantrymen are no longer needed on the battlefield and are now assisting with laundry service or in the kitchen.

Occupational therapists may also be active on prevention teams, providing "house calls" throughout the wartime environment. Oftentimes, soldiers cannot physically make it to behavioral health services due to the operational environment, and small prevention teams travel to visit them in their deployed locations. These services more closely resemble one-on-one patient care, addressing specific dysfunctions in occupational performance, and allowing for triage, if necessary.

Army Reserve OTs are a particularly unique group of practitioners in that the vast majority deploy with Combat Stress Control (CSC) units for behavioral health practice. The profession of occupational therapy has experienced a loosening foothold in the behavioral healthcare field for several decades (Gutman, 2012). Ethridge (1976) was one of the first authors to address this decrease. The author noted that OTs would need to increase training, research, innovative programming, and management to account for the current disparity (Ethridge, 1976). Kleinman (1992) describes a continually decreasing number of OT's in behavioral health, possibly contributing to the many issues experienced by deployed OT reservists.

In 2007, the American Occupational Therapy Association's Commission on Education found that less than 5% of OT programs were providing education for Specialized Services for People with Severe and Persistent Mental Illness (SPMI) and that only 21.6% of OT programs required fieldwork rotations in behavioral health settings (Commission on Education, 2007). There has been no research to date specifically on Army Reserve OT's perception of their training in behavioral health care. Likewise, there has been no research performed on Active Duty Army OTs' perception of behavioral healthcare competence.

Objective measurement of clinical competence within the field of Occupational Therapy is rarely done within the United States. While many states and national organizations require

continuing education to maintain licensure or certification, there is not currently a tool being utilized to allow researchers to determine a clinician's clinical competence after graduation. One study performed in Canada focused on the combined knowledge, skills and professional behavior of the occupational therapist (Salvatori, Baptiste, Ward, 2000). This pilot study performed by Salvatori, et al. (2000) describes the development of a measure to test clinical competence through chart-simulated recall. The author's measure was based on the Canadian Guidelines for Client-Centered Practice. These guidelines include: (a) measures of use of theory, (b) assessment, (c) program planning, (d) intervention, (e) discharge planning, (f) follow-up, (g) program evaluation, (h) clinical reasoning, and (i) professional behavior. Authors concluded the measure to be reliable and valid for use within a clinical setting to measure performance competency. They additionally found it to be a promising method to incorporate into quality measurement and assurance (Salvatori, et al., 2000).

While behavioral health care competence has not been tested in practicing OTs, a similar competence has been measured in nurses in the Army. OTs and nurses are managed by a similar professional filler system that selects nurses for varied deployments. This system, known as the Army Personnel Management Command (APMC), is charged with administrative and deployment functions for the majority of healthcare providers within the Army Reserves. Rivers, Wartenberger, and Lindgren (2006) studied the perceived readiness of Army Nurses for wartime deployment. The authors specifically studied 131 Registered Nurses, Licensed Practical Nurses, and Certified Nursing Assistants from two regional areas. They found that significant differences in personal and psychological readiness existed between subjects and that a structured core competency tool was needed to provide occupation-focused training to ensure deployment readiness.

The treatment and diagnosis of clients with altered mental statuses is a difficult practice for any profession. Evidence exists that the field of OT is not the only profession facing difficulty in assessing competence. A study by Lee, Erickson, Short, and Roth (2008) reviewed the diagnostic characteristics of 61 new physician interns entering a teaching hospital in Texas. They found the new physicians were not prepared to evaluate patients with altered mental status evidenced by missed diagnoses of urinary tract infections, seizures, and sugar tests, all variables capable of impacting mental status. The interns additionally failed to perform neurological examinations on nearly 60% of their patients. Decreased competencies in behavioral healthcare likely go beyond traditional medicine and therapy services. The ability to measure behavioral health care competence through individual practitioner perception may reveal that if a problem exists with the military training structure for OTs as it does in the civilian environment.

Little research has been performed within the United States on OT's perception of their own behavioral health competence. A pilot study by Cottrell (1990) discusses perceived competence of civilian OTs working within behavioral health care. Cottrell's findings encourage basic, continuing, and post-professional education in behavioral health care to increase competence. Her findings also indicated that continued education may provide therapists with the knowledge and skills required to perceive themselves as competent within the behavioral healthcare field. The sample studied did not address entry-level practitioners or per-diem employees. This sample may also be less representative of the

Army Reserve occupational therapy population as they were employed entirely within behavioral healthcare units. The ease of integrating into an Army Reserve clinical environment can be varied due to the OT's civilian practice setting and specialty. Their only experience in behavioral health care may be during a deployment to a wartime environment.

A study performed in Queensland, Australia compared the self-perceived behavioral health competence of 55 OTs with that of other medical fields. Researchers found that OT's perceived competence was similar to other behavioral health practitioners within a community setting, but trended much lower for OTs working within a hospital setting (Greaves, et al., 2002). Since community-based settings provide a greater opportunity for OTs to use their behavioral health care skills daily, these results are not surprising. Results indicate that a greater length of experience in behavioral health was predictive of levels of reported competence (Greaves, King, Yellowlees, Spence, Lloyd, 2002). Results additionally suggest that OTs can adapt well to the demands of behavioral health care settings, though education through experience is required. As the majority of Army Reserve OTs, as well as OTs as a whole, are not employed in community-based healthcare settings, similar trends may be expected when relating to Army Reserve OTs.

The current and future tempo of Army Reservists' deployments necessitates the study of competence of OTs within the behavioral health care field. Ever-increasing DNBI's will require OTs with practicing behavioral healthcare skill sets both in the Army Reserves and beyond. This study seeks to identify Army Reservist OTs' current perceived behavioral healthcare competence in order to determine future training needs and directions in OT education and performance.

Method

Sample and Participants

This was a pilot study included a sample of convenience. Upon receipt of the letter of cooperation from the chief of Army Reserve Occupational Therapy, the focus group was identified. This group consisted of 23 Army Reserve OTs who met inclusion criteria for the study parameters. The inclusion criteria for this study required soldiers to have been US Army Reserve OTs during the entirety of their deployment to a wartime environment. They also must have been deployed performing behavioral health care operations and still be in the US Army Reserves or have been discharged honorably.

Exclusion criteria from this study were those who were not nationally certified to practice occupational therapy at deployment and/or who had served in a wartime environment as OTs in other settings or under alternate statuses than with the US Army Reserves. Additional exclusion criteria excluded any participants who had been discharged from the US Army or Army Reserves in other-than-honorable conditions or a failure to complete the questionnaire in its entirety. The research study included all soldiers who met the inclusion criteria and who were willing and able to participate in the study.

Design and Procedure

The design of the study was a focus group with phenomenological qualitative and also quantitative data collection. The qualitative data enabled the researcher to recognize themes and suggest new areas of future research if consistencies were found in self-report. The quantitative data allowed for frequencies and valid percentages of results for comparison and correlation across variables. Mixed method designs are complementary to pilot studies as they allow for the examination of theoretical framework, recruitment methods, study procedures, and instrument validation to enhance outcomes in future studies (Secomb, J. M., & Smith, C., 2011).

The Chief of Army Reserve OT identified 23 US Army Reserve OTs who met the inclusion criteria and provided their military email addresses. Emails were sent including a link for a SurveyMonkey questionnaire (Appendix A). Participants were given 6 weeks to respond to the questionnaire. Emails mirroring the original email were sent as reminders at 4 and 6 weeks, totaling 3 emails to each participant. Data were processed at The University of Indianapolis School of Occupational Therapy.

The questionnaire was designed in relation to the process of occupational therapy, as it was outlined in the 2nd Edition of the Occupational Therapy Practice Framework (AOTA, 2008). Initial questions were focused on evaluation, intervention, and outcome monitoring of the behavioral health patient. Later questions surveyed frequency of answers related to the process of occupational therapy with select clients, as well as the location of resources, or potential resources participants might find helpful for future practice in behavioral health care. Primary competence questions strictly involved occupational process language; qualitative items were added to ensure potential dimensions were considered along with quantitative data.

Data Analysis

The researcher met with a statistician to perform quantitative and thematic data analysis, allowing for the identification of similarities within data. Data were processed through SPSS Version 18 quantitative software. Descriptive statistics for the current study were generated through frequency reports. The study included all soldiers who met the inclusion criteria and who were willing to participate.

Results

A total of fourteen participants (61%) of the population submitted data. Two respondents were eliminated because no data were entered after the first question (acknowledgement), lowering the actual response rate to 52.1% (twelve participants). Demographic collection revealed that 58.3% were males, and 41.7% females. None of the participants were currently employed in behavioral health care settings in their civilian roles. All participants have been practicing OTs for over 11 years as is illustrated in Table 1. Participants report that 50% hold entry-level master's degrees and 58.4% have pursued post-secondary degrees beyond entry-level.

Results indicated that a minority of participants (41.7%) had questions regarding OT assessment and evaluation. Remaining participants reported never questioning these variables (Table 2). Over 41% ($n = 5$) of participants had questions about treatment planning while deployed.

The majority of participants (58.4%) reported questioning their treatment progress with patients once a month, or more, during their deployment (Table 3). Participants additionally reported being unsure of how to treat a patient's medical or rehabilitation diagnosis during deployment. Review of qualitative remarks revealed questions regarding which standardized assessments would work best with the Army's documentation software, as well as a generalized need for more standardized assessments while deployed.

The majority of participants (66.7%) reported having questions regarding delivery of services that went unanswered during deployment (Figure 1). Participants described "role confusion" as a significant obstacle in provision of care. "I did not feel like OT was a primary part of my job: I was a counselor, just like the social worker and just like the 68X (behavioral health technician)", wrote one participant. Others described a lack of resources currently available within the Army specific to OTs working in behavioral health environments.

All but one participant reported feeling competent to work with patients in a behavioral health setting during deployment. Participants who reported feeling competent reported a reliance on a variety of resources to maintain competency (Figure 2). Through the qualitative reporting option, participants revealed that taking specific courses in behavioral health prior to deployment, as well as networking with their peers aided in their ability to remain competent. When asked to identify resources that could better prepare them for deployment, participants listed: (a) continuing education unit(CEU) opportunities in behavioral health, (b) general Content in behavioral health, (c) PowerPoint education in behavioral health, (c) fieldwork level II placement, and (d) information from entry-level education.

Discussion

Implications for entry-level education

With over 72% of respondents relying on their fieldwork experience for behavioral health competency, and only 21.6% of OT programs requiring fieldwork placement in this area (Commission on Education, 2007), a need for increased behavioral health fieldwork requirements is evident. The 63.6% of Army Reserve OTs relying on their entry-level education is certainly problematic, as 100% of these participants had been away from their entry-level education for 11 years or more. This has been partially addressed in the revised standards by the Accreditation Council for Occupational Therapy Education (ACOTE), to be effective in 2013, requiring academic programs to include the implementation of psychological dimensions into a fieldwork experience (ACOTE, 2012). Additional questions from participants regarding medical and rehabilitation diagnoses signal a renewed need for entry level focus on behavioral health conditions in core curricula.

Participants additionally questioned the implementation and use of standardized assessments for behavioral health care practice. While standardized assessments are mandated by ACOTE in the current B 4.0 standards, instructions in assessments specifically intended for behavioral health are not required (ACOTE, 2012). While generally holistic approaches are identified, the introduction valid and reliable of assessments specifically for behavioral health environments is probably warranted.

Implications for the Army Reserves

While mental health is explicitly described and required within current ACOTE standards for program curricula, it may also be possible that OTs working exclusively within rehabilitative and medical models may find difficulty transferring to psychosocial models of practice. Although 33.3% ($n = 4$) participants reported questions regarding the OT intervention process, over 66% questioned their treatment progress with a patient during deployment. This may be caused by, as Kleinman (1992) suggested, a continued reliance on the medical model for treatment in behavioral health.

Dallas (2011) described psychosocial rehabilitation as the model most commonly used by practitioners within a behavioral health care setting, suggesting a possible difficulty for practitioners who are not traditionally working in this environment. As no participants reported working as civilians within a behavioral healthcare environment, social and psychosocial models of care may be more difficult to adapt to for deployments when the medical model is being used within their chosen profession stateside. As instruction in these models is being taught in accredited institutions, additional material may be needed by the Army Reserve to aid in the transition of therapists to work within a behavioral health care environment.

Perceived competencies in behavioral health care were similar to Cottrell (1990), with over 90% of participants reporting competence to work in a behavioral healthcare setting during deployment. This is probably related to the inclusion criteria of this study, requiring participants to have been deployed within a behavioral health care environment. Cottrell's evaluation, intervention, and treatment findings differ significantly from that of the Army Reserve OTs, though this is probably a result of Cottrell's participants ordinarily working within behavioral health care environments. Results indicate that as Army Reservist OTs are not working within behavioral health environments in civilian capacities, and therefore additional training and reference materials must be created and used to offset the practice and model differences.

While this study exclusively measured behavioral health care competence while deployed, clinical competence should be an area of future emphasis. In order for this to occur, the authors believe that there would need to be a standardized valid tool to measure competence, to include behavioral health care competence. The creation and validation of a reliable and responsive tool to measure behavioral health competence could extend beyond the profession in addition to serving as a benchmark for practice standards within OT. This may be possible through the use of a generic Chart Simulated Recall (CSR) Measure, as was suggested, and found to be valid and reliable by Salvatori, et al. (2000). The performance of chart audits and clinician interviews through standardized measurements can allow for

internal checks and balances within the behavioral healthcare environment to ensure competence and mediate unanswered practice questions.

On-the-job training and learning is indicative of the perceived competence displayed by study participants. All participants had deployed in behavioral healthcare capacities and may be expected to report higher levels of competence due to their experiences. It would be valuable to perform a pre-and post-deployment inventory for Army Reserve OTs, measuring behavioral health competence prior to deployment, and then again upon returning home. Greaves, et al. (2002) suggest that a greater length of experience in behavioral health was predictive of levels of reported competence, which may have been the case in this dataset, resulting in higher levels of perceived competency than hypothesized.

This study did not seek to measure the perceived behavioral health competence of all US Army Reserve OTs, but only those who have deployed in support of behavioral health care operations and had volunteered to take part in the study. The continued need for competent OTs in behavioral health is evident. A study by the Rand Center for Military Health Policy Research (2008) reveals that over 1.6 million Soldiers have deployed for Operations Enduring Freedom and Iraqi Freedom since 2001. Of the deployed Soldiers, approximately 18.5%, 300,000, have reported psychological injury (RAND, 2008). Behavioral health resources will continue to be needed both stateside and abroad. Future studies should additionally concentrate on the Active Duty Army OT force. Each therapist has the potential to deploy within a behavioral health care environment and should feel competent to perform their duties effectively.

Of the participants, 81.8% ($n = 9$) listed Continuing Education Units (CEU)'s as an educational resource to better prepare them for deployment into a wartime environment. CEU's are especially relevant for a cohort that is long removed from entry-level education. As findings revealed the reliance on entry-level and fieldwork education for competence, results suggest that additional media are needed to provide current methodology for practice. CEU's may be provided by the Army Reserve OT Department via existing learning portals at a minimal cost as the training structure is already in place and a number of training providers are available for such material.

Results suggest that that CEU's should be designed with focus on the evaluation and treatment planning process, and recording of treatment progress. Generalized confusion regarding diagnoses in behavioral healthcare suggests that CEU's can additionally be employed for this instruction or relearning if needed. Additional training emphasis should be on the identification of the role of occupational therapists within behavioral health care. This may be implemented through the initial Army OT training performed, prior to deployment, or through the construction of an Army Field Manual.

Limitations

This was a pilot strictly designed to determine current behavioral health competence levels of Army Reserve OTs. This study employed a convenience sample, and specifically a cohort who had been employed in a behavioral health environment while deployed. These factors limit the analysis and external validity of the results as they are not sufficient to describe the

entirety of the Army Reserve OT population and its current behavioral health competence. This study was designed to provide the Chief of Army Reserve Occupational Therapy with a snapshot of the current competence of deploying reservists, allowing for material changes in support if warranted, and suggestions for future study.

A Likert Scale may have been useful to determine participants level of competence. This questionnaire asked only if Army Reserve OTs felt competent on a “yes” or “no” basis, rather than allowing for levels of competence to be measured and compared. Although fewer points on a scale allow for distinctive distribution, this also limits the variability that can be measured related to competence. Additional limitations regarding cultural and military expectations for competence and performance may have prompted participants to answer as they did. Questions were additionally designed uniformly, with the answer “Never” being on the top, potentially invoking a test-taking bias of responding to the first choice by preference, habit or consistency.

An authorial bias was present, in that the author had been active within a unit providing behavioral health care for over 10 years, both stateside and overseas. The author had previously experienced many first-hand questions from Army Reserve OTs regarding their roles within behavioral health care.

Conclusion

The behavioral health care competence of Army Reserve OTs was measured to determine future training needs and directions in OT education and competence measurement, as well as to give the Chief of Army Reserve OT a snapshot of current competencies within the force. While Army Reserve OTs were found to have a high degree of perceived competence within a behavioral health care setting (91.7%), ($n = 11$), significant questions regarding diagnosis, assessment, evaluation, treatment planning, intervention, and progress were revealed, thereby raising question about the high perceived competence levels initially reported. This study signals the need for more education in behavioral health care prior to deployment for Army Reserve OTs. The identification of educational needs is significant and highlights the importance of entry-level education, fieldwork experience, and post-professional education. Results suggest directions for future research as well as needed introduction of creative educational media to include CEU opportunities, PowerPoint presentations, and general content within behavioral health care. High levels of perceived competence, while helpful, are not sufficient to ensure that America’s military are receiving the highest quality of behavioral health care available and suggest that competency measures may be vital to ensure quality care.

Supplementary Material

Refer to Web version on PubMed Central for supplementary material.

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FIGURE 1.
Percentage of Unanswered Questions During Deployment

FIGURE 2.

Resources Aiding in Ability to Maintain Competency

TABLE 1

Years Practiced as a Licensed/Registered OT

11–15 Years	25% ($n = 3$)
16–20 Years	58.30% ($n = 7$)
21+ Years	16.70% ($n = 2$)

TABLE 2

Questions Regarding OT Assessment & Evaluation

Never	58.3% ($n = 7$)
Once a Month	25.0% ($n = 3$)
Several Times a Month	16.7% ($n = 2$)

TABLE 3

Questions Regarding Treatment Progress with Patient

Never	41.7% ($n = 5$)
Once a Month	41.7% ($n = 5$)
Several Times a Month	16.7% ($n = 2$)