VA

U.S. Department of Veterans Affairs

Veterans Health Administration

Community Clergy Training Program

Train WKH)DFLOLWDWRU 2YHUYLHZ

"Recognizing the Challenges of Reintegration and Building a Pathway to Care and Resources"

RURAL CLERGY TRAINING PROGRAM
TRAIN-THE-TRAINER INITIATIVE OVERVIEW

Program Vision

Members of the clergy with a heart for the care of Veterans and active duty service members in their rural community call together friends, colleagues and others to learn more about warriors' needs and ways to serve and support them. Those who are called come together to engage in group learning activities. They view web-based training videos and participate in facilitator-led discussions about the information in the video presentations. They explore the unique challenges and opportunities in their rural setting. Through the time spent together and sharing of perspectives and experiences, bonds of common passion and purpose are formed and a network to care for warriors is created. The shared mission serves as a new foundation for community ministry and partnerships among community Veteran resources are forged. Rural Clergy Training Program training participants influence change in their rural community resulting in improved access to VA and community services; a reduction of mental health issues, relationship problems, and difficulties for the children of military families; lower levels of substance abuse and homelessness; and improved physical health and well-being. Rural clergy are energized and empowered to bring healing of the wounds caused by military service to Veterans and families in their congregation and in their community.

55 percent of Iraq and Afghanistan Veterans said they feel disconnected from civilian life.

Need for the Program

From October 2001 through July 2015, more than 2.2 million troops have served in battle with more than 6,800 fatalities and 52,000 service members wounded in action in Operation Iraqi Freedom (OIF), Operation Enduring Freedom (OEF), and Operation New Dawn (OND) (Fischer, 2015). Post-traumatic stress disorder (PTSD), traumatic brain injury (TBI), and depression are frequent diagnoses among Veterans of the wars in Iraq and Afghanistan. Better body armor and emergency care and transport have substantially increased combat survival rates, but many survivors, however, are struggling with amputations or

25 percent of today's combat Veterans develop PTSD or stress response.

TBI from blast exposure. Though prevalence rates vary depending on specific study population, measurement and methodology, it is clear that between 7 percent (Smith et al., 2008) and 25 percent (Milliken, Auchterlonie, & Hoge, 2007) of today's combat Veterans develop PTSD or stress response, and many others develop depression (Wells et al., 2010) or substance use disorders (Jacobson et al., 2008). PTSD and TBI share many symptoms and can be difficult to differentiate, and individuals can have both conditions, complicating diagnosis and treatment. It is not uncommon for PTSD and/or TBI to go undiagnosed, so the connection between a change in behavior and an underlying medical condition is missed.

Many Veterans seek services provided by clergy as they are "an attractive solution to many of the barriers to rural mental health, such as the lack of accessibility, availability, and anonymity associated with services in rural areas.

Veterans from all eras continue to struggle with issues related to their combat experience and reintegration to civilian life following military service. The majority of current combat troops belong to the National Guard and Reserves and many of them live in rural settings. When their deployment ends, they typically return quickly to their home communities to reintegrate into civilian life. Emerging symptoms of PTSD, TBI, and depression often go unrecognized or may be slow to develop (Milliken et al., 2007) and are not addressed until problems become critical. Members of the Guard or Reserves, especially those who anticipate additional combat deployments, worry that a diagnosis or even a rumor of mental health care treatment will negatively affect their opportunities for military promotion. Mental health stigma may cause Veterans and active duty service members to delay seeking help until crisis makes it inevitable.

Rural Veterans in particular have limited health care options, especially for mental health care. Many returning Veterans living in rural areas have limited knowledge about VA facilities, and are likely to search for assistance first among people they know. According to a Hall and Gjesfjeld (2013) study, many Veterans seek services provided by clergy as they are "an attractive solution to many of the barriers to rural mental health, such as the lack of accessibility, availability, and anonymity associated with services in rural areas." Up to one-fourth of individuals who seek help for a mental health problem do so from

"Thank you for providing this training to rural clergy who, many times, don't have the training or resources that you provide."

clergy. This is significantly higher than those seeking help from psychiatrists (16.7 percent) or primary care doctors (16.7 percent) (Wang, Berglund, & Kessler, 2003). Most rural communities in America have clergy-led faith-group specific organizations (usually in the form of "houses of worship"). Clerics are recognized community leaders and can have a wide influence on public opinion and behavior. Since rural Veterans benefit from supportive communities to assist them with reintegration into civilian life, matching rural Veteran needs with faith-group resources (including clergy) seems like "a match made in heaven." However, many members of the clergy have a limited understanding of the essential issues common to returning warriors and lack the necessary skills to deliver therapy for mental health related issues (Hall & Gjesfjeld, 2013). With greater understanding, faith communities might better use their resources to support Veterans and family members who otherwise may feel isolated, alienated and helpless. Educating rural clergy and faith communities might also reduce the stigma of mental health needs that further complicate the problems.

Clergy organizations, rural faith-based congregations, National Guard and Reserve chaplains, Veteran Service Organization chaplains, and other organizational chaplains have all expressed a strong interest in learning how to increase effectiveness in meeting the needs of Veterans. Additionally, these organizations can ally to work together to increase community-based Veteran services. Providing essential, accurate training for these groups and collaborating with community partners is the intent of this project.

Furthermore, clergy who are educated about posttraumatic stress disorder (PTSD), traumatic brain injury (TBI) and depression can serve as useful resources to guide Veterans in gaining appropriate mental health care in the VA or through other community resources.

A Brief History of the Rural Clergy Training Program (RCTP)

The Rural Clergy Training Program (RCTP) was initiated in 2010 by the National VA Chaplain Center with support from the VA Office of Rural Health. Program work in Fiscal Years (FYs) 2012, 2013 and 2014 developed, implemented, evaluated and refined a training program curriculum designed to teach rural clergy about the readjustment needs of returning Veterans and their families. During these years, several innovations added to the effectiveness of the program.

Recruitment

- Mailing lists were purchased or developed through Internet research to identify community clergy and representatives of Veteran Service Organizations.
- Announcements of training were sent in two steps, "Save-the-Date" postcards were mailed and followed approximately two weeks later by a more formal invitation letter.

Training

- The curriculum was fine-tuned to increase effectiveness.
- A simplified referral mechanism was introduced.

Evaluation

- An evaluation system was introduced that included pre- and post-workshop evaluation and 12-month follow-up measures.
- Outcome evaluation was initiated.
- Statistical procedures were introduced that allowed for significance testing.

Extended Learning

- *The Clergy Connection*, a quarterly topical newsletter, was introduced to extend learning.
- Topical webinars were initiated to extend learning beyond that of the core curriculum.

- The core curriculum was restructured into four one-hour modules and the live training broadcast was recorded for on demand viewing through the VA eHealth University (VeHU) publically available "MyVeHU Campus" (in preparation for transfer of activities from live presentations to facilitated "viewing events" in FY2015).

Critical Relationships

- Relationships with national and regional partners were established.
- Multiple types of partners were tested and evaluated (e.g., National Guard, Army Reserve, denominational groups, professional associations) to determine the effectiveness of each organization type.
- Close collaboration and cooperation with the "VA/Clergy Partnership for Rural Veterans" (another VA Office of Rural Health supported program) was initiated.
- Critical documents were developed to help partners understand the nature of the RCTP, its operations and RCTP and partner roles in the set up and delivery of training events.

The RCTP live training curriculum was modified to become a series of "viewing events" for groups in rural communities, providing the opportunity to reach a larger audience in more locations.

The one-day live training events (conducted in FY2012-FY2014) enhanced the knowledge and skills of rural clergy in recognizing the holistic healthcare needs of returning Veterans and taught clergy to guide eligible Veterans of all eras to VA Medical Centers, VA Outpatient Clinics or other alternatives for care. The intent of these efforts was to increase rural Veterans' access to and utilization of needed VA or alternative care, to smooth their reintegration into family and community, to enhance community understanding of rural Veterans readjustment needs, and to increase Veterans sense of belonging to a supportive community.

In FY2015, live training ceased and a new direction for training was established. For this innovation the RCTP live training curriculum was modified to become a series of facilitated MyVeHU "viewing events" for groups in rural communities, providing the opportunity to reach a larger audience in more locations. During each viewing event, recorded content was paused and discussion questions introduced by an in-session leader who facilitated group discussions. The RCTP has found this activity very valuable in extending learning, in helping training

participants to "own" training material and to serve as a foundation for future joint efforts in rural settings.

Four one-hour modules comprise the MyVeHU series **"***Rural Chaplains and Clergy Caring for Veterans: Paving the Way Home after the Wounds of War"* and are available for viewing online:

- **Military Culture and the Wounds of War,**
- **Pastoral Care for Veterans and Their Families,**
- **Mental Health Services and Referrals, and**
- **Building Community Partnerships.**

The "viewing event" implementation strategy was created and tested in collaboration with RCTP's national partners. In preparation for FY2016, increasing degrees of control over local events was handed to the community representatives of RCTP's partners. Recruitment decisions were placed in the hands of community clergy, supported by RCTP staff.

Measuring Program Effectiveness

RCTP resource materials from the workshop were used in the year following training by 83 percent of one-year evaluation respondents.

To measure the effectiveness of RCTP events, end-of-day evaluations are conducted to obtain feedback from training participants. A one-year follow-up evaluation of live training (FY2013) compared the reports of training participants in the year prior to training to the same measures for the year following training. Results indicated the following statistically significant differences.

- there was a large increase in referrals to the VA,
- there was a very large increase in referrals to community mental health, and
- there was a large increase in clergy participation in community ministries for Veterans.

Additionally, 83 percent of evaluation respondents reported they used RCTP resource materials from the workshop in the year following training, and

67 percent of participants reported they had actively worked to reduce stigma related to military personnel and mental health in their community.

These results strongly suggest that RCTP workshops change community behavior in a way that promotes the welfare of Veteran, Guard and Reserve warriors.

In FY2015, evaluations compared live training to training via facilitated viewing events. While most training participant responses for live training were superior to those of viewing events, differences were surprisingly small. Table I compares ratings for live and recorded training (5-point scale:
1 = ineffective training and 5 = effective training).

Table I. RCTP Live Training vs. Facilitated Viewing Event

	Live Training (FY2014)	**Viewing Event (FY2015)**
Achievement of training goals	4.65	4.54
Knowledge of trainers	4.78	4.65
Understanding of Veteran needs	4.73	4.65
Understanding problems of re-integration	4.63	4.65
Improvement in pastoral care abilities	4.59	4.57

All scores from both types of training were in the highly effective range, indicating a very positive evaluation of training by those trained through both live and viewing events.

The RCTP Promising Practice

In FY2015, the VA Office of Rural Health designated the RCTP Train-the-Trainer approach as a "Promising Practice." Program efforts and lessons learned in past years served as the foundation for this new and expanded approach to

expanding community infrastructure to train denominational, faith-based and other community leaders to utilize existing curriculum. Ultimately, this Promising Practice will transition the delivery of training events to our community partners and increase the reach of the RCTP across the country.

The vision of the VA Office of Rural Health is that Veterans thrive in rural communities; and the mission is to improve access to care for Veterans living in rural and highly rural areas. The three primary objectives and aims of the RCTP Promising Practice align with and support the ORH vision and mission by:

1. Transitioning the RCTP into the hands of national partners who share our vision and mission, and who have demonstrated a commitment to share the RCTP curriculum and the specialized knowledge it provides to better serve and support rural Veterans and their families.
2. Supplementing the RCTP core curriculum with additional educational opportunities designed to expand knowledge and mutual exploration that supports the development of clergy peer groups.
3. Recruiting additional national partners to participate in the RCTP Train-the-Trainer initiative so more educators can deliver the training to rural community clergy and others to further improve access to care for rural Veterans.

References

Fischer, H. (2015). *A Guide to U.S. Military Casualty Statistics: Operation Freedom's Sentinel, Operation Inherent Resolve, Operation New Dawn, Operation Iraqi Freedom, and Operation Enduring Freedom* (RS22452). Retrieved from https://www.fas.org/sgp/crs/natsec/RS22452.pdf

Hall, S. A., & Gjesfjeld, C. D. (2013). Clergy: A partner in rural mental health? *Journal of Rural Mental Health, 37*(1), 50-57. doi:10.1037/rmh0000006

Jacobson, I. G., Ryan, M. K., Hooper, T. I., Smith, T. C., Amoroso, P. J., Boyko, E. J., . . . Bell, N. S. (2008). ALcohol use and alcohol-related problems before and after military combat deployment. *JAMA, 300*(6), 663-675. doi:10.1001/jama.300.6.663

Milliken, C. S., Auchterlonie, J. L., & Hoge, C. W. (2007). Longitudinal assessment of mental health problems among active and reserve component soldiers returning from the Iraq war. *JAMA, 298*(18), 2141-2148. doi:10.1001/jama.298.18.2141

Smith, T. C., Ryan, M. A. K., Wingard, D. L., Slymen, D. J., Sallis, J. F., & Kritz-Silverstein, D. (2008). New onset and persistent symptoms of posttraumatic stress disorder self-reported after deployment and combat exposures: Prospective population-based US military cohort study. *British Medical Journal, 336*(7640), 366-371. Retrieved from http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2244768/

Wang, P. S., Berglund, P. A., & Kessler, R. C. (2003). Patterns and Correlates of Contacting Clergy for Mental Disorders in the United States. *Health Services Research, 38*(2), 647-673. doi:10.1111/1475-6773.00138

Wells, T. S., LeardMann, C. A., Fortuna, S. O., Smith, B., Smith, T. C., Ryan, M. A. K., . . . for the Millennium Cohort Study, T. (2010). A Prospective Study of Depression Following Combat Deployment in Support of the Wars in Iraq and Afghanistan. *American Journal of Public Health, 100*(1), 90-99. doi:10.2105/AJPH.2008.155432