Implementation Principles for Mental Health Training

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ABSTRACT

The goal of the NATO Human Factors & Medicine (HFM) Research & Technology Task Group (RTG-203) "Mental Health Training" is to develop prototypes of mental health and resilience training for service members. Mental health and resilience training has the potential to strengthen the ability of service members to respond to the psychological demands of military life. Beside the content also the implementation strategy is to be considered to meet the goals of such training. Because military demands are so diverse, mental health and resilience training should be integrated with and focused on the service member's military career phase and point in the deployment cycle. One of the objectives of RTG 203 is to identify the principles of implementation of such mental health and resilience training.

This presentation will give a description of key implementation principles regarding mental health training in a military context.

In the presentation I will also report on implementation experiences and best practices with current mental health training programs within different nations.

1.0 INTRODUCTION

Serving in the military is mentally challenging. Military life, training, deployments and combat places tremendous demands on the mental health of service members. Military organisations are challenged with establishing conditions to ameliorate the negative impact of these demands on service members as well as enhance the adaptation and performance of service members.

Mental health resilience training has the potential to teach and/or increase skills and self-confidence to ensure service members can handle stress, grow and thrive in the face of challenges in the military and bounce back from adversity.

Mental health resilience training should systematically prepare service members for the mental challenges they will confront throughout their military careers. The objective of mental health resilience training is to enable service members to identify the realities of challenging environments, to develop skills to thrive and be resilient in the face of these realities, and to know how to use these skills to help themselves, fellow service members, and those they lead.

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14. ABSTRACT
The goal of the NATO Human Factors & Medicine (HFM) Research & Technology Task Group (RTG-203) Mental Health Training is to develop prototypes of mental health and resilience training for service members. Mental health and resilience training has the potential to strengthen the ability of service members to respond to the psychological demands of military life. Ideally, these kinds of mental health and resilience training should begin during basic training and be followed across the individuals military career. To-date, there has not been an international review of resilience training during basic training nor an assessment of what service members perceive as useful from their perspective. In response to this knowledge gap, RTG-203 has initiated a survey and interview with approximately ten new recruits from each participating nation to inform the development of such training. Panel members are responsible for conducting data collection in their own nation. The presentation reports on the initial results of this international study from four participating nations. The survey and interview target perceptions of training demands, approaches to coping, case studies to demonstrate coping strategies, and the perceived need for mental health training. Results will summarize these findings and demonstrate how such research can be used to inform a NATO prototype of training materials. Limitations of the research methods and the development of internationally-relevant lessons learned will be discussed. This presentation is intended for the Psychological Resiliency and Mental Health Training tracks.

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When mental health training content is being developed and validated, how the training will be implemented should be considered. While distinct, the training content and the implementation strategy dramatically influence each other.

One of the objectives of the NATO HFM-203/RTG 'Mental Health Training' is identifying considerations for training implementation. In this paper we discuss the fundamental principles of mental health training and implementation.

The paper is based on a (none published) paper 'Military Mental Health Training: Building Resilience' by Castro and Adler (Castro, C. A., & Adler, A. B., 2009) which was discussed within the RTG.

2.0 FUNDAMENTAL PRINCIPLES OF MENTAL HEALTH TRAINING AND IMPLEMENTATION

All good training, regardless of the topic or domain, rest on several fundamental principles (*see Table 1 for an overview*). This is not different for an effective mental health training program in the military. Explicitly stating these principles can guide the development of new modules, thus contributing to the coherency of an integrated training system. Furthermore, without these specific principles, one or more of them may be more likely to be overlooked or violated in the attempt to develop mental health training.

In the following sections, each of these principles is discussed.

Fundamental Principles of Mental Health Training and Implementation	
Mental Health Training	**Implementation**
Relevant Purpose and Content	Appropriately Timed
Experience-based	Quality Control
Explanatory	Train-the-Trainer Program
Team-based	Exportable and Scalable
Action Focused	Training Guidelines
Developmental	Refresher Training
Comprehensive, Integrated	Mobile Training Teams
User Acceptability	Sustainable
Evidence-based and Validated	Program Improvement
	Policy
	Leader Supported
	Verifiable Claims
	Packaging and Multi-media
	Ownership

Table 1: Fundamental Principles of Mental Health Training and Implementation (Castro, C. A., & Adler, A. B., 2009)

2.1 FUNDAMENTAL PRINCIPLES OF MENTAL HEALTH TRAINING

2.1.1 Strength-Based

Effective mental health training should build on skills and strengths that soldiers already possess. A strength-based approach explicitly rejects a deficit or medical model. Practically, being strength-based means providing a positive approach that sets the expectation of success for the individual, and does not reinforce stereotypes that individuals are weak or will become sick as a result of some stressful experience like deployment.

The strength-based approach also explicitly builds on existing skills and abilities. New skills tap into these existing skills. For example, mental health training can emphasize the importance of building relationships back home. The individuals are reminded that they already have the skills to build relationships as evidenced by the strong bonds they have formed with their buddies. Existing strengths and skills provide a scaffold by which new skills and information can contribute to the resilience of an individual. In addition, since a medical model is rejected, mental health training does not need to include a list of mental health symptoms or include a discussion of mental health diagnosis, as is found in many military mental health training programs.

There is a fine line, however, between avoiding a medical model in which symptoms are prescribed or at least elucidated and providing individuals enough information about typical reactions so that they know what's normal and what might be a sign that professional help is warranted. This balance must be maintained throughout the training and continually re-examined. One way to maintain this balance is to obtain feedback from participants about their perception of the training message and to ensure that the training addresses how existing strengths and new skills can be applied and that there is sufficient time to practice those skills before they are needed.

2.1.2   Relevant Purpose and Content

All training should have a clear purpose or objective, and all the training content should support that purpose. Consistent with this principle, the content for mental health training should be based on documented needs. Rather than making assumptions about what soldiers experience, or what they need to know, the training must evolve out of an on-going systematic needs assessment. Feedback from this research is important for the (continuous) development of the content of each training module. By using this kind of rigorous approach, the training can avoid being the product of a trainer's idiosyncratic experience, which can lead to a training program of limited value.

Relevance refers not only to content but to the timing of the training so that the training matches the needs of the group at that time.

2.1.3   Experience-Based

Good mental health training should also include scenarios and situational training that reinforces the information and skills being trained (Thompson & McCreary, 2006). For every skill or educational point addressed in the training, there should be a real-world example that can be used to reinforce that point. Examples should be used that the soldiers and/or families can relate to and that use the language of the military. These examples should be based on experiences of soldiers, not on the experiences of the trainer. When trainers are mental health professionals, their personal examples may undermine their credibility. The trainers may appear misguided if they appear to think that their experience of deployment or stress mirrors the experience of a junior soldier on patrol, an NCO in logistics, or an officer in command of a combat arms unit. To overcome this problem the mental health trainer needs to have detailed speaker notes that contain numerous real-world examples from experienced soldiers.

2.1.4   Explanatory

Good mental health training is explanatory; it highlights conflicted or misunderstood reactions that service members might experience. For instance, while soldiers are happy to be home from a long combat deployment, they also often report being angry and on edge. The training normalizes this dual experience and explains that while many soldiers report being happy to see their family and friends, they are often angry about being deployed for a year or angry about how they were treated during the deployment. Providing soldiers with the words to understand this mixed reaction can help them to understand and

normalize it. The development of explanations for such complex and conflicted reactions requires professional expertise in behavioral health.

2.1.5   Team-Based

The military organization is fundamentally based on teams, on leadership, and on unit cohesion. Any mental health training with the military needs to integrate these fundamental components of the organization. Military mental health training should take advantage of the natural camaraderie and hierarchy that exists within all military cultures. Unit cohesion and buddy support are core elements of all military training. Mental health training should teach participants how to look after other unit members and use this buddy-focus as a way to increase self-awareness as well. Specific training modules for leadership can highlight the role of leaders and the leaders' responsibilities for ensuring that their subordinates get the mental health care they need. By providing the training in a unit context, unit members will comment to one another and point out particular reactions that relate to a unit member, interacting in a way that enhances the relevance of the material.

2.1.6   Action Focused

Mental health training should be more than a theoretical description of stress responses. The training should address specific actions individuals can take. In keeping with the team-based approach mentioned above, these actions include behaviors that soldiers can take to help themselves, buddies, and those they lead.

One of the key components to teaching action-based strategies is the need for flexible and adaptive coping in response to a myriad of potential stressors. The training needs to specifically advance the idea that there are different types of stressors and which coping mechanism is best depends on how much direct control the individual has over the stressor. For many military personnel, significant stressors are outside of their direct control and so they need to practice action-based strategies that are not "action" in the sense of getting rid of the stressor. The action may involve a change in cognitive coping, a reduction in physiological arousal, seeking social support, or acceptance. Redefining action as incorporating each of these kinds of skills, and emphasizing the need to match the appropriate coping response to the situation, is a key part of an integrated mental health training system.

2.1.7   Developmental

Effective training builds on prior training or upon existing strengths and skills and progressively adds new concepts and skills. Ideally, we believe that a mental health training system should strive to develop skills of increasing complexity, beginning with simple concepts. For example, the training can introduce a simple approach to cognitive restructuring in managing the stressors of basic combat training while waiting until later in the career of a soldier to teach how cognitive restructuring can be used to manage a high-stress environment like a combat deployment. Another example of the developmental approach is to introduce the concepts of posttraumatic stress disorder (PTSD) without detailing the complexities of the diagnostic criteria. The initial training could include an overall appreciation for how PTSD-related reactions can interfere with getting along with friends, family and at work without discussing the disorder itself. This approach avoids the temptation of presenting PTSD criteria in an oversimplified manner which might inadvertently lead soldiers to think that they have PTSD if they have only a few PTSD symptoms. In subsequent courses for certain personnel such as leaders or medics, more information could be presented about symptoms, symptom clusters, and time course. Such information underscore the need for content to be informed by experts in mental health, as will be discussed under implementation principles.

2.1.8   Comprehensive, Integrated

Mental health training needs to be more than a one-session event. Mental health training should not be one-off training that occurs only once a year or only when the service member gets ready to deploy or only when the service member returns from deployment. Mental health training should be integrated with and focused on the service member's military career phase and point in the deployment cycle.

By conceptualizing mental health training as an integrated system, the lesson plans can build on one another and can reinforce the points of each training module. It needs to provide the target population with an integrated and comprehensive system that builds skills, reinforces concepts, and targets areas of relevance to the group at the right time.

In a wider perspective mental health training should be part of an overall comprehensive and integrated paradigm for maintaining health, well-being, readiness and performance.

2.1.9   User Acceptability

Mental health training must be perceived to be useful by those being trained in order for the training to become accepted into the organizational culture. Even if the training is efficacious, if the training is not face valid, the audience does not accept it, and the trainers do not support it, then the training quality is likely to deteriorate or drift and resentment may preclude the training from helpful. However, while user acceptability is necessary, it is not sufficient for establishing good mental health training (Iversen et al., 2008; McKibben et al., 2009; Sharpley et al., 2007). In order to demonstrate that mental health training improves mental fitness, randomized controlled studies must be conducted.

2.1.10   Evidence-based and validated

What does it mean to say "evidence-based"? As mentioned previously, the material in the training needs to be based on research evidence. In addition, the training itself needs to be validated. This validation extends beyond satisfaction ratings or demonstration of changes from pre- to post-training. The standard needed for demonstrating mental health training efficacy is a randomized controlled trial. This approach can be difficult, time-consuming, and complex statistically but the end result is evidence assessing the training's effectiveness. Exactly what these studies assess as markers of effectiveness depends on the goal of the training.

There are many possible markers of a successful mental health training program. Typically, in order to assess a program's effectiveness, the outcomes should match the intent of the program. For our purposes, military mental health training outcomes should include measures of (1) attitude, (2) skill attainment, (3) mental health fitness, (4) training satisfaction, (5) unit climate and leadership.

First, in terms of attitudes, mental health training should target stigma associated with seeking mental health care. Seeking care should be regarded as a sign of strength and readiness, not as a sign of weakness. Second, in terms of skill sets, outcomes should address the specific skills and knowledge addressed in the training. For example, training may address knowledge about when to seek professional care or skills associated with anxiety management. These skills should be assessed as part of mental health training. Third, in terms of mental health fitness, outcome indicators should include measures of distress that go beyond traditional PTSD symptoms. Outcomes of relevance to the organization should be included such as aggression, sleep problems, relationship conflict, and risk-taking behaviors. If the aim of the mental health training is to enhance well-being, then assessment of positive psychological health is also merited. Fourth, as mentioned previously, measures of training satisfaction and user acceptability should be included. Fifth, measures of unit climate should be included because the training can have an impact on the way the unit climate is perceived and because the training can have an impact on the leadership itself. Thus, these measures should address the degree to which mental health training may

have had an impact on cohesion and leadership quality. Similarly, the training should also assess the degree to which leaders support the mental health skills and training provided by the organization. Without support from the leadership, the training will likely be less effective.

2.2 PRINCIPLES OF IMPLEMENTATION FOR MENTAL HEALTH TRAINING

Below is a description of key implementation principles (see Table 1 for an overview) regarding mental health training in organizations that must be kept in mind as the mental health training is being developed. While this is not an exhaustive list of all the implementation issues that need to be considered when developing mental health training, it does represent the common issues that arise when implementing mental health training.

2.2.1 Integrated into Organizational Culture

Military mental health training must be integrated into the organization's culture (Thomas & Castro, 2003). Ideally mental health and resilience training should be integrated with and focused on the service member's military career phase and point in the deployment cycle. Whether the program is seen as an education or as training depends largely on the timing and the place where it is delivered. In the context of a military academy, the terminology may need to emphasize "education" rather than "training." In general all mental health training contains educational material and involves skill strengthening or skill development. The two concepts can also be regarded as sequential. Thus the first phase of the program has to be termed "education" and the second phase in which the skills are practiced is termed "training". The larger issue is that the language used to describe and promote the program needs to make sense within the organizational context.

Mental health training should also be conducted within existing units, preferably at the platoon or company level in order to optimize the impact of small group dynamics and leadership. Conducting mental health training in small, pre-existing groups ensures group members will have the opportunity to share their experiences with each and that group members will feel comfortable enough to share their experiences. Training conducted in large groups in an auditorium or gymnasium runs the risk of being too impersonal, and too large for focused skill development to occur. In general, mental health training conducted in large groups is likely to become educational or didactic in nature, with little interaction or sharing of the group members' personal experiences.

The degree to which group size actually influences the efficacy of the training remains unclear. Indeed, Thomas et al. (2007) compared the small and large group Battlemind Training and did not find reliable differences between the two types of training.

2.2.2 Appropriately Timed

Mental health training should be relevant to the phase of the deployment cycle or the service members' level of professional development. This point has been made earlier but it deserves repeating. For instance, mental health training designed to be given prior to deploying shouldn't be given during the deployment, nor should mental health training designed to be given at post-deployment be given during the deployment or prior to deploying. Since the content of mental health training should vary depending on the phase of the deployment it stands to reason that the training cannot be used interchangeably.

Creating a one-size-fits-all approach to the training cycle is not likely to meet the needs of service members as their needs change depending on the phase of the deployment. Proponents and/or developers of such global approaches to mental health training fail to recognize the organizational context and may not have ensured that the needs of the service members are adequately addressed.

2.2.3   Quality Control

Any standardized training program requires a robust quality control program to ensure that the training is being conducted as intended. Constant vigilance is required to ensure that the content of the mental health training is maintained; the content should not be altered nor should additional material be inserted into the training modules. Further, the mental health training needs to be conducted using the procedures that have been validated. A mental health training quality control program should systematically ensure that trainers are prepared to conduct the training, that the training materials and lesson plans are clear and detailed, and that the training conducted remains consistent. Maintaining quality training can be difficult in a large organization like the military. Mechanisms such as refresher courses, team teaching, training evaluation, and spot checking by a mobile team responsible for training quality can facilitate quality sustainment over time.

2.2.4   Train-the-Trainer Program

The first step in preventing drift in the content and implementation is to develop a train-the-trainer program in which each mental health trainer receives formal training and certification that documents they are capable of delivering the training program to standard. At a minimum, a train-the-trainer program should include the training material, a detailed course syllabus, and detailed speaker notes. A train-the-trainer course should also include practice for the individuals who are being certified as trainers and an evaluation of their training performance. Only after the individual being trained has shown competence in giving the mental health training and in answering anticipated questions regarding the training should they be certified. A train-the-trainer program, however, does not preclude the need for a quality control program as drift in training can still occur.

Obviously during the development of a mental health training program it must be decided who will be conducting the training. For example, will the mental health training be conducted by behavioral health care providers, chaplains, experienced combat arms service members or some other group? This decision needs to be addressed early in the training development process because the decision regarding who conducts the training is likely to shape the content of the training material. Regardless of what decision is made regarding who conducts the mental health training, it should be noted that although individuals may have a personal preference for one type of trainer, the training material itself needs to be the key ingredient rather than a trainer's personal style. Personal style cannot be dictated in a set of lesson plan instructions. Regardless of who these trainers are, they will need to acknowledge what they are not. If they are not experts in mental health, they can talk about how the material has been developed by mental health professionals experienced in working with the military. If they have not been deployed, they can talk about how the material has been developed based on what soldiers have said is important to know. Even if the trainer has deployment experience, this experience can be misleading – establishing a link to the service members that is not really there. For example, most trainers with deployment experience are not likely to have been a junior enlisted combat arms soldier out on patrol every day. The train-the-trainer course needs to underscore the reality that the trainers can not be everything to all people. The trainers can acknowledge what they do bring to training in terms of their expertise, but most importantly they can bring their level of commitment, their enthusiasm, and their professionalism.

2.2.5   Exportable and Scalable

Regardless of who conducts the mental health training, a mental health training program must be designed with the average trainer in mind, not the ideal trainer. Whatever the mental health training program, it must be exportable and scalable. For example, a mental health training program will be of little utility to large organizations such as the military if only a handful of people in the world are capable of conducting the training or if it takes years to train others to conduct the training.

2.2.6   Training Guidelines

Another means to ensure that mental health training is conducted consistently across military installations and over time is to develop clear guidelines as to how the training is to be conducted. In military language, this approach to training is known as establishing "task, condition, and standard." Task, conditions and standards are applied to every form of training conducted in the military, regardless of the type of training. The "task" component of this approach specifies exactly what needs to be accomplished. The "conditions" specify the context or the variables in a situation that may affect performance. Finally, the "standards" delineate the markers of success. Thus, a "task, condition, standard" approach to mental health training details the exact training that is to be conducted, who is to be trained, who is to conduct the training, the environment in which the training is conducted, and the means for assessing the effectiveness of the training. This standardized approach to mental health training will also facilitate a rigorous quality control program that can evaluate if the training is being conducted as intended.

2.2.7   Refresher Training

Like most effective training, mental health training should contain refresher training modules. Service members should not be repeatedly subjected to the exact same mental health training material because the training will inevitably become stale, which will likely blunt its effectiveness. Off course, various modules provided over time and over the course of the deployment cycle serve to reinforce the key principles but refresher modules could certainly also be developed.

2.2.8   Mobile Training Teams

Implementing mental health training on a large scale can be facilitated through the use of mobile training teams. These teams can train service members directly but, more importantly, they can conduct train-the-trainer courses to certify other trainers.

2.2.9   Sustainable

Whatever mental health training program is adopted, it must be sustainable and supportable. The importance of the trainer and standardization has already been discussed in some detail. Equally important is how long the training needs to be in order for it to be effective in increasing mental fitness. In the military context, training time is a valuable commodity that must compete with a myriad of other demands. Whatever system results, it must remain cognizant of the issue of time as well as other resources such as personnel, equipment, and coordination. If too many resources are required, then in the long run, the training program may not be sustainable.

2.2.10   Program Improvement

Along with ensuring that the training program can be sustained in terms of implementation, there also needs to be a vigorous system for continually assessing whether the mental health training program is achieving its stated goals and to identify how the program can be improved. Unfortunately, military leaders may be reluctant to commit resources for program assessment and improvement. Without such a

program in place, however, there will be no systematic, on-going analyses to ensure that the mental health needs of service members and families are still being met. These program improvement efforts are not only important for ensuring the program remains effective, but these efforts are another way to ensure that service members do not become bored by the same material.

2.2.11 Policy

Even the most effective mental health training cannot be successful without a parallel effort on the part of the organization to institutionalize its implementation (Thomas & Castro, 2003). In the case of the military, policy must be developed that supports and directs that mental health training be conducted. There must also be guidance issued that describes how the training will be implemented. In short, orders must be given that mandate that the military mental health training occur. Otherwise, such training will be left up to the discretion of each commander, usually with the result that the training is not conducted to the standard that has been shown to be effective, or it will not be conducted at all.

2.2.12 Leader Supported

Whether the training is mandated or not, leaders are critical for the successful implementation of mental health training. Leaders at all levels play an important role in service member mental health both directly and indirectly (see Britt, Davison, Bliese, & Castro, 2004; Castro, Thomas, & Adler, 2006). The findings of an international military leaders' survey on operational stress show that leaders themselves state that it are the commanding officers who should be responsible for the psychological readiness of unit members (Adler et al., 2008). Consequently, their explicit and implicit support for a program can mean the difference between a supportive training environment and one in which the training is conducted as a way to "check the block" that simply meets a specific organizational requirement. Leaders can demonstrate their support for mental health training by attending the training themselves, by emphasizing the importance of the mental health training to their subordinates, and by ensuring that the training is a priority on the unit calendar. Research evidence demonstrating the efficacy of mental health training can directly impact the leader's endorsement of the program. If scientific findings can be provided to leaders showing them that mental health training is effective in increasing the mental fitness of their unit then the leaders are more likely to support the training. Obtaining high profile endorsements from senior enlisted service members and officers can also enhance the acceptability of mental health training.

2.2.13 Verifiable Claims

Credibility requires that any claims made regarding mental health training be consistent with verifiable facts that are based on scientific. Leaders need to be provided with realistic expectations about what mental health training will achieve and what it won't, the organization needs to make decisions based on science in order to differentiate between effective training and another good idea, and professionals need to uphold the integrity of the field.

2.2.14 Packaging and Multi-media

Effective mental health training needs good packaging. While this implementation principle may sound superficial it is critical because it ultimately means that the information will be presented in such a way that the organization and the individual service member will be more likely to accept it. Furthermore, good packaging through catchy slogans or the use of easy-to-remember acronyms, enhance the degree to which individuals are likely to remember the training content. The use of humor can also make mental health training more engaging. Still, care must be exercised that the training does not become so slick that the trainees are put off by the training or that the style distracts from the training objective or message.

Wherever possible, multi-media (e.g., interactive computer simulations, video scenarios, music, gaming technology) should be considered in developing a mental health training program. While there is no clear evidence that mental health training is more effective if it employs multi-media, the training is likely to be more engaging which increases the likelihood that individuals will attend to the training content. Appropriately incorporated, multi-media training can also enhance standardization of training. Multi-media approaches also help to underscore a central tenet of training: training should be conducted to engage the three fundamental types of learners. Visual learners prefer to be able to see the point written out, or visually depicted in a diagram. Auditory learners prefer to listen and discuss the information. Finally, experiential learners prefer to practice a concept and grapple with some task related to the concept.

2.2.15 Ownership

The final implementation principle reviewed here is ownership: who actually controls the content of the training program and retains the right to revise it. Mental health and mental fitness issues facing service members and their families are complex and varied. How to build resilience and increase mental fitness in order to help these folks meet the demands of combat and deployment are equally complex and nuanced. Thus, the content of the mental health training program needs to belong to military behavioral health care experts. The content of mental health training must be determined by behavioral health experts. They are the subject matter experts - not the commander, not the chaplains, not the policy makers or others who are interested in helping service members. Obviously, these individuals are expert in their own areas and their input is invaluable for ensuring that the training material addresses issues in a way that is relevant to the audience. In fact, the training development process should actively solicit input from a variety of domains such as operational leadership, the chaplaincy, military families and soldiers themselves. However, caring about service member mental health or having been deployed to a combat environment does not make one an expert in mental health training; the behavioral care experts should own the content of the training,

3.0 CONCLUSIONS

The goal of the RTG is to develop a NATO mental health resilience training package. Deliverables are Resilience Training Guidelines, Implementation Principles, as well as a standardized train the trainer program for mental health training. Through explicitly stating these implementation principles we can build toward delivering a system of mental health training for service members that is integrated, relevant, and effective. While this is not an exhaustive list of all the implementation issues that need to be considered when developing mental health training, it does represent the common issues that arise when implementing mental health training.

Based on these fundamentals the RTG will study current mental health training modules that are delivered in participating NATO countries on how and when it is being delivered. It will provide valuable information to develop a NATO mental health training package to enhance the overall mental fitness of NATO forces.

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