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ORIGINAL PAPER

Faith-Based Groups as a Bridge to the Community for Military Veterans: Preliminary Findings and Lessons Learned in Online Surveying

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Abstract
This report examines responses to a brief online survey, comparing how faith-based (n = 27) and non-faith-based (n = 61) organizations engage with Veteran populations as well as the supportive services they provide. Data were analyzed using two-sample z-tests and Chi-squared tests. No significant differences were noted between respondents for self-reported confidence in responding to health care issues/concerns or engagement with Veteran populations. Faith-based respondents were found to provide significantly less mental health, suicide prevention, education/outreach, and other services, while providing significantly more spiritual care. There appears to be ample opportunity for expanding the supportive services provided by faith-based organizations.

Keywords Faith-based communities · Veterans · Military · Community engagement

Introduction

Achieving meaningful community engagement and effective community participation is sometimes difficult and challenging for military Veterans (Hann 2005; Maurana and Goldenberg 1996; Plough and Olafson 1994). Faith-based communities (FBCs) and faith leaders act as a crucial bridge for helping some Veterans engage and integrate with their local communities. For example, Veterans see FBCs as a source of private, confidential,

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safe, and judgment-free support (Werber et al. 2015). Many Veterans also ascribe importance to their religion and spirituality, with an estimated 49% attending religious services at least once per month (LaPierre 1994; Pew Social and Demographic Trends 2011).

Faith leaders are recognized for actively engaging with and providing mental health support to Veterans (Blosnich et al. 2015; Cook 1997; Kopacz and Karras 2015; Sullivan et al. 2014). For example, following their discharge from military service, some Veterans will struggle with health concerns (e.g., mental health and behavioral adjustment disorders, substance use disorders), hampering their ability to meaningfully engage and participate in their local community (Eibner et al. 2016; Olenick et al. 2015; Waszak and Holmes 2017). Of note, however, is that faith leaders may not always be mindful of the military history of their congregants or the individuals they support (Kopacz et al. 2016). For this reason, it is important to also consider the support provided by FBCs and faith leaders in the wider community.

FBCs help plan community health interventions, develop faith-based understandings of health (e.g., promoting tenets which discourage substance abuse), and sometimes serve as a site for the delivery of health services (Chatters et al. 1998; Maclin 2012). FBCs also serve as a means for reaching poor, underserved, or otherwise hard-to-reach populations (Koenig 2003; Murray et al. 2014). Both FBCs and faith leaders are perceived as an accessible source of mental health support, sometimes more so than formal health care providers (Wang et al. 2003; Wang et al. 2004; Wang et al. 2005). For example, faith leaders report a measure of regularity in engaging with individuals at increased risk of suicide or in various states of distress/crisis (Hedman 2016; Mason et al. 2017; Mason et al. 2016; Mason et al. 2011).

The aim of this brief report is to present the findings of an online survey, comparatively examining how faith-based and non-faith-based organizations engage with Veteran populations as well as the different supportive services they provide. It is reasonable to presume that most FBCs will provide a less diverse repertoire of supportive options compared to non-faith-based or more service-driven organizations. Still, a paucity of published data exists to guide basic understandings of how FBCs are supporting Veterans in the community. Baseline measures, inclusive of any differences which might exist between the two types of organizations, could highlight opportunities for developing the role of FBCs. Lessons learned in the planning and execution of this survey also serve to inform the development of research collaboration with FBCs, ensuring responsiveness to the needs of both Veterans and the wider community.

Methods

Survey Respondents

In September 2017, the US Department of Veterans Affairs (VA) Center for Faith and Opportunity Initiative (CFOI) distributed an online survey through its global listserv of $n = 4929$ unique e-mail subscribers. This listserv is made up of subscribers in leadership positions across a variety of community organizations. The survey was addressed to all subscribers on the global listserv, regardless of organizational profile or self-reported Veteran status. The acting assumption is that they are in a position to authoritatively speak on behalf of their organization. This survey was designed as a quality improvement effort intended to enhance the services provided by the VA CFOI, which partners and

collaborates with community-level organizations in support of Veterans, their families, Survivors, and caregivers (Department of Veterans Affairs 2017). The VA CFOI cultivates and develops relationships with faith-based (e.g., ecumenical denominations), nonprofit (e.g., YMCA or Salvation Army), and community/neighborhood organizations (e.g., Veteran Service Organizations, Military Family Research Institute at Purdue University).

Survey Design

The questions included in this survey were first prepared by staff affiliated with the VA CFOI. As a quality improvement effort, the underlying intention was to collect baseline data reflective of activities undertaken by the VA CFOI. The survey was intended to be relevant to a large number of potential respondents and was kept purposefully brief, with questions general in scope, so as to minimize any time burden or inconvenience for potential respondents. Keeping the survey anonymous (i.e., no individual or organizational identifiers were collected) was intended to mitigate any confidentiality and privacy concerns to ensure meaningful data collection and garner the greatest possible number of respondents (Podsakoff et al. 2003). The survey was first pilot tested in pencil-and-paper form during a community event of VA CFOI partners. Following feedback, it was subsequently shortened and refined. No additional feedback was garnered in follow-up pilot testing. The finalized eight-question survey was uploaded to an online survey Web site which assigned a unique link connecting directly to the survey. This link and an invitation to complete the survey were included in the headline of a VA CFOI bulletin distributed through its global listserv. A follow-up reminder e-mail was also sent through the global listserv 2 weeks after the bulletin was distributed. A link to this survey was also available on the Center's Internet homepage. After 3 weeks, the survey was closed to completion, yielding a response rate of $n = 88$ (1.8%).

Survey Measures

Demographics

Respondents were asked their sex, age, and "Are you a veteran?"

Organizational Affiliation

Respondents were asked "Please describe your primary organizational affiliation." Answer options included faith-based (for example, a congregation, church, mosque, or synagogue); clinical services or health care (for example, a hospital or clinic); non-governmental, Veterans service, or nonprofit organization; local/regional/state government; and other.

Confidence

Respondents were asked "How confident do you feel in supporting your clients/attendees with their health care issues or concerns?" Answer options included very confident, somewhat confident, or not very confident.

Services Provided

Respondents were asked "Which services/supports does your organization provide the community?" Respondents checked all that applied. Answer options included job training; on-site mental health services; referrals to other clinical providers; suicide prevention; housing; social activities/events, fellowship; spiritual and pastoral care; support groups (e.g., recovery, grief, etc.); education, outreach; or other.

Engagement with Veterans

Respondents were asked "In your opinion, approximately what percentage of your organization's clients/attendees are military Veterans?" Answer options included $< 5\%$, 5–10%, 10–15%, 15–20%, $> 20\%$, or not sure. Respondents were next asked "Does your organization offer any services/ministries specifically directed towards military Veterans?" Answer options included yes, no, or not sure.

Statistical Analysis

Respondents were divided into two subsamples based on endorsing either a faith-based or non-faith-based (i.e., clinical services or health care; non-governmental, Veterans service, or nonprofit organization; local/regional/state government; and other) affiliation. Two-sample z-tests (z) were used to compare population proportions for services provided. Chi-square tests (χ^2) were used to examine differences in respondent demographics, responses for self-perceived confidence, and engagement with Veterans. Statistical significance was defined as $p < .05$.

Table 1 Demographics of the sample population

	Faith-based (n = 27, 30.7%)	Non-faith-based (n = 61, 69.3%)	Total (n = 88, 100%)
*Sex**			
Male	24 (88.9%)	39 (63.9%)	63 (71.6%)
Female	3 (11.1%)	22 (36.1%)	25 (28.4%)
*Age**[a]			
18–24	0	0	0
25–34	0	2 (3.3%)	2 (2.3%)
35–44	1 (3.7%)	5 (8.2%)	6 (6.8%)
45–54	1 (3.7%)	13 (21.3%)	14 (15.9%)
55 +	25 (92.6%)	41 (67.2%)	66 (75.0%)
Is the respondent a Veteran?			
Yes	21 (77.8%)	47 (77.0%)	68 (77.3%)
No	6 (22.2%)	14 (23.0%)	20 (22.7%)

*$p < .05$

[a]For statistical analysis, age groups were reduced to two cells: (a) 18–54 and (b) 55+

Results

Participants

Participant demographics are reported in Table 1. Significant differences were noted for sex [$\chi^2(1) = 5.73$, $p < .05$), with more males in the faith-based ($n = 24$, 88.9%) than in the non-faith-based subsample ($n = 39$, 63.9%). Significant differences were also noted for age [$\chi^2(1) = 6.43$, $p < .05$], with more respondents aged 55 + years in the faith-based ($n = 25$, 92.6%) than in the non-faith-based subsample ($n = 41$, 67.2%). No significant differences were noted for respondents' self-reported Veteran status.

Confidence in Responding to Health Care Issues or Concerns

Most faith-based respondents reported feeling either very ($n = 10$, 37.0%) or somewhat ($n = 10$, 37.0%) confident in responding to health concerns among their service users (Table 2). Non-faith-based respondents most often reported feeling somewhat confident ($n = 27$, 44.3%). No significant differences in self-reported confidence were noted between the subsamples.

Services Provided

Table 3 presents how many respondents endorsed providing a given type of service. Faith-based respondents most often endorsed providing spiritual care (endorsed 24 times) and least often providing mental health services (endorsed 1 time). Non-faith-based respondents most often endorsed providing other services (endorsed 30 times) and least often providing housing and spiritual care, respectively (each endorsed 12 times).

Faith-based institutions provide significantly less mental health ($z = -2.99$, $p < .01$), suicide prevention ($z = -2.57$, $p < .05$), education/outreach ($z = -2.50$, $p < .05$), and other ($z = -3.81$, $p < .01$) services. Faith-based institutions provide significantly more spiritual care ($z = 6.04$, $p < .01$). No significant differences were noted for the provision of job training, clinical referrals, housing services, social activities, or support groups.

Engagement with Veterans

Both faith-based ($n = 9$, 33.3%) and non-faith-based ($n = 21$, 35.0%) respondents most often reported not being sure what percentage of their service users were Veterans (Table 4). No significant differences were noted between the subsamples in this regard.

Table 2 Confidence in responding to health concerns among service users

	Faith-based ($n = 27$, 30.7%)	Non-faith-based ($n = 61$, 69.3%)	Total ($n = 88$, 100%)
Very confident	10 (37.0%)	22 (36.0%)	32 (36.4%)
Somewhat confident	10 (37.0%)	27 (44.3%)	37 (42.0%)
Not very confident	7 (26.0%)	12 (19.7%)	19 (21.6%)

Table 3 Services provided by an organization

	Faith-based (n = 27)	Non-faith-based (n = 60)[a]
Job training	2	15
Mental health**	1	20
Clinical referrals	6	23
Suicide prevention*	3	23
Housing	2	12
Social activities	12	24
Spiritual care**	24	12
Support groups	11	22
Education/outreach*	5	28
Other**	2	30

Values represent the number of times a given service was endorsed by a group of respondents

*$p < .05$; **$p < .01$

[a]Question left blank by one respondent

Table 4 Percentage of Veteran service users

	Faith-based (n = 27, 31.0%)	Non-faith-based (n = 60, 69.0%)[a]	Total (n = 87, 100%)
< 5%	5 (18.5%)	7 (11.7%)	12 (13.8%)
5–10%	0	2 (3.3%)	2 (2.3%)
10–15%	4 (14.8%)	5 (8.3%)	9 (10.3%)
15–20%	4 (14.8%)	6 (10.0%)	10 (11.5%)
> 20%	5 (18.5%)	19 (31.7%)	24 (27.6%)
Not sure	9 (33.3%)	21 (35.0%)	30 (34.5%)

For statistical analysis, we compared two groups, (a) not sure of the percentage of an organization's service users who were Veterans: and (b) <5% to >20% of an organization's service users were Veterans

[a]Question left blank by one respondent

Table 5 Institution provides Veteran-specific services

	Faith-based (n = 26, 30.2%)[a]	Non-faith-based (n = 60, 69.8%)[a]	Total (n = 86, 100%)
Yes	9 (34.6%)	25 (41.7%)	34 (39.5%)
No	10 (38.5%)	21 (35.0%)	31 (36.0%)
Not sure	7 (26.9%)	14 (23.3%)	21 (24.4%)

[a]Question left blank by one respondent

Faith-based respondents most often reported not providing any Veteran-specific services (n = 10, 38.5%; Table 5). Non-faith-based respondents most often reported that Veteran-specific services were available at their institution (n = 25, 41.7%). No significant differences were noted between the two subsamples in this regard.

Discussion

This brief report presented the findings of a quality improvement survey examining how some faith-based and non-faith-based organizations support Veteran populations. No significant differences were noted for self-reported confidence of responding to health care concerns, the provision of Veteran-specific services, or percentage of Veteran service users. As could be expected, faith-based organizations provide a less diverse repertoire of supportive services. These preliminary findings suggest several avenues for enhancing partnerships and collaboration with both faith-based and non-faith-based organizations.

There appears to be ample opportunity for expanding the types of services provided by FBCs. This could be achieved by having FBCs develop their own resources and facilities by partnering with formal health care providers and/or non-faith-based, service-driven organizations to offer supportive services on-site (e.g., on church grounds; Pappas-Rogich and King 2014). Another option might include developing referral capabilities (e.g., to a health care provider). For example, VA has a variety of programs and activities (e.g., mobile clinical units, Veterans Crisis Line, telemedicine) for supporting Veteran populations. Especially as related to mental health outcomes, supporting Veterans not otherwise enrolled in VA services or benefits remains a strategic VA priority. Available data find that approximately 20 Veterans die by suicide each day, of which 14 are not users of VA health care services (Department of Veterans Affairs 2016). Such observations underscore the need for tangibly engaging with FBCs to identify and support Veterans in need of specialized mental health services.

Despite the differential in services provided, it was surprising that both faith-based and non-faith-based respondents had comparable levels of confidence in responding to health care issues or concerns as well as engagement with Veterans. Future research should consider examining how confidence is perceived and understood among FBCs, inclusive of any practical implications. Confidence on the part of community-based partners is an important part of building and implementing sustainable community health programs (Frieden 2014; Meillier et al. 1997). An additional avenue for future research might include more precisely defining what resources FBCs and faith leaders have at their disposal when encountering individuals with health care needs.

Online surveys traditionally yield lower response rates compared to pencil-and-paper surveys (Nulty 2008). Yet the exceedingly low response rate for this survey could perhaps be indicative of certain larger issues. One real possibility is that of "survey fatigue," where potential respondents make the conscious decision to categorically opt-out of all survey invitations (Porter et al. 2004). Potential respondents may have also thought the survey was not relevant to them and/or their organization. For example, previous research as well as the present findings suggests that respondents might not be aware of the extent to which their organization's service users include Veterans (Kopacz et al. 2016). The low response rate also serves as a lesson learned in organizing data collection efforts with community-level organizations. Specifically, a one-size-fits-all approach may not be effective in surveying large numbers of community-level respondents.

Of special note is that significantly more non-faith-based, compared to faith-based, respondents endorsed providing supportive services described as "other" (Table 3). Such observations might be reflective of a "new approach" to customer service, driven more by an understanding of customer needs and expectations as defined by the customers themselves (Schlesinger and Heskett 1991). This new approach to service reinforces the importance of developing novel avenues and strategies for tangibly engaging FBCs in data

collection efforts as well as community-level partnerships. Future data collection efforts could, for example, focus more on delineating between service-driven and non-service-driven organizations, treating any faith-based component to an organization's work as a covariate. Research has posited a relationship linking increases in self-rated spirituality with an increased willingness to participate in health-related research (Ojukwu et al. 2018).

In keeping with its mission statement, the work of the VA CFOI is not exclusively limited to faith-based organizations. In the present survey, non-faith-based respondents accounted for more than double the number of faith-based respondents, outwardly suggesting a greater interest and/or motivation to participate in such data collection efforts. There remains a paucity of the literature to understand what best "speaks to" FBCs and their potential engagement in health-related research (Milstein et al. 2010; Milstein et al. 2017). Alternative data collection strategies may include focusing instead on a specific subset of organizations (e.g., health care, Veterans service organizations, regional church councils) and targeting only specific types of respondents (e.g., program officers, lead pastors). Other suggestions include designing a survey in collaboration with potential respondents as well as developing reminder algorithms which could be applied at a community level, especially with faith-based organizations, without being perceived as a nuisance or overly burdensome (Van Mol 2017; Schulz et al. 1998).

Several limitations apply to these findings. This includes the use of a sample of convenience, precluding any ability to assume representativeness of any of the respondent categories. The survey was, by design, descriptive and does not constitute a validated measure. An exceedingly low response rate for this survey, largely limited to older males who themselves identify as Veterans, further precludes any generalizability and is a strong indicator of selection bias. While the global listserv used to distribute the survey includes subscribers in leadership positions, the exact functional/organizational position of respondents could not be precisely defined. Due to dataset limitations, it was not possible to reliably ascertain if respondent affiliations, as reported in the present survey, were proportional to those listed on the global listserv.

Conclusions

The strength of this survey was undoubtedly the novelty of the data. These preliminary findings offer a measure of insight into how some FBCs, compared to non-faith-based organizations, support Veterans as well as the larger community. The findings are intended to support ongoing discussions and efforts aimed at developing practicable strategies for collaborating with FBCs in support of Veteran health outcomes (Kopacz et al. in press). Most importantly, the findings could be used to enhance the quality of partnerships between local, state, and national government institutions and community stakeholders, such as FBCs. Suggestions are made for future research aimed at enhancing the quality of these partnerships. Methodological lessons learned in this survey could also be used to support data collection efforts with FBCs. The responsibility of supporting our Nation's Veterans is one shared collectively across communities.

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Author Contributions Principal responsibility for the study design and statistical analysis was assumed by MSK. Responsibility for data collection and management was assumed by ED. Subject matter expertise was provided by SD. All authors read and approved the final manuscript.

Compliance with Ethical Standards

Conflict of interest The authors do not declare any conflict of interest. This survey was conducted independent of any external funding mechanism.

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