Faith-Based Organizations and Veteran Reintegration

Enriching the Web of Support

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Key findings

- Faith-based organizations (FBOs) not only attend to veterans' spiritual needs but also address many other areas of veteran health and wellness.
- FBOs are already interacting with other organizations in the web of reintegration support but to varying degrees and with different levels of success.
- FBO efforts are sometimes limited by resource and capacity constraints, insufficient connections within the web of support, lack of awareness or experience with veterans, and characteristics of veterans themselves.
- Partnerships may be necessary to fully realize FBO capacity to support veterans and to gauge the effectiveness of such support.

SUMMARY ■ Faith-based organizations (FBOs) are an important community-based resource for veterans as they readjust to civilian life. Since little is known about the nature of this support, we conducted exploratory interviews with 14 national organizations involved in faith-based support of veterans and 15 smaller, local FBOs from three distinct metropolitan areas, including religious congregations, retreat centers, and those that provide transitional assistance, to understand better their current and potential roles in veteran reintegration.

Interviewees suggested that veterans may look to FBOs for support because they are a resource that offers privacy and confidentiality, two features that may be especially critical when a potential stigma is involved. Some FBOs have also developed reputations as safe places for veterans, providing supportive, judgment-free environments. We found that FBOs not only help veterans with spiritual matters, such as moral injury, but, as a group, also address diverse areas of veteran health and wellness, including vocation, education, financial and legal stability, shelter, access to goods and services, mental health, access to health care, physical health, family, and social networks. In some cases, the support is offered to veterans directly; in other instances, the support is indirect, via training individuals to help veterans or educating the public about veterans' reintegration challenges.

In the process of providing this support, FBOs interact with different kinds of organizations, including government entities, private nonprofits, and one another, for purposes including training, outreach, referrals, information exchange, obtaining donations, and collaboration. Yet insufficient connections with chaplains and others in the web of support at times limit FBOs' work with veterans. Other barriers to support include resource and capacity constraints, lack of awareness or expe-

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rience with veterans, issues related to religious philosophy or orientation, and characteristics of veterans themselves. In addition, some FBOs do not measure their impact, which can hinder their ability to support veterans most effectively and efficiently.

To move forward, we offer several recommendations for policymakers, organizations that interact with FBOs, and FBOs themselves to help FBOs engage fully in the web of reintegration support:

1. Help FBOs learn more about the veterans in their midst and how to help them most effectively. We interviewed several organizations that are ramping up efforts to do this, but the U.S. Department of Veterans Affairs (VA) and Veterans Service Organizations (VSOs) can assist on this front as well.
2. Government agencies, VSOs, and policymakers should acknowledge FBOs as a source of reintegration support for veterans, particularly for moral injury.
3. Government agencies and others that facilitate support should ensure FBOs are well integrated into veterans' resource directories, especially more comprehensive compendiums, such as the federally sponsored National Resource Directory.
4. Connect chaplains and FBOs at the local level. Community institutions that have chaplains, such as police departments, universities, and hospitals, along with chaplains' associations and the VA, can all help to facilitate these linkages.
5. Build capacity among FBOs to measure the extent and effectiveness of their support. Organizations that train FBOs to support veterans, as well as those that seek to partner with FBOs, could provide guidance to or even mentor FBOs.

FBOs have potential as a force multiplier in reintegration support, but our findings also suggest that policymakers and those who seek to work with FBOs must be mindful of their limitations and, ideally, develop strategies to help mitigate them.

INTRODUCTION

More than 2.7 million military veterans have served in the post-9/11 era,[1] and the U.S. military includes approximately 850,000 National Guard and Reserve personnel who toggle between reserve status and active duty, repeatedly reentering civilian society.[2] In addition, an unusually large number of service members are expected to leave the military within the next decade as a result of planned cutbacks.[3] Reintegration—the transition from military service into civilian life—thus is an important process both for these current and future veterans and for the entire country. This adjustment may include reestablishing family bonds, locating meaningful civilian employment, pursuing higher education, securing housing, and building a social network after spending years or even decades in the Army, Navy, Air Force, Marine Corps, or Coast Guard. Some veterans may have additional challenges during reintegration, such as recovering from physical wounds or injuries, contending with mental health issues, or learning to live with a service-related disability.

While many veterans navigate readjustment to civilian life with little difficulty and even great success, research suggests that reintegration can present considerable challenges, particularly for those who supported military operations in Iraq and Afghanistan. In a 2011 survey, 44 percent of post-9/11 veterans reported that this reentry was difficult—a figure higher than those for veterans who had served in earlier eras.[4] Further, 48 percent of the veterans surveyed indicated strains in family relations since their military service ended, and almost as many noted frequent irritability or anger. A national survey of Iraq-Afghanistan combat veterans who visited a VA facility at least once over a four-year period provides more insights about the prevalence of reintegration challenges. Approximately one-fourth to one-half of these veterans experienced difficulty in social functioning (e.g., making new friends, maintaining friendships), productivity (e.g., finding or keeping a job, taking care of household chores), and community involvement. In addition, over 40 percent of this group also found it difficult to find meaning or purpose in life and had lost touch with their spirituality or religion.[5]

Although the VA and DoD are prominent reintegration care resources, an extensive web of support is available to veterans. This web comprises over 42,000 organizations,[6] including not only governmental organizations (VA, DoD, other federal agencies, and state and local agencies), but also private for-profit organizations, private nonprofit organizations, and FBOs.[7] Concurrent with the growth and reach of this web of support, the federal government has looked more to the nonprofit and

voluntary sector to help address community health and social needs. For example, legislation, such as the Charitable Choice provisions of the 1996 Personal Responsibility and Work Opportunity Reconciliation Act, and the 2001 establishment of the White House Office of Faith-Based and Community Initiatives (subsequently known as the Office of Faith-Based and Neighborhood Partnerships) have sought to increase FBOs' federal funding to promote their role in the provision of social services.[8]

As part of this trend, religious congregations and other FBOs are increasingly recognized as important partners for delivery of health and social services, especially in light of current funding constraints. FBOs may be especially well situated to assist veterans, given the ubiquity of these organizations in local communities and the important roles they play not only in providing social support and addressing members' spiritual needs but also in providing social services to members and local communities. For example, a national survey found that 82 percent of congregations offer social services either formally or informally.[9] FBOs, such as congregations, are often embedded within communities, which affords them a special understanding of local needs. FBOs may also have an intimate knowledge of such needs because they are aware of issues that people may be hesitant to discuss but feel more comfortable doing so with trusted clergy or others within the faith community. RAND research supports this premise,[10] and in the military or veteran context, this trust may be especially relevant, given the reluctance to disclose and seek help for mental health issues and sexual assault.[11] Further, additional research suggests that local clergy tend to have a global and holistic view of veterans' needs, while healthcare providers (physicians, psychologists, social workers, and nurses) tend to focus more on the specific issues that assist in making a differential clinical diagnosis.[12]

Evidence suggests that FBOs have indeed stepped up to support veterans' reintegration needs. In a national survey of religious congregations, 27 percent reported having a group that met in the last 12 months to support military veterans and their families.[14] In a different study, RAND found that, even when DoD resources were available, some veterans preferred faith-based support.[15] In a 2012 U.S. House of Representatives' Veterans' Affairs Committee hearing convened to discuss the interactions between the VA and faith-based and community organizations to support veterans, clergy and FBOs were cited as important partners in meeting veterans' day-to-day needs.[16]

Despite evidence that FBOs are helping address veterans' reintegration needs, very little is actually known about the range of activities being conducted, particularly those outside traditional healthcare settings. The VA is working to train rural clergy as first responders for veteran mental health issues and to promote partnerships between churches and mental health providers.[17] In addition, a number of studies from clinical psychology, psychiatry, and chaplaincy have addressed the important roles of VA-based chaplains in addressing veterans' spiritual and mental health needs.[18] But the nature of the support that congregations and other FBOs that operate outside healthcare institutions provide is not as well understood.

Accordingly, we sought to understand the current and potential roles congregations and other FBOs play in supporting veterans. In this report, we examine the nature and extent of the support FBOs offer veterans and their families and provide insights into the reasons that veterans may be inclined to seek this support even when other resources are available. We also describe how FBOs connect with veterans and their families to offer support, the nature and extent of FBO interactions with other resource providers, the extent to which FBOs gauge the effectiveness of their support, and what limits it. In doing so, we identify how FBOs can best enrich the web of support and suggest ways that policymakers, organizations that seek to partner with FBOs, and FBOs themselves can facilitate greater FBO involvement to ease veterans' reintegration.

What Is a Faith-Based Organization?

FBOs include religious congregations and coordinating bodies, as well as faith-based (denominational, interdenominational, interfaith, or nonsecular) nongovernmental organizations that engage in health or social-service activities. We regard six categories of religious service organizations as FBOs: (1) local congregations (or houses of worship), (2) interfaith agencies and ecumenical coalitions, (3) citywide or regionwide sectarian agencies, (4) national projects and organizations under religious auspices, (5) paradenominational advocacy and relief organizations, and (6) religiously affiliated international organizations.[13]

APPROACH

As a first step in understanding FBOs' contributions to veteran reintegration, we set out to understand exactly what FBOs do and how they do it. Our approach included interviews with two types of stakeholders: organizations with a national perspective

on faith-based support for veterans and local FBOs. Interviews with a third stakeholder group, veterans themselves, were beyond the scope of this exploratory study. We identified organizations for interviews through a combination of using Internet search engines, reviewing veterans' resource guides (e.g., National Resource Directory, state and city veterans' initiative websites), and obtaining referrals from other organizations. This multipronged, nonrandom approach was necessary, given the lack of a single FBO database or directory; congregations that support veterans are particularly hard to locate from afar. This means that our sample is not representative of all FBOs, and accordingly, we focus on overall patterns rather than report specific figures.

Our interview sample includes 14 national organizations involved in faith-based support of veterans. They are listed in Table 1 along with brief descriptions of their mission or veteran-related programming. To obtain a local perspective, we also interviewed representatives from 15 local FBOs in one of three metropolitan areas: San Diego, Houston, and Philadelphia.[19] These locations are all in states with relatively high concentrations of veterans but vary in terms of geography and with respect to military presence in the community.[20] The local FBOs include religious congregations, FBOs that serve the local homeless population or provide transitional assistance, and retreat-focused centers. Taken together, our national- and local-level interviews represent a variety of faith traditions, including Protestant, Catholic, Jewish, Muslim, and nondenominational organizations.

Interview topics included the following:

- nature and type of support offered to veterans
- how the FBO's support for veterans is organized
- target population for support and outreach to that group
- reasons that veterans seek support from FBOs and/or prefer it
- resources required for support
- interactions with other resource providers
- limits on support
- how the FBO gauges the effectiveness of its support.

All 29 interviews were conducted over the telephone, with one researcher leading the interview and another serving as a dedicated note taker, and interview notes were coded using qualitative data analysis software that facilitates systematic, rigorous analysis of qualitative data by topic and other characteristics.[21] Through this process, we were able to categorize the nature of support for veterans and to identify patterns across the interviews, such as the likely reasons veterans turn to FBOs for support and the factors that may limit FBOs' ability to support veterans. In this report, we summarize the themes that emerged from our analysis that are consistent with past research on reintegration and have implications for policy and practice.

What Is Moral Injury?

Moral injury is an inner conflict that stems from observing, failing to prevent, or committing acts that go against deeply held moral beliefs and expectations.[23] Shay introduced the concept in his work about Vietnam veterans, defining it as betrayal by leaders, particularly in high-stakes situations.[24] Other researchers later documented a second form of moral injury, one in which it is the veteran who did something in war that violated his or her own beliefs about what is right.[25]

Betrayal experiences that may contribute to moral injury include

- torture of prisoners
- abuse of human remains
- incidents involving civilians (e.g., assault, destruction of property)
- disproportionate violence (e.g., acts of revenge)
- violence within military ranks (e.g., sexual assault, friendly fire).[26]

While moral injury is not a formal diagnosis, there are support providers in both the faith community and the mental health care system who are intent on helping veterans recover from this form of trauma.

WHAT SUPPORT DO FBOs PROVIDE VETERANS?

Perhaps not surprisingly, a major focus of FBOs' support for veterans is related to spirituality or religion. Guiding this work is the belief that veterans' experiences while in the military may have created spiritual wounds that FBOs are uniquely qualified to address. As one interviewee put it, "We believe war is a spiritual issue, best solved through spiritual healing, and that comes best from the faith community." For many veterans, standard clinical approaches are not fully effective in addressing these concerns, and effective clinical approaches for moral injury are in development that incorporate elements of cognitive behavioral therapy and include an imagined dialogue with a benevolent moral authority (e.g., parent, grandparent, coach, clergy).[22] Accordingly, FBOs provide support when veterans are having

Table 1. National-Level Interview Participants

National FBOs That Serve Veterans	
Coming Home Project	Provides care, support, education, and stress management tools for Iraq and Afghanistan veterans, service members, their families, and their care providers (http://www.cominghomeproject.net)
Cru Military	Mobilizes and trains churches, counselors, and communities to minister to military members, veterans, and their families (http://crumilitary.org/)
Military Outreach USA	Educates and equips individuals, congregations, and other organizations to support the military community, including veterans (http://www.militaryoutreachusa.org/)
Salvation Army	Supports a wide range of veterans' needs through its Veterans' Affairs Service; programming varies by community (http://www.salvationarmyusa.org/)
Samaritan's Purse: Operation Heal Our Patriots	Provides wounded veterans and their spouses an opportunity for spiritual refreshment, physical renewal, and marriage enrichment (http://www.samaritanspurse.org/what-we-do/about-operation-heal-our-patriots/)
Soldier's Heart	Provides direct support to veterans to heal their psychological and spiritual wounds and trains individuals and organizations to support veterans and help them heal (http://www.soldiersheart.net/)
Organizations That Train Chaplains	
Association for Clinical Pastoral Education	Seeks to provide education and improve the quality of ministry and pastoral care that spiritual caregivers of all faiths offer (http://www.acpe.edu/)
Association of Muslim Chaplains	Supports and encourages the professional development of Muslims who provide spiritual care and counsel as chaplains and/or religious counselors (http://associationofmuslimchaplains.com/)
Association of Professional Chaplains	Promotes quality chaplaincy care through advocacy, education, professional standards, and service to its members (http://www.professionalchaplains.org/)
Jewish Welfare Board Jewish Chaplains Council	Offers a range of services to support Jewish chaplains; provides for the religious, educational, and morale needs of Jewish military personnel, their families, and VA hospital patients; through its Project Welcome home, positions Jewish Community Centers as a resource for post-9/11 veterans (http://jcca.org/jwb/)
National Association of Jewish Chaplains	Works to promote the highest standards of training, certification, and delivery of care by Jewish chaplains (http://www.najc.org)
Soul Repair Center, Brite Divinity School	Conducts research about and offers public education pertaining to moral injury (http://www.brite.edu/academics/programs/soul-repair/)
VA National Chaplain Center	Empowers VA chaplains to meet veterans' spiritual health care needs; provides training to rural clergy and other professionals (http://www.va.gov/chaplain/)
Other Stakeholder	
VA Center for Faith-Based and Neighborhood Partnerships	Develops partnerships with, provides information to, and expands participation of faith-based, nonprofit, and community or neighborhood organizations in VA programs to better serve the needs of veterans, their families, survivors, caregivers, and other beneficiaries (http://www.va.gov/cfbnpartnerships/)

spiritual crises or are wrestling with moral questions. Interviewees described various spiritual activities, including pastoral care, spiritual guidance, and healing retreats. Some also referred specifically to veterans' "soul wounds" or "moral injury," which, as one interviewee told us, "is not a clinical condition that you can treat through clinical approaches; it's a lingering sense of shame or guilt or anguish about the moral struggles that war involves." Another explained how these soul wounds can cause reintegration problems:

> Many veterans . . . when they return are marginalized because of their soul wounds and the isolation, the alienation they feel. As we pondered that, we realized one of our calls was to reach out to veterans who might respond to the invitation to not just address their psychic or bodily wounds, but their spiritual suffering too.

Moral injury and other spiritual matters are typically addressed through prayer sessions, retreats, and spiritual consultation or counseling. For example, one congregation described its "healing prayer" service, which entails asking veterans questions about their experience and praying both with and for them. FBOs offering retreats discussed providing "psychospiritual" or strictly spiritual support that enables veterans to open up, "reawaken," and regain a vision for their lives. Interviewees emphasized that the support must come from a "benevolent moral authority" in an atmosphere free from judgment, with unconditional acceptance. This may be important for veteran reintegration, given research that found that improvements in veteran spiritual functioning (i.e., higher adaptive aspects, lower levels of negative religious coping) can help reduce combat-related posttraumatic stress disorder (PTSD).[27]

FBO reintegration support goes beyond issues of spirituality, however. To categorize the myriad FBO activities we heard about in our interviews, we used Berglass and Harrell's veteran wellness model.[28] This approach enabled us to document how FBOs help veterans with reintegration problems and to learn about the more-proactive ways that FBOs support veterans, potentially heading off readjustment difficulties before they occur. Table 2 lists the 11 health and wellness domains included in the model, with examples from our interviews for each domain. Although FBO representatives regarded veterans' spiritual needs as both a frequent and distinctive FBO contribution, as shown in Table 2, FBOs' efforts touch on every domain of veterans' health and wellness. As a whole, FBOs cover the full spectrum of veterans' health and wellness, and most of the FBOs in our study address multiple domains in their work with veterans.

In addition, FBOs not only provide reintegration assistance directly *to* veterans but also support veterans indirectly by raising community awareness about and training people, such as chaplains, clergy, and congregational lay leaders, on veterans' issues. These approaches aim to build capacity among FBOs to assist in the reintegration process, and as one interviewee explained, to address the isolation that veterans may feel:

> Part of the problem [is that the] needs of the veteran are not understood. They are often isolated from the community that sent them to war in the first place. We can serve veterans by educating the larger community.

Others echoed this sentiment, describing efforts to increase knowledge and understanding about veterans' experiences. This is especially the case for organizations with a national presence, but some congregations also engage in these activities. To increase civilian awareness of the unique challenges veterans face during reintegration, several FBOs conduct activities for individuals, such as university staff, law enforcement personnel, and chaplains or clergy. One local FBO described its efforts to sensitize FBO members to recent veterans' experiences: "We had a veterans' miniseminar with 100 people from faith communities, and listening posts where we've invited people from Iraq and Afghanistan to come and tell their stories." Others focus on making congregations, nonprofit organizations, and other organizations that may encounter veterans aware of the resources available to them, particularly those from the VA. Finally, we also learned about efforts that go beyond information and actually train people to help veterans with reintegration. These efforts include not only workshops and conferences for chaplains, clergy, and congregation laity but also manuals on how to teach veterans to apply spirituality to their lives.

HOW DO FBOs REACH VETERANS?

All the FBOs we interviewed extend their support beyond their own members and even beyond veterans of the same faith tradition. In fact, some of the congregations told us that none of the veterans they serve are congregants. Veteran support is often offered in conjunction with support for members of the active

Table 2. Domains of Veteran Health and Wellness

Health and Wellness Domain	Examples of FBO Activities
Vocation	Resumé preparation; interview skill training; employer referrals
Education	Computer classes
Financial and legal stability	Referrals to financial counseling; referrals to legal assistance
Shelter	Temporary or transitional housing; rent assistance
Access to goods and services	Providing food; furniture and clothing donations; home-improvement assistance
Mental health	Counseling for PTSD and depression; referrals to the VA and community resources for clinical treatment
Access to health care	Transportation assistance for medical appointments; helping veterans understand and apply for benefits
Physical health	Promoting healthy eating habits; sports activities (e.g., hikes, bicycle rides)
Family	Marriage retreats and counseling; marriage rededications; date nights
Social networks	Support groups based on life stage or gender (e.g., men's ministry); baseball game outings
Spirituality	Healing prayer; pastoral care; moral injury–focused retreats

NOTE: Domains from Berglass and Harrell, 2012; examples from our interviews.

duty military, although some services, such as assistance finding civilian employment, are especially for veterans. In addition, our analysis of a nationally representative survey of congregations did not reveal any differences among various denominational groupings (e.g., Roman Catholic; mainline Protestant; or conservative, evangelical, or fundamentalist congregations) in how likely they were to offer programming for veterans.[29]

Since FBOs often support veterans outside their membership and even beyond their local community, effective outreach is especially important. While many of the FBOs make use of printed media, social media, websites, and presentations to publicize their efforts, they tend to view connections with other organizations and word of mouth as more effective means of making veterans aware of their reintegration support. FBOs reach out to other organizations, including Veterans Service Organizations (VSOs), the VA, nonprofits, and other FBOs, to make them aware of their resources and receive referrals from such organizations. Word of mouth from other resource providers to veterans and from veterans to veterans is key. One interviewee explained that such an approach is effective because it comes from a trusted source:

> We try to let them know [about our activities] through any organization that deals with veterans or whatever marketing tools we have, especially by word of mouth. Veterans respond better to someone they trust. We work at making connections with veterans and then inviting them into these programs. . . . The more veterans we can touch, they get the word out to others.

WHY DO VETERANS TURN TO FBOs?

While word of mouth may be the pivotal factor that motivates some veterans to seek help from FBOs, there are other reasons that veterans may turn to FBOs or even regard them as a preferred resource. Although we did not interview veterans, our FBO interviews and the literature on veterans and chaplaincy services offer insights on this front. For example, chaplains at VA and DoD facilities are extensively involved in caring for veterans' mental health needs, often preferred as trusted confidants with whom veterans can discuss moral, spiritual, and religious functioning.[30] In a complementary finding, some of our interviewees felt that veterans' familiarity with chaplains during their military service influenced them to regard FBOs as safe havens, especially for relationship concerns and psychological issues. As a former chaplain explained, veterans often

> Within the military, the chaplain is safe. The chaplain is someone you can go to who isn't going to tell your story everywhere. The confidentiality and safety that the chaplain has in the military makes it easier for veterans to go to a chaplain, to go to clergy; they've gotten into the habit of seeing a religious figure as someone you can confide in.
>
> —National FBO interviewee

view chaplains and, by extension, FBOs as resources that offer *privacy* and *confidentiality*—two issues of particular importance when potential stigma is involved:

> The chaplain is often a trusted resource because of confidentiality and lack of stigma that is often associated with mental health care. I think that carries over into our organization; there's less stigma in going to an organization like ours than in going into behavioral health or mental health services in VA.

In the military, communication with a chaplain is subject to different confidentiality standards than is communication with mental health professionals.[31] Noncommissioned officers identified chaplains as the first person to whom they would refer someone they suspect is suicidal, and the main reason they turned to chaplains was because of the confidentiality they afford.[32] For veterans, this "legacy" of a higher standard of confidentiality could mean that they may prefer to confide in clergy or FBO staff about mental health, especially if they think disclosure of such issues could affect their civilian employment or another aspect of the civilian life they are carefully building. One interviewee told us,

> If a veteran is employed in a position where he or she feels that PTS or PTSD could affect their opportunity for promotion, they might shy away from typical organizations that will give them help, but they will go through their church about an issue because they know that, with a civilian ministry, confidentiality is intact.

In a related vein, several FBOs conduct support groups for female veterans and/or those who had been sexually assaulted, thereby addressing another sensitive subject individuals may be reluctant to discuss or to seek treatment for.

FBOs that actively support veterans often cultivate a reputation as safe places for veterans not only because of the privacy and confidentiality they offer veterans but also because they strive to provide a nurturing, supportive, judgment-free environment. For example, a ministry leader emphasized how creating such an environment would be particularly attractive to veterans:

> [Local FBO] has a good reputation as far as wanting to truly help people and not being judgmental. They are good as far as loving people. They teach that to the ministry leaders. We're all sinners: be loving and accept them. That's probably what would separate us versus going to somewhere else. That's how I handle the ministry, and my ministry leader friends are the same way. We listen to the problem and don't cast judgment and then we try to help to the best of our ability.

This combination of being a comfortable sanctuary and a place where confidences are kept draws veterans to FBOs for support.

HOW DO FBOs FIT WITHIN THE WEB OF SUPPORT?

Earlier, we noted that the web of support comprises governmental organizations, private for-profit organizations, private nonprofit organizations, and FBOs. We found that, in their support of veterans, FBOs interact with many government organizations and with private nonprofit organizations. FBOs also work with one another to support veterans. Government organizations include the VA, first and foremost, but also county and city social service agencies. In San Diego, FBOs also reported connections with the local military bases. Private nonprofits include social service agencies, such as the United Way; VSOs and other organizations focused on serving veterans; community colleges; and organizations that assist the homeless.

Many of the interactions revolve around *training*: Chaplains' associations focus on teaching chaplains and FBOs how to communicate with veterans and to address their needs; the VA Center for Faith-Based and Neighborhood Partnerships invites faith-based, nonprofit, and community organization leaders to briefings; and other FBOs provide training to different niches within the web of support, such as community

college staff, counselors at social service agencies, and clergy and lay leaders from congregations seeking to help veterans. As mentioned in the last section, FBOs connect with other organizations in the web of support for *outreach* purposes and as a resource for *referrals*. FBOs also *exchange information* with other organizations about topics, such as their services, changing veteran demographics, new developments in veteran care, and other issues related to reintegration support. In some cases, this information exchange occurs within the context of a local organizational coalition or veterans' collaborative. For example, the San Diego Fellowship of Churches and Ministries meets monthly to exchange best practices. Some interactions with other organizations revolve around *obtaining donations of goods or services* to aid FBOs in their direct work with veterans. Finally, FBOs also join with other organizations in a more collaborative sense, i.e., an ongoing joint effort or partnership. This includes *working together* to provide support to veterans directly, such as during a veterans' "stand down" event intended to help the homeless and regularly working with a VA or Veterans Benefits Administration liaison to help veterans understand and apply for benefits. Although we did not tally the number of organizations that the FBOs in our study interact with, they typically engage in different types of interactions with several organizations—they are clearly, and, in some cases, extensively linked to other organizations in the web of support.

WHAT LIMITS FBOs' WORK WITH VETERANS?

Although their ubiquity, the level of trust they may enjoy with veterans, and their potentially unique ability to address moral injury suggest that FBOs are an important part of the web of reintegration support, their efforts are limited. We found five types of limits: (1) resource and capacity constraints, (2) insufficient connections with chaplains and others in the web of support, (3) lack of awareness or experience with veterans, (4) issues related to religious philosophy or orientation, and (5) characteristics of the veterans themselves.

Funding is a key concern for FBOs that provided transitional housing assistance or long-term convalescent support and for those that are seeking to expand their capacity. Healthy finances are important not only to cover staff salaries and facilities but also to enable FBOs to offer support to veterans for free or at low cost. FBOs' efforts are primarily donor funded, but some reported receiving grants as well. Grants are hard to come by, however, because most FBOs do not collect evidence of their program's effectiveness. Several FBOs expressed concern about being able to sustain operations in the years to come, and one noted that, "We're so devoted and over the top, we often do more than we should be doing."

Other FBOs, particularly congregations, tend to focus less on funding and more on the people who carry out the support of veterans. A ministry leader emphasized how such people can often be in short supply, saying, "Money will always be a concern because it fluctuates, but what is really scarce is qualified volunteers or qualified people, professionals on staff." Most of the FBOs rely extensively on volunteer support; at times, their numbers are insufficient, or their skill set or limited experience with veterans' issues presents challenges. Despite the lack of certain qualifications, however, few FBOs provide any sort of training to their volunteers, and other FBOs in our sample (e.g., chaplains' associations) acknowledged and seek to bridge this gap. A third staffing-related concern was burnout, given the potentially intense nature of work with veterans, particularly related to moral injury or other types of trauma.

Although many of the FBOs interact extensively with other organizations, they encounter obstacles as well. One prominent obstacle is the difficulties local FBOs had connecting with chaplains. Several had tried but failed to engage local chaplains. We did not interview individuals in their capacities as chaplains, however, and it is unclear where the problem lies. In some cases, FBOs reached indirectly to chaplains through others that intended to broker the connection. This finding is somewhat surprising, however, given that we also learned that some national chaplains' associations have been specifically trying to raise awareness among their members about veterans' issues. With respect to interactions with other organizations, some FBOs identified administrative impediments. This was especially the case with government agencies but was also a problem with local FBOs, such as congregations that had to obtain denominational approval before participating in a joint effort.

The lack of experience with veterans also can limit FBOs' reintegration support. For some FBOs, this unfamiliarity prevents them from any initial involvement because even those who were aware of veterans in their midst do not know what to do to help. This is consistent with other research, in which clergy reported that it is difficult to recognize symptoms of PTSD and traumatic brain injury and to identify resources for the veterans who sought their assistance.[33] A chaplains' association representative explained how it tries to make it easier for congregational and community members to assist:

> People in churches, synagogues, and community centers want to help but don't know how to begin. When a leader figure stands up and says, "Here are five concrete ways you can do this," it's a lot easier for people to jump onto something concrete. There is a deep need for help, but people don't always know how to do it. We are trying to do that.

In other cases, clergy's lack of awareness of veterans' issues is a barrier to sustaining support. One veterans' ministry leader told us he planned to stop trying to address veterans' reintegration needs because his pastor "just doesn't get it. Not unusual. People who don't have anyone in the military do not get their struggles."

We noted earlier that some FBOs go to great lengths to appear welcoming to veterans and to provide safe havens. However, the religious orientation or beliefs of other FBOs may limit their ability to work with veterans. One interviewee described how two extreme views present among faith traditions can both affect FBOs' inherent ability to serve veterans:

> A lot of faith traditions demonize veterans. Vietnam veterans that did stay [in their faith communities] had to bury their stories and bite their lips. Our sanctuaries were not safe places for veterans. The other side is where congregations project a "hero myth" on veterans. Again, this creates a lack of safety; they can't talk about guilt or shame or that they feel like a monster because of what they did or were a part of. . . . In some sense, denominations have a difficult history they have to confront in order to become the sanctuary they're called to be.

Some FBOs described internal debates over their support of veterans because of an opposition to war (or commitment to peace), although others had reconciled this through a belief that anyone who is suffering (e.g., a veteran dealing with moral injury) is someone they should help. From perhaps a more-practical standpoint, it was hard for the Jewish FBOs to support social service projects on a Friday or Saturday, when many community events for veterans tend to be scheduled, because that conflicts with their Sabbath.

Finally, characteristics of veterans themselves also can serve as a barrier. Veterans' tendency to keep problems to themselves rather than seek help and younger veterans' disinclination to join organizations are issues that affect most, if not all, organizations within the web of support. Younger veterans' lack of affiliation with a congregation or general lack of religion is of special concern to the FBOs that seek to help them, however. One interviewee confided that, "Quite a few of them are afraid of the church and wouldn't go into a religious setting." This may pose more of a barrier for congregations than for other types of FBOs (e.g., transitional housing facilities, retreat centers) that regard themselves as less religious and more spiritual.

DO FBOs KNOW HOW WELL THEY ARE DOING?

During interviews, we asked FBOs how they know how well they are doing in helping veterans with reintegration. There was a wide variation in the response to our question. At one extreme, we had FBOs that neither collected data nor perceived a compelling need to do so, making remarks such as

> No, we don't collect any data. We're there for you, and if you come, we do what we can. If you don't, there's not much we can do. No, we don't measure ourselves.

Others did see the value in collecting information that would enable them to measure the effectiveness of their work and expressed either the desire to do so or actual plans to begin that practice. One reason for a lack of measurement was the newness of FBOs' efforts; they initially focused on ramping up and refining their programming before trying to quantify their impact. In addition, some FBOs provide support on more of an ad hoc and varying basis, making it less clear what they should track. Another reason is related to the resource constraints noted earlier. Specifically, FBOs do not always have someone to develop, collect, and analyze indicators of effectiveness. As one interviewee explained, this is especially frustrating because such information could help use those limited resources more efficiently:

> It's difficult to gauge because we do not have any metrics available to measure our impact. I can give you data on how many care packages we gave out by month but not on the type and level of services

> provided to families. As I said earlier, we could use a staff person just for military. The pastor may have a better idea about how our work impacts peoples' lives—some persons may mention something to him, but it stays there [between him and the person], so I won't know. We need this information for other reasons too; I need to know where to direct limited resources. But it's a staffing problem; there are few of us to do all the work that is necessary.

The size of our interview sample prevented us from analyzing results by FBO type, but we did notice that none of the eight congregations in our sample measures the effectiveness of its support.

At the other end of the spectrum, we did encounter FBOs that collect indicators of effectiveness. They span health and wellness domains and include both objective measures, such as housing placements, benefits claims filed, and substance abuse relapses, and subjective measures, such as client satisfaction and family member feedback. As the following comments demonstrate, however, some FBOs evaluate even programming related to spirituality:

> Our protocol is on our homepage with the measures we use that are incredibly reliable across retreats. They're questionnaires, pre-, post-, and six to eight weeks out after the end of the retreat. They address posttraumatic growth variables (for example, are you better able to soothe and support yourself now than you were at the beginning?).

> We always do subjective evaluations and invites for personal and subjective feedback. We have subject reports and evaluations. We work with some people over many years and have intensive case studies. We've had a PhD do his dissertation on our retreats using qualitative and quantitative research on the civilians attending the retreat and its impact on them. We also have statistical analyses; we do preretreat and postretreat self-evaluations of veterans and nonveteran attendees.

The lack of universal assessment meant that we could not document the extent to which FBOs' support for veterans is successful across the different areas of health and wellness. As a whole, our interviewees felt they were making a positive difference in the lives of the veterans they served, but their ability to demonstrate that varies greatly.

HOW CAN WE MOVE FORWARD?

Veterans do not always know where to turn for help, or are reluctant to do so. Many FBOs are trusted entities within their communities and have the potential either to provide services directly or to serve as a liaison between veterans and other organizations that can offer support. As we learned through our interviews, FBOs that support veterans may have their trust as well. This trust means that FBOs can be a less-threatening venue for veterans to seek help from, given confidentiality concerns and the stigma of seeking treatment from mental health providers. Moreover, by virtue of their spiritual focus, FBOs may be uniquely qualified to heal veterans' moral injuries. Yet, some FBOs want to help but are not quite sure how they can, and others encounter obstacles to providing reintegration support to veterans. Accordingly, we offer the following recommendations for policymakers, organizations that interact with FBOs, and FBOs themselves to engage FBOs more fully in the web of reintegration support:

- **Help FBOs learn more about the veterans in their midst and how to help them most effectively**. Several organizations in our study are already dedicated to this pursuit, publishing manuals, developing web-based tools, and offering workshops for free or at little cost. Policymakers; government agencies, such as the VA; and VSOs can assist on this front as well. Such efforts can help clergy, FBO staff, and FBO volunteers alike in better supporting veterans' health and wellness.
- On the flip side, the same stakeholders should **acknowledge FBOs as a source of reintegration support for veterans, particularly for moral injury**. Veterans may not realize that faith-based support is an option for them, especially if they do not have a particular religious affiliation. Further, evidence suggests there are veterans in moral crisis, and FBOs have a distinct competency in spiritual health matters. We found that FBOs regularly support all veterans, regardless of faith tradition, and some are expressly focused on addressing veterans' spiritual needs.

As a corollary to this suggestion, FBOs can contribute to developing evidence-based treatments for moral injury that could then be used to scale up effective FBO efforts in this area.

- **Include FBOs in veterans' resource directories.** One of the FBOs in our study maintains a database of military-friendly churches, but as a whole, FBO support is not well integrated into more-comprehensive compendiums, such as the federally sponsored National Resource Directory.[34] This would be a complement to, not a substitute for, FBOs' ongoing outreach efforts, and would help to establish their legitimacy as a reintegration resource.
- **Connect chaplains and FBOs at the local level.** Veterans' familiarity and comfort with chaplains is rooted in their military service, and chaplains can use this foundation to guide veterans to other faith-based support to which veterans have less exposure. Chaplains are present in many community institutions where veterans are (e.g., universities, police departments, hospitals), and thus can serve as a bridge to link veterans to other faith-based providers. Such institutions, along with chaplains' associations and local VA facilities, can play a prominent role in brokering these linkages.
- **Build capacity among FBOs to measure the extent and effectiveness of their support.** We found that FBOs differ in their ability to demonstrate that their support has a positive influence on veterans' health and wellness. A lack of evidence can undermine an FBO's ability to obtain outside funding, and it may affect their inclusion in databases, such as the aforementioned National Resource Directory. It may not be feasible for FBOs, such as religious congregations, to collect and analyze data in a matter that satisfies typical program evaluation–level standards, but even simple efforts to track outputs (e.g., number of veterans supported in a specific time frame) and outcomes (e.g., veteran satisfaction with support, perceived improvement in well-being, housing placement) could help FBOs assess whether they are making the best use of limited resources and consider refinements to their support for veterans. Organizations that offer training to FBOs, as well as those that seek to partner with FBOs, could provide guidance to or even mentor FBOs that are less savvy about this aspect of reintegration support.

Future research can inform how these recommendations are implemented. For example, obtaining the perspective of veterans themselves, such as through interviews or focus groups, can guide refinements to outreach strategies and to FBO support. Collaborative research with FBOs to develop measures of effectiveness will ensure they are both meaningful and practical. Finally, a look at how different types of FBOs vary in terms of the nature of their support and the limitations they face may suggest refinements to policy and practice. For example, organizations that seek to partner with congregations may take a different approach from those collaborating with a national FBO.

In offering these recommendations, we acknowledge FBOs' potential as a force multiplier in reintegration support. At the same time, however, policymakers and organizations that seek to work with FBOs must be mindful of their limitations. Funding and staffing challenges suggest FBOs may be better suited as collaborators with health and social service providers than as the primary infrastructure for ongoing service provision. Some FBOs seem to recognize this already, given their focus on training counselors, chaplains, and other organizations to address moral injury rather than trying to expand their own capacity to support veterans' needs directly. All in all, the web of support can be strengthened by FBOs' distinct ability to discern and address veterans' needs, particularly those related to sensitive issues and spirituality, and to serve as a conduit to other types of reintegration support.

Notes

[1] U.S. Census Bureau, *2013 American Community Survey*, Washington, D.C., 2013; as of May 7, 2015: http://factfinder.census.gov/faces/tableservices/jsf/pages/productview.xhtml?pid=ACS_13_1YR_S2101&prodType=table

[2] Selected Reserve personnel, including Coast Guard Reserve personnel, as cited in U.S. Department of Defense (DoD), *2012 Demographics: Profile of the Military Community*, Washington, D.C., 2012; as of October 6, 2014: http://www.militaryonesource.mil/12038/MOS/Reports/2012-Demographics-Report.pdf.

[3] See, for instance, DoD, *Quadrennial Defense Review*, Washington, D.C., 2014, Ch. III; as of October 6, 2014: http://www.defense.gov/home/features/2014/0314_sdr/qdr.aspx.

[4] Pew Research Center, *War and Sacrifice in the Post-9/11 Era: The Military-Civilian Gap*, Washington, D.C., October 5, 2011; as of April 28, 2015: http://www.pewsocialtrends.org/2011/10/05/war-and-sacrifice-in-the-post-911-era/

[5] Nina A. Sayer, Siamak Noorbaloochi, Patricia Frazier, Kathleen Carlson, Amy Gravely, and Maureen Murdoch, "Reintegration Problems and Treatment Interests Among Iraq and Afghanistan Combat Veterans Receiving VA Medical Care," *Psychiatric Services*, Vol. 61, No. 6, June 2010, pp. 589–597. Other, smaller-scale studies convey more about the nature of veterans' problems. A New York state veterans' needs assessment found that they were at higher risk for mental health problems and had worse physical functioning than similar individuals in the population. In addition, they had a higher unemployment rate than the overall New York unemployment rate. Researchers also learned that, after returning from Iraq or Afghanistan, veterans had trouble reconnecting with friends and family and difficulties securing employment on par with their qualifications (Terry L. Schell and Terri Tanielian, eds., *A Needs Assessment of New York State Veterans: Final Report to the New York State Health Foundation*, Santa Monica, Calif.: RAND Corporation, TR-920-NYSHF, 2011; as of April 28, 2015: http://www.rand.org/pubs/technical_reports/TR920.html). In another study of veterans still affiliated with the National Guard or Reserve, emotional or mental health problems and civilian employment concerns were again prominent, as were health care or medical issues and relationship issues with a spouse or partner (Laura Werber, Agnes Gereben Schaefer, Karen Chan Osilla, Elizabeth Wilke, Anny Wong, Joshua Breslau, and Karen E. Kitchens, *Support for the 21st Century Reserve Force: Insights on Facilitating Successful Reintegration for Citizen Warriors and Their Families*, Santa Monica, Calif.: RAND Corporation, RR-206-OSD, 2013; as of April 28, 2015: http://www.rand.org/pubs/research_reports/RR206.html). Similarly, a California National Guard study found that, after personnel were demobilized (i.e., left active duty and returned to veteran status), they tended to contact the guard about marriage or family problems, employment or financial concerns, post-traumatic stress disorder, and substance abuse (Unpublished California National Guard study, as cited in Steven J. Danish, and Bradley J. Antonides, "The Challenges of Reintegration for Service Members and Their Families," *American Journal of Orthopsychiatry*, Vol. 83, No. 4, October 2013, pp. 550–558).

[6] Nancy Berglass and Margaret C. Harrell, *Well After Service: Veteran Reintegration and American Communities*, Washington, D.C.: Center for a New American Security, 2012.

[7] Werber et al., 2013.

[8] Laura Werber, Peter J. Mendel, and Kathryn Pitkin Derose, "Social Entrepreneurship in Religious Congregations' Efforts to Address Health Needs," *American Journal of Health Promotion*, Vol. 28, 2014, pp. 231–238.

[9] Mark Chaves and Shawna L. Anderson, "Continuity and Change in American Congregations: Introducing the Second Wave of the National Congregations Study," *Sociology of Religion*, Vol. 69, No. 4, 2008, pp. 415–440.

[10] Werber, Mendel, and Derose, 2014.

[11] See, for example, Samantha Suffoletta-Maierle, Anouk L. Grubaugh, Kathryn Marley Magruder, Jeannine Monnier, and B. Cristopher Frueh, "Trauma-Related Mental Health Needs and Service Utilization Among Female Veterans," *Journal of Psychiatric Practice*, Vol. 9, No. 5, October 2003, pp. 367–375; Charles W. Hoge, Carl A. Castro, Stephen C. Messer, Dennis McGurk, Dave I. Cotting, and Robert L. Koffman, "Combat Duty in Iraq and Afghanistan, Mental Health Problems, and Barriers to Care," *New England Journal of Medicine,* Vol. 351, July 1, 2004, pp. 13–22; Terri Tanielian and Lisa H. Jaycox, eds., *Invisible Wounds of War: Psychological and Cognitive Injuries, Their Consequences, and Services to Assist Recovery*, Santa Monica, Calif.: RAND Corporation, MG-720-CCF, 2008; as of April 28, 2015: http://www.rand.org/pubs/monographs/MG720.html; and Paul Y. Kim, Jeffrey L. Thomas, Joshua E. Wilk, Carl A. Castro, and Charles W. Hoge, "Stigma, Barriers to Care, and Use of Mental Health Services Among Active Duty and National Guard Soldiers After Combat," *Psychiatric Services*, Vol. 61, No. 6, June 2010, pp. 582–588.

[12] Lydia Chevalier, Elizabeth Goldfarb, Jessica Miller, Bettina Hoeppner, Tristan Gorrindo, and Robert J. Birnbaum, "Gaps in Preparedness of Clergy and Healthcare Providers to Address Mental Health Needs of Returning Service Members," *Journal of Religion and Health*, Vol. 54, No. 1, 2015, pp. 327–338.

[13] Ram A. Cnaan, Robert J. Wineburg, and Stephanie C. Boddie, *The Newer Deal: Social Work and Religion in Partnership*, New York: Columbia University Press, 1999.

[14] National Congregations Study, Wave 3, 2012; as of May 4, 2015: http://www.thearda.com/ncs/explorencsfreq.asp?V=238)

[15] Werber et al., 2013.

[16] U.S. House of Representatives, "Building Bridges Between VA and Community Organizations to Support Veterans and Families," hearing before the Subcommittee on Health of the Committee on Veterans' Affairs, February 27, 2012.

[17] See, for example, G. Sullivan, J. Hunt, T. F. Haynes, K. Bryant, A. M. Cheney, J. M. Pyne, C. Reaves. S. Sullivan, C. Lewis, B. Barnes, M. Barnes, C. Hudson, S. Jegley, B. Larkin, S. Russell, and P. White, "Partnerships with Rural Arkansas Faith Communities to Promote Veterans' Mental Health: Lessons Learned," *Progress in Community Health Partnerships: Research Education and Action*, Vol. 8, No. 1, 2014, pp. 11–29; U.S. Department of Veterans Affairs, *VA Offering Training for Rural Clergy: Finding New Ways to Connect Rural Vets with VA Services*, Washington, D.C.: Office of Public and Intergovernmental Affairs, 2012.

[18] Bei-Hung Chang, Nathan R. Stein, Kelly Trevino, Max Stewart, Ann Hendricks, and Lara M. Skarf, "Spiritual Needs and Spiritual Care for Veterans at End of Life and Their Families," *American Journal of Hospice & Palliative Medicine*, Vol. 29, No. 8, December 2012, pp. 610–617; Mark S. Kopacz, "Providing Pastoral Care Services in a Clinical Setting to Veterans at Risk of Suicide," *Journal of Religion and Health,* Vol. 52, No. 3, 2013, pp. 759–767; and J. A. Nieuwsma, J. E. Rhodes, G. L. Jackson, W. C. Cantrell, M. E. Lane, M. J. Bates, M. B. Dekraai, D. J. Bulling, K. Ethridge, K. D. Drescher, G. Fitchett, W. N. Tenhula, G. Milstein, R. M. Bray, and K. G. Meador, "Chaplaincy and Mental Health in the Department of Veterans Affairs and Department of Defense," *Journal of Health Care Chaplaincy*, Vol. 19, No. 1, 2013, pp. 3–21.

[19] During the consent process for these FBOs, we assured them that we would not identify local FBOs in any publication. Accordingly, we cannot list them in this report.

[20] We used data from the 2012 American Community Survey to learn how the veteran population was distributed across the 50 states.

[21] We analyzed the interview notes using QSR NVivo 10. This software package enables its users to review, categorize, and analyze qualitative data, such as text, visual images, and audio recordings. For this analysis, we developed a coding tree to facilitate the tagging of relevant interview excerpts. A coding tree is a set of labels for assigning units of meaning to information compiled during a study. Codes are used in the data reduction process to retrieve and organize qualitative data by topic and other characteristics. We based our codes largely on the interview protocols (e.g., nature of reintegration support, reasons veterans turn to FBOs for support, resources used to provide support), then reviewed and coded notes from the 29 national and local interviews. An iterative process of coding a series of interview transcripts independently, sharing examples of coding, and making refinements as needed ensured consistent application of the codes.

[22] See, for example, Matt J. Gray, Yonit Schorr, William Nash, Leslie Lebowitz, Amy Amidon, Amy Lansing, Melissa Maglione, Ariel J. Lang, and Brett T. Litz, "Adaptive Disclosure: An Open Trial of a Novel Exposure-Based Intervention for Service Members with Combat-Related Psychological Stress Injuries," *Behavior Therapy*, Vol. 43, No. 2, June 2012, pp. 407–415; Maria M. Steenkamp, Brett T. Litz, Matt J. Gray, Leslie Lebowitz, William P. Nash, Lauren Conoscenti, Amy Amidon, and Ariel Lang, "A Brief Exposure-Based Intervention for Service Members with PTSD," *Cognitive and Behavioral Practice*, Vol. 18, No. 1, February 2011, pp. 98–107; and Brett T. Litz, Nathan Stein, Eieleen Delaney, Leslie Lebowitz, William P. Nash, Caroline Silva, and Shira Maguen, "Moral Injury and Moral Repair in War Veterans: A Preliminary Model and Intervention Strategy," *Clinical Psychology Review*, Vol. 29, 2009, pp. 695–706.

[23] Litz et al., 2009.

[24] Jonathan Shay, *Achilles in Vietnam: Combat Trauma and the Undoing of Character*, New York: Simon & Schuster, 1995.

[25] Jonathan Shay, "Moral Injury," *Psychoanalytic Psychology*, Vol. 31, No. 2, April 2014, pp.182–191.

[26] Gabriella Lettini, "Engaging the Moral Injuries of War: A Call to Spiritual Leaders," *Reflective Practice: Formation and Supervision in Ministry*, Vol. 33, 2013, pp. 37–46; Kent D. Drescher, David W. Foy, Caroline Kelly, Anna Leshner, Kerrie Schutz, and Brett Litz, "An Exploration of the Viability and Usefulness of the Construct of Moral Injury in War Veterans," *Traumatology*, Vol. 17, No. 1, March 2011, pp. 8–13.

[27] Joseph M. Currier, Jason M. Holland, and Kent D. Drescher, "Spirituality Factors in the Prediction of Outcomes of PTSD Treatment for U.S. Military Veterans," *Journal of Traumatic Stress*, Vol. 28, February 2015, pp. 57–64.

[28] Berglass and Harrell, 2012.

[29] This finding emerged from our analysis of data from the 2012 National Congregations Study, a nationally representative survey of 1,331 congregations in the United States to examine the overall prevalence of congregational support to veterans and their families and to identify characteristics that predict such activity. The survey data include measures of congregational composition (e.g., ethnic or racial breakdown), congregational resources, external engagement, and religious doctrine and policy. We augmented these data with 2010 U.S. Census data and American Community Survey data pertaining to the prevalence of veterans in an area, household poverty rates, and urbanicity. Using statistical techniques, we determined what factors were significantly related to a congregation's tendency to have a group that had met in the last 12 months to support military veterans and their families.

[30] Nieuwsma et al., 2013.

[31] The confidentiality of communications in the military is a nebulous subject, but overall, chaplains are held to a different standard than mental health professionals (Nieuwsma et al., 2013). *Manual for Courts Martial*, Military Rule of Evidence, Rule 503, p. III-24, states that "A person has a privilege to refuse to disclose and to prevent another from disclosing a confidential communication by the person to a clergyman or to a clergyman's assistant, if such communication is made either as a formal act of religion or as a matter of conscience" (DoD, *Manual for Courts Martial*, 2012; as of May 4, 2015: http://www.loc.gov/rr/frd/Military_Law/pdf/MCM-2012.pdf). *Clergy* includes chaplains and chaplain's assistants. The military services have

issued guidance consistent with this rule. For example, the Army has stated that, "The privilege of total confidentiality of communications with a Chaplain is a right of every Army constituent and an essential component of the Chaplain's ministry" (Department of Army, "Policy for Protection of Confidential Communications Between Unit Ministry Team Members and Military Constituents," memorandum, September 2007). Guidance for mental health professionals does not provide a similar privilege of total confidentiality. While regulations outline a general prohibition on the disclosure or use of individuals' identifiable health information, disclosure of private health information is permitted "for activities deemed necessary by the appropriate military command authorities to assure the proper execution of the military mission" (Department of Defense 6025.18-R, "DoD Health Information Privacy Regulation," Washington, D.C.: Assistant Secretary of Defense for Health Affairs, January 2003, p. 69).

[32] Rajeev Ramchand, Lynsay Ayer, Lily Geyer, and Aaron Kofner, "Army Chaplains' Perceptions About Identifying, Intervening, and Referring Soldiers at Risk of Suicide," *Spirituality in Clinical Practice*, Vol. 2, No. 1, March 2015, pp. 36–47.

[33] John A. Fromson, Kristin E. Iodice, Karen Donelan, and Robert J. Birnbaum, "Supporting the Returning Veteran: Building Linkages Between Clergy and Health Professionals," *Journal of Psychiatric Practice*, Vol. 20, No. 6, November 2014, pp. 479–483.

[34] The National Resource Directory is a partnership among the departments of Defense, Labor, and Veterans Affairs (National Resource Directory, website, undated; as of October 6, 2014: https://m.nrd.gov/home/about_us). Its entries are from federal, state, and local government agencies; veteran and military service organizations; nonprofit and community-based organizations; academic institutions; and professional associations that provide assistance to wounded warriors and their families. Some FBOs are listed in the directory, but their numbers are limited.

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