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DEPARTMENT OF VETERANS AFFAIRS

# VISN 16: Developing a VA/Clergy Partnership to Increase Access to Mental Health Services among Rural Veterans

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## Introduction

It can be difficult for individuals with mental illness to access mental health (MH) care. These difficulties are exacerbated in rural areas where access to specialists that provide MH care may be limited.[1] Additionally, individuals in need of MH care might be reluctant to seek such care due to the stigma associated with mental illness.[2]

The ability to access quality MH treatment is particularly important for Veterans. According to the Veterans Affairs (VA) Planning Systems Support Group, approximately one-third of Operations Enduring and Iraqi Freedom (OEF/OIF) Veterans will return from active duty to rural, or highly rural, areas.[3] MH problems occur in approximately one in five of these Veterans and suicide rates are significantly higher among rural residents.[4]

Previous studies indicate that rural Veterans may not access needed MH care, even when it is available through Veterans Health Administration (VHA) services and outreach programs.[4, 5] Thus, it is important to develop other channels through which Veterans can learn about (and utilize) MH services.

VISN 16 investigators have attempted to address these concerns by developing networks of churches,

## Key Findings

- There are a large number of resources available to Veterans and their families, even in rural areas.
- Making faith communities and Veterans aware of those resources, and how to access them, is crucial.
- Pastors have many demands on their time and it may be hard to engage them around Veteran issues, making laypeople in the church and community volunteers key partners.
- Military support services in the local community, such as Family Assistance Centers at the armory, have been invaluable to local partnerships.
- Disconnects between and among those in the faith community and mental health communities can be overcome through education, building relationships, and identification of shared goals.

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community mental health providers, VA, and military support services in order to help rural Veterans get the MH care they need.

## Methods

This initiative began in 2009 and was sponsored by the VA South Central Mental Illness Research Education and Clinical Center (MIRECC), which is headquartered at North Little Rock, AR VA Medical Center.

The Office of Rural Health (ORH) funded a pilot program that trained pastors as first responders to returning Veterans in the community. An additional purpose of the pilot program was to build networks in rural communities between the churches, community mental health providers, VA and other community groups and military support services.

This program is unique in that we use a "community based participatory model." The community based participatory model suggests that if you partner equally with community members, the program that develops is more likely to be sustained over time—compared to a top-down approach. As a result our program is different at each site and tailored to the needs of each community.

### *Site 1: El Dorado, AR*

We chose El Dorado, Arkansas, located in the southern part of the state, as our first site. A local advisory board was formed and a three-hour training session was offered for pastors. This training was broad in scope, encompassing issues such as military culture, the effects of combat, the spiritual effects of war on the soul, an introduction to Veteran mental health issues, and an introduction to the local MH providers, VA staff, OIF Veterans, local clergy, and local mental health (MH) providers who were involved in the presentations.

Continued monthly meetings were supplemented by a retreat. Despite these efforts, ongoing engagement stalled except for two prominent pastors with a vision for this program. A little more than a year later, a local church and a community leader joined forces and marshaled support from various community groups and churches, eventually forming a faith-based community group committed to the needs of soldiers, Veterans, and their families. The group adopted the name "Project SOUTH (Serving Our Units aT Home)." Our partners identified five areas of focus for Project SOUTH: Prayer, Resources, Publicity, Partnership (having church members' "adopt" soldiers and families) and mental health.

Since Project SOUTH's formation, several community driven activities have taken place. The first, a breakfast, fed over 50 troops training at a local armory. Another event, a Military Family Banquet, was held at the El Dorado Convention Center and was sponsored by local churches. The banquet was attended by approximately 170 people.

We held four weekly training sessions in January and February 2012, targeting the faith community with an average attendance of 27 individuals. Additionally, 12 church families agreed to adopt a service member and his or her family to provide ongoing support.

### *Site 2: Russellville, AR*

The second site, Russellville, AR, is located in NW-Central Arkansas. The town experienced the suicide of a young Veteran in the community. A lay person, close to the family of the Veteran, was deeply concerned and mobilized pastors and community leaders to come together for a suicide prevention workshop and eventually partnered with our program. Interest in Russellville from the mental health community grew while clergy interest waned. The existence of a strong ministerial alliance and excellently planned events did not result in much pastor participation.

In Russellville, we focused on creating a dialogue between pastors and mental health providers. We did this by inviting a dozen of these individuals to lunch once every two or three months to talk and get to know each other. This proved to be an effective, non-threatening way to slowly build

relationships that have led to increased trust and cross-referrals between therapists, churches, and military support services.

Momentum is growing and the community is beginning to take ownership of the program. The local Russellville group recently planned a breakfast for the local armory, providing meals for 150 service members in addition to community volunteers. We presented, "The Pew vs. The Couch" in early February 2012, which was attended by 25 pastors and 10 mental health providers.

### *Site 3: Pine Bluff, AR*

In contrast to the first two sites which were either bi-racial or mostly Caucasian, Pine Bluff is a predominantly African American community where a pastor who has partnered with us is focusing on identifying Veterans and family members in his own church and then using their stories to motivate other pastors with an interest in reaching Veterans and their families. Work in Pine Bluff began in August 2011, with the formation of a community advisory board (CAB.) The CAB requested training and information on common MH problems among rural Veterans, reintegration challenges following deployment, and resources available to Veterans and their families. The CAB has now identified a peer-to-peer model as central to the program in their community to increase access to MH services among rural Veterans.

## Findings

### *Successes*

The program has been successful on a number of levels.

First, we noted an increased awareness in the faith community of the needs of rural Veterans and their families. Through education and dialogue, we have begun to heighten awareness of the problems associated with deployment and reintegration.

Communication and cooperation in the community has also increased. We are now seeing communication emerge between military support groups, VA mental health providers, and the local faith community. We are now seeing greater numbers of Veterans and family members being referred to MH services by clergy and the faith community as a result of our efforts. This is the ultimate challenge and goal of our program. Most notably this is a community-driven partnership program that leads to efforts unique to each community and with promising odds of being self-sustained.

### *Challenges*

This project is not without its challenges. Achieving racial diversity in the leadership of some of the sites has been challenging, and we are seeking creative ways to address this issue. Pastors may be too busy to commit large amounts of time so we also partner with church lay leadership.

One of the bigger struggles has been both finding Veterans and educating them on the myriad of resources available to them. We find that family members play a key role in encouraging Veterans to seek care.

We have found that developing these partnerships requires a great deal of work and patience. In the two initial sites, it has taken approximately 18 months for these networks to coalesce.

Unfortunately, there are no easy formulas for how to develop a successful local program. Each site is unique and grows to meet its needs in very different ways. We aim to let each community form its own agenda and mobilize its own resources. This is essential to the development of a self-sustaining network that can continue to meet the needs of Veterans.

One final challenge is maintaining the mental health focus. Our El Dorado site has been quite successful and now involves at least 20 churches and other community groups. We have found that these organizations tend to focus on the more

tangible, physical needs to families and service members. While these are certainly excellent preventive measures that benefit service members, we must actively encourage a focus on mental health treatment as the problems faced by returning Veterans have not been the focus to date.

### *Program Administration*

The program is directed by Steve Sullivan, a VA chaplain who devotes at least half of his time to the program, and Greer Sullivan, a psychiatrist and the director of the SC MIRECC. Additionally, three other part-time chaplains are involved in the program.

Our summary of the program costs, per site, is as follows:

**Table 1. Program Cost, Per Site**

| | |
|---|---|
| 0.50 FTE Chaplain | $36,000 |
| 0.50 FTE Admin | $34,000 |
| Travel | $8,000 |
| Materials | $3,000 |
| Total | $81,000 |

The uniqueness of our partnership approach lies in our dedication to making it community-based. We rely on those in the community to identify the needs, resources and direction of the partnership in that area. That means that the partnership looks different in every site and that there is no simple step-by-step formula for best practices.

However, we have identified the following guiding principles that would be beneficial to those hoping to replicate this approach.

First, we begin by identifying a location that is close to a rural, VA, community-based outpatient clinic. Building relationships with key members of the local faith community, mental health providers or military personnel who are interested in being involved in this partnership is crucial to the success of this approach. This step is very time consuming but is, in our opinion, the most important.

We then hold regular meetings with an "advisory board" to create awareness of Veteran issues. We invite pastors from different denominations, mental health providers, military-related personnel, and Veterans to form community advisory boards.

Finally, we emphasize the importance of training that will begin to increase the faith community's MH literacy, awareness of Veterans in their community, and knowledge of resources available to Veterans.

Throughout this process, we emphasize sensitivity, confidentiality, and inclusiveness of all faith and military perspectives. There is no formulaic approach to establishing community-based partnerships. However, these have been some of the guiding principles that have been helpful to us and would likely support other attempts to form faith-based partnerships to address the needs of Veterans.

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