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Abstract

Chaplains play important roles in caring for Veterans and Service members with mental health problems. As part of the Department of Veterans Affairs (VA) and Department of Defense (DoD) Integrated Mental Health Strategy, we used a sequential approach to examining intersections between chaplaincy and mental health by gathering and building upon: (1) input from key subject matter experts; (2) quantitative data from the VA/DoD Chaplain Survey (N = 2,163; response rate of 75% in VA and 60% in DoD); and (3) qualitative data from site visits to 33 VA and DoD facilities. Findings indicate that chaplains are extensively involved in caring for individuals with mental health problems, yet integration between mental health and chaplaincy is frequently limited due to difficulties between the disciplines in establishing familiarity and trust. We present recommendations for improving integration of services, and we suggest key domains for future research.

Keywords: mental health, chaplaincy, military, veterans, integrated care

Introduction

Chaplains have served the needs of military personnel dating back over centuries of recorded military conflict (Bergen, 2004). In the United States, chaplains have been part of the military since the nation's inception, with the Second Constitutional Congress voting in 1775 to pay chaplains to serve the Army (*Journal of the Continental Congress*, 1775). Then in 1865, President Abraham Lincoln made provision for chaplaincy when he established the first national Homes for Disabled Volunteer Services (*Journal of the Senate of the United States of America*, 1864), the foundation for what has become the Department of Veterans Affairs (VA). Chaplains' roles have undoubtedly fluctuated some over time, but the enduring presence of chaplains in the military context over the centuries is a testament to the significance of a chaplain's presence in the midst of some of life's most challenging moments for many military personnel. As members of the U.S. military return home from recent conflicts of the post-9/11 era, it is crucial for VA and the Department of Defense (DoD) to carefully consider how to best involve chaplains in the care of Veterans and Service members.

Recognizing that chaplains can play a crucial role in relation to mental health, VA and DoD responded in the fall of 2010 by launching the VA/DoD Integrated Mental Health Strategy (IMHS; DoD and VA, 2010), with a key component of the VA/DoD IMHS focusing on roles for chaplains in caring for Veterans and Service members with mental health needs. Chaplains have long been front-line service providers in understanding and caring for Veterans and Service members who are dealing with mental health issues (Bonner et al., 2013; Department of the Army, 2012; Elbogen et al., 2013; Hamilton, Jackson, Abbott, Zullig, & Provenzale, 2011; Zullig et al., 2012), ranging from problems like adjusting to military life or a medical diagnosis to significant psychiatric problems like posttraumatic stress disorder (PTSD), mood disorders, and suicidality. In the extensive 2010 report produced by the DoD Task Force on the Prevention of Suicide by Members of the Armed Forces, chaplains were frequently cited as vital to the prevention of suicide by members of the military (Department of Defense Task Force on the Prevention of Suicide by Members of the Armed Forces, 2010). Recent efforts within different branches of the Armed Forces to conceptualize spirituality as meaningfully related to health and fitness (Fravell, Nasser, & Cornum, 2011; Hufford, Fritts, & Rhodes, 2010; Pargament & Sweeney, 2011) further underscore a recognition within the military that chaplains can assume a fundamentally integral role in attending to the overall mental, emotional, relational, and spiritual needs of those they serve.

While Service members and Veterans with mental health problems certainly turn to clergy for many of the same reasons as non-military personnel—for example, familiarity and convenience (Weaver, Revilla, & Koenig, 2002), reduced stigma (Milstein, Manierre, & Yali, 2010), accessibility in times of crisis (Oppenheimer, Flannelly, & Weaver, 2004), and shared spiritual or religious worldview (Curlin et al., 2007)—there are also important particularities for why Service members and Veterans may seek out a chaplain. For Service members, the chaplain can serve not only as a spiritual advisor who ensures the provision of religious observances but also as a trusted confidant. Many Service members might be reluctant to seek care from a mental health professional for fear of stigma or negative impact on their career (Kim, Britt, Klocko, Riviere, & Adler, 2011; Kim, Thomas, Wilk, Castro, & Hoge, 2010), but they may be willing to turn to a chaplain. In the military, chaplains operate by a different standard than mental health professionals with respect to confidentiality. All communications are to be treated as confidential with a military chaplain for Service members on active duty (Department of the Air Force, 2005; Department of the Army, 2007; Department of the Navy, 2008; Joint Staff, 2009; U.S. Coast Guard & U.S. Department of Homeland Security, 2012; U.S. Marine Corps, 1997). Such confidentiality can appeal to Service members who are afraid of being seen as weak or who fear that damaging information about their emotional state could be passed along to their commanding officers. In addition, chaplains often have established relationships with Service members that facilitate Service members seeking care from chaplains and enable chaplains to understand the broader context surrounding the individual seeking help.

The nature of military service exposes many Service members to distinct challenges and emotional strains that can have consequences for moral, spiritual, and religious functioning. Much recent attention has been devoted to the construct of "moral injury"—that is,

the idea that war can present profound moral and ethical challenges that can have corresponding deleterious spiritual and psychosocial consequences (Drescher et al., 2011; Gray et al., 2012; Litz et al., 2009). In research examining Veterans with PTSD, more severe PTSD has been found among those who harbor combat guilt (Henning & Frueh, 1997) and those who have difficulty with forgiveness (Witvliet, Phipps, Feldman, & Beckham, 2004). Studies of Veterans in treatment for PTSD have found that many abandoned their religious faith during war and that many feel abandoned or punished by God (Drescher, 2010; Drescher & Foy, 1995). These findings suggest that guilt, forgiveness, religious belief, and perceptions of God are intertwined with the experience of PTSD. In keeping with this, a study of Veterans with PTSD who sought VA services found that these Veterans were motivated to seek treatment not so much by their PTSD symptom severity or social deficits as by their search for life meaning (Fontana & Rosenheck, 2004).

Veterans and Service members need systems of care in place that can adequately address the complexity of their emotional, relational, spiritual, and mental health care needs. For many, this will entail more effectively integrating chaplaincy with mental health care services, an objective that is consistent with the mission of VA. As the nation's largest fully integrated healthcare system (Modern Healthcare, 2012), VA has become a leader in advancing models of integrated care. Examples of VA's leadership include the Primary Care-Mental Health Integration Initiative (Post & Van Stone, 2008; Zeiss & Karlin, 2008), the implementation of Patient Aligned Care Teams (PACTs; Klein, 2011), and of direct relevance for the current project, the VA Mental Health and Chaplaincy Program (Meador, Drescher, Swales, & Nieuwsma, 2010; Nieuwsma, 2010). Including chaplaincy as a core component in integrated systems of care holds promise as an approach for improving health outcomes for Veterans and Service members.

The current project, delineated as Strategic Action (SA) #23 of the VA/DoD IMHS, embodies two aims: (1) describe the current state of chaplaincy in VA and DoD with a focus on chaplains' engagement in mental health issues; and (2) provide recommendations for better integrating chaplaincy with mental health care that are grounded in empirical findings and input from leadership. These aims were accomplished using a combination of quantitative and qualitative methods.

Methods

The present project, conducted from January 2011 to December 2012, relied on a sequential approach to gathering and building upon: (1) input from key subject matter experts as part of a task group as well as a multidisciplinary forum; (2) quantitative data from a survey of all full-time VA chaplains and all active duty DoD chaplains; and (3) qualitative data from interviews conducted with mental health providers and chaplains during a series of visits to VA and DoD facilities. Each of these components is described in the following sections.

Task Group Proceedings
We assembled a task group composed of 38 leaders and experts in the field, with 17 coming from VA, 14 from DoD, and 7 from outside organizations. In addition to providing regular guidance, input, and support throughout the project, the task group convened for a kickoff

meeting, a multidisciplinary forum, sub-task group meetings, and a final meeting. At all of these meetings, task group members supplied input by answering open-ended questions, providing guidance on next steps as part of the project, and giving feedback on potential recommendations. Transcripts were created from the group discussions at all of these proceedings, and thematic content from the transcripts was later extracted.

VA Mental Health and Chaplaincy Forum

The VA Mental Health and Chaplaincy Forum brought together a group of 71 experts with complementary and professionally diverse backgrounds (including but not limited to task group members) to examine the relationships between spirituality and health and provide input on how chaplains, clergy, and other spiritual care providers might be integrated optimally into a public health model that better addresses the complex health needs of Veterans, Service members, and their families. Attendees came from VA, DoD, and academic institutions; served as clinicians, researchers, and national leaders; and represented the disciplines of mental health, chaplaincy, and affiliated health care professions. Written transcripts of the group discussions were recorded and analyzed.

VA/DoD Chaplain Survey

All full-time VA chaplains and all active duty military chaplains were invited to anonymously complete a web-based survey that assessed chaplain practices with respect to spiritual and mental health care, collaboration with mental health providers, and attitudes and knowledge about mental health issues. This information was collected to help elucidate chaplain care practices in VA and DoD, develop effective approaches to training and integrating chaplains with other health professionals, and provide a baseline from which to measure efforts to implement and disseminate effective models of integrated chaplain and mental health care. The VA/DoD Chaplain Survey was developed with input from multiple task group members. The Director of the National Chaplain Center in VA and the Chiefs of Chaplains in DoD encouraged chaplains to voluntarily complete the anonymous survey. The survey included a core component (average of 37 minutes to complete), as well as a supplemental component (average of 6 minutes to complete) that respondents were separately invited to complete after finishing the core survey. A total of 2,163 chaplains participated. The response rates were generally high, with the survey being completed by 75% of VA chaplains (n = 440 of 585 invited) and 60% of DoD chaplains (n = 1,723 of 2,879 invited). Approval to conduct the VA/DoD Chaplain Survey was obtained from appropriate authorities within VA and DoD.

VA/DoD Site Visits

A series of visits to VA and DoD facilities were conducted for the purpose of building an in-depth understanding of existing chaplain-mental health collaboration in VA and DoD. The site visits were designed to provide a qualitative counterpart to the quantitative data collected in the VA/DoD Chaplain Survey. In particular, the site visits aimed to determine: (1) opportunities for creating integrated mental health-chaplain care; (2) barriers to creating such an integrated system of care; (3) existing practices in the field that further or hinder integration; and (4) gaps in knowledge, practice, or structure related to integration of

chaplain and mental health work. A diversity of sites were selected for inclusion on the basis of geographic location, facility type (e.g., size of medical center, academic affiliation), and current state of chaplain-mental health integration. Site visits were conducted at 33 facilities: 17 were VA facilities; 15 were DoD facilities; and 1 was a joint VA/DoD facility (see Appendix 1). In addition, five phone interviews were conducted with Air Force chaplains. A total of 291 interviews were conducted with chaplains and mental health professionals. Using a grounded theory approach (Strauss & Corbin, 1998), the interviews were coded to identify important themes. Approval to conduct the VA/DoD Site Visits was obtained from appropriate authorities in VA and DoD.

Findings

The following qualitative findings from subject matter experts and site visit interviewees are synthesized with quantitative findings from the VA/DoD Chaplain Survey to provide an overview of chaplaincy in VA and DoD, a summary of the major barriers identified to integrating chaplaincy and mental health care, and a synopsis of proposed solutions.

Overview of Chaplaincy in VA and DoD
While common threads run through the work of both VA and DoD chaplains, it was apparent from the outset of task group meetings that chaplains in VA and DoD are also distinct in many ways. The most evident distinction is that VA chaplains work in a healthcare environment (primarily inpatient settings), whereas most DoD chaplains are in non-clinical settings (only 11% indicated serving in a healthcare setting on the survey; see table 1). Because DoD has a different mission than VA, military chaplains tend to fulfill more "organic" roles (assigned on a permanent basis and part of daily life in their command) and are more focused on enhancing Service members' resilience. Survey data evidenced a number of other differences between VA and DoD chaplains. Compared to chaplains in DoD, VA chaplains are older, are less likely to identify as an evangelical Protestant, have more years of experience in chaplaincy, and have more training for work in clinical environments (see table 1). Importantly, over half of VA chaplains are themselves Veterans.

Table 1. Demographics from VA/DoD Chaplain Survey

	VA *n* (%)	DoD *n* (%)	*p*
Age ≥ 55 y/o	304 (77%)	252 (18%)	<.001
Sex			< .001
Male	330 (83%)	1,370 (96%)	
Female	68 (17%)	59 (4%)	
Race			< .001
White	288 (73%)	1,091 (79%)	
Black	72 (18%)	92 (7%)	
Asian	13 (3%)	98 (7%)	
Other	13 (3%)	72 (5%)	
Multiple	8 (2%)	35 (3%)	
Education/Certification			
Doctoral degree	114 (28%)	227 (16%)	< .001
At least 3 units of CPE	290 (72%)	436 (30%)	< .001
Board Certified Chaplain	197 (49%)	353 (25%)	<. 001
At least 20 years as chaplain	173 (43%)	321 (22%)	< .001
Religious Affiliation			< .001
Evangelical Protestant	105 (26%)	745 (53%)	
Mainline Protestant	119 (30%)	292 (21%)	
Catholic	83 (21%)	113 (8%)	
Historically Black Protestant	20 (5%)	19 (1%)	
Other	43 (11%)	134 (9%)	
Multiple	32 (8%)	109 (8%)	
Military Experience			
Veteran/Service member	213 (54%)	—	
Rank ≥ O4	109 (27%)	796 (56%)	
Iraq deployment	29 (7%)	983 (68%)	
Afghanistan deployment	24 (6%)	627 (43%)	
Stationed in health care facility	—	164 (11%)	

CPE = clinical pastoral education. Immediately prior to completing questions in the "Demographics" portion of the VA/DoD Chaplain Survey, participants were explicitly reminded that "answering these questions is voluntary and there is no penalty for not answering." The majority of chaplains still answered these questions, with missing data for the above variables ranging from 36 (8%) to 46 (10%) cases out of the total VA sample (*n* = 440) and 273 (16%) to 335 (19%) cases out of the total DoD sample (*n* = 1,723). Percentages in the table are based out of the total number of those that responded to each question. Participants were able to select from a more extensive listing of racial and religious affiliation categories than presented in the table. Participants who selected more than one racial or religious category are included in the Multiple category and infrequently endorsed racial and religious affiliations were collapsed into the Other category.

Survey findings also point to important similarities between chaplains in VA and DoD. Among chaplains who work in healthcare settings (all VA chaplains and a subset of DoD chaplains), it is more common for them to work in inpatient settings than outpatient settings and to work in general medical settings than mental health settings (see table 2). Both VA and DoD chaplains indicated that they see Veterans and Service members with com-

mon mental health problems somewhat more frequently than they see Veterans and Service members with overtly spiritual issues (see table 3). Notably and predictably, consistent with their historical and important core mission, chaplains in both VA and DoD reported feeling better trained to care for individuals with spiritual issues. The top problems that VA chaplains reported seeing were largely psychiatric in nature; whereas the top problems that DoD chaplains reported seeing reflect a generally less severe range of life stressors and mental health issues. As many task group members emphasized, the mental health problems that chaplains encounter often cannot be easily disentangled from related spiritual problems, underscoring the importance of having chaplains function as part of integrated health care teams. In both VA and DoD, qualitative findings indicate that chaplains may be more likely to be sought out for care than mental health care providers for reasons such as reduced stigma, greater confidentiality, more flexible availability, and comfort with clergy as natural supports within a community. On the survey, 59% of VA chaplains and 79% of DoD chaplains agreed that Veterans and Service members with mental health problems commonly seek help from chaplains instead of mental health providers, with the most common reason being a desire for confidentiality (33% of VA chaplains and 65% of DoD chaplains identified this as a frequent reason).

Table 2. Locations of Clinical Work – VA/DoD Chaplain Survey

Clinical setting	VA n (%)	DoD HC n (%)	p	DoD Non-HC
Inpatient medical	356 (83%)	101 (62%)	< .001	94 (7%)
Inpatient psychiatric/mental health	244 (58%)	47 (29%)	< .001	87 (7%)
Inpatient substance abuse programs	206 (49%)	27 (17%)	< .001	45 (4%)
Outpatient medical	176 (41%)	61 (37%)	.432	111 (9%)
Outpatient mental health	146 (34%)	30 (19%)	< .001	162 (13%)
Outpatient substance abuse programs	136 (32%)	21 (13%)	< .001	78 (6%)
Specialized PTSD treatment—inpatient	138 (32%)	24 (15%)	.009	45 (4%)
Specialized PTSD treatment—outpatient	112 (26%)	32 (20%)	.895	92 (7%)

HC = health care. Percentages are of chaplains who reported spending a "moderate amount" to "large amount" of time in the listed clinical settings. DoD health care chaplains are those that indicated being stationed in a health care facility (n = 164). DoD non-health care chaplains are those that indicated not being stationed in a health care facility (n = 1,269). DoD chaplains that did not answer this question (n = 290) were not included in this analysis. All VA chaplains were included in this analysis (n = 440), as all VA chaplains work in healthcare settings. The p-values are for differences between VA chaplains and DoD health care chaplains. DoD non-health care chaplains were significantly different (p < .001) from both groups for all clinical settings. Missing data for the above variables ranged from 12 (3%) to 16 (4%) cases out of the total VA sample, 0 (0%) to 2 (1%) cases out of the total DoD health care chaplain sample, and 6 (0%) to 16 (1%) cases out of the total DoD non-health care sample. Percentages in the table are based out of the total number of those that responded to each item.

Table 3. Problems Encountered and Trained for – VA/DoD Chaplain Survey

Most frequently encountered problems		Problems for which best trained	
VA	DoD	VA	DoD
1. Anxiety (2.76)*	1. Relationship/family stress (2.79)*	1. Struggle with religious belief system (2.87)	1. Struggle with religious belief system (2.89)
2. Physical health problems (2.71)*	2. Work stress (2.74)*	2. Guilt (2.82)*	2. Other spiritual struggle (2.85)*
3. Alcohol abuse (2.70)*	3. Anger (2.52)	3. Difficulty forgiving others (2.82)	3. Spiritual struggle understanding loss/trauma (2.83)
4. Depression (2.69)*	4. Anxiety (2.40)	4. Spiritual struggle understanding loss/trauma (2.82)	4. Difficulty forgiving others (2.80)
5. Guilt (2.67)*	5. Depression (2.38)	5. Difficulty accepting forgiveness (2.80)	5. Relationship/family stress (2.80)*
6. Spiritual struggle understanding loss/trauma (2.67)*		6. Difficulty forgiving self (2.78)	6. Suicidal thoughts/ intentions (2.78)*
7. Anger (2.67)*		7. Other spiritual struggle (2.78)	7. Difficulty forgiving self (2.77)
8. PTSD (2.65)*			8. Difficulty accepting forgiveness (2.76)

Survey respondents were presented with a list of 32 items and asked (1) How often do you see Veterans/Service members with the following problem? (scale of 1 = Rarely to 3 = Frequently); and (2) How well has your training prepared you to provide pastoral care to Veterans/Service members with the following problems? (scale of 1 = Not Prepared to 3 = Very Prepared). Items are presented in rank order of those that received the highest average scores, with mean scores displayed in parentheses. We ceased listing problems in each column when the mean score for the next most common problem was notably lower. Missing data for the above variables ranged from 5 (1%) to 24 (5%) cases out of the total VA sample (n = 440), and 47 (3%) to 91 (5%) cases out of the total DoD sample (n = 1,723).

*Indicates that chaplains from this Department (VA or DoD) were significantly more likely (p < .01) than chaplains from the other Department to report (1) encountering or (2) feeling well trained to encounter the problem.

Barriers to Integrating Chaplaincy with Mental Health

Task group members and site visit interviewees recurrently noted benefits of better integrating mental health and chaplain services—including the provision of more holistic care, reduced stigma in receiving mental health care, and improved access to care—but they also acknowledged substantial barriers to achieving integration. The site visits evidenced that while notable models of successful integration exist, there is much variability between facilities and much depends on the chaplain taking initiative to form relationships with mental health providers. On the VA/DoD Chaplain Survey, substantial proportions of chaplains reported rarely (less than monthly or never) making referrals to mental health (43% in VA; 37% in DoD) or receiving referrals from mental health (36% in VA; 74% in DoD). The limited integration between mental health and chaplaincy frequently appears to be the result of difficulties in establishing trust and confidence, which in turn appears to be often caused by a lack of familiarity between the disciplines.

In both VA and DoD, the vast majority of chaplains indicated on the survey that the role of mental health professionals is one they understand (96% agreed in VA; 94% in DoD) and value (99% in VA; 96% in DoD), but fewer chaplains feel that their work is something

that mental health professionals understand (56% agreed in VA; 46% in DoD) and value (85% in VA; 70% in DoD). When chaplain–mental health relations are not strong, Veterans and Service members may not receive the spiritual or mental health care services they most need. Additionally, a fundamental barrier to integration, particularly in VA, is that chaplains are already stretched thin with existing responsibilities (such as conducting spiritual assessments) and many facilities have chaplain staff shortages.

Improving Integration of Chaplaincy with Mental Health

The primary solution to limited mental health–chaplaincy integration that emerged from the current project is to provide cross-disciplinary opportunities for interaction and training among chaplains and mental health care providers (see fig. 1). On the VA/DoD Chaplain Survey, 95% of all chaplains agreed that mental health providers and chaplains can closely collaborate while retaining identities and abilities unique to their respective professions. Approaches identified by the task group for improving collaboration and integration include: (1) jointly training chaplains and mental health care providers; (2) enhancing communication via reliable documentation of chaplains' assessment and care practices in a way that honors confidentiality concerns; (3) promoting organizational mechanisms and models that encourage teamwork (e.g., joint clinical rounds and clinical team meetings); and (4) providing opportunity for interaction between VA and DoD chaplains in order to create continuity of care for Service members transitioning to civilian life.
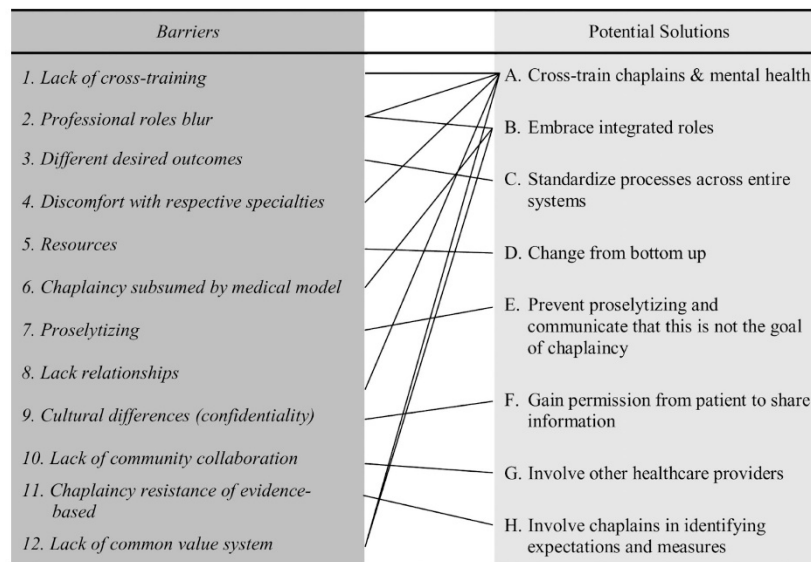

Barriers	Potential Solutions
1. Lack of cross-training	A. Cross-train chaplains & mental health
2. Professional roles blur	B. Embrace integrated roles
3. Different desired outcomes	C. Standardize processes across entire systems
4. Discomfort with respective specialties	D. Change from bottom up
5. Resources	E. Prevent proselytizing and communicate that this is not the goal of chaplaincy
6. Chaplaincy subsumed by medical model	F. Gain permission from patient to share information
7. Proselytizing	G. Involve other healthcare providers
8. Lack relationships	H. Involve chaplains in identifying expectations and measures
9. Cultural differences (confidentiality)	
10. Lack of community collaboration	
11. Chaplaincy resistance of evidence-based	
12. Lack of common value system	

Figure 1. Barriers to integration and solutions – VA mental health and chaplaincy forum. The left column displays barriers that were generated by participants in the four VA Mental Health and Chaplaincy Forum breakout groups. The right column displays a selection of the most prominent solutions to barriers that were generated by the groups during a subsequent breakout session. Lines connect barriers to the corresponding main solutions that were generated by forum attendees.

Pursuing improved integration of mental health and chaplain services can also help VA achieve some of its current mental health care objectives, including reducing homelessness, enhancing care for women Veterans, and preventing suicides (U.S. Department of Veterans Affairs, 2010). On the survey, 72% of VA chaplains reported caring for homeless Veterans on a weekly to daily basis, demonstrating that chaplains are a major point of contact for this population. While still a minority at 17%, VA contains four times the proportion of female chaplains as DoD, with 9% of VA chaplains indicating that they are members of a women's health clinic team and 100% of those chaplains reporting that team members understand and value their contribution. The previously noted psychosocial problems frequently seen by chaplains are also risk factors for suicidality. Indeed, 84% of VA chaplains and 81% of DoD chaplains indicated that it is not uncommon for them to see Veterans or Service members with suicidal thoughts/intentions. Importantly, suicide prevention was a notable area on the survey in which DoD chaplains indicated feeling well prepared via training (79% indicated feeling "very prepared," compared to 58% in VA; see table 3), evidencing that DoD's training efforts in this domain are having an impact on chaplains and suggesting that such trainings are worth pursuing in VA as well.

Discussion

Chaplains play a crucial role in mitigating mental health problems and in caring for Veterans and Service members who are suffering from emotional, relational, and mental health struggles. Chaplains fulfill this role in tandem with their responsibilities in caring for religious and spiritual needs. It is of utmost importance that efforts to more effectively integrate mental health and chaplain services not detract from the core identity and role of chaplaincy in caring for the spiritual and religious needs of those they serve.

Although there are examples in VA and DoD of mental health and chaplain services being well integrated, there is extensive variability in whether and how chaplains engage with local mental health care systems. In general, integration of services is limited. However, chaplains and mental health care providers alike generally express an openness and interest in more effectively integrating their services. While a number of specific barriers to chaplain–mental health integration were identified during the course of our project, a large percentage of the barriers are related to issues of trust and confidence between the disciplines. Mental health providers, and chaplains to a lesser extent, noted a reluctance to refer to one another without increased interpersonal familiarity with their colleagues representing the other discipline and an increased understanding of respective professional roles and capacities. Establishing this familiarity, on both personal and professional levels, is crucial if the disciplines are to attain meaningful confidence in one another.

The integration of mental health and chaplaincy services can be improved. A primary suggestion for accomplishing this coming out of the present project is to promote cross-disciplinary opportunities for interaction and training among chaplains and mental health care providers. Using findings from the current project, we have developed a model that aims to: (1) enhance training of individual chaplains and mental health care providers; and (2) encourage organizational-level efforts to enhance integration (see fig. 2). We provide a

brief overview of the individual-level and organizational-level aspects of this model in the following section.
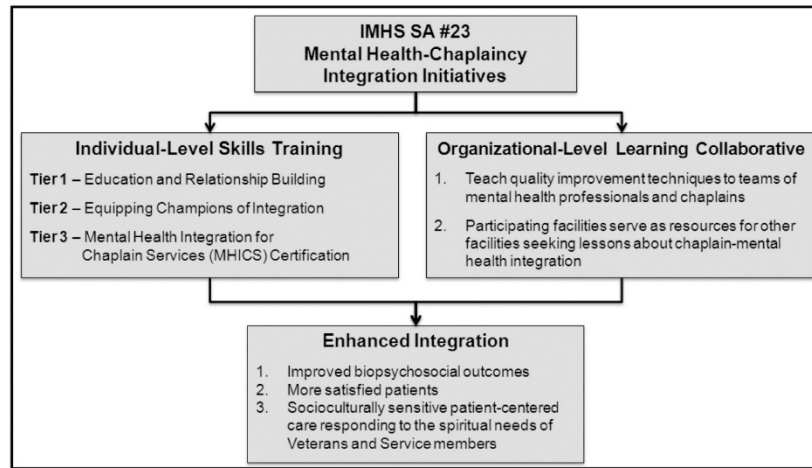

Figure 2. Mental health and chaplaincy integration initiatives. IMHS SA #23 = VA/DoD Integrated Mental Health Strategy, Strategic Action #23 (Chaplains' Roles).

Individual-Level Training

The individual-level training initiatives developed out of this project are divided into three tiers, with each succeeding tier focusing on more select groupings of chaplains and mental health professionals and more intensive approaches. In the first tier, "Education and Relationship Building," the target group includes all chaplains and mental health care providers. Via activities such as webinars, onsite trainings, and basic relationship building opportunities, the goal within this most global tier is to educate mental health care providers and chaplains about each other's respective disciplines and introduce basic approaches to collaboration. In the second tier, "Equipping Champions of Integration," the focus is on mental health providers and chaplains who work in settings where integration of services is a feasible objective within the system. The goal in this tier is to equip providers to be engaged in close professional integrative work, to be accomplished through activities such as co-education of interns and residents, support for chaplain and mental health provider pairs to jointly attend appropriate evidence-based training roll-outs, and recurring seminar series that explore integration. In the third tier, "Mental Health Integration for Chaplain Services (MHICS)," the primary target audience is chaplains who are dedicating a significant portion of their professional effort to working in mental health care settings. This program would provide interested chaplains an intensive, focused training experience aimed at better equipping them to participate as part of integrated mental health care teams.

Organizational-Level Collaboratives

In addition to individual-level training, we propose to build on the successful utilization of the collaborative learning model in VA to conduct a Mental Health–Chaplain Integration Learning Collaborative. This effort will bring together motivated teams of chaplain and mental health representatives to develop and implement tools to enhance integration based on findings from the current project (including enhanced documentation practices, collaborative assessments, and joint clinical conferences). As with other collaboratives, teams will learn about quality improvement techniques used to implement effective changes (Jackson et al., 2010). Collaboratives are typically conducted over the course of one year and include in-person learning sessions with facilitated interaction in-between.

Limitations

The current project represents an unprecedented investigation into the intersections between chaplaincy and mental health care in VA and DoD, yet there are notable limitations to this project and much work remains. First, practical limitations prevented us from systematically soliciting quantitative input from mental health providers (although they were included in qualitative aspects of the current project) or from Veterans and Service members. Clearly, more input from these groups is needed. Second, although extensive, the VA/DoD Chaplain Survey necessarily contained a number of previously untested scales and was limited to questions about professional practices (questions about chaplains' personal experiences, such as self-care habits or their experience with mental health problems, were not included). Third, our recommended model for integration of mental health and chaplain services remains to be evaluated. The current project provided the much needed groundwork for developing recommendations, but there is a clear need to evaluate and refine recommendations throughout the implementation process.

Future Evaluation and Research

There is significant need for more research on topics where chaplaincy and mental health converge. We propose the following domains for future research:

1. Descriptive Epidemiology: Studies are needed to provide a better baseline understanding of issues pertaining to the intersection of chaplaincy and mental health within different patient populations.

2. Assessment and Measurement: There is significant opportunity to better understand the characteristics of spiritual assessments and how to effectively utilize results, particularly for mental health populations.

3. Clinical Interventions: Possibilities in this domain are extensive with respect to utilization of clinical trial and controlled study research methodologies. Given the interest evidenced by many recently developed psychotherapeutic models in practices such as mindfulness and meditation, research that acknowledges and incorporates the spiritual aspects of these practices is warranted. We note that any research in this domain should entail very careful consideration of what constitute appropriate outcome measures.

4. Implementation Science: As efforts are implemented to better integrate chaplaincy and mental health care, it will be necessary to study the broad array of organizational-level and individual-level factors that can impact both the degree of implementation and effectiveness of integration strategies.

Conclusion

Quality of care for Veterans, Service members, and patients in the civilian sector is likely to improve via a more intentional integration of chaplaincy with mental health care services. While there are gaps in the integration of chaplain and mental health care services, VA and DoD are taking proactive steps to ensure that chaplains and mental health care providers work together to provide the best care possible. As men and women of the Armed Forces return home after over a decade of post-9/11 conflict, there is no more important time than the present to improve the systems of care dedicated to meeting the needs of those who have served.

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Appendix 1. VA and DoD Site Visit Locations

1. Fort Bragg
2. **Brooke Army Medical Center**
3. **South Texas Veterans Healthcare System**
4. Naval Hospital – Marine Corps Base Camp Pendleton
5. Naval Medical Center San Diego
6. Marine Corps Recruit Depot
7. Surface Force Ministry Center, U.S. Navy Pacific Fleet
8. **VA San Diego Health Care System**
9. Marine Corps Air Ground Combat Center, Twentynine Palms
10. Walter Reed National Military Medical Center
11. **Washington DC VA Medical Center**

12. **Charles George VA Medical Center**
13. *Captain James A Lovell Federal Health Care Center*
14. **Edward Hines Jr. VA Hospital**
15. **Minneapolis VA Healthcare System**
16. **Tennessee Valley Healthcare System**
17. **White River Junction VA Medical Center**
18. **Ralph H Johnson VA Medical Center**
19. Naval Health Clinic Charleston
20. Fort Hood
21. Naval Hospital Bremerton
22. **VA Puget Sound Healthcare System**
23. **Central Arkansas Veterans Healthcare System**

24. Schofield Barracks
25. Tripler Army Medical Center
26. VA Pacific Islands Healthcare System
27. Joint Base Pearl Harbor-Hickam
28. Marine Corps Base Hawaii
29. **Louis Stokes Cleveland VA Medical Center**
30. **VA New York Harbor Healthcare System**
31. **Boise VA Medical Center**
32. **Eastern Kansas VA Medical Center**
33. **Cheyenne VA Medical Center**

VA facilities
DoD facilities
Joint VA/DoD facility

Note: Telephone interviews were also conducted with Air Force and Marine Reserve chaplains. The map is geographically parceled according to the separate Veterans Integrated Service Networks (VISNs).