VA / DoD Integrated Mental Health Strategy

The Intersection of Chaplaincy and Mental Health Care in VA and DoD: Expanded Report on Strategic Action #23

Prepared for:

VA / DoD Health Executive Council (HEC) Psychological Health and Traumatic Brain Injury Work Group
Washington, DC

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PREFACE

The Department of Veterans Affairs (VA) and Department of Defense (DoD) Integrated Mental Health Strategy (IMHS) was launched in the Fall of 2010 with the stated mission of advancing "an integrated and coordinated public health model to improve the access, quality, effectiveness, and efficiency of mental health services for all Active Duty Service members, National Guard and Reserve members, Veterans, and their families." The strategy proposed four overarching strategic goals that encompassed a total of 28 separate strategic actions. The focus of this report is to detail findings from Strategic Action (SA) #23, which focused on the intersection of chaplaincy and mental health care services in VA and DoD.

This expanded report is the basis for a more abbreviated report on IMHS SA #23, and it serves as a more detailed complement to that summary report. Comments on this expanded report as well as the summary report are welcome and can be sent to the IMHS leads for this project. In VA, these are Dr. Keith Meador (keith.meador@va.gov), Chaplain Keith Ethridge (keith.ethridge@va.gov), and Dr. Jason Nieuwsma (jason.nieuwsma@va.gov). In DoD, these are Dr. Mark Bates (mark.j.bates.civ@mail.mil) and Dr. Chaplain Jeff Rhodes (jeffrey.e.rhodes4.ctr@mail.mil).

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Superscript notations following task group members' names indicate participation as a member of: 1) Task Group Kickoff Meeting; 2) VA Mental Health and Chaplaincy Forum (there were additional participants at the forum who were not task group members); 3) Documentation Practices Sub-Task Group; 4) Assessment and Screening Practices Sub-Task Group; and 5) Task Group Final Meeting.

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EXECUTIVE SUMMARY

Background: Chaplains play important roles in caring for Veterans and Service members with mental health problems – including suicidality, posttraumatic stress disorder (PTSD), and post-deployment adjustment – as well as in addressing high priority issues such as homelessness, women's health, and family caregiver needs. Chaplains need to be more intentionally integrated with the mental health care systems in VA and DoD. Recognizing this, a specific strategic action focusing on chaplains was included in the Department of Veterans Affairs (VA) and the Department of Defense (DoD) Integrated Mental Health Strategy (IMHS).

Methods: We used a sequential approach to gathering and building upon: 1) input from subject matter experts at task group meetings, sub-task group proceedings, and a two-day multidisciplinary forum; 2) quantitative data from the VA / DoD Chaplain Survey (*M* = 42 minutes to complete), which surveyed all full-time VA chaplains (*n* = 440 completed of 585 invited; 75% response rate) and active duty DoD chaplains (*n* = 1,723 of 2,879; 60% response rate); and 3) qualitative data from site visits to 33 VA and DoD facilities at which 396 individuals were interviewed (195 chaplains, 201 mental health).

Findings: Key findings from the VA / DoD Chaplain Survey include: the most common problems that chaplains see are psychosocial (anxiety, depression, stress) rather than overtly spiritual; 59% of chaplains in VA and 79% in DoD perceive that Veterans and Service members with mental health problems commonly seek help from chaplains instead of mental health providers; many 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); 72% of VA chaplains reported caring for homeless Veterans on a weekly to daily basis; 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; and 54% of VA chaplains are themselves Veterans. Qualitative findings from subject matter experts and site visits indicate that suboptimal integration between chaplaincy and mental health frequently appears to be the result of difficulties between chaplains and mental health professionals in establishing trust and confidence, which in turn is often caused by a lack of familiarity and understanding of each other's roles and capabilities.

Conclusions and Recommendations: Chaplains in VA and DoD are central to the care of Veterans and Service members with mental health problems. However, there are substantial gaps in the integration of mental health and chaplain services. The primary solution to suboptimal integration emerging from this project is to provide cross-disciplinary opportunities for interaction and training among chaplains and mental health care providers. We have developed a three-tier training model that aims to: 1) broadly educate providers across disciplines on the importance of chaplains and spiritual care in holistic mental health care; 2) equip leaders at local facilities to champion and facilitate integration; and 3) provide an in-depth certification program for chaplains specializing to work in mental health care settings. Further, we propose complementing these three-tiered individual-level training efforts with organizational-level change efforts based in a learning collaborative model. We also suggest key domains for much needed future research. Integrating chaplaincy with mental health care as proposed in this report will cultivate more resilient, meaningful, flourishing lives for Veterans and Service members.

EXPANDED REPORT

INTRODUCTION

As members of the U.S. military return home from conflicts of the post-9/11 era, the Nation is faced with ensuring that Veterans and Service members from all service periods receive the care that they need and deserve. The responsibility to provide optimal care for Veterans and Service members will require coordination between multiple federal and community entities. Recognizing this, the Department of Veterans Affairs (VA) and Department of Defense (DoD) responded in the fall of 2010 by launching the Integrated Mental Health Strategy (IMHS). The IMHS aims to advance "an integrated and coordinated public health model to improve the access, quality, effectiveness, and efficiency of mental health services for all Active Duty Service members, National Guard and Reserve members, Veterans, and their families" (DoD and VA, 2010). The IMHS encompasses a total of 28 separate strategic actions (SA), each focusing on a different domain relevant to mental health care services. The purpose of this report is to detail findings from IMHS SA #23, which focuses on the intersection of chaplaincy and mental health care services in VA and DoD.

IMHS SA #23 embodies an examination of two different domains of integration: one is the integration between VA and DoD; the other is the integration between chaplaincy and mental health. Both are important. Optimizing coordination between chaplaincy in VA and DoD should result in fewer Service members falling through the cracks as they make the transition from military to civilian life.

Military chaplains are front-line service providers in understanding and caring for Service members who are dealing with mental health issues (Department of the Army, 2012), ranging from mild problems like adjusting to military life to significant psychiatric problems such as posttraumatic stress disorder (PTSD) 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). The report emphasized the non-stigmatizing benefits of seeing a chaplain who maintains confidentiality, and it contained numerous recommendations pertaining to military chaplains (see Table 1). The Task Force report concluded

Table 1. Suicide Prevention Recommendations

Recommendations Pertaining to Chaplains from the DoD Task Force on the Prevention of Suicide by Members of the Armed Forces	
Recommendation #17	Promote values that encourage seeking the assistance of ***chaplains***, health care, and behavioral health care professionals to enhance spiritual, physical, and psychological fitness.
Recommendation #43	Encourage Service members to have annual face-to-face "conferences" with ***chaplains*** for the purpose of resolving questions of guilt and to obtain referrals to appropriate caregivers for other concerns beyond the chaplain's scope of expertise and experience.

Table 1(cont.) Suicide Prevention Recommendations

Recommendations Pertaining to Chaplains from the DoD Task Force on the Prevention of Suicide by Members of the Armed Forces	
Recommendation #61	Train all military health care providers (including behavioral health providers) and ***chaplains*** on evidence-informed suicide risk assessment, management, and treatment planning. Create and provide continuing education tailored to their specialty and area of expertise.
Recommendation #63	Train first responders, ***chaplains***, casualty notification officers, and family interviewers on how to best respond to suicide and suicide-related events when working with families or next of kin.

that with respect to suicide prevention "The training of chaplains cannot be emphasized enough." In conjunction with the report's recurring emphasis on the centrality of military chaplains in preventing suicide (perhaps the most significant and severe of all mental health problems), this imperative to adequately train chaplains on how to approach suicide prevention underscores a recognition within DoD that military chaplains assume a fundamentally integral role in attending to the overall mental health of Service members and their families. Indeed, spirituality has been recently conceptualized by different branches of the Armed Forces as being meaningfully related to the health and fitness of Service members (Fravell, Nasser, & Cornum, 2011; Hufford, Fritts, & Rhodes, 2010; Pargament & Sweeney, 2011). In order to enhance continuity of care as Service members make the transition to civilian life, it is imperative that an appreciation of the distinctive mental health roles assumed by military chaplains be reflected in how chaplains are understood to operate within VA.

There are opportunities in both VA and DoD to enhance the roles of chaplains and mental health providers within integrated care teams. In recent years, integrating mental health care services with other patient care services has been recognized as a public health priority (Adams & Corrigan, 2003). Integrated mental health services provide patients with better access to a full spectrum of care (Adams & Corrigan, 2003), improve patient health outcomes (O'Donohue et al., 2003), decrease the stigma attached to receiving mental health treatment (O'Donohue et al., 2003), and embody scientific understandings of persons as biopsychosocial beings (White, 2005). Integrating mental health care services into the primary care context in particular has been a major focus within VA, with the VA Primary Care-Mental Health Integration Initiative serving as a prime example of a truly innovative and pioneering effort that has been developed and advanced within VA (Post & Van Stone, 2008; Zeiss & Karlin, 2008).

To date, even though a substantial proportion of patients in VA see chaplains as part of their health care (Hamilton, Jackson, Abbott, Zullig, & Provenzale, 2011), chaplains have not been officially incorporated into some of the most prominent integrated health care initiatives to be implemented in VA. In a recent qualitative study that gathered data from 15 chaplains and 15 members of Patient-Aligned Care Teams (PACTs) in mid-western VA Medical Centers, the investigators concluded that chaplains are not commonly part of outpatient care teams, including PACTs, but that chaplains could play an important role in increasing Veterans' access to and satisfaction with their health care (Bauer, Hogan, Smith, & Weaver, 2012). Indeed, there is an

increasing recognition of the role of chaplains in providing patient-centered services to Veterans. This is perhaps best evidenced by the VA Office of Mental Health Services launch of the VA Mental Health and Chaplaincy Program (Meador, Drescher, Swales, & Nieuwsma, 2010; Nieuwsma, 2010), a program that aims to better integrate mental health and chaplain services via research and educational activities, such as a recurring quarterly series of Bridging Chaplaincy and Mental Health Care Conferences (Meador & Nieuwsma, 2011). As another example, the Office of Patient Centered Care and Cultural Transformation recently funded a series of chaplain-led marriage enhancement retreats to be conducted at sites across the country over the summer of 2012.

Chaplains should be more intentionally incorporated into the mental health care context for at least two reasons: 1) people suffering from mental health problems frequently turn to clergy for help; and 2) spirituality is integrally intertwined with mental health. With respect to the first reason, data from the National Comorbidity Study indicate that among individuals who have ever sought treatment for a mental disorder 24% turned to clergy – whereas only 17% turned to psychiatrists and 17% to physicians (Wang, Berglund, & Kessler, 2003). Reliance on religious support is perhaps even more pronounced in times of crisis. After the September 11, 2001 terrorist attacks, 90% of Americans reported turning to religion for support (Schuster et al., 2001), with religious counselors being 50% more likely to be contacted for help than mental health professionals (American Red Cross, 2002).

There are multiple reasons and hypotheses for why individuals with mental health problems turn to clergy: clergypersons are familiar and accessible (Weaver, Revilla, & Koenig, 2002); they tend to be less stigmatized than mental health care professionals (Milstein, Manierre, & Yali, 2010); they are frequently the first responders in crisis (Oppenheimer, Flannelly, & Weaver, 2004); they may abide by a more stringent form of confidentiality; and they may be more likely than a mental health care provider to share a common worldview with the individual seeking care (Curlin et al., 2007). To functionally appreciate patterns of care seeking among individuals with mental health problems, and to construct a system of care that both accommodates their preferences and meets their needs, chaplains need to be incorporated into health care systems as close partners with their mental health colleagues.

The second notable reason why chaplains should be integrated into the mental health care context is that there is a fundamental interrelation between spiritual / religious issues and mental health. This has been borne out time and again in recent decades as research attention has dramatically increased in the field of spiritually and health (Koenig, King, & Carson, 2012). Much of this attention has focused on the link between mental health and participation in institutional religious activities. In general, findings suggest that persons who regularly participate in religious activities (e.g., attend church) have a marked reduction in risk of mortality (Hill, Angel, Ellison, & Angel, 2005; Powell, Shahabi, & Thoresen, 2003), a reduced risk of suicidal ideation (Kay & Francis, 2006; Martin, 1984), and lower rates of mental health problems (Law & Sbarra, 2009; Merrill & Salazar, 2002).

Importantly, the relationship between religiosity and health is complex. For example, some studies have found that within particular populations a higher rate of church attendance can in fact be connected with worse mental health outcomes (Abbotts, Williams, Sweeting, & West,

2004; Norton et al., 2006). One of the pioneering studies in the field of religion and health found that as psychopathology increased, people prayed more but attended church less (Lindenthal, Myers, Pepper, & Stern, 1970). A more recent study questioned whether church attendance protects against depression or whether this proposition is accounted for by the finding that women who develop depression attend church less often (Maselko, Hayward, Hanlon, Buka, & Meador, 2012). Findings such as these underscore the dynamic, complex, and still inadequately understood nature of the relationship between spirituality and health.

An additional layer of complexity is presented by the appearance of clinical applications for religion and spirituality in health care settings. Traditional distinctions between spiritual practices, religious practices, and mental health care practices have been blurred by recent clinical research into the use of practices such as mindfulness (Baer, 2003; Hathaway & Tan, 2009; Hayes, 2002; Hofmann, Sawyer, Witt, & Oh, 2010), yoga (Descilo et al., 2010; Nieuwsma, Pepper, Maack, & Birgenheir, 2011), meditation (Ciarrochi, Robb, & Godsell, 2005; Cruz et al., 2009; Nieuwsma et al., 2011), prayer (Harris et al., 2011; Tan, 2007), and participation in various religious and spiritual activities (Armento, McNulty, & Hopko, 2011; Plante, 2009) as elements of mental health care treatments. As scientific conceptions of health evolve to further appreciate ways in which spiritual and mental domains are dynamically related aspects of wellness, health care systems are challenged to create correspondingly dynamic teams of professionals that adequately address all aspects of wellness. It is our opinion that these teams should include chaplains.

While health care systems in general are likely to benefit from an intentional incorporation of chaplains into the mental health care infrastructure, the case for undertaking this integration is even more compelling in contexts of VA and DoD. 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 has a clear appeal to Service members who are afraid of being seen as weak, who fear that damaging information about their emotional state could be passed along to their commanding officers, or who are otherwise concerned that indications of a mental health problem could have a negative impact on their military careers.

In addition, chaplains in the military have traditionally been more "organic" (assigned on a permanent basis and part of daily life) to their commands than mental health professionals. The familiarity that Service members have with chaplains due to the shared experiences of training together and deploying together encourages the development of a natural and trusting relationship. When crises strike, that established relationship not only facilitates Service members seeking care from chaplains but also enables chaplains to understand the broader context surrounding the individual seeking help.

Finally, chaplains in the military are expected to advise their commanding officers. Chaplains provide commanding officers with moral and ethical counsel, religious and cultural information, emotional and spiritual support, and vital information about the morale and well-being of their unit (Joint Staff, 2009). While the role of the VA health care chaplain differs from the DoD chaplain, the VA health care system would be wise to reflect in its organization of care an understanding of the pivotal mental health roles played by chaplains for members of the Armed Forces.

In addition to supporting the inclusion of chaplains in mental health care on the basis of the above noted reasons, there is also compelling reason to do this on the basis of Veterans' and Service members' unique mental and spiritual needs. 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. This is probably most apparent among individuals who have lived through traumatic experiences during their military service and have subsequently developed PTSD. In research examining Veterans with PTSD, more severe PTSD has been found in those who harbor combat guilt (Henning & Frueh, 1997) and who have difficulty with forgiveness (Witvliet, Phipps, Feldman, & Beckham, 2004). In a study of 100 Vietnam Veterans in treatment for PTSD, 58% reported abandoning their religious faith during war (Drescher & Foy, 1995). Another study conducted by Drescher and colleagues, this time in a sample of 50 Post-9/11 Veterans in treatment for PTSD, found over half to report feeling abandoned by God and over half to report feeling that they were being punished by God (Drescher, 2010). Findings from these studies with Veterans suggest that guilt, forgiveness, religious belief, and perceptions of God are frequently intertwined with the experience of PTSD. In keeping with these findings, a study of Veterans with PTSD who sought VA services found that 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).

The fact that Veterans with PTSD are suffering from and seek help in response to existential crises suggests to some researchers that more attention is warranted with respect to the spiritual and moral aspects of PTSD. The construct of "moral injury" has been introduced as a way to conceptualize how experiencing "acts that transgress deeply held moral beliefs and expectations" in the context of a combat setting can result in lasting intrapersonal injury (Litz et al., 2009). At this time, moral injury is a concept in need of further research. Indeed, there is a substantial need for much more research to be done generally on the interrelation between spirituality and mental health in Veterans and Service members and the ways in which VA and DoD can provide appropriately constructed spiritual and mental health care. To the extent that research on these kinds of topics takes place among Veterans and Service members, and insofar as this type of research produces implications for clinical work, it is crucial to solicit engagement from chaplains in VA and DoD.

Current Project: The current project fulfills the objectives of IMHS SA #23 by systematically soliciting input and expertise from VA and DoD chaplains on the role of chaplains in caring for Veterans and Service members with mental health problems. As part of the project, professionals in mental health and other health care disciplines also provided input. The fact that this project was originally conceived as a core strategic action included within the larger IMHS evidences a

meaningful understanding by mental health leadership in VA and DoD that chaplains are essential partners in the provision of high-quality mental health care for Veterans and Service members. Because chaplains have not always been understood in this way, there is a paucity of data on the intersection of chaplaincy and mental health care. In response to this, the current project employed both quantitative and qualitative methodological approaches to help describe the current state of chaplain and mental health care integration in VA and DoD and to inform recommendations for improvement.

METHODS

Topic Development

The VA / DoD IMHS was developed following a VA / DoD Mental Health Summit that was held in October 2009. The Summit brought together mental health leadership from VA and DoD for a weeklong working meeting to identify ways to meet the evolving mental health needs of Veteran and Service member populations. The resulting IMHS was formed with a mission to "advance an integrated and coordinated public health model to improve the access, quality, effectiveness, and efficiency of mental health services for all Active Duty Service members, National Guard and Reserve members, Veterans, and their families" (DoD and VA, 2010). A total of 28 strategic actions were identified within the IMHS, each falling under one of the following four overarching strategic goals:

1. Expanding access to behavioral health care in VA and DoD
2. Ensuring quality and continuity of care across the Departments for Service members, Veterans, and their families
3. Advancing care through community partnership, education, successful public communication, and use of innovative technologies
4. Promoting resilience and building better behavioral health care systems for tomorrow

The IMHS strategic action on chaplains' roles (IMHS SA #23) was categorized under the fourth of these overarching strategic goals, yet this strategic action was conceptualized in a manner that clearly linked it to all four of the above defined goals. In late spring of 2010, leadership in VA and DoD identified the following individuals to lead IMHS SA #23: Dr. Keith Meador (Director of the VA Mental Health and Chaplaincy Program; VA lead), Chaplain Keith Ethridge (Director, VA National Chaplain Center; VA co-lead), Dr. Jason Nieuwsma (Associate Director of the VA Mental Health and Chaplaincy Program; VA co-lead), Dr. Mark Bates (Director of Resilience and Prevention Directorate, Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury (DCoE); DoD lead), and Dr. Jeff Rhodes (Retired Navy Chaplain and Contractor, Resilience and Prevention Directorate, DCoE; DoD co-lead). This team refined the objectives for IMHS SA #23 and proposed actionable steps. Work on IMHS SA #23 then officially commenced following approval of strategic action plans by the VA / DoD Health Executive Council (HEC) in November 2010.

The aim of IMHS SA #23 was to examine chaplains' roles in the mental health care of Veterans and Service members in order to provide recommendations to VA and DoD leadership on how to optimize chaplains' involvement in achieving the overarching goals of the VA / DoD IMHS. To

accomplish this, the IMHS SA #23 leads formulated a sequential approach to soliciting input from identified stakeholders, gathering data from the field, and developing and refining recommendations. Appendix B provides a full description of the originally conceived implementation plan and performance measurement elements. All action steps and end states as originally described for IMHS SA #23 were achieved in their entirety. Further, the process of completing IMHS SA #23 allowed for the objectives to be more fully developed and optimally approached over the course of the project.

IMHS SA #23 Task Group

The IMHS SA #23 task group contained a total of 38 members representing a wide variety of VA, DoD, and outside constituencies and disciplines. These included 17 VA representatives from: VA Mental Health and Chaplaincy; Veterans Integrated Service Network (VISN) 6 Mental Illness Research, Education, and Clinical Center (MIRECC); VA National Chaplain Center; Coatesville, PA Veterans Affairs Medical Center (VAMC); Mountain Home, TN VAMC; VA North Texas Health Care System (VANTHCS); VA Ambulatory Care Center, Columbus, OH (VAACC); Hampton, VA VAMC; Health Services Research & Development (HSR&D) Center of Excellence, Durham, NC VAMC; Danville, IL VAMC; Durham, NC VAMC; and the National Center for PTSD, Menlo Park, CA.

Representation from DoD consisted of 14 representatives who were from: DCoE; the Service Chiefs of Chaplains offices; the Navy Bureau of Medicine and Surgery; the U.S. Army Medical Command Headquarters; Walter Reed National Military Medical Center; Joint Force Headquarters State Chaplain, Kentucky Army National Guard; U.S. Army Public Health Command; Air National Guard Chaplain Offices; Air Force Chaplain Corps College; Portsmouth Naval Hospital, Navy Medicine East; and the U.S. Air Force 460th Space Wing.

To provide additional subject matter expertise, a group of seven outside experts was also engaged to provide additional support from the research and academic arenas. These consisted of representatives from: Research Triangle Institute (RTI); Dynamics Research Corporation; Health Care Chaplaincy; City College New York; and Rush University Medical Center. A complete listing of all individuals who served on the IMHS SA #23 task group can be found at the beginning of this report.

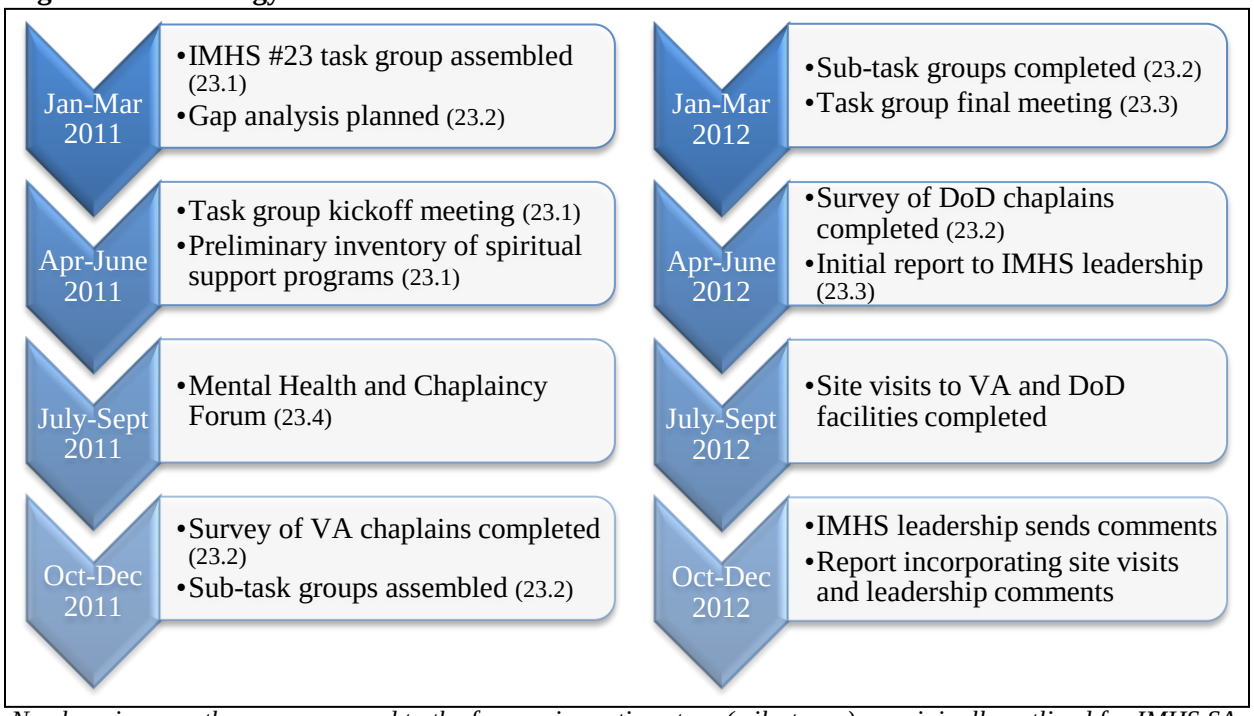
Chronology of IMHS SA #23

The process for completing IMHS SA #23 was structured to solicit both formal and informal input from important stakeholders and subject matter experts throughout various phases of the project. At the outset of the project, a task group containing carefully identified stakeholders was formed under the auspices of the HEC Psychological Health and Traumatic Brain Injury Work Group (HEC PH / TBI WG). Task Group members participated in onsite meetings in Washington, DC in May 2011, September 2011, and March 2012; they participated as members of six, 90-minute, structured sub-task group calls held between December 2011 and February 2012; and they informally contributed their time and effort as requested throughout the project in order to complete innumerable tasks in service of IMHS SA #23. Their input, feedback, and

administrative assistance were instrumental in successfully completing all aspects of the project. A listing of task group members is provided at the beginning of this report.

Information gathered during each phase of the project was used to inform subsequent steps. As examples: input from the preliminary gap analytic work performed as part of the task group kickoff meeting was systematically considered in constructing the VA / DoD Chaplain Survey; findings from the VA Mental Health and Chaplaincy Forum breakout groups contributed to the development of the two IMHS SA #23 sub-task groups; and discussions as part of multiple task group and sub-task group meetings led to the development of methodologies for VA and DoD site visits, a clergy engagement project in New York City, and a project on evidence-based spiritual assessments in the mental health context. This report details the processes and findings from the task group kickoff meeting, the VA Mental Health and Chaplaincy Forum, the two sub-task groups (chaplain documentation practices and chaplain assessment and screening practices), the VA / DoD Chaplain Survey, the site visits to VA and DoD facilities, and the task group final meeting. The chronology for conducting IMHS SA #23 is presented in Figure 1.

Figure 1: Chronology of IMHS SA #23



Numbers in parentheses correspond to the four major action steps (milestones) as originally outlined for IMHS SA #23. With the completion of the initial report in June 2012, all of these action steps were completed. The VA / DoD site visits were initiated as an outgrowth of IMHS SA #23 and were therefore not included in the initial report. However, as the site visits were completed by the time that comments on the initial report were received back from IMHS leadership in November 2012, the decision was made to incorporate findings from the VA / DoD site visits along with revisions suggested by IMHS leadership into the present report.

Task Group Kickoff Meeting

The task group kickoff meeting for IMHS SA #23 was held at the Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury (DCoE) in Silver Spring, MD (in Washington Metropolitan Area) on May 25-26, 2011. The purpose of this meeting was to examine current chaplain practices in VA and DoD and consider innovative opportunities for integrating mental health and spiritual care services by assembling a task group of experienced chaplains in VA and DoD along with other identified subject matter experts. Within VA, appropriate task group members were identified via a collaborative process with the Director of the VA National Chaplain Center and other VA National Chaplain Center staff. In DoD, Dr. Jeff Rhodes obtained necessary approvals and buy-in from the Chiefs of Chaplains of the Army, Navy, and Air Force to task appropriate chaplains from each Service branch to serve as task group members. The attendees present at this kickoff meeting are designated in the listing of attendees at the beginning of this report.

The agenda for the two day meeting included an overview of IMHS SA #23, two brief presentations from outside experts intended to spur large group discussion, three breakout sessions, and four large group discussions (see Appendix C). Particular focus was devoted to the topics of community engagement, the state of chaplaincy in VA and DoD, continuity between chaplain care in VA and DoD, evidence-based practices, and barriers to improving integration. For each of the three breakout sessions, attendees were divided into two breakout groups. The first session was divided so as to have one breakout group composed of VA personnel and the other of DoD personnel, with the second and third sessions being composed of a mix of personnel from VA and DoD. Breakout group facilitator guides were developed by IMHS SA #23 leads and contractor personnel prior to the meeting and were used to gather data during the group discussions (see Appendix C). Transcripts of the group discussions were created, and thematic content from the transcripts was later extracted. In addition, input from the task group kickoff meeting was used to develop and refine our approach to next steps within the IMHS SA #23 plan.

VA Mental Health and Chaplaincy Forum

The VA Mental Health and Chaplaincy Forum was held on September 1-2, 2011 in Washington, DC. The purpose of the forum was to bring together a group of approximately 70 experts with complementary and professionally diverse backgrounds in order to examine the relationships between spirituality and health and to provide input on how chaplains, clergy, and other spiritual care providers might be optimally integrated into a public health model that better addresses the complex health needs of Veterans, Service members, and their families. In addition to inviting IMHS SA #23 task group members to the meeting, invitations were sent to subject matter experts in VA, DoD, and academia. IMHS SA #23 leads worked in coordination with VA and DoD leadership to develop the invitation list. Invitations were extended to subject matter experts working in chaplaincy, mental health, the broader health care sector, and community outreach.

The agenda for the VA Mental Health and Chaplaincy Forum included five plenary presentations, three breakout group sessions, and one large group discussion session (see

Appendix D). Plenary speakers included a psychiatrist, an epidemiologist, a sociologist, a chaplain, and a psychologist – all nationally known experts in their fields who presented on different aspects of the interrelations between spirituality and mental health. Because the forum contained multiple educational components intended to stimulate discussion, the meeting received accreditation from the Accreditation Council for Continuing Medical Education (ACCME), American Nurses Credentialing Center (ANNC), American Psychological Association (APA), and Association of Social Work Boards (ASWB) for continuing education units. For the three breakout sessions, participants were divided into four groups. For the first breakout session, attendees were divided into groups according to their professional roles: one group consisted of chaplains, another of mental health professionals, another of a broader compilation of health care providers, and another of persons involved in community outreach. Participants in these first breakout groups were then evenly divided into four different breakout groups that retained the same compositions for the second and third breakout sessions.

The three breakout sessions focused on the topic of mental health and chaplain integration by way of examining: the state of integration (session 1); models for integration (session 2); and barriers to integration (session 3). The breakout questions used to guide group discussions were developed by IMHS SA #23 leads in coordination with contractor personnel from RTI International and identified breakout group facilitators (see Appendix D). For the breakout session on barriers to integration that occurred on the second day of the forum, barriers were first solicited from attendees during the last 10-15 minutes of the breakout group at the end of the first day of the forum. Breakout group facilitators then convened at the end of the first day to compile a list of the main barriers that were identified. Twelve barriers were compiled, and these were then divided among the four breakout groups on the second day of the forum so that each group problem-solved three barriers. Written transcripts of the group discussions were recorded and analyzed. For the first breakout group, themes from each of the different groups were identified and compared to each other. For the second breakout group, thematic content was identified and recorded to denote the number of groups that identified the theme and the degree to which the theme was significantly emphasized in the group discussion. For the third breakout group, proposed solutions were summarized for each barrier and then cross-referenced with solutions to other barriers and notated to indicate the degree to which the solution was significantly emphasized in the group discussion. Appendix E contains details of this analytic process along with the expanded tables that were created from the breakout group discussions.

Sub-task groups

Input received in the context of the IMHS SA #23 task group kickoff meeting and the VA Mental Health and Chaplaincy Forum indicated that there is significant diversity in the extent to which chaplains engage in documentation and assessment / screening. This diversity was noted as a systematic barrier to integration, both in terms of integration between VA and DoD as well as integration between chaplaincy and mental health. As such, these two areas were identified as deserving of additional focus by IMHS SA #23, and sub-task groups were identified to address: 1) chaplains' documentation practices; and 2) chaplains' assessment and screening practices. The VA National Chaplain Center and DoD chaplain leadership assisted with identification of additional task group members with expertise in either documentation practices or assessment

and screening practices to participate as members of the sub-task groups. The sub-task group compositions were finalized in November 2011, and each sub-task group then held three 90-minute conference calls between December 2011 and February 2012.

Documentation Practices

The purpose of the IMHS SA #23 sub-task group on documentation practices was to describe the existing documentation practices of VA and DoD chaplains and to determine approaches for improving the documentation of chaplains' services in a manner that honors the distinct policies regarding chaplain confidentiality and contributes to enhanced spiritual and mental health care for Service members, Veterans, and their families. The sub-task group was formed on the understanding that documentation practices are at the heart of how clinical information is conveyed between professionals, with appropriate documentation of services facilitating effective clinical care and insufficient or ambiguous documentation of services impeding the continuity of care. The first and second 90-minute conference calls were structured to each include a 15-minute presentation from a DoD representative and a 15-minute presentation from a VA representative, followed by a 45-minute guided group discussion. The third 90-minute call included a brief synopsis of what was learned from the first two calls and a longer group discussion focusing on next steps. All calls were transcribed. The goals and objectives of the sub-task group on documentation practices were defined as:

1. Describe the state of existing and planned documentation practices in VA and DoD, including information on the field as a whole and on existing best practices.
2. Share information about approaches to documentation that have been attempted in the past, with specific attention to those aspects of past approaches that have worked well and those that have not worked well (i.e., lessons learned).
3. As a group, articulate a vision for documentation practices that incorporates long-term goals and achievable near-term objectives with specific steps for implementation.
4. Identify key stakeholders and strategies for effectively engaging them.
5. Identify barriers to accomplishing the agreed upon vision for documentation practices and offer potential solutions for approaching these barriers.

Appendix F includes a more detailed description of the sub-task group on documentation practices along with the questions used to guide group discussions.

Assessment and Screening Practices

The purpose of the IMHS SA #23 sub-task group on assessment and screening practices was to describe the existing practices of VA and DoD chaplains and to determine approaches for improving the use of assessment and screening tools in a manner that contributes to enhanced spiritual and mental health care for Service members, Veterans, and their families. The sub-task group was formed on the understanding that assessment and screening practices are central to determining appropriate care services for Veterans and Service members, with assessment and screening instruments having the capacity to help identify persons in need of chaplain services, contribute to creating a plan of care, allow for clinical changes to be tracked over time, and assist in the triaging of care between professionals. The first and second 90-minute conference calls were structured to each include a 15-minute presentation from a DoD representative and a 15-minute presentation from a VA representative, followed by a 45-minute guided group discussion.

The third 90-minute call included a proposal for next steps in the development of spiritual assessment tools and a longer group discussion about how to accomplish the objectives identified by the sub-task group. All calls were transcribed. The goals and objectives of the sub-task group on assessment and screening practices were defined as:

1. Describe the state of the development and implementation of spiritual assessments and screening practices in VA and DoD, including information on the field as a whole and on existing best practices.
2. Share information about spiritual assessments and screening approaches that have been used in the past, with specific attention to those aspects of past approaches that have worked well and those that have not worked well (i.e., lessons learned).
3. As a group, articulate a vision for spiritual assessments and screening practices that incorporates long-term goals and achievable near-term objectives with specific steps for implementation.
4. Identify key stakeholders and strategies for effectively engaging them.
5. Identify barriers to accomplishing the agreed upon vision for spiritual assessments and screening practices and offer potential solutions for approaching and overcoming these barriers.

Appendix G includes a more detailed description of the sub-task group on assessment and screening practices along with the questions used to guide group discussions.

VA / DoD Chaplain Survey

Survey Development

The VA / DoD Chaplain Survey was developed in coordination with the IMHS SA #23 task group, with specific assistance from representatives of: the VA Mental Health and Chaplaincy Program; Durham, NC HSR&D Center of Excellence; Resilience and Prevention Directorate, DCoE; the VA National Chaplain Center; the National Center for PTSD; and RTI International (survey contractor). Potential domains to assess in the survey were discussed at the IMHS SA #23 kickoff meeting in May 2011. Following that meeting, a survey was drafted and then sent to key members of the task group for their feedback. Their suggestions were incorporated into a refined survey. The survey then underwent further revisions in response to comments from other stakeholders and approving bodies in VA and DoD. Important revisions made at this stage included: 1) making demographic questions less precise in order to further de-identify information (e.g., participants were explicitly reminded that providing demographic information was voluntary, questions about age and rank were made categorical); and 2) taking a subset of questions deemed less essential to the survey and placing them in a "supplemental survey" to decrease the time burden of completing the "core survey." The different sections included in the core and supplemental components of the VA / DoD Chaplain Survey are outlined below.

Core Survey:

- Populations Served: This section asked questions about the individuals served in the respondents' work as chaplains. Items included duty status (Active, Guard / Reserve,

Retired), frequency of encountering various types of individuals, presenting problems, and perceived preparedness for dealing with these problems.

- Work Settings: This section asked questions about the settings in which respondents performed their duties as chaplains.
- Work Activities: This section asked questions about the activities performed by the respondents in their chaplaincy work. Items included frequency of engagement in various activities, practices, and services; and frequency and types of interactions with other health care providers and community clergy.
- Interaction with Mental Health Professionals: This section asked questions about interaction with mental health professionals. Items included frequency and types of interactions with mental health professionals; perceptions of activities performed by chaplains and mental health professionals; components of chaplains' and mental health care providers' jobs; and perceived stigma of seeking care from a chaplain instead of from a mental health professional.
- Further Information and Training: This section asked questions about areas in which respondents would like further information or training.
- Professional Activities: This section asked about other professional activities that respondents may engage in.
- Demographics: This section included questions on age, gender, affiliation (VA or DoD Service branch), active or prior military service, educational credentials and clinical pastoral education (CPE) training.

Supplemental Survey:

- Components of Spirituality and Mental Health: This section asked about the extent to which chaplains viewed various constructs to be part of a person's spirituality, mental health, or both.
- Measurement Tools: This section asked about chaplains' use of different measurement tools.
- Tobacco Questionnaire: This section was included only in the VA Chaplain Survey and assessed chaplains' comfort with participating in smoking cessation efforts.

The core survey required approximately 37 minutes to complete (M = 36.80, SD = 18.11); the supplemental survey required approximately 6 minutes to complete (M = 6.23, SD = 7.04). Respondents who completed both pieces took approximately 42 minutes to complete the core plus supplemental components of the VA / DoD Chaplain Survey (M = 42.34, SD = 19.73). The codebooks in Appendix H and Appendix I contain all of the questions and instructions that were included in the VA / DoD Chaplain Survey.

VA / DoD Chaplain Survey Approval Process

The Durham VA Institutional Review Board (IRB) was contacted regarding the VA / DoD Chaplain Survey, and the IRB chair ruled that by VA standards this project was not considered to be "research" and therefore did not require IRB approval. Memos attesting to their support for the VA / DoD Chaplain Survey and other information gathering aspects of IMHS SA #23 were signed by Dr. Sonja Batten, Deputy Chief Consultant for Specialty Mental Health in VA and the VA lead for the IMHS, and by Chaplain Keith Ethridge, Director of the VA National Chaplain Center. RTI International received approval for their role in the project from the RTI IRB.

For surveys launched within DoD, approval authority was obtained through Tricare Management Agency (TMA). VA and DoD co-leads along with RTI completed authorization paperwork that was reviewed by the Defense Health Cost Assessment and Program Evaluation division of TMA. After confirmation from this division that the paperwork was adequately completed, the information was forwarded on November 14, 2011 for further review by the TMA Privacy and Civil Liberties Office (CLO). The CLO reviewed the questionnaire and the information contained in the IMHS SA #23 Supporting Statement, and determined on December 16, 2011 that the survey did not contain personally identifying information. Furthermore, the CLO concluded that the collection and use of survey responses was not part of a Privacy Act system of records. Consequently, the collection of responses through the survey did not require inclusion of a Privacy Act Statement.

Appendix J includes copies of the aforementioned approvals.

VA / DoD Chaplain Survey Sample

The sample frame included all full time VA chaplains and all active duty DoD chaplains. DoD chaplains included active Army, Navy, and Air Force chaplains (note that the Marine Corps and Coast Guard are served by Navy chaplains). The sample of VA chaplains was obtained from an e-mail distribution list of full time VA chaplains that is maintained by the VA National Chaplain Center. The sample of DoD chaplains was obtained with support from the Service Chiefs of Chaplains for Army, Navy, and Air Force. Part-time VA chaplains and Reserve / National Guard chaplains were not invited to complete the survey due to difficulties encountered in attempting to secure definitive listings and contact information for these individuals.

VA / DoD Chaplain Survey Administration

The VA / DoD Chaplain Survey was administered via a secure website hosted and maintained by RTI International. Initial communications were distributed by VA and DoD chaplain leadership, informing chaplains about the survey and encouraging them to participate. These communications were followed within 24 hours by invitations to participate in the survey. The invitations included a hyperlink to the web survey and personalized login credentials (username and password). Over the next six weeks, four e-mail reminders were sent. The e-mail notifications for the VA sample were managed using Microsoft Access. An overview of e-mail communications is presented in Table 2, with dates and numbers of communications sent for each survey population detailed in Table 3. Text of the e-mail communications is included in Appendix K.

Non-response follow-up

The survey administrators tracked and monitored the data collection progress of the respondents via summary reports for each group of VA and DoD chaplains. Information regarding respondents' logging in to the web survey was saved to the database and could be used to track their survey progress, including whether they had started and completed the survey in full, had partially completed the survey, or had not started the survey. Survey completions were flagged based on the following two parts of the VA / DoD Chaplain Survey:

1. *Core Survey*. The core survey was flagged as complete when the respondent progressed to the end of the core survey and arrived at the transition screen to supplemental survey.

2. *Supplemental Survey*. The supplemental survey was flagged as complete when the respondent progressed to the end of the supplemental survey and arrived at the final "thank you" screen.

Table 2. Overview of Survey-Related Communications

Pre-survey notification	VA / DoD Chief of Chaplains sends blanket communication to eligible population, introducing the survey and encouraging participation.
Invitation	Within 24 hours of the pre-survey notification, survey administrators send a survey invitation e-mail containing a hyperlink and individualized User IDs and passwords.
Reminder 1	One week after initial invitation, survey administrators send a reminder e-mail with individualized User IDs and passwords to the full sample.
Reminder 2	Two weeks after initial invitation, survey administrators send a second reminder e-mail with individualized User IDs and passwords to sample members who have not started the survey or who have partially completed the survey.
Reminder 3	Four weeks after the initial invitation, VA / DoD Chief of Chaplains sends blanket reminder to the full sample to thank those who have completed the survey, inform chaplains of the response rate, and encourage those who have not completed the survey to do so. Survey administrators send follow-up within 24 hours of reminder from Chief of Chaplains that includes individualized User IDs and passwords to those sample members who have not started the survey or who have partially completed the survey.
Reminder 4	Six weeks after the initial invitation, survey administrators send final reminder with individualized User IDs and passwords to those sample members who have not started the survey or who have partially completed the survey.

Table 3. Schedule of Survey Communications

	Communication				
Population	**Invitation**	**Reminder 1**	**Reminder 2**	**Reminder 3**	**Reminder 4**
VA					
Date sent	11/2/2011	11/9/2011	11/16/2011	11/30/2011	12/14/2011
# of e-mails	618	605	305	249	155
Air Force					
Date sent	1/26/2012	2/2/2012	2/9/2012	2/16/2012	2/28/2012
# of e-mails	475	284	215	183	162
Army					
Date sent	2/16/2012	2/28/2012	3/2/2012	3/15/2012	3/28/2012
# of e-mails	1592	1117	936	835	784
Navy					
Date sent	3/1/2012	3/5/2012	3/15/2012	4/3/2012	NA
# of e-mails	820	630	551	545	NA

Note. Due to delays in securing an e-mail distribution list for Navy chaplains, the schedule of survey communications had to be modified such that no fourth reminder was sent in the Navy sample.

Table 4. Survey Response Rates

	Department / Branch											
	VA		Air Force		Army		Navy		Total DoD		Total Sample	
Status	n	%	n	%	n	%	n	%	n	%	N	%
Total sample[1]	585	100.0%	475	100.0%	1591	100.0%	813	100.0%	2879	100.0%	3464	100.0%
Only core survey complete	79	13.5%	50	10.5%	152	9.6%	47	5.8%	249	8.6%	328	9.5%
Core & supplement survey complete	336	57.4%	279	58.7%	692	43.5%	246	30.3%	1217	42.3%	1553	44.8%
Partial survey complete	25	4.3%	57	12.0%	173	10.9%	27	3.3%	257	8.9%	282	8.1%
Refusal	0	0.0%	0	0.0%	0	0.0%	1	0.1%	1	0.0%	1	0.0%
Not started	145	24.8%	89	18.7%	574	36.1%	492	60.5%	1155	40.1%	1300	37.5%
Total responses (response rates)	**440**	**75.2%**	**386**	**81.3%**	**1017**	**63.9%**	**320**	**39.4%**	**1723**	**59.8%**	**2163**	**62.4%**

[1]*The total sample includes all cases that were deemed as potentially eligible at the end of the survey. Ineligible cases included respondents who received an e-mail invitation to participate in the survey but indicated either via e-mail or on the survey that they were not chaplains, that they belonged to a different organization than the one that they were contacted as belonging to (i.e., contacted as part of the VA chaplain sample but indicated on the survey that they belonged primarily to DoD, or vice versa), or that they were Reserve or National Guard rather than Active Duty within DoD. No more than 1% of all cases contacted were deemed ineligible.*

If the respondent logged in but had not completed the above two parts of the survey, this respondent was flagged as partially completed. This information was used when preparing follow-up e-emails to query the database for respondents who had not started or had started but only partially completed. Survey response rates are detailed in Table 4.

Statistical analyses

The main comparisons presented in this report are between VA and DoD chaplains. Because of the large sample sizes, small differences are likely to be statistically significant. Therefore, data in the findings section are often presented with straightforward percentages and language that attempts to convey the relative meaningfulness of effect sizes. Most statistical analyses were descriptive cross-tabulations and means. Statistical significance for these data was assessed using t-tests (or ANOVA in the case of 3-group comparisons).

Estimates considered unreliable were omitted from the tables in this report. More specifically, estimates of means and proportions were omitted if they could not be reported with confidence because they were based on small sample sizes ($n < 10$) to protect the anonymity of respondents.

VA and DoD Mental Health and Chaplaincy Site Visits

Starting in early 2012, a site visit team consisting of contractors from the University of Nebraska and directed by VA Mental Health and Chaplaincy leadership began a series of visits to VA and DoD facilities with the purpose of building an in-depth understanding of existing chaplain-mental health collaboration in VA and DoD. This project was initiated in service to IMHS SA #23, although it was not initially included among the originally identified action steps and milestones for IMHS SA #23. Via visits to 33 VA and DoD facilities, the site visits aimed particularly at identifying factors that contribute to or detract from the integration of chaplain services with mental health care services, other health care services, and community resources.

Goals and Objectives

The site visits sought to accomplish the following goals and objectives:

1. With regard to chaplaincy, describe a) the range of job-related activities in which chaplains are engaged, b) the various ways in which chaplains articulate their identities as spiritual care providers, c) the extent to which chaplains conceptualize the intersections of their work with the mental and physical health of those they serve, and d) the degree of receptivity among chaplains to participating more closely with other health care providers and community organizations.

2. With regard to mental health care and other health care providers, describe a) perceptions of what chaplains do, b) ideas about how chaplains are or could be valuable members of an integrated care team, c) the extent to which spiritual issues are viewed as an important aspect of health in patients they serve, and d) the degree of receptivity to working more closely with chaplains.

3. With regard to community organizations, describe how community representatives have worked with chaplains and what services community organizations feel would be useful for chaplains to provide.

4. Describe the existing state of integration of chaplain services with mental health care and other care services, and determine a) factors that inhibit effective integration, and b) factors that facilitate effective integration.

5. Identify system-level issues that have or could have an impact on efforts to implement a model of care that more systematically incorporates the chaplain into an integrated care team.

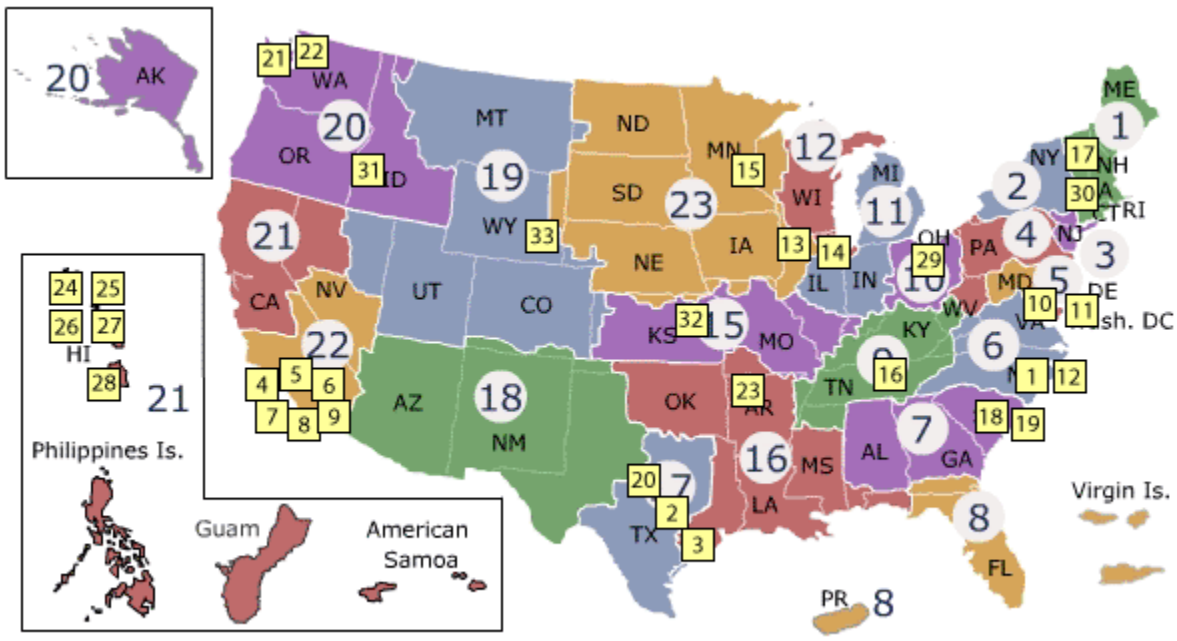
6. Identify sites that are interested in committing a portion of their pastoral care staff to work with the VA Mental Health and Chaplaincy Program in receiving focused training in the care of persons with mental health problems for the purpose of implementing a model of integrated mental health and chaplain care.

Site Selection

A total of 33 VA and DoD facilities were selected to ensure diversity on the basis of the following characteristics: 1) current chaplain practices with regard to mental health services; 2) innovative models of chaplain integration with other services; 3) geographic location; and 4) facility type (e.g., large medical center, smaller outpatient clinic).

Sites were initially contacted by one of the IMHS SA #23 leads with an e-mailed invitation letter (see Appendix L), which was followed within 1-3 days by a telephone call to points of contact at the local facilities. Coordinating sites visits in DoD frequently required more effort than in VA to secure all necessary approvals. Local points of contact were offered letters of approval from appropriate persons of leadership and were also informed that the site visits were determined by the Durham VAMC IRB not to be research and hence released from further human ethics review (see Appendix J). Figure 2 displays the locations of sites selected for visits.

Figure 2. VA and DoD Site Visit Locations



1. Fort Bragg
2. Brooke Army Medical Center
3. **South Texas Veterans Health Care 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, Twenty-nine 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 Health Care System**
16. **Tennessee Valley Health Care 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 Health Care System**
23. **Central Arkansas Veterans Health Care System**
24. Schofield Barracks
25. Tripler Army Medical Center
26. **VA Pacific Islands Health Care System**
27. Joint Base Pearl Harbor-Hickam
28. Marine Corps Base Hawaii
29. **Louis Stokes Cleveland VA Medical Center**
30. **VA New York Harbor Health Care System**
31. **Boise VA Medical Center**
32. **Eastern Kansas VA Medical Center**
33. **Cheyenne VA Medical Center**

VA facilities

DoD facilities

Joint VA/DoD facilities

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

Methodology

A mixed methods framework guided the site visit protocol. Information from the site visits was gathered in a manner to provide a qualitative counterpart to the quantitative data collected in the VA / DoD Chaplain Survey. A multiple case study approach was relied upon to structure the collection and analysis of site visit data. The following domains of interest guided the approach to conducting interviews and gathering information as part of the site visits:

- **Organizational structure and nature of the facilities visited:** One objective of the site visits was to develop an understanding about how the organizational structures of the facilities and the two disciplines affect the working relations between chaplains and mental health. Of particular interest was how supervisory structures, reporting relationships, leadership, physical proximity, and resource availability influence relationships.

- **Relationships:** Another objective was to understand the existing relationships between chaplaincy and mental health and how these relationships are influenced by the type of chaplain (e.g., operational chaplains, chaplains with CPE units) and the type of mental health professional (e.g., social work, substance abuse professionals). We were also interested in the relations of chaplains and mental health providers to the leadership structure within the program and to external community stakeholders.

- **Characteristics and needs of individuals served:** A key purpose of the site visits was to examine how the relationship between mental health and chaplaincy is influenced by the needs of the Veterans and Service members served within the program or facility (e.g., Veterans versus active duty, inpatient versus outpatient, mental health versus substance abuse, behavioral health versus other health care programs like palliative care or hospice, acute care versus chronic care, deployed versus non-deployed Service members, traditional versus specialized medical programs such as wounded warrior units).

- **Issues addressed:** The site visits aimed to examine the domains in which mental health professionals and chaplains have responsibilities and the extent to which issues addressed by each discipline overlap.

- **Activities:** Another purpose of the site visits was to document the regular and special activities of chaplains and mental health professionals and to understand how the scope of activities for each discipline influences working relations. We were also interested in how chaplaincy staff resources are allocated to mental health as well as to other medical programs.

- **Practices:** The site visits aimed to describe the nature of the collaborative practices between chaplains and mental health, such as referral patterns, how chaplains and mental health work as a team related to patient care, and how they work as a team related to program decisions. We were particularly interested in exemplary practices that could be replicated across sites and whether these practices are institutionalized in policy or more dependent on individual working relations.

- **Knowledge:** The site visits explored what mental health providers know about chaplaincy and what chaplains know about mental health. We also explored what knowledge each discipline should have about the other, the potential opportunities for shared training experiences, and collaboration around evidence based practices.

- **Documentation:** Another objective of the site visits was to better understand how spiritual needs are screened and assessed, how chaplaincy and mental health providers collect and report information about what they do and how this information is shared across disciplines, and how each discipline documents success.

Multiple data collection methods were used to sample each domain, including observations, interviews, and a review of site specific documentation. Appendix M contains the interview guide that was used to direct questioning.

Interviewees

Interviews were conducted individually in most cases and in a few cases in small groups. In the case of groups, we adapted the interview guide for use in a group format. The majority of interviews lasted 45-60 minutes. In VA, chaplain interviews included chiefs of chaplains, hospital staff chaplains, and CPE supervisors and residents. In DoD, chaplain interviews included supervisory and staff chaplains in DoD medical centers and hospitals as well as supervisory and staff chaplains in operational commands. Mental health interviews included psychologists, psychiatrists, social workers, psychiatric technicians, substance abuse treatment professionals, nursing, and general medical providers who treat patients with mental health problems.

At the beginning of each site visit, the site visit team offered an in-brief session with facility leadership (e.g., chiefs of chaplains, chiefs of mental health services, directors of patient care services, medical center directors, ranking chaplain officers on base). Often this time was used to provide the site visit team with an overview of the facility, and for the site visit team to explain more fully what the visit aimed to accomplish. An out-brief was offered at the end of the site visit, during which examples of ideas generated by the interviewees and next steps in the study process were briefly discussed.

Analytic Approach

The interviews were initially coded using the constant comparative technique, a method that consists of simultaneously coding and analyzing data in order to make comparisons in and between categories and to look for similarities, differences, and consistency of meaning (Glaser & Strauss, 1967; Lincoln & Guba, 1985). This resulted in nine major areas that included themes which arose from the data. The initial coding was done with the aid of Atlas.ti©, a qualitative software package. A coding guide was constructed with a broad definition for each major area. Three Ph.D. trained coders coded fifteen interviews in two rounds of coding, followed by formal discussions to refine the code definitions when agreement was not present. Periodic meetings to discuss coding questions ensured that agreement was maintained. Once initial coding was complete, the report function of Atlas.ti © was used to generate a list of interview quotations for each code. The lists of quotations were divided among the coders, who employed a deductive

process to arrive at themes for each area. Themes were thus identified from the data rather than from a prescribed code book.

Once we arrived at common themes, a more complete code book was constructed (see Appendix N). This codebook contains 118 themes, each theme belonging to a code family. The code book includes brief and full definitions of each theme, instructions about when to apply or not apply the code, and examples drawn from the data. Three coders were again relied upon to code interviews. This time, each interview was reviewed for the presence or absence of each of the 118 themes. If a theme was detected, coders extracted the quotation they relied upon as evidence.

We were able to calculate the inter-rater reliability statistically for this round because the coding involved quantification of the presence or absence of a code. Inter-rater reliability across all 118 coded variables was calculated for approximately ten percent of the interviews. Randolph's free-marginal multi-rater *kappa* (Randolph, 2005; Warrens, 2010) was calculated for three rounds (five interviews per round), with results presented in Table 5. Disagreements in coding were discussed by raters and the coding definitions adjusted to increase agreement after each round. Following the third round of coding to determine reliability, each rater was assigned interviews to code individually along with 13 interviews that were coded by all interviewers. The *kappa* score was periodically calculated using these 13 interviews. Any shift in reliability was addressed through review of coding disagreements. A free-marginal *kappa* score of .8 or better is considered acceptable for inter-rater agreement. Appendix O displays the frequency with which codes were applied to interviews with VA chaplains, VA mental health professionals, DoD chaplains, and DoD mental health professionals.

Table 5: Inter-rater reliability for coded site visit interviews

Review Period	# Interviews	Free-marginal *kappa*	Overall % Agreement
Round 1	5	0.785	89.26
Round 2	5	0.820	90.99
Round 3	5	0.781	89.05
Periodic testing time 1	2	0.871	93.57
Periodic testing time 2	2	0.851	92.59
Periodic testing time 3	3	0.828	91.42
Periodic testing time 4	3	0.849	92.47
Periodic testing time 5	3	0.883	94.16

It should be noted that the unit of analysis is the interview. Some interviews were conducted with individuals and some were conducted with groups of individuals. For group interviews, themes were coded as a response by the group; we did not associate responses to individuals within group interviews. Groups were classified as either VA or DoD, and as chaplains or mental health based on the affiliations of the majority of participants. In most group interviews, participants were of the same affiliation. To the extent that information was available, we included with the coding of each interview the following information:

1. Interview number
2. Whether the interview was individual or group
3. Number of males and females in each interview
4. Race and ethnicity of interviewees

5. Number of mental health and chaplain interviewees in each interview
6. For mental health providers, their affiliation (e.g., mental health units, substance abuse units, medical units, social work units)
7. For mental health providers, their function/profession (e.g., psychiatrists, psychologists)
8. For chaplains, the type of chaplain (e.g., clinical setting, base/operational setting)
9. Site visit location for each interview
10. Branch of military or VA
11. Classification of VA or DoD for purposes of the frequency table
12. Classification of chaplain or mental health for purposes of the frequency table

It is important to be mindful of the limitations inherent in analyzing and interpreting the qualitatively collected data from the site visits. For one, in coding for the presence or absence of different themes, various nuances from the individual interviews are necessarily lost (e.g., the degree to which an interviewee stressed a particular theme, related a theme to something else, or talked about a theme in his/her particular context). For the purposes of this report, we have used the above described analytic approach to help summarize findings while simultaneously attempting to retain the richness of the interview methodology (such as by integrating quotes from interviewees into our findings). While this report aims to capture larger system-level lessons and hence summarizes information from the site visits, each site was supplied with an individualized report after the visit that captured site-specific information and could be used by the site in pursuing internal follow-up. Further, these individualized reports can serve to guide implementation of the facility-level recommendations presented later in this report. Another limitation to summarizing site visit findings is that while interviewees were all asked common questions, they were also encouraged to speak in depth about particular insights that they might provide. We desired to explore unique or innovative ideas as much as commonalities among sites, which entailed flexibility in questioning and often resulted in differing length and depth of interviews. The inconsistencies common in practical research included time and availability limitations for interviewees, differences in environments which were not always conducive to questioning, and variance in the level of detail provided by each interviewee. For example, at some sites the interviewees were asked to come to an area set up for interviews, but at other locations the interviews took place between regular appointments in offices, aboard ships, or in common areas like meeting halls or lunchrooms. This produced variability in depth and length of the interviews. Another limitation of the dataset was that the data consisted of interview notes rather than audio transcripts of the interviews. The interviewers took notes at each interview, attempting to capture as much verbatim as possible because audio recording was not approved as part of the site visit protocol. Hence, quotations presented in this report are reconstructed as accurately as possible.

Task Group Final Meeting

The task group final meeting for IMHS SA #23 was held in Washington, DC on March 19, 2012. The purpose of this meeting was to bring together the IMHS SA #23 task group to review findings from approximately one year of combined efforts on the strategic action and to collaboratively consider appropriate next steps. All but one of the 25 individuals in attendance had participated as part of at least one prior meeting or sub-task group committee. Presentations

at the meeting focused on findings from prior task groups and sub-task groups, preliminary findings from the VA / DoD Chaplain Survey, and recommendations coming out of the work done as part of IMHS SA #23. Time for task group input was incorporated throughout the meeting, with particular feedback solicited in reference to the recommendations that were put forth at the meeting. Much of the content of the current report was initially presented at the task group final meeting and has subsequently been refined for this report in accordance with the suggestions of task group members. A transcript of the group discussion was created, and this was relied upon in refining the recommendations that are presented in the present report. Appendix P contains the meeting agenda and the structured questions that were posed to the task group members.

Report Review

All IMHS SA #23 members in attendance at the final task group meeting were briefed on the major parts of the current report and were encouraged to supply verbal and written feedback. That feedback was used in crafting the present report. In addition, key task group members from all branches of the military and from VA provided feedback on prior versions of this report. A draft version of this report was sent to IMHS leadership in VA and DoD. Their feedback was integrated into the current report, and the report was then submitted for approval by the co-chairs of the HEC PH/TBI WG.

FINDINGS

Task Group Kickoff Meeting

A total of 27 task group members attended the kickoff meeting. Of these, 10 were from VA, 11 were from DoD (2 Army, 3 Navy, 4 Air Force, and 2 DCoE), and 6 were identified subject matter experts from outside institutions. The task group consisted of 16 chaplains, 9 mental health care providers, and 2 identified subject matter experts from other fields. The large majority of attendees were at a senior leadership level and had years of experience working in VA and DoD contexts.

In the first breakout group, in which attendees were divided according to whether they served VA or DoD, participants articulated different descriptions of how the chaplaincy operates within VA and DoD. Table 6 lists highlights from the group discussions. In general, comments illustrated how the professional roles and responsibilities assumed by chaplains in VA and DoD are primarily dictated by the populations being served (i.e., Veterans or Service members). The group of VA chaplains described their work as being formed by the health care context within which they operate, with much of their work taking place on inpatient units and with chronically medically ill individuals. DoD chaplains, on the other hand, described a more organic approach to care that emphasizes relationship building and integration within units. They also described professional roles that were clearly driven by the military context. For example, chaplains in the DoD group described one of their main roles as enhancing "resiliency" among Service members, which stands in notable contrast to the VA model of serving long-term care patients who have

been diagnosed with diseases and disorders. Still, chaplains in both the VA and DoD groups noted that it would be very helpful to cross-train with mental health professionals on how to enhance integration of chaplaincy into mental health care.

Table 6. Task Group Kickoff Meeting Breakout #1: State of Chaplaincy

	VA (n = 8)	DoD (n = 11)
Populations Served	• Veterans with health problems (primarily inpatient); VA staff	• Service members; DoD staff; other chaplains
Routes to Care	• Referrals and consultations	• Build relationship at unit level
Services Provided to Veterans / Service members	• Long-term health care • Primarily inpatient; also outpatient • Medical model (i.e., "disorders")	• 1st responder in units • Communicate with command • Resilience / suicide prevention
Services Provides to Families	• Chaplains can do more for families • ICU & palliative care models • Marriage/family models emerging	• Caregiver stress control • Pre/post deployment activities
Training Needs	• Learn to embrace integrated roles • Learn common language(s) • CPE across the board	• Spiritual dynamics of trauma • Self-care • Bi-directional education w/ MH

CPE: Clinical Pastoral Education; ICU: Intensive Care Unit; MH: Mental Health.

In the second breakout session, in which attendees were divided to evenly disburse VA and DoD attendees between the two groups, meeting participants discussed challenges in communicating between VA and DoD as well as commonalities with respect to the practice of chaplaincy. Attendees acknowledged that learning to navigate both the VA and DoD systems can be difficult but noted that multiple programs are in place that are attempting to better facilitate access to care. Within these programs and within the existing VA and DoD infrastructures, meeting participants noted that there is potential for significantly greater utilization of chaplains as "cultural liaisons" – meaning that by virtue of their pastoral formation and their professional roles, chaplains are in a prime position to function as liaisons between Veterans, Service members, mental health care providers, hospital staff, unit and command leadership and personnel, families, faith communities, and other community resources. This was identified as an important role that could be enhanced in both VA and DoD. This also closely related to discussions in both groups about why Veterans and Service members choose to seek out a chaplain.

As multiple task group members stated, Veterans and Service members typically are not coming to a chaplain with explicit spiritual or religious concerns but are rather bringing other concerns, such as marital problems, financial problems, loss of identity, and a host of other life stressors or crises. Of importance, these types of issues were identified by chaplains at the meeting as warranting a theologically informed approach by a chaplain with a well-formed pastoral identity – an approach in which application of theological principles need not entail overt reference to religion or theology. Chaplains in this second breakout session also noted that documentation of chaplain care practices is highly variable (i.e., it is often not done, and it is lacking standardized

format when it is done) and that it is very important to address confidentiality issues from the outset of an encounter with a Service member or Veteran.

In the third and final breakout session, in which attendees retained the same group assignments as for the second breakout session, the discussion focused on barriers to providing continuity of care between chaplaincy and mental health, both within and across VA and DoD settings. The major barriers that were identified and possible solutions to dealing with these barriers are listed below. The below listed barriers and solutions do not correspond in a one-to-one fashion but rather are overarching issues that were identified in the group discussions.

Known & Potential Barriers

- Communication between VA and DoD is difficult.
- There is not a standardized approach to documentation and other chaplain care practices.
- What chaplains do has often not been translated for mental health providers.
- Chaplains and mental health providers are unfamiliar to each other.
- Chaplain staffing is inadequate.
- There are concerns about confidentiality.

Possible Solutions

- ☐ Support joint training of chaplains and mental health providers.
- ☐ Pursue other approaches to relationship building for chaplains and mental providers.
- ☐ Standardize electronic medical records between VA and DoD as well as for chaplain documentation practices.
- ☐ Create a mechanism for chaplains and MH to share best practices with one another.
- ☐ Provide more staffing and support.

VA Mental Health and Chaplaincy Forum

Invitations to attend the VA Mental Health and Chaplaincy Forum were extended to 141 health professionals in VA, DoD, and other contexts. Of these, 90 accepted the invitation to attend, 48 declined, and 3 did not respond. Out of the 90 that accepted, 71 attended both days of the forum, 7 attended only one day (these attendees did not participate in breakout groups), and 12 did not end up attending. The findings presented here are from the 71 attendees who participated in both days of the forum and who provided input in the breakout groups. Table 7 displays the characteristics of these 71 attendees.

Plenary presentations were largely front-loaded near the beginning of the forum so as to provide attendees with information and concepts to consider in the breakout groups. Feedback from attendees on the plenary presentations as gathered by the VA Employee Education System (EES) was positive: for the five plenary presentations, percentages of participants who felt that the content was effectively presented were 100%, 100%, 96%, 100%, and 81%. The overall forum also received positive ratings from attendees, with 96% reporting that they were satisfied with the forum and given the chance would recommend it to others.

In the first breakout group session, in which meeting participants were divided into one of the four professional groups displayed in Table 8 on the basis of their training and current work responsibilities, attendees discussed various aspects of integration of chaplain and mental health

Table 7: VA Mental Health and Chaplaincy Forum Attendees

Attendee Characteristics	n (%)
Organization	
VA	49 (69%)
DoD	12 (17%)
Non-federal	10 (14%)
Professional Role	
National (VACO/DCoE)	20 (28%)
Clinician	12 (17%)
Research / Academic	21 (30%)
Other	18 (25%)
Discipline	
Mental Health	27 (38%)
Psychologists	*20 (28%)*
Psychiatrists	*7 (10%)*
Chaplains	24 (34%)
Affiliated Health Care	14 (20%)
Nurse practitioners	*2 (3%)*
Nurses	*7 (10%)*
Physicians (non-psych)	*5 (7%)*
Other	6 (8%)
Total	**71 (100%)**

DCoE = Defense Centers of Excellence; VACO = Veterans Affairs Central Office

care services. Table 8 provides a synopsis of the thematic content that emerged within the different group discussions (note that the absence of a checkmark for breakout groups in this table indicates only that the theme did not surface as part of the group discussion, not necessarily that the breakout group viewed the theme as unimportant). Many of the same advantages to integrating chaplaincy and mental health care were noted in the four breakout groups, including that integrating chaplains into mental health care facilitates a holistic approach to health care, a reduction in the stigma attached to receiving mental health care, and better access to mental health care. Many of the groups were aware of existing models of chaplains partnering with local clergy to enhance the care of Veterans and Service members. The breakout group discussions also evidenced an overarching acknowledgement that too little interaction takes place between mental health and chaplaincy, with participants in both the mental health group and chaplain group pointing to cross-training of chaplains and mental health care providers as a possible solution to this problem. Appendix E contains an expanded table with findings from the first breakout.

In the second breakout session, in which attendees from the four professional groups used to organize the first breakout session were evenly disbursed across four new breakout group assignments, participants discussed the perceived needs of the target populations in VA and DoD and how to develop models of integrated chaplain and mental health care to address these needs. Table 9 displays the most common topics of discussion that emerged from these breakout groups, with notation to indicate how many groups discussed a topic and how much the topic was emphasized in the group discussions. The important spiritual issues among Veterans and Service members that were identified in some form by all groups included moral injury, forgiveness, shame/guilt, coping with loss of faith, and building relationships with one's family and community. To optimally respond to these needs, all groups raised the suggestion of conducting appropriately constructed cross-disciplinary trainings aimed at educating chaplains on mental health issues and educating mental health professionals on spiritual issues and chaplain care practices. Throughout this breakout session and at other occasions during the forum, attendees repeatedly emphasized the need for cross-disciplinary hybridization between chaplaincy and mental health. Appendix E contains an expanded table with findings from the second breakout.

Table 8. State of Integration (Forum Breakout #1)

		Chaplaincy (n=20)	Mental Health (n=18)	Broader Health (n=17)	Community (n=16)
Benefits of Integration	Holistic care	✓	✓	✓	✓
	Stigma reduction	✓	✓	✓	✓
	Access / entry point to MH	✓	✓		✓
Ideal for a Model of Integration	Cross-train chaplains and MH	✓	✓		
	Liaison for MH-spiritual		✓		
	Chaplain available as needed			✓	
Existing Models of Integration	Integration is rare		✓		
	MH-trained chaplains	✓			
	Local clergy partnership	✓		✓	✓
Challenges to Integration	Lack on interaction	✓	✓		
	Territorialism / turf issues	✓	✓		
	Unaware of chaplains			✓	
	Limited chaplain time		✓	✓	

Check marks indicate that the identified theme was discussed within the corresponding breakout group. The themes listed are those that came up as part of multiple group discussions or were significantly emphasized in at least one of the group discussions. The absence of a checkmark does not indicate that the breakout group considered the theme unimportant but simply that the theme did not happen to emerge as part of the group discussion.

In the third breakout session, in which attendees remained in the same groups that they were in for the second session, each group was assigned three "barriers to integration" to collectively consider and problem-solve. The total of 12 barriers (3 distinct barriers assigned to each of the 4 groups) were identified at the end of the second breakout session and compiled by breakout group facilitators prior to the third breakout session. While there were a number of specific barriers identified, a common theme that ran through most of them related to the trust and confidence that mental health providers and chaplains hold for one another. Difficulties in establishing trust and confidence were noted as often being caused by a lack of familiarity between the disciplines.

Among chaplains, closer collaboration with mental health is viewed by some as leading to chaplaincy losing its distinctiveness by being subsumed within the medical model and the pressures of evidence-based health care. Among mental health professionals, the suggestion of closer collaboration with chaplaincy can raise fears about proselytizing and chaplains' competency levels in caring for patients with mental health problems. Both chaplains and mental health professionals voiced concerns about professional roles and boundaries blurring.

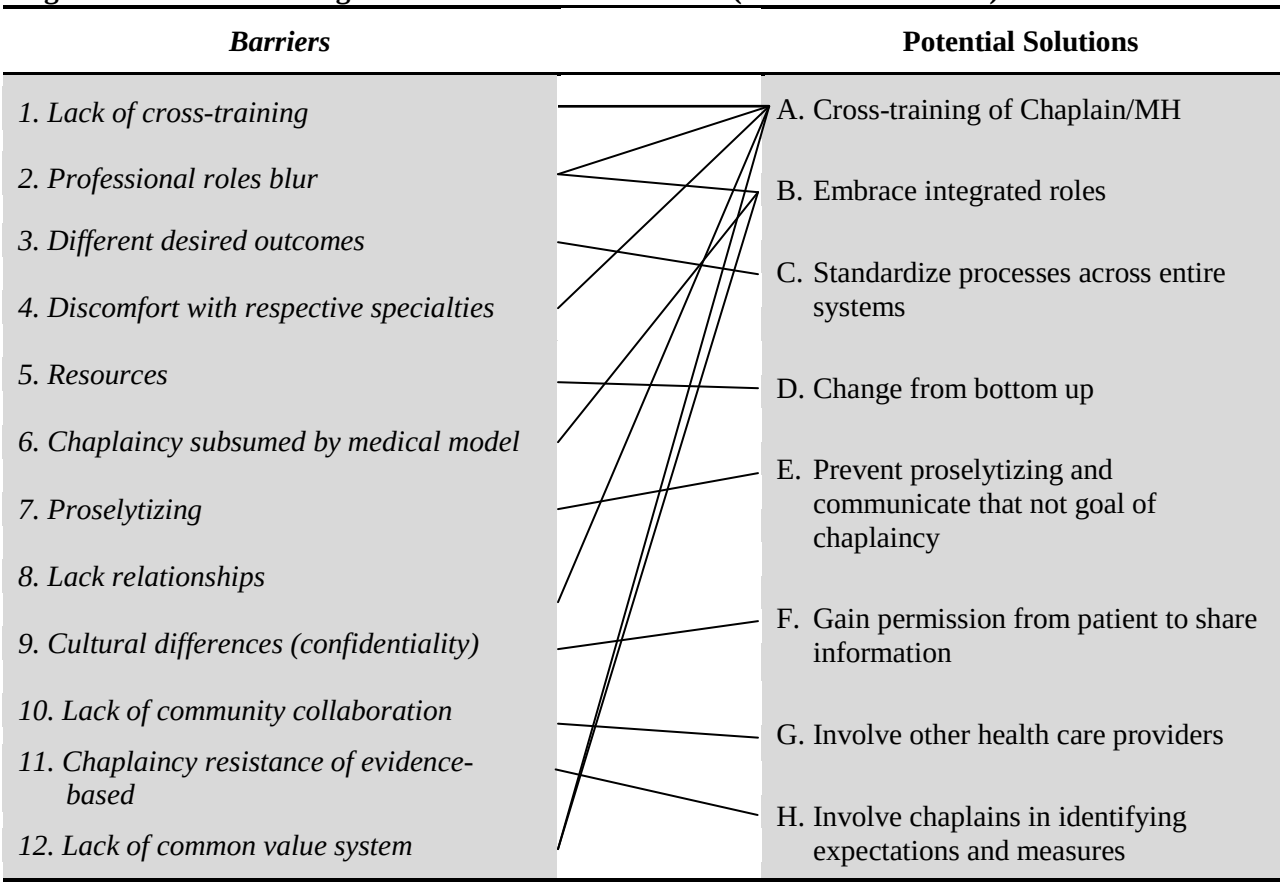
Figure 3 displays the possible solutions that attendees formulated to address the identified barriers. Some solutions were identified as addressing multiple barriers. Notably, cross-training chaplains and mental health professionals was identified as a solution to five of the barriers, and working toward a culture in which chaplains and mental health care providers embrace integrated roles (as opposed to functioning in professional "silos") was identified as a solution to three of the barriers. Other barriers required more circumscribed solutions. A table with expanded findings from the third breakout session is presented in Appendix E.

Table 9: Models for Integration (Forum Breakout #2)

Question	Thematic responses
What appear to be the spiritual needs of Veterans, Service members, and family members?	- Moral injury, forgiveness, freedom from shame and guilt[4++] - Loss of faith and how to reintegrate into the family after loss of faith[4+] - Building healthy relationships with family, community[4+] - Reconnect with spiritual side[3+] - Safe environment to tell their story[3+]
What are the educational needs of chaplains, mental health providers, other health care providers, clergy and community leaders, Veterans and Service members, and other stakeholders?	- Cross-training on multiple disciplines[4++] - Educate chaplains on MH issues (e.g. diagnoses, clinical issues)[4+] - Educate MH providers on religion/spirituality issues[3+] - True integration requires collaboration among all groups[2] - Define provider roles and how providers can help each other[2] - Training for specific MH issues (especially suicide prevention)[2]
If you could specify roles for providers and participants (chaplains, mental health providers, primary care providers, clergy, community leaders, Veterans / Service members, family members) in a more integrated system of care, what would those roles be?	- Allow for different levels/degrees of integration.[3+] - "Roles" are not helpful; there is already an obsession with "lanes." Should allow for organic, flexible, and based on individual relationships.[2+] - Chaplains can serve as liaisons, outpatient clinicians, sources of referral.[2]

The most commonly identified themes from the group discussions are listed in this table. The numeric notation following each theme (2-4) indicates the number of groups that discussed the theme. Themes that were emphasized as important in 1-2 group discussions are notated with one plus sign (+), and themes that were emphasized as important in 3-4 of the group discussions are notated with two plus signs (++).

Figure 3: Barriers to Integration and Potential Solutions (Forum Breakout #3)



Barriers listed in the left column were identified by attendees at the end of the second breakout session. Solutions in the right column were generated during the third breakout session. Lines connect barriers to the corresponding main solutions that were generated by attendees.

Sub-task groups

Following the VA Mental Health and Chaplaincy Forum, IMHS SA #23 leads met with key stakeholders from the IMHS SA #23 task group and reviewed input from the forum to determine areas warranting additional focus within sub-task groups. The sub-task groups were scheduled to occur as part of the original strategic action plan. Two sub-task group topics were identified: 1) chaplain documentation practices; and 2) chaplain assessment and screening practices.

Documentation Practices

A total of 15 sub-task group members were selected to participate in the documentation practices sub-task group. Of these, 9 were from VA, 5 were from DoD (1 Army, 2 Navy, 0 Air Force, and 2 DCoE), and 1 was an identified subject matter expert from an outside institution. The task group consisted of 11 chaplains and 4 mental health care providers.

Chaplains representing VA and DoD presented on the conference calls to stimulate discussion around the similarities and differences of chaplains' documentation practices in VA and the military. Within the military, it was noted that documentation of services is not part of the work

culture for chaplains in operational settings. For military chaplains in hospital settings, documentation of services is more common and shares similarities with the documentation practices of VA chaplains: both rely on electronic medical record systems and for both confidentiality of care is a major concern. Chaplains in both VA and DoD have approached maintaining confidentiality by using drop-down lists and checkboxes to document services provided. A drawback to this approach is that clinical information can be less meaningful than if more narrative notes were provided. Chaplains noted that more detailed information is sometimes shared informally in communication with health care professionals, but there is considerable variability in whether such communications occur.

Chaplains in both VA and DoD noted a number of reasons why many chaplains are reluctant to document care or to providing detailed documentation. These included:

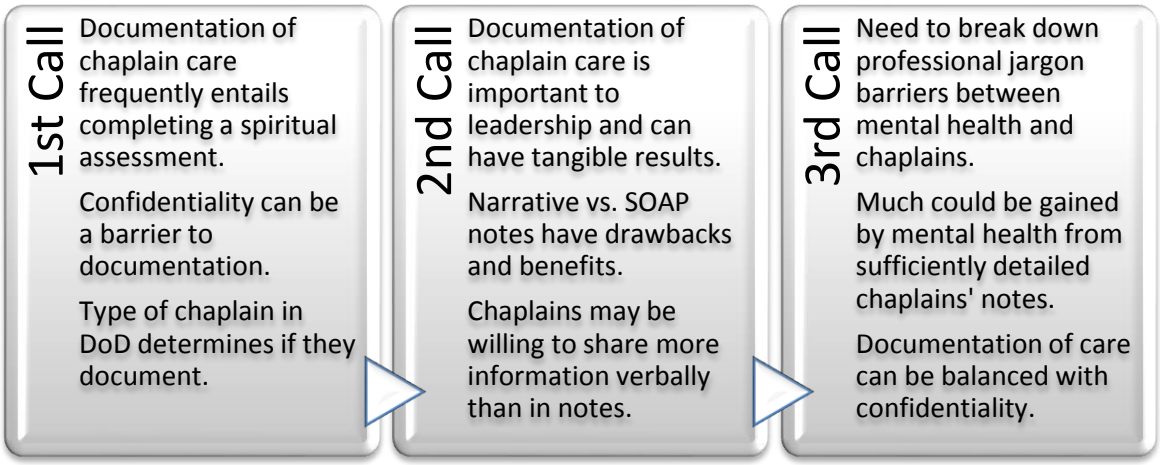
1. Chaplains may feel like requiring detailed documentation of care implies that they are being conceptualized as a mental health professional rather than a chaplain.
2. Too much documentation of care may be seen as violating confidentiality.
3. Lack of role clarity for chaplains and mental health care providers can dissuade some chaplains from detailing their encounters with patients.
4. Writing notes is typically not a focus in chaplains' training, certainly not in seminary.
5. Chaplains who do not rely on other health care providers' notes may see less need for providing notes on their care to other providers.
6. Chaplains who lack relationships with mental health professionals might see less of a need to document care or may be concerned about how their notes could be used.
7. Chaplains and mental health care providers use different professional languages.

Members of the sub-task group proposed the following potential approaches to problem-solve these barriers (the below suggestions do not correspond in a one-to-one manner to the above noted barriers):

1. Encourage relationship building between chaplains and mental health care providers via multiple mechanisms, such as joint trainings. Sub-task group members emphasized how crucial it is that these trainings not be one-sided, noting that in the past there has been a perception among chaplains that they need to learn from mental health but not vice versa.
2. Find ways for chaplains and mental health professionals to educate one another on their disciplines' respective languages and approaches to caring for patients.
3. Help chaplains who are reluctant to include information in notes form trusting relationships with mental health providers.
4. Make documentation of practices a part of training chaplains (e.g., be more intentional about incorporation of this into CPE programs, involve endorsing agencies and seminaries).
5. Incorporate training in documentation of care as part of the training of chaplains and mental health care providers being recommended out of IMHS SA #23.
6. Identify themes that are important for mental health care providers to see in chaplains' notes (e.g., grief, loss, suffering, guilt, forgiveness). Teach chaplains how to document these themes in a manner that is helpful in the health care context, and articulate to mental health the value of attending to chaplains' notes.

Figure 4 provides a basic overview of the flow of the three conference calls held for the sub-task group on chaplains' documentation practices.

Figure 4. Highlights from Sub-task Group Calls on Documentation Practices



SOAP: subjective, objective, assessment, plan

Assessment and Screening

A total of 13 sub-task group members were selected to participate in the assessment and screening sub-task group. Of these, 7 were from VA, 5 were from DoD (2 Army, 1 Navy, 0 Air Force, and 2 DCoE), and 1 was an identified subject matter expert from an outside institution. The task group consisted of 9 chaplains and 4 mental health care providers.

Chaplains representing VA and DoD presented on the conference calls to stimulate discussion around the similarities and differences of chaplains' assessment and screening practices in VA and the military. The VA National Chaplain Center recently undertook a large-scale review of all assessment tools being used by chaplains at VA medical centers. The committee in charge of this review either approved or made recommendations regarding the assessments tools that were submitted, allowing for substantial variance within a range of acceptability that was determined by the committee. In the DoD operational context, the Army employs the Global Assessment Tool (GAT) that asks about spiritual fitness, and spiritual fitness has been advanced as an important construct in the Navy as well. Chaplains are not directly involved in administering these measures or in examining the results. Among health care providers in DoD, a uniform structured assessment is being advanced as part of the implementation of ESSENTRIS (the electronic medical record system). Sub-task group members expressed concern that when spiritual assessments are conducted by chaplains, findings may not always be optimally used.

Three major barriers to optimizing the use of chaplains' spiritual assessments were noted:

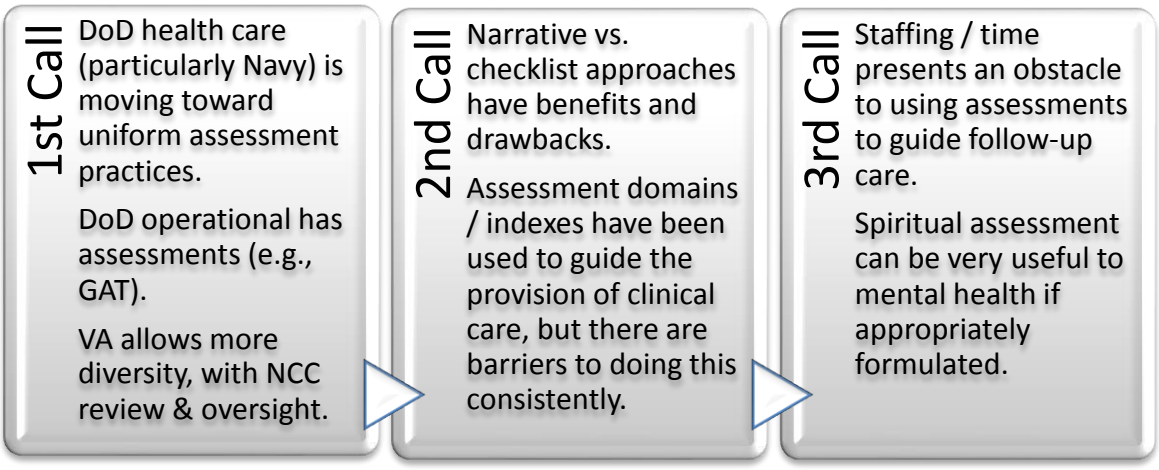
1. Chaplains are often spread so thin in attempting to complete spiritual assessments that they may not have time to use the assessment to guide follow-up care.
2. Chaplains may not be adequately trained in how to use a spiritual assessment tool, and/or they may be averse to adopting a seemingly quantitative approach.
3. Too much variability exists, preventing providers from being able to communicate about an accepted and familiar measure.

Four solutions were advanced by members of the sub-task group as approaches to addressing the above noted barriers:

1. Provide adequate staffing to allow for chaplains to provide follow-up care as indicated by findings from spiritual assessments.
2. Develop approaches to screenings and assessments that allow chaplains to meet requirements for completing spiritual assessments while also minimizing the time chaplains spend on patients in less need of their services and maximizing the time chaplains spend with patients likely to benefit.
3. Train chaplains in the use of spiritual assessment tools as part of how to provide quality pastoral care.
4. Develop spiritual assessment tools with good psychometric properties that are capable of informing care in the mental health care context.

Figure 5 provides a basic overview of the flow of the three conference calls held for the sub-task group on chaplains' assessment and screening practices.

Figure 5. Highlights from Sub-task Group Calls on Assessment and Screening



NCC: VA National Chaplain Center

VA / DoD Chaplain Survey

The overall response rate on the VA / DoD Chaplain Survey was high (n = 2,163 of 3,464; 62% response rate), with specific response rates of 75% in VA (n = 440 of 585), 64% in the Army (n = 1,017 of 1,591), 39% in the Navy (n = 320 of 813), and 81% in the Air Force (n = 386 of 475). Chaplains were explicitly reminded that answering demographic questions was voluntary and they were separately invited to complete questions on the supplemental survey, so while the majority of chaplains completed the items on these sections of the survey, there were expectedly larger proportions of missing data in these sections (exact numbers for missing data are indicated in the below tables and figures). For all survey findings, numbers of chaplains and percentages are presented based out of those who completed a given item. Data presented in this report are from full-time VA chaplains and active duty chaplains in DoD. In addition to the grouping of chaplains by whether they belong to VA or DoD (and Army, Navy, or Air Force within DoD),

survey respondents have also been categorized into the following groups for certain analyses (based on answers given on the survey):

- *DoD health care chaplains (n = 164).* DoD chaplains who indicated on demographic item #8 that they are stationed at a health care facility.
- *DoD non-health care chaplains (n = 1,269).* DoD chaplains who indicated on demographic item #8 that they are not stationed at a health care facility.
- *VA mental health chaplains (n = 172).* VA chaplains who indicated spending "a large amount of time" in at least one of the following mental health-related clinical settings: inpatient psychiatric/mental health (64% of 172 VA mental health chaplains), outpatient mental health (32%), inpatient substance abuse programs (55%), outpatient substance use programs (29%), inpatient specialized PTSD treatment (34%), and outpatient specialized PTSD treatment (21%).

Demographics

The majority of chaplains in VA and DoD identified as white, with VA containing more black chaplains and fewer Asian chaplains than DoD. VA chaplains were more likely than DoD chaplains to be female, to be over age 55, and to have served more than 20 years as a chaplain. VA chaplains were also more likely to hold a doctoral degree, to have at least 3 units of CPE, and to be a board certified chaplain. A total of 54% of VA chaplains identified themselves as Veterans. Chaplains in VA were more likely than those in DoD to claim their religious affiliation as mainline Protestant, Catholic, or historically black Protestant. They were less likely than chaplains in DoD to claim an evangelical Protestant religious affiliation. Overall job satisfaction was high, with 92% of VA chaplains and 92% of DoD chaplains reporting that they are satisfied with their current chaplain role.

Among DoD chaplains, 11% identified themselves as working in a health care setting (whereas all VA chaplains work in health care). With respect to rank, roughly half of DoD chaplains identified as an O4 or above. When asked about number of deployments since September 11, 2001, 60% reported having been on 1–2 deployments and 30% reported 3 or more deployments. More chaplains deployed to Iraq than Afghanistan. Table 10 displays demographic information for the samples.

Work Settings

Chaplains indicated working in inpatient settings more frequently than outpatient settings and working in medical settings more frequently than mental health settings. When chaplains did report working in mental health settings, it was more likely to be in inpatient settings. This was true for both VA and DoD chaplains. Table 11 displays these trends.

Table 10: 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.

Table 11. Locations of Clinical Work

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. 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 (n = 440), 0 (0%) to 2 (1%) cases out of the total DoD health care chaplain sample (n = 164), and 6 (0%) to 16 (1%) cases out of the total DoD non-health care sample (n = 1,269). Percentages in the table are based out of the total number of those that responded to each item.

Separate from the question about location of clinical work, chaplains were asked about membership on clinical teams. Chaplains in VA and health care chaplains in DoD were more likely to report being included as part of the inpatient medical/surgical team (53% in VA, 51% in DoD HC) than any other health care team. For mental health clinical teams, VA chaplains most commonly indicated being included as team members on the inpatient psychiatric / mental health team (47%) and the substance use clinic team (34%), followed by the PTSD clinic team (24%) and the outpatient mental health clinic team (21%). DoD health care chaplains were also most likely to report being included as team members on the inpatient psychiatric/mental health team (38%), followed by the outpatient mental health clinic team (26%), substance use clinic team (23%), and the PTSD clinic team (22%). Chaplains who indicated being included as part of any clinic team were then asked whether they felt that their role as a chaplain on that team was understood and valued. The large majority (range of 89% to 97%) of VA and DoD health care chaplains who indicated that they were members of one of the four mental health clinical teams reported feeling that they were understood and valued as members of these teams.

Routes to Care and Populations Served

Chaplains reported multiple routes by which they come into contact with Veterans and Service members (see Table 12). Individual initiative, either on the part of the chaplain (i.e., chaplain going to see a Veteran / Service member without a referral) or that of the Veteran / Service member (i.e., Veteran / Service member going to see a chaplain without a referral), was behind the two most commonly endorsed routes to care in both VA and DoD. VA chaplains were more likely than DoD chaplains to report going to see Veterans without a referral, whereas DoD chaplains were more likely than VA chaplains to report having Service members come to see them without a referral. Referrals were more likely to be initiated by professionals than by Veteran peers for VA chaplains, whereas in DoD referrals were more likely to come from Service member peers than from commanding officers.

In VA, chaplains were asked to report on how frequently they see Veterans from different eras of conflict. A total of 93% of VA chaplains indicated seeing Vietnam Veterans on at least a weekly

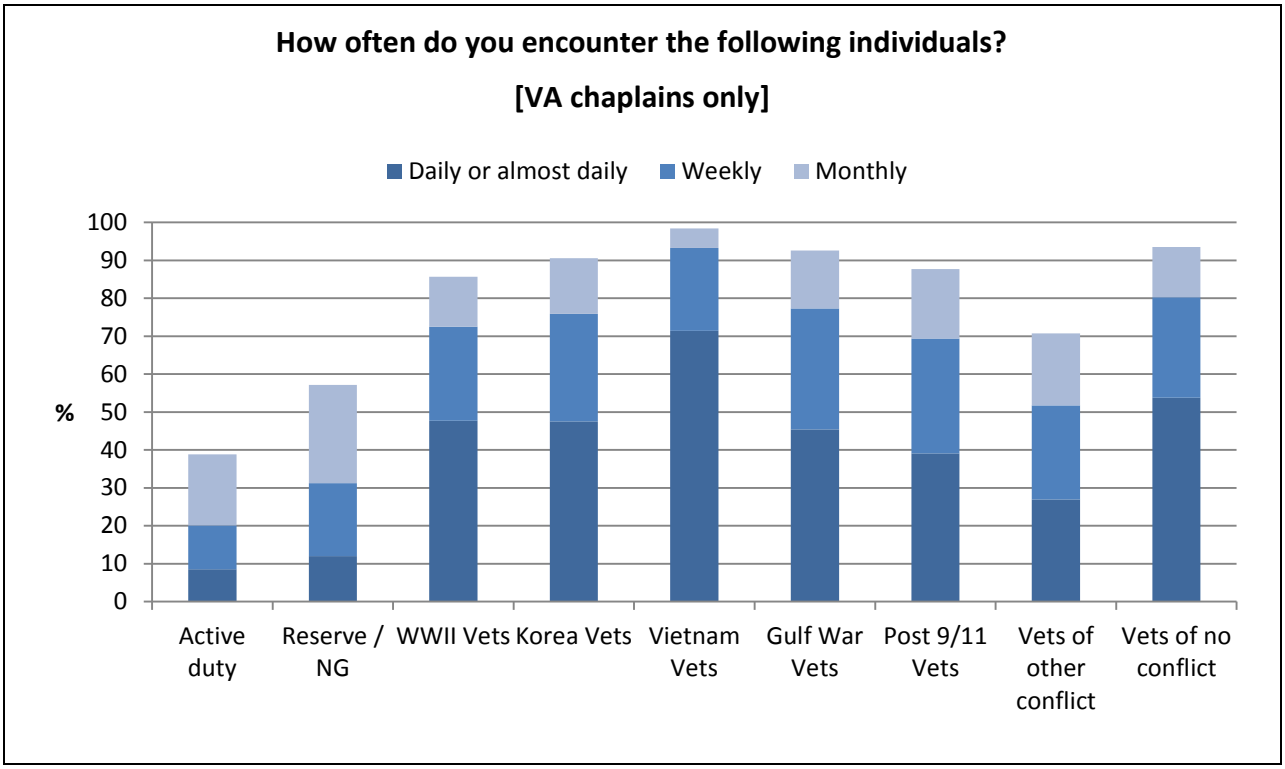
basis, the most frequently encountered group of Veterans from any conflict. Sixty-nine percent of VA chaplains reported seeing Veterans from post-9/11 conflicts on at least a weekly basis. Figure 6 provides detail.

Table 12. Routes to Care

	VA n (%)	DoD n (%)	*P*
Veterans/SMs come to me on their own without referral.	295 (68%)	1,511 (89%)	<.001
I go to Veterans/SMs without them being referred to me.	372 (85%)	1,080 (64%)	<.001
Veterans/SMs are referred to me by other professionals / their commanding officers.	268 (62%)	627 (37%)	<.001
Veterans/SMs are referred to me by their fellow Veterans/SMs.	154 (36%)	803 (47%)	<.001
Veterans/SMs are referred to me by non-Veteran/SM family or friends.	75 (17%)	266 (16%)	.731

SM = Service member. Percentages are of chaplains who reported that they come into contact with Veterans or Service members "Frequently" or "Almost always" in the manners listed. VA chaplains were asked about "Veterans" and "professionals." DoD chaplains were asked about "Service members" and "commanding officers." Missing data for the above variables ranged from 4 (1%) to 9 (2%) cases out of the total VA sample (n = 440), and 26 (2%) to 41 (2%) 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 item.

Figure 6. VA Clinical Populations



NG = National Guard. Figure displays percentages of VA chaplains who report regularly seeing different categories of Veterans. Missing data for the above variables ranged from 4 (1%) to 20 (5%) cases out of the total VA sample (n = 440). Percentages in the table are based out of the total number of those that responded to each item.

Problems Encountered and Preparedness to Encounter

Out of a list of 32 items, the problems that chaplains in both VA and DoD indicated encountering most frequently in their work were mental health problems. In VA, these problems tended to be more clinical in nature (e.g., anxiety, depression), whereas in DoD the problems tended to be more along the lines of adjustment difficulties (e.g., relationship / family stress, work stress). Given the settings in which they work, VA chaplains were expectedly more likely than DoD chaplains to regularly encounter Veterans with problems that merited intervention from health care professionals (see Table 13).

Table 13. Problems Encountered by Chaplains and Corresponding Training

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.*

After indicating how commonly they encounter Veterans and Service members with each of the 32 items listed on the questionnaire, chaplains were asked to indicate how well their training has prepared them to provide pastoral care to individuals with these problems (see Table 13). Chaplains in both VA and DoD indicated feeling best trained to provide care for problems of a spiritual nature (e.g., struggle with religious belief system, difficulties with forgiveness, understanding loss and trauma). Hence, while chaplains are best trained to encounter overtly spiritual problems, the problems that they most regularly encounter are mental health problems.

Of note, DoD chaplains were more likely than VA chaplains to report being well trained to encounter relationship and family stress as well as suicidal issues, likely reflecting an emphasis that DoD has placed on training chaplains in these domains.

Work Activities

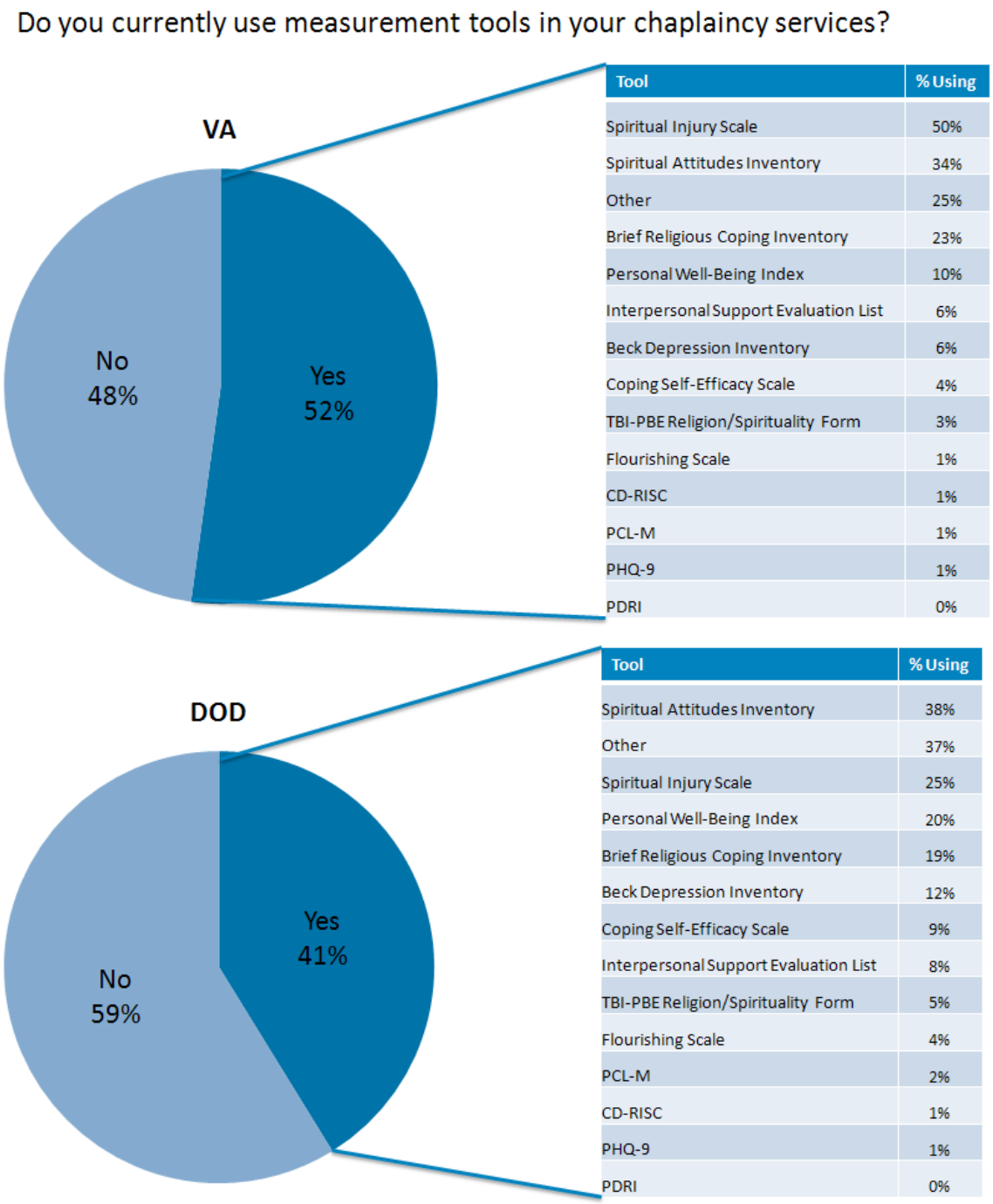
From a list of 18 various work activities, the activities most commonly indicated by VA chaplains as occurring on a daily basis were praying with Veterans (77%) and spiritually counseling Veterans (75%). Among DoD chaplains, these activities were the second and third most commonly endorsed daily activities (52% and 50% respectively). The most commonly endorsed daily activity among DoD chaplains was advising Service members (55%), an activity that was less commonly endorsed among VA chaplains (36%). Three out of five chaplains in both VA and DoD reported engaging with local clergy on at least a monthly basis in the course of their work as chaplains, with half of chaplains in VA and DoD reporting that they engage this often with other community representatives. The majority of chaplains reported their administration as being supportive of such outreach.

When asked about their current chaplain care practices, 77% of VA chaplains and 74% of DoD chaplains indicated that they consider their current practices to be evidence-based. A large majority of chaplains reported that they read professional journal articles on at least a monthly basis (79% in VA and 73% in DoD). A slight majority in VA and a sizable minority in DoD indicated using measurement tools in their chaplaincy services (see Figure 7). The most commonly used measure in VA was the Spiritual Injury Scale, and the most commonly used measure in DoD was the Spiritual Attitudes Inventory (used most among Army chaplains). When asked if they would like their chaplain care practices to be more evidence-based, 63% of VA chaplains and 50% of DoD chaplains indicated that they would.

Engagement with Mental Health

VA chaplains were more likely to report regular engagement with mental health professionals than DoD health care chaplains, who in turn were more likely to regularly engage with mental health professionals than their non-health care counterparts (see Figure 8). There were a substantial number of chaplains who reported exchanging very few referrals with mental health care professionals. The percentage of chaplains who reported making referrals to mental health either less than monthly or never was 43% within VA, 34% within DoD health care chaplains, and 38% within DoD non-health care chaplains. The percentage of chaplains who reported receiving referrals from mental health either less than monthly or never was 36% within VA, 57% within DoD health care chaplains, and 76% within DoD non-health care chaplains. Of interest, VA chaplains reported receiving more referrals from mental health professionals than they give to mental health, whereas DoD chaplains reported giving more referrals to mental health professionals than they receive (see Figure 8). Figure 9 displays how frequently chaplains indicated participating in four different types of engagement with mental health professionals. Overall, VA chaplains were more likely than DoD health care chaplains to report engaging with mental health professionals in the ways listed.

Figure 7. Use of Measurement Tools among VA and DoD Chaplains

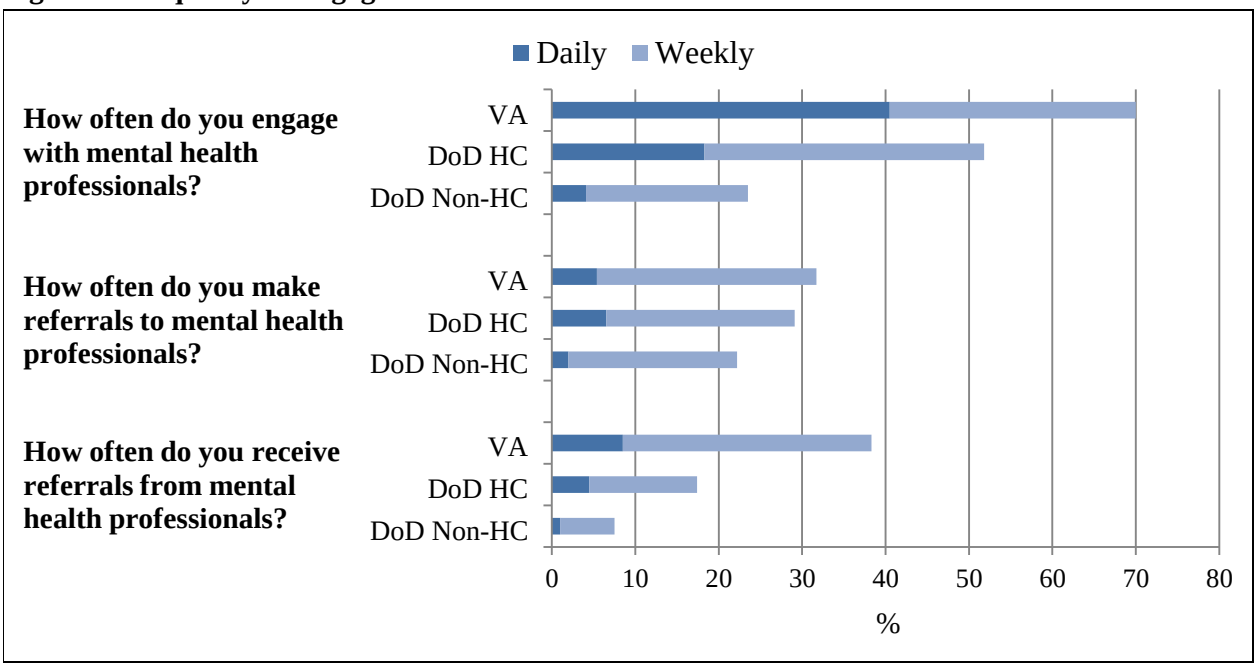


Tool	% Using
Spiritual Injury Scale	50%
Spiritual Attitudes Inventory	34%
Other	25%
Brief Religious Coping Inventory	23%
Personal Well-Being Index	10%
Interpersonal Support Evaluation List	6%
Beck Depression Inventory	6%
Coping Self-Efficacy Scale	4%
TBI-PBE Religion/Spirituality Form	3%
Flourishing Scale	1%
CD-RISC	1%
PCL-M	1%
PHQ-9	1%
PDRI	0%

Tool	% Using
Spiritual Attitudes Inventory	38%
Other	37%
Spiritual Injury Scale	25%
Personal Well-Being Index	20%
Brief Religious Coping Inventory	19%
Beck Depression Inventory	12%
Coping Self-Efficacy Scale	9%
Interpersonal Support Evaluation List	8%
TBI-PBE Religion/Spirituality Form	5%
Flourishing Scale	4%
PCL-M	2%
CD-RISC	1%
PHQ-9	1%
PDRI	0%

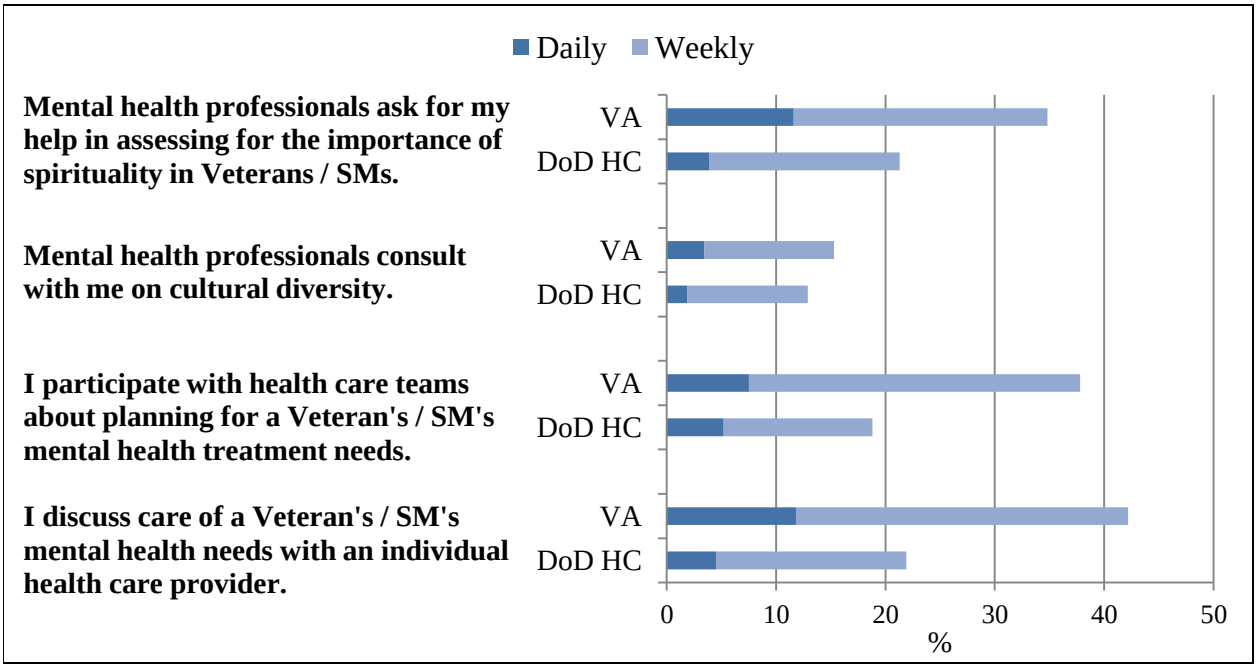
Survey participants who indicated that they used measurement tools (n = 167 in VA; n = 493 in DoD) were presented with the measures listed and asked to check all measures that they use. This information was gathered as part of the Supplemental Survey, which participants were separately invited to complete after finishing the Core Survey. The majority of chaplains still answered these questions on measurement, with 120 (27%) chaplains out of the total VA sample (n = 440) and 525 (30%) of chaplains out of the total DoD sample (n = 1,723) not answering this question about use of measurement tools. Percentages in the table are based out of the total number of those that responded to the question about use of measurement tools.

Figure 8. Frequency of Engagement with Mental Health Professionals



HC = health care. Missing data for the above variables ranged from 13 (3%) to 30 (7%) cases out of the total VA sample (n = 440), 0 (0%) to 9 (5%) cases out of the total DoD health care chaplain sample (n = 164), and 3 (0%) to 94 (7%) cases out of the total DoD non-health care sample (n = 1,269). Percentages in the table are based out of the total number of those that responded to each question.

Figure 9. Manners of Engagement with Mental Health Professionals



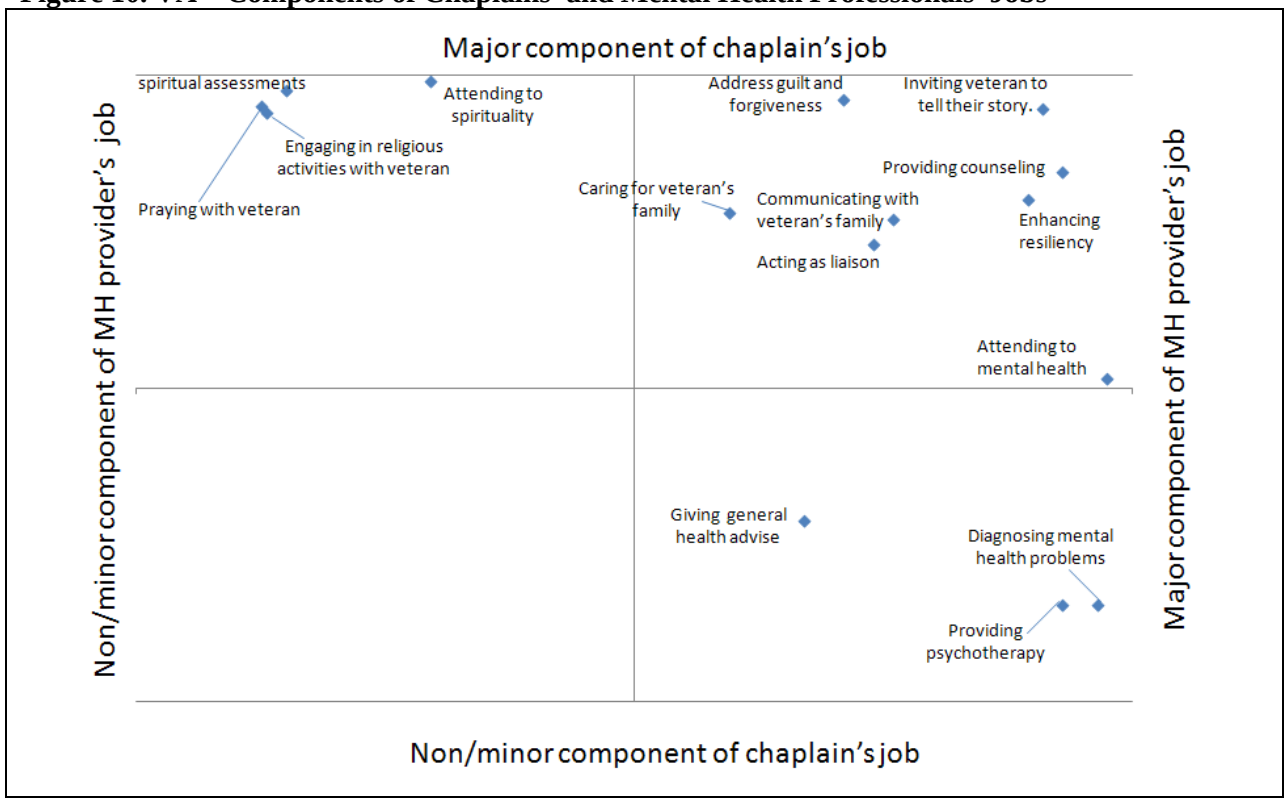
HC = health care; SM = Service member. For DoD non-health care chaplains, 6% or less indicated daily to weekly participation with mental health care professionals in any of the ways listed; hence, they are excluded from the figure. Missing data for the above variables ranged from 28 (6%) to 30 (7%) cases out of the total VA sample (n = 440), and 9 (5%) to 10 (6%) cases out of the total DoD health care chaplain sample (n = 164). Percentages in the table are based out of the total number of those that responded to each question.

To assess perceived professional boundaries between chaplains and mental health professionals, survey respondents were presented with a list of 16 job components and asked to rate the extent to which each item was a minor, moderate, or major component of 1) a chaplains' job and 2) a mental health care provider's job. As evidenced in Figures 10 and 11, chaplains in VA and DoD made highly similar distinctions between the job components. VA and DoD chaplains viewed the activities of conducting spiritual assessments, praying with Veterans / Service members, engaging in religious activities with Veterans / Service members, and attending to Veterans' / Service members' spirituality as mainly pieces of a chaplain's job. Chaplains in VA and DoD also agreed in viewing the activities of giving health advice, providing psychotherapy, and diagnosing mental health problems as mainly parts of mental health providers' jobs. There were numerous items that VA and DoD chaplains viewed as important job components for both chaplains and mental health care providers. These included but were not limited to inviting Veterans / Service members to share their story, providing counseling, addressing guilt and forgiveness, and communicating with family members. While there was general agreement between chaplains in VA and DoD about which professionals are responsible for different job components, VA chaplains were somewhat more likely than DoD chaplains to view the chaplain's role as entailing work as a liaison between Veterans / Service members and health care providers. DoD chaplains were somewhat more likely than VA chaplains to view the chaplain's role as entailing the provision of counseling, enhancement of Veteran / Service member resiliency, and care of family members.

A total of 95% of the overall survey sample agreed with the statement that mental health providers and chaplains can closely collaborate while retaining identities and abilities unique to their respective profession – 78% of VA chaplains and 63% of DoD chaplains strongly agreed with this statement. However, chaplains in VA and DoD perceived a significant imbalance of professional understanding and valuing between chaplaincy and mental health. Figure 12 shows that in both VA and DoD chaplains feel that 1) they understand the work of mental health professionals more than mental health professionals understand chaplaincy's work, and 2) they value the role of mental health professionals more than mental health professionals value their role as chaplains.

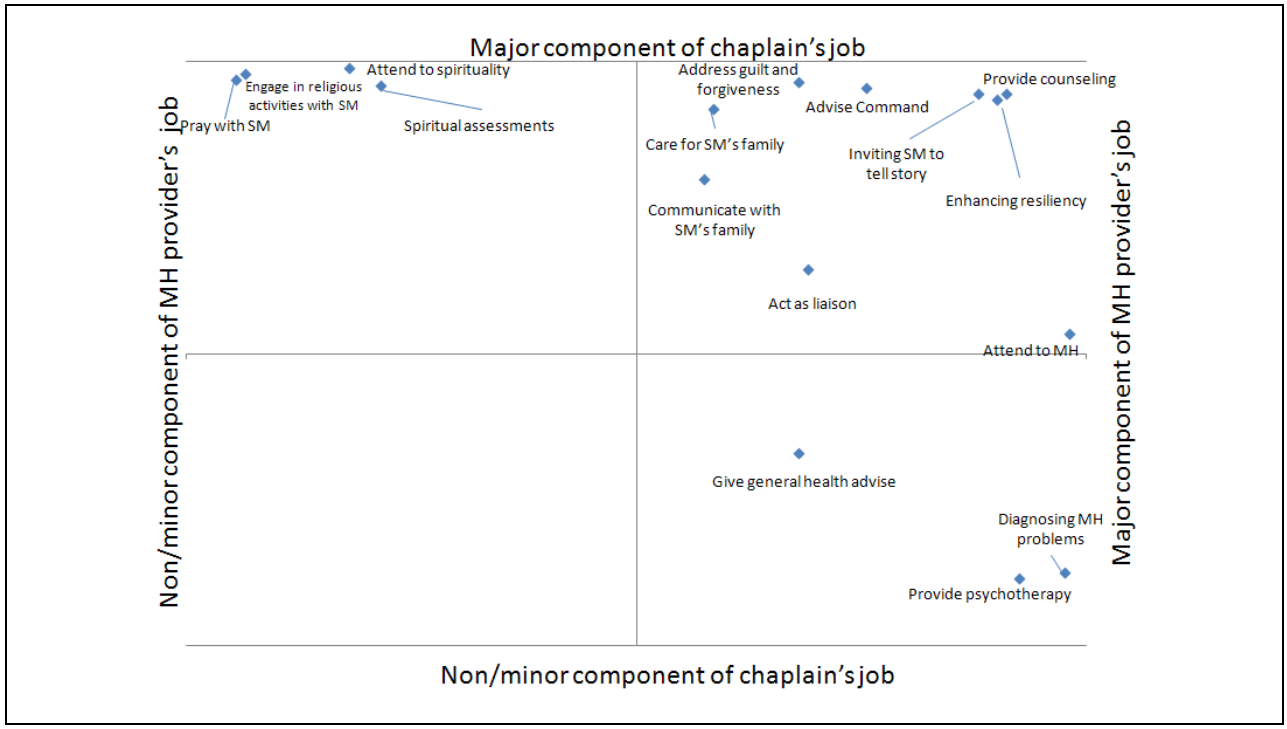
A total of 59% of VA chaplains and 79% of DoD chaplains believe that Veterans and Service members with mental health problems commonly seek help from chaplains instead of mental health providers. When presented with a list of 18 potential reasons for why Veterans and Service members may turn to chaplains instead of mental health, the most commonly endorsed reason in both VA and DoD was that Veterans and Service members desire confidentiality (33% of VA chaplains and 65% of DoD chaplains identified this as a frequent reason). Stigma attached to mental health care also plays a role. As shown in Figure 13, many chaplains perceive that Veterans and Service members could experience negative consequences as a result of seeing a mental health professional but not as a result of seeing a chaplain, a finding that was most pronounced in DoD.

Figure 10. VA – Components of Chaplains' and Mental Health Professionals' Jobs



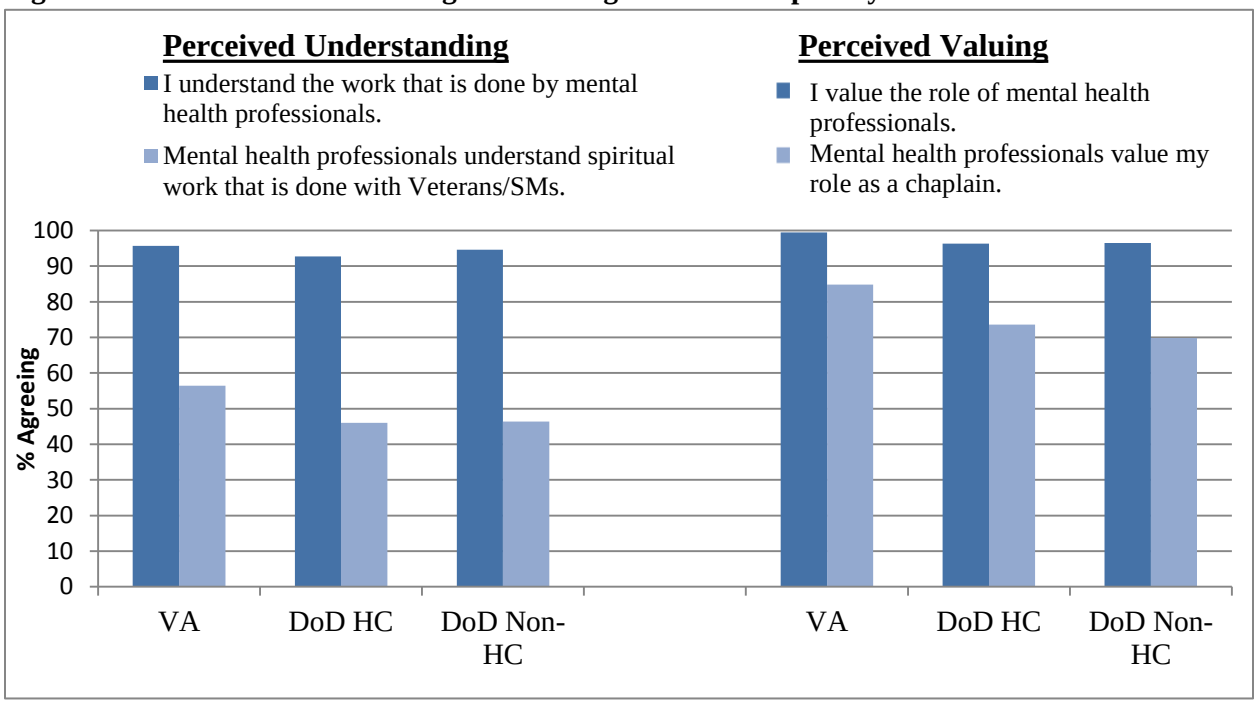
Missing data for the above variables ranged from 30 (7%) to 46 (10%) cases out of the total VA sample (n = 440).

Figure 11. DoD – Components of Chaplains' and Mental Health Professionals' Jobs



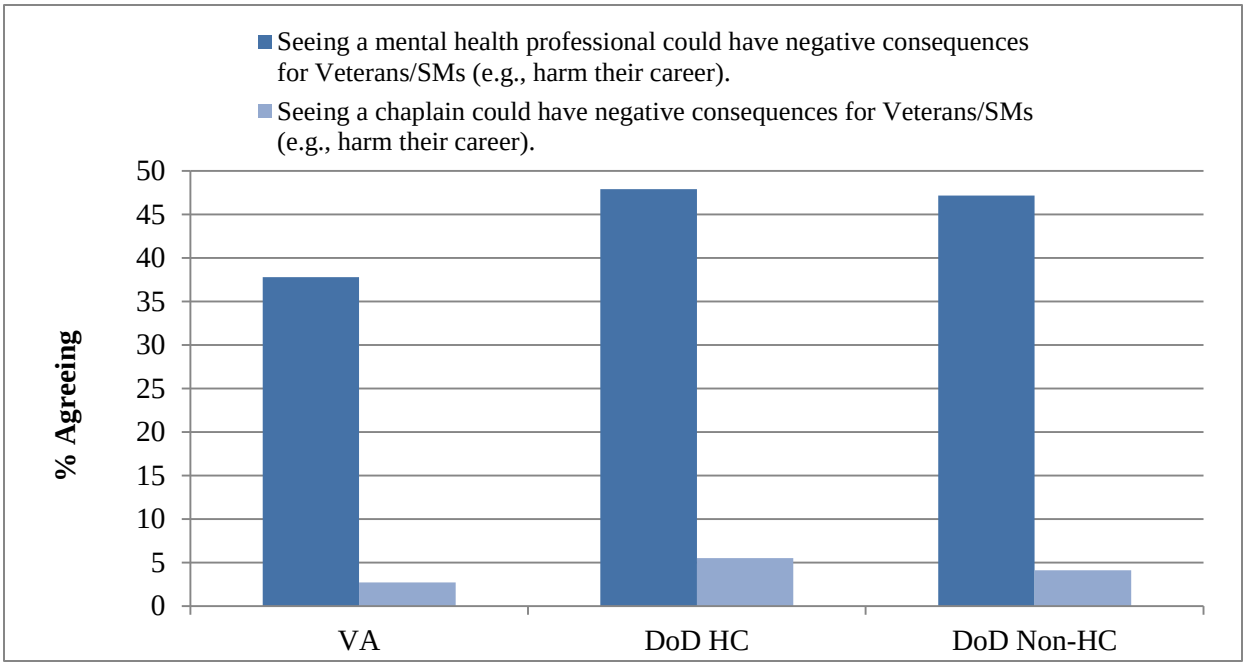
MH = mental health; SM = Service member. Missing data for the above variables ranged from 284 (16%) to 319 (19%) cases out of the total DoD sample (n = 1,723).

Figure 12. Perceived Understanding and Valuing Between Chaplaincy and Mental Health



HC = health care. SM = Service Member. Missing data for the above variables ranged from 24 (5%) to 25 (6%) cases out of the total VA sample (n = 440), 0 (0%) to 1 (1%) cases out of the total DoD health care chaplain sample (n = 164), and 6 (0%) to 15 (1%) cases out of the total DoD non-health care sample (n = 1,269). Percentages in the table are based out of the total number of those that responded to each item.

Figure 13. Perceived Stigma of Mental Health and Chaplaincy



SM = Service Member. Missing data for the above variables ranged from 29 (7%) to 30 (7%) cases out of the total VA sample (n = 440), 1 (1%) case out of the total DoD health care chaplain sample (n = 164), and 4 (0%) to 7 (1%) cases out of the total DoD non-health care sample (n = 1,269). Percentages in the table are based out of the total number of those that responded to each item.

Chaplaincy and Mental Health in VA

In recent years, VA has identified a number of priority areas that have important linkages to mental health. Among these priorities are reducing homelessness, enhancing care for women Veterans, and preventing suicides (U.S. Department of Veterans Affairs, 2010). We looked at VA chaplains' engagement in each of these areas. Regarding homelessness, 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. As for engagement with women Veterans, 9% of VA chaplains indicated that they are members of a women's health clinic team, with 100% of those chaplains reporting that team members understand and value their contribution. Of note, findings from the VA / DoD Chaplain Survey indicate that 17% of chaplains in VA are female and only 4% of DoD chaplains are female.

As already reported, VA chaplains frequently see Veterans suffering from mental health problems such as anxiety, depression, and alcohol abuse – all risk factors for suicidality. Indeed, 84% of VA chaplains and 81% of DoD chaplains indicated that it is not uncommon ("sometimes" or "frequently") 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), 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.

Table 14. Practices and Perspectives of VA Mental Health Chaplains

	VA MH *M* (SD)	VA Non-MH *M* (SD)	*P*
Use of Psychotherapeutic Practices			
Helping Veterans practice directly dealing with fears in order to help them become less afraid	3.21 (.76)	2.83 (.83)	<.001
Teaching Veterans methods of physical relaxation	2.47 (.95)	2.34 (.99)	.163
Helping Veterans look at their thoughts more realistically	3.64 (.55)	3.38 (.66)	<.001
Helping Veterans see mistakes in their thinking	3.55 (.62)	3.11 (.67)	<.001
Helping Veterans understand how their thoughts and feelings are related	3.73 (.50)	3.27 (.70)	<.001
Asking Veterans to do "homework" between visits	2.78 (.89)	2.45 (.91)	<.001
Perspectives on Relationships with Mental Health			
I understand the work that is done by mental health professionals.	3.42 (.56)	3.21 (.57)	<.001
I value the role of mental health professionals.	3.66 (.51)	3.49 (.53)	.001
Mental health professionals understand spiritual work that is done with veterans.	2.52 (.73)	2.54 (.67)	.822
Mental health professionals value the role of the chaplain.	3.09 (.69)	2.98 (.65)	.089

MH = mental health. For Use of Psychotherapeutic Practices, chaplains rated their use of each practice on a scale of 1 (Never) to 4 (Frequently). For Perspective on Relationships with Mental Health, chaplains rated their agreement with each of the statements on a scale from 1 (Strongly disagree) to 4 (Strongly agree). Missing data for the above variables ranged from 1 (1%) to7 (4%) cases out of the total VA mental health chaplain sample (n = 172) and from 2 (1%) to 12 (5%) cases out of the total VA non-mental health chaplain sample (n = 257).

In addition to looking at particular priority areas for mental health care in VA, we also examined whether VA chaplains who spend a large amount of their time in mental health settings (i.e., mental health chaplains; n = 172) are different from VA chaplains who do not (n = 257). Table

14 indicates that VA mental health chaplains are more likely than non-mental health chaplains in VA to make use of a variety of psychotherapeutic practices, a number of which are cognitive-behavioral in nature. In addition, VA mental health chaplains were also more likely than non-mental health chaplains to report that they both understand the work that is done by mental health professionals and value the role of mental health professionals. However, VA mental health chaplains were not significantly more likely than non-mental health chaplains to report perceiving that mental health professionals understand spiritual work that is done with veterans, or that mental health professionals value the role of the chaplain.

VA and DoD Mental Health and Chaplaincy Site Visits

Demographics and Overview

Between January and June of 2012, site visits were conducted at 33 facilities: 17 VA; 15 DoD; and 1 joint VA / DoD. The median number of chaplains interviewed per site visit was five, and the median number of mental health providers was four. Sites were geographically diverse, with VA sites located in 16 of the 21 Veterans Integrated Service Networks (VISNs). Using the U.S. Center for Disease Control classification scheme for urban-rural counties (Centers for Disease Control and Prevention, 2012), 14 of the sites were classified as being located in large central metro areas, 1 in a large fringe metro area, 13 in medium metro areas, 3 in small metro regions, and 2 in micropolitan areas.

Table 15: Demographics from VA / DoD Site Visits

Interview Characteristics N = 291		**Interviewee Characteristics N = 396**	
Interview Format		Sex	
Individual	246 (84.5)	Male	249 (62.9)
Group	45 (15.5)	Female	147 (37.1)
Department		Department	
VA	140 (48.1)	VA	194 (49.0)
DoD	146 (50.2)	DoD	186 (47.0)
Army	*51 (17.5)*	*Army*	*65 (16.4)*
Navy	*45 (15.5)*	*Navy*	*65 (16.4)*
USMC	*31 (10.7)*	*USMC*	*36 (9.1)*
Air Force	*6 (2.1)*	*Air Force*	*7 (1.8)*
DoD NOS	*13 (4.5)*	*DoD NOS*	*13 (3.3)*
Joint VA / DoD	5 (1.7)	Joint VA / DoD	16 (4.0)
Discipline		Discipline	
Chaplain	156 (53.6)	Chaplain	195 (49.2)
Mental Health	135 (46.4)	Mental Health	201 (50.8)

NOS = Not Otherwise Specified (This includes DoD personnel working in settings that combine military branches – e.g., Walter Reed). The Interviewee Characteristics column includes data from the 246 persons who were interviewed individually and from the 148 persons who were interviewed as part of 45 group interviews. Only four of the group interviews contained mixed disciplines (i.e., chaplains and mental health professionals), and as the minority discipline accounted for ≤ 20% of the group makeup in each of these four interviews, these interviews were coded as either "chaplain" or "mental health" according to the majority of the group makeup.

Based on the FY 2008 facility complexity model for VA – which determines the "complexity" of VA facilities on the basis of characteristics such as size and diversity of patient population, intensiveness of clinical programs, and involvement in research and educational activities (level 1a is most complex, level 3 is least) – nine of the VA sites we visited were level 1a, two were level 1b, three were level 1c, three were level 2, and one was level 3. Of DoD sites, six were clinical, four were operational, and five contained clinical and operational facilities. With respect to representation of different

branches, five sites were Army, eight were Navy and/or Marine Corps, and two were cross-branch facilities. In addition, six telephone interviews were conducted with Air Force chaplains.

In total, 291 interviews were conducted with 396 individuals – 246 interviews were conducted one-on-one and 45 interviews were conducted in a group format. Table 15 displays basic demographic information for the 291 interviews as well as for the 396 interviewees. Since input from group interviews was gathered as one collective piece of information, the unit of analysis that we use for comparative purposes is the interview (not interviewee). Apart from the 5 interviews (16 interviewees) conducted with joint VA / DoD personnel at the Captain James A. Lovell Federal Health Care Center, we conducted 60 interviews with VA chaplains (82 interviewees), 80 with VA mental health professionals (112 interviewees), 94 with DoD chaplains (108 interviewees), and 52 with DoD mental health professionals (78 interviewees).

Integration of Mental Health and Chaplaincy in VA

> *"We need to build trust. This is a very key piece. The base of any operation has got to be trust. It is not earned over night."*
> - ***VA chaplain***

Overall, chaplains and mental health professionals noted many of the same themes in the VA interviews (see Figure 14). Both disciplines frequently noted that effective integration of services often hinges on the existence of good professional relationships. While good cross-disciplinary relationships obviously provide a foundation for effective integration across any type of service (e.g., integrating mental health and primary care services), relationships are even more important for integration of chaplain services with mental health. This appears to be the result of there being little to no formalized institutional guidance communicating an expectation that services be integrated. Therefore, integration of chaplain and mental health services is typically accomplished by individual providers who establish cross-disciplinary relationships out of their own initiative.

> *"Chaplains need to be seen more as integral to the team. They are assigned to units, but they need to be seen with the clinicians. Doing joint rounds or collaboratively leading groups would be ways to accomplish this."*
> - ***VA mental health professional***

Mental health professionals and chaplains in VA frequently acknowledged a need to learn more about one another's disciplines, with both disciplines being somewhat more likely to acknowledge a need for mental health providers to learn about chaplaincy. Experienced mental health providers often indicated that the site visit interview prompted them to thoughtfully consider the incorporation of chaplains with mental health services for the first time. Upon considering the possibilities, mental health

> *"It would be good for chaplains and substance abuse providers to be at more of the same meetings. There is currently not a systematic discussion about how chaplains and substance abuse treatment teams can work together."*
> - ***VA mental health professional***

professionals were very open to suggesting that chaplains be incorporated into interdisciplinary teams and into the programming of mental health care services. Mental health professionals frequently suggested that chaplains could benefit from education on mental health topics as well as from training in appropriate evidence-based approaches to mental health care, suggestions that many chaplains advocated for as well.

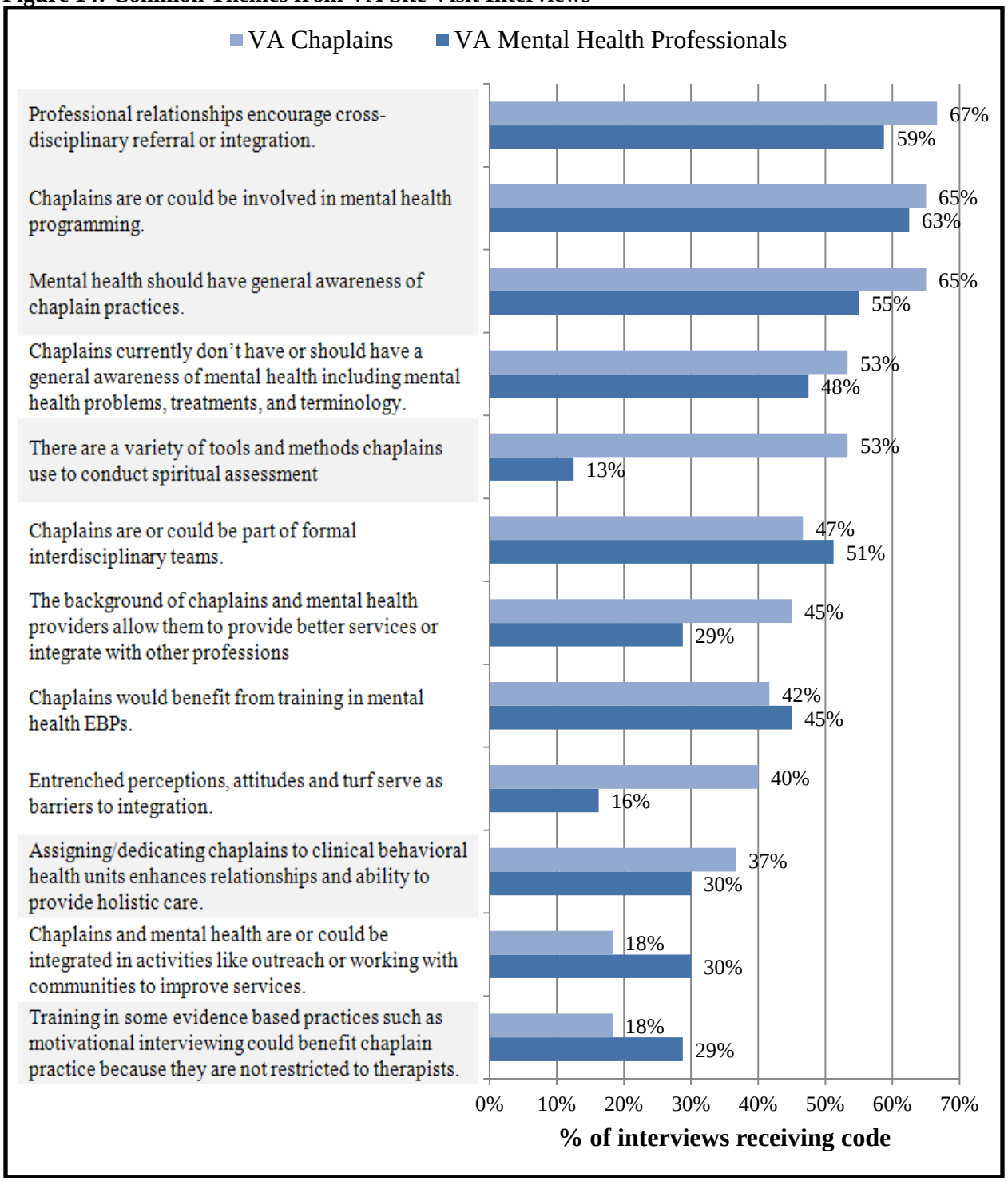
> *"I think one of the weaknesses of pastoral care is that we don't have all the same assessment tools. We don't use the same language ourselves."*
> - ***VA chaplain***

There were some noteworthy differences between chaplains and mental health professionals in VA. Chaplains were more likely than mental health professionals to indicate that perceptions about "turf" or negative perceptions and attitudes about the other discipline serve as barriers to the integration of services. The disciplines also spoke differently about the role of spiritual assessment, with chaplains being more likely to emphasize ongoing efforts to ensure uniformity in the tools and methods used to conduct spiritual assessments and mental health professionals being more likely to discuss ways in which spiritual and religious issues are attended to in existing mental health screenings and assessments. VA mental health professionals were also somewhat more likely to propose that chaplains and mental health professionals work together in community outreach activities.

While not frequently occurring themes, there was a notable minority of chaplains (22%) who were more likely to raise the issue of spiritual outcomes being difficult (some said impossible) to measure, and a notable of minority mental health professionals (13%) were more likely to express concern about the appropriateness of training chaplains in evidence-based mental health interventions. A sizeable minority of mental health professionals (25%) suggested that chaplains be encouraged to attend in-house mental health trainings. Overall, these findings suggest considerable openness on the part of both chaplains and mental health professionals to including chaplains in *appropriate* evidence-based mental health trainings (e.g., motivational interviewing, as opposed to prolonged exposure therapy).

> *"Any evidence based training would be helpful once that chaplain knows how to adapt it."*
> - ***VA chaplain***

Figure 14: Common Themes from VA Site Visit Interviews



EBP = evidence based psychotherapy. The top 10 most frequently received codes for VA chaplains (n = 60) and for VA mental health professionals (n = 80) are included in this graph.

Integration of Mental Health and Chaplaincy in DoD

Compared to the VA interviews, chaplains and mental health professionals in DoD displayed more divergence in the types of themes that commonly arose (see Figure 15). This is likely a reflection of the fact that chaplains and mental health professionals typically serve in very different contexts within DoD. Still, a number of themes were consistent between the disciplines. As in VA, both disciplines noted a need to learn more about one another, especially for mental health to learn about chaplaincy. Both disciplines also again stressed that professional, trusting relationships are paramount in being able to achieve effective collaboration between chaplaincy and mental health.

> *"There is a need to educate each other and gain a sense of mutual respect. We had a battalion doctor who was surprised at how much counseling chaplains do. I don't think she was clear about why that would be the case and how that would work. We need for mental health to understand how chaplains are educated and what it takes to qualify as a chaplain."*
>
> - ***DoD chaplain***

In the DoD interviews, mental health professionals were more likely than chaplains to focus on various aspects of how chaplains can fit within the existing health care system. For one, mental health professionals were more likely to discuss how chaplains can participate as formal members of interdisciplinary health care teams. Also, mental health professionals were more likely to talk about how in the current health care system: 1) there are a number of ways that spirituality is assessed apart from chaplain involvement; and 2) referrals between chaplains and mental health tend to occur through informal processes, like personal contact or telephone calls, rather than official consults. Finally, mental health professionals were more likely than chaplains to discuss the benefits of training chaplains in evidence-based approaches to mental health care.

> *"Chaplains should know the basics, like active listening, which is fundamental for all EBPs [evidence-based psychotherapies]. They should also know about how to make a referral appropriately. They should have a basic understanding of mental health issues (what disorders look like and when to refer), and their role as a gatekeeper should be emphasized. Since many EBPs follow a prescribed course, I'm not sure why a chaplain couldn't take part in leading groups if they were trained. They could contribute the spiritual component of an EBP."*
>
> - ***DoD mental health professional***

These themes being noted more often by mental health professionals in DoD evidences that 1) mental health professionals are more confined to health care environments than chaplains, and 2) mental health professionals are very open to more formally integrating chaplains into these health care settings.

DoD chaplains, by comparison, focused more than their mental health counterparts on topics like spiritual assessment and other themes related to the uniqueness of chaplaincy. As already described, military chaplains embody a distinctive position in many commands by virtue of being intimately involved in the daily life of that command while simultaneously being set

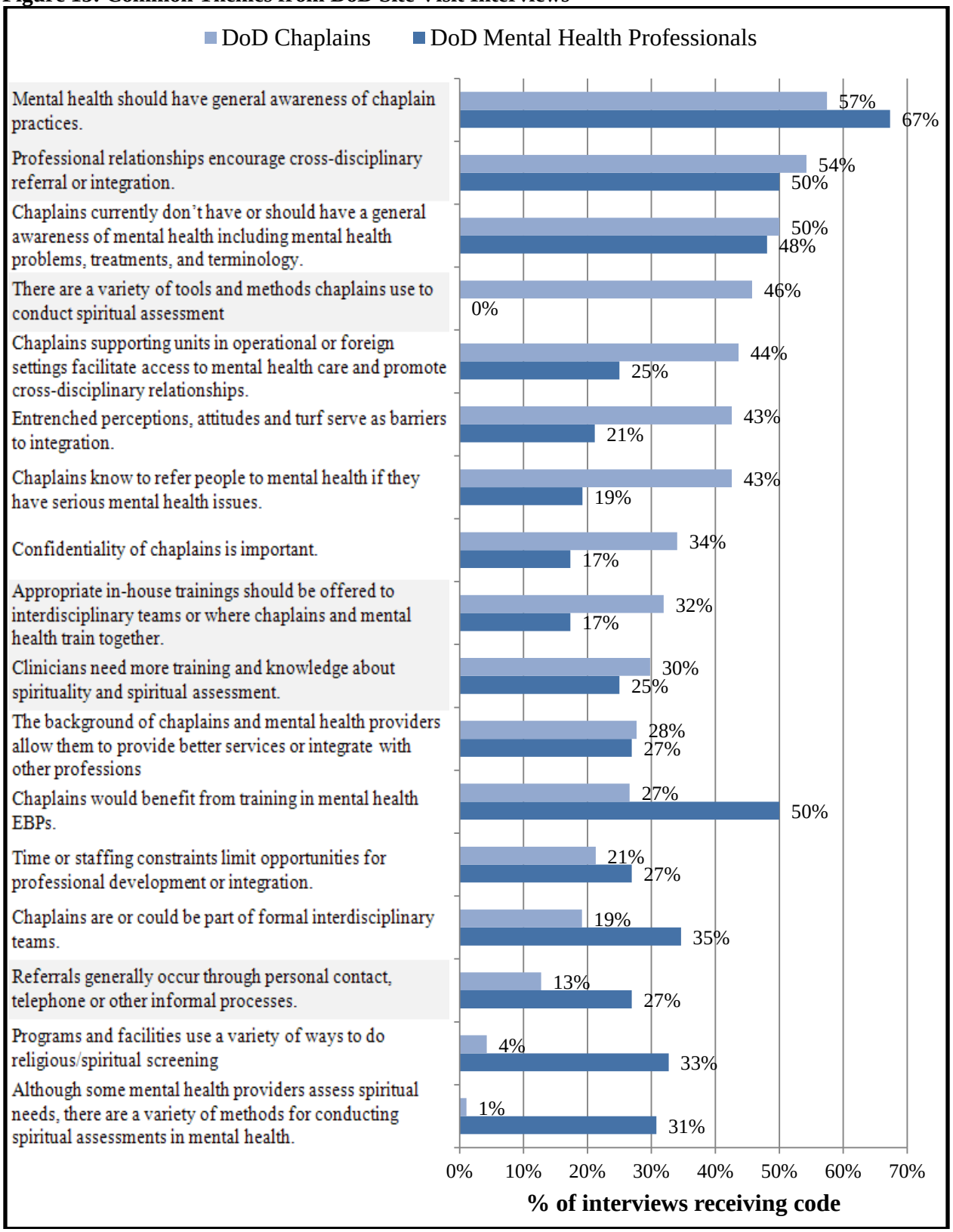
apart in key ways. Perhaps most notable is that communications shared with chaplains are treated as confidential. Hence, chaplains were more likely than mental health professionals to discuss ways in which chaplains can maintain confidentiality while at the same time facilitating referrals and access to mental health care for Service members who need it. Yet even though they described the importance of such collaboration with mental health and advocated for conducting interdisciplinary trainings, DoD chaplains were more likely than their mental health colleagues to feel like entrenched perceptions (e.g., a concern by mental health providers that chaplains are mainly trying to proselytize) persist and present a barrier to more effective integration between chaplaincy and mental health.

> *"Mental health should know that chaplains bring a lot to the table. We are embedded with everyone from the junior sailor to the commander, and we can provide a wealth of information about the climate and situations that sailors are operating in. We can share information about family situations or history that doesn't violate confidentiality. Mental health may at times be overwhelmed by the number of people we are referring to them, but sometimes the Service member's needs are beyond what we can do."*
>
> - ***DoD chaplain***

In part due to the structure and function of DoD, chaplains and mental health professionals in the military can often be isolated from one another. Such isolation not only by definition prevents integration but also can serve to perpetuate negative stereotypes that may exist. For instance, chaplains who rarely or never encounter mental health professionals are unlikely to be presented with counterevidence to the belief that mental health professionals unfairly view chaplains as proselytizers, and vice versa for mental health. Although systemic changes in DoD undoubtedly could help rectify this problem, one finding from the site visits is that in many cases the mere visit provided opportunity for mental health professionals and chaplains to interact (e.g., in planning the visit, in in-briefs and out-briefs, in receiving and following-up on the site specific report). This relatively simple interaction often served to introduce chaplains and mental health professionals to one another, to challenge preconceived notions each discipline may have had, and to inspire ideas for collaboration. All of this again points to how essential it is to nurture and sustain good cross-disciplinary relationships.

> *"We don't work with chaplains, but we get a lot of referrals from chaplains."*
>
> - ***DoD mental health professional***

Figure 15: Common Themes from DoD Site Visit Interviews



EBP = evidence based psychotherapy. The top 10 most frequently received codes for DoD chaplains (n = 94) and for DoD mental health professionals (n = 52) are included in this graph.

Using VA / DoD Distinctions to Inform Models for Integration

Different thematic content emerged from the VA interviews than the DoD interviews, evidencing the different missions of the two Departments and the distinct ways in which chaplains serve Veterans and Service members. Consistent with the health care setting in which they serve, VA interviewees more commonly focused on ways for chaplains to be integrated into formal, interdisciplinary teams (such as the permanent assignment of chaplains to mental health settings). Since VA chaplains function in a less transitory capacity than DoD chaplains (i.e., military chaplains, like most Service members, are reassigned on a regular basis), permanent assignment of specific chaplains to mental health settings is in some ways more achievable in VA. Chaplains' capacity to help educate community leaders and engage in community outreach was also more commonly noted in VA, particularly by mental health interviewees.

Within DoD, a number of themes emerged from the interviews that revealed military-specific dynamics of chaplain-mental health collaboration. DoD respondents were more likely to emphasize chaplains' unique abilities to flexibly support a range of Service members' needs, especially in foreign and operational settings. DoD interviewees were also more likely than those in VA to suggest that clearer policies on integration would be useful, consistent with a culture in DoD that is more strictly responsive to formal policies. Because Service members with psychosocial problems so often seek out a military chaplain instead of a mental health provider, DoD chaplains have extensive experience in balancing their commitment to confidentiality with the need to refer certain Service members for professional mental health treatment. Hence, DoD chaplains were more likely than their VA counterparts to discuss the importance of confidentiality and to note that they (at least those in operational settings) typically do not document the care they provide (i.e., it does not show up on a Service member's "record"). Hence, many Service members may be more likely to turn to chaplains. This dynamic is more pronounced in DoD than in VA, resulting in DoD interviewees being more likely than their VA counterparts to discuss the importance of chaplains knowing when refer and how to encourage Service members to take initiative in seeking mental health care services.

In comparing the roles of chaplains and mental health care providers across the two Departments, it is apparent that in many ways chaplains' roles are more different between VA and DoD than are mental health professionals' roles. Regardless of whether they serve VA or DoD, mental health professionals primarily attend to persons with identified health care needs. While the same could be said for VA chaplains and DoD chaplains in health care settings, the large majority of DoD chaplains serve in operational contexts where they are not caring exclusively for persons with identified health care needs. By operating outside of the health care context, these chaplains have an opportunity to identify potential mental health problems early on, to prevent mental health problems from developing, to provide care to Service members who are unwilling to be seen in a health care setting, and to destigmatize entry into mental health care services.

These differences between the Departments should be both recognized and capitalized upon in applying recommendations from IMHS SA #23. The differences need to be recognized insofar as trainings and other actionable steps should aim to equip mental health providers and chaplains to serve the unique needs of the two different populations that they serve. For example, it makes

sense that DoD places more emphasis on enhancing Service members' resilience and readiness while VA places more emphasis on adjustment and health following military service. Yet the Departments can also capitalize upon the strengths of each in ways that are mutually beneficial. For instance, VA can structure care to capitalize on the formative relationship that often develops between military chaplains and Service members. One tangible way to do this would be to locate VA chaplains in settings where they can help destigmatize mental health care (e.g., primary care settings), much in the same way that military chaplains do in operational contexts.

As VA faces a major shift in its patient population to include Veterans of post-9/11 conflicts, DoD personnel can help VA mental health providers and chaplains better understand the needs of this younger population. At the same time, years of engagement in post-9/11 conflicts has DoD facing significant proportions of active duty and reserve Service members with combat-related mental health problems, and VA can leverage health care expertise to help DoD mental health providers and chaplains work together to meet these needs. Findings from the site visits suggest that the diverse settings in which chaplains and mental health professionals operate necessitate a nuanced approach to implementing certain recommendations jointly across VA and DoD while implementing other recommendations on a Department-specific basis.

Task Group Final Meeting

There were a total of 25 attendees at the final IMHS SA #23 task group meeting held on March 19, 2012 in Washington, DC. Of these, 18 were chaplains, 6 were mental health professionals, and 1 was a health services researcher. With respect to organizational affiliation, 12 were from VA, 9 from DoD (3 Army, 2 Navy, 2 Air Force, and 2 DCoE), and 4 from academic institutions. Of the total 25 attendees, 16 were present at the May 2011 task group kickoff meeting, 18 were at the VA Mental Health and Chaplaincy Forum, and 16 participated as members of at least one of the sub-task groups. Dialogue at the final task group meeting was fluid and purposefully interspersed throughout the scheduled presentations of IMHS SA #23 findings. Overall, the group was very interested in the findings that were presented, agreed with the way that material was synthesized, and was highly supportive of the recommendations that were proposed.

An overarching consideration that permeated group discussion throughout the meeting was the degree to which chaplains are "organic" (i.e., an integral part of the life of a command or unit) versus "embedded" (i.e., an auxiliary resource). Organic chaplains have developed personal relationships with Service members / Veterans. Hence, when crises strike, these chaplains become a natural resource. Embedded chaplains are inserted into an assignment with a command that is not directly associated with their billet (e.g., temporarily moved from a medical treatment facility to a deployed combat unit in Afghanistan) where they can be perceived as "just passing through" and not integral to the functioning of a command or unit. Because of this, these chaplains can end up targeting "problem" Service members / Veterans and tend to function in more of a reactive rather than a proactive capacity. Within DoD, task group members noted that operational chaplains are typically more familiar to and integrated with their command than are mental health professionals. In the health care setting, both in VA and DoD, the reverse was noted as being the case: chaplains are often conceived as more peripheral to patient care than are mental health care providers.

While there are clearly advantages associated with an organic role for chaplaincy – such as decreased stigma, easy access to care, and a more natural process for providing care – there is also the disadvantage that this approach is often accompanied by a lack of structure around the role of the chaplain. This makes the chaplain's role vulnerable to becoming devalued and underutilized should there be changes in personnel, should leadership not value the chaplaincy, or should a chaplain not easily coalesce with his or her command. Such vulnerability due to lack of a structured role for the chaplain can deprive Service members / Veterans of benefiting from what a chaplain can offer. Task Group members posited that it is essential to protect the organic nature of chaplaincy, in large part because this is a distinguishing and uniquely helpful aspect of what chaplains can offer, while at the same time looking for ways to systematize roles for chaplains so that their inclusion in systems of care is less vulnerable to devaluation.

As evidenced in Table 16, the recommendations for systematized education and training proposed at the meeting were viewed by task group members as both practical and desirable. The proposed model is detailed in the recommendations section of this report, with revisions that have been adopted in response to feedback from task group members at this final meeting.

Table 16. Most Common Responses from Task Group Members at Final Meeting

Attributes of successful chaplain-mental health integration:
1) Standardized curriculum for cross-training chaplains and mental health care providers. 2) Mental health care providers and chaplains cross-refer patients, with institutionalized system in place to facilitate this. 3) Adequate funding and staffing. 3) Chaplain is a full, equal, and necessary member of the team.
Impressions of recommendations for training model/program:
1) The proposed program is needed and would be well-received. 2) Suggest utilizing MHICS Certification Program in both VA and DoD. 2) Tiered levels make good sense. 4) Taking time out for full MHICS program is difficult, especially for DoD.
Logical next steps:
1) Determine best practices for provision of spiritual care, including spiritual assessment practices and charting. 2) Develop learning collaborative for chaplains and mental health to build working interdisciplinary teams. 2) Formalize curriculum model for certification. 4) Incorporated tailored versions of training into existing DoD mechanisms (e.g., chaplain schools at Ft. Jackson, Air Guard training days). 4) Assemble information on collaborations already in place.

MHICS: Mental Health Integration for Chaplain Services. Responses are listed in rank order of those that were most commonly reported on the questionnaire completed by task group members at the conclusion of the final task group meeting. Appendix Q gives a more complete listing of task group members' responses on the questionnaire.

CONCLUSIONS AND RECOMMENDATIONS

The collection of extensive data using both qualitative and quantitative methodologies resulted in a rich understanding of the intersection between chaplaincy with mental health care in VA and DoD. Overall, we feel that the many strands of information gathered throughout the various phases of IMHS SA #23 cohere in a complementary fashion, engendering a greater sense of confidence in many of our findings as well as our recommendations. In the following sections, we synthesize our findings, propose tangible steps for implementing recommendations, and suggest future research that needs to be conducted.

Synthesis of Findings

Two categories of findings were compiled: 1) qualitative findings from task group members, subject matter experts, and individuals interviewed on site visits; and 2) quantitative findings from the VA / DoD Chaplain Survey. While the different meetings, task groups, and sub-task groups each had separate purposes and systematically built on one another, there were thematic issues that recurrently emerged and were developed throughout these proceedings. Below, these qualitative findings are synthesized with quantitative results from the VA / DoD Chaplain Survey to provide: 1) an overview of chaplaincy in VA and DoD; 2) a summary of the major advantages and barriers identified to integrating chaplaincy and mental health care; and 3) a synopsis of proposed solutions to these barriers.

Overview of Chaplaincy in VA and DoD

While there are significant areas of overlap, chaplains in VA and DoD are distinct in terms of their individual characteristics and in terms of their mission. Demographically, VA chaplains are older (three quarters are over age 55, compared to one sixth in DoD) with more years of experience in chaplaincy and more training for work in clinical environments. They are more likely than DoD chaplains to identify as Catholic, mainline Protestant, or historically black Protestant and half as likely to identify as evangelical Protestant (58% of DoD chaplains identified as such). At 18%, the proportion of black chaplains in VA is over twice that of DoD; and at 17%, the proportion of female chaplains in VA is quadruple that of DoD. Importantly, half of all chaplains in VA are themselves Veterans. This has important implications for establishing trust and rapport since many patients may feel more comfortable opening up with a chaplain whom they know has also served in the military.

In terms of their missions, VA chaplains serve exclusively in a health care environment, whereas only a minority of DoD chaplains are assigned to a health care context. DoD chaplains in operational settings (non-health care), particularly those who are organic to commands, build relationships with Service members in a fundamentally different setting than the setting in which VA chaplains work. The operational setting can allow for relationships between chaplains and Service members to evolve organically, so that trust and rapport can be established prior to a moment of crisis. By virtue of being stationed in health care settings, VA chaplains often initially come into contact with Veterans in the midst of crisis. Differences in the populations they serve mean that DoD chaplains tend to be focused more on issues of resilience, prevention, and

advising Service members, while VA chaplains are focused more on working within a medical environment and helping patients cope with readjustment issues, illness, and end of life issues.

In terms of problems that Veterans and Service members present with, chaplains in both VA and DoD reported encountering psychosocial problems more frequently than overtly spiritual problems. In VA, these problems tended to be of a more clinical nature (e.g., anxiety, depression), whereas in DoD these problems were most often having to do with daily stressors (e.g., relationship problems, work stress). In both VA and DoD, chaplains are frequently viewed as more accessible than mental health care providers for reasons such as reduced stigma, greater confidentiality, more flexible availability, and naturalness of interactions. When looking at chaplains who serve in the health care environment, chaplains in both VA and DoD are much more likely to be assigned to work on an inpatient as opposed to outpatient basis and are also more likely to be working on medical rather than mental health units.

Advantages and Barriers to Integration of Chaplaincy and Mental Health

Task Group members and other informants recurrently noted benefits of better integrating mental health and chaplain services. These included the provision of more holistic care, reduced stigma in receiving mental health care, and improved access to care. Table 17 provides a summary of the different advantages of integrating mental health and chaplain services for veterans and service members, mental health providers and chaplains, the health care delivery system, and family members and the community. In addition to the advantages listed, it is important to note that VA chaplains can be key partners in helping VA address some of its identified priorities, such as reducing homelessness, preventing suicide, and caring for female Veterans. VA chaplains are already very engaged with these patient populations and could be more intentionally integrated with the mental health treatment system to optimally address these key issues.

While there are examples of chaplains who frequently collaborate with mental health professionals, over a third of chaplains in both VA and DoD exchange very few if any referrals with mental health. This evidences a gap in integration of services, especially in light of the survey finding that chaplains more frequently have Veterans and Service members presenting to them with psychosocial problems than spiritual problems. Referrals may not happen in some circumstances because Veterans and Service members are intentionally turning to chaplains instead of mental health professionals due to fear that seeing a mental health professional could have negative consequences (e.g., harm their career). Survey findings suggest that chaplains are very interested in how they as less stigmatized providers can help to facilitate entry into mental health treatment for Veterans and Service members when appropriate.

Some notable models of successful integration exist, but there is considerable variability between facilities and much depends on the chaplain taking initiative to form relationships with mental health providers. Suboptimal integration frequently appears to be the result of difficulties in establishing trust and confidence between chaplains and mental health providers, which in turn appears to be often caused by a lack of familiarity between the disciplines. Findings from the VA / DoD Chaplain Survey suggest some imbalance in perceived understanding and valuing between the disciplines. In both VA and DoD, chaplains feel that they understand and value mental health providers' roles more than mental health providers understand and value chaplains. 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 (e.g., conducting mandatory spiritual assessments) and many facilities have chaplain staff shortages. This presents an obvious barrier to chaplains dedicating more time to mental health. In particular, chaplaincy's responsibilities in inpatient settings prevent many outpatients from receiving the benefits of chaplain services.

Table 17. Advantages of Mental Health-Chaplain Integration

For Veterans and Service Members	**For Mental Health Providers and Chaplains**
✓ Improves care by increasing coordination of services, especially when spiritual issues are presented. ✓ Reduces stigma of receiving mental health treatment. ✓ Integrates mental health care and spiritual care to address a wide range of problems and needs from a holistic perspective. ✓ Empowers Veterans and Service members in acknowledging the value of their faith / spirituality. ✓ Serves patients with increased sensitivity to their diverse cultural and religious backgrounds.	✓ Increases professional satisfaction in providing holistic care. ✓ Facilitates shift in emphasis from acute, episodic care to long-term, preventive care. ✓ Enables the chaplain to learn new skills and evidence-based approaches to use in their pastoral care activity. ✓ Encourages innovation and expansive thinking by mental health providers in addressing spiritual concerns. ✓ Provides opportunity for professionals of each discipline to focus on individual areas of expertise. ✓ Fosters appreciation and understanding of other disciplines.
For Families, Caregivers, and the Community	**For the Health Care Delivery System**
✓ Educates community clergy about mental health needs. ✓ Facilitates optimal, evidence-based care for families and caregivers. ✓ Extends reach of services through inherent social networks. ✓ Enhances trust and reduces perceived stigma of mental health care. ✓ Capitalizes on chaplain's unique history of connection with families and community.	✓ Enhances potential for more efficient delivery of care. ✓ Recognizes and employs chaplain as a "force multiplier," improving effective allocation of time and resources for mental health care. ✓ Decreases burden on mental health services due to increased opportunity for pre-clinical intervention. ✓ Nurtures comprehensive team approaches to integrated care. ✓ Fosters holistic patient-centered and recovery-oriented care. ✓ Stimulates ethical deliberation and discernment in the health care delivery system.

Solutions to Integration Barriers

The primary solution to suboptimal chaplain-mental health integration that emerged from IMHS SA #23 is to provide cross-disciplinary opportunities for interaction and training among chaplains and mental health care providers. 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. Identified approaches to 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 (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. The next section provides detailed recommendations coming out of IMHS SA #23 along with proposals for how to implement these recommendations.

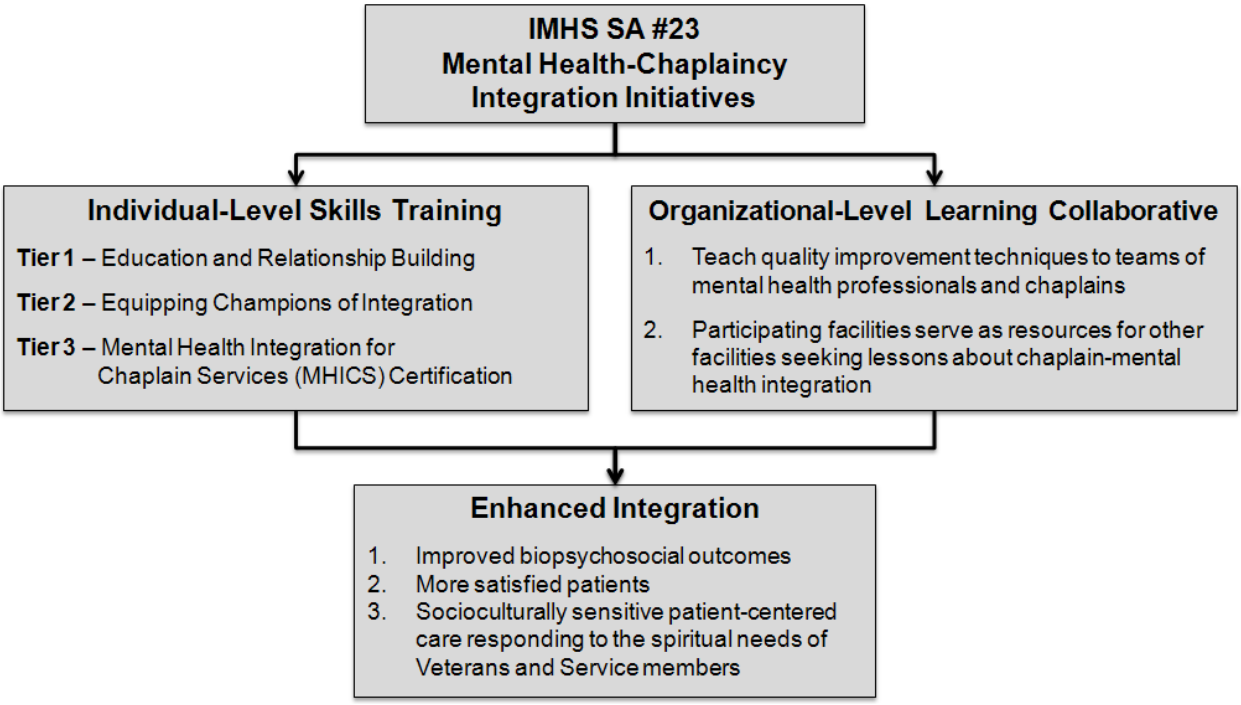
Integration Learning Initiatives

We believe that the recommendations advanced in this section have the potential to significantly improve chaplain and mental health collaboration, resulting in enhanced care for Veterans and Service members. Implementation of these recommendations will entail ongoing refinement of proposed initiatives in partnership with the collaborators noted below.

The suboptimal integration of mental health and chaplaincy services in VA and DoD can be improved. The primarily suggestion for accomplishing this to come out of IMHS SA #23 is to promote cross-disciplinary opportunities for interaction and training among chaplains and mental health care providers. We propose efforts to both 1) enhance training of individual chaplains and mental health care providers, and 2) encourage organizational-level efforts to enhance integration (see Figure 16). We aim to improve mental health-chaplain integration via a three-tiered approach to promoting training among chaplains and mental health care providers. Further, we propose to conduct a series of organizational-level quality improvement collaboratives that will aid health care facilities in the process of developing structures and tools that will allow trained individuals to take advantage of their new skills. Specific goals include:

- Enhance existing relationships between chaplains and mental health professionals.
- Provide training for chaplains and mental health professionals to enhance spiritual care and clinical skills to improve outcomes of care for Veterans and Service members.
- Expand mutual understanding of the roles, competencies, perspectives, training, and professional formation of chaplains and mental health providers.
- Aid facilities and organizations (e.g., VA Medical Centers) in developing structures that enhance the patient-centered delivery of spiritual/pastoral and mental health care in a fashion seamless to the patient that complements mental health treatment plans.
- Work with facilities and organizations to develop tools that can aid in the provision of care and communication among professionals.

Figure 16. Integration Learning Initiatives Overview

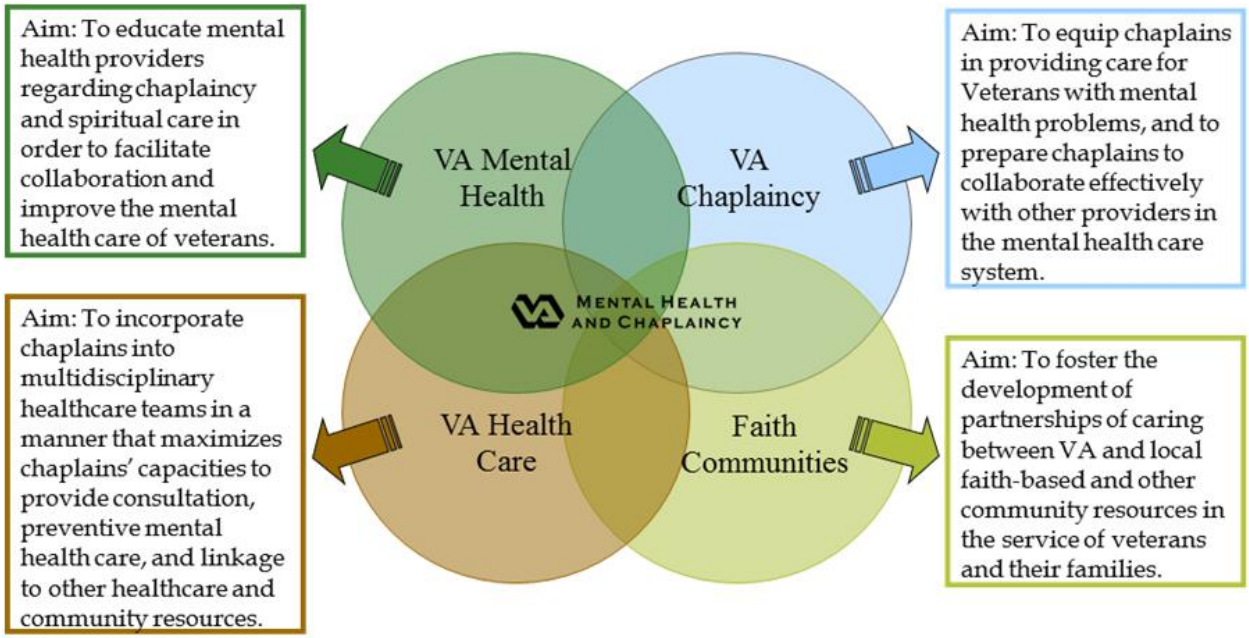


The three-tiered model for individual learning and the learning collaborative methodology for organizational change were originally developed by staff from the VA Mental Health and Chaplaincy Program in partnership with staff from the Durham, NC Health Services Research and Development (HSR&D) Center of Excellence as actionable approaches to advancing the recommendations coming out of IMHS SA #23. The approach reflects similar multi-prong efforts for implementing broad-based training of VA clinical staff (Gaudet, 2011; Goldstein & Minor, 2011; Jackson et al., 2010). While the model was developed so as to be most applicable for VA – consistent with the IMHS SA#23 focus on "defining the role of VA Chaplain Services" in "mental health care at VA" – when the model was presented at the final IMHS SA #23 task group meeting in March 2012, DoD task group members of all branches voiced substantial interest in adapting the model for application in the military. We concur with our DoD task group members in believing that the model can be adapted for use among military chaplains and mental health care providers, and so our approach in describing the recommendations that are presented below is to first detail how each recommendation can be implemented in VA and then describe how the recommendation can be implemented in partnership with DoD.

Figure 17 displays the VA Mental Health and Chaplaincy approach to integrative health care. The aims in this Venn diagram have been successfully used to guide VA Mental Health and Chaplaincy Program efforts in a number of domains (Meador & Nieuwsma, 2011; Nieuwsma & Cantrell, 2012), and it is helpful to think about how the training recommendations coming out of IMHS SA #23 can fit within this model. Our focus with the IMHS SA #23 individual training recommendations is most detailed for chaplains and for mental health care providers, but we also propose that there is benefit in extending appropriate training opportunities to all providers throughout the VA health care system. Organizational-level efforts focus on structures and tools

that can be used by the health care system to encourage integration both within the system and with faith communities to enhance services.

Figure 17. VA Mental Health and Chaplaincy Integrative Care Model



Individual-level Learning

Our individual-level training model contains three tiers. Each is described in detail below. We have structured the training model so that it can be fruitfully applied across a diverse range of facilities and providers. Providers will vary according to the nature of their employment, job responsibilities, location, and prior educational specialization. For example, GS-11 chaplains in VA are often hired on a part-time basis for the primary purpose of providing for the religious and sacramental needs of a particular faith tradition, whereas GS-12 chaplains are typically hired to function as members of interdisciplinary clinical health care teams. Job descriptions for mental health care providers are even more diverse, spanning not just job functions but different disciplines. With these realities in mind, we have developed a model that can be flexibly adapted for different contexts.

Tier 1: Education and Relationship Building

Findings from IMHS SA #23 are strongly suggestive of a need among the majority of mental health care providers and chaplains for a broad-based approach to cross-disciplinary education and relationship building. This first tier represents the broadest level for integrative efforts and encompasses all mental health care providers and chaplains in VA. For mental health care providers, the aim at this level is to better inform them about spiritual and religious issues that are relevant to mental health. The intention for chaplaincy at this level is to better inform chaplains about mental health issues and to equip them with appropriate clinical skills as well as resources to function as liaisons in the health care system.

Target Audience: The target group at this level includes all chaplains and mental health care providers, with appropriate training opportunities being extended to all health care providers in VA. Via activities such as online training, webinars, and on-site presentations, 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.

Proposed Activities: Specific trainings will be developed via a partnership between VA Mental Health and Chaplaincy and the VA National Chaplain Center in cooperation with the VA Employee Education System. Broadly, trainings are likely to include topics such as: overlapping and unique roles of chaplaincy and mental health; the role of spirituality and related topics, such as moral injury; assessment of spirituality and potentially related mental health topics; and skills that will aid in encouraging integration of services (e.g., charting). Training materials are likely to be disseminated via outlets such as: on-line training available through the VA Talent Management System (TMS); online teleconferences; development of slide sets that can be adapted by integration champions to provide in-person talks about chaplain-mental health integration at local facilities; and other written materials to reinforce skills.

Table 18. Summary of Tier 1 – Education and Relationship Building

Target Audience	Overall Learning Objective	Learning items
• All chaplains • Mental health providers, and all other health care providers as indicated	Informed about spiritual and religious issues relevant to mental health	• Online training • Online teleconferences • Educational materials available to facilities • Written materials on spirituality and health

Intersections for DoD: The objective of Tier 1 training within the Department of Defense is to equip chaplains with counseling, intervention and communication skills beyond the combat stress and deployment adjustment training normally provided for general support to Armed Forces personnel. Tier 1 training will provide a conceptual framework for establishing close collaborative relationships with mental health providers for the benefit of military personnel. Due to the diverse missions, locations and settings where mental health providers and chaplains serve, as well as the distinctions between military branches for each domain, this training would include slight adjustments to accommodate those distinctions. The core content would raise the awareness of chaplains and mental health providers regarding: 1) the benefits of chaplain-mental health collaboration for Service members; 2) the rationale behind the use of evidence based approaches in mental health; 3) the medical model and spiritual care; and 4) barriers to and opportunities for integration. These trainings can be integrated with existing venues for chaplain training in the military, such as the DCoE Chaplain Working Group (a series of monthly trainings calls for military chaplains that VA chaplains are also invited to attend) or the Combat Operational Stress Control (COSC) Annual Conference.

Tier 2: Equipping Champions of Integration

At this level, 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 here is to equip providers to be engaged as champions of close professional integrative work, which will be accomplished through activities like 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.

Target Audience: Tier 2 training will be made available to both chaplains and mental health providers who wish to serve as facility champions for integration. The VA Mental Health and Chaplaincy Program has accumulated a database of chaplains and mental health providers from across the VA system who would be candidates for this role. These individuals will be provided the opportunity to lead efforts such as co-education of trainees, establishing partnership opportunities, and providing in-person education within their facilities or related organizations.

Proposed Activities: Tier 2 training builds on activities proposed for Tier 1. As with Tier 1, materials will be developed through a partnership between VA Mental Health and Chaplaincy, the VA National Chaplain Center, and the VA Employee Education System. A core component will be continuing to offer two-day Bridging Chaplaincy and Mental Health Care Conferences, an ongoing service of the VA Mental Health and Chaplaincy Program. Four such conferences were held in geographically diverse locations in FY2011 and another four in FY2012. At present, conference attendees are provided with education on particular topic areas such as the development of mental and spiritual problems in OEF/OIF Veterans, Veterans' beliefs about mental illness, red flags for spiritual issues, the development of theodicy for Veterans, women's issues, and family issues. Attendees are also provided with a basic overview of evidence-based mental health treatments and given basic training in how they might utilize certain principles of evidence-based approaches to mental health care. Conferences to date have devoted specific attention to exploring how evidence-based principles from Acceptance and Commitment Therapy (ACT), which has been identified in the VA Uniform Handbook of Mental Health Services as an evidence-based psychotherapy (Department of Veterans Affairs, 2008a), can be synergistically integrated with the work of chaplaincy (Nieuwsma & Cantrell, 2012).

Individuals at the Bridging Chaplaincy and Mental Health Care Conferences have frequently reported back that as a result of attending the conference they have initiated integration activities at their facilities. Data compiled from the four conferences held in FY2011 evidence that attendees ($n = 199$) had a highly favorable impression of the conference series, with 99% reporting that the conference was valuable to them and 98% reporting that they would recommend the conference to a colleague. A questionnaire measuring attendee's self-assessments in the domains of spiritual care (subscale $\alpha = .88$), mental health care ($\alpha = .93$), integrated care ($\alpha = .71$), mental health knowledge ($\alpha = .87$), and knowledge about mental health diagnoses ($\alpha = .87$) is always administered pre and post conference. FY2011 conference attendees evidenced significant improvement ($p < .001$) on all subscales as a result of attending the conference (Nieuwsma & Meador, 2011). The most substantial gains came in the areas of knowledge about general mental health topics ($t = 6.53$, $p < .001$) and confidence in being able to care for persons with mental health problems ($t = 4.75$, $p < .001$). Please see Appendix R for an example of an agenda from a previous Bridging Conference.

In addition to the Bridging Conferences, seminars concerning issues of spirituality will be developed for delivery at regional and national professional conferences. Finally, a curriculum will be developed for co-education of chaplains and mental health providers that will focus on the topics of spirituality, assessment, and skills necessary for working as a team. As specific

tools are developed for organizational-level integration activities through the learning collaboratives (described below), those tools will also be made available to integration champions receiving Tier 2 training.

Table 19. Summary of Tier 2 – Equipping Champions of Integration

Target Audience	Overall Learning Objective	Learning items
• Chaplain integration champions • Mental Health integration champions	Provide skills necessary to lead facility-level training and integration activities to individuals who want to serve as integration champions	• In-person, regional Bridging Conferences • Seminars at major VA meetings • Curriculums for joint training • Building on Tier 1 tools and training

Intersections for DoD: DoD chaplains and mental health providers are seeing an increase in Service members returning from OIF/OEF and other combat or operational settings who present with "invisible injuries of war," to include PTSD, traumatic brain injury (TBI) and a variety of comorbid disorders. DoD chaplains are not universally trained in understanding the provision of care and therapeutic approaches of mental health care providers. DoD chaplains would benefit from a broad level of training that highlights both DoD and VA use of evidence-based practices within mental health, some which may be incorporated into and enhance spiritual care practices. Additionally, DoD chaplains could attend the Bridging Chaplaincy and Mental Health Care Conferences in person and could contribute by informing other conference participants about the current mental and spiritual needs of Service members. This level of training may also be integrated into existing programs, such as the Navy's annual Professional Development Training Course (PDTC) or courses taught at the chaplain schools in Fort Jackson. These military training venues may in turn be able to accommodate VA chaplains as appropriate.

Tier 3: Mental Health Integration for Chaplain Services (MHICS) Certification

Meeting the mental health needs of Veterans is a core component of the obligation that VA has in providing the highest possible health care to those who have served. Unfortunately, many Veterans identify suffering from a variety of spiritual struggles in connection with mental health conditions. For example, Veterans suffering from PTSD may also suffer from spiritual injury (Barton & Lapierre, 1999). These patients may benefit from a treatment team that includes appropriate chaplain and mental health expertise. Through the IMHS SA #23 needs assessment process, we have identified the opportunity to develop a curriculum that can equip appropriate VA chaplains to serve as clinical leaders in providing spiritual care as integral members of mental health teams. We provide below a basic outline for this intensive training under the operating title of Mental Health Integration for Chaplain Services (MHICS; pronounced "mix") Certification. This effort will build on the successful series of Bridging Chaplaincy and Mental Health Care Conferences in which the VA Mental Health and Chaplaincy Program has brought together VA and DoD chaplains, mental health providers, and community clergy for two-day education and skills-building sessions.

Target Audience: The MHICS Certification is primarily aimed at chaplains who intend to dedicate at least half of their professional effort to working in a mental health care setting. The certification program will take place over the course of 18 months, with four separate weeks of

onsite training each divided by a 6-month interval for application of learning in the clinical setting. In between on-site training weeks, trainees will complete structured learning exercises as well as participate in clinical case supervision. This process will be directed by identified content experts, to include both chaplains and mental health professionals.

At the conclusion of the MHICS Certification, chaplains will be equipped to:

- Closely collaborate with mental health care professionals in the provision of mental health and spiritual care services.
- Integrate appropriate evidence-based psychotherapeutic interventions with the practice of chaplaincy.
- Identify and address common spiritual dynamics/conflicts in persons suffering from mental health problems.
- Translate and document relevant spiritual considerations for mental health providers while preserving confidentiality.
- Conduct spiritual assessments and document practices that inform the ongoing provision of mental health care services.
- Collaboratively participate as appropriate with local researchers on spirituality and health projects.

While there are VA chaplains who already collaborate with mental health in some of the above described ways, findings from the site visits make clear that chaplains who have forged collaborative relationships with mental health have usually done so by their own initiative and without the benefit of training in how to integrate with mental health in an organized, systematic, evidence-based fashion. The MHICS Certification will fill this gap. Chaplains will learn how to enhance their pastoral care with principles from evidence-based approaches to mental health care. For example, the MHICS Certification aims to train chaplains in ACT, a psychotherapeutic approach to caring for persons with mental health problems that is identified by VA as evidence-based (Department of Veterans Affairs, 2008a). ACT has a number of synergies with pastoral approaches to care, including a focus on clarifying values, the promotion of spiritual practices that patients identify as helpful, and an emphasis on valued-living rather than an exclusive focus on symptom reduction. The MHICS training in ACT will go beyond familiarizing chaplains with this approach, as has been done in the Bridging Chaplaincy and Mental Health Care Conferences, to truly equipping chaplains to integrate ACT with their existing pastoral care approaches and regularly apply it in encounters with patients.

Although the MHICS Certification is aimed at chaplains, we propose including a smaller cadre of mental health professionals in aspects of the MHICS training for the purpose of equipping them to serve as leaders in national mental health-chaplain integration efforts. In particular, these mental health professionals will aid in the implementation of Tier 1 and Tier 2 training and serve as content experts for the organizational-learning collaboratives outlined below.

Proposed Activities: The program will include approximately four one-week sessions over the course of 12 to 18 months. We anticipate approximately15-30 chaplains participating in the first MHICS Certification cohort. The new curriculum will be jointly developed by staff from the VA Mental Health and Chaplaincy Program and the VA National Chaplain Center in cooperation with VA Employee Education Services, Mental Health Services, the National Center for PTSD,

and potentially other relevant VA offices. Evaluation will be led by HSR&D and the VA Mental Health and Chaplaincy Program. Draft topics to be refined by partner organizations upon approval of this proposal are outlined in Table 20.

Table 20. Summary of Tier 3 – Draft Proposal for Mental Health Integration for Chaplain Services (MHICS) Certification

Week	Learning Tools	Integrative Topics
Week 1	• Clinical presentations and interventions • Spiritual care practices • EBP – ACT, concepts in religion & spirituality	• Spiritual Assessments & Care for MH population • Documentation practices • Spiritual dimensions of MH problems (e.g., guilt, shame, forgiveness, grief, moral injury) • Clinical specialty content areas (e.g., PTSD, suicide, substance abuse, SMI, couples and family) • Special populations (e.g., women, rural, homeless) • Pharmacotherapy • Research involvement • Community engagement • Primary care • Lexicon: Spiritual terms related to common MH concerns
Week 2	• Clinical presentations and interventions • Spiritual care practices • EBP – Motivational Interviewing, ACT	
Week 3	• Clinical presentations and interventions • Spiritual care practices • VA-DoD Partnership • ECP – PAIRS training	
Week 4	• Clinical presentations and interventions • Spiritual care practices • EBP – Problem-solving therapy, ACT	

ACT: Acceptance and Commitment Therapy; EBP: Evidence-based Practice; MH: Mental Health; PAIRS: Practical Application of Intimate Relationship Skills; SMI: Serious Mental Illness

Intersections for DoD: While each military branch currently provides chaplains with different levels of training on psychosocial issues (e.g., education about combat stress), this Tier 3 MHICS Certification program embodies a focus and intensity distinct from these existing trainings. Most DoD chaplains have not had the benefit of training in advanced, evidence-based therapeutic approaches, yet findings from the VA / DoD Chaplain Survey indicate that psychosocial problems like anxiety, anger, depression, and stress in work and family relationships are among the most frequent problems that Service members bring to military chaplains. Hence, equipping chaplains via the MHICS Certification program with the ability to apply evidence-based approaches to caring for Service members with psychosocial problems will help chaplains better address the needs of Service members and may also alleviate burden on the mental health care system. DoD chaplains are particularly well situated to apply evidence-based therapeutic skills with Service members who are reluctant to seek mental health care as well as with Service members who may have sub-diagnostic mental health problems, thus preventing these problems from developing into more serious mental health problems. A key component of the MHICS Certification program will involve education on how to better integrate with mental health care providers. In no way will this training aim to replace mental health professionals with chaplains for those Service members who need professional mental health attention. On the contrary, this training will equip DoD chaplains to reduce the stigma attached to mental health care by

educating chaplains about issues that need professional mental health intervention and thereby empowering chaplains to more effectively facilitate entry into mental health care for Service members who need this.

Organizational-level Learning: Chaplain-Mental Health Partnership Collaboratives

Based on the quality improvement collaborative methodology developed by the Institute for Healthcare Improvement (IHI) in the 1990's (Kilo, 1999) and use of such methodology in VA (Jackson et al., 2010), we propose using the learning collaborative framework to help VA medical centers increase the integration of chaplain and mental health services to enhance the provision of patient-centered spiritual and mental health care. Initially, the one-year collaborative we propose would involve one facility from each of the 21 VISNs.

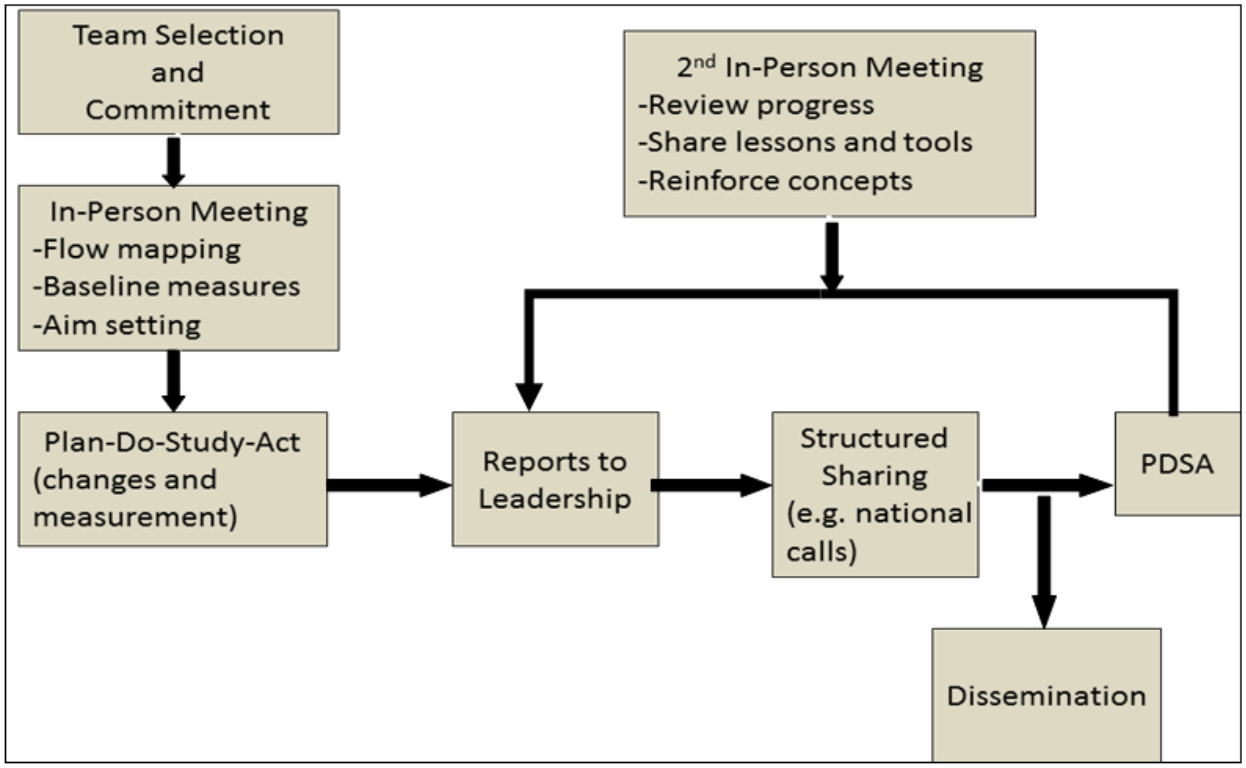
Specific goals include:

- Conduct at least one VA national learning collaborative to include one facility per VISN aimed at developing chaplain-mental health partnerships.
- Train integration teams in techniques of quality improvement.
- Develop organizational structures (e.g., joint rounds and referral procedures described in a service agreement) and tools (e.g., enhanced spiritual assessments, template notes) that can be used to encourage integration.
- Make tools available to facilities that have not yet participated in a collaborative.

Each facility will have teams led by a designated project manager and will consist of clinicians and administrators involved in delivering care or organizing related resources, including information technology. Teams will initially conduct "pre-work" that includes flow-mapping current care systems, initial measurement of care processes, and setting overall improvement aims. Two in-person meetings will be held for each collaborative. The first will focus on disseminating information about clinical care, teaching about evaluating care processes for changing systems, and completing pre-work and collaborative logistics. The second meeting focuses on teams learning from each other's initial improvement changes and reinforcing quality improvement and system redesign lessons. During the collaborative, teams will conduct a series of rapid-cycle changes to care (process discussed below) and measured progress in achieving objectives. There will also be monthly reports sent to collaborative and facility leadership, structured sharing through monthly collaborative calls, an intranet website, and a listserv.

Facility teams will conduct a series of rapid changes to the care systems utilizing Plan-Do-Study-Act (PDSA) cycles, which apply concepts of the scientific method to drive improvement (Anderson, Rungtusanatham, & Schroeder, 1994). Each PDSA cycle involves: 1) planning objectives and how to carry out tests of change; 2) doing the change and documenting observations (measurement); 3) studying/analyzing measurements about what happened during the change; and 4) acting upon what was learned to plan the next change. Facilities choose small scale changes that can be tested over a short period of time. Each new change builds on what was previously learned until significant changes in the health care system have occurred (see Figure 18).

Figure 18. Depiction of a Learning Collaborative



PDSA: Plan-Do-Study-Act

In addition to potential improvements at participating VA Medical Centers, we expect the following products from the collaborative (all tools that can be adopted by VAs throughout the system):

- CPRS notes template
- CPRS referral templates
- Sample service agreements between chaplaincy and mental health
- Training materials on how to interpret progress notes written by professionals of different backgrounds
- Examples of best spiritual assessments that can be utilized by the health care team

The VA Mental Health and Chaplaincy Program will work the Office of Systems Redesign to organize the collaborates with support from the National Chaplain Center, Office of Mental Health Services, and Health Services Research and Development for the development of the substantive curriculum, measures of effectives, and evaluation.

Intersections for DoD: DoD medical treatment facilities (MTFs) are a potential starting point for implementing the above described learning collaborative model in DoD. MTFs included in the VA / DoD site visits may be particularly amenable for application, as baseline information has already been gathered at these sites. DoD task group members detailed a number of ways in which chaplaincy is beginning to implement new practices at MTFs (e.g., standardized approach to documentation). The systematic implementation of these new practices could be enhanced via use of a learning collaborative model, as this model helps health care team members identify barriers and solutions to successful implementation. Hence, conducting a learning collaborative

in DoD could provide lessons to leadership on how to more effectively implement new practices across the entire system. The learning collaborative model could further be adapted for use in operational settings. Indeed, this novel application of the learning collaborative model could reveal instructive lessons in how best to implement IMHS SA #23 recommendations in the diverse non-health care settings in which many military chaplains operate.

Partnerships and Evaluation Framework

VA Partners

This effort will represent a true partnership. Involved organizations may include:

1. **VA Mental Health & Chaplaincy (MH&C)** [VISN 6 Mental Illness Research, Education and Clinical Center (MIRECC)] (expertise in linking chaplaincy and mental health, training chaplains and mental health professionals, integrating clinical approaches of chaplaincy and mental health)
2. **National Chaplain Center (NCC)** (expertise on spiritual care, role of chaplains, operation of VA chaplain services, and tools/resources used in spiritual care)
3. **Mental Health Services (MHS)** (expertise on mental health care, role of mental health professionals, operation of VA mental health services, and tools/resources used in mental health care)
4. **Office of Mental Health Operations (OMHO)** (operational knowledge of mental health care in VA, expertise in implementation of new systems for providing mental health care)
5. **Office of Research and Development** [Durham HSR&D Center of Excellence] (expertise in program evaluation, outcomes/process measurement, quality improvement)
6. **Office of Patient-Centered Care and Cultural Transformation** (focus on creating customized patient-centered models of care, expertise in adapting to changing demands of fluid health care system)
7. **Office of Systems Redesign** (expertise in quality improvement, efficiency of health care, experience conducting quality improvement collaboratives)
8. **VA Center Faith-based and Neighborhood Partnerships** (focus on building partnerships between government and faith-based and community organizations)

Other partners are also likely to be important. The VA Mental Health and Chaplaincy Program has closely participated with other offices in previous endeavors (including the National Centers for PTSD, the National Suicide Prevention Program, and other MIRECCs), and we anticipate that development and implementation of the learning initiatives described in this section are likely to again entail involvement from such partners.

DoD Partners

Although the learning initiatives described in this section were developed with a focus on VA, we believe that there is substantial opportunity for the proposal outlined in this report to be useful within DoD. The Resilience and Prevention Directorate within DCoE will coordinate efforts to involve appropriate DoD partners. This directorate served as the lead DoD organization for IMHS SA #23, bringing together the large contingent of DoD partners described in this report.

Proposed Evaluation Framework

The goal of the evaluation will be to assess the effectiveness of a multi-tier individual and organizational training approach for VA chaplains concerning the issue of integrating chaplain and mental health services in VA. We propose that the evaluation will be conducted as an extension of the current partnership between the VA Mental Health and Chaplaincy Program and HSR&D. These entities are collocated at the Durham VA Medical Center and have partnered closely in the analysis of the VA / DoD Chaplain Survey as well as in the development of organizational-level recommendations and corresponding evaluative approaches that are described in this report.

This will be done utilizing the RE-AIM framework for evaluation. RE-AIM includes the following aspects of intervention implementation: 1) reach; 2) effectiveness (i.e. outcomes); 3) adoption; 4) implementation; and 5) maintenance (Glasgow, McKay, Piette, & Reynolds, 2001; Glasgow, Nelson, Strycker, & King, 2006; Glasgow, Vogt, & Boles, 1999). Example measures of these areas are outlined in Table 21.

Table 21. Potential Examples of RE-AIM Evaluation Measures

RE-AIM Domain	Domain Description[2]	Proposed Measures	Proposed Data Sources
Reach	Degree to which target population is impacted.	Overall 1. % of VA patients targeted for spiritual assessment who actually receive an assessment 2. % of VA mental health patients with an encounter with a chaplain 3. % of VA patients reporting that they receive desired chaplain services Tier 1 1. Number/% of chaplains receiving training materials 2. % of VA facilities that report providing in-service workshops 3. % of chaplains attending in-service workshops 4. % of facilities with written procedures for integrating chaplain and mental health services (e.g. service agreements) 5. Facilities/% reporting additional refinement to spiritual assessment templates to enhance collaboration 6. % of individual chaplains reporting that they participated in training Tier 2 1. % of facilities sending individuals to training conferences 2. Number of individuals attending	Overall 1. VA electronic health record 2. Brief survey of VA patients* Tier 1 3. Mailings by VA mental health chaplaincy program 4. Facility reports through the National Chaplain Center 5. Brief survey of VA chaplains ** Tier 2 1. Conference registration 2. Follow-up survey of training participants Tier 3 1. Training registration 2. Follow-up survey of training participants Collaborative 1. Collaborative reports 2. Intranet site statistics

RE-AIM Domain	Domain Description[2]	Proposed Measures	Proposed Data Sources
		training conferences 3. % of chaplains coordinating training at their facilities <u>Tier 3</u> 1. Number of individuals participating in certification program 2. % of facilities sending individuals to training 3. % of chaplains reporting using specific psychosocial-spiritual EBP treatment approaches (e.g. ACT) in their patient encounters <u>Collaboratives</u> 1. Number facilities participating in the collaboratives 2. Downloading of tools from collaborative intranet site	
Effectiveness	Success of the intervention to change outcomes.	<u>Overall</u> 1. % of all VA chaplains reporting significant training needs for topics identified using the IMHS chaplain survey 2. % of chaplains reporting high job satisfaction 3. % of VA patients receiving chaplain services reporting satisfaction with those services <u>Tier 1</u> 1. Content of chaplain-mental health policies or service agreements 2. Individual chaplain awareness of trainings and topics covered by training. 3. % of targeted VA patients with a chaplain encounter 4. % of targeted VA patients with a spiritual assessment <u>Tier 2</u> 1. % of chaplains reporting using specific psychosocial-spiritual treatment approaches (e.g. motivational interviewing) in their patient encounters. <u>Tier 3</u> 1. % of chaplains reporting using specific psychosocial-spiritual	<u>Overall</u> 1. Brief survey of VA chaplains 2. Brief survey of VA patients <u>Tier 1</u> 1. Report to the National Chaplain Center 2. Brief survey of VA chaplains 3. VA electronic health record <u>Tier 2</u> 1. Follow-up survey of training participants <u>Tier 3</u> 1. Follow-up survey of training participants 2. Aggregate report of trainers 3. Patient satisfaction survey targeted to treated patients and controls 4. Process dependent on resources. Can start with pre-post evaluation of treated individuals. Can also

RE-AIM Domain	Domain Description[2]	Proposed Measures	Proposed Data Sources
		treatment approaches (e.g. ACT) in their patient encounters. 2. Quality of patient notes assessed as part of psychotherapy technique training 3. Satisfaction with chaplain services among a sample of patients receiving care from a certified chaplain compared to a matched cohort that do not. 4. Change in patient reported outcomes <u>Collaboratives</u> (dependent of facility goals) 1. % of VA patients targeted for spiritual assessment who actually receive an assessment. 2. % of VA mental health patients with an encounter with a chaplain 3. % of VA patients reporting that they receive desired chaplain services	include a trial where patients are assigned to treatment with a certified chaplain vs. usual care <u>Collaborative</u> 1. VA electronic health record 2. Brief survey of VA patients
Adoption	Degree to which interventions are taken up by organizations.	<u>Overall</u> 1. Reported satisfaction by senior VA chaplain and mental health leadership <u>Tier 1</u> 1. Overall improvement in the degree of chaplain-mental health integration reported by VA chaplains (compared to initial IMHS survey). 2. % of facilities developing new policies or procedures as a result of the training system. 3. % of facilities reporting joint programs (e.g. joint rounds) between chaplain and mental health service. <u>Tier 2</u> 1. % of the facility trainers who actively engaged in trainings at their facilities. <u>Tier 3</u> 1. % of facilities that have integrated training outlined in the certification program into CPE training programs 2. % of certified mental health chaplains that participate in joint chaplain-mental health provider	<u>Overall</u> 1. Narrative discussions and continued funding <u>Tier 1</u> 1. Brief survey of VA chaplains 2. Report to the National Chaplain Center <u>Tier 2</u> 1. Follow-up survey of training participants <u>Tier 3</u> 1. Follow-up survey of training participants <u>Collaborative</u> 1. Collaborative reports 2. Intranet site statistics 3. Brief survey of VA chaplains

RE-AIM Domain	Domain Description[2]	Proposed Measures	Proposed Data Sources
		teams. Collaboratives 1. Tools utilized by participating facilities 2. Tools utilized by other VA facilities	
Implementation	Degree to which interventions are implemented as intended.	Tier 1 1. % of facilities covering intended topics 2. % of facilities completing training within recommended timeframe 3. % of facilities reporting changes in integration between chaplain and mental health services Level 2 1. % of the facility trainers who actively engaged in trainings at their facilities. 2. % of trainers covering program topics aimed at all chaplains as part of the program Tier 3 1. % of certified mental health chaplains that participate in joint chaplain-mental health provider teams. Collaborative 1. Degree of adaption of tools for local needs and related collaborative effectiveness (see above for sample effectiveness measures) [some adaptation is appropriate]	Tier 1 1. Report to the National Chaplain Center Tier 2 1. Follow-up survey of training participants Tier 3 1. Follow-up survey of training participants Collaborative 1. Collaborative reports linked to effectiveness measures
Maintenance	Can the program be sustained over time?	Overall 1. Identifying barriers and facilitators of maintenance during the program.	Post-implementation qualitative interviews with. a. Chiefs of VA Chaplain Services b. Participates in Tier 2 training c. Participants in Tier 3 training

*EBP = Evidence-based Practices, ACT = Acceptance and Commitment Therapy. *While there are multiple places in this table where a brief survey of VA patients is mentioned as a potential data source, we anticipate collecting all information on the same survey.*
***While there are multiple places in this table where a brief survey of VA chaplains is mentioned as a potential data source, we anticipate collecting all information on the same survey.*

Future Research

While there is a growing literature base to indicate important linkages between religion, spirituality, and health (Koenig et al., 2012), there remains significant opportunity to conduct further research in this domain. The evolving nature of this knowledge base presents both a challenge and an opportunity for the integration of chaplain and mental health care services in VA and DoD. The challenge lies in providing a tangible response to the immediate spiritual and mental health needs of Veterans and Service members based on compelling logic but a base of empirical knowledge that is still being accumulated. The opportunity lies in VA and DoD being truly unparalleled systems in which to learn about the relationships between spirituality and health and advance innovative models of integrated care. As with other multifactorial aspects of health and health care, an in-depth research agenda involves multiple domains that address perspectives of Veterans, Service members, patients, staff, and organizations (Bosworth & Oddone, 2002; Damush et al., 2010; Jackson et al., 2011). To provide an idea of possible domains for study, a select listing of potential research domains and projects is provided below.

- **Descriptive Epidemiology.** Studies are needed to provide a better baseline understanding of issues pertaining to the intersection of chaplaincy and mental health in Veteran and Service member populations. At present, there is a need complement the VA / DoD Chaplain Survey by conducting surveys among 1) VA and DoD mental health care providers, and 2) Veterans and Service members. These surveys would allow for an enhanced understanding of important issues to attend to in integrating chaplaincy and mental health care and would provide the crucial perspective of Veterans and Service members.

- **Assessment and Measurement.** While VA has certain requirements regarding the conduct spiritual assessments in different patient populations at all VA Medical Centers (Department of Veterans Affairs, 2008b), there is significant opportunity to better understand the characteristics of these assessments and how to effectively utilize results, particularly for mental health populations. For example, there has been a call for additional research and better understanding of "moral injury" as a clinical phenomenon (Drescher et al., 2011). This construct has been described in the literature, but to date a scale to measure moral injury has yet to be adequately developed and tested. Being able to measure such a construct could prove of significant clinical utility.

- **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. Also of value would be research on whether training chaplains in the use of certain interventions helps to extend access to care for persons with mental health problems. We note that any research in this domain should entail very careful consideration of what constitute appropriate outcome measures.

- **Implementation Science.** Many areas of health care have significant evidence concerning the delivery of specific clinical interventions. However, those interventions

> are often not utilized or utilized incorrectly in the broader health care environment. As we implement efforts 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 (Curran, Bauer, Mittman, Pyne, & Stetler, 2012).

Many other projects could certainly prove of value to VA and DoD. By virtue of their service, many Veterans and Service members have unique experiences with religion and spirituality that existing evidence suggests are closely related to their experience of mental health. Investing in future research in this domain will pay dividends for Veterans and Service members, for VA and DoD systems of care, and for the broader health care sector.

With adequate support and staffing, the steps outlined in this report will improve the VA and DoD mental health care systems. Ultimately, our sole reason for wanting to better integrate chaplain and mental health care services is to improve the care provided to our Veterans and Service members. We are convinced that this intentional commitment to systematic, evidence-based, holistic care will result in more resilient, meaningful, flourishing lives for those who have faithfully served our country.

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APPENDIX A

ACRONYMS AND ABBREVIATIONS

ACCME	Accreditation Council for Continuing Medical Education
ANNC	American Nurses Credentialing Center
ANOVA	Analysis of Variance
APA	American Psychological Association
ASWB	Association of Social Work Boards
CCNY	City College of New York
CHC	Chaplain Corps
CLO	Civil Liberties Office
CPE	Clinical Pastoral Education
CUNY	City University of New York
DCoE	Defense Centers of Excellence
DMDC	Defense Manpower Data Center
DoD	Department of Defense
DUA	Data Use Agreement
EES	Employee Education System
GAT	Global Assessment Tool
HEC	Health Executive Council
HIPAA	Health Insurance Portability and Accountability Act
HSR&D	Health Services Research & Development
ID	Identification
IMHS	Integrated Mental Health Strategy
IMHS SA	Integrated Mental Health Strategy Strategic Action
IRB	Institutional Review Board
MHICS	Mental Health Integration for Chaplain Services
MIRECC	Mental Illness Research, Education & Clinical Center
OEF	Operation Enduring Freedom
OIF	Operation Iraqi Freedom
OND	Operation New Dawn
PAS	Privacy Act Statement

PHI	Personal Health Information
PII	Personal Identifiable Information
PROC GLM	Procedure for General Linear Models
PTSD	Posttraumatic Stress Disorder
RTI	Research Triangle Institute
SAI	Spiritual Attitudes Inventory
SIS	Spiritual Injury Scale
TBI	Traumatic Brain Injury
TMA	Tricare Management Agency
USA	United States Army
USAF	United States Air Force
USN	United States Navy
VA	Department of Veterans Affairs
VISN	Veterans Integrated Service Network

APPENDIX B

IMHS SA #23 ACTION PLAN AND PERFORMANCE MEASUREMENT

Strategic Action Plan #23 – Chaplains Role

Part I: Action Plan

Part I of the Implementation Plan should outline in moderate detail the activities and milestones means by which the Strategic Action across the VA and DoD. Plans should be built on existing programs and structures, when appropriate, and should emphasize strengths as informed by each Department's current best practices.

Strategic Action #: 23	Include input and expertise from DoD Chaplains in defining the role of VA Chaplain Services and community clergy in mental health care at VA medical centers and clinics.
Functional End State(s)	Increased support of continuity in the role of the chaplain between the Services and VA.
Proposed DoD & VA Implementation Leads	Improved identification of how to facilitate access to mental health care through collaboration with community clergy and faith communities to promote care in a way that is consistent with the values and preferences of the many individuals we serve.
	DoD Lead: Dr. Mark Bates DoD Collaborators: Dr. Jeffrey Rhodes (Ret Navy Chaplain) VA Lead: Dr. Keith Meador VA Collaborators: Dr. Jason Nieuwsma; Chaplain Keith Ethridge

Action Step Number	Major Activities to Achieve End State(s) (Action Step)	Milestones and Projected Completion Dates	Substantive Obstacles to Success
23.1	Initiate the development of collaborative DoD-VA task groups – which will include mental health professionals and chaplains from both VA and DoD – in service of constructing partnerships through which to consider innovative opportunities for integrated mental health and spiritual care.	**By the end of plan approval + 6 months:** Identification and inclusion of participants into collaborative task groups of key VA and DoD stakeholders and additional collaborators is accomplished in conjunction with Service Chiefs of Chaplains and VA National Chaplain Center Director. Pending funding availability, initiate hiring action to add chaplain to provide undivided chaplaincy representation in VA Mental Health and Chaplaincy, requiring addition of one full-time chaplain with particular mental health expertise.	Adequately synthesizing DoD and V language and conceptual thinking about the intersections of mental health and spirituality. Garnering buy-in from chaplains with backgrounds in various diverse faith traditions, particularly as this pertains to varying beliefs in the importance of and approach toward holistic treatment of mental health conditions

		Conduct preliminary inventory of specific DoD spiritual care support programs that directly benefit DoD Service members and their families to share with collaborative task group. Hold a one or two-day off-site workshop to review findings regarding current spiritual care programs and resources to identify and select options for integrated spiritual care programs and resources that can be recommended for enhancing VA chaplain care. Likely in the DC area hosted by the VA.	
23.2	Identify key domains for improvement in the delivery of coordinated VA Mental Health and Chaplaincy services through participation in DoD-VA collaboration, devoting intentional and directed efforts toward discerning the most important elements of effective approaches through the formation and tasking of joint DoD-VA sub-task groups.	**By the end of plan approval + 7 months:** Establish task sub-task groups from two-day off-site workshop to further address specified and implied tasks as determined through DoD-VA collaboration. **By the end of plan approval + 8 months:** Conduct an analysis of VA spiritual care programs and resources to identify any gaps in provision of care in consultation with Mental Health and Chaplaincy program.	Engaging high-level VA and DoD personnel (e.g., Service Chiefs of Chaplains; VA National Chaplaincy leadership) in providing input to guide task groups' efforts.
23.3	Assimilate the products of joint DoD-VA sub-task group efforts for moving forward with innovations in mental health care that optimally equips VA chaplains in their varied roles and utilizes their distinctive capacities as spiritual care providers to improve the quality of Veteran care.	**By the end of plan approval + 10 months:** Hold final face-to-face meeting of all identified DoD-VA integrative task group collaborators and stakeholders, likely in DC to provide visibility on and finalize recommendations. **By the end of plan approval + 12 months:** Recommendations and action feasibility comments from additional DoD-VA, local clergy, and identified stakeholders are presented to DoD Chiefs of Chaplain and VA National Chaplaincy leadership for initial	Formulating an approach to integrated care that is sensitive to the broad diversity among chaplains and clergy from different faith traditions. Acquiring sufficient local and federal support from VA and DoD leadership as well as from providers in both mental health and chaplaincy.

		socialization and feedback.	
23.4	Host a "Mental Health and Chaplaincy Summit" within the VA system. Mental health providers, chaplains, and primary care providers will discuss and learn from an inter-disciplinary approach about topics to include: spirituality, health, and resilience. Service Chiefs of Chaplains and the VA National Chaplain Center Director will be consulted regarding representation and participation by DoD-VA.	**By the end of plan approval + 8-12 months:** VA to host the Mental Health and Chaplaincy Summit for VA care providers and DoD collaborators. Incorporate results of the Summit into the recommendations to VA and DoD leadership (see 23.3) that includes final recommendations for developing an inter-disciplinary approach that includes provision of pastoral and spiritual care as an integral part of VA mental health care.	Achieving adequate publicity and inspiring sufficient interest for high-level VA and DoD personnel to attend. Engagement of the broad range of health care provision leadership necessary to create context for substantive inclusion of spiritual care in overall provision of mental health services for Veterans and Service members.

Part II: Strategic Action Performance Measurement

Part II of the Implementation Plan outlines the measures by which progress towards or success in reaching the Strategic Action's end state can be gauged. The questions to be answered are:

- What are the measures that will indicate progress towards reaching the identified End State? and
- What are the measures that will define successful achievement of End State(s)

Progress/success may be measured in different ways, depending on the nature of each strategic action. Not every action will lend itself to all of the types of measures. Potential measures may be categorized in the following ways:

Measure Type	Description
Outcome Measure	Measures the impact or results generated by activity; degree to which the set of activities affect the desired end state
Output Measure	Measures the products or activities generated by effort, often expressed in terms of quantity or quality
Process Measure	Measures the efficiency, effectiveness, and accuracy of implementing desired activities; may reflect the success in completing stated actions listed in Part I of this Implementation Plan

End State or Action Step Number	Proposed Measure	Data Source	Measure Type
23.1	Preliminary inventory of specific DoD spiritual care support programs that directly benefit DoD Service members and their families is disseminated to task group.	Collaborative DoD-VA task group	Output
23.2	Identified standards of continuity that translate across VA and DoD through a comprehensive assessment of current practices in VA and DoD settings. Results of gap analysis of VA spiritual care programs and resources to identify any gaps in provision of care.	Sub- task groups from two-day off-site workshop Gap analysis conducted by government staff and/or contractors	Output Output
23.3	Written report summarizing findings and recommendations to be presented to VA and DoD leadership.	Collaborative DoD-VA task group	Output
23.4	Results of the Summit incorporated into the above noted written report (see 23.3) that includes final recommendations for developing an inter-disciplinary approach that includes provision of pastoral and spiritual care into mental health care.	Summit/Collaborative DoD-VA task group	Output

APPENDIX C

TASK GROUP KICKOFF MEETING AGENDA AND BREAKOUT QUESTIONNAIRES

VA / DoD Collaborative Task Group Meeting

for

VA / DoD Integrated Mental Health Strategy (IMHS)
Strategic Action #23: Chaplains' Roles

Date: May 25-26, 2011

Location: First Floor Conference Room
Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury
1335 East West Highway
Silver Spring, MD 20910

Meeting Background and Objectives: In 2010, the Department of Defense (DoD) and Department of Veterans Affairs (VA) launched an Integrated Mental Health Strategy (IMHS) that aims to advance a more integrated and better coordinated public health model to improve care for Service members, Veterans, and their families. One of the strategic actions within this strategy focuses on enhancing the roles of chaplains and community clergy in regard to mental health care. This meeting brings together experts from the DoD, VA, and research community to consider innovative opportunities for integrated mental health and spiritual care.

Attendees:

DoD:	VA:	Outside Researchers:
Dr. Mark Bates	Dr. Keith Meador	Dr. Glen Milstein
Dr. Jeff Rhodes	Dr. Jason Nieuwsma	Dr. George Fitchett
CDR George Durgin	Chaplain Keith Ethridge	Dr. Becky Lane
Captain Shelia Robertson	Dr. George Jackson	Dr. Bob Bray
Captain Jessie Tate	Dr. Kent Drescher	Ms. Erin Anderson
Commander Kim Donahue	Chaplain Michael Pollitt	Ms. Kristine Rae Olmsted
LTC Robert Wichman	Chaplain Michael Carter	Dr. Jennifer Clark
Major Abner Valenzuela	Chaplain Marion Thullbery	Dr. Penny Brierley-Bowers
LtCol Michael Reynolds	Chaplain David Ballantyne	
Col Charles Woods	Chaplain Susan Cross	
Ms. Renee Tribbett		
LTC David Graetz		

Day 1 Agenda	
Time	**Content**
8:45-9:00	Registration / Check-In
9:00-9:30	*Welcome & IMHS Overview* **Presenters: Dr. Keith Meador & Dr. Mark Bates**
9:30-10:00	*Goals and Process for Meeting* **Presenters: Dr. Jason Nieuwsma & Dr. Jeff Rhodes**
10:00-10:30	*Introductions*
10:30-10:45	Break
10:45-12:00	*Large Group Discussion #1: Community Engagement* **Presenter: Dr. Glen Milstein; Facilitator: Dr. Jason Nieuwsma**
12:00-1:00	**Lunch**
1:00-2:00	*Breakout #1: State of Chaplaincy* **Facilitators: Drs. Nieuwsma, Rhodes, Lane, & Bray**
2:00-3:00	*Breakout #2: VA / DoD Continuity* **Facilitators: Drs. Nieuwsma, Rhodes, Lane, & Bray**
3:00-3:30	Break
3:30-5:00	*Large Group Discussion #2: Where do we stand?* **Facilitator: Dr. Keith Meador**

Day 2 Agenda	
Time	**Content**
8:45-9:00	Check-In
9:00-9:30	*Day 1 Summary & Objectives for Day 2* **Presenters: Dr. Keith Meador and Dr. Mark Bates**
9:30-10:45	*Large Group #3: Evidence-based Chaplaincy* **Presenter: Dr. George Fitchett; Facilitator: Dr. Jason Nieuwsma**
10:45-11:00	Break
11:00-12:00	*Breakout #3: Barriers* **Facilitators: Drs. Nieuwsma, Rhodes, Lane, & Bray**
12:00-1:00	Lunch
1:00-2:30	*Large Group #4: Next Steps* **Facilitator: Dr. Keith Meador**

Day 1: Wednesday, May 25

Large Group Discussion #1: Community Engagement
10:45am – 12:00pm (75 minutes)

Moderator:
Assistant:
Group type (DoD, VA, or Mixed):
Group size:
Group composition/demographics:

Agenda:

1. Glen Milstein presents COPE model and topic of community engagement (20 minutes)

2. Questions to be addressed during large group discussion:

   i) First, we would like to hear from you about existing engagement between chaplains and various faith communities. (20 minutes)

      (1) What engagement do you and your staff have with faith communities in the local civilian and/or base communities? (5 minutes)

      (2) What engagement do you have with broader faith communities (e.g., broader military community and/or broader community-based faith organizations, social networking resources, etc.)? (5 minutes)

      (3) What are barriers to engagement with these local and broader communities? (10 minutes)

   ii) The next topic we would like to address is ways you think the existing model of community engagement can or should be changed. (20 minutes)

      (1) How might chaplains facilitate increased or better quality interactions between community clergy, patients, their families and the hospital clinicians? (10 minutes)

         (a) Probe: In particular, how might issues of adherence to care and continuity of care involve the chaplain?

         (b) Probe: How should engagement with faith communities be included within your regular scope of work? (if time remains; may be addressed under primary question)

      (2) In terms of existing engagement, are models leaning more toward educating local clergy/faith communities or toward active participation with local clergy/faith communities in the course of clinical care? (10 minutes)

   iii) Our last topic for discussion concerns the types of education and training that you receive and conduct with various populations. (10 minutes)

(1) What kinds of education regarding engaging with faith communities have you/your staff received? (5 minutes)

(2) What educational activities do you/your staff conduct: (5 minutes)

(a) For clergy?

(b) For clinicians?

Review/wrap-up: Other comments? (5 minutes)

Day 1: Wednesday, May 25
Small Group Discussion #1: State of Chaplaincy
1:00pm – 2:00pm (60 minutes)

Moderator:
Assistant:
Group type (DoD, VA, or Mixed):
Group size:
Group composition/demographics:

Agenda:

i) To get started, we would like to hear from you about the populations that you interact with as chaplains. (20 minutes)

(1) What are the populations that chaplains serve? (10 minutes)

(a) Probe: How are these populations representative of or distinct from the broader Service member / Veteran populations? (if time)

(2) What are the routes by which Service members / Veterans come into contact with chaplains? (10 minutes)

(a) Probe: What are barriers to chaplain contact with Service members / Veterans?

ii) Next, we would like to hear from you about specific services provided by chaplains to Veterans and Service members, and their families. (25 minutes)

(1) What are the major services provided by chaplains that have implications for the mental health of Service members / Veterans? (10 minutes)

(a) Probe: What are "best practices" in these services?

(b) Probe: Are there any especially innovative interdisciplinary approaches in existence?

(2) What are the services offered to families of Veterans and Service members? (5 minutes)

(3) What services that chaplains can provide are most underutilized? (10 minutes)

(a) Probe: Why do you think these services are underutilized?

iii) Lastly, we would like to discuss educational requirements and training opportunities/needs that you may have. (10 minutes)

(1) What advanced academic degree or training do chaplains need/have? (5 minutes)

(2) What training opportunities are provided within your organization? (5 minutes)

(a) Probe: What additional trainings are needed to better help our Veterans and Service members?

Review/wrap-up: Other comments? (5 minutes)

Additional notes/thoughts on group:

Day 1: Wednesday, May 25
Small Group Discussion #2: VA / DoD Continuity
2:00pm – 3:00pm (60 minutes)

Moderator:
Assistant:
Group type (DoD, VA, or Mixed):
Group size:
Group composition/demographics:

Agenda:

i) First, we would like to ask you about overall continuity of care between VA and DoD. (20 minutes)

(1) What transitional care is available in moving from active duty to Veteran? (5 minutes)

(2) How do you make chaplain services such as rituals and rites understandable to mental health professionals as part of the continuum of services available to Veterans and Service members? (5 minutes)

(3) What are the gaps in continuity of care between VA and DoD? (10 minutes)

ii) Next, we would like to hear from you about the types of spiritual and/or moral issues that you see as affecting the populations you work with. (20 minutes)

(1) What are the major issues of soul and spirit that you see as affecting Veterans, Service members, and their families? (10 minutes)

(a) Probe: Describe some of the mental/spiritual issues that VA clients typically bring?

(b) Probe: What trends have been identified over the past three years?

(2) How do you integrate spirituality in serving patient populations with particular diagnoses (e.g., dementia, PTSD, depression, MST)? (5 minutes)

(3) How is "moral injury" addressed? (5 minutes) (Note: If participants need a structured definition of "moral injury" to frame the discussion, it is a construct that Dr. Brett Litz has begun to explore, and that others have referred to similarly as "spiritual injury," and is defined as "perpetrating, failing to prevent, bearing witness to, or learning about acts that transgress deeply held moral beliefs and expectations."

iii) Lastly, we would like to cover communication strategies between chaplains and other professionals as related to continuity of care. (15 minutes)

(1) What are differences in terms of "privileged" communication and confidentiality? (5 minutes)

(2) How to you "chart" in a way that honors the relationship with the patient and also serves the rest of the treatment team? (5 minutes)

(3) How else do you communicate about Veterans and Service members with other professionals? (5 minutes)

Review/wrap-up: Other comments? (5 minutes)

Additional notes/thoughts on group:

Day 1: Wednesday, May 25
Large Group Discussion #2: Where Do We Stand?
3:30pm – 5:00pm (90 minutes)

Moderator:
Assistant:
Group type (DoD, VA, or Mixed):
Group size:
Group composition/demographics:

Agenda:

1. Report-ins from small group discussions (40 minutes; 10 minutes per group)
   i) States of chaplaincy in VA and DoD

   ii) Differences between VA and DoD chaplaincy

2. Integrated large group discussion (30 minutes)
   i) What we might hope to learn from each other? (10 minutes)

(1) Probe: What processes are similar across populations?

(2) Probe: What processes are different across populations?

ii) What does the integration process look like currently? (10 minutes)

iii) What ***should*** it look like? (10 minutes)

Review/wrap-up: Other comments? (15 minutes)

Parting words/thanks/any instructions for preparing for Thursday's discussions (5 minutes)

Additional notes/thoughts on group:

Day 2: Thursday, May 26
Large Group Discussion #3: Evidence-Based Chaplaincy
9:30am – 10:45am (75 minutes)

Moderator:
Assistant:
Group type (DoD, VA, or Mixed):
Group size:
Group composition/demographics:

Agenda:

1) George Fitchett provides presentation on evidence-based chaplaincy (20 minutes)

2) Questions to be addressed in large group discussion:

i) The first topic we would like to address concerns the metrics that you use in your work. (10 minutes)

(1) What metrics do you/your staff use? (5 minutes)

(2) What are the assessment or screening tools that VA / DoD chaplain or mental health providers have used? (5 minutes)

(a) Probe: Do these tools provide interventions for PTSD sufferers and other individuals with combat-related problems?

ii) Next, we would like to hear from you about the presence or absence of evidence-based practices. (25 minutes)

(1) What organizational dynamics around chaplaincy as an "evidence-based" service? (10 minutes)

(a) Probe: What does DoD want to see?

(b) Probe: What does VA want to see?

(2) What are the domains in which you want to see evidence (perhaps domains in which no evidence currently exists)? (15 minutes)

(a) Probe: How could "evidence" be useful?

(b) Probe: How could evidence be obtained through surveys of chaplains?

(c) Probe: Do you think that learning about the experiences and services provided by other chaplains would provide meaningful evidence? How so?

iii) Lastly, we would like to ask about some "best practices" in providing evidence-based services. (15 minutes)

(1) What "evidence" do affiliated professionals want to see about chaplaincy? (5 minutes)

(2) What does good research / evidence-based practice look like for chaplaincy? (5 minutes)

(3) What does bad research / evidence-based practice look like for chaplaincy? (5 minutes)

Review/wrap-up: Other comments? (5 minutes)

Additional notes/thoughts on group:

Day 2: Thursday, May 26
Small Group Discussion #3: Barriers
11:00am – 12:00pm (60 minutes)

Moderator:
Assistant:
Group type (DoD, VA, or Mixed):
Group size:
Group composition/demographics:

Agenda:

i) During this time, we would like to cover barriers to providing care and continuity of care within and across VA and DoD settings.

(1) What are barriers to increasing continuity of care between VA and DoD? (15 minutes)

(2) What are ways to problem-solve around these barriers? (10 minutes)

(3) What barriers exist between chaplains and mental health providers? (10 minutes)

(4) What challenges have you faced to integrating chaplaincy with mental health care? (10 minutes)

(5) Describe some of the mental/spiritual issues that chaplains themselves currently face (e.g. compassion fatigue, burnout, stress, etc)? (10 minutes)

(6) Probe: What are some of the ways VA / DoD chaplains do to take care of themselves (e.g., care for care-giver opportunities)?

Review/wrap-up: Other comments? (5 minutes)

Additional notes/thoughts on group:

Day 2: Thursday, May 26
Large Group Discussion #4: Where Do We Stand?
1:00pm – 2:30pm (90 minutes)

Moderator:
Assistant:
Group type (DoD, VA, or Mixed):
Group size:
Group composition/demographics:

Agenda:

1. Report-ins from small group discussions (20 minutes; 10 minutes per group)

2. Questions for large group discussion:
   i) How to we maintain the distinctive nature of mental health and pastoral care disciplines throughout the integration process? (10 minutes)

3. Discuss next step directions:
   ii) What impact do we want these discussions to have on VA and DoD practices? (15 minutes)

   iii) What training/cultural education would be useful moving forward? (15 minutes)

   iv) In what way can we best assist others outside our disciplines to understand our importance in collaboration, not competition? (15 minutes)

Review/wrap-up: Other comments? (10 minutes)

Parting words/thanks (5 minutes)

Additional notes/thoughts on group:

APPENDIX D

VA MENTAL HEALTH AND CHAPLAINCY FORUM AGENDA AND QUESTIONNAIRES

Department of Veterans Affairs, Employee Education System

and

VA Mental Health and Chaplaincy

In conjunction with the VA / DoD Integrated Mental Health Strategy
Present

VA Mental Health and Chaplaincy Forum

Program Start: September 1, 2011 **Program End:** September 2, 2011

Sofitel Washington DC Lafayette Square, 806 15th Street, Washington, DC

Purpose Statement

The research literature from recent decades has evidenced important linkages between religious/spiritual practices and health outcomes. In Veteran samples, research suggests that spiritual issues such as crises of faith, difficulty extending and receiving forgiveness, and lack of life purpose are correlated not only with mental health problems but also with seeking mental health care services. For a variety of reasons, people who are experiencing mental and emotional suffering can be more likely to seek help from clergy and other spiritual care providers than from mental health care professionals.

Although there are some notable models of integrated mental health and chaplain services at different VA medical centers, overall there remains substantial room for improvement in better incorporating religious and spiritual issues into the overall care of Veterans in the Veterans Health Administration. Additionally, there is a gap in how consistently issues of religion and spirituality are addressed by mental health and primary care providers. These providers often do not integrate religious and spiritual issues into the care of patients due to a lack of knowledge, awareness, and formal training in the importance of religious and spiritual issues for health. As such, there is a need for education among mental health and primary care providers regarding collaboration with chaplaincy services and with established community religious leaders.

This training will equip mental health and primary care providers with information, principles, and techniques on how to further optimize health care to Veterans via the incorporation of religious/spiritual issues and collaboration with chaplains and spiritual care providers in the community. This training will also elicit input from key VA policymakers, stakeholders, and subject matter experts to form and guide next steps in the creation and implementation of integrated models of care that will more optimally address the interrelations of spirituality with mental and physical health.

Target Audience

Physicians/Psychiatrists, Chaplains, Nurses, Social Workers, and Psychologists

Outcome/Objectives

At the conclusion of this educational program, learners will be able to:

1. Describe the relationship between spirituality and health and the importance of integrating mental health and chaplain services;
2. Discuss approaches for more optimally integrating spirituality with the mental and physical health care of Veterans, and;
3. Develop methods for advancing a research-informed approach to integrated spiritual, mental, and physical health care.

Accreditation/Approval

The accreditation organizations for this course are listed below.

Accreditation Council for Continuing Medical Education (ACCME)

The VA Employee Education System is accredited by the Accreditation Council for Continuing Medical Education to provide continuing medical education for physicians.

American Psychological Association (APA)

The VA EES is approved by the American Psychological Association to sponsor continuing education for psychologists. The Employee Education System maintains responsibility for this program and its content.

American Nurses Credentialing Center (ANCC)

VA Employee Education System is accredited as a provider of continuing nursing education by the American Nurses Credentialing Center's Commission on Accreditation.

> ***Note:*** *ANCC continuing nursing education contact hours are not accepted by the California Board of Registered Nursing (CA BRN) toward license renewal for CA-licensed registered nurses (RNs) and advanced practice nurses (APNs), unless the CA-licensed nurse-participants are physically outside of the state of CA when they start and complete activities sponsored by an ANCC accredited provider of continuing education for nurses.*

Continuing Education Credit

Accreditation Council for Continuing Medical Education (ACCME)

The VA Employee Education System designates this live activity for a maximum of 9 *AMA PRA Category 1 Credit(s)* ™. Physicians should claim only credit commensurate with the extent of their participation in the activity.

American Psychological Association (APA)

As an organization approved by the American Psychological Association, the VA Employee Education System is sponsoring this activity for 9 hours of continuing education credit. The Employee Education System maintains responsibility for this program and its content.

American Nurses Credentialing Center (ANCC)

VA Employee Education System designates this educational activity for 9 contact hours in continuing nursing education.

Note: ANCC continuing nursing education contact hours are not accepted by the California Board of Registered Nursing (CA BRN) toward license renewal for CA-licensed registered nurses (RNs) and advanced practice nurses (APNs), unless the CA-licensed nurse-participants are physically outside of

the state of CA when they start and complete activities sponsored by an ANCC accredited provider of continuing education for nurses.

Association of Social Work Boards (ASWB)

VA Employee Education System, Provider Number 1040, is approved as a provider for continuing education by the Association of Social Work Boards, 400 South Ridge Parkway, Suite B, Culpeper, VA 22701. http://www.aswb.org ASWB Approval Period: 00000004/7/10 - 4/7/13. Social workers should contact their regulatory board to determine course approval.
Social workers will receive 9 continuing education clock hours in participating in this course.

Statement of Participation

A certificate of completion will be awarded to participants and accreditation records will be on file at the Employee Education System. In order to receive a certificate of completion from EES, you must sign in at the beginning of this activity, complete an evaluation, attend 100% of the program, and pick up your own certificate at the conclusion of the program (certificates will not be mailed). EES cannot issue certificates for less than 100% participation as required by accrediting body regulations.

Report of Training

It is the program participant's responsibility to ensure that this training is documented in the appropriate location according to his/her locally prescribed process.

Program Schedule

Thursday, September 1, 2011

Time	Location	Topic or Title	Faculty
7:30 – 8:25	1st Floor	Registration	
8:25 – 8:40	1st Floor	--Welcome	Dr. Sonja Batten and Chaplain Keith Ethridge
8:40 – 9:40	1st Floor	Spirituality and Health: A Vision for Integrated VA Health Care	Dr. Keith Meador
9:40 – 10:00		--Break	
10:00 – 11:00	1st Floor	Why Religion Matters for Health: An Epidemiologist's Perspective	Dr. Jeff Levin
11:00 – 12:00	1st Floor	Religion and Health: A Public Health Paradigm	Dr. Ellen Idler
12:00 – 1:00		--Lunch	
1:00 – 2:00	2nd Floor	Breakout 1: State of Integration	Breakout Facilitators
2:00 – 3:00	2nd Floor	Breakout2: Models for Integration	Breakout Facilitators
3:00 – 3:20		--Break	
3:20 – 4:20	1st Floor	Envisioning a Research-informed Chaplaincy	Dr. George Fitchett
4:20 – 4:30	1st Floor	Wrap Up/Adjourn	Dr. Keith Meador

Friday, September 2, 2011

8:00 – 8:15	1st Floor	Sign-In	
8:15 – 8:30	1st Floor	--Welcome to Day 2	Dr. Keith Meador
8:30 – 9:30	1st Floor	Complexities of Evidence-based Therapies	Dr. Mark Bates
9:30 – 9:45		--Break	
9:45 – 10:45	2nd Floor	Breakout 3: Barriers to Integration	Breakout Facilitators
10:45 – 11:00		--Break	
11:00 – 12:00	1st Floor	Summary Discussion	Dr. Keith Meador
12:00		Evaluations/Adjourn	

Faculty and Planning Committee Listing

* Denote planning committee
+ Denotes faculty

+Mark Bates	*Kate Bowen, RN, MSN, RN-BC, NE-BC Chief Nurse, Mental Health Palo Alto VA Health Care System Palo Alto, CA
*Lauren Elliott, MEd Project Manager St. Louis Employee Education Resource Center St. Louis, MO	+George Fitchett
Betty Hammon, CPBA Education Specialist Employee Education Resource Center, Tuskegee Campus Tuskegee, AL	+Ellen Idler Professor, Department of Sociology Emory University Atlanta, GA
+Jeff Levin, PhD, MPH Director, Program on Religion and Population Health Baylor University Waco, TX	*Keith Meador, MD, ThM, MPH Director, Mental Health and Chaplaincy VISN 6 MIRECC, Durham VA Medical Center Durham, NC Planning Member for ACCME
*Jason Nieuwsma, PhD Associate Director VA Mental Health and Chaplaincy VISN 6 MIRREC, Durham VA Medical Center Durham, NC Planning Member for APA	*Jeffrey Rhodes, DMin Program manager Performance Enhancement Creative Computing Solutions, Inc. Silver Springs, MD
*Andrew Sioleti	

EES Program Staff for Trace Code: 11.ST.MH.CHAPLAINCY.A

Betty Hammon
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Lauren Elliott
Project Manager
Employee Education Resource Center
St. Louis, MO

Christine Strum
Program Support Assistant
Employee Education Resource Center
Tuskegee, AL

Face-to-Face Conference:

Please register by 04:30 PM on 8/25/2011. Information on participation may be obtained from Betty Hammon, Project Manager, Employee Education Resource Center, 2400 Hospital Road, Tuskegee, AL, phone: 334-727-0550, ext. 3858, or e-mail: betty.hammon@va.gov.

Cancellation Policy

Those individuals who have been accepted to attend and need to cancel should notify Christine Strum, Birmingham Employee Education Resource Center, Tuskegee Campus by phone at least two weeks prior to the program at 334-727-0550 ext. 3591.

The Rehabilitation Act of 1973 as Amended in 1998

The Employee Education System wishes to ensure no individual with a disability is excluded, denied services, segregated or otherwise treated differently from other individuals participating in its educational activities, because of the absence of auxiliary aids and services. If you require any special arrangements to attend and fully participate in this educational activity, please contact Betty Hammon, Project Manager, Employee Education Resource Center, 2400 Hospital Road, Tuskegee, AL, phone: 334-727-0550, ext. 3585, or e-mail: betty.hammon@va.gov.

Disclosure Statement

The VA EES must ensure balance, independence, objectivity, and scientific rigor in all of its individually sponsored or jointly EES sponsored educational activities. All prospective faculty and planning committee members participating in an EES activity must disclose any relevant financial interest or other relationship with: (a) the manufacturer(s) of any commercial product(s) and / or provider(s) of commercial services discussed in an educational presentation, and (b) any commercial supporters of the activity. Relevant financial interest or other relationship includes, but is not limited to, such things as personal receipt of grants or research support, employee or consultant status, stockholder, member of speakers' bureau, within the prior 12 months. EES is responsible for collecting such information from prospective planners and faculty, evaluating the disclosed information to determine if a conflict of interest is present and, if a conflict of interest is present, to resolve such conflict. Information regarding such disclosures and the resolution of the conflicts for planners and faculty shall be provided to activity participants. When an unlabeled use of a commercial product or an investigational use

not yet approved by the FDA for any purpose is discussed during an educational activity, EES shall require the speaker to disclose that the product is not labeled for the use under discussion or that the product is still investigational.

The faculty and planning committee members reported that they had no relevant financial relationships with commercial entities in any amount that occurred within the past 12 months that create a conflict of interest.

This activity includes no discussion of uses of FDA regulated drugs or medical devices which are experimental or off-label.

* The ACCME defines “relevant financial relationships” as financial relationships in any amount occurring within the past 12 months that creates a conflict of interest.

VA MENTAL HEALTH AND CHAPLAINCY FORUM ATTENDEES

Attendee	Position
Allen, John Paul PhD, MPA	VA, National Mental Health Program Director, Addictive Disorders, Durham VAMC
Allen, Karen MSN, RN	VA, Nurse, Associate Director Patient Care Services VA Southern Oregon
Ballantyne, David, DMin, BCC, AAMFT	VA, Chaplain, Chaplaincy Program Manager, Coatesville VAMC
Barclay, Kleet, MAJ, Ch	DoD, Chaplain, Air Force Office of the Chief of Chaplains
Bates, Mark, PhD	DoD, Director, Resilience and Prevention (R&P), DCoE
Batten, Sonja, PhD	VA, Assistant Deputy Chief PCS Officer for Mental Health
Beal, Alice, MD	VA, Palliative Care Physician, Brooklyn VAMC
Beckham, Jeannie, PhD	VA, Duke University Medical Center, Psychologist, Durham VAMC
Bowen, (Catherine) Kate, MSN	VA, Chief Nurse, Mental Health, VA Palo Alto Health Care System/ Menlo Park
Bray, Robert, PhD	Research Triangle Institute, Director Substance Abuse Epidemiology & Military Behavioral Health Program
Brierley-Bowers, Penny, PhD	Dynamics Research Corporation, Psychologist
Burnett, James Ch, MDiv, BCC	VA, Chief, Chaplain Service, Hines VAMC
Cantrell, William, Ch, MDiv CDR, CHC, USN	VA, Chaplain for Education and Research, VA Mental Health and Chaplaincy, VISN 6 MIRECC, Durham VAMC
Carter, Michael, Ch, MRE	VA, Chief, Chaplain Service, North Texas VHCS
Chambers, Steven, PsyD	VA, Psychologist, Coatesville VAMC
Clark, Jennifer, PhD	Dynamics Research Corporation
Cross, Kayla, RN	VA, Mental Health Nurse, Spokane VAMC
Cross, Susan Ch, DMin	VA, Chaplain, Chief, Chaplain Service, Hampton VAMC
Day, Jackson, DMin, MPH	Vietnam Veterans of America, Executive Director, International Conference of War Veteran Ministers
Drescher, Kent, PhD, MDiv	VA, Health Science Specialist, Menlo Park - Palo Alto VAMC - National Center for PTSD
Ethridge, (Alton) Keith, Ch, MDiv	VA, Director National Chaplain Center, CHAPVACO (SES EQV), Hampton
Fitchett, George, PhD	Rush University, Associate Professor, Director of Research
Fitzgerald, Ray, PhD, ABPP	DoD, Psychologist, Walter Reed National Military Medical Center
Flannelly, Kevin, PhD	Health Care Chaplaincy Inc., Associate Director of Research
Gibson, William, PhD	VA, Psychologist, Canandaigua VAMC
Graetz, David, COL, Ch, MDiv	DoD, Joint Force Headquarters State Chaplain – Army National Guard
Hall, Charles, Ch, MDiv	VA, Chaplain, NYC - Brooklyn Campus, NYHHS
Hamlett-Berry, Kim, PhD	VA, Clinical Psychologist, Director Office of Public Health and Prevention (SES EQV)
Harris, (Irene) Jeanette, PhD	VA, Clinical Psychologist, Minneapolis VAMC
Haynes, Tiffany, PhD	VA, University of Arkansas for Medical Sciences Psychologist, Post-doctoral Fellow, VA South Central MIRECC, Little Rock AR
Hosein, Shareda, Ch	Islamic Society of America, Muslim Chaplain, Islamic Society of North America
Hunt, Justin MD, MS	VA, University of Arkansas for Medical Sciences Psychiatrist, Research Fellow Little Rock VAMC; Assistant Professor- Dept. of Research, UAMS
Idler, Ellen, PhD	Emory University, Professor of Sociology
Jackson, George, PhD, MHA	VA, Health Research Scientist, HSR&D, Durham VAMC

Jackson, Virginia, Ch, DMin, MDiv, BCC	VA, Menlo Park - VA Palo Alto Health Care System
Jaycox, Lisa, PhD	RAND Corporation, Senior Behavioral Scientist and Clinical Psychologist
Katz, Ira MD, PhD	VA, Senior Consultant for Mental Health Program Analysis
Kearney, Lisa, PhD	VA, Psychologist - National Integrated Care Coordinator, VACO Office of Mental Health Operations
Kerkhoff, Marilyn, FNP-BC	VA, Associate Director Patient Care Services/Nurse Executive, Memphis VAMC
Kinghorn, Warren, MD, ThD	VA, Duke Divinity School, Staff Psychiatrist, Durham VAMC, Duke Divinity School & Duke University Medical Center Affiliate
Kronick, Lowell, Ch, MHL, BCC	VA, Chaplain, Associate Director, National Chaplain Center, Hampton
Lane, (Marian) Becky, PhD	Research Triangle Institute, Research Psychologist
Lavelle, E. Terri, Rev., BSN, MATS	VA, Director, Center for Faith Based & Neighborhood Partnerships - White House
Levin, Jeff, PhD	Baylor University, Director of the Program on Religion and Population Health, Adjunct Professor of Psychiatry and Behavioral Sciences
McSherry, Elisabeth (Green), MD, MPH	VA, Consultant in Research, National Chaplains Office
Meador, Keith MD, ThM, MPH	VA, Director, Mental Health and Chaplaincy, VISN 6 MIRECC, Durham VAMC, Vanderbilt University
Michel, Andrew, MD	VA, Psychiatrist, Nashville VAMC – TVHS
Millspaugh, Dick, Ch, BS, MDiv	VA, Chief, Chaplain Service, San Diego VAMC
Milstein, Glen, PhD	City College of NY, Licensed Clinical Psychologist, Associate Professor of Psychology
Muhammad, Abdul, LTC, Ch, BS, MS, MSW	DoD, Muslim Chaplain, Program Manager for the Behavioral Health Program, Health Promotion and Wellness Directorate, US Army Public Health Command
Nieuwsma, Jason, PhD	VA, Associate Director, VA Mental Health and Chaplaincy, VISN 6 MIRECC, Durham, NC, Duke University Medical Center
O'Reilly, Laurie, PhD, BCC	VA, Chief, Chaplain Service (118C) Detroit VAMC
Ott, Karen RN, MSN	VA, Nurse, Clinical Executive, Office of Nursing Services, Central Office
Pomerantz, Andy, MD	VA, National Mental Health Director Integrated Care, OMHS, VACO
Post, Edward, MD, PhD	VA, University of Michigan, Investigator, Center for Clinical Management Research, HSR&D Ann Arbor
Reynolds, Michael, Lt Col, Ch	DoD, Chaplain, Clinical Pastor Education ANG Chaplain Offices
Rhodes, Jeff, Ch, DMin	DoD, Program Manager Performance Enhancement Creative Computing Solutions, Inc. Contract Support for DCoE Traumatic Brain Injury Resilience and Prevention Directorate
Robertson, Sheila, CAPT, Ch, MDiv	DoD, Chaplain of Naval Medicine (M00G), Special Assistant for Pastoral Care
Russo, Arthur (Chris), PhD	VA, Psychologist, New York Harbor HCS - Brooklyn Campus
Shuster, John, MD	VA, Attending Physician Palliative Care, Tennessee Valley HCS
Simpson, Colleen, BSN	VA, NP Oncology, Chair Professional Advancement of Pastoral Education, Seattle VAMC
Sioleti, Andrew, Ch, MSW, MDiv	VA, Chief, Chaplain Service, LCWS, New York Campus, NYHHCS
Stephenson, Krista, MSN	VA, DCoE Research Operations Coordinator, Canandaigua VAMC
Sullivan, Steve, Ch	VA, Dir. VA/Clergy Partnership for Rural Veterans, Little Rock, AR
Tate, Jessie CAPT, Ch, MDiv	DoD, Fleet Chaplain at USFFC
Tenhula, Wendy, PhD	VA, Senior Consultant Liaison for Psychological Health
Thullbery, Marion Ch, MDiv, PhD	VA, Chaplain, NC Chaplain Service, Clinical Pastoral Education

	Supervisor, Durham VAMC
Tischner, Casey, MS	Research Triangle Institute, Survey Researcher
Tsevat, Joel MD, MPH	VA, Director of HSR&D - Cincinnati VAMC, University of Cincinnati
Virtue, Jerri, N.P.	VA, Nurse Practitioner, Palliative Care, Seattle VAMC
Wichman, Robert, LTC, Ch	DoD, Chaplain Army Medical Command
Yerardi, Ruth, PhD, RN	VA, Nurse, Associate Director for Patient Care, Chillicothe VAMC

FORUM BREAKOUT #1: State of Integration

Group A (Chaplaincy) Facilitators: Chaplain Keith Ethridge & Chaplain Jeff Rhodes
Group B (Mental Health) Facilitators: Dr. Jason Nieuwsma & Dr. Becky Lane
Group C (Broader Health) Facilitators: Kate Bowen, MSN & Dr. Warren Kinghorn
Group D (Community) Facilitators: Chaplain Bill Cantrell & Dr. Glen Milstein

[Note that questions 1 & 2 are intended to be relatively open questions that invite for the incorporation of reactions to the morning plenary presentations.]

1. Following on the morning plenary presentations and speaking from your area of expertise, do you perceive benefit from integrating care between chaplaincy, mental health, other health care services, and the community? If so, what is the benefit? *[How do you do that? How important are systemic issues vs. personalities of providers?]*

2. Again following on the morning plenary presentations and speaking from your area of expertise, how would you envision a model of health care that optimally integrates issues of religion and spirituality in patient care? *[Invite discussion on the "important characteristics" (e.g., adequately trained providers) of such a model as well as "key considerations" (e.g., respecting patients' religious preferences; benefits/drawbacks of asking pts a question like "Would you like to see a chaplain?" screen).]*

3. What existing models are you aware of? What has worked well and why? What hasn't and why? *[Inform people that if they are not aware of any, we want to know that as well.]*

4. *Group A:* From your perspective and experience, describe the successes and challenges that you have seen in the development and maintenance of collaborative relationships between chaplains and:
    - mental health.
    - the broader health care system.
    - clergy and community organizations.
    - collaboration between VA and DoD chaplains.

4. *Groups B,C,D:* From your perspective and experience, describe your understanding of:
    - what chaplains do. *[Assure people that this is not a quiz. If they don't have clarity on what chaplains do, we want to hear from them and know that.]*
    - how chaplains have or have not interacted with [*Group B* mental health] [*Group C* the broader health care system] [*Group D* clergy and community organizations].
    - whether there is an openness or interest among [*Group B* mental health] [*Group C* the broader health care system] [*Group D* clergy and community organizations] in closer interaction with chaplains.

5. *[If time, can note some of the barriers that came up in this breakout and mention that barriers will be specifically asked about in next breakout.]*

FORUM BREAKOUT #2: Models for Integration

Group E (Chaplaincy) Facilitators: Chaplain Keith Ethridge & Chaplain Jeff Rhodes
Group F (Mental Health) Facilitators: Dr. Jason Nieuwsma & Dr. Becky Lane
Group G (Broader Health) Facilitators: Kate Bowen, MSN & Dr. Warren Kinghorn
Group H (Community) Facilitators: Chaplain Bill Cantrell & Dr. Glen Milstein

1. From your perspective and experience, what appear to be the spiritual needs of Veterans, Service members, and family members? Which of these needs are not being optimally met by the current system? *[For each need that is identified, ask how important the need is and if it is currently being met in the current system. "What are top 3 spiritual needs?" and allow attendees to rank if can. Ask specifically about spiritual assessment / screening tools.]*

2. In order for a more optimally integrated model of care to be effective, what are the educational needs of chaplains, mental health providers, other health care providers, clergy and community leaders, Veterans and Service members, and other stakeholders? *[If people having trouble responding, can give example of intensive training in MH for chaplains, training in spirituality or what chaplains do for MH. Can also think of this as asking "What do I as a MH provider / chaplain / etc. think a chaplain / MH provider / etc. needs to know in order to work with me?" Or "What do I need to know in order to work with___?"]*

3. If you could specify roles for providers and participants (chaplains, mental health providers, primary care providers, clergy, community leaders, Veterans / Service members, family members) in a more integrated system of care, what would those roles be? *[If people have trouble responding, can offer examples of chaplain as a "cultural liaison" between provider, community, and Veteran and their family…or Chaplain Derrel Hughes as outpatient MH chaplain…or Afghanistan chaplain embedded in TBI unit. Can also think of this question as "What would you like from a ___ (MH provider, chaplain, primary care provider, clergyperson)?"]*

4. What are barriers to accomplishing a more integrated system of care? *[Record these as discussion goes along, and make sure to provide at least 10-15 minutes to discussion of this question.]*

FORUM BREAKOUT #3: Barriers to Integration

Group E (Chaplaincy) Facilitators: Chaplain Keith Ethridge & Chaplain Jeff Rhodes
Group F (Mental Health) Facilitators: Dr. Jason Nieuwsma & Dr. Becky Lane
Group G (Broader Health) Facilitators: Kate Bowen, MSN & Dr. Warren Kinghorn
Group H (Community) Facilitators: Chaplain Bill Cantrell & Dr. Glen Milstein

[Barriers identified as part of the breakouts from Day 1 will be compiled into a master list. From this list, approximately 4-10 themes will be generated for use during the Day 2 breakouts. Each group will then problem-solve around 2-4 barriers. Following Day 1, we will have a sense of how to best structure Breakout 3. In discussing the barriers, consider using questions like "What might we do about __?" "What might be some ways to problem-solve around __?" Also, attempt to emphasize things that facilitate good collaboration and integration (e.g., development of trusting professional relationships) and paraphrase these themes as they arise.]

1. Barrier: _____

2. Barrier: _____

3. Barrier: _____

4. Are there any other comments that you feel are important but have not had an opportunity to share during the course of these breakouts? *[5-10 minutes]*

APPENDIX E

VA MENTAL HEALTH AND CHAPLAINCY FORUM EXPANDED BREAKOUT TABLES

Table 1: State of Integration (Breakout #1)

Question	Provider Group			
	CHAPLAINCY (n = [20])	MENTAL HEALTH (n = [18])	BROAD HEALTH CARE (n = [17])	COMMUNITY (n = [15])
1. Following on the morning plenary presentations and speaking from your area of expertise, do you perceive benefit from integrating care between chaplaincy, mental health, other health care services, and the community? If so, what is the benefit?	- Provides holistic care. - Prevents patients from falling through the cracks. - Chaplain-MH communication via relationship building, presentations, etc. alleviates professional ownership fears, promotes clinical collaboration. - Chaplains should know and articulate what they can offer (e.g., spirituality groups, clinical expertise) to earn trust and respect. - Veterans / Service members may prefer that Chaplain is not connected to MH for reasons of stigma and confidentiality.	- Provides holistic care. - Provides sense of connectedness. - Provides greater continuity of care. - Better collective support & consistency for Veterans. - Makes services available through all entry points. - Referral for faith based support groups for crisis of faith issues. - Chaplains can be one avenue of family connection. - Decreased stigma; often more comfortable going to Chaplain than to other MH providers.	- Huge benefit to integrated care – feel lucky to have Chaplains on the tx team. - Interdisciplinary approach works, since different patients will establish different levels of trust with different members of the tx team. - Chaplain provides a different perspective from the purely clinical disciplines. - It's incredibly important but sometimes gets bogged down in the mechanics/structural requirements.	- Definite benefit to integration. - Considerable overlap between areas; potential confusion and harm without integration (messages from multiple sources). - Chaplains can provide a whole-person assessment, including spiritual needs. - Clergy are gatekeepers to MH system. - People may feel more comfortable talking to Chaplains than other MH professionals – less stigma. - Need to understand what is helpful and ensure assurance of quality across care systems.
2. Again following on	- CPE and clinical training for chaplains is	- VA Chaplains have CPE training,	- Similar to integrated	[No notes provided.]

the morning plenary presentations and speaking from your area of expertise, how would you envision a model of health care that optimally integrates issues of religion and spirituality in patient care?	crucial. - Chaplains and MH providers share cases with entire team. - Chaplains and MH should educate each other. - Need opportunities for MH and chaplains to become acquainted on personal and professional levels.	but no standardized requirements. - Chaplain should be liaison between MH and spiritual health. - Shared training of MH providers and Chaplains in areas of expertise. - Respectfully share health information but support patients' decisions. - Spiritual support and guidance accepted as part of multidisciplinary approach to care.	palliative care. - Resource and funding issues to staff enough Chaplains. - Should be a Chaplain on the tx team so they can be utilized if and when needed. - Having Chaplains who were optimally equipped might help patient feel less stigmatized. - Encourage education; work with caregivers and start support group where educational model used for spirituality. - More systematic needs assessment, screening, & proactive offering of services.	
3. What existing models are you aware of? What has worked well and why? What hasn't and why?	- "Model" is difficult. - Model for substance abuse interdisciplinary training has worked well, especially for getting foot in the door for Chaplains working with MH; helps to build trust and respect. - Interdisciplinary team approach works well. - Helps to be fluent in more than one language. - Chaplains' cross-training in multiple disciplines. - Partnering local clergy/faith community with local MH providers & community groups.	- Very few opportunities for MH and Chaplains to train together. - MH and Chaplain attending rounds; would encourage training and dialog. - Too few Chaplains to be fully integrated into MH work. - Need to broaden view of what Chaplains do to incorporate moral injury, etc. to argue for more resources. - Having Chaplain representation on MH tx teams or local MH	- Comparisons to palliative care models, suggestions that Chaplaincy models could work the same way. - Use of local community. - Fears about losing funding and ability to justify existence. - When Chaplains are members of a treatment team, they are very helpful; once others recognize their worth, they are called upon more. - Stepped-care	- Practical application of intimate relationship skills (PAIRS) model; Chaplain and MH work together with couples. - Community outreach to connect clergy. - Develop community advisory boards, link to other community resources. - Local churches develop own programs, take ownership and

		councils. - Cross training of MH and Chaplain residents.	model, mediated by local leadership.	responsibility for maintaining. - Outreach to VA centers; clinical chaplains educate community clergy about reintegration into society. - Community connector (CC) model; clergy serve as referral point to other resources. - Need linkages between the trusted person and the experts; positive relationships critical.

4. From your perspective and experience, describe your understanding of what chaplains do, how they have or have not interacted with other providers and organizations, and whether there is an interest among other providers and organizations to collaborate with chaplains.	- Building relationships with community.
	- Regular meetings between Chaplains and MH.
	- Instances of successful collaboration.
	- Inpatients well integrated into health care model.
	- Challenges:
	  - Weak community link.
	  - Territorialism, fear of straying outside prescribed roles.
	  - Low morale due to administrative/structural changes.
	  - Lack of trust across professional lines.
	  - Lack of regular communications.
		- Chaplains provide spiritual counseling/guidance, lead services, provide moral support to staff and patients.
		- Tx of spirituality concerns (grieving, crises of faith).
		- Work collaboratively with MH in interdisciplinary tx and training teams.
		- Provide connection with community clergy.
		- Challenges:
		  - Limited time for Chaplains to interact with outpatient care.
		  - Little to no
			- Chaplains help patients ***and families*** recognize and strengthen personal beliefs.
			- Veterans more willing to talk to Chaplains than other MH.
			- Interest in collaboration, especially where there is familiarity with chaplaincy.
			- Education is important – training seminary students in clinical care and vice versa.
			- Challenges:
			  - Health care providers unaware of chaplaincy services.
				[No notes provided.]

		interaction between MH & Chaplains in some locations. - "Turf issues."	- Limited time for Chaplains to interact with outpatients. - Proximity & relationship issues. - Workload, limited resources.	

Table 2: Models for Integration (Breakout #2)

Question 1: From your perspective and experience, what appear to be the spiritual needs of Veterans, Service members, and family members? Which of these needs are not being optimally met by the current system?

- Reconnect with spiritual side[3+]
- Safe environment to tell their story[3+]
- Help formulating and understanding spiritual aspects of MH issues[1]
- Help with moral injury, forgiveness, freedom from shame and guilt[4++]
- Loss of faith and how to reintegrate into the family after loss of faith[4+]
- Building healthy relationships with family, community[4+]
- Bereavement care for families and access to care after the Veteran has died[1]

Question 2: In order for a more optimally integrated model of care to be effective, what are the educational needs of chaplains, mental health providers, other health care providers, clergy and community leaders, Veterans and Service members, and other stakeholders?

- Educate family, build trust and partnerships with community[1]
- True integration requires collaboration among all groups[2]
- Educate MH providers on religion/spirituality issues[3+]
- Educate chaplains on MH issues (e.g. diagnoses, clinical issues)[4+]
- Educate patients on benefits of spirituality[1]
- Cross-training on multiple disciplines[4++]
- One-on-one training/mentoring[1]
- Define provider roles and how providers can help each other[2]
- Training for specific MH issues (especially suicide prevention)[2]
- Communication and understanding of one another's needs[1]

Question 3: If you could specify roles for providers and participants (chaplains, mental health providers, primary care providers, clergy, community leaders, Veterans / Service members, family members) in a more integrated system of care, what would those roles be?

- "Roles" are not helpful; there is already an obsession with "lanes." Should be organic, flexible, and based on individual relationships.[2+]
- Chaplaincy consult offered for patients with various physical and MH issues.[1]
- Meet and greet sessions where there are team building times to build working relationships on an out of work context.[1]
- Chaplains would partner with mental health providers in encouraging community provider connections.[1]
- Flexibility and time for MH and Chaplains to decide ***with*** Veteran what will be helpful.[1]
- Primary and secondary ***integrated*** systems of care.[3+]
- Chaplains can serve as liaisons, outpatient clinicians, sources of referral.[2]
- Having Chaplains who are also trained in another "language" is beneficial.[1]
- Provide a safe place for patients to express themselves.[1]
- Use simple, common language that patients (and each other) can understand.[1]

Attendee comments of less thematic importance are not listed in the table.
[1-4] Denotes number of groups in which theme was identified.
[+] Theme was significantly emphasized in 1-2 of the group discussions.
[++] Theme was significantly emphasized in 3-4 of the group discussions.

Table 3: Barriers to Integration (Breakout #3)

Barrier	Proposed Solutions / Comments
1. There is a lack of cross-training between chaplains in VA and DoD.	- Leverage Reserve centers as liaison points between VA and DoD.[+] - Leverage Yellow Ribbon events as liaison points between VA and DoD.[+] - Create formal cross-training opportunities.[2,4,8,12+] - Encourage cross-training through informal channels (networking, local meetings, etc.).[2,4+]
2. Professional roles can be blurred between mental health providers and chaplains.	- Think of roles as integrated rather than trying to separate, might also help in actually integrating the roles.[6,12+] - Try to know and understand boundaries, but do not sacrifice patient care by refusing to discuss a need if it falls outside specific roles. - Collaborate; avoid getting too turf-y and fearful about having person-centered conversations. - Increase knowledge of what each member of the team does and how everyone can work together while respecting each other's roles.[+] - Leverage formal and informal opportunities to develop collaborative relationships with other professionals.[1,4,8,12] - Clear encouragement and provision of resources at the local and leadership levels collaboration to facilitate collaboration.
3. Chaplains and mental health providers can have different concepts of health, goals, and desired outcomes.	- Concern about emphasis on clinical setting in VA vs. outcomes in DoD. - Create strategic vision institution-wide by funding, manning, and documenting teams/units with resources to provide capabilities to fulfill needs. - Standardize and validate larger programs/processes across entire systems.[+]
4. Chaplains and mental health providers can have discomfort with the other specialty's topic of expertise.	- Hold education/training workshops and conferences to provide cross-training of chaplains and MH providers.[1,2,8,12+] - Communicate with each other, both within and across disciplines – "Physicians talking about the importance of spirituality may have more impact with other physicians than a chaplain would."
5. Resources – staffing, time, funding – are inadequate to achieve integrative objectives.	- Leveraging extant research as opposed to solely relying on new. - Leverage implementation experts and their expertise. - Change from the bottom up.[+]
6. Chaplaincy is subject to pressure to be subsumed by medical model and to pathologize spiritual issues.	- Chaplains claiming that which is theirs.[+] - Embrace integration of different fields in patient care team.[2,12+]
7. The reputation of chaplaincy can be damaged due to former chaplains proselytizing.	- Chiefs and chaplains are charged with advocating for protection from proselytizing across the board.[+] - This can be very destructive; does not happen often, but even one occurrence can be very damaging. - Communicate that proselytizing is not a goal of chaplaincy.[+]
8. Many chaplains and mental	- Create mentoring programs.

health providers lack the personal and professional relationships that would foster collaboration.	- Create mixed discipline training opportunities.[1,2,4,12+] - Create collaborative training and educational programs.[1,2,4,12+] - Recruit and hire personnel steeped in two or more disciplines.
9. Differences in culture and regulations (e.g., confidentiality) exist between mental health and chaplaincy, as well as between VA and DoD.	- Communicate with patients to gain permission to discuss tx with others on the tx team.[+] - Communicate with one another to share "home-grown" successful strategies.
10. There is not enough collaboration with communities (e.g., Vet Centers, FAPs, families).	- Take time to develop relationships and understand one another. - Increase resources (Chaplain staffing) to meet recognized needs. - Provide basic training to Chaplains, connect family with local clergy. - Bring nurses and other care providers into communication.[+]
11. Many chaplains fear and/or resist moving toward evidence based practice.	- Need increased knowledge of available measures, effectiveness of measures, agreement of what to measure and how. - Need to reduce resistance to measuring outcomes - identify expectations and best ways to measure.[+]
12. Chaplains and mental health providers may not share a common value system.	- Provide cross-training and education to share knowledge and skills between Chaplains and MH providers.[1,2,4,8+] - Make MH therapy more holistically focused through integrated care[2,6.]

Barriers 1-3 were addressed by Breakout Group E, 4-6 by Group F, 7-9 by Group G, and 10-12 by Group H.

[+] Solution or comment was particularly emphasized in the group discussion and recognized as important.

[1-12] Denotes other barriers for which this solution / comment was also discussed.

APPENDIX F

CHAPLAIN DOCUMENTATION PRACTICES SUB-TASK GROUP CALLS

Documentation Practices Task Group
For
VA / DoD Integrated Mental Health Strategy (IMHS)
Strategic Action #23: Chaplains' Roles

IMHS Strategic Action #23 Overview:

The overall mission of the VA / DoD Integrated Mental Health Strategy (IMHS) is for the VA and DoD to advance an integrated and coordinated public health model to improve the access, quality, effectiveness, and efficiency of mental health services for all Active Duty Service members, National Guard and Reserve members, Veterans, and their families. The VA / DoD IMHS consists of 28 specific strategic actions, with Strategic Action #23 focusing on the role of chaplains. The aim of SA #23 is to include input and expertise from DoD Chaplains in defining the role of VA Chaplain Services and community clergy in mental health care at VA medical centers and clinics. The functional end states of SA #23 are 1) Increased support of continuity in the role of the chaplain between the Services and VA; and 2) Improved identification of how to facilitate access to mental health care through collaboration with community clergy and faith communities to promote care in a way that is consistent with the values and preferences of the many individuals we serve.

Documentation Practices Task Group Overview:

In order for SA #23 to have a meaningful impact, it is crucial to examine the documentation practices of chaplains in VA and DoD. Documentation practices are at the heart of how clinical information is conveyed between professionals. Appropriate documentation of services facilitates effective clinical care, whereas insufficient or ambiguous documentation of services impedes the continuity of care. The purpose of this IMHS SA #23 sub-task group on documentation practices is to describe the existing documentation practices of VA and DoD chaplains and to determine approaches for improving the documentation of chaplain services in a manner that honors the distinct policies regarding chaplain confidentiality and contributes to enhanced spiritual and mental health care for Service members, Veterans, and their families.

Task Group Goals & Objectives:

6. Describe the state of existing and planned documentation practices in VA and DoD, including information on the field as a whole and on existing best practices.
7. Share information about approaches to documentation that have been attempted in the past, with specific attention to those aspects of past approaches that have worked well and those that have not worked well (i.e., lessons learned).
8. As a group, articulate a vision for documentation practices that incorporates long-term goals and achievable near-term objectives with specific steps for implementation.
9. Delineate who are stakeholders and how to most effectively engage them.

10. Identify barriers to accomplishing the agreed upon vision for documentation practices and offer potential solutions for approaching these barriers.

Task Group Calls:

Group members will take part in three 90-minute conference calls. The purpose of these calls will be to complete the above described goals and objectives in a systematic manner that allows for input from sub-task group members to be captured and reported as part of the IMHS SA #23 final report. The calls will take place from 2:30-4:00 EST on the first Thursdays of December, January, and February. The schedule with dial-in information is as follows:

December 1, 2011, 2:30 - 4:00 EST (Call-in: **1-800-767-1750; Pass code: 23617**)

January 5, 2012, 2:30 - 4:00 EST (Call-in: **1-800-767-1750; Pass code: 23617**)

February 2, 2012, 2:30 - 4:00 EST (Call-in: **1-800-767-1750; Pass code: 23617**)

Task Group Members:

- Shelia Robertson, CAPT, MDiv, CHC, USN, Chaplain of Naval Medicine (M00G), Special Assistant for Pastoral Care, Bureau of Navy Medicine
- Jessie Tate, CAPT, MDiv, CHC, USN, Fleet Chaplain at USFFC, Portsmouth Naval Hospital, Navy Medicine East
- Abdul R. Muhammad Sr., LTC, MSW, Program Manager for the Behavioral Health Program, Health Promotion and Wellness Directorate, US Army Public Health Command (presenting Jan 5)
- George Handzo, MDiv, Vice President, Chaplaincy Care Leadership and Practice, Healthcare Chaplaincy (presenting on Dec 1)
- John Milewski, KCHS, MDiv, Associate Director, National Chaplain Center (presenting on Dec 1)
- Thomas Mills, MDiv, Protestant Staff Chaplain, Danville VAMC (presenting Jan 5)
- Carla Cherry, MDiv, THM, BCC, Chaplain, Columbus VAACC
- David Ballantyne, DMin, BCC, AAMFT, Chaplaincy Program Manager, Coatesville VAMC
- Kent Drescher, PhD, MDiv, Health Science Specialist, Palo Alto VAMC – National Center for PTSD
- Bill Cantrell, MDiv, Chaplain for Education and Research, VA Mental Health & Chaplaincy
- Mark Bates, PhD, Director, Resilience and Prevention, Defense Center of Excellence (DoD SA #23 Lead)
- Keith Meador, MD, ThM, MPH, Director, VA Mental Health & Chaplaincy (VA SA #23 Lead)
- Jeff Rhodes, DMin, Contract Support for Defense Center of Excellence Traumatic Brain Injury Resilience and Prevention Directorate (DoD SA #23 Co-lead)
- Jason Nieuwsma, PhD, Associate Director, VA Mental Health & Chaplaincy (VA SA #23 Co-lead)

First Conference Call Meeting
For
VA / DoD IMHS SA #23
Documentation Practices Task Group

Date: December 1, 2011
Time: 2:30 p.m. – 4:00 p.m. EST
Dial-in: 1-800-767-1750; Pass code: 23617

Agenda:

2:30 10-minute introduction of task group and members
2:40 15-minute presentation from Dr. George Handzo
2:55 15-minute presentation from Chaplain John Milewski
3:10 45-minute group discussion*
3:55 5-minute wrap-up and preview next call

Group Discussion Questions:

1. Describe the similarities and differences between current practices with regard to documentation of chaplain services in VA and DoD.

2. Discuss important "lessons learned" with regard to different approaches to documentation, benefits or drawbacks of documenting services, and attempts to change how chaplains document the services that they provide.

3. How can continuity of mental and spiritual care between VA and DoD be optimized via documentation of chaplain services?

4. Ideally, how would you envision chaplains documenting their services in a manner that best meets the needs of chaplains, mental health care providers, other health care providers, administration, and Service members / Veterans?

5. Based on the group discussion, identify tangible next steps necessary to accomplish the vision.

* Group discussion will be guided by both the presentations and the above questions.

Second Conference Call Meeting
For
VA / DoD IMHS SA #23
Documentation Practices Task Group

Date: January 5, 2012
Time: 2:30 p.m. – 4:00 p.m. EST
Dial-in: 1-800-767-1750; Pass code: 23617

Agenda:

2:30 10-minute housekeeping and introduction to call
2:40 15-minute presentation from Chaplain Abdul Muhammad
2:55 15-minute presentation from Chaplain Thomas Mills
3:10 45-minute group discussion*
3:55 5-minute wrap-up and preview next call

Group Discussion Questions:

1. With respect to the documentation of services provided by chaplains, what are the needs of patients, chaplains, mental health care providers, other health care providers, and administration?

2. Who are the stakeholders to involve in any attempt to modify chaplains' documentation of services (particularly with respect to mental health care), and how can these stakeholders be most effectively engaged?

3. What barriers exist to modifying chaplains' documentation practices? What barriers exist to enhancing continuity of documentation between VA and DoD?

4. What are potential approaches to problem-solving around noted barriers?

5. How might educating VA and DoD chaplains via joint specialty trainings in mental health issues best approach documentation of chaplain services?

* Group discussion will be guided by both the presentations and the above questions.

Final Conference Call Meeting
For
VA / DoD IMHS SA #23
Documentation Practices Task Group

Date: February 2, 2012
Time: 2:30 p.m. – 4:00 p.m. EST
Dial-in: 1-800-767-1750; Pass code: 23617

Agenda:

- Roll call, housekeeping, and introduction to call
- Review of tables generated from first two calls
- Group Discussion Questions
- Wrap-up and look toward March 19 meeting

Group Discussion Questions:

1. What could/should mental health providers gain from attending to chaplains' notes? For those mental health professionals not currently devoting attention to chaplains' notes, how do we convince them of the utility of doing so?

2. Is standardization of chaplain documentation practices feasible across VA and DoD settings? What is feasible with respect to enhancing continuity of care for Veterans and Service members in this domain?

3. If mental health were to engage with chaplaincy around training experiences, what should each discipline (i.e., mental health and chaplaincy) bring to the trainings with regard to education in documentation practices?

4. See "Summary of Challenges" at the bottom of page 6 from the table summarizing our second conference call. Are there any other "barriers" to add to this list? How do we best approach these challenges?

5. Who are the stakeholders that need to be engaged in VA and in the different branches of the military moving forward?

APPENDIX G: ASSESSMENT AND SCREENING PRACTICES SUB-TASK GROUP CALLS

Assessment and Screening Practices Task Group
For
VA / DoD Integrated Mental Health Strategy (IMHS)
Strategic Action #23: Chaplains' Roles

IMHS Strategic Action #23 Overview:

The overall mission of the VA / DoD Integrated Mental Health Strategy (IMHS) is for the VA and DoD to advance an integrated and coordinated public health model to improve the access, quality, effectiveness, and efficiency of mental health services for all Active Duty Service members, National Guard and Reserve members, Veterans, and their families. The VA / DoD IMHS consists of 28 specific strategic actions, with Strategic Action #23 focusing on the role of chaplains. The aim of SA #23 is to include input and expertise from DoD Chaplains in defining the role of VA Chaplain services and community clergy in mental health care at VA medical centers and clinics. The functional end states of SA #23 are 1) Increased support of continuity in the role of the chaplain between the Services and VA; and 2) Improved identification of how to facilitate access to mental health care through collaboration with community clergy and faith communities to promote care in a way that is consistent with the values and preferences of the many individuals we serve.

Documentation Practices Task Group Overview:

In order for SA #23 to have a meaningful impact, it is crucial to examine the assessment and screening practices of chaplains in VA and DoD. Assessment and screening practices are central to determining appropriate care services for Veterans and Service members. Spiritual assessment and screening instruments have the capacity to help identify persons in need of chaplain services, contribute to creating a plan of care, allow for clinical changes to be tracked over time, and assist in the triaging of care between professionals. The purpose of this IMHS SA #23 sub-task group on assessment and screening practices is to describe the existing practices of VA and DoD chaplains and to determine approaches for improving the use of assessment and screening tools in a manner that contributes to enhanced spiritual and mental health care for Service members, Veterans, and their families.

Task Group Goals & Objectives:

1. Describe the state of the development and implementation of spiritual assessments and screening practices in VA and DoD, including information on the field as a whole and on existing best practices.
2. Share information about spiritual assessments and screening approaches that have been used in the past, with specific attention to those aspects of past approaches that have worked well and those that have not worked well (i.e., lessons learned).
3. As a group, articulate a vision for spiritual assessments and screening practices that incorporates long-term goals and achievable near-term objectives with specific steps for implementation.
4. Delineate who are stakeholders and how to most effectively engage them.

5. Identify barriers to accomplishing the agreed upon vision for spiritual assessments and screening practices and offer potential solutions for approaching and overcoming these barriers.

Task Group Calls:

Group members will take part in three 90-minute conference calls. The purpose of these calls will be to complete the above described goals and objectives in a systematic manner that allows for input from sub-task group members to be captured and reported as part of the IMHS SA #23 final report. The calls will take place from 2:30-4:00 EST on the second Mondays of December, January, and February. The schedule with dial-in information is as follows:

December 12, 2011, 2:30 - 4:00 EST (Call-in: **1-800-767-1750; Pass code: 23617**)

January 9, 2012, 2:30 - 4:00 EST (Call-in: **1-800-767-1750; Pass code: 23617**)

February 13, 2012, 2:30 - 4:00 EST (Call-in: **1-800-767-1750; Pass code: 23617**)

Task Group Members:

- Shelia Robertson, CAPT, MDiv, CHC, USN, Chaplain of Naval Medicine (M00G), Special Assistant for Pastoral Care, Bureau of Navy Medicine (presenting Dec 12)
- Robert Wichman, LTC, CHC, HQ, US Army Medical Command
- Abdul R. Muhammad Sr., LTC, MSW, Program Manager for the Behavioral Health Program, Health Promotion and Wellness Directorate, US Army Public Health Command (presenting Jan 9)
- Steven Richardson, MAJ, Chaplain, US Air Force
- Keith Ethridge, Chaplain, Director, VA National Chaplain Center
- Theodore (Ted) Bleck-Doran, Chaplain, Chief, Mountain Home, TN (presenting Jan 9)
- William Kinnaird, Chaplain, Associate Director, National Chaplain Center (presenting Dec12)
- George Fitchett, PhD, Associate Professor, Director of Research, Rush University
- John Paul Allen, PhD, MPA, National Mental Health Program Director, Addictive Disorders
- Bill Cantrell, MDiv, Chaplain for Education and Research, VA Mental Health & Chaplaincy
- Mark Bates, PhD, Director, Resilience and Prevention, Defense Center of Excellence (DoD SA #23 Lead)
- Keith Meador, MD, ThM, MPH, Director, VA Mental Health & Chaplaincy (VA SA #23 Lead)
- Jeff Rhodes, DMin, Contract Support for Defense Center of Excellence Traumatic Brain Injury Resilience and Prevention Directorate (DoD SA #23 Co-lead)
- Jason Nieuwsma, PhD, Associate Director, VA Mental Health & Chaplaincy (VA SA #23 Co-lead)

First Conference Call Meeting
For
VA / DoD IMHS SA #23
Assessment and Screening Practices Task Group

Date: December 12, 2011
Time: 2:30 p.m. – 4:00 p.m. EST
Dial-in: 1-800-767-1750; Pass code: 23617

Agenda:

2:30 10-minute introduction of task group and members
2:40 15-minute presentation from Chaplain Shelia Robertson
2:55 15-minute presentation from Chaplain Will Kinnaird
3:10 45-minute group discussion*
3:55 5-minute wrap-up and preview next call

Group Discussion Questions:

1. Describe the similarities and differences between current use of spiritual assessment and screening tools in VA and DoD.

2. Discuss important "lessons learned" with regard to use of spiritual assessment and screening tools, benefits or drawbacks to using these tools, and attempts to change how chaplains use assessments and screens.

3. How can continuity of mental and spiritual care between VA and DoD be optimized via use of spiritual assessment and screening tools?

4. Ideally, how would you envision chaplains utilizing spiritual assessments and screens in a manner that best meets the needs of chaplains, mental health care providers, other health care providers, administration, and Service members / Veterans?

5. Based on the group discussion, identify tangible next steps necessary to accomplish the vision.

* Group discussion will be guided by both the presentations and the above questions.

Second Conference Call Meeting
For
VA / DoD IMHS SA #23
Assessment and Screening Practices Task Group

Date: January 9, 2012
Time: 2:30 p.m. – 4:00 p.m. EST
Dial-in: 1-800-767-1750; Pass code: 23617

Agenda:

2:30 10-minute housekeeping and introduction to call
2:40 15-minute presentation from Chaplain Abdul Muhammad
2:55 15-minute presentation from Chaplain Ted Bleck-Doran
3:10 45-minute group discussion*
3:55 5-minute wrap-up and preview next call

Group Discussion Questions:

1. To what extent do spiritual screens result in chaplains utilizing their time to care for Veterans and Service members who are most in need of and most likely to benefit from chaplain services?

2. How are spiritual assessments used to guide the follow-up care that is provided by both chaplains and other health care providers?

3. What barriers exist to making good clinical use of spiritual assessments in DoD and in VA?

4. What are potential approaches to problem-solving around noted barriers?

5. How might training in the use of spiritual assessments be optimally incorporated into chaplain education on mental health issues?

* Group discussion will be guided by both the presentations and the above questions.

Final Conference Call Meeting
For
VA / DoD IMHS SA #23
Assessment and Screening Practices Task Group

Date: February 13, 2012
Time: 2:30 p.m. – 4:00 p.m. EST
Dial-in: 1-800-767-1750; Pass code: 23617

Agenda:

- Roll call, housekeeping, and introduction to call
- 15-min presentation from Dr. George Fitchett
- Review of tables generated from first two calls
- Group Discussion Questions
- Wrap-up and look toward March 19 meeting

Group Discussion Questions:

1. What could/should mental health providers learn from reviewing a spiritual assessment conducted by a chaplain? How can results from spiritual assessments be communicated in a way that more effectively engages mental health care professionals?

2. With respect to continuity of care for Veterans and Service members, is there a common thread that runs through all chaplain assessments that other health care professionals could come to expect?

3. The issue of professional boundaries between chaplains and health care providers came up multiple times on the first two calls. What should be guiding principles for establishing appropriate boundaries with respect to assessment and screening?

4. See "Barriers to use of spiritual assessments" on pages 6-7 of the table summarizing our second conference call (including: lack of education on assessment tools; tradition of training; setting / context; distrust of numerical approach; dislike of assessment; staffing / spread too thin). Are there any other "barriers" to add to this list? How do we best approach these challenges?

5. Who are the stakeholders that need to be engaged in VA and in the different branches of the military moving forward?

APPENDIX H

CHAPLAIN SURVEY CODEBOOKS – VA, DoD

The survey organization consists of 3 parts:

1. **Core Survey**: this should take approximately 20 minutes to complete.
2. **Demographics**: these come at the end of the Core Survey with explicit instructions emphasizing that answering the questions is **voluntary**.
3. **Supplemental Survey**: this should take around 15 minutes to complete.

Chaplain Survey – Final Instrument

Introduction

Thank you for your time in completing the Survey of Chaplains' Roles in support of the Department of Defense (DoD) and Department of Veterans Affairs (VA) Integrated Mental Health Strategy (IMHS). Your feedback will be crucial to accomplishing the objectives of the DoD/VA IMHS in constructing more optimally integrated systems of care for our Service members and Veterans.

[FILL CLIENT] throughout survey, DoD respondent = "Service member" and VA respondent = "Veteran"

Are you a Chaplain?

☐	Yes **[GO TO NEXT ITEM]**	440 (100.0)	**1723 (100.0)**
☐	No **[Do not enter survey. Show participant, "Thank you for your interest, but this is a survey to be completed by DoD or VA Chaplains. Since you indicated that you are not a Chaplain, you are not eligible to participate in this survey."]**		

With which organization do you serve? [GO TO 1] [USE TO TRIGGER APPROPRIATE SKIPS]

☐	Department of Defense (DoD)	0 (0.0)	**1723 (100.0)**
☐	Veterans' Affairs (VA)	440 (99.8)	**0 (0.0)**

KEY:

VA Sample – Regular Font

DoD Sample – Bold Font

Populations

This section asks questions about the individuals you serve in your work as a chaplain.

1. In the course of your work as a chaplain, how often do you encounter each of the following types of individuals?

	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
a. Active duty Service members	64 (15.1) **0**	195 (46.1) **5 (0.3)**	79 (18.7) **4 (0.2)**	49 (11.6) **13 (0.8)**	36 (8.5) **1692 (98.7)**
b. Reserve or National Guard	48 (11.5) **94 (5.7)**	131 (31.4) **409 (24.7)**	108 (25.9) **330 (19.9)**	80 (19.2) **444 (26.8)**	50 (12.0) **381 (23.0)**
c. Veterans (not active or reserve duty)	12 (2.8) **111 (6.7)**	4 (0.9) **302 (18.3)**	2 (0.5) **225 (13.6)**	25 (5.8) **550 (33.3)**	390 (90.1) **463 (28.0)**

2. When you provide care for Service members or Veterans, how often do you see them...

a. individually	0 **9 (0.5)**	7 (1.6) **67 (4.0)**	12 (2.8) **85 (5.0)**	107 (24.8) **616 (36.3)**	305 (70.8) **919 (54.2)**
b. with spouse or partner	21 (5.0) **46 (2.8)**	91 (21.6) **270 (16.2)**	68 (16.2) **379 (22.7)**	154 (36.6) **824 (49.4)**	87 (20.7) **149 (8.9)**
c. with family other than spouse/partner	26 (6.3) **175 (10.6)**	113 (27.4) **647 (39.0)**	77 (18.6) **343 (20.7)**	124 (30.0) **407 (24.6)**	73 (17.7) **85 (5.1)**
d. in a group with other Service members or Veterans	36 (8.5) **260 (15.6)**	61 (14.4) **401 (24.1)**	54 (12.8) **290 (17.4)**	183 (43.3) **482 (28.9)**	89 (21.0) **234 (14.0)**

3. How often do you encounter:

a. Homeless **[FILL CLIENT]**	13 (3.0) **1083 (63.9)**	45 (10.4) **487 (28.7)**	63 (14.5) **79 (4.7)**	128 (29.6) **38 (2.2)**	184 (42.5) **8 (0.5)**
b. Family of **[FILL CLIENT]** without **[FILL CLIENT]** present	31 (7.2) **143 (8.4)**	120 (27.8) **544 (32.1)**	75 (17.4) **460 (27.1)**	124 (28.7) **404 (23.8)**	82 (19.0) **145 (8.5)**
c. **[VA ONLY]** WWII era Veterans	7 (1.6)	55 (12.7)	57 (13.2)	107 (24.8)	206 (47.7)
d. **[VA ONLY]** Korean War era Veterans	7 (1.6)	34 (7.8)	64 (14.7)	124 (28.4)	207 (47.5)
e. **[VA ONLY]** Vietnam War era Veterans	0	7 (1.6)	22 (5.1)	95 (21.9)	310 (71.4)
f. **[VA ONLY]** Gulf War era Veterans	4 (0.9)	28 (6.5)	66 (15.3)	138 (31.9)	196 (45.4)
g. **[VA ONLY]** Post 9/11 era Veterans (e.g., OEF/OIF)	6 (1.4)	47 (10.9)	79 (18.3)	131 (30.3)	169 (39.1)
h. **[VA ONLY]** Veterans of other conflicts	23 (5.5)	100 (23.8)	80 (19.0)	104 (24.8)	113 (26.9)
i. **[VA ONLY]** Veterans who did not serve in a conflict	6 (1.4)	22 (5.1)	57 (13.2)	114 (26.5)	232 (53.8)

4. How often do you come into contact with Veterans in the following ways?

	Never	Rarely	Sometimes	Frequently	Almost always
a. **[FILL CLIENT]** come to me on their own without referral.	3 (0.7) **5 (0.3)**	23 (5.3) **23 (1.4)**	113 (26.0) **158 (9.3)**	215 (49.5) **882 (52.0)**	80 (18.4) **629 (37.1)**
b. I go to **[FILL CLIENT]** without them being referred to me.	3 (0.7) **21 (1.2)**	18 (4.1) **145 (8.6)**	43 (9.9) **443 (26.2)**	154 (35.3) **806 (47.7)**	218 (50.0) **274 (16.2)**
c. **[VA ONLY]** Veterans are referred to me by other professionals.	3 (0.7)	19 (4.4)	143 (33.0)	210 (48.5)	58 (13.4)
d. **[DoD ONLY]** Service members are referred to me by their commanding officers.	0 **24 (1.4)**	0 **201 (12.0)**	0 **830 (49.3)**	0 **559 (33.2)**	0 **68 (4.0)**
e. **[VA ONLY]** Veterans are referred to me by their fellow Veterans.	10 (2.3)	70 (16.2)	197 (45.7)	123 (28.5)	31 (7.2)

f.	**[DoD ONLY]** Service members are referred to me by their fellow Service members.	0 **11 (0.6)**	0 **123 (7.3)**	0 **756 (44.7)**	0 **720 (42.5)**	0 **83 (4.9)**
g.	**[FILL CLIENT]** are referred to me by **non-[FILL CLIENT]** family or friends.	26 (6.0) **73 (4.3)**	151 (34.9) **560 (33.1)**	181 (41.8) **793 (46.9)**	59 (13.6) **236 (13.9)**	16 (3.7) **30 (1.8)**

5. For each of the below issues, please provide two ratings. First, rate how often you see Veterans with the below problems. Second, indicate how well your training has prepared you to provide pastoral care to Veterans with the problems listed below.

	1. How often?			**2. How well has training prepared?**		
	Rarely	**Sometimes**	**Frequently**	**Not Prepared**	**Somewhat Prepared**	**Very Prepared**
a. Anxiety	2 (0.5) **108 (6.4)**	99 (22.8) **786 (46.9)**	334 (76.8) **782 (46.7)**	4 (0.9) **52 (3.1)**	107 (24.8) **658 (39.4)**	321 (74.3) **960 (57.5)**
b. Guilt	7 (1.6) **246 (14.7)**	130 (30.0) **1060 (63.5)**	297 (68.4)3 **362 (21.7)**	0 **37 (2.2)**	78 (18.0) **422 (25.2)**	355 (82.0) **1213 (72.5)**
c. Depression	2 (0.5) **87 (5.2)**	131 (30.5) **864 (51.8)**	296 (69.0) **716 (43.0)**	8 (1.9) **85 (5.1)**	154 (35.8) **777 (46.8)**	268 (62.3) **799 (48.1)**
d. Posttraumatic stress	7 (1.6) **368 (22.2)**	139 (32.2) **997 (60.1)**	286 (66.2) **293 (17.7)**	10 (2.3) **192 (11.6)**	204 (47.7) **907 (54.8)**	214 (50.0) **555 (33.6)**
e. Traumatic brain injury (TBI)	119 (28.0) **1178 (71.1)**	234 (55.1) **419 (25.3)**	72 (16.9) **59 (3.6)**	101 (23.9) **748 (45.3)**	242 (57.2) **727 (44.0)**	80 (18.9) **177 (10.7)**
f. Psychosis	74 (17.4) **1204 (72.8)**	192 (45.1) **423 (25.6)**	160 (37.6) **27 (1.6)**	64 (15.1) **819 (49.6)**	239 (56.5) **673 (40.7)**	120 (28.4) **160 (9.7)**
g. Anger	6 (1.4) **46 (2.8)**	131 (30.4) **699 (42.5)**	291 (68.1) **900 (54.7)**	4 (0.9) **22 (1.3)**	123 (28.7) **564 (34.3)**	301 (70.3) **1058 (64.4)**
h. Difficulty forgiving others	18 (4.3) **184 (11.2)**	165 (39.1) **950 (57.8)**	239 (56.6) **510 (31.0)**	1 (0.2) **17 (1.0)**	76 (18.0) **289 (17.5)**	346 (81.8) **1341 (81.4)**
i. Work stress	55 (13.2) **21 (1.3)**	230 (55.2) **390 (23.8)**	132 (31.7) **1230 (75.0)**	8 (1.9) **17 (1.0)**	161 (38.6) **392 (24.0)**	248 (59.5) **1226 (75.0)**
j. Relationship or family stress	7 (1.7) **19 (1.2)**	175 (41.4) **308 (18.8)**	241 (57.0) **1315 (80.1**)	1 (0.2) **13 (0.8**)	118 (27.9) **303 (18.4)**	304 (71.9) **1333 (80.8)**
k. Sleep problems	102 (24.3) **521 (31.8)**	214 (51.0) **883 (53.8)**	104 (24.8) **236 (14.4)**	113 (27.0) **408 (24.9)**	231 (55.1) **903 (55.2)**	75 (17.9) **325 (19.9)**
l. Spiritual struggle understanding loss/trauma	5 (1.2) **112 (6.8)**	128 (30.3) **950 (57.3)**	290 (68.6) **596 (35.9)**	2 (0.5) **12 (0.7)**	73 (17.3) **265 (16.0)**	348 (82.3) **1379 (83.3)**
m. Suicidal thoughts/intentions	67 (16.0) **318 (19.1)**	233 (55.6) **1081 (65.1)**	119 (28.4) **262 (15.8)**	13 (3.1) **20 (1.2)**	163 (38.7) **330 (19.9)**	245 (58.2) **1308 (78.9)**
n. Financial problems	70 (16.5) **278 (16.8)**	203 (48.0) **1013 (61.3)**	150 (35.5) **362 (21.9)**	71 (16.8) **114 (6.9)**	242 (57.2) **740 (44.8)**	110 (26.0) **796 (48.2)**
o. Legal problems	126 (29.6) **462 (27.9)**	223 (52.3) **1026 (61.9)**	77 (18.1) **169 (10.2)**	170 (39.7) **419 (25.2)**	207 (48.4) **921 (55.4)**	51 (11.9) **322 (19.4)**
p. Homelessness	47 (10.9) **1550 (93.3)**	184 (42.6) **98 (5.9)**	201 (46.5) **14 (0.8)**	48 (11.1) **728 (43.6)**	236 (54.8) **760 (45.5)**	147 (34.1) **182 (10.9)**
q. Difficulty forgiving self	18 (4.2) **264 (16.0)**	160 (37.0) **1085 (65.9)**	255 (58.9) **298 (18.1)**	4 (0.9) **17 (1.0)**	85 (19.9) **344 (20.9)**	339 (79.2) **1282 (78.0)**
r. Sexual assault victimization	162 (37.5) **916 (55.8)**	199 (46.1) **669 (40.7)**	71 (16.4) **57 (3.5)**	69 (16.1) **117 (7.1)**	248 (57.9) **879 (53.4)**	111 (25.9) **649 (39.5)**
s. Sexual assault perpetration	273 (63.9) **1323 (80.3)**	132 (30.9) **310 (18.8)**	22 (5.2) **15 (0.9)**	120 (28.2) **292 (17.8)**	249 (58.6) **899 (54.7)**	56 (13.2) **452 (27.5)**
t. Domestic violence victimization	166 (38.9) **714 (43.6)**	219 (51.3) **854 (52.2)**	42 (9.8) **69 (4.2**)	49 (11.5) **115 (7.0)**	256 (60.2) **880 (53.7)**	120 (28.2) **644 (39.3**)
u. Domestic violence perpetration	227 (53.7) **1028 (62.7)**	169 (40.0) **567 (34.6)**	27 (6.4) **44 (2.7)**	88 (20.7) **206 (12.6)**	250 (58.7) **914 (55.8)**	88 (20.7) **518 (31.6)**
v. Struggle accepting significant life events	18 (4.2) **152 (9.3)**	173 (40.7) **938 (57.3)**	234 (55.1) **548 (33.5)**	3 (0.7) **27 (1.6)**	138 (32.5) **456 (27.8)**	284 (66.8) **1155 (70.5)**
w. Alcohol abuse	15 (3.6) **445 (27.3)**	96 (22.7) **935 (57.3)**	311 (73.7) **252 (15.4)**	15 (3.6) **119 (7.3)**	133 (31.5) **856 (52.7**)	274 (64.9) **649 (40.0)**
x. Illicit drug use	32 (7.6) **1051 (64.6)**	139 (32.9) **514 (31.6)**	252 (59.6) **61 (3.8)**	34 (8.0) **274 (16.9)**	156 (36.9) **874 (53.8)**	233 (55.1) **477 (29.4)**

y. Prescription drug misuse	91 (21.7) **1171 (72.3)**	186 (44.3) **409 (25.2)**	143 (34.0) **40 (2.5)**	54 (12.8) **339 (20.9)**	179 (42.4) **874 (53.9)**	189 (44.8) **409 (25.2)**
z. Physical health problems	15 (3.6) **430 (26.3)**	90 (21.6) **914 (55.9)**	311 (74.8) **290 (17.7)**	17 (4.1) **170 (10.4)**	155 (37.2) **871 (53.4)**	245 (58.8) **591 (36.2)**
aa. Difficulty accepting forgiveness	25 (6.0) **434 (26.6)**	167 (40.0) **941 (57.7)**	225 (54.0) **257 (15.7)**	1 (0.2) **26 (1.6)**	82 (19.7) **334 (20.5)**	333 (80.0) **1273 (78.0)**
bb. Chronic pain	28 (6.6) **883 (54.4)**	187 (44.2) **626 (38.6)**	208 (49.2) **113 (7.0)**	63 (14.9) **452 (27.7)**	224 (53.0) **855 (52.4)**	136 (32.2) **324 (19.9)**
cc. Moral injury	30 (7.1) **428 (26.2)**	198 (47.0) **971 (59.5)**	193 (45.8) **232 (14.2)**	9 (2.1) **43 (2.6)**	133 (31.5) **578 (35.4)**	280 (66.4) **1012 (62.0)**
dd. Separation/Discharge from the military	168 (40.1) **303 (18.5)**	177 (42.2) **954 (58.4)**	74 (17.7) **377 (23.1)**	60 (14.3) **82 (5.0)**	219 (52.1) **703 (43.2**)	141 (33.6) **843 (51.8)**
ee. Struggle with religious belief system	16 (3.7) **247 (15.1)**	183 (42.6) **1018 (62.2)**	231 (53.7) **372 (22.7)**	3 (0.7) **11 (0.7)**	52 (12.1) **156 (9.5)**	375 (87.2) **1476 (89.8)**
ff. Other spiritual struggle	13 (3.0) **148 (9.1)**	178 (41.7) **1013 (62.0)**	236 (55.3) **472 (28.9)**	1 (0.2) **10 (0.6)**	92 (21.6) **226 (13.7)**	332 (78.1) **1408 (85.6)**

Work Settings

This section asks about the settings in which you work as a chaplain.

6. How much of your time is spent providing services in each of the following settings?

	None	A small amount	A moderate amount	A large amount
a. Inpatient medical	19 (4.4) **711 (43.3)**	53 (12.4) **710 (43.2)**	71 (16.6) **133 (8.1)**	285 (66.6) **89 (5.4)**
b. Outpatient medical	66 (15.5) **749 (45.6)**	183 (43.1) **695 (42.3)**	125 (29.4) **158 (9.6)**	51 (12.0) **40 (2.4)**
c. Inpatient psychiatric/mental health	49 (11.6) **913 (55.7)**	131 (30.9) **582 (35.5)**	136 (32.1) **109 (6.7)**	108 (25.5) **35 (2.1)**
d. Outpatient mental health	108 (25.4) **782 (48.0)**	172 (40.4) **623 (38.3)**	92 (21.6) **185 (11.4)**	54 (12.7) **38 (2.3)**
e. Inpatient substance use programs	97 (22.8) **1172 (71.6)**	122 (28.7) **389 (23.8)**	112 (26.4) **62 (3.8)**	94 (22.1) **13 (0.8)**
f. Outpatient substance use programs	144 (33.6) **1029 (63.1)**	148 (34.6) **489 (30.0)**	86 (20.1) **97 (6.0)**	50 (11.7) **15 (0.9)**
g. Specialized PTSD treatment – inpatient	140 (32.8) **1261 (77.2)**	149 (34.9) **299 (18.3)**	80 (18.7) **59 (3.6)**	58 (13.6) **14 (0.9)**
h. Specialized PTSD treatment – outpatient	162 (38.1) **1069 (65.3)**	151 (35.5) **428 (26.1)**	76 (17.9) **113 (6.9)**	36 (8.5) **27 (1.6)**
i. Nursing home care	110 (25.9) **1444 (88.1)**	96 (22.6) **167 (10.2)**	79 (18.6) **26 (1.6)**	139 (32.8) **2 (0.1)**
j. Women's health	148 (35.0) **1252 (76.8)**	205 (48.5) **321 (19.7)**	57 (13.5) **49 (3.0)**	13 (3.1) **9 (0.6)**
k. Community setting	191 (44.8) **552 (33.9**)	159 (37.3) **441 (27.1)**	56 (13.1) **372 (22.9)**	20 (4.7) **262 (16.1)**
l. Other setting (specify below)	200 (59.2) **660 (48.3)**	51 (15.1) **101 (7.4)**	37 (10.9) **107 (7.8)**	50 (14.8) **499 (36.5)**

Specify: _____

7. Please check the following settings in which you as the chaplain are included as a member of the care team.

☐ Inpatient medical/surgical team **[GO TO 7A]**	230 (53.2)	**223 (13.5)**
☐ Inpatient psychiatric/mental health team **[GO TO 7A]**	203 (47.0)	**194 (11.7)**
☐ TBI Clinic team **[GO TO 7A]**	31 (7.2)	**69 (4.2)**
☐ OEF/OIF Clinic team **[GO TO 7A]**	84 (19.4)	**172 (10.4)**

☐	PTSD Clinic team **[GO TO 7A]**	103 (23.8)	**146 (8.8)**
☐	Outpatient Mental Health Clinic team **[GO TO 7A]**	91 (21.1)	**173 (10.5)**
☐	Substance Use Clinic team **[GO TO 7A]**	148 (34.3)	**125 (7.6)**
☐	Women's Health Clinic team **[GO TO 7A]**	39 (9.0)	**43 (2.6)**
☐	Other mental health related team (specify below) **[GO TO 8]**	83 (19.2)	**279 (16.9)**
	Specify: _____		
☐	None **[GO TO 8]**	68 (15.7)	**934 (56.5)**

a. Please indicate your agreement with the following statements. [FOR EACH OF THE ABOVE TEAMS THAT IS CHECKED, ASK THE FOLLOWING QUESTION.]

	Strongly disagree	Disagree	Agree	Strongly agree
a. The **inpatient medical/surgical team** understands and values my role as a chaplain.	3 (1.3) **1 (0.5)**	12 (5.2) **11 (5.0)**	109 (47.4) **112 (50.5)**	106 (46.1) **98 (44.1)**
b. The **inpatient psychiatric/mental health team** understands and values my role as a chaplain.	1 (0.5) **4 (2.1)**	15 (7.4) **21 (10.8)**	93 (46.0) **93 (47.9)**	93 (46.0) **76 (39.2)**
c. The **TBI Clinic team** understands and values my role as a chaplain.	1 (3.2) **3 (4.5)**	3 (9.7) **10 (14.9)**	15 (48.4) **31 (46.3)**	12 (38.7) **23 (34.3)**
d. The **OEF/OIF Clinic team** understands and values my role as a chaplain.	2 (2.4) **2 (1.2)**	2 (2.4) **8 (4.7)**	37 (44.6) **76 (45.0)**	42 (50.6) **83 (49.1)**
e. The **PTSD Clinic team** understands and values my role as a chaplain.	1 (1.0) **2 (1.4)**	2 (1.9) **13 (9.0)**	41 (39.8) **78 (53.8)**	59 (57.3) **52 (35.9)**
f. The **Outpatient Mental Health Clinic team** understands and values my role as a chaplain.	0 **4 (2.3)**	3 (3.3) **19 (11.0)**	41 (45.6) **85 (49.4)**	46 (51.1) **64 (37.2)**
g. The **Substance Use Clinic team** understands and values my role as a chaplain.	2 (1.4) **3 (2.4)**	5 (3.4) **12 (9.7)**	52 (35.1) **54 (43.5)**	89 (60.1) **55 (44.4)**
h. The **Women's Health Clinic team** understands and values my role as a chaplain.	0 **0**	0 **4 (9.3)**	18 (46.2) **17 (39.5)**	21 (53.8) **22 (51.2)**
i. The **other specified team** understands and values my role as a chaplain.	2 (2.4) **7 (2.5)**	7 (8.4) **38 (13.8)**	39 (47.0) **129 (46.9)**	35 (42.2) **101 (36.7)**

Work activities

This section asks questions about the activities of your work as a chaplain.

8. How often do you engage in each of the following practices <u>in your interactions with</u> [FILL CLIENT]?

	Never	Rarely	Sometimes	Frequently
a. Help **[FILL CLIENT]** practice directly dealing with things that made them afraid (such as places, people, memories or feelings) in order to become less afraid of them	20 (4.7) **143 (8.9)**	87 (20.4) **523 (32.6)**	197 (46.2) **715 (44.6)**	122 (28.6) **223 (13.9)**
b. Teach **[FILL CLIENT]** methods of physical relaxation, such as slow breathing	95 (22.4) **293 (18.2)**	122 (28.7) **551 (34.2)**	154 (36.2) **576 (35.8)**	54 (12.7) **189 (11.7)**
c. Help **[FILL CLIENT]** look at their thoughts more realistically	3 (0.7) **20 (1.3)**	22 (5.3) **66 (4.2)**	163 (38.9) **565 (35.9)**	231 (55.1) **924 (58.7)**
d. Help **[FILL CLIENT]** to see mistakes in their thinking - for example, all or nothing thinking or always fearing the worst will happen	5 (1.2) **29 (1.8)**	40 (9.4) **98 (6.1)**	209 (48.9) **687 (43.0)**	173 (40.5) **783 (49.0)**
e. Help **[FILL CLIENT]** to understand how their thoughts and feelings are related	3 (0.7) **19 (1.2)**	32 (7.5) **78 (4.9)**	160 (37.4) **621 (38.7)**	233 (54.4) **887 (55.3)**
f. Ask **[FILL CLIENT]** to do "homework" between visits (Homework can include activities like writing down their thoughts, feelings, and activities or practicing something they learned during their visit.)	57 (13.4) **60 (3.7)**	132 (31.0) **262 (16.3)**	169 (39.7) **685 (42.6)**	68 (16.0) **600 (37.3)**
g. Provide resilience training or education, such adaptive coping behaviors and ways to "bounce back" after illness, injury, or other hardships	76 (17.9) **72 (4.5)**	105 (24.8) **236 (14.7)**	162 (38.2) **678 (42.3)**	81 (19.1) **618 (38.5)**

h.	Help **[FILL CLIENT]** explore their values	3 (0.7) **7 (0.4)**	25 (5.8) **79 (4.9)**	139 (32.4) **576 (35.8)**	262 (61.1) **945 (58.8)**
i.	Help **[FILL CLIENT]** explore issues of life meaning	1 (0.2) **9 (0.6)**	17 (4.0) **79 (4.9)**	102 (23.8) **519 (32.5)**	308 (72.0) **990 (62.0)**
j.	Help **[FILL CLIENT]** make sense of trauma or loss	1 (0.2) **18 (1.1)**	34 (7.9) **118 (7.4)**	141 (32.9) **724 (45.1)**	252 (58.9) **745 (46.4)**
k.	Have conversations concerning spiritual struggles or moral injury	0 **7 (0.4)**	15 (3.5) **73 (4.5)**	106 (24.7) **566 (35.3)**	308 (71.8) **959 (59.8)**

9. How *often* do you engage in the following activities or services?

		Never	**Less than monthly**	**Monthly**	**Weekly**	**Daily or almost daily**
a.	Praying with **[FILL CLIENT]**	1 (0.2) **1 (0.1)**	9 (2.1) **47 (2.9)**	14 (3.3) **78 (4.9)**	74 (17.2) **636 (39.8)**	331 (77.2) **836 (52.3)**
b.	Anointing **[FILL CLIENT]**	88 (21.0) **498 (31.4)**	143 (34.1) **710 (44.7)**	50 (11.9) **219 (13.8)**	65 (15.5) **120 (7.6)**	73 (17.4) **40 (2.5)**
c.	Spiritually counseling **[FILL CLIENT]**	1 (0.2) **5 (0.3)**	5 (1.2) **43 (2.7)**	10 (2.4) **148 (9.3)**	89 (21.1) **602 (37.9)**	316 (75.1) **789 (49.7)**
d.	Spiritually counseling fellow chaplains or clergy	43 (10.1) **92 (5.8)**	139 (32.6) **392 (24.7)**	82 (19.2) **395 (24.9)**	87 (20.4) **490 (30.8)**	75 (17.6) **220 (13.8)**
e.	Advising **[FILL CLIENT]** (e.g., direct advice)	27 (6.5) **12 (0.8)**	62 (14.9) **60 (3.8)**	56 (13.4) **121 (7.6)**	124 (29.7) **525 (33.2)**	148 (35.5) **864 (54.6)**
f.	Advising fellow chaplains or clergy (e.g., direct advice)	48 (11.5) **60 (3.8)**	118 (28.2) **300 (18.9)**	78 (18.6) **331 (20.9)**	112 (26.7) **547 (34.5)**	63 (15.0) **348 (21.9)**
g.	Providing education about mental health to **[FILL CLIENT]**	69 (16.5) **179 (11.4)**	94 (22.5) **440 (28.0)**	75 (18.0) **436 (27.7)**	113 (27.1) **397 (25.2)**	66 (15.8) **121 (7.7)**
h.	Providing education about physical health to **[FILL CLIENT]**	100 (23.8) **282 (17.9)**	119 (28.3) **521 (33.0)**	75 (17.9) **370 (23.4)**	89 (21.2) **325 (20.6)**	37 (8.8) **81 (5.1)**
i.	Supervising fellow chaplains or clergy	157 (37.0) **479 (30.3)**	59 (13.9) **234 (14.8)**	34 (8.0) **108 (6.8)**	40 (9.4) **175 (11.1)**	134 (31.6) **585 (37.0)**
j.	Conducting staff consultation activities about **[FILL CLIENT]** care	85 (20.2) **406 (25.6)**	91 (21.7) **399 (25.1)**	54 (12.9) **340 (21.4)**	111 (26.4) **338 (21.3)**	79 (18.8) **105 (6.6)**
k.	Leading worship services	19 (4.6) **32 (2.0)**	80 (19.2) **217 (13.6)**	80 (19.2) **337 (21.2)**	155 (37.2) **817 (51.3)**	83 (19.9) **189 (11.9)**
l.	Directing **[FILL CLIENT]** to other services	10 (2.4) **35 (2.2)**	60 (14.4) **187 (11.8)**	76 (18.2) **426 (26.9)**	160 (38.3) **699 (44.2)**	112 (26.8) **236 (14.9)**
m.	Offering **[FILL CLIENT]** other spiritual programs	12 (2.8) **26 (1.6)**	63 (14.9) **182 (11.5)**	88 (20.9) **383 (24.3)**	150 (35.5) **762 (48.3)**	109 (25.8) **224 (14.2)**
n.	Arranging for services to be provided by clergy of another tradition	58 (13.7) **108 (6.8)**	160 (37.7) **550 (34.6)**	89 (21.0) **467 (29.4)**	87 (20.5) **372 (23.4)**	30 (7.1) **92 (5.8)**
o.	Speaking engagements within the local community	88 (20.9) **267 (16.8)**	194 (46.1) **795 (50.0)**	84 (20.0) **390 (24.5)**	40 (9.5) **111 (7.0)**	15 (3.6) **28 (1.8)**
p.	Teaching students	143 (34.0) **305 (19.2)**	94 (22.4) **478 (30.2)**	55 (13.1) **315 (19.9)**	72 (17.1) **379 (23.9)**	56 (13.3) **108 (6.8)**
q.	**[DoD ONLY]** Consulting with commanding officer	0 **54 (3.4)**	0 **181 (11.4)**	0 **301 (18.9)**	0 **775 (48.7)**	0 **280 (17.6)**
r.	**[VA ONLY]** Consulting with immediate supervisor	15 (3.5) **0**	52 (12.3) **0**	99 (23.3) **0**	139 (32.8) **0**	119 (28.1) **0**
s.	Addressing issues of housing or homelessness	76 (17.9) **963 (60.6)**	140 (32.9) **501 (31.5)**	96 (22.6) **83 (5.2)**	73 (17.2) **30 (1.9)**	40 (9.4) **13 (0.8)**

10. In your work as a chaplain, how often do you engage with:

		Never	**Less than monthly**	**Monthly**	**Weekly**	**Daily or almost daily**
a.	Local clergy **[IF NEVER, SKIP TO 12]**	28 (6.5) **125 (7.9)**	142 (33.2) **514 (32.5)**	100 (23.4) **480 (30.4)**	139 (32.5) **432 (27.3)**	19 (4.4) **30 (1.9)**
b.	Other community representatives **[IF NEVER, SKIP TO 12]**	47 (11.0) **200 (12.6)**	171 (40.1) **636 (40.1)**	118 (27.7) **497 (31.3)**	77 (18.1) **217 (13.7)**	13 (3.1) **37 (2.3)**

In the course of engaging with local clergy or other community representatives, how often do you:

a.	Lead presentations	92 (22.5) **380 (25.5)**	221 (54.2) **715 (48.0)**	59 (14.5) **231 (15.5)**	29 (7.1) **144 (9.7)**	7 (1.7) **20 (1.3)**
b.	Conduct programs focused on stigma toward mental illness or mental health care	197 (48.8) **952 (63.9)**	171 (42.3) **424 (28.5)**	25 (6.2) **73 (4.9)**	8 (2.0) **32 (2.1)**	3 (0.7) **8 (0.5)**
c.	Discuss the role of religious or other communities in helping persons reintegrate into the community	92 (22.7) **483 (32.3)**	204 (50.2) **629 (42.0)**	69 (17.0) **263 (17.6)**	33 (8.1) **103 (6.9)**	8 (2.0) **18 (1.2)**

11. How supportive is your organization's administration of outreach to:

		Very supportive	**Somewhat supportive**	**Neither supportive nor unsupportive**	**Somewhat unsupportive**	**Very unsupportive**
a.	Community clergy	155 (37.9) **520 (34.9)**	139 (34.0) **406 (27.3)**	58 (14.2) **393 (26.4)**	27 (6.6) **87 (5.8)**	30 (7.3) **82 (5.5)**
b.	Other community representatives	148 (36.5) **546 (36.8)**	147 (36.2) **439 (29.6)**	57 (14.0) **343 (23.1)**	27 (6.7) **82 (5.5)**	27 (6.7) **74 (5.0)**

Interaction with Mental Health Professionals

This section asks questions about your interaction with mental health professionals in your work as a chaplain.

12. How often do you engage with mental health professionals?

☐ Never **[If Never→go to Q16]**	11 (2.6)	**103 (6.5)**
☐ Less than monthly	54 (12.6)	**543 (34.4)**
☐ Monthly	63 (14.8)	**514 (32.5)**
☐ Weekly	126 (29.5)	**329 (20.8)**
☐ Daily or almost daily	173 (40.5)	**91 (5.8)**

13. How often do you engage with mental health professionals in the following ways?

		Never	**Less than monthly**	**Monthly**	**Weekly**	**Daily or almost daily**
a.	I make referrals to mental health professionals.	36 (8.8) **42 (2.9)**	139 (33.9) **506 (34.5)**	105 (25.6) **586 (39.9)**	108 (26.3) **297 (20.2)**	22 (5.4) **36 (2.5)**
b.	I receive referrals from mental health professionals.	31 (7.6) **469 (32.0)**	117 (28.5) **620 (42.3)**	105 (25.6) **249 (17.0)**	122 (29.8) **105 (7.2)**	35 (8.5) **21 (1.4)**
c.	Mental health professionals ask for my help in assessing for the importance of spirituality in **[FILL CLIENT]**.	48 (11.7) **623 (42.6)**	125 (30.3) **532 (36.4)**	95 (23.1) **196 (13.4)**	96 (23.3) **95 (6.5)**	48 (11.7) **17 (1.2)**
d.	Mental health professionals consult with me on cultural diversity.	121 (29.5) **927 (63.3)**	159 (38.8) **383 (26.1)**	67 (16.3) **96 (6.6)**	49 (12.0) **48 (3.3)**	14 (3.4) **11 (0.8)**
e.	I participate with health care teams about planning for a **[FILL CLIENT]** mental health treatment needs.	104 (25.2) **765 (52.4)**	109 (26.5) **441 (30.2)**	43 (10.4) **166 (11.4)**	125 (30.3) **71 (4.9)**	31 (7.5) **16 (1.1)**
f.	I discuss care of a **[FILL CLIENT]** mental health needs with an individual health care provider.	54 (13.0) **628 (42.8)**	115 (27.8) **551 (37.6)**	70 (16.9) **179 (12.2)**	126 (30.4) **91 (6.2)**	49 (11.8) **18 1.2)**

14. Please rate your agreement with the following statements.

	Strongly disagree	Disagree	Agree	Strongly agree	Not applicable
a. I think mental health providers and chaplains can closely collaborate while retaining identities and abilities unique to their respective professions.	11 (2.7) **49 (3.4)**	2 (0.5) **40 (2.7)**	76 (18.5) **437 (30.0)**	319 (77.8) **922 (63.2)**	2 (0.5) **11 (0.8)**
b. My office space is in close physical proximity to offices of mental health professionals.	92 (22.5) **436 (29.8)**	135 (33.1) **462 (31.6)**	78 (19.1) **318 (21.8)**	82 (20.1) **152 (10.4)**	21 (5.1) **94 (6.4)**
c. I have close relationships with mental health professionals.	13 (3.2) **123 (8.4)**	66 (16.2) **402 (27.6)**	169 (41.4) **567 (38.9)**	155 (38.0) **321 (22.0)**	5 (1.2) **46 (3.2)**
d. I have received substantial prior training in mental health issues.	22 (5.4) **157 (10.8)**	89 (21.7) **494 (33.9)**	145 (35.4) **487 (33.4)**	146 (35.6) **296 (20.3)**	8 (2.0) **25 (1.7)**

15. To what extent do you view the following activities as job components for chaplains and mental health care providers?

	Chaplain's Job			Mental Health Provider's Job		
	Non or minor component	Moderate component	Major component	Non or minor component	Moderate component	Major component
a. Providing counseling	10 (2.4) **3 (0.2)**	107 (26.1) **147 (10.2)**	293 (71.5) **1289 (89.6)**	6 (1.5) **31 (2.2)**	45 (11.2) **195 (13.8)**	352 (87.3) **1191 (18.1)**
b. Giving general health advice	208 (51.1) **590 (41.1)**	163 (40.0) **744 (51.8)**	36 (8.8) **102 (7.1)**	33 (8.2) **93 (6.6)**	200 (49.9) **719 (50.7)**	168 (41.9) **607 (42.8)**
c. Praying with a **[FILL CLIENT]**	3 (0.7) **3 (0.2)**	33 (8.1) **73 (5.1)**	372 (91.2) **1357 (94.7)**	316 (79.2) **1273 (90.0)**	65 (16.3) **129 (9.1)**	18 (4.5) **12 (0.8)**
d. Providing psychotherapy	292 (71.6) **1142 (79.9)**	104 (25.5) **250 (17.5)**	12 (2.9) **38 (2.7)**	8 (2.0) **20 (1.4)**	40 (9.9) **171 (12.1)**	356 (88.1) **1222 (86.5)**
e. Engaging in religious activities with a **[FILL CLIENT]**	4 (1.0) **3 (0.2)**	40 (9.8) **58 (4.1)**	364 (89.2) **1367 (95.7)**	313 (77.7) **1237 (87.7)**	74 (18.4) **162 (11.5)**	16 (4.0) **12 (0.9)**
f. Inviting **[FILL CLIENT]** to express their personal story.	4 (1.0) **6 (0.4)**	38 (9.3) **143 (10.1)**	365 (89.7) **1273 (89.5)**	8 (2.0) **28 (2.0)**	55 (13.7) **276 (19.7)**	338 (84.3) **1098 (78.3)**
g. Diagnosing mental health problems	300 (73.9) **1102 (77.2)**	88 (21.7) **292 (20.4)**	18 (4.4) **34 (2.4)**	8 (2.0) **13 (0.9)**	14 (3.5) **45 (3.2)**	378 (94.5) **1354 (95.9)**
h. Enhancing resiliency among **[FILL CLIENT]**	13 (3.3) **8 (0.6)**	133 (33.6) **173 (12.2)**	250 (63.1) **1240 (87.3)**	1 (0.3) **31 (2.2)**	79 (20.1) **217 (15.4)**	314 (79.7) **1162 (82.4)**
i. Conducting spiritual assessments	3 (0.7) **7 (0.5)**	14 (3.4) **95 (6.6)**	389 (95.8) **1333 (92.9)**	307 (76.4) **865 (61.2)**	69 (17.2) **485 (34.3)**	26 (6.5) **63 (4.5)**
j. Acting as a liaison between the **[FILL CLIENT]**, health care providers, and other relevant persons	25 (6.2) **186 (13.1)**	168 (41.6) **640 (44.9)**	211 (52.2) **599 (42.0)**	20 (5.0) **109 (7.8)**	168 (42.0) **651 (46.4)**	212 (53.0) **644 (45.9)**

k. Caring for family members of a **[FILL CLIENT]**	20 (4.9) **9 (0.6)**	141 (34.6) **208 (14.6)**	246 (60.4) **1208 (84.8)**	59 (14.7) **316 (22.5)**	207 (51.6) **538 (38.3)**	135 (33.7) **552 (39.3)**
l. Communicating with family members of a **[FILL CLIENT]**	17 (4.2) **63 (4.4)**	152 (37.5) **448 (31.5)**	236 (58.3) **910 (64.0)**	17 (4.3) **266 (18.9)**	159 (39.8) **661 (47.1)**	224 (56.0) **477 (34.0)**
m. Attending to the **[FILL CLIENT]** spirituality	1 (0.2) **1 (0.1)**	5 (1.2) **26 (1.8)**	398 (98.5) **1394 (98.1)**	198 (49.6) **954 (67.9)**	166 (41.6) **399 (28.4)**	35 (8.8) **52 (3.7)**
n. Attending to the **[FILL CLIENT]** mental health	77 (19.2) **223 (15.7)**	235 (58.6) **882 (62.1)**	89 (22.2) **316 (22.2)**	2 (0.5) **11 (0.8)**	16 (4.0) **28 (2.0)**	380 (95.5) **1368 (97.2)**
o. Addressing issues of guilt and forgiveness	2 (0.5) **2 (0.1)**	27 (6.6) **95 (6.6)**	378 (92.9) **1336 (93.2)**	41 (10.3) **127 (9.0)**	150 (37.6) **649 (45.8)**	208 (52.1) **640 (45.2)**
p. **[DoD ONLY]** Advising the Command	0 **16 (1.1)**	0 **94 (6.6)**	0 **1319 (92.3)**	0 **142 (10.0)**	0 **408 (28.8)**	0 **868 (61.2)**
q. **[VA ONLY]** Advising VA leadership	45 (11.2) **0**	150 (37.3) **0**	207 (51.5) **0**	32 (8.0) **0**	155 (38.8) **0**	212 (53.1) **0**

16. Please rate your agreement with the following statements.

	Strongly disagree	**Disagree**	**Agree**	**Strongly agree**
a. Mental health professionals understand spiritual work that is done with **[FILL CLIENT]**.	31 (7.5) **219 (14.5)**	150 (36.1) **601 (39.7)**	219 (52.6) **635 (41.9)**	16 (3.8) **59 (3.9)**
b. Mental health professionals value my role as a chaplain.	13 (3.1) **115 (7.6)**	50 (12.0) **337 (22.4)**	268 (64.4) **845 (56.1)**	85 (20.4) **209 (13.9)**
c. Mental health professionals impinge on spiritual work that is done with **[FILL CLIENT]**.	37 (9.1) **133 (8.9)**	248 (60.9) **964 (64.7)**	97 (23.8) **347 (23.3)**	25 (6.1) **47 (3.2)**
d. Mental health professionals view chaplains as impinging on mental health care.	35 (8.6) **102 (6.8)**	238 (58.5) **800 (53.3)**	115 (28.3) **509 (33.9)**	19 (4.7) **90 (6.0)**
e. Non-mental health professionals (e.g., primary care providers) understand spiritual work that is done with **[FILL CLIENT]**.	20 (4.9) **91 (6.1)**	128 (31.1) **461 (31.0)**	234 (56.8) **851 (57.2)**	30 (7.3) **85 (5.7)**
f. Non-mental health professionals (e.g., primary care providers) value my role as a chaplain.	9 (2.2) **35 (2.3)**	45 (10.9) **214 (14.2)**	283 (68.4) **1028 (68.4)**	77 (18.6) **227 (15.1)**
g. Non-mental health professionals (e.g., primary care providers) impinge on spiritual work that is done with **[FILL CLIENT]**.	52 (12.7) **161 (10.7)**	281 (68.4) **1103 (73.6)**	64 (15.6) **212 (14.2)**	14 (3.4) **22 (1.5)**
h. Non-mental health professionals (e.g., primary care providers) view chaplains as impinging on mental health care.	52 (12.7) **147 (9.8)**	289 (70.3) **1052 (70.3)**	61 (14.8) **266 (17.8)**	9 (2.2) **31 (2.1)**

17. Please rate your agreement with the following statements.

	Strongly disagree	**Disagree**	**Agree**	**Strongly agree**
a. I understand the work that is done by mental health professionals.	4 (1.0) **10 (0.7)**	14 (3.4) **76 (5.0)**	254 (61.2) **929 (61.5)**	143 (34.5) **495 (32.8)**
b. I value the role of mental health professionals.	2 (0.5) **10 (0.7)**	0 **45 (3.0)**	178 (43.0) **753 (50.2)**	234 (56.5) **693 (46.2)**
c. I understand the work that is done by non-mental health professionals (e.g., primary care providers).	2 (0.5) **6 (0.4)**	8 (1.9) **57 (3.8)**	229 (55.4) **914 (61.0)**	174 (42.1) **522 (34.8)**
d. I value the role of non-mental health professionals (e.g., primary care providers).	2 (0.5) **5 (0.3)**	0 **16 (1.1)**	181 (43.6) **728 (48.3)**	232 (55.9) **757 (50.3)**

e. **[FILL CLIENT]** with mental health problems commonly seek help from the chaplain instead of a mental health provider.	10 (2.4) **27 (1.8)**	158 (38.3) **285 (19.0)**	190 (46.1) **821 (54.6)**	54 (13.1) **370 (24.6)**

18. In your opinion, how helpful is the use of chaplaincy services in the following aspects of mental health care?

	Very unhelpful	Somewhat unhelpful	Neither helpful nor unhelpful	Somewhat helpful	Very helpful
a. Entry into mental health treatment	16 (3.9) **52 (3.5)**	10 (2.4) **55 (3.7)**	35 (8.5) **121 (8.1)**	152 (36.9) **574 (38.2)**	199 (48.3) **701 (46.6)**
b. Compliance with mental health treatment	13 (3.2) **33 (2.2)**	12 (2.9) **62 (4.1)**	25 (6.1) **249 (16.6)**	143 (35.0) **652 (43.5)**	215 (52.7) **502 (33.5)**
c. Family stability	14 (3.4) **53 (3.5)**	14 (3.4) **23 (1.5)**	21 (5.1) **33 (2.2)**	122 (29.7) **340 (22.7)**	240 (58.4) **1050 (70.0)**
d. **[DoD ONLY]** Deployability	0 **51 (3.4)**	0 **24 (1.6)**	0 **67 (4.5)**	0 **396 (26.5)**	0 **958 (64.0)**
e. **[DoD ONLY]** Decrease in negative behavior (UCMJ involvement, etc.)	0 **43 (2.9)**	0 **29 (1.9)**	0 **70 (4.7)**	0 **498 (33.2)**	0 **859 (57.3)**
f. **[VA ONLY]** Decrease in negative behavior	13 (3.2) **0**	13 (3.2) **0**	18 (4.4) **0**	147 (35.8) **0**	220 (53.5) **0**

19. How often have you encountered Veterans who seek care from a chaplain instead of from a mental health professional for the following reasons?

	Never	Occasionally	Often	Frequently
a. They do not trust mental health professionals.	31 (7.6) **55 (3.7)**	246 (60.3) **590 (39.8)**	101 (24.8) **455 (30.7)**	30 (7.4) **382 (25.8)**
b. **[DoD ONLY]** Unit leadership might treat them differently if they see a mental health provider.	0 **61 (4.1)**	0 **455 (30.7)**	0 **491 (33.1)**	0 **477 (32.1)**
c. **[VA ONLY]** Their job supervisor might treat them differently if they see a mental health provider.	57 (14.2) **0**	203 (50.5) **0**	110 (27.4) **0**	32 (8.0) **0**
d. It would be too embarrassing to seek help from a mental health provider.	58 (14.3) **51 (3.5)**	215 (53.0) **532 (36.0)**	103 (25.4) **517 (35.0)**	30 (7.4) **376 (25.5)**
e. They would be seen as weak.	71 (17.6) **70 (4.7)**	191 (47.3) **508 (34.4)**	104 (25.7) **512 (34.6)**	38 (9.4) **388 (26.3)**
f. Seeing a mental health provider would harm their career.	80 (19.7) **61 (4.1)**	189 (46.6) **411 (27.8)**	96 (23.6) **491 (33.3)**	41 (10.1) **513 (34.8)**
g. Members of their unit/task group would have less confidence in them.	85 (21.0) **101 (6.9)**	207 (51.2) **537 (36.5)**	83 (20.5) **526 (35.8)**	29 (7.2) **307 (20.9)**
h. They do not know where to get help.	51 (12.6) **203 (13.8)**	194 (48.0) **722 (49.0)**	115 (28.5) **382 (26.0)**	44 (10.9) **165 (11.2)**
i. Mental health care costs too much money.	147 (36.7) **1083 (73.5)**	143 (35.7) **268 (18.2)**	77 (19.2) **79 (5.4)**	34 (8.5) **44 (3.0)**
j. They would feel the need to hide from others that they had seen a mental health treatment provider.	69 (17.2) **143 (9.7)**	194 (48.3) **605 (41.0)**	100 (24.9) **444 (30.1)**	39 (9.7) **285 (19.3)**

k. It is difficult to schedule an appointment with a mental health provider.	131 (32.8) **412 (27.9)**	185 (46.3) **520 (35.2)**	57 (14.3) **302 (20.4)**	27 (6.8) **244 (16.5)**
l. They would feel inadequate if they went to a mental health professional for a mental health problem.	78 (19.5) **202 (13.7)**	235 (58.6) **706 (48.0)**	67 (16.7) **402 (27.3)**	21 (5.2) **162 (11.0)**
m. Professional mental health care does not work.	144 (35.9) **419 (28.4)**	207 (51.6) **771 (52.3)**	43 (10.7) **213 (14.4)**	7 (1.7) **72 (4.9)**
n. They see their mental health problem as being best addressed by a chaplain.	50 (12.4) **125 (8.5)**	225 (55.8) **790 (54.0)**	103 (25.6) **385 (26.3)**	25 (6.2) **162 (11.1)**
o. They perceive their mental health as closely related to spiritual issues.	19 (4.7) **157 (10.7)**	178 (44.3) **774 (52.5)**	165 (41.0) **418 (28.4)**	40 (10.0) **124 (8.4)**
p. They have more confidence in chaplains than mental health providers.	25 (6.2) **73 (5.0)**	212 (52.5) **598 (40.7)**	127 (31.4) **499 (34.0)**	40 (9.9) **298 (20.3)**
q. They do not see their problem as a mental health issue in need of mental health treatment.	28 (7.0) **55 (3.7)**	207 (51.8) **643 (43.5)**	134 (33.5) **553 (37.4)**	31 (7.8) **226 (15.3)**
r. They seek confidentiality.	17 (4.2) **10 (0.7)**	117 (28.8) **160 (10.8)**	139 (34.2) **345 (23.3)**	133 (32.8) **966 (65.2)**
s. They seek wisdom and understanding.	13 (3.2) **16 (1.1)**	106 (26.2) **234 (15.8)**	159 (39.4) **576 (38.9)**	126 (31.2) **653 (44.2)**

20. Please rate your agreement with the following statements.

	Strongly disagree	**Disagree**	**Agree**	**Strongly agree**
a. Seeing a mental health professional could have negative consequences for **[FILL CLIENT]** (e.g., harm their career).	98 (23.9) **238 (16.0)**	168 (41.0) **549 (36.9)**	116 (28.3) **528 (35.5)**	28 (6.8) **171 (11.5)**
b. Seeing a chaplain could have negative consequences for **[FILL CLIENT]** (e.g., harm their career).	253 (61.6) **973 (65.6)**	147 (35.8) **447 (30.1)**	7 (1.7) **51 (3.4)**	4 (1.0) **13 (0.9)**

Further Information and Training

This section asks questions about areas in which you would like further information or training.

21. How helpful would each of the following educational topics be in your work?

	Not at all helpful	**Somewhat helpful**	**Quite helpful**	**Extremely helpful**
a. Information about of mental health problems specific to **[FILL CLIENT]**.	6 (1.5) **42 (2.9)**	66 (16.4) **431 (29.7)**	178 (44.3) **594 (41.0)**	152 (37.8) **383 (26.4)**
b. Diagnostic criteria for mental health problems.	19 (4.7) **137 (9.5)**	114 (28.3) **514 (35.5)**	171 (42.4) **503 (34.7)**	99 (24.6) **295 (20.4)**
c. Making a referral to mental health	19 (4.8) **91 (6.3)**	102 (25.6) **411 (28.5)**	177 (44.5) **578 (40.1)**	100 (25.1) **362 (25.1)**
d. Improving collaborative relationships between chaplains and mental health	7 (1.7) **29 (2.0)**	39 (9.7) **258 (17.8)**	151 (37.5) **514 (35.5)**	206 (51.1) **645 (44.6)**
e. Addressing concerns about mental health stigma	13 (3.2) **96 (6.7)**	83 (20.6) **367 (25.4)**	176 (43.8) **530 (36.7)**	130 (32.3) **450 (31.2)**
f. Information about empirically supported mental health treatments	15 (3.7) **109 (7.6)**	95 (23.6) **458 (31.8)**	172 (42.7) **535 (37.1)**	121 (30.0) **339 (23.5)**
g. Information about traumatic brain injury	4 (1.0) **46 (3.2)**	71 (17.7) **394 (27.3)**	155 (38.7) **534 (37.0)**	171 (42.6) **468 (32.5)**

h.	Information about disability and poly-trauma	7 (1.7) **101 (7.0)**	78 (19.4) **477 (33.1)**	175 (43.5) **505 (35.1)**	142 (35.3) **357 (24.8)**
i.	Spiritual consequences of combat trauma and PTSD	5 (1.3) **17 (1.2)**	34 (8.5) **169 (11.7)**	130 (32.5) **465 (32.1)**	231 (57.8) **798 (55.1)**
j.	How to utilize spiritual resources in ways consistent with mental health treatment	5 (1.3) **49 (3.4)**	41 (10.3) **201 (14.0)**	147 (36.8) **507 (35.2)**	207 (51.8) **683 (47.4)**
k.	Information about spiritual and religious needs specific to **[FILL CLIENT]**.	6 (1.5) **42 (2.9)**	42 (10.4) **231 (16.0)**	139 (34.6) **486 (33.8)**	215 (53.5) **681 (47.3)**
l.	Information about PTSD	6 (1.5) **32 (2.2)**	45 (11.3) **314 (21.7)**	172 (43.0) **538 (37.2)**	177 (44.3) **561 (38.8)**
m.	How to identify **[FILL CLIENT]** particular mental health problems	9 (2.3) **60 (4.2)**	61 (15.4) **379 (26.3)**	174 (43.9) **548 (38.0)**	152 (38.4) **456 (31.6)**
n.	Information about mood disorders (e.g., depression, bipolar disorder)	7 (1.7) **44 (3.0)**	68 (17.0) **372 (25.7)**	175(43.6) **558 (38.6)**	151 (37.7) **471 (32.6)**
o.	How to address diverse spiritual and religious concerns	11 (2.8) **65 (4.5)**	62 (15.6) **270 (18.7)**	143 (35.9) **509 (35.3)**	182 (45.7) **599 (41.5)**
p.	Information about psychotic disorders (e.g., schizophrenia)	7 (1.7) **112 (7.8)**	87 (21.6) **508 (35.3)**	164 (40.8) **473 (32.9)**	144 (35.8) **346 (24.0)**
q.	Information about the particular mental health needs of women **[FILL CLIENT]**	6 (1.5) **64 (4.4)**	57 (14.3) **412 (28.5)**	163 (40.9) **558 (38.6)**	173 (43.4) **413 (28.5)**
r.	Information about substance abuse disorders (e.g., alcohol abuse)	9 (2.3) **56 (3.9)**	65 (16.5) **396 (27.5)**	153 (38.8) **563 (39.2)**	167 (42.4) **423 (29.4)**
s.	**[VA only]** Information about the characteristics and mental health needs of OEF/OIF Veterans	3 (0.8) **0**	49 (12.3) **0**	155 (38.9) **0**	191 (48.0) **0**
t.	How to effectively use therapeutic approaches to care for patients' spiritual and religious needs	8 (2.0) **72 (5.0)**	49 (12.3) **291 (20.3)**	139 (34.9) **527 (36.7)**	202 (50.8) **547 (38.1)**
u.	How to effectively use therapeutic approaches to care for patients' mental health problems	19 (4.8) **128 (8.9)**	79 (19.9) **439 (8.9)**	161 (40.6) **526 (36.5)**	138 (34.8) **347 (24.1**)
v.	Information about personality disorders (e.g., borderline personality disorder)	7 (1.8) **79 (5.5)**	72 (18.0) **453 (31.5)**	168 (42.0) **519 (36.0**)	153 (38.3) **389 (27.0)**
w.	Information about the characteristics and mental health needs of **[FILL CLIENT]** families	5 (1.3) **64 (4.5)**	65 (16.5) **404 (28.1)**	178 (45.2) **574 (40.0)**	146 (37.1) **394 (27.4)**
x.	Information about housing and homelessness	10 (2.5) **398 (27.6)**	101 (25.3) **576 (40.0)**	158 (39.6) **295 (20.5)**	130 (32.6) **172 (11.9)**
y.	Other (specify below)	46 (34.1) **405 (63.6)**	17 (12.6) **66 (10.4)**	33 (24.4) **58 (9.1)**	39 (28.9) **108 (17.0)**

Specify: _____

Professional Activities

This section asks about other professional activities in your work as a chaplain.

22. How often do you engage in the following professional activities?

		Never	**Less than yearly**	**Yearly**	**Monthly**	**Weekly or more**
a.	Reading professional journal articles	15 (3.7) **44 (3.0)**	24 (5.9) **127 (8.8)**	46 (11.4) **226 (15.7)**	191 (47.3) **658 (45.6)**	128 (31.7) **389 (26.9)**
b.	Writing articles for publication in professional journals	234 (58.5) **732 (51.0)**	111 (27.8) **419 (29.2)**	43 (10.8) **205 (14.3)**	9 (2.3) **67 (4.7)**	3 (0.8) **13 (0.9)**
c.	Participating as part of a research team for formal health care studies	258 (64.0) **1067 (74.1)**	92 (22.8) **252 (17.5)**	27 (6.7) **69 (4.8)**	19 (4.7) **36 (2.5)**	7 (1.7) **15 (1.0)**
d.	Attending chaplaincy continuing educational events	8 (2.0) **34 (2.3)**	48 (11.9) **190 (13.1)**	213 (53.0) **861 (59.5)**	116 (28.9) **320 (22.1)**	17 (4.2) **43 (3.0)**
e.	Attending mental health continuing educational events	73 (18.3) **741 (51.5)**	130 (32.7) **400 (27.8)**	140 (35.2) **248 (17.2)**	48 (12.1) **42 (2.9)**	7 (1.8) **7 (0.5)**
f.	Attending national chaplaincy conferences	75 (18.8) **213 (14.7)**	112 (28.1) **311 (21.5)**	202 (50.6) **904 (62.5**)	6 (1.5) **14 (1.0)**	4 (1.0) **4 (0.3)**
g.	Presenting at national chaplaincy conferences	273 (69.1) **997 (69.2)**	82 (20.8) **306 (21.3)**	38 (9.6) **130 (9.0)**	2 (0.5) **5 (0.3)**	0 **2 (0.1)**

h.	Attending national mental health conferences	241 (60.3) **1149 (79.6)**	114 (28.5) **191 (13.2)**	41 (10.3) **94 (6.5)**	4 (1.0) **8 (0.6)**	0 **2 (0.1)**
i.	Presenting at national mental health conferences	340 (85.2) **1321 (92.4)**	39 (9.8) **73 (5.1)**	19 (4.8) **28 (2.0)**	1 (0.3) **6 (0.4)**	0 **2 (0.1)**
j.	Attending national meetings (e.g., convention, conference, assembly) within my tradition	47 (11.7) **162 (11.3)**	99 (24.7) **332 (23.1)**	236 (58.9) **920 (63.9)**	16 (4.0) **21 (1.5)**	3 (0.7) **4 (0.3)**
k.	Other (specify below)	52 (52.5) **376 (78.3)**	8 (8.1) **20 (4.2)**	23 (23.2) **40 (8.3)**	10 (10.1) **27 (5.6)**	6 (6.1) **17 (3.5)**

Specify: _____

23. I consider my current chaplain care practices to be evidence-based.

☐ Strongly agree	131 (32.3)	**462 (32.0)**
☐ Agree	181 (44.7)	**604 (41.9)**
☐ Neither agree nor disagree	84 (20.7)	**321 (22.3)**
☐ Disagree	8 (2.0)	**46 (3.2)**
☐ Strongly disagree	1 (0.2)	**9 (0.6)**

24. I would like my chaplain care practices to be more evidence-based.

☐ Strongly agree	105 (27.2)	**236 (16.8)**
☐ Agree	139 (36.0)	**459 (32.7)**
☐ Neither agree nor disagree	120 (31.1)	**618 (44.0)**
☐ Disagree	16 (4.1)	**74 (5.3)**
☐ Strongly disagree	6 (1.6)	**18 (1.3)**

25. Overall, how satisfied are you with your current chaplain role?

☐ Very satisfied	237 (59.3)	**792 (54.6)**
☐ Satisfied	131(32.8)	**547 (37.7)**
☐ Neither satisfied nor dissatisfied	19 (4.8)	**54 (3.7)**
☐ Dissatisfied	12 (3.0)	**46 (3.2)**
☐ Very dissatisfied	1 (0.3)	**11 (0.8)**

Demographics

We would appreciate if you would answer the following demographic questions. We want to emphasize that answering these questions is voluntary and there is no penalty for not answering. As with your responses to all items on this survey, your answers to the following questions will remain confidential.

1. What is your service affiliation?

☐	Active Duty **[GO TO 1A]**	0	**1450 (100.0)**
☐	Guard **[GO TO 1B]**	5 (1.3)	
☐	Reserve **[GO TO 1B]**	11 (2.8)	
☐	Civilian, Veteran **[GO TO 1D]**	197 (49.5)	
☐	Civilian, non-Veteran **[GO TO 2]**	185 (46.4)	

a. In what branch of the uniformed services do you serve? [GO TO 1C]

☐	Army	**840 (58.1)**
☐	Navy	**256 (17.7)**
☐	Air Force	**324 (22.4)**
☐	Marine Corps	**22 (1.5)**
☐	Coast Guard	**4 (0.3)**

b. In what branch of the uniformed services do you serve? [GO TO 1C]

☐	Army Reserve	5 (31.3)	**0**
☐	Army National Guard	1 (6.3)	**0**
☐	Navy Reserve	2 (12.5)	**0**
☐	Air Force Reserve	4 (25.0)	**0**
☐	Air National Guard	4 (25.0)	**0**
☐	Marine Corps Reserve	0	**0**
☐	Coast Guard Reserve	0	**0**

c. What is your current rank? [GO TO 1F]

☐	E1-E3	1 (6.3)	**1 (0.1)**
☐	E4-E6		
☐	E7-E9		
☐	W1-W5		
☐	O1-O3	1 (6.3)	**636 (44.4)**
☐	O4-O10	14 (87.5)	**796 (55.5)**

d. In what branch of the uniformed services did you serve? (Mark all that apply) [GO TO 1E]

☐	Army	91 (46.7)	**0**
☐	Navy	55 (28.2)	**0**
☐	Air Force	45 (22.8)	**0**
☐	Marine Corps	16 (8.2)	**0**
☐	Coast Guard	4 (2.1)	**0**
☐	Army Reserve	30 (15.4)	**0**
☐	Army National Guard	21 (10.8)	**0**
☐	Navy Reserve	23 (11.8)	**0**
☐	Air Force Reserve	11 (5.6)	**0**
☐	Air National Guard	3 (1.5)	**0**
☐	Marine Corps Reserve	7 (3.6)	**0**
☐	Coast Guard Reserve	1 (0.5)	**0**

e. What was your rank at the completion of your uniformed services service? [GO TO 1F]

☐	E1-E3	9 (4.8)	**0**
☐	E4-E6	42 (22.2)	**0**
☐	E7-E9	3 (1.6)	**0**
☐	W1-W5	1 (0.5)	**0**
☐	O1-O3	39 (20.6)	**0**
☐	O4-O10	95 (50.3)	**0**

f. How many deployments (including peacekeeping missions) have you been on since September 11, 2001? [GO TO 1G]

☐	0	149 (72.0)	**145 (10.1)**
☐	1	21 (10.1)	**425 (29.5)**
☐	2	17 (8.2)	**433 (30.0)**
☐	3 or 4	12 (5.8)	**354 (24.6)**
☐	5 or 6	4 (1.9)	**61 (4.2)**
☐	7 or more	4 (1.9)	**23 (1.6)**

g. When did you return from your last deployment? [GO TO 1H]

☐	Does not apply, I have never been deployed	79 (100.0)	**127 (100.0)**
☐	Month (pull down)		
	January	95 (44.6)	**284 (19.6)**
	February	3 (1.4)	**76 (5.2)**
	March	22 (10.3)	**111 (7.7)**
	April	11 (5.2)	**99 (6.8)**
	May	16 (7.5)	**119 (8.2)**
	June	7 (3.3)	**111 (7.7)**
	July	13 (6.1)	**133 (9.2)**
	August	16 (7.5)	**87 (6.0)**
	September	14 (6.6)	**106 (7.3)**
	October	3 (1.4)	**98 (6.8)**
	November	6 (2.8)	**119 (8.2)**
	December	7 (3.3)	**106 (7.3)**
	Year (pull down)		
	1946	1 (0.8)	
	1953	1 (0.8)	
	1955	1 (0.8)	
	1964	1 (0.8)	
	1967	3 (2.3)	
	1968	1 (0.8)	
	1969	1 (0.8)	
	1970	8(6.1)	
	1971	3 (2.3)	
	1974	1 (0.8)	
	1975	3 (2.3)	
	1976	2 (1.5)	
	1978	1 (0.8)	
	1979	1 (0.8)	
	1980	1 (0.8)	
	1983	1 (0.8)	
	1984	1 (0.8)	
	1985	1 (0.8)	
	1986	2 (1.5)	
	1989	2 (1.5)	
	1990	2 (1.5)	
	1991	18 (13.6)	**6 (0.5)**
	1992	0	**1 (0.1)**
	1993	3 (12.3)	**4 (0.3)**
	1994	5 (3.8)	**1 (0.1)**
	1995	2 (1.5)	**3 (0.2)**
	1996	6 (4.5)	**4 (0.3)**
	1997	0	**1 (0.1)**
	1998	3 (2.3)	**4 (0.3)**
	1999	1 (0.8)	**1 (0.1)**
	2000	3 (2.3)	**3 (0.2)**
	2001	3 (2.3)	**4 (0.3)**
	2002	8 (6.1)	**11 (0.9)**
	2003	3 (2.3)	**31 (2.4)**
	2004	7 (5.3)	**50 (3.9)**
	2005	9 (6.8)	**60 (4.7)**
	2006	6 (4.5)	**86 (6.7)**
	2007	3 (2.3)	**75 (5.8)**
	2008	2 (1.5)	**131 (10.2)**
	2009	5 (3.8)	**190 (14.7)**
	2010	6 (4.5)	**242 (18.8)**
	2011	1 (0.8)	**281 (21.8)**
	2012		**90 (7.0)**
	2013		**3 (0.2)**

h. In which of the following missions did you serve? (Mark all that apply) [GO TO 2]

☐	Does not apply, I have never been deployed	28 (13.1)	**78 (5.4)**

☐	World War II	2 (0.9)	**0**
☐	Korean War	2 (0.9)	**1 (0.1)**
☐	Vietnam War	50 (23.5)	**14 (1.0)**
☐	Operations Desert Shield or Desert Storm (e.g., Iraq, Kuwait, Saudi Arabia)	68 (31.9)	**292 (20.2)**
☐	Operation Enduring Freedom (e.g., Afghanistan)	24 (11.3)	**627 (43.3)**
☐	Operation Iraqi Freedom or New Dawn (e.g., Iraq)	29 (13.6)	**983 (67.8)**
☐	Tsunami Relief (e.g., South Asia)	0	**33 (2.3)**
☐	Hurricane Relief (e.g., Louisiana, Texas, Mississippi)	19 (8.9)	**105 (7.2)**
☐	Earthquake Relief (e.g., Haiti, Chile)	3 (1.4)	**40 (2.8)**
☐	Other combat or Special Operations deployment	21 (9.9)	**231 (15.9)**
☐	Other peacekeeping deployment	36 (16.9)	**264 (18.2)**
☐	Other noncombat deployment	55 (25.8)	**340 (23.5)**
☐	None of the above	21 (9.9)	**34 (2.3)**

2. How long have you served as a chaplain? (Please include total time served, including both uniformed services and civilian status)

☐	1 year or less	3 (0.7)	**27 (1.9)**
☐	More than 1 year but less than 5 years	49 (12.2)	**224 (15.5)**
☐	More than 5 years but less than 10 years	56 (13.9)	**343 (23.7)**
☐	More than 10 years but less than 20 years	122 (30.3)	**534 (36.9)**
☐	20 years or more	173 (42.9)	**321 (22.2)**

3. What is your gender?

☐	Male	330 (82.9)	**1370 (95.9)**
☐	Female	68 (17.1)	**59 (4.1)**

4. How old are you?

☐	24 or younger	0	**0**
☐	25-34	0	**81 (5.7)**
☐	35-44	19 (4.8)	**495 (34.7)**
☐	45-54	74 (18.6)	**598 (41.9)**
☐	55-64	200 (50.4)	**246 (17.3)**
☐	65 or older	104 (26.2)	**6 (0.4)**

5. Are you Spanish/Hispanic/Latino?

☐	No, not Spanish/Hispanic/Latino	389 (97.7)	**1341 (96.0)**
☐	Yes, Mexican/Mexican-American/Chicano	2 (0.5)	**19 (1.4)**
☐	Yes, Puerto Rican	2 (0.5)	**12 (0.9)**
☐	Yes, Cuban	0	**5 (0.4)**
☐	Yes, other Spanish/Hispanic/Latino	5 (1.3)	**20 (1.4)**

6. What is your race? (Mark one or more races to indicate what you consider yourself to be.)

☐	White	294 (72.6)	**1121 (76.9)**
☐	Black or African American	73 (18.0)	**99 (6.8)**
☐	American Indian or Alaska Native	10 (2.5)	**33 (2.3)**
☐	Asian (e.g., Asian Indian, Chinese, Filipino, Japanese, Korean, Vietnamese)	13 (3.2)	**102 (7.0)**
☐	Native Hawaiian or other Pacific Islander (e.g., Samoan, Guamanian, Chamorro)	0	**4 (0.3)**
☐	Other	13 (3.2)	**67 (4.6)**

7. What is your religious affiliation? (You can select more than one option if appropriate – mark all that apply)

☐	Evangelical Protestant	122 (30.1)	**838 (57.6)**
☐	Mainline Protestant	139 (34.3)	**371 (25.5)**
☐	Historically Black Protestant	31 (7.7)	**30 (2.1)**
☐	Catholic	85 (21.0)	**114 (7.8)**
☐	Mormon	2 (0.5)	**18 (1.2)**
☐	Orthodox	8 (2.0)	**9 (0.6)**
☐	Jehovah's Witness	0	**0**
☐	Other Christian Traditions	17 (4.2)	**50 (3.4)**
☐	Jewish	10 (2.5)	**12 (0.8)**
☐	Muslim	0	**4 (0.3)**

☐	Hindu	1 (0.2)	**0**
☐	Buddhist	0	**2 (0.1)**
☐	Agnostic	0	**0**
☐	Atheist	0	**1 (0.1)**
☐	Other faith (specify below)	24 (5.9)	**83 (5.7)**

Specify: _____

8. [DoD ONLY] Please indicate whether you are stationed in any of the below contexts. (Mark all that apply)

☐	Deployed in combat zone	0	**297 (20.4)**
☐	Deployed in non-combat zone	0	**188 (12.9)**
☐	Health care facility	0	**164 (11.3)**
☐	None of the above	0	**953 (65.5)**

9. What is your highest level of education?

☐	High School/GED	0	
☐	Some College/Associate Degree/Technical School	1 (0.2)	
☐	Bachelor's Degree	6 (1.5)	**1 (0.1)**
☐	Master's Degree	282 (69.8)	**1211 (84.0)**
☐	Doctoral Degree	114 (28.2)	**227 (15.8)**
☐	Other	1 (0.2)	**2 (0.1)**

10. Do you have Clinical Pastoral Education (CPE) training?

☐	None	30 (7.4)	**671 (46.7)**
☐	1-2 units	84 (20.8)	**331 (23.0)**
☐	3-4 units	140 (34.7)	**273 (19.0)**
☐	5+ units	150 (37.1)	**163 (11.3)**

11. Are you a CPE supervisor?

☐	No	373 (92.8)	**1419 (98.9)**
☐	Yes: ACPE certified supervisor	24 (6.0)	**6 (0.4)**
☐	Yes: other supervisor certification	5 (1.2)	**10 (0.7)**

12. Are you a board certified chaplain?

☐	Yes	197 (49.4)	**353 (25.3)**
☐	No	202 (50.6)	**1045 (74.7)**

13. Do you have other certification(s)?

☐	No	231 (59.7)	**1047 (76.5)**
☐	Yes, specify: _____	156 (40.3)	**321 (23.5)**

Other comments

Please feel free to share any comments you may have about any additional topics not covered elsewhere in this survey, or about the survey itself. Please do not put your name or any other identifying information as part of your comments.

_____

_____

Thank you very much for your time, effort, and cooperation in completing this survey. If you would be willing, we have a few additional questions we would like to ask about your experiences related to your work as a chaplain. These questions will provide further context for the roles that chaplains fulfill and your use of measurement tools in your work.

These additional questions will take you approximately 10 minutes to complete. If you agree, please click on the "Next" button to continue. If you do not agree, please click on the "Logoff" button to exit the survey.

Thank you for agreeing to complete the supplemental survey. The following questions should take about 10 minutes to complete.

Supplemental survey

The following items ask for some additional information about your experiences related to your work as a chaplain. These questions will provide further context for the roles that chaplains fulfill and your use of measurement tools in your work.

1. Please indicate whether you consider the following items to be components primarily of one's spirituality, primarily of one's mental health, or roughly equal components of both one's spirituality and mental health.

	Primarily a Component of Spirituality	Primarily a Component Mental health	Roughly Equal Component of Spirituality and Mental Health
a. Beliefs about God or higher power	196 (60.7) **829 (68.2)**	2 (0.6) **2 (0.2)**	125 (38.7) **385 (31.7)**
b. Ability to control and/or harness emotions	19 (5.9) **107 (8.8)**	56 (17.4) **143 (11.8)**	247 (76.7) **960 (79.3)**
c. Ability to control and/or harness thoughts	17 (5.3) **116 (9.6)**	70 (21.8) **142 (11.7)**	234 (72.9) **951 (78.7)**
d. Ability to develop a meaningful life vision	85 (26.4) **451 (37.3)**	5 (1.6) **10 (0.8)**	232 (72.0) **749 (61.9)**
e. Acceptance of shortcomings and imperfections	52 (16.3) **237 (19.5)**	12 (3.8) **27 (2.2)**	256 (80.0) **950 (78.3)**
f. Active engagement in a religious community	224 (69.3) **920 (76.1)**	3 (0.9) **7 (0.6)**	96 (29.7) **282 (23.3)**
g. Appreciation of one's values and beliefs	96 (29.8) **462 (38.2)**	6 (1.9) **9 (0.7)**	220 (68.3) **737 (61.0)**
h. Assumption of responsibility	24 (7.5) **165 (13.6)**	30 (9.3) **49 (4.1)**	268 (83.2) **995 (82.3)**
i. Attendance and participation in religious services	242 (74.9) **954 (78.8)**	5 (1.5) **8 (0.7)**	76 (23.5) **248 (20.5)**
j. Authenticity	47 (14.6) **242 (20.0)**	14 (4.3) **31 (2.6)**	261 (81.1) **938 (77.5)**
k. Beliefs concerning meaning and purpose in life	111 (34.7) **567 (47.3)**	5 (1.6) **8 (0.7)**	204 (63.8) **625 (52.1)**
l. Beliefs concerning truths about the world and human existence	124 (38.5) **631 (52.4)**	7 (2.2) **8 (0.7)**	191 (59.3) **565 (46.9)**
m. Capacity to achieve a meaningful vision for one's life	63 (19.6) **359 (29.7)**	8 (2.5) **18 (1.5)**	250 (77.9) **830 (68.8)**
n. Central values and beliefs	111 (34.6) **544 (44.9)**	4 (1.2) **9 (0.7)**	206 (64.2) **658 (54.3)**
o. Courage to behave in moral and ethical manner	91 (28.3) **434 (35.9)**	5 (1.6) **21 (1.7)**	226 (70.2) **755 (62.4)**
p. Creating a life worth living	64 (19.9) **367 (30.5)**	9 (2.8) **15 (1.2)**	249 (77.3) **820 (68.2)**
q. Desire to seek growth experiences to develop spirit	139 (43.7) **659 (54.7)**	8 (2.5) **7 (0.6)**	171 (53.8) **539 (44.7)**
r. Empathy	45 (14.0) **216 (17.9)**	14 (4.3) **37 (3.1)**	263 (81.7) **954 (79.0)**
s. Engaging in behaviors that are in line with values, beliefs, and goals	48 (14.9) **297 (24.7)**	10 (3.1) **20 (1.7)**	264 (82.0) **886 (73.6)**
t. Exercise of psychological autonomy	11 (3.4) **79 (6.6)**	127 (39.7) **490 (40.6)**	182 (56.9) **637 (52.8)**
u. Expectation that life path will lead to realization of deepest aspirations	88 (27.8) **399 (33.7)**	20 (6.3) **51 (4.3)**	209 (65.9) **733 (62.0)**
v. Faith and trust in God or higher power	239 (74.7) **928 (77.9)**	2 (0.6) **4 (0.3)**	79 (24.7) **260 (21.8)**
w. Fulfilling one's potential	35 (11.0) **235 (19.8)**	19 (6.0) **36 (3.0)**	265 (83.1) **917 (77.2)**

x. Internal sources of strength and hope	97 (30.5) **412 (34.6)**	7 (2.2) **20 (1.7)**	214 (67.3) **759 (63.7)**
y. Intrinsic motivation	48 (15.0) **258 (21.7)**	41 (12.9) **90 (7.6)**	230 (72.1) **843 (70.8)**
z. Loving others	98 (31.2) **469 (39.4)**	5 (1.6) **6 (0.5)**	211 (67.2) **714 (60.1)**
aa. Moral and ethical standards of behavior	96 (30.3) **469 (39.5)**	5 (1.6) **11 (0.9)**	216 (68.1) **707 (59.6)**
bb. Openness to alternative viewpoints	26 (8.2) **132 (11.2)**	36 (11.4) **143 (12.1)**	255 (80.4) **903 (76.7)**
cc. Personal application of theological beliefs	219 (68.7) **844 (70.8)**	2 (0.6) **8 (0.7)**	98 (30.7) **340 (28.5)**
dd. Personal identity	32 (10.1) **228 (19.2)**	30 (9.4) **51 (4.3)**	256 (80.5) **911 (76.6)**
ee. Practice of religious rituals	250 (79.1) **951 (80.3)**	3 (0.9) **6 (0.5)**	63 (19.9) **228 (19.2)**
ff. Practicing beliefs through behavior/action	91 (28.7) **429 (36.0)**	12 (3.8) **37 (3.1)**	214 (67.5) **725 (60.9)**
gg. Prayer or meditation	227 (71.8) **871 (73.3)**	2 (0.6) **3 (0.3)**	87 (27.5) **314 (26.4)**
hh. Pursuit of a fulfilling life	39 (12.4) **291 (24.6)**	12 (3.8) **14 (1.2)**	264 (83.8) **879 (74.2)**
ii. Quest to gain insight into life's pressing questions	63 (20.1) **412 (34.8)**	18 (5.8) **21 (1.8)**	232 (74.1) **750 (63.4)**
jj. Realization of being "primary author of own life"	35 (11.2) **233 (19.8)**	66 (21.1) **339 (28.9)**	212 (67.7) **602 (51.3)**
kk. Recognizing a power greater than oneself	180 (56.8) **721 (60.7)**	9 (2.8) **12 (1.0)**	128 (40.4) **454 (38.2)**
ll. Relationship with God or higher power	230 (72.3) **910 (76.6)**	2 (0.6) **4 (0.3)**	86 (27.0) **274 (23.1)**
mm. Relationships with significant others	29 (9.1) **180 (15.2)**	17 (5.3) **34 (2.9)**	272 (85.5) **969 (81.9)**
nn. Resolve to persevere in face of challenges	34 (10.7) **187 (15.7)**	19 (6.0) **24 (2.0)**	265 (83.3) **978 (82.3)**
oo. Respect for others	33 (10.4) **174 (14.7)**	11 (3.5) **17 (1.4)**	274 (86.2) **992 (83.9)**
pp. Responsibility to develop spirit	170 (53.5) **690 (58.3)**	9 (2.8) **5 (0.4)**	139 (43.7) **488 (41.3)**
qq. Self-awareness	18 (5.6) **141 (11.9)**	39 (12.2) **85 (7.2)**	262 (82.1) **957 (80.9)**
rr. Self-motivation	19 (6.0) **125 (10.6)**	46 (14.5) **104 (8.8)**	253 (79.6) **947 (80.5)**
ss. Self-reflection and introspection	33 (10.3) **169 (14.3)**	30 (9.4) **61 (5.2)**	256 (80.3) **952 (80.5)**
tt. Self-regulation	18 (5.7) **131 (11.1)**	52 (16.5) **108 (9.1)**	245 (77.8) **946 (79.8)**
uu. Sense of agency	20 (6.5) **137 (11.8)**	60 (19.5) **175 (15.0)**	228 (74.0) **853 (73.2)**
vv. Sense of global self-efficacy	23 (7.5) **133 (11.4)**	59 (19.2) **204 (17.5)**	225 (73.3) **831 (71.1)**
ww. Shaping of "core self"	39 (12.3) **239 (20.3)**	30 (9.4) **83 (7.1)**	249 (78.3) **854 (72.6)**
xx. Strength to exercise values-based leadership	50 (15.9) **290 (24.7)**	28 (8.9) **41 (3.5)**	236 (75.2) **842 (71.8)**
yy. Study of religious or spiritual texts	256 (80.5) **914 (77.5)**	1 (0.3) **6 (0.5)**	61 (19.2) **260 (22.0)**
zz. Taking care of one's physical well-being	16 (5.0) **106 (9.0)**	27 (8.5) **119 (10.1)**	276 (86.5) **959 (81.0)**
aaa. Tolerance and appreciation of diversity	26 (8.2) **138 (11.7)**	27 (8.5) **87 (7.4)**	265 (83.3) **951 (80.9)**
bbb. Trust of others	23 (7.3) **143 (12.1)**	20 (6.3) **49 (4.2)**	273 (86.4) **987 (83.7)**
ccc. Understanding how thoughts influence perceptions, motivation, and behavior	14 (4.4) **106 (9.0)**	70 (22.2) **201 (17.1)**	231 (73.3) **870 (73.9)**
ddd. Understanding the source of one's behaviors	19 (6.0) **133 (11.3)**	73 (23.0) **178 (15.1)**	225 (71.0) **871 (73.7)**
eee. Understanding the source of one's emotions	16 (5.1) **119 (10.1)**	67 (21.2) **202 (17.1)**	233 (73.7) **858 (72.8)**

fff. Vision for realizing one's full potential and purpose	41 (13.0) **261 (22.2)**	20 (6.3) **41 (3.5)**	255 (80.7) **874 (74.3)**
ggg. Willingness to critique aspects of religion	136 (42.9) **580 (49.2)**	7 (2.2) **21 (1.8)**	174 (54.9) **579 (49.1)**
hhh. Willingness to self-sacrifice	92 (28.9) **388 (32.8)**	10 (3.1) **13 (1.1)**	216 (67.9) **781 (66.1)**

2. Please rate your agreement with the following statements.

	Strongly disagree	Disagree	Agree	Strongly agree
a. War can cause moral injury to a person.	3 (0.9) **22 (1.8)**	3 (0.9) **29 (2.4)**	58 (17.9) **416 (34.8)**	260 (80.2) **729 (61.0)**
b. Trauma can cause moral injury to a person.	4 (1.2) **20 (1.7)**	4 (1.2) **34 (2.8)**	69 (21.3) **441 (36.9)**	247 (76.2) **701 (58.6)**
c. War can cause spiritual injury to a person.	3 (0.9) **20 (1.7)**	0 **35 (2.9)**	55 (17.1) **407 (34.1)**	264 (82.0) **731 (61.3)**
d. Trauma can cause spiritual injury to a person.	3 (0.9) **20 (1.7)**	0 **28 (2.4)**	61 (19.0) **427 (35.9)**	257 (80.1) **714 (60.1)**
e. Moral injury and spiritual injury are the same.	35 (10.9) **234 (19.7)**	162 (50.3) **582 (49.0)**	77 (23.9) **212 (17.8)**	48 (14.9) **160 (13.5)**

Use of Measurement Tools

This section asks questions about your use of measurement tools in the course of your work as a chaplain.

Do you currently use any measurement tools in your chaplaincy services?

☐ Yes **[GO TO 4]**	167 (52.2)	**493 (41.2)**
☐ No **[GO TO 7]**	153 (47.8)	**705 (58.8)**

4. What measures do you use? (Mark all that apply)

☐ Spiritual Injury Scale	87 (50.3)	**127 (25.1)**
☐ Brief Religious Coping Inventory	40 (23.1)	**98 (19.4)**
☐ Spiritual Attitudes Inventory	59 (34.1)	**193 (38.1)**
☐ TBI-PBE Religion/Spirituality Form	5 (2.9)	**26 (5.1)**
☐ Flourishing Scale	1 (0.6)	**22 (4.3)**
☐ Personal Well-Being Index	18 (10.4)	**99 (19.6)**
☐ Coping Self-Efficacy Scale	6 (3.5)	**45 (8.9)**
☐ CD-RISC	1 (0.6)	**3 (0.6)**
☐ PDRI	0	**1 (0.2)**
☐ Interpersonal Support Evaluation List	10 (5.8)	**41 (8.1)**
☐ PCL-M	2 (1.2)	**11 (2.2)**
☐ Beck Depression Inventory	11 (6.4)	**62 (12.3)**
☐ PHQ-9	1 (0.6)	**6 (1.2)**
☐ Other (specify below)	43 (24.9)	**189 (37.4)**

Specify: _____

5. Please select the factor(s) that most influence your choice of measure(s). (Mark up to 3 reasons.)

☐ Convenience	66 (38.2)	**178 (35.3)**
☐ Colleagues/others are using it	61 (35.3)	**117 (23.2)**
☐ Suggestion from a colleague	25 (14.5)	**116 (23.0)**
☐ Interest in that particular outcome	73 (42.2)	**134 (26.6)**
☐ Psychometric properties	9 (5.2)	**49 (9.7)**
☐ Experience with a measure	72 (41.6)	**261 (51.8)**
☐ Availability	72 (41.6)	**224 (44.4)**

6. What outcomes or constructs does your chosen measure(s) track? (Mark all that apply.)

☐ Symptom improvement	50 (28.9)	**150 (29.8)**
☐ Quality of life	106 (61.3)	**284 (56.3)**

☐ Satisfaction with care	47 (27.2)	**103 (20.4)**
☐ Spiritual growth	118 (68.2)	**306 (60.7)**
☐ Coping skills	107 (61.8)	**306 (60.7)**
☐ Other, specify: _____	22 (12.7)	**98 (19.4)**

7. To what degree are the following issues a barrier in your use of measurement tools?

	Not a barrier	Minor barrier	Moderate barrier	Major barrier
a. Access to measures	97 (32.7) **328 (29.2)**	62 (20.9) **251 (22.4)**	82 (27.6) **324 (28.9)**	56 (18.9) **220 (19.6)**
b. Time	70 (23.1) **290 (25.9)**	51 (16.8) **251 (22.4)**	105 (34.7) **365 (32.6)**	77 (25.4) **213 (19.0)**
c. Leadership support	145 (49.5) **567 (50.9)**	47 (16.0) **290 (26.1)**	66 (22.5) **178 (16.0)**	35 (11.9) **78 (7.0)**
d. Awareness of measures	89 (29.5) **265 (23.5)**	54 (17.9) **264 (23.4)**	92 (30.5) **295 (26.2)**	67 (22.2) **304 (27.0)**
e. Other, specify: _____	52 (69.3) **284 (68.8)**	4 (5.3) **27 (6.5)**	6 (8.0) **31 (7.5)**	13 (17.3) **71 (17.2)**

Tobacco Questionnaire [VA ONLY]

8. In regards to the Veterans you interact with, how comfortable would you feel:

	Very uncomfortable	Somewhat uncomfortable	Somewhat comfortable	Very comfortable
a. Asking about tobacco use	30 (9.3)	36 (11.2)	75 (23.4)	180 (56.1)
b. Advising them to quit using tobacco	40 (12.5)	47 (14.7)	97 (30.4)	135 (42.3)
c. Assessing their readiness to quit using tobacco	45 (14.1)	54 (16.9)	100 (31.3)	121 (37.8)
d. Assisting them to quit whether or not they are immediately ready	74 (23.2)	68 (21.3)	85 (26.6)	92 (28.8)
e. Arranging for smoking cessation follow-up	43 (13.5)	45 (14.2)	110 (34.6)	120 (37.7)
f. Serving as a social support during a quit attempt	20 (6.3)	29 (9.1)	112 (35.3)	156 (49.2)
Providing information about smoking cessation treatment in the form of:				
g. A pocket card	29 (9.4)	29 (9.4)	91 (29.4)	161 (51.9)
h. An 800 number	27 (8.6)	27 (8.6)	94 (30.0)	165 (52.7)
i. Verbal information from you	28 (8.9)	31 (9.8)	100 (31.6)	157 (49.7)
j. An informational website	24 (7.7)	22 (7.1)	99 (31.8)	166 (53.4)

APPENDIX I

CHAPLAIN SURVEY CODEBOOKS – ARMY, NAVY, AIR FORCE

The survey organization consists of 3 parts:

1. **Core Survey**: this should take approximately 20 minutes to complete.
2. **Demographics**: these come at the end of the Core Survey with explicit instructions emphasizing that answering the questions is **voluntary**.
3. **Supplemental Survey**: this should take around 15 minutes to complete.

Chaplain Survey – Final Instrument

Introduction

Thank you for your time in completing the Survey of Chaplains' Roles in support of the Department of Defense (DoD) and Department of Veterans Affairs (VA) Integrated Mental Health Strategy (IMHS). Your feedback will be crucial to accomplishing the objectives of the VA / DoD IMHS in constructing more optimally integrated systems of care for our Service members and Veterans.

[FILL CLIENT] throughout survey, DoD respondent = "Service member" and VA respondent = "Veteran"

Are you a Chaplain?

☐	Yes **[GO TO NEXT ITEM]**	1017 (100.0) **320 (100.0)** *386 (100.0)*
☐	No **[Do not enter survey. Show participant, "Thank you for your interest, but this is a survey to be completed by DoD or VA Chaplains. Since you indicated that you are not a Chaplain, you are not eligible to participate in this survey."]**	

With which organization do you serve? [GO TO 1] [USE TO TRIGGER APPROPRIATE SKIPS]

☐	Department of Defense (DoD)	1017 (100.0) **320 (100.0)** *386 (100.0)*
☐	Veterans' Affairs (VA)	0 **0** *0*

KEY:

Army Sample – Regular Font

Navy Sample – Bold Font

Air Force Sample – Italics Font

Populations

This section asks questions about the individuals you serve in your work as a chaplain.

1. In the course of your work as a chaplain, how often do you encounter each of the following types of individuals?

	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
a. Active duty Service members	0 **0** *0*	3 (0.3) **1 (0.3)** *1 (0.3)*	2 (0.2) **1 (0.3)** *1 (0.3)*	7 (0.7) **3 (0.9)** *3 (0.8)*	1001 (98.8) **315 (98.4)** *376 (98.7)*
b. Reserve or National Guard	67 (6.9) **22 (7.1)** *5 (1.3)*	246 (25.3) **106 (34.3)** *57 (15.2)*	153 (15.7) **77 (24.9)** *100 (26.6)*	240 (24.7) **71 (23.0)** *133 (35.4)*	267 (27.4) **33 (10.7)** *81 (21.5)*
c. Veterans (not active or reserve duty)	75 (7.7) **24 (7.7)** *12 (3.2)*	191 (19.7) **74 (23.9)** *37 (9.9)*	135 (13.9) **56 (18.1)** *34 (9.1)*	295 (30.5) **93 (30.0)** *162 (43.4)*	272 (28.1) **63 (20.3)** *128 (34.3)*

2. When you provide care for [FILL CLIENT], how often do you see them...

a. individually	6 (0.6) **3 (0.9)** *0*	38 (3.8) **11 (3.5)** *18 (4.8)*	47 (4.7) **15 (4.7)** *23 (6.1)*	378 (37.6) **100 (31.6)** *138 (36.8)*	536 (53.3) **187 (59.2)** *196 (52.3)*
b. with spouse or partner	30 (3.0) **5 (1.6)** *11 (3.0)*	156 (15.9) **64 (20.4)** *50 (13.5)*	227 (23.1) **89 (28.4)** *63 (17.0)*	483 (49.1) **129 (41.2)** *212 (57.1)*	88 (8.9) **26 (8.3)** *35 (9.4)*
c. with family other than spouse/partner	112 (11.5) **36 (11.6)** *27 (7.3)*	383 (39.2) **146 (46.9)** *118 (32.1)*	206 (21.1) **66 (21.2)** *71 (19.3)*	230 (23.5) **48 (15.4)** *129 (35.1)*	47 (4.8) **15 (4.8)** *23 (6.3)*
d. in a group with other Service members or Veterans	171 (17.4) **45 (14.4)** *44 (11.9)*	244 (24.8) **69 (22.0)** *88 (23.8)*	171 (17.4) **66 (21.1)** *53 (14.3)*	262 (26.6) **95 (30.4)** *125 (33.8)*	136 (13.8) **38 (12.1)** *60 (16.2)*

3. How often do you encounter:

a. Homeless **[FILL CLIENT]**	674 (67.4) **187 (59.2)** *222 (58.6)*	256 (25.6) **106 (33.5)** *125 (33.0)*	43 (4.3) **9 (2.8)** *27 (7.1)*	22 (2.2) **11 (3.5)** *5 (1.3)*	5 (0.5) **3 (0.9)** *0*
b. Family of **[FILL CLIENT]** without **[FILL CLIENT]**present	101 (10.1) **20 (6.3)** *22 (5.8)*	338 (33.8) **117 (37.0)** *89 (23.4)*	271 (27.1) **91 (28.8)** *98 (25.8)*	215 (21.5) **71 (22.5)** *118 (31.1)*	75 (7.5) **17 (5.4)** *53 (13.9)*
c. **[VA ONLY]** WWII era Veterans	0 **0** *0*	0 **0** *0*	0 **0** *0*	0 **0** *0*	0 **0** *0*
d. **[VA ONLY]** Korean War era Veterans	0 **0** *0*	0 **0** *0*	0 **0** *0*	0 **0** *0*	0 **0** *0*
e. **[VA ONLY]** Vietnam War era Veterans	0 **0** *0*	0 **0** *0*	0 **0** *0*	0 **0** *0*	0 **0** *0*
f. **[VA ONLY]** Gulf War era Veterans	0 **0** *0*	0 **0** *0*	0 **0** *0*	0 **0** *0*	0 **0** *0*
g. **[VA ONLY]** Post 9/11 era Veterans (e.g., OEF/OIF)	0 **0** *0*	0 **0** *0*	0 **0** *0*	0 **0** *0*	0 **0** *0*
h. **[VA ONLY]** Veterans of other conflicts	0 **0** *0*	0 **0** *0*	0 **0** *0*	0 **0** *0*	0 **0** *0*
i. **[VA ONLY]** Veterans who did not serve in a conflict	0 **0** *0*	0 **0** *0*	0 **0** *0*	0 **0** *0*	0 **0** *0*

4. How often do you come into contact with [FILL CLIENT] in the following ways?

	Never	Rarely	Sometimes	Frequently	Almost always
a. **[FILL CLIENT]** come to me on their own without referral.	3 (0.3) **1 (0.3)** *1 (0.3)*	17 (1.7) **1 (0.3)** *5 (1.3)*	105 (10.4) **20 (6.3)** *33 (8.8)*	531 (52.8) **166 (52.5)** *185 (49.2)*	349 (34.7) **128 (40.5)** *152 (40.4)*
b. I go to **[FILL CLIENT]** without them being referred to me.	15 (1.5) **1 (0.3)** *5 (1.3)*	76 (7.6) **21 (6.7)** *48 (12.8)*	267 (26.7) **79 (25.2)** *97 (25.9)*	467(46.7) **170 (54.3)** *169 (45.1)*	176 (17.6) **42 (13.4)** *56 (14.9)*
c. **[VA ONLY]** Veterans are referred to me by other professionals.	0 **0** *0*	0 **0** *0*	0 **0** *0*	0 **0** *0*	0 **0** *0*
d. **[DoD ONLY]** Service members are referred to me by their commanding officers.	13 (1.3) **1 (0.3)** *10 (2.7)*	90 (9.0) **42 (13.4)** *69 (18.6)*	488 (48.9) **160 (51.1)** *182 (49.1)*	359 (36.0) **98 (31.3)** *102 (27.5)*	48 (4.8) **12 (3.8)** *8 (2.2)*
e. **[VA ONLY]** Veterans are referred to me by their fellow Veterans.	0 **0** *0*	0 **0** *0*	0 **0** *0*	0 **0** *0*	0 **0** *0*
f. **[DoD ONLY]** Service members are referred to me by their fellow Service members.	8 (0.8) **0** *3 (0.8)*	75 (7.5) **15 (4.7)** *33 (8.8)*	468 (46.8) **131 (41.5)** *157 (41.8)*	402 (40.2) **151 (47.8)** *167 (44.4)*	48 (4.8) **19 (6.0)** *16 (4.3)*
g. **[FILL CLIENT]**are referred to me by **non-[FILL CLIENT]** family or friends.	52 (5.2) **13 (4.1)** *8 (2.1)*	354 (35.4) **95 (30.2)** *111 (29.5)*	441 (44.1) **155 (49.2)** *197 (52.4)*	133 (13.3) **47 (14.9)** *56 (14.9)*	21 (2.1) **5 (1.6)** *4 (1.1)*

5. For each of the below issues, please provide two ratings. First, rate how often you see [FILL CLIENT] with the below problems. Second, indicate how well your training has prepared you to provide pastoral care to [FILL CLIENT] with the problems listed below.

	3. How often?			4. How well has training prepared?		
	Rarely	**Sometimes**	**Frequently**	**Not Prepared**	**Somewhat Prepared**	**Very Prepared**
a. Anxiety	67 (6.7) **13 (4.1)** *28 (7.6)*	462 (46.5) **122 (38.7)** *202 (54.9)*	464 (46.7) **180 (57.1)** *138 (37.5)*	32 (3.2) **8 (2.5)** *12 (3.3)*	387 (39.1) **111 (35.2)** *160 (43.8)*	571 (57.7) **196 (62.2)** *193 (52.9)*
b. Guilt	166 (16.8) **39 (12.4)** *41 (11.2)*	613 (62.1) **199 (63.2)** *248 (67.8)*	208 (21.1) **77 (24.4)** *77 (21.0)*	21 (2.1) **8 (2.5)** *8 (2.2)*	260 (26.2) **68 (21.6)** *94 (25.7)*	710 (71.6) **239 (75.9)** *264 (72.1)*
c. Depression	52 (5.3) **12 (3.8)** *23 (6.3)*	498 (50.6) **147 (46.8)** *219 (59.5)*	435 (44.2) **155 (49.4)** *126 (34.2)*	50 (5.1) **15 (4.8)** *20 (5.5)*	460 (46.8) **129 (41.1)** *188 (51.6)*	473 (48.1) **170 (54.1)** *156 (42.9)*
d. Posttraumatic stress	192 (19.6) **66 (21.2)** *110 (30.1)*	573 (58.4) **197 (63.1)** *227 (62.2)*	216 (22.0) **49 (15.7)** *28 (7.7)*	106 (10.8) **23 (7.4)** *63 (17.5)*	550 (56.0) **155 (50.0)** *202 (56.0)*	327 (33.3) **132 (42.6)** *96 (26.6)*
e. Traumatic brain injury (TBI)	640 (65.2) **231 (73.8)** *307 (85.0)*	295 (30.0) **74 (23.6)** *50 (13.9)*	47 (4.8) **8 (2.6)** *4 (1.1)*	416 (42.5) **120 (38.2)** *212 (58.9)*	445 (45.5) **158 (50.3)** *124 (34.4)*	117 (12.0) **36 (11.5)** *24 (6.7)*
f. Psychosis	704 (72.1) **220 (71.0)** *280 (76.1)*	255 (26.1) **85 (27.4)** *83 (22.6)*	17 (1.7) **5 (1.6)** *5 (1.4)*	487 (49.9) **127 (40.8)** *205 (56.2)*	399 (40.9) **148 (47.6)** *126 (34.5)*	90 (9.2) **36 (11.6)** *34 (9.3)*
g. Anger	31 (3.2) **5 (1.6)** *10 (2.7)*	384 (39.6) **116 (37.2)** *199 (54.7)*	554 (57.2) **191 (61.2)** *155 (42.6)*	12 (1.2) **6 (1.9)** *4 (1.1)*	344 (35.5) **84 (27.0)** *136 (37.5)*	614 (63.3) **221 (71.1)** *223 (61.4)*
h. Difficulty forgiving others	123 (12.6) **31 (10.0)** *30 (8.4)*	573 (58.7) **172 (55.3)** *205 (57.4)*	280 (28.7) **108 (34.7)** *122 (34.2)*	13 (1.3) **2 (0.6)** *2 (0.6)*	189 (19.3) **47 (15.2)** *53 (14.8)*	777 (79.4) **260 (84.1)** *304 (84.7)*
i. Work stress	16 (1.7) **3 (1.0)** *2 (0.5)*	256 (26.4) **58 (18.8)** *76 (20.9)*	697 (71.9) **247 (80.2)** *286 (78.6)*	7 (0.7) **4 (1.3)** *6 (1.7)*	250 (25.8) **56 (18.4)** *86 (23.8)*	712 (73.5) **245 (80.3)** *269 (74.5)*
j. Relationship or family stress	14 (1.4) **2 (0.6)** *3 (0.8)*	202 (20.8) **56 (18.1)** *50 (13.8)*	753 (77.7) **252 (81.3)** *310 (85.4)*	7 (0.7) **3 (1.0)** *3 (0.8)*	188 (19.3) **49 (15.8)** *66 (18.2)*	780 (80.0) **259 (83.3)** *294 (81.0)*

k.	Sleep problems	306 (31.5) **86 (27.9)** *129 (35.7)*	514 (52.9) **168 (54.5)** *201 (55.7)*	151 (15.6) **54 (17.5)** *31 (8.6)*	259 (26.7) **64 (20.8)** *85 (23.6)*	518 (53.5) **179 (58.3)** *206 (57.2)*	192 (19.8) **64 (20.8)** *69 (19.2)*
l.	Spiritual struggle understanding loss/trauma	70 (7.1) **22 (7.1)** *20 (5.5)*	566 (57.6) **175 (56.3)** *209 (57.3)*	346 (35.2) **114 (36.7)** *136 (37.3)*	7 (0.7) **2 (0.6)** *3 (0.8)*	169 (17.3) **45 (14.4)** *51 (14.0)*	803 (82.0) **266 (85.0)** *310 (85.2)*
m.	Suicidal thoughts/intentions	209 (21.3) **37 (11.8)** *72 (19.8)*	618 (62.9) **215 (68.5)** *248 (68.1)*	156 (15.9) **62 (19.7)** *44 (12.1)*	14 (1.4) **4 (1.3)** *2 (0.6)*	184 (18.7) **52 (16.7)** *94 (26.0)*	787 (79.9) **256 (82.1)** *265 (73.4)*
n.	Financial problems	157 (16.0) **55 (17.8)** *66 (18.1)*	591 (60.4) **187 (60.5)** *235 (64.4)*	231 (23.6) **67 (21.7)** *64 (17.5)*	72 (7.3) **15 (4.9)** *27 (7.5)*	424 (43.3) **144 (46.8)** *172 (47.5)*	484 (49.4) **149 (48.4)** *163 (45.0)*
o.	Legal problems	295 (29.9) **64 (20.8)** *103 (28.4)*	591 (59.9) **207 (67.2)** *228 (62.8)*	100 (10.1) **37 (12.0)** *32 (8.8)*	284 (28.8) **64 (20.4)** *71 (19.7)*	523 (53.0) **183 (58.3)** *215 (59.6)*	180 (18.2) **67 (21.3)** *75 (20.8)*
p.	Homelessness	909 (92.6) **299 (95.2)** *342 (93.4)*	65 (6.6) **12 (3.8)** *21 (5.7)*	8 (0.8) **3 (1.0)** *3 (0.8)*	440 (44.4) **130 (41.4)** *158 (43.3)*	440 (44.4) **155 (49.4)** *165 (45.2)*	111 (11.2) **29 (9.2)** *42 (11.5)*
q.	Difficulty forgiving self	182 (18.7) **41 (13.1)** *41 (11.3)*	637 (65.6) **193 (61.9)** *255 (70.1)*	152 (15.7) **78 (25.0)** *68 (18.7)*	10 (1.0) **3 (1.0)** *4 (1.1)*	212 (21.9) **60 (19.2)** *72 (20.0)*	748 (77.1) **250 (79.9)** *284 (78.9)*
r.	Sexual assault victimization	579 (59.7) **151 (48.7)** *186 (51.4)*	358 (36.9) **146 (47.1)** *165 (45.6)*	33 (3.4) **13 (4.2)** *11 (3.0)*	88 (9.1) **11 (3.5)** *18 (5.0)*	547 (56.3) **151 (48.4)** *181 (50.1)*	337 (34.7) **150 (48.1)** *162 (44.9)*
s.	Sexual assault perpetration	805 (82.8) **235 (75.1)** *283 (78.0)*	161 (16.6) **71 (22.7)** *78 (21.5)*	6 (0.6) **7 (2.2)** *2 (0.6)*	190 (19.5) **45 (14.4)** *57 (15.9)*	543 (55.9) **165 (52.7)** *191 (53.4)*	239 (24.6) **103 (32.9)** *110 (30.7)*
t.	Domestic violence victimization	424 (43.8) **128 (41.3)** *162 (45.0)*	497 (51.4) **168 (54.2)** *189 (52.5)*	46 (4.8) **14 (4.5)** *9 (2.5)*	77 (7.9) **12 (3.9)** *26 (7.2)*	529 (54.5) **156 (50.5)** *195 (54.2)*	364 (37.5) **141 (45.6)** *139 (38.6)*
u.	Domestic violence perpetration	596 (61.8) **181 (57.8)** *251 (69.5)*	341 (35.3) **122 (39.0)** *104 (28.8)*	28 (2.9) **10 (3.2)** *6 (1.7)*	127 (13.1) **33 (10.6)** *46 (12.8)*	552 (57.1) **164 (52.6)** *198 (55.2)*	288 (29.8) **115 (36.9)** *115 (32.0)*
v.	Struggle accepting significant life events	97 (10.0) **34 (11.0)** *21 (5.8)*	586 (60.4) **157 (50.8)** *195 (54.3)*	287 (29.6) **118 (38.2)** *143 (39.8)*	14 (1.4) **6 (1.9)** *7 (2.0)*	283 (29.2) **84 (27.0)** *89 (24.9)*	673 (69.4) **221 (71.1)** *261 (73.1)*
w.	Alcohol abuse	276 (28.7) **48 (15.4)** *121 (33.7)*	536 (55.7) **192 (61.2)** *207 (57.7)*	150 (15.6) **71 (22.8)** *31 (8.6)*	78 (8.1) **9 (2.9)** *32 (9.0)*	525 (54.7) **136 (44.2)** *195 (54.8)*	357 (37.2) **163 (52.9)** *129 (36.2)*
x.	Illicit drug use	584 (60.6) **193 (63.1)** *274 (76.8)*	338 (35.1) **97 (31.7)** *79 (22.1)*	41 (4.3) **16 (5.2)** *4 (1.1)*	164 (17.0) **37 (12.1)** *73 (20.6)*	520 (54.0) **157 (51.1)** *197 (55.5)*	279 (29.0) **113 (36.8)** *85 (23.9)*
y.	Prescription drug misuse	663 (69.1) **217 (70.7)** *291 (82.2)*	266 (27.7) **83 (27.0)** *60 (16.9)*	30 (3.1) **7 (2.3)** *3 (0.8)*	207 (21.6) **44 (14.2)** *88 (24.9)*	509 (53.1) **171 (55.3)** *194 (54.8)*	243 (25.3) **94 (30.4)** *72 (20.3)*
z.	Physical health problems	250 (25.9) **95 (30.8)** *85 (23.5)*	540 (56.0) **167 (54.2)** *207 (57.3)*	175 (18.1) **46 (14.9)** *69 (19.1)*	110 (11.4) **29 (9.4)** *31 (8.6)*	523 (54.3) **163 (53.1)** *185 (51.1)*	330 (34.3) **115 (37.5)** *146 (40.3)*
aa.	Difficulty accepting forgiveness	281 (29.1) **84 (27.2)** *69 (19.3)*	545 (56.4) **166 (53.7)** *230 (64.4)*	140 (14.5) **59 (19.1)** *58 (16.2)*	20 (2.1) **3 (1.0)** *3 (0.8)*	214 (22.1) **51 (16.6)** *69 (19.2)*	733 (75.8) **253 (82.4)** *287 (79.9)*
bb.	Chronic pain	503 (52.6) **169 (54.9)** *211 (59.1)*	375 (39.2) **122 (39.6)** *129 (36.1)*	79 (8.3) **17 (5.5)** *17 (4.8)*	268 (27.8) **86 (27.7)** *98 (27.4)*	496 (51.5) **162 (52.3)** *197 (55.0)*	199 (20.7) **62 (20.0)** *63 (17.6)*
cc.	Moral injury	270 (28.0) **70 (22.7)** *88 (24.5)*	562 (58.3) **194 (63.0)** *215 (59.9)*	132 (13.7) **44 (14.3)** *56 (15.6)*	30 (3.1) **2 (0.6)** *11 (3.1)*	342 (35.5) **92 (29.6)** *144 (40.1)*	591 (61.4) **217 (69.8)** *204 (56.8)*
dd.	Separation/Discharge from the military	193 (20.1) **33 (10.6)** *77 (21.3)*	567 (59.1) **182 (58.3)** *205 (56.6)*	200 (20.8) **97 (31.1)** *80 (22.1)*	51 (5.3) **9 (2.9)** *22 (6.1)*	421 (44.0) **129 (41.5)** *153 (42.5)*	485 (50.7) **173 (55.6)** *185 (51.4)*
ee.	Struggle with religious belief system	168 (17.4) **43 (13.9)** *36 (10.0)*	618 (63.9) **187 (60.5)** *213 (59.0)*	181 (18.7) **79 (25.6)** *112 (31.0)*	9 (0.9) **2 (0.6)** *0*	91 (9.4) **27 (8.7)** *38 (10.5)*	872 (89.7) **281 (90.6)** *323 (89.5)*
ff.	Other spiritual struggle	106 (11.0) **26 (8.4)** *16 (4.5)*	618 (64.0) **194 (62.6)** *201 (56.1)*	241 (25.0) **90 (29.0)** *141 (39.4)*	9 (0.9) **1 (0.3)** *0*	130 (13.4) **43 (13.7)** *53 (14.7)*	831 (85.7) **269 (85.9)** *308 (85.3)*

Work Settings

This section asks about the settings in which you work as a chaplain.

6. How much of your time is spent providing services in each of the following settings?

	None	A small amount	A moderate amount	A large amount
a. Inpatient medical	409 (42.2) **117 (37.6)** *185 (51.0)*	422 (43.6) **143 (46.0)** *145 (39.9)*	89 (9.2) **26 (8.4)** *18 (5.0)*	49 (5.1) **25 (8.0)** *15 (4.1)*
b. Outpatient medical	436 (45.0) **115 (37.0)** *198 (54.7)*	406 (41.9) **155 (49.8)** *134 (37.0)*	101 (10.4) **33 (10.6)** *24 (6.6)*	26 (2.7) **8 (2.6)** *6 (1.7)*
c. Inpatient psychiatric/mental health	513 (53.1) **155 (49.8)** *245 (67.9)*	351 (36.3) **129 (41.5)** *102 (28.3)*	80 (8.3) **20 (6.4)** *9 (2.5)*	23 (2.4) **7 (2.3)** *5 (1.4)*
d. Outpatient mental health	449 (46.8) **128 (41.7)** *205 (56.6)*	359 (37.4) **134 (43.6)** *130 (35.9)*	123 (12.8) **41 (13.4)** *21 (5.8)*	28 (2.9) **4 (1.3)** *6 (1.7)*
e. Inpatient substance use programs	677 (70.0) **207 (66.8)** *288 (80.2)*	242 (25.0) **80 (25.8)** *67 (18.7)*	42 (4.3) **17 (5.5)** *3 (0.8)*	6 (0.6) **6 (1.9)** *1 (0.3)*
f. Outpatient substance use programs	596 (62.0) **168 (54.4)** *265 (73.6)*	288 (30.0) **113 (36.6)** *88 (24.4)*	67 (7.0) **24 (7.8)** *6 (1.7)*	10 (1.0) **4 (1.3)** *1 (0.3)*
g. Specialized PTSD treatment – inpatient	736 (76.2) **222 (72.3)** *303 (84.2)*	182 (18.8) **68 (22.1)** *49 (13.6)*	39 (4.0) **14 (4.6)** *6 (1.7)*	9 (0.9) **3 (1.0)** *2 (0.6)*
h. Specialized PTSD treatment – outpatient	622 (64.5) **184 (59.4**) *263 (72.5)*	246 (25.5) **96 (31.0)** *86 (23.7)*	82 (8.5) **22 (7.1)** *9 (2.5)*	14 (1.5) **8 (2.6)** *5 (1.4)*
i. Nursing home care	859 (88.9) **270 (86.8)** *315 (87.0)*	94 (9.7) **34 (10.9)** *39 (10.8)*	12 (1.2) **7 (2.3)** *7 (1.9)*	1 (0.1) **0** *1 (0.3)*
j. Women's health	753 (78.2) **216 (70.1)** *283 (78.6)*	174 (18.1) **78 (25.3)** *69 (19.2)*	31 (3.2) **11 (3.6)** *7 (1.9)*	5 (0.5) **3 (1.0)** *1 (0.3)*
k. Community setting	348 (36.4) **99 (32.0)** *105 (29.0)*	256 (26.8) **100 (32.4)** *85 (23.5)*	210 (22.0) **74 (23.9)** *88 (24.3)*	142 (14.9) **36 (11.7)** *84 (23.2)*
l. Other setting (specify below)	407 (50.7) **113 (43.8)** *140 (45.6)*	61 (7.6) **19 (7.4)** *21 (6.8)*	68 (8.5) **16 (6.2)** *23 (7.5)*	266 (33.2) **110 (42.6)** *123 (40.1)*

Specify: _____

7. Please check the following settings in which you as the chaplain are included as a member of the care team.

☐	Inpatient medical/surgical team **[GO TO 7A]**	143 (14.7)	**42 (13.5)**	*38 (10.4)*
☐	Inpatient psychiatric/mental health team **[GO TO 7A]**	127 (13.0)	**41 (13.1)**	*26 (7.1)*
☐	TBI Clinic team **[GO TO 7A]**	49 (5.0)	**14 (4.5)**	*6 (1.6)*
☐	OEF/OIF Clinic team **[GO TO 7A]**	107 (11.0)	**28 (9.0)**	*37 (10.1)*
☐	PTSD Clinic team **[GO TO 7A]**	79 (8.1)	**33 (10.6)**	*34 (9.3)*
☐	Outpatient Mental Health Clinic team **[GO TO 7A]**	106 (10.9)	**38 (12.2)**	*29 (7.9)*
☐	Substance Use Clinic team **[GO TO 7A]**	73 (7.5)	**38 (12.2)**	*14 (3.8)*
☐	Women's Health Clinic team **[GO TO 7A]**	26 (2.7)	**9 (2.9)**	*8 (2.2)*
☐	Other mental health related team (specify below) **[GO TO 8]**	141 (14.4)	**58 (18.6)**	*80 (21.9)*

Specify: _____

☐ None **[GO TO 8]**	576 (59.0)	**161 (51.6)**	*197 (54.0)*	

a. Please indicate your agreement with the following statements. [FOR EACH OF THE ABOVE TEAMS THAT IS CHECKED, ASK THE FOLLOWING QUESTION.]

	Strongly disagree	Disagree	Agree	Strongly agree
a. The inpatient medical/surgical team understands and values my role as a chaplain.	1 (0.7) **0** *0*	7 (4.9) **1 (2.4)** *3 (7.9)*	69 (48.6) **21 (50.0)** *22 (57.9)*	65 (45.8) **20 (47.6)** *13 (34.2)*
b. The inpatient psychiatric/mental health team understands and values my role as a chaplain.	3 (2.4) **1 (2.4)** *0*	13 (10.2) **5 (12.2)** *3 (11.5)*	57 (44.9) **22 (53.7)** *14 (53.8)*	54 (42.5) **13 (31.7)** *9 (34.6)*
c. The TBI Clinic team understands and values my role as a chaplain.	2 (4.3) **1 (7.1)** *0*	6 (12.8) **2 (14.3)** *2 (33.3)*	22 (46.8) **6 (42.9)** *3 (50.0)*	17 (36.2) **5 (35.7)** *1 (16.7)*
d. The OEF/OIF Clinic team understands and values my role as a chaplain.	1 (1.0) **1 (3.6)** *0*	2 (1.9) **3 (10.7)** *3 (8.3)*	45 (42.9) **14 (50.0)** *17 (47.2)*	57 (54.3) **10 (35.7)** *16 (44.4)*
e. The PTSD Clinic team understands and values my role as a chaplain.	1 (1.3) **1 (3.0)** *0*	6 (7.7) **6 (18.2)** *1 (2.9)*	40 (51.3) **13 (39.4)** *25 (73.5)*	31 (39.7) **13 (39.4)** *8 (23.5)*
f. The Outpatient Mental Health Clinic team understands and values my role as a chaplain.	3 (2.9) **1 (2.6)** *0*	15 (14.3) **3 (7.9)** *1 (3.4)*	49 (46.7) **16 (42.1)** *20 (69.0)*	38 (36.2) **18 (47.4)** *8 (27.6)*
g. The Substance Use Clinic team understands and values my role as a chaplain.	3 (4.2) **0** 0	7 (9.7) **3 (7.9)** *2 (14.3)*	31 (43.1) **15 (39.5)** *8 (57.1)*	31 (43.1) **20 (52.6)** *4 (28.6)*
h. The Women's Health Clinic team understands and values my role as a chaplain.	0 **0** *0*	2 (7.7) **1 (11.1)** *1 (12.5)*	9 (34.6) **4 (44.4)** *4 (50.0)*	15 (57.7) **4 (44.4)** *3 (37.5)*
i. The other specified team understands and values my role as a chaplain.	6 (4.3) **0** *1 (1.3)*	16 (11.5) **12 (20.7)** *10 (12.8)*	66 (47.5) **26 (44.8)** *37 (47.4)*	51 (36.7) **20 (34.5)** *30 (38.5)*

Work activities

This section asks questions about the activities of your work as a chaplain.

8. How often do you engage in each of the following practices <u>in your interactions with [FILL CLIENT]?</u>

	Never	Rarely	Sometimes	Frequently
a. Help **[FILL CLIENT]** practice directly dealing with things that made them afraid (such as places, people, memories or feelings) in order to become less afraid of them	87 (9.2) **18 (5.9)** *38 (10.8)*	285 (30.2) **98 (31.9)** *140 (39.8)*	425 (45.0) **149 (48.5)** *141 (40.1)*	148 (15.7) **42 (13.7)** *33 (9.4)*
b. Teach **[FILL CLIENT]** methods of physical relaxation, such as slow breathing	175 (18.5) **32 (10.4)** *86 (24.3)*	330 (34.8) **95 (30.9)** *126 (35.6)*	331 (34.9) **128 (41.7)** *117 (33.1)*	112 (11.8) **52 (16.9)** *25 (7.1)*
c. Help **[FILL CLIENT]** look at their thoughts more realistically	14 (1.5) **0** *6 (1.7)*	43 (4.6) **10 (3.3)** *13 (3.8)*	350 (37.7) **85 (28.2)** *130 (37.6)*	521 (56.1) **206 (68.4)** *197 (56.9)*
d. Help **[FILL CLIENT]** to see mistakes in their thinking - for example, all or nothing thinking or always fearing the worst will happen	21 (2.2) **0** *8 (2.3)*	62 (6.6) **12 (3.9)** *24 (6.8)*	406 (43.2) **114 (37.3)** *167 (47.4)*	450 (47.9) **180 (58.8)** *153 (43.5)*
e. Help **[FILL CLIENT]** to understand how their thoughts and feelings are related	15 (1.6) **0** *4 (1.1)*	48 (5.1) **9 (2.9)** *21 (5.9)*	367 (38.8) **102 (33.3)** *152 (42.9)*	515 (54.5) **195 (63.7)** *177 (50.0)*
f. Ask **[FILL CLIENT]** to do "homework" between visits (Homework can include activities like writing down their thoughts, feelings, and activities or practicing something they learned during their visit.)	39 (4.1) **12 (3.9)** *9 (2.5)*	157 (16.6) **52 (16.9)** *53 (14.9)*	396 (41.9) **136 (44.3)** *153 (43.1)*	353 (37.4) **107 (34.9)** *140 (39.4)*

g.	Provide resilience training or education, such adaptive coping behaviors and ways to "bounce back" after illness, injury, or other hardships	46 (4.9) **17 (5.6)** *9 (2.5)*	154 (16.3) **41 (13.4)** *41 (11.6)*	399 (42.3) **128 (41.8)** *151 (42.7)*	345 (36.5) **120 (39.2)** *153 (43.2)*
h.	Help **[FILL CLIENT]** explore their values	7 (0.7) **0** *0*	58 (6.1) **4 (1.3)** *17 (4.8)*	355 (37.5) **103 (33.6)** *118 (33.3)*	526 (55.6) **200 (65.1)** *219 (61.9)*
i.	Help **[FILL CLIENT]** explore issues of life meaning	8 (0.9) **1 (0.3)** *0*	48 (5.1) **8 (2.6)** *23 (6.5)*	324 (34.5) **92 (30.3)** *103 (29.1)*	559 (59.5) **203 (66.8)** *228 (64.4)*
j.	Help **[FILL CLIENT]** make sense of trauma or loss	13 (1.4) **2 (0.7)** *3 (0.8)*	75 (7.9) **19 (6.2)** *24 (6.8)*	420 (44.4) **128 (41.8)** *176 (49.7)*	437 (46.2) **157 (51.3)** *151 (42.7)*
k.	Have conversations concerning spiritual struggles or moral injury	6 (0.6) **1 (0.3)** *0*	48 (5.1) **9 (2.9)** *16 (4.5)*	339 (35.9) **104 (33.9)** *123 (34.8)*	552 (58.4) **193 (62.9)** *214 (60.6)*

9. How *often* do you engage in the following activities or services?

		Never	**Less than monthly**	**Monthly**	**Weekly**	**Daily or almost daily**
a.	Praying with **[FILL CLIENT]**	1 (0.1) **0** *0*	33 (3.5) **7 (2.3)** *7 (2.0)*	44 (4.7) **13 (4.2)** *21 (5.9)*	375 (39.9) **116 (37.9)** *145 (41.1)*	486 (51.8) **170 (55.6)** *180 (51.0)*
b.	Anointing **[FILL CLIENT]**	299 (32.1) **100 (32.7)** *99 (28.3)*	407 (43.7) **143 (46.7)** *160 (45.7)*	130 (14.0) **35 (11.4)** *54 (15.4)*	71 (7.6) **18 (5.9)** *31 (8.9)*	24 (2.6) **10 (3.3)** *6 (1.7)*
c.	Spiritually counseling **[FILL CLIENT]**	2 (0.2) **1 (0.3)** *2 (0.6)*	30 (3.2) **6 (2.0)** *7 (2.0)*	98 (10.5) **25 (8.2)** *25 (7.2)*	362 (38.8) **110 (36.2)** *130 (37.2)*	442 (47.3) **162 (53.3)** *185 (53.0)*
d.	Spiritually counseling fellow chaplains or clergy	53 (5.7) **18 (5.9)** *21 (6.0)*	243 (26.0) **76 (24.9)** *73 (20.9)*	237 (25.4) **72 (23.6)** *86 (24.6)*	278 (29.8) **95 (31.1)** *117 (33.4)*	123 (13.2) **44 (14.4)** *53 (15.1)*
e.	Advising **[FILL CLIENT]** (e.g., direct advice)	8 (0.9) **1 (0.3)** *3 (0.9)*	47 (5.0) **4 (1.3)** *9 (2.6)*	79 (8.5) **18 (5.9)** *24 (6.9)*	308 (33.1) **80 (26.4)** *137 (39.4)*	489 (52.5) **200 (66.0)** *175 (50.3)*
f.	Advising fellow chaplains or clergy (e.g., direct advice)	34 (3.6) **13 (4.3)** *13 (3.7)*	203 (21.7) **52 (17.0)** *45 (13.0)*	208 (22.3) **62 (20.3)** *61 (17.6)*	301 (32.2) **112 (36.7)** *134 (38.6)*	188 (20.1) **66 (21.6)** *94 (27.1)*
g.	Providing education about mental health to **[FILL CLIENT]**	123 (13.4) **24 (7.8)** *32 (9.2)*	262 (28.5) **76 (24.8)** *102 (29.4)*	244 (26.5) **95 (31.0)** *97 (28.0)*	219 (23.8) **84 (27.5)** *94 (27.1)*	72 (7.8) **27 (8.8)** *22 (6.3)*
h.	Providing education about physical health to **[FILL CLIENT]**	188 (20.3) **43 (14.1)** *51 (14.7)*	314 (33.8) **97 (31.9)** *110 (31.7)*	204 (22.0) **68 (22.4)** *98 (28.2)*	175 (18.9) **79 (26.0)** *71 (20.5)*	47 (5.1) **17 (5.6)** *17 (4.9)*
i.	Supervising fellow chaplains or clergy	294 (31.6) **91 (29.8)** *94 (27.2)*	147 (15.8) **46 (15.1)** *41 (11.8)*	67 (7.2) **21 (6.9)** *20 (5.8)*	111 (11.9) **35 (11.5)** *29 (8.4)*	311 (33.4) **112 (36.7)** *162 (46.8)*
j.	Conducting staff consultation activities about **[FILL CLIENT]** care	240 (25.7) **61 (20.1)** *105 (30.1)*	225 (24.1) **70 (23.0)** *104 (29.8)*	214 (22.9) **68 (22.4)** *58 (16.6)*	196 (21.0) **80 (26.3)** *62 (17.8)*	60 (6.4) **25 (8.2)** *20 (5.7)*
k.	Leading worship services	15 (1.6) **8 (2.6)** *9 (2.6)*	105 (11.2) **54 (17.7)** *58 (16.6)*	209 (22.3) **68 (22.3)** *60 (17.1)*	500 (53.4) **138 (45.2)** *179 (51.1)*	108 (11.5) **37 (12.1)** *44 (12.6)*
l.	Directing **[FILL CLIENT]**to other services	27 (2.9) **0** *8 (2.3)*	111 (11.9) **17 (5.6)** *59 (17.0)*	251 (27.0) **74 (24.2)** *101 (29.1)*	410 (44.1) **159 (52.0)** *130 (37.5)*	131 (14.1) **56 (18.3)** *49 (14.1)*
m.	Offering **[FILL CLIENT]**other spiritual programs	16 (1.7) **2 (0.7)** *8 (2.3)*	118 (12.8) **26 (8.6)** *38 (10.8)*	231 (25.0) **70 (23.1)** *82 (23.4)*	438 (47.5) **151 (49.8)** *173 (49.3)*	120 (13.0) **54 (17.8)** *50 (14.2)*

n. Arranging for services to be provided by clergy of another tradition	67 (7.2) **12 (3.9)** *29 (8.3)*	329 (35.2) **86 (28.2)** *135 (38.6)*	275 (29.4) **86 (28.2)** *106 (30.3)*	211 (22.6) **101 (33.1)** *60 (17.1)*	52 (5.6) **20 (6.6)** *20 (5.7)*
o. Speaking engagements within the local community	197 (21.1) **34 (11.1)** *36 (10.3)*	449 (48.0) **144 (47.1)** *202 (57.7)*	208 (22.2) **101 (33.0)** *81 (23.1)*	61 (6.5) **23 (7.5)** *27 (7.7)*	20 (2.1) **4 (1.3)** *4 (1.1)*
p. Teaching students	214 (22.9) **42 (13.7)** *49 (14.2)*	282 (30.2) **84 (27.5)** *112 (32.5)*	177 (19.0) **74 (24.2)** *64 (18.6)*	188 (20.1) **87 (28.4)** *104 (30.1)*	73 (7.8) **19 (6.2)** *16 (4.6)*
q. **[DoD ONLY]** Consulting with commanding officer	36 (3.9) **8 (2.6)** *10 (2.8)*	95 (10.2) **47 (15.5)** *39 (11.1)*	147 (15.7) **44 (14.5)** *110 (31.3)*	460 (49.2) **157 (51.6)** *158 (44.9)*	197 (21.1) **48 (15.8)** *35 (9.9)*
r. **[VA ONLY]** Consulting with immediate supervisor	0 **0** *0*	0 **0** *0*	0 **0** *0*	0 **0** *0*	0 **0** *0*
s. Addressing issues of housing or homelessness	585 (62.6) **166 (54.4)** *212 (60.4)*	269 (28.8) **113 (37.0)** *119 (33.9)*	51 (5.5) **17 (5.6)** *15 (4.3)*	21 (2.2) **6 (2.0)** *3 (0.9)*	8 (0.9) **3 (1.0)** *2 (0.6)*

10. In your work as a chaplain, how often do you engage with:

	Never	**Less than monthly**	**Monthly**	**Weekly**	**Daily or almost daily**
a. Local clergy **[IF NEVER, SKIP TO 12]**	92 (9.9) **17 (5.6)** *16 (4.6)*	328 (35.3) **77 (25.5)** *109 (31.2)*	272 (29.2) **89 (29.5)** *119 (34.1)*	223 (24.0) **112 (37.1)** *97 (27.8)*	15 (1.6) **7 (2.3)** *8 (2.3)*
b. Other community representatives **[IF NEVER, SKIP TO 12]**	143 (15.3) **29 (9.6)** *28 (8.0)*	378 (40.6) **112 (37.0)** *146 (41.5)*	271 (29.1) **105 (34.7)** *121 (34.4)*	116 (12.4) **55 (18.2)** *46 (13.1)*	24 (2.6) **2 (0.7)** *11 (3.1)*

In the course of engaging with local clergy or other community representatives, how often do you:

c. Lead presentations	240 (27.9) **62 (21.0)** *78 (23.2)*	400 (46.6) **143 (48.5)** *172 (51.2)*	124 (14.4) **59 (20.0)** *48 (14.3)*	81 (9.4) **28 (9.5)** *35 (10.4)*	14 (1.6) **3 (1.0)** *3 (0.9)*
d. Conduct programs focused on stigma toward mental illness or mental health care	546 (63.6) **180 (61.2)** *226 (67.3)*	245 (28.5) **88 (29.9)** *91 (27.1)*	43 (5.0) **13 (4.4)** *17 (5.1)*	19 (2.2) **11 (3.7)** *2 (0.6)*	6 (0.7) **2 (0.7)** *0*
e. Discuss the role of religious or other communities in helping persons reintegrate into the community	305 (35.3) **84 (28.5)** *94 (27.8)*	354 (41.0) **118 (40.0)** *157 (46.4)*	148 (17.1) **62 (21.0)** *53 (15.7)*	42 (4.9) **29 (9.8)** *32 (9.5)*	14 (1.6) **2 (0.7)** *2 (0.6)*

11. How supportive is your organization's administration of outreach to:

	Very supportive	**Somewhat supportive**	**Neither supportive nor unsupportive**	**Somewhat unsupportive**	**Very unsupportive**
a. Community clergy	279 (32.6) **111 (37.8)** *130 (38.3)*	225 (26.3) **59 (20.1)** *122 (36.0)*	259 (30.3) **87 (29.6)** *47 (13.9)*	51 (6.0) **15 (5.1)** *21 (6.2)*	41 (4.8) **22 (7.5)** *19 (5.6)*
b. Other community representatives	295 (34.6) **117 (39.9)** *134 (39.6)*	255 (29.9) **66 (22.5)** *118 (34.9)*	225 (26.4) **69 (23.5)** *49 (14.5)*	44 (5.2) **19 (6.5)** *19 (5.6)*	34 (4.0) **22 (7.5)** *18 (5.3)*

Interaction with Mental Health Professionals

This section asks questions about your interaction with mental health professionals in your work as a chaplain.

12. How often do you engage with mental health professionals?

☐ Never **[If Never→go to Q16]**	75 (8.1)	**13 (4.3)**	*15 (4.3)*
☐ Less than monthly	328 (35.4)	**111 (36.6)**	*104 (29.7)*
☐ Monthly	284 (30.6)	**94 (31.0)**	*136 (38.9)*
☐ Weekly	190 (20.5)	**57 (18.8)**	*82 (23.4)*
☐ Daily or almost daily	50 (5.4)	**28 (9.2)**	*13 (3.7)*

13. How often do you engage with mental health professionals in the following ways?

	Never	Less than monthly	Monthly	Weekly	Daily or almost daily
a. I make referrals to mental health professionals.	24 (2.9) **7 (2.4)** *11 (3.3)*	303 (36.0) **75 (25.7)** *128 (38.4)*	312 (37.1) **137 (46.9)** *137 (41.1)*	182 (21.6) **65 (22.3)** *50 (15.0)*	21 (2.5) **8 (2.7)** *7 (2.1)*
b. I receive referrals from mental health professionals.	288 (34.2) **99 (33.9)** *82 (24.8)*	351 (41.7) **106 (36.3)** *163 (49.2)*	137 (16.3) **52 (17.8)** *60 (18.1)*	51 (6.1) **30 (10.3)** *24 (7.3)*	14 (1.7) **5 (1.7)** *2 (0.6)*
c. Mental health professionals ask for my help in assessing for the importance of spirituality in **[FILL CLIENT]**	363 (43.2) **127 (43.5)** *133 (40.3)*	299 (35.6) **96 (32.9)** *137 (41.5)*	115 (13.7) **36 (12.3)** *45 (13.6)*	53 (6.3) **29 (9.9)** *13 (3.9)*	11 (1.3) **4 (1.4)** *2 (0.6)*
d. Mental health professionals consult with me on cultural diversity.	528 (62.6) **199 (68.4)** *200 (60.4)*	219 (26.0) **67 (23.0)** *97 (29.3)*	60 (7.1) **12 (4.1)** *24 (7.3)*	27 (3.2) **11 (3.8)** *10 (3.0)*	9 (1.1) **2 (0.7)** *0*
e. I participate with health care teams about planning for a **[FILL CLIENT]** mental health treatment needs.	413 (49.3) **151 (51.7)** *201 (61.1)*	273 (32.6) **79 (27.1)** *89 (27.1)*	98 (11.7) **38 (13.0)** *30 (9.1)*	42 (5.0) **21 (7.2)** *8 (2.4)*	12 (1.4) **3 (1.0)** *1 (0.3)*
f. I discuss care of a **[FILL CLIENT]** mental health needs with an individual health care provider.	334 (39.6) **91 (31.2)** *203 (61.3)*	323 (38.3) **123 (42.1)** *105 (31.7)*	121 (14.3) **43 (14.7)** *15 (4.5)*	54 (6.4) **30 (10.3)** *7 (2.1)*	12 (1.4) **5 (1.7)** *1 (0.3)*

14. Please rate your agreement with the following statements.

	Strongly disagree	Disagree	Agree	Strongly agree	Not applicable
a. I think mental health providers and chaplains can closely collaborate while retaining identities and abilities unique to their respective professions.	27 (3.2) **10 (3.5)** *12 (3.6)*	20 (2.4) **6 (2.1)** *14 (4.3)*	258 (30.7) **70 (24.2)** *109 (33.1)*	530 (63.0) **202 (69.9)** *190 (57.8)*	6 (0.7) **1 (0.3)** *4 (1.2)*
b. My office space is in close physical proximity to offices of mental health professionals.	246 (29.3) **77 (26.6)** *113 (34.1)*	271 (32.2) **93 (32.1)** *98 (29.6)*	176 (20.9) **70 (24.1)** *72 (21.8)*	87 (10.3) **36 (12.4)** *29 (8.8)*	61 (7.3) **14 (4.8)** *19 (5.7)*
c. I have close relationships with mental health professionals.	71 (8.5) **37 (12.8)** *15 (4.6)*	236 (28.1) **83 (28.6)** *83 (25.2)*	322 (38.3) **98 (33.8)** *147 (44.7)*	175 (20.8) **66 (22.8)** *80 (24.3)*	36 (4.3) **6 (2.1)** *4 (1.2)*
d. I have received substantial prior training in mental health issues.	99 (11.8) **21 (7.3)** *37 (11.2)*	273 (32.5) **92 (31.9)** *129 (39.0)*	274 (32.6) **108 (21.9)** *105 (31.7)*	174 (20.7) **63 (21.9)** *59 (17.8)*	20 (2.4) **4 (1.4)** *1 (0.3)*

15. To what extent do you view the following activities as job components for chaplains and mental health care providers?

	Chaplain's Job			Mental Health Provider's Job		
	Non or minor component	**Moderate component**	**Major component**	**Non or minor component**	**Moderate component**	**Major component**
a. Providing counseling	2 (0.2) **0** *1 (0.3)*	84 (10.2) **30 (10.5)** *33 (10.1)*	741 (89.6) **255 (89.5)** *293 (89.6)*	21 (2.6) **8 (2.9)** *2 (0.6)*	128 (15.7) **48 (17.1)** *19 (5.9)*	667 (81.7) **224 (80.0)** *300 (93.5)*
b. Giving general health advice	361 (43.8) **90 (31.7)** *139 (42.4)*	415 (50.4) **163 (57.4)** *166 (50.6)*	48 (5.8) **31 (10.9)** *23 (7.0)*	54 (6.6) **13 (4.6)** *26 (8.0)*	399 (49.0) **141 (50.0)** *179 (55.4)*	361 (44.3) **128 (45.4)** *118 (36.5)*
c. Praying with a **[FILL CLIENT]**	1 (0.1) **1 (0.4)** *1 (0.3)*	36 (4.4) **20 (7.0)** *17 (5.2)*	786 (95.5) **264 (92.6)** *307 (94.5)*	717 (88.1) **253 (90.0)** *303 (95.0)*	86 (10.6) **28 (10.0)** *15 (4.7)*	11 (1.4) **0** *1 (0.3)*
d. Providing psychotherapy	628 (76.6) **237 (83.5)** *277 (85.0)*	167 (20.4) **37 (13.0)** *46 (14.1)*	25 (3.0) **10 (3.5)** *3 (0.9)*	13 (1.6) **2 (0.7)** *5 (1.6)*	108 (13.3) **29 (10.3)** *34 (10.6)*	689 (85.1) **251 (89.0)** *282 (87.9)*
e. Engaging in religious activities with a **[FILL CLIENT]**	0 **1 (0.4)** *2 (0.6)*	33 (4.0) **13 (4.6)** *12 (3.7)*	788 (96.0) **268 (95.0)** *311 (95.7)*	691 (85.0) **248 (89.2)** *298 (93.1)*	116 (14.3) **28 (10.1)** *18 (5.6)*	6 (0.7) **2 (0.7)** *4 (1.3)*
f. Inviting **[FILL CLIENT]**to express their personal story.	4 (0.5) **1 (0.4)** *1 (0.3)*	81 (9.9) **20 (7.1)** *42 (13.0)*	731 (89.6) **262 (92.6)** *280 (86.7)*	19 (2.4) **2 (0.7)** *7 (2.2)*	162 (20.1) **47 (16.8)** *67 (21.1)*	624 (77.5) **230 (82.4)** *244 (76.7)*
g. Diagnosing mental health problems	620 (75.7) **224 (78.9)** *258 (79.4)*	177 (21.6) **53 (18.7)** *62 (19.1)*	22 (2.7) **7 (2.5)** *5 (1.5)*	8 (1.0) **1 (0.4)** *4 (1.3)*	27 (3.3) **12 (4.3)** *6 (1.9)*	775 (95.7) **269 (95.4)** *310 (96.9)*
h. Enhancing resiliency among **[FILL CLIENT]**	6 (0.7) **1 (0.4**) *1 (0.3)*	122 (14.9) **32 (11.3)** *19 (5.9)*	689 (84.3) **249 (88.3)** *302 (93.8)*	21 (2.6) **5 (1.8)** *5 (1.6)*	149 (18.3) **39 (13.9)** *29 (9.1)*	642 (79.1) **236 (84.3)** *284 (89.3)*
i. Conducting spiritual assessments	2 (0.2) **3 (1.1)** *2 (0.6)*	61 (7.4) **19 (6.7)** *15 (4.6)*	760 (92.3) **263 (92.3)** *310 (94.8)*	497 (61.2) **159 (56.8)** *209 (65.1)*	283 (34.9) **102 (36.4)** *100 (31.2)*	32 (3.9) **19 (6.8)** *12 (3.7)*
j. Acting as a liaison between the **[FILL CLIENT]**, health care providers, and other relevant persons	101 (12.4) **23 (8.1)** *62 (19.1)*	390 (47.8) **104 (36.5)** *146 (45.1)*	325 (39.8) **158 (55.4)** *116 (35.8)*	66 (8.2) **23 (8.2)** *20 (6.3)*	393 (48.8) **115 (41.1)** *143 (45.0)*	347 (43.1) **142 (50.7)** *155 (48.7)*
k. Caring for family members of a **[FILL CLIENT]**	4 (0.5) **1 (0.4)** *4 (1.2)*	108 (13.2) **54 (19.3)** *46 (14.1)*	706 (86.3) **225 (19.3)** *277 (84.7)*	180 (22.2) **72 (26.1)** *64 (19.9)*	304 (37.6) **118 (42.8)** *116 (36.1)*	325 (40.2) **86 (31.2)** *141 (43.9)*
l. Communicating with family members of a **[FILL CLIENT]**	23 (2.8) **14 (4.9)** *26 (8.1)*	237 (29.0) **90 (31.7)** *121 (37.7)*	556 (68.1) **180 (63.4)** *174 (54.2)*	133 (16.4) **60 (21.4)** *73 (23.2*)	382 (47.2) **133 (47.3)** *146 (46.5)*	294 (36.3) **88 (31.3)** *95 (30.3)*
m. Attending to the **[FILL CLIENT]**spirituality	1 (0.1) **0** *0*	18 (2.2) **4 (1.4)** *4 (1.2)*	798 (97.7) **276 (98.6)** *320 (98.8)*	543 (67.2) **180 (64.7)** *231 (72.4)*	236 (29.2) **86 (30.9)** *77 (24.1)*	29 (3.6) **12 (4.3)** *11 (3.4)*

n. Attending to the **[FILL CLIENT]**mental health	117 (14.4) **44 (15.5)** *62 (19.1)*	514 (63.3) **168 (59.2)** *200 (61.5)*	181 (22.3) **72 (25.4)** *63 (19.4)*	9 (1.1) **0** *2 (0.6)*	18 (2.2) **3 (1.1)** *7 (2.2)*	779 (96.7) **278 (98.9)** *311 (97.2)*
o. Addressing issues of guilt and forgiveness	1 (0.1) **0** *1 (0.3)*	60 (7.3) **16 (5.6)** *19 (5.8)*	762 (92.6) **269 (94.4)** *305 (93.8)*	81 (10.0) **25 (8.9)** *21 (6.6)*	373 (45.8) **142 (50.4)** *134 (41.9)*	360 (44.2) **115 (40.8)** *165 (51.6)*
p. **[DoD ONLY]** Advising the Command	4 (0.5) **3 (1.1)** *9 (2.8)*	57 (7.0) **15 (5.3)** *22 (6.7)*	757 (92.5) **267 (93.7)** *295 (90.5)*	81 (9.9) **39 (13.8)** *22 (6.9)*	235 (28.8) **89 (31.6)** *84 (26.2)*	499 (61.2) **154 (54.6)** *215 (67.0)*
q. **[VA ONLY]** Advising VA leadership	0 **0** *0*	0 **0** *0*	0 **0** *0*	0 **0** *0*	0 **0** *0*	0 **0** *0*

16. Please rate your agreement with the following statements.

	Strongly disagree	**Disagree**	**Agree**	**Strongly agree**
a. Mental health professionals understand spiritual work that is done with [FILL CLIENT].	132 (14.9) **43 (14.7)** *44 (13.1)*	345 (39.0) **131 (44.7)** *125 (37.2)*	375 (42.4) **108 (36.9)** *152 (45.2)*	33 (3.7) **11 (3.8)** *15 (4.5)*
b. Mental health professionals value my role as a chaplain.	66 (7.5) **28 (9.6)** *21 (6.3)*	193 (21.9) **85 (29.1)** *59 (17.7)*	498 (56.5) **142 (48.6)** *205 (61.6)*	124 (14.1) **37 (12.7)** *48 (14.4)*
c. Mental health professionals impinge on spiritual work that is done with **[FILL CLIENT]**.	73 (8.4) **24 (8.4)** *36 (10.8)*	552 (63.2) **185 (64.9)** *227 (68.4)*	220 (25.2) **65 (22.8)** *62 (18.7)*	29 (3.3) **11 (3.9)** *7 (2.1)*
d. Mental health professionals view chaplains as impinging on mental health care.	62 (7.0) **11 (3.8)** *29 (8.8)*	454 (51.6) **161 (55.3)** *185 (56.1)*	310 (35.2) **96 (33.0)** *103 (31.2)*	54 (6.1) **23 (7.9)** *13 (3.9)*
e. Non-mental health professionals (e.g., primary care providers) understand spiritual work that is done with **[FILL CLIENT]**.	55 (6.3) **18 (6.2)** *18 (5.5)*	253 (29.1) **111 (38.4)** *97 (29.4)*	510 (58.7) **145 (50.2)** *196 (59.4)*	51 (5.9) **15 (5.2)** *19 (5.8)*
f. Non-mental health professionals (e.g., primary care providers) value my role as a chaplain.	21 (2.4) **8 (2.7)** *6 (1.8)*	120 (13.6) **49 (16.8)** *45 (13.6)*	595 (67.6) **199 (68.2)** *234 (70.5)*	144 (16.4) **36 (12.3)** *47 (14.2)*
g. Non-mental health professionals (e.g., primary care providers) impinge on spiritual work that is done with **[FILL CLIENT]**.	95 (10.8) **30 (10.4)** *36 (10.8)*	639 (72.9) **210 (72.7)** *254 (76.5)*	128 (14.6) **44 (15.2)** *40 (12.0)*	15 (1.7) **5 (1.7)** *2 (0.6)*
h. Non-mental health professionals (e.g., primary care providers) view chaplains as impinging on mental health care.	90 (10.3) **19 (6.6)** *38 (11.4)*	606 (69.3) **207 (71.6)** *239 (72.0)*	157 (17.9) **54 (18.7)** *55 (16.6)*	22 (2.5) **9 (3.1)** *0*

17. Please rate your agreement with the following statements.

	Strongly disagree	**Disagree**	**Agree**	**Strongly agree**
a. I understand the work that is done by mental health professionals.	6 (0.7) **2 (0.7)** *2 (0.6)*	52 (5.9) **10 (3.4)** *14 (4.2)*	550 (62.4) **170 (58.2)** *209 (62.2)*	274 (31.1) **110 (37.7)** *111 (33.0)*
b. I value the role of mental health professionals.	7 (0.8) **2 (0.7)** *1 (0.3)*	32 (3.6) **4 (1.4)** *9 (2.7)*	454 (51.8) **136 (46.9)** *163 (48.8)*	384 (43.8) **148 (51.0)** *161 (48.2)*
c. I understand the work that is done by non-mental health professionals (e.g., primary care providers).	5 (0.6) **1 (0.3)** *0*	43 (4.9) **5 (1.7)** *9 (2.7)*	542 (61.9) **168 (57.9)** *204 (61.3)*	286 (32.6) **116 (40.0)** *120 (36.0)*
d. I value the role of non-mental health professionals (e.g., primary care providers).	4 (0.5) **1 (0.3)** *0*	9 (1.0) **3 (1.0)** *4 (1.2)*	442 (50.2) **124 (42.6)** *162 (48.4)*	425 (48.3) **163 (56.0)** *169 (50.4)*

e. **Veterans** with mental health problems commonly seek help from the chaplain instead of a mental health provider.	14 (1.6) **6 (2.1)** *7 (2.1)*	179 (20.4) **53 (18.2)** *53 (15.9)*	497 (56.5) **158 (54.3)** *166 (49.8)*	189 (21.5) **74 (25.4)** *107 (32.1)*

18. In your opinion, how helpful is the use of chaplaincy services in the following aspects of mental health care?

	Very unhelpful	Somewhat unhelpful	Neither helpful nor unhelpful	Somewhat helpful	Very helpful
a. Entry into mental health treatment	27 (3.1) **16 (5.5)** *9 (2.7)*	37 (4.2) **8 (2.8)** *10 (3.0)*	83 (9.5) **14 (4.8)** *24 (7.1)*	320 (36.4) **97 (33.6)** *157 (46.7)*	411 (46.8) **154 (53.3)** *136 (40.5)*
b. Compliance with mental health treatment	21 (2.4) **8 (2.8)** *4 (1.2)*	36 (4.1) **13 (4.5)** *13 (3.9)*	151 (17.3) **27 (9.3)** *71 (21.2)*	360 (41.2) **132 (45.5)** *160 (47.8)*	305 (34.9) **110 (37.9)** *87 (26.0)*
c. Family stability	28 (3.2) **17 (5.9)** *8 (2.4)*	13 (1.5) **3 (1.0)** *7 (2.1)*	24 (2.7) **1 (0.3)** *8 (2.4)*	203 (23.3) **55 (19.0)** *82 (24.4)*	605 (69.3) **214 (73.8)** *231 (68.8)*
d. **[DoD ONLY]** Deployability	28 (3.2) **15 (5.2)** *8 (2.4)*	14 (1.6) **3 (1.0)** *7 (2.1)*	43 (4.9) **4 (1.4)** *20 (6.0)*	236 (27.1) **60 (20.8)** *100 (29.8)*	551 (63.2) **206 (71.5)** *201 (59.8)*
e. **[DoD ONLY]** Decrease in negative behavior (UCMJ involvement, etc.)	26 (3.0) **13 (4.5)** *4 (1.2)*	14 (1.6) **4 (1.4)** *11 (3.3)*	54 (6.2) **3 (1.0)** *13 (3.9)*	300 (34.3) **79 (27.2)** *119 (35.5)*	480 (54.9) **191 (65.9)** *188 (56.1)*
f. **[VA ONLY]** Decrease in negative behavior	0 **0** *0*	0 **0** *0*	0 **0** *0*	0 **0** *0*	0 ***0*** *0*

19. How often have you encountered Veterans who seek care from a chaplain instead of from a mental health professional for the following reasons?

	Never	Occasionally	Often	Frequently
a. They do not trust mental health professionals.	34 (4.0) **15 (5.2)** *6 (1.8)*	362 (42.1) **133 (46.0)** *95 (28.5)*	282 (32.8) **70 (24.2)** *103 (30.9)*	182 (21.2) **71 (24.6)** *129 (38.7)*
b. **[DoD ONLY]** Unit leadership might treat them differently if they see a mental health provider.	44 (5.1) **11 (3.8)** *6 (1.8)*	273 (31.7) **85 (29.4)** *97 (29.0)*	306 (35.5) **90 (31.1)** *95 (28.4)*	238 (27.6) **103 (35.6)** *136 (40.7)*
c. **[VA ONLY]** Their job supervisor might treat them differently if they see a mental health provider.	0 **0** *0*	0 **0** *0*	0 **0** *0*	0 **0** *0*
d. It would be too embarrassing to seek help from a mental health provider.	38 (4.4) **4 (1.4)** *9 (2.7)*	307 (35.9) **114 (39.4)** *111 (33.3)*	313 (36.7) **94 (32.5)** *110 (33.0)*	196 (23.0) **77 (26.6)** *103 (30.9)*
e. They would be seen as weak.	41 (4.8) **7 (2.4)** *22 (6.7)*	288 (33.5) **99 (34.3)** *121 (36.7)*	313 (36.4) **96 (33.2)** *103 (31.2)*	217 (25.3) **87 (30.1)** *84 (25.5)*
f. Seeing a mental health provider would harm their career.	47 (5.5) **11 (3.8)** *3 (0.9)*	268 (31.3) **75 (26.0)** *68 (20.5)*	303 (35.4) **92 (31.9)** *96 (29.0)*	239 (27.9) **110 (38.2)** *164 (49.5)*
g. Members of their unit/task group would have less confidence in them.	66 (7.7) **11 (3.8)** *24 (7.3)*	312 (36.5) **107 (37.2)** *118 (35.9)*	312 (36.5) **105 (36.5)** *109 (33.1)*	164 (19.2) **65 (22.6)** *78 (23.7)*
h. They do not know where to get help.	121 (14.1) **32 (11.2)** *50 (15.2)*	415 (48.4) **137 (48.1)** *170 (51.5)*	226 (26.4) **79 (27.7)** *77 (23.3)*	95 (11.1) **37 (13.0)** *33 (10.0)*

i.	Mental health care costs too much money.	632 (73.8) **213 (74.0)** *238 (72.1)*	146 (17.1) **51 (17.7)** *71 (21.5)*	52 (6.1) **12 (4.2)** *15 (4.5)*	26 (3.0) **12 (4.2)** *6 (1.8)*
j.	They would feel the need to hide from others that they had seen a mental health treatment provider.	84 (9.8) **19 (6.6)** *40 (12.0)*	351 (41.0) **122 (42.2)** *132 (39.8)*	274 (32.0) **81 (28.0)** *89 (26.8)*	147 (17.2) **67 (23.2)** *71 (21.4)*
k.	It is difficult to schedule an appointment with a mental health provider.	226 (26.3) **73 (25.4)** *113 (34.0)*	293 (34.1) **114 (39.7)** *113 (34.0)*	172 (20.0) **64 (22.3)** *66 (19.9)*	168 (19.6) **36 (12.5)** *40 (12.0)*
l.	They would feel inadequate if they went to a mental health professional for a mental health problem.	112 (13.1) **34 (11.8)** *56 (16.9)*	406 (47.5) **141 (49.1)** *159 (48.0)*	246 (28.8) **78 (27.2)** *78 (23.6)*	90 (10.5) **34 (11.8)** *38 (11.5)*
m.	Professional mental health care does not work.	227 (26.6) **79 (27.4)** *113 (33.8)*	445 (52.2) **157 (54.5)** *169 (50.6)*	127 (14.9) **45 (15.6)** *41 (12.3)*	54 (6.3) **7 (2.4)** *11 (3.3)*
n.	They see their mental health problem as being best addressed by a chaplain.	70 (8.3) **28 (9.8)** *27 (8.2)*	455 (53.8) **163 (57.0)** *172 (52.0)*	231 (27.3) **61 (21.3)** *93 (28.1)*	89 (10.5) **34 (11.9)** *39 (11.8)*
o.	They perceive their mental health as closely related to spiritual issues.	97 (11.3) **32 (11.1)** *28 (8.5)*	458 (53.6) **152 (53.0)** *164 (49.5)*	239 (28.0) **76 (26.5)** *103 (31.1)*	61 (7.1) **27 (9.4)** *36 (10.9)*
p.	They have more confidence in chaplains than mental health providers.	44 (5.2) **12 (4.2)** *17 (5.1)*	348 (40.9) **132 (46.2)** *118 (35.6)*	302 (35.5) **89 (31.1)** *108 (32.6)*	157 (18.4) **53 (18.5)** *88 (26.6)*
q.	They do not see their problem as a mental health issue in need of mental health treatment.	32 (3.7) **9 (3.1)** *14 (4.2)*	373 (43.6) **133 (46.0)** *137 (41.1)*	324 (37.9) **100 (34.6)** *129 (38.7)*	126 (14.7) **47 (16.3)** *53 (15.9)*
r.	They seek confidentiality.	9 (1.0) **1 (0.3)** *0*	106 (12.3) **32 (11.1)** *22 (6.6)*	240 (27.9) **62 (21.5)** *43 (12.9)*	504 (58.7) **194 (67.1)** *268 (80.5)*
s.	They seek wisdom and understanding.	10 (1.2) **5 (1.7)** *1 (0.3)*	132 (15.4) **53 (18.3)** *49 (14.8)*	357 (41.6) **98 (33.9)** *121 (36.4)*	359 (41.8) **133 (46.0)** *161 (48.5)*

20. Please rate your agreement with the following statements.

		Strongly disagree	Disagree	Agree	Strongly agree
a.	Seeing a mental health professional could have negative consequences for **[FILL CLIENT]** (e.g., harm their career).	152 (17.6) **44 (15.3)** *42 (12.5)*	324 (37.5) **101 (35.1)** *124 (37.0)*	304 (35.2) **110 (38.2)** *114 (34.0)*	83 (9.6) **33 (11.5)** *55 (16.4)*
b.	Seeing a chaplain could have negative consequences for **[FILL CLIENT]** (e.g., harm their career).	529 (61.2) **182 (63.6)** *262 (78.4)*	293 (33.9) **85 (29.7)** *69 (20.7)*	35 (4.1) **16 (5.6)** *0*	7 (0.8) **3 (1.0)** *3 (0.9)*

Further Information and Training

This section asks questions about areas in which you would like further information or training.

21. How helpful would each of the following educational topics be in your work?

		Not at all helpful	Somewhat helpful	Quite helpful	Extremely helpful
a.	Information about of mental health problems specific to **[FILL CLIENT]**.	26 (3.1) **7 (2.5)** *9 (2.8)*	253 (30.1) **67 (23.7)** *111 (33.9)*	343 (40.8) **123 (43.5)** *128 (39.1)*	218 (26.0) **86 (30.4)** *79 (24.2)*

b.	Diagnostic criteria for mental health problems.	77 (9.2) **25 (8.8)** *35 (10.7)*	300 (35.8) **96 (33.8)** *118 (36.1)*	285 (34.0) **103 (36.3)** *115 (35.2)*	176 (21.0) **60 (21.1)** *59 (18.0)*
c.	Making a referral to mental health	45 (5.4) **21 (7.4)** *25 (7.7)*	240 (28.7) **67 (23.7)** *104 (32.1)*	340 (40.7) **122 (43.1)** *116 (35.8)*	210 (25.1) **73 (25.8)** *79 (24.4)*
d.	Improving collaborative relationships between chaplains and mental health	19 (2.3) **2 (0.7)** *8 (2.5)*	162 (19.3) **35 (12.3)** *61 (18.8)*	298 (35.6) **92 (32.4)** *124 (38.3)*	359 (42.8) **155 (54.6)** *131 (40.4)*
e.	Addressing concerns about mental health stigma	46 (5.5) **19 (6.7)** *31 (9.6)*	229 (27.4) **63 (22.2)** *75 (23.1)*	295 (35.3) **102 (35.9)** *133 (41.0)*	265 (31.7) **100 (35.2)** *85 (26.2)*
f.	Information about empirically supported mental health treatments	58 (7.0) **20 (7.1)** *31 (9.5)*	272 (32.6) **74 (26.2)** *112 (34.5)*	312 (37.4) **114 (40.4)** *109 (33.5)*	192 (23.0) **74 (26.2)** *73 (22.5)*
g.	Information about traumatic brain injury	18 (2.2) **10 (3.5)** *18 (5.5)*	231 (27.7) **61 (21.6)** *102 (31.4)*	302 (36.2) **118 (41.7)** *114 (35.1)*	283 (33.9) **94 (33.2)** *91 (28.0)*
h.	Information about disability and poly-trauma	50 (6.0) **14 (5.0)** *37 (11.4)*	277 (33.2) **84 (29.8)** *116 (35.8)*	289 (34.7) **113 (40.1)** *103 (37.8)*	218 (26.1) **71 (25.2)** *68 (21.0)*
i.	Spiritual consequences of combat trauma and PTSD	10 (1.2) **3 (1.1)** *4 (1.2)*	108 (12.9) **32 (11.3)** *29 (8.9)*	265 (31.6) **84 (29.7)** *116 (35.5)*	456 (54.4) **164 (58.0)** *178 (54.4)*
j.	How to utilize spiritual resources in ways consistent with mental health treatment	33 (4.0) **6 (2.1)** *10 (3.1)*	116 (13.9) **36 (12.8)** *49 (15.0)*	289 (34.7) **105 (37.2)** *113 (34.7)*	394 (47.4) **135 (47.9)** *154 (47.2)*
k.	Information about spiritual and religious needs specific to **[FILL CLIENT]**.	22 (2.6) **11 (3.9)** *9 (2.8)*	138 (16.6) **48 (17.0)** *45 (13.8)*	289 (34.7) **91 (32.3)** *106 (32.6)*	384 (46.1) **132 (46.8)** *165 (50.8)*
l.	Information about PTSD	17 (2.0) **9 (3.2)** *6 (1.9)*	193 (23.0) **54 (19.1)** *67 (20.7)*	313 (37.4) **109 (38.5)** *116 (35.8)*	315 (37.6) **111 (39.2)** *135 (41.7)*
m.	How to identify **[FILL CLIENT]** particular mental health problems	38 (4.6) **8 (2.8)** *14 (4.3)*	218 (26.2) **69 (24.3)** *92 (28.1)*	322 (38.7) **100 (35.2)** *126 (38.5)*	254 (30.5) **107 (37.7)** *95 (29.1)*
n.	Information about mood disorders (e.g., depression, bipolar disorder)	25 (3.0) **5 (1.8)** *14 (4.3)*	232 (27.7) **60 (21.3)** *80 (24.5)*	308 (36.8) **120 (42.6)** *130 (39.9)*	272 (32.5) **97 (34.4)** *102 (31.3)*
o.	How to address diverse spiritual and religious concerns	36 (4.3) **18 (6.4)** *11 (3.4)*	155 (18.5) **60 (21.4)** *55 (16.9)*	311 (37.2) **84 (29.9)** *114 (35.1)*	335 (40.0) **119 (42.3)** *145 (44.6)*
p.	Information about psychotic disorders (e.g., schizophrenia)	66 (7.9) **14 (5.0)** *32 (9.8)*	298 (35.7) **92 (33.1)** *118 (36.2)*	259 (31.0) **103 (37.1)** *111 (34.0)*	212 (25.4) **69 (24.8)** *65 (19.9)*
q.	Information about the particular mental health needs of women **[FILL CLIENT]**	37 (4.4) **9 (3.2)** *18 (5.5)*	244 (29.2) **66 (23.3)** *102 (31.2)*	317 (37.9) **123 (43.5)** *118 (36.1)*	239 (28.6) **85 (30.0)** *89 (27.2)*
r.	Information about substance abuse disorders (e.g., alcohol abuse)	26 (3.1) **9 (3.2)** *21 (6.4)*	232 (27.9) **69 (24.6)** *95 (29.1)*	323 (38.9) **112 (39.9)** *128 (39.3)*	250 (30.1) **91 (32.4)** *82 (25.2)*
s.	**[VA only]** Information about the characteristics and mental health needs of OEF/OIF Veterans	0 **0** *0*	0 **0** *0*	0 **0** *0*	0 **0** *0*
t.	How to effectively use therapeutic approaches to care for patients' spiritual and religious needs	33 (4.0) **19 (6.8)** *20 (6.2)*	183 (22.0) **55 (19.6)** *53 (16.3)*	312 (37.5) **97 (34.5)** *118 (36.3)*	303 (36.5) **110 (39.1)** *134 (41.2)*
u.	How to effectively use therapeutic approaches to care for patients' mental health problems	69 (8.3) **27 (9.6)** *32 (9.8)*	243 (29.1) **85 (30.2)** *111 (34.2)*	307 (36.8) **103 (36.7)** *116 (35.7)*	215 (25.8) **66 (23.5)** *66 (20.3)*
v.	Information about personality disorders (e.g., borderline personality disorder)	47 (5.6) **12 (4.3)** *20 (6.2)*	271 (32.5) **73 (25.9)** *109 (33.5)*	284 (34.1) **114 (40.4)** *121 (37.2)*	231 (27.7) **83 (29.4)** *75 (23.1)*
w.	Information about the characteristics and mental health needs of **[FILL CLIENT]** families	35 (4.2) **12 (4.3)** *17 (5.2)*	242 (29.2) **65 (23.0)** *97 (29.8)*	318 (38.4) **122 (43.3)** *134 (41.2)*	234 (28.2) **83 (29.4)** *77 (23.7)*
x.	Information about housing and homelessness	210 (25.2) **78 (27.7)** *110 (33.8)*	329 (39.4) **114 (40.4)** *133 (40.9)*	186 (22.3) **57 (20.2)** *52 (16.0)*	109 (13.1) **33 (11.7)** *30 (9.2)*

y. Other (specify below)	225 (57.7) **76 (73.1)** *104 (72.7)*	51 (13.1) **1 (1.0)** *14 (9.8)*	43 (11.0) **5 (4.8)** *10 (7.0)*	71 (18.2) **22 (21.2)** *15 (10.5)*

Specify: _____

Professional Activities

This section asks about other professional activities in your work as a chaplain.

22. How often do you engage in the following professional activities?

	Never	Less than yearly	Yearly	Monthly	Weekly or more
a. Reading professional journal articles	23 (2.8) **12 (4.3)** *9 (2.8)*	70 (8.4) **20 (7.1)** *37 (11.3)*	137 (16.4) **33 (11.7)** *56 (17.1)*	371 (44.4) **134 (47.5)** *153 (46.8)*	234 (28.0) **83 (29.4)** *72 (22.0)*
b. Writing articles for publication in professional journals	386 (46.6) **151 (53.7)** *195 (59.8)*	245 (29.6) **82 (29.2)** *92 (28.2)*	146 (17.6) **32 (11.4)** *27 (8.3)*	46 (5.5) **11 (3.9**) *10 (3.1)*	6 (0.7) **5 (1.8)** *2 (0.6)*
c. Participating as part of a research team for formal health care studies	590 (70.9) **218 (77.3)** *259 (79.7)*	166 (20.0) **42 (14.9)** *44 (13.5)*	46 (5.5) **11 (3.9)** *12 (3.7)*	22 (2.6) **5 (1.8)** *9 (2.8)*	8 (1.0) **6 (2.1)** *1 (0.3)*
d. Attending chaplaincy continuing educational events	19 (2.3) **2 (0.7)** *13 (4.0)*	86 (10.3) **8 (2.8)** *96 (29.3)*	440 (52.5) **219 (77.7)** *202 (61.6)*	262 (31.3) **47 (16.7)** *11 (3.4)*	31 (3.7) **6 (2.1)** *6 (1.8)*
e. Attending mental health continuing educational events	425 (51.1) **111 (39.6)** *205 (62.9)*	223 (26.8) **92 (32.9)** *85 (26.1)*	150 (18.0) **67 (23.9)** *31 (9.5)*	32 (3.8) **6 (2.1)** *4 (1.2)*	2 (0.2) **4 (1.4)** *1 (0.3)*
f. Attending national chaplaincy conferences	110 (13.1) **39 (13.8)** *64 (19.6)*	163 (19.5) **48 (17.0)** *100 (30.7)*	553 (66.0) **190 (67.4)** *161 (49.4)*	10 (1.2) **3 (1.1)** *1 (0.3)*	2 (0.2) **2 (0.7)** *0*
g. Presenting at national chaplaincy conferences	569 (68.4) **199 (70.6)** *229 (70.2)*	168 (20.2) **59 (20.9)** *79 (24.2)*	90 (10.8) **22 (7.8)** *18 (5.5)*	5 (0.6) **0** *0*	0 **2 (0.7)** *0*
h. Attending national mental health conferences	678 (81.1) **188 (66.7)** *283 (86.8)*	100 (12.0) **60 (21.3)** *31 (9.5)*	50 (6.0) **32 (11.3)** *12 (3.7)*	8 (1.0) **0** *0*	0 **2 (0.7)** ***0***
i. Presenting at national mental health conferences	756 (91.3) **255 (92.1)** *310 (95.4)*	49 (5.9) **13 (4.7)** *11 (3.4)*	17 (2.1) **7 (2.5)** *4 (1.2)*	6 (0.7) **0** *0*	0 **2 (0.7)** *0*
j. Attending national meetings (e.g., convention, conference, assembly) within my tradition	110 (13.2) **21 (7.5)** *31 (9.5)*	181 (21.7) **62 (22.2)** *89 (27.3)*	527 (63.2) **190 (68.1)** *203 (62.3)*	15 (1.8) **3 (1.1)** *3 (0.9)*	1 (0.1) **3 (1.1)** *0*
k. Other (specify below)	223 (77.4) **71 (77.2)** *82 (82.0)*	14 (4.9) **1 (1.1)** *5 (5.0)*	25 (8.7) **7 (7.6)** *8 (8.0)*	17 (5.9) **7 (7.6)** *3 (3.0)*	9 (3.1) **6 (6.5)** *2 (2.0)*

Specify: _____

23. I consider my current chaplain care practices to be evidence-based.

☐ Strongly agree	287 (34.3)	**78 (27.7)**	*97 (30.0)*
☐ Agree	353 (42.2)	**122 (43.3)**	*129 (39.9)*
☐ Neither agree nor disagree	169 (20.2)	**71 (25.2)**	*81 (25.1)*
☐ Disagree	20 (2.4)	**11 (3.9)**	*15 (4.6)*
☐ Strongly disagree	8 (1.0)	**0**	*1 (0.3)*

24. I would like my chaplain care practices to be more evidence-based.

☐ Strongly agree	134 (16.4)	**53 (19.5)**	*49 (15.5)*
☐ Agree	274 (33.5)	**91 (33.5)**	*94 (29.7)*

☐ Neither agree nor disagree	360 (44.1)	**101 (37.1)**	*157 (49.7)*
☐ Disagree	42 (5.1)	**20 (7.4)**	*12 (3.8)*
☐ Strongly disagree	7 (0.9)	**7 (2.6)**	*4 (1.3)*

25. Overall, how satisfied are you with your current chaplain role?

☐ Very satisfied	492 (58.6)	**140 (49.6)**	*160 (48.8)*
☐ Satisfied	295 (35.1)	**116 (41.1)**	*136 (41.5)*
☐ Neither satisfied nor dissatisfied	23 (2.7)	**13 (4.6)**	*18 (5.5)*
☐ Dissatisfied	25 (3.0)	**11 (3.9)**	*10 (3.0)*
☐ Very dissatisfied	5 (0.6)	**2 (0.7)**	*4 (1.2)*

Demographics

We would appreciate if you would answer the following demographic questions. We want to emphasize that answering these questions is voluntary and there is no penalty for not answering. As with your responses to all items on this survey, your answers to the following questions will remain confidential.

1. What is your service affiliation?

☐	Active Duty **[GO TO 1A]**	841 (100.0)	**282 (100.0)**	*327 (100.0)*
☐	Guard **[GO TO 1B]**			
☐	Reserve **[GO TO 1B]**			
☐	Civilian, Veteran **[GO TO 1D]**			
☐	Civilian, non-Veteran **[GO TO 2]**			

a. In what branch of the uniformed services do you serve? [GO TO 1C]

☐	Army	840 (100.0)		
☐	Navy		**256 (90.8)**	
☐	Air Force			*324 (100.0)*
☐	Marine Corps		**22 (7.8)**	
☐	Coast Guard		**4 (1.4)**	

b. In what branch of the uniformed services do you serve? [GO TO 1C]

☐ Army Reserve
☐ Army National Guard
☐ Navy Reserve
☐ Air Force Reserve
☐ Air National Guard
☐ Marine Corps Reserve
☐ Coast Guard Reserve

c. What is your current rank? [GO TO 1F]

☐	E1-E3	1 (0.1)		
☐	E4-E6			
☐	E7-E9			
☐	W1-W5			
☐	O1-O3	357 (42.9)	**121 (43.2)**	*158 (49.4)*
☐	O4-O10	475 (57.0)	**159 (56.8)**	*162 (50.6)*

d. In what branch of the uniformed services did you serve? (Mark all that apply) [GO TO 1E]

☐ Army
☐ Navy
☐ Air Force
☐ Marine Corps
☐ Coast Guard
☐ Army Reserve
☐ Army National Guard
☐ Navy Reserve
☐ Air Force Reserve
☐ Air National Guard
☐ Marine Corps Reserve
☐ Coast Guard Reserve

e. What was your rank at the completion of your uniformed services service? [GO TO 1F]

☐ E1-E3
☐ E4-E6
☐ E7-E9
☐ W1-W5
☐ O1-O3
☐ O4-O10

f. How many deployments (including peacekeeping missions) have you been on since September 11, 2001? [GO TO 1G]

☐	0	78 (9.3)	**40 (14.3)**	*27 (8.4)*
☐	1	301 (35.9)	**33 (11.8)**	*91 (28.2)*
☐	2	274 (32.7)	**72 (25.7)**	*87 (26.9)*
☐	3 or 4	155 (18.5)	**106 (37.9)**	*93 (28.8)*
☐	5 or 6	21 (2.5)	**17 (6.1)**	*23 (7.1)*
☐	7 or more	9 (1.1)	**12 (4.3)**	*2 (0.6)*

g. When did you return from your last deployment? [GO TO 1H]

☐	Does not apply, I have never been deployed	65 (100.0)	**38 (100.0)**	*24 (100.0)*

☐	Month (pull down)			
	January	139 (16.5)	**52 (18.4)**	*93 (28.4)*
	February	46 (5.5)	**20 (7.1)**	*10 (3.1)*
	March	75 (8.9)	**24 (8.5)**	*12 (3.7)*
	April	52 (6.2)	**25 (8.9)**	*22 (6.7)*
	May	68 (8.1)	**23 (8.2)**	*28 (8.6)*
	June	75 (8.9)	**14 (5.0)**	*22 (6.7)*
	July	76 (9.0)	**18 (6.4)**	*39 (11.9)*
	August	44 (5.2)	**23 (8.2)**	*20 (6.1)*
	September	45 (5.4)	**30 (10.6)**	*31 (9.5)*
	October	56 (6.7)	**26 (9.2)**	*16 (4.9)*
	November	86 (10.2)	**17 (6.0)**	*16 (4.9)*
	December	78 (9.3)	**10 (3.5)**	*18 (5.5)*

Year (pull down)			
08			*1 (0.3)*
09			*1 (0.3)*
1990			
1991	5 (0.7)	**1 (0.4)**	
1992	1 (0.1)		
1993	3 (0.4)	**1 (0.4)**	
1994			*1 (0.3)*
1995	2 (0.3)		*1 (0.3)*
1996	4 (0.5)		
1997	1 (0.1)		
1998	3 (0.4)		*1 (0.3)*
1999			*1 (0.3)*
200	1 (0.1)		
2000	2 (0.3)		*1 (0.3)*
2001	3 (0.4)		*1 (0.3)*
2002	3 (0.4)	**4 (1.7)**	*4 (1.4)*
2003	20 (2.6)	**5 (2.1)**	*6 (2.1)*
2004	32 (4.2)	**6 (2.5)**	*12 (4.2)*
2005	38 (5.0)	**14 (5.8)**	*8 (2.8)*
2006	60 (7.9)	**13 (5.4)**	*13 (4.5*)
2007	45 (5.9)	**17 (7.1)**	*13 (4.5)*
2008	79 (10.4)	**25 (10.4)**	*27 (9.4)*
2009	103 (13.5)	**28 (11.7)**	*59 (20.5)*
2010	136 (17.9)	**39 (16.3)**	*67 (23.3)*
2011	160 (21.0)	**65 (27.1**)	*56 (19.4)*
2012	54 (7.1)	**21 (8.8)**	*15 (5.2)*
2013	3 (0.4)		

h. In which of the following missions did you serve? (Mark all that apply) [GO TO 2]

☐	Does not apply, I have never been deployed	33 (3.9)	**25 (8.9)**	*20 (6.1)*
☐	World War II	0	**0**	*0*
☐	Korean War	0	**0**	*1 (0.3)*
☐	Vietnam War	9 (1.1)	**2 (0.7)**	*3 (0.9)*
☐	Operations Desert Shield or Desert Storm (e.g., Iraq, Kuwait, Saudi Arabia)	146 (17.4)	**63 (22.3)**	*83 (25.4)*
☐	Operation Enduring Freedom (e.g., Afghanistan)	324 (38.6)	**116(41.1)**	*187 (57.2)*
☐	Operation Iraqi Freedom or New Dawn (e.g., Iraq)	604 (71.9)	**170 (60.3)**	*209 (63.9)*
☐	Tsunami Relief (e.g., South Asia)	1 (0.1)	**25 (8.9)**	*7 (2.1)*
☐	Hurricane Relief (e.g., Louisiana, Texas, Mississippi)	51 (6.1)	**29 (10.3)**	*25 (7.6)*
☐	Earthquake Relief (e.g., Haiti, Chile)	10 (1.2)	**22 (7.8)**	*8 (2.4)*
☐	Other combat or Special Operations deployment	99 (11.8)	**66 (23.4)**	*66 (20.2)*
☐	Other peacekeeping deployment	166 (19.8)	**62 (22.0)**	*36 (11.0)*

☐	Other noncombat deployment	151 (18.0)	**120 (42.6)**	*69 (21.1)*
☐	None of the above	16 (1.9)	**9 (3.2)**	*9 (2.8)*

2. How long have you served as a chaplain? (Please include total time served, including both uniformed services and civilian status)

☐	1 year or less	21 (2.5)	**5 (1.8)**	*1 (0.3)*
☐	More than 1 year but less than 5 years	138 (16.4)	**51 (18.0)**	*35 (10.8)*
☐	More than 5 years but less than 10 years	206 (24.5)	**56 (19.8)**	*81 (24.9)*
☐	More than 10 years but less than 20 years	287 (34.1)	**114 (40.3)**	*133 (40.9)*
☐	20 years or more	189 (22.5)	**57 (20.1)**	*75 (23.1)*

3. What is your gender?

☐	Male	804 (97.0)	**261 (92.6)**	*305 (95.9)*
☐	Female	25 (3.0)	**21 (7.4)**	*13 (4.1)*

4. How old are you?

☐	24 or younger	0	**0**	*0*
☐	25-34	48 (5.8)	**18 (6.5)**	*15 (4.7)*
☐	35-44	279 (33.7)	**103 (36.9)**	*113 (35.4)*
☐	45-54	343 (41.4)	**116 (41.6)**	*139 (43.6)*
☐	55-64	153 (18.5)	**42 (15.1)**	*51 (16.0)*
☐	65 or older	5 (0.6)	**0**	*1 (0.3)*

5. Are you Spanish/Hispanic/Latino?

☐	No, not Spanish/Hispanic/Latino	782 (96.0)	**262 (95.3)**	*297 (96.7)*
☐	Yes, Mexican/Mexican-American/Chicano	10 (1.2)	**5 (1.8)**	*4 (1.3)*
☐	Yes, Puerto Rican	9 (1.1)	**1 (0.4)**	*2 (0.7)*
☐	Yes, Cuban	2 (0.2)	**2 (0.7)**	*1 (0.3)*
☐	Yes, other Spanish/Hispanic/Latino	12 (1.5)	**5 (1.8)**	*3 (1.0)*

6. What is your race? (Mark one or more races to indicate what you consider yourself to be.)

☐	White	647 (76.7)	**227 (79.9)**	*247 (74.8)*
☐	Black or African American	55 (6.5)	**19 (6.7)**	*25 (7.6)*
☐	American Indian or Alaska Native	18 (2.1)	**6 (2.1)**	*9 (2.7)*
☐	Asian (e.g., Asian Indian, Chinese, Filipino, Japanese, Korean, Vietnamese)	70 (8.3)	**14 (4.9)**	*18 (5.5)*
☐	Native Hawaiian or other Pacific Islander (e.g., Samoan, Guamanian, Chamorro)	2 (0.2)	**0**	*2 (0.6)*
☐	Other	38 (4.5)	**14 (4.9)**	*15 (4.5)*

7. What is your religious affiliation? (You can select more than one option if appropriate – mark all that apply)

☐	Evangelical Protestant	511 (60.7)	**157 (55.3)**	*170 (51.5)*
☐	Mainline Protestant	200 (23.8)	**85 (29.9)**	*86 (26.1)*
☐	Historically Black Protestant	16 (1.9)	**6 (2.1)**	*8 (2.4)*
☐	Catholic	60 (7.1)	**18 (6.3)**	*36 (10.9)*
☐	Mormon	11 (1.3)	**4 (1.4)**	*3 (0.9)*
☐	Orthodox	3 (0.4)	**3 (1.1)**	*3 (0.9)*
☐	Jehovah's Witness	0	**0**	*0*
☐	Other Christian Traditions	30 (3.6)	**10 (3.5)**	*10 (3.0)*
☐	Jewish	6 (0.7)	**1 (0.4)**	*5 (1.5)*
☐	Muslim	2 (0.2)	**1 (0.4)**	*1 (0.3)*
☐	Hindu	0	**0**	*0*
☐	Buddhist	1 (0.1)	**1 (0.4)**	*0*
☐	Agnostic	0	**0**	*0*
☐	Atheist	0	**1 (0.4)**	*0*
☐	Other faith (specify below)	41 (4.9)	**26 (9.2)**	*16 (4.8)*

Specify: _____

8. [DoD ONLY] Please indicate whether you are stationed in any of the below contexts. (Mark all that apply)

☐	Deployed in combat zone	194 (23.0)	**43 (15.1)**	*60 (18.2)*
☐	Deployed in non-combat zone	88 (10.5)	**64 (22.5)**	*36 (10.9)*
☐	Health care facility	87 (10.3)	**52 (18.3)**	*25 (7.6)*
☐	None of the above	550 (65.3)	**166 (58.5)**	*237 (72.0)*

9. What is your highest level of education?

☐	High School/GED			
☐	Some College/Associate Degree/Technical School			
☐	Bachelor's Degree	1 (0.1)		
☐	Master's Degree	711 (85.0)	**227 (80.2)**	*273 (84.8)*
☐	Doctoral Degree	122 (14.6)	**56 (19.8)**	*49 (15.2)*
☐	Other	2 (0.2)		

10. Do you have Clinical Pastoral Education (CPE) training?

☐	None	408 (48.9)	**138 (49.3)**	*125 (38.6)*
☐	1-2 units	174 (20.9)	**72 (25.7)**	*85 (26.2)*
☐	3-4 units	162 (19.4)	**47 (16.8)**	*64 (19.8)*
☐	5+ units	90 (10.8)	**23 (8.2)**	*50 (15.4)*

11. Are you a CPE supervisor?

☐	No	821 (98.6)	**280 (99.6)**	*318 (99.1)*
☐	Yes: ACPE certified supervisor	4 (0.5)	**1 (0.4)**	*1 (0.3)*
☐	Yes: other supervisor certification	8 (1.0)		*2 (0.6)*

12. Are you a board certified chaplain?

☐	Yes	229 (28.2)	**60 (21.8)**	*64 (20.6)*
☐	No	583 (71.8)	**215 (78.2)**	*247 (79.4)*

13. Do you have other certification(s)?

☐	No	591 (74.2)	**205 (76.5)**	*251 (82.6)*
☐	Yes, specify: _____	205 (25.8)	**63 (23.5)**	*53 (17.4)*

Other comments

Please feel free to share any comments you may have about any additional topics not covered elsewhere in this survey, or about the survey itself. Please do not put your name or any other identifying information as part of your comments.

_____
_____
_____
_____
_____

Thank you very much for your time, effort, and cooperation in completing this survey. If you would be willing, we have a few additional questions we would like to ask about your experiences related to your work as a chaplain. These questions will provide further context for the roles that chaplains fulfill and your use of measurement tools in your work.

These additional questions will take you approximately 10 minutes to complete. If you agree, please click on the "Next" button to continue. If you do not agree, please click on the "Logoff" button to exit the survey.

Thank you for agreeing to complete the supplemental survey. The following questions should take about 10 minutes to complete.

Supplemental survey

The following items ask for some additional information about your experiences related to your work as a chaplain. These questions will provide further context for the roles that chaplains fulfill and your use of measurement tools in your work.

1. Please indicate whether you consider the following items to be components primarily of one's spirituality, primarily of one's mental health, or roughly equal components of both one's spirituality and mental health.

	Primarily a Component of Spirituality	Primarily a Component Mental health	Roughly Equal Component of Spirituality and Mental Health
a. Beliefs about God or higher power	461 (66.2) **151 (64.0)** *217 (76.4)*	2 (0.3) **0** *0*	233 (33.5) **85 (36.0)** *67 (23.6)*
b. Ability to control and/or harness emotions	64 (9.2) **12 (5.1)** *31 (11.1)*	67 (9.7) **29 (12.2)** *47 (16.8)*	562 (81.1) **196 (82.7)** *202 (72.1)*
c. Ability to control and/or harness thoughts	70 (10.1) **13 (5.5)** *33 (11.7)*	77 (11.1) **33 (14.0)** *32 (11.4)*	545 (78.8) **190 (80.5)** *216 (76.9)*
d. Ability to develop a meaningful life vision	259 (37.4) **84 (35.6)** *108 (38.4)*	7 (1.0) **1 (0.4)** *2 (0.7)*	427 (61.6) **151 (64.0)** *171 (60.9)*
e. Acceptance of shortcomings and imperfections	143 (20.6) **41 (17.3)** *53 (18.7)*	16 (2.3) **7 (3.0)** *4 (1.4)*	535 (77.1) **189 (79.7)** *226 (79.9)*
f. Active engagement in a religious community	512 (74.3) **176 (74.3)** *232 (82.0)*	6 (0.9) **0** *1 (0.4)*	171 (24.8) **61 (25.7)** *50 (17.7)*
g. Appreciation of one's values and beliefs	272 (39.4) **92 (39.0)** *98 (34.9)*	6 (0.9) **0** *3 (1.1)*	413 (59.8) **144 (61.0)** *180 (64.1)*
h. Assumption of responsibility	101 (14.6) **25 (10.6)** *39 (13.8)*	31 (4.5) **7 (3.0)** *11 (3.9)*	560 (80.9) **203 (86.4)** *232 (82.3)*
i. Attendance and participation in religious services	534 (77.2) **187 (78.9)** *233 (82.9)*	7 (1.0) **0** *1 (0.4)*	151 (21.8) **50 (21.1)** *47 (16.7)*
j. Authenticity	145 (20.9) **44 (18.6)** 53 (18.9)	19 (2.7) **7 (3.0)** *5 (1.8)*	529 (76.3) **186 (78.5)** 223 (79.4)
k. Beliefs concerning meaning and purpose in life	332 (48.5) **108 (46.0)** *127 (45.4)*	5 (0.7) **0** *3 (1.1)*	348 (50.8) **127 (54.0)** *150 (53.6)*
l. Beliefs concerning truths about the world and human existence	365 (52.9) **118 (50.2)** *148 (53.0)*	4 (0.6) **1 (0.4)** *3 (1.1)*	321 (46.5) **116 (49.4)** *128 (45.9)*
m. Capacity to achieve a meaningful vision for one's life	217 (31.4) **58 (24.6)** *84 (29.9)*	12 (1.7) **2 (0.8)** *4 (1.4)*	461 (66.8) **176 (74.6)** *193 (68.7)*
n. Central values and beliefs	325 (46.9) **102 (43.0)** *117 (41.6)*	6 (0.9) **1 (0.4)** *2 (0.7)*	362 (52.2) **134 (56.5)** *162 (57.7)*
o. Courage to behave in moral and ethical manner	258 (37.2) **79 (33.5)** *97 (34.6)*	14 (2.0) **4 (1.7)** *3 (1.1)*	422 (60.8) **153 (64.8)** *180 (64.3)*
p. Creating a life worth living	219 (31.8) **67 (28.5)** *81 (29.0)*	10 (1.5) **1 (0.4)** *4 (1.4)*	459 (66.7) **167 (71.1)** *194 (69.5)*
q. Desire to seek growth experiences to develop spirit	379 (54.8) **121 (51.5)** *159 (57.0)*	7 (1.0) **0** *0*	305 (44.1) **114 (48.5)** *120 (43.0)*

r. Empathy	141 (20.3) **34 (14.4)** *41 (14.7)*	24 (3.5) **5 (2.1)** *8 (2.9)*	528 (76.2) **197 (83.5)** *229 (82.4)*
s. Engaging in behaviors that are in line with values, beliefs, and goals	181 (26.3) **51 (21.7)** *65 (23.3)*	14 (2.0) **3 (1.3)** *3 (1.1)*	494 (71.7) **181 (77.0)** *211 (75.6)*
t. Exercise of psychological autonomy	51 (7.4) **6 (2.6)** *22 (7.9)*	263 (38.1) **106 (45.1)** *121 (43.2)*	377 (54.6) **123 (52.3)** *137 (48.9)*
u. Expectation that life path will lead to realization of deepest aspirations	238 (35.2) **67 (29.1)** *94 (34.1)*	26 (3.8) **11 (4.8)** *14 (5.1)*	413 (61.0) **152 (66.1)** *168 (60.9)*
v. Faith and trust in God or higher power	525 (77.0) **175 (75.4)** *228 (82.0)*	4 (0.6) **0** *0*	153 (22.4) **57 (24.6)** *50 (18.0)*
w. Fulfilling one's potential	144 (21.2) **36 (15.7)** *55 (19.7)*	23 (3.4) **5 (2.2)** *8 (2.9)*	513 (75.4) **188 (82.1)** *216 (77.4)*
x. Internal sources of strength and hope	256 (37.6) **69 (29.7)** *87 (31.3)*	13 (1.9) **4 (1.7)** *3 (1.1)*	412 (60.5) **159 (68.5)** *188 (67.6)*
y. Intrinsic motivation	160 (23.5) **37 (15.9)** *61 (22.0)*	53 (7.8) **16 (6.9)** *21 (7.6)*	469 (68.8) **179 (77.2)** *195 (70.4)*
z. Loving others	275 (40.4) **80 (34.6)** *114 (41.2)*	4 (0.6) **0** *2 (0.7)*	402 (59.0) **151 (65.4)** *161 (58.1)*
aa. Moral and ethical standards of behavior	283 (41.6) **83 (35.9)** *103 (37.3)*	8 (1.2) **1 (0.4)** *2 (0.7)*	389 (57.2) **147 (63.6)** *171 (62.0)*
bb. Openness to alternative viewpoints	85 (12.6) **19 (8.3)** *28 (10.2)*	82 (12.2) **27 (11.7)** *34 (12.4)*	506 (75.2) **184 (80.0)** *213 (77.5)*
cc. Personal application of theological beliefs	480 (70.3) **162 (70.1)** *202 (72.7)*	8 (1.2) **0** *0*	195 (28.6) **69 (29.9)** *76 (27.3)*
dd. Personal identity	151 (22.2) **29 (12.6)** *48 (17.3)*	32 (4.7) **4 (1.7)** *15 (5.4)*	498 (73.1) **198 (85.7)** *215 (77.3)*
ee. Practice of religious rituals	535 (78.6) **183 (79.2)** *233 (85.3)*	5 (0.7) **1 (0.4)** *0*	141 (20.7) **47 (20.3)** *40 (14.7)*
ff. Practicing beliefs through behavior/action	250 (36.6) **76 (32.8)** *103 (37.3)*	23 (3.4) **7 (3.0)** *7 (2.5)*	410 (60.0) **149 (64.2)** *166 (60.1)*
gg. Prayer or meditation	498 (73.3) **163 (70.3)** *210 (75.8)*	3 (0.4) **0** *0*	178 (26.2) **69 (29.7)** *67 (24.2)*
hh. Pursuit of a fulfilling life	188 (27.8) **45 (19.6)** *58 (20.9)*	8 (1.2) **0** *6 (2.2)*	480 (71.0) **185 (80.4)** *214 (77.0)*
ii. Quest to gain insight into life's pressing questions	241 (35.5) **74 (32.0)** *97 (35.5)*	15 (2.2) **1 (0.4)** *5 (1.8)*	423 (62.3) **156 (67.5)** *171 (62.6)*
jj. Realization of being "primary author of own life"	147 (21.9) **38 (16.7)** *48 (17.4)*	185 (27.6) **74 (32.6)** *80 (29.0)*	339 (50.5) **115 (50.7)** *148 (53.6)*
kk. Recognizing a power greater than oneself	409 (60.4) **141 (60.8)** *171 (61.5)*	6 (0.9) **2 (0.9)** *4 (1.4)*	262 (38.7) **89 (38.4)** *103 (37.1)*
ll. Relationship with God or higher power	521 (76.6) **169 (73.2)** *220 (79.4)*	4 (0.6) **0** *0*	155 (22.8) **62 (26.8)** *57 (20.6)*
mm. Relationships with significant others	114 (16.8) **30 (13.0)** *36 (13.1)*	19 (2.8) **4 (1.7)** *11 (4.0)*	545 (80.4) **196 (85.2)** *228 (82.9)*
nn. Resolve to persevere in face of challenges	121 (17.8) **27 (11.7)** *39 (14.0)*	13 (1.9) **4 (1.7)** *7 (2.5)*	546 (80.3) **200 (86.6)** *232 (83.5)*

oo. Respect for others	112 (16.6) **26 (11.2)** *36 (13.0)*	8 (1.2) **3 (1.3)** *6 (2.2)*	555 (82.2) **203 (87.5)** *234 (84.8)*
pp. Responsibility to develop spirit	387 (57.4) **134 (57.8)** *169 (61.0)*	4 (0.6) **0** *1 (0.4)*	283 (42.0) **98 (42.2)** *107 (38.6)*
qq. Self-awareness	86 (12.8) **24 (10.3)** *31 (11.2)*	39 (5.8) **18 (7.8)** *28 (10.1)*	549 (81.5) **190 (81.9)** *218 (78.7)*
rr. Self-motivation	79 (11.8) **18 (7.8)** *28 (10.1)*	58 (8.7) **22 (9.5)** *24 (8.7)*	532 (79.5) **191 (82.7)** *224 (81.2)*
ss. Self-reflection and introspection	100 (14.9) **25 (10.7)** *44 (15.9)*	33 (4.9) **10 (4.3)** *18 (6.5)*	540 (80.2) **198 (85.0)** *214 (77.5)*
tt. Self-regulation	76 (11.3) **17 (7.3)** *38 (13.7)*	59 (8.7) **23 (9.9)** *26 (9.4)*	540 (80.0) **193 (82.8)** *213 (76.9)*
uu. Sense of agency	82 (12.3) **22 (9.8)** *33 (12.0)*	96 (14.4) **34 (15.1)** *45 (16.4)*	488 (73.3) **169 (75.1)** *196 (71.5)*
vv. Sense of global self-efficacy	79 (11.9) **20 (8.8)** *34 (12.4)*	109 (16.4) **46 (20.2)** *49 (17.8)*	477 (71.7) **162 (71.1)** *192 (69.8)*
ww. Shaping of "core self"	141 (21.1) **40 (17.3)** *58 (21.0)*	50 (7.5) **11 (4.8)** *22 (8.0)*	478 (71.4) **180 (77.9)** *196 (71.0)*
xx. Strength to exercise values-based leadership	175 (26.2) **46 (19.9)** *69 (25.2)*	19 (2.8) **10 (4.3)** *12 (4.4)*	474 (71.0) **175 (75.8)** *193 (70.4)*
yy. Study of religious or spiritual texts	513 (76.2) **183 (78.9)** *218 (79.3)*	6 (0.9) **0** *0*	154 (22.9) **49 (21.1)** *57 (20.7)*
zz. Taking care of one's physical well-being	69 (10.2) **13 (5.6)** *24 (8.7)*	65 (9.6) **24 (10.4)** *30 (10.9)*	543 (80.2) **194 (84.0)** *222 (80.4)*
aaa. Tolerance and appreciation of diversity	88 (13.2) **18 (7.8)** *32 (11.6)*	50 (7.5) **16 (6.9)** *21 (7.6)*	531 (79.4) **198 (85.3)** *222 (80.7)*
bbb. Trust of others	98 (14.6) **16 (6.9)** *29 (10.6)*	26 (3.9) **10 (4.3)** *13 (4.7)*	549 (81.6) **206 (88.8)** *232 (84.7)*
ccc. Understanding how thoughts influence perceptions, motivation, and behavior	69 (10.3) **15 (6.5)** *22 (8.1)*	105 (15.6) **51 (22.0)** *45 (16.5)*	499 (74.1) **166 (71.6)** *205 (75.4)*
ddd. Understanding the source of one's behaviors	88 (13.0) **17 (7.3)** *28 (10.2)*	90 (13.3) **43 (18.5)** *45 (16.4)*	497 (73.6) **173 (74.2)** *201 (73.4)*
eee. Understanding the source of one's emotions	80 (11.9) **14 (6.0)** *25 (9.1)*	103 (15.4) **44 (19.0)** *55 (19.9)*	488 (72.7) **174 (75.0)** *196 (71.0)*
fff. Vision for realizing one's full potential and purpose	151 (22.5) **47 (20.3)** *63 (23.1)*	19 (2.8) **7 (3.0)** *15 (5.5)*	502 (74.7) **177 (76.6)** *195 (71.4)*
ggg. Willingness to critique aspects of religion	330 (49.3) **108 (46.4)** *142 (51.3)*	12 (1.8) **6 (2.6)** *3 (1.1)*	328 (49.0) **119 (51.1)** *132 (47.7)*
hhh. Willingness to self-sacrifice	225 (33.4) **77 (33.2)** *86 (31.2)*	6 (0.9) **2 (0.9)** *5 (1.8)*	443 (65.7) **153 (65.9)** *185 (67.0)*

2. Please rate your agreement with the following statements.

	Strongly disagree	**Disagree**	**Agree**	**Strongly agree**
a. War can cause moral injury to a person.	12 (1.8) **5 (2.1)** *5 (1.8)*	23 (3.4) **3 (1.3)** *3 (1.1)*	270 (39.5) **53 (22.6)** *93 (33.5)*	379 (55.4) **173 (73.9)** *177 (63.7)*

b. Trauma can cause moral injury to a person.	11 (1.6) **5 (2.1)** *4 (1.4)*	26 (3.8) **4 (1.7)** *4 (1.4)*	290 (42.3) **49 (21.0)** *102 (36.7)*	358 (52.3) **175 (75.1)** *168 (60.4)*
c. War can cause spiritual injury to a person.	11 (1.6) **6 (2.6)** *3 (1.1)*	29 (4.3) **4 (1.7)** *2 (0.7)*	264 (38.7) **52 (22.3)** *91 (32.7)*	378 (55.4) **171 (73.4)** *182 (65.5)*
d. Trauma can cause spiritual injury to a person.	11 (1.6) **6 (2.6)** *3 (1.1)*	21 (3.1) **4 (1.7)** *3 (1.1)*	279 (40.8) **52 (22.5)** *96 (34.9)*	372 (54.5) **169 (73.2)** *173 (62.9)*
e. Moral injury and spiritual injury are the same.	130 (19.1) **51 (21.9)** *53 (19.3)*	321 (47.2) **107 (45.9)** *154 (56.0)*	134 (19.7) **39 (16.7)** *39 (14.2)*	95 (14.0) **36 (15.5)** *29 (10.5)*

Use of Measurement Tools

This section asks questions about your use of measurement tools in the course of your work as a chaplain.

3. Do you currently use any measurement tools in your chaplaincy services?

☐ Yes **[GO TO 4]**	276 (40.2)	**108 (46.0)**	*109 (39.4)*
☐ No **[GO TO 7]**	410 (59.8)	**127 (54.0)**	*168 (60.6)*

4. What measures do you use? (Mark all that apply)

☐ Spiritual Injury Scale	71 (25.0)	**33 (29.7)**	*23 (20.7)*
☐ Brief Religious Coping Inventory	61 (21.5)	**22 (19.8)**	*15 (13.5)*
☐ Spiritual Attitudes Inventory	131 (46.1)	**30 (27.0)**	*32 (28.8)*
☐ TBI-PBE Religion/Spirituality Form	20 (7.0)	**2 (1.8)**	*4 (3.6)*
☐ Flourishing Scale	15 (5.3)	**2 (1.8)**	*5 (4.5)*
☐ Personal Well-Being Index	78 (27.5)	**12 (10.8)**	*9 (8.1)*
☐ Coping Self-Efficacy Scale	32 (11.3)	**9 (8.1)**	*4 (3.6)*
☐ CD-RISC	2 (0.7)	**1 (0.9)**	0
☐ PDRI	1 (0.4)	**0**	0
☐ Interpersonal Support Evaluation List	27 (9.5)	**8 (7.2)**	*6 (5.4)*
☐ PCL-M	7 (2.5)	**2 (1.8)**	*2 (1.8)*
☐ Beck Depression Inventory	43 (15.1)	**9 (8.1)**	*10 (9.0)*
☐ PHQ-9	4 (1.4)	**1 (0.9)**	*1 (0.9)*
☐ Other (specify below)	100 (35.2)	**44 (39.6)**	*45 (40.5)*

Specify: _____

5. Please select the factor(s) that most influence your choice of measure(s). (Mark up to 3 reasons.)

☐ Convenience	98 (34.8)	**40 (36.0)**	*40 (36.0)*
☐ Colleagues/others are using it	59 (20.9)	**33 (29.7)**	*25 (22.5)*
☐ Suggestion from a colleague	65 (23.0)	**24 (21.6)**	*27 (24.3)*
☐ Interest in that particular outcome	86 (30.5)	**30 (27.0)**	*18 (16.2)*
☐ Psychometric properties	30 (10.6)	**11 (9.9)**	*8 (7.2)*
☐ Experience with a measure	147 (52.1)	**54 (48.6)**	*60 (54.1)*
☐ Availability	124 (44.0)	**48 (43.2)**	*52 (46.8)*

6. What outcomes or constructs does your chosen measure(s) track? (Mark all that apply.)

☐ Symptom improvement	84 (29.8)	**35 (31.5)**	*31 (27.9)*
☐ Quality of life	167 (59.2)	**63 (56.8)**	*54 (48.6)*
☐ Satisfaction with care	51 (18.1)	**26 (23.4)**	*26 (23.4)*
☐ Spiritual growth	175 (62.1)	**70 (63.1)**	*61 (55.0)*
☐ Coping skills	183 (64.9)	**69 (62.2)**	*54 (48.6)*
☐ Other, specify: _____	49 (17.4)	**21 (18.9)**	*28 (25.2)*

7. To what degree are the following issues a barrier in your use of measurement tools?

	Not a barrier	Minor barrier	Moderate barrier	Major barrier
a. Access to measures	203 (31.3) **48 (21.8)** *77 (30.3)*	146 (22.5) **54 (24.5)** *51 (20.1)*	180 (27.7) **70 (31.8)** *74 (29.1)*	120 (18.5) **48 (21.8)** *52 (20.5)*
b. Time	175 (27.0) **53 (24.2)** *62 (24.6)*	143 (22.1) **54 (24.7)** *54 (21.4)*	205 (31.6) **78 (35.6)** *82 (32.5)*	125 (19.3) **34 (15.5)** *54 (21.4)*
c. Leadership support	329 (50.9) **99 (45.4)** *139 (55.8)*	161 (24.9) **68 (31.2)** *61 (24.5)*	109 (16.9) **35 (16.1)** *34 (13.7)*	47 (7.3) **16 (7.3)** *15 (6.0)*
d. Awareness of measures	158 (24.3) **48 (21.8)** *59 (22.9)*	164 (25.2) **49 (22.3)** *51 (19.8)*	160 (24.6) **71 (32.3)** *64 (24.8)*	168 (25.8) **52 (23.6)** *84 (32.6)*
e. Other, specify: _____	171 (71.0) **54 (66.7)** *59 (64.8)*	18 (7.5) **2 (2.5)** *7 (7.7)*	16 (6.6) **6 (7.4)** *9 (9.9)*	36 (14.9) **19 (23.5)** *16 (17.6)*

APPENDIX J

PROJECT APPROVALS

Department of Veterans Affairs **Memorandum**

Date: February 4, 2011

From: Jason Nieuwsma, PhD
Associate Director, VA Mental Health and Chaplaincy

Subj: DoD/VA Chaplains and Mental Health Quality Improvement Project

To: **Chairperson**
Durham Institutional Review Board

1) In an attempt to enhance continuity of care between the Department of Defense (DoD) and Department of Veterans Affairs (VA), the two departments launched in the Fall of 2010 a series of 28 strategic action implementation plans under the title of "DoD/VA Integrated Mental Health Strategy (IMHS)." Strategic Action #23 of the DoD/VA IMHS is to increase support of continuity in the role of the chaplain between the Services and VA and improve identification of how to facilitate access to mental health care through collaboration with community clergy and faith communities to promote care that is consistent with the values and preferences of Veterans. These aims will be addressed in the current project via a gap analysis, which will consist of the following tasks: a) access and analyze existing data on utilization of DoD and VA chaplain services; b) conduct surveys of DoD and VA chaplains and allied health professionals; c) conduct phone interviews with DoD and VA chaplains and other health professionals; d) conduct local program assessments via 1-2 day onsite visits to programs; and e) survey Service Members and Veterans regarding utilization of chaplain services.

2) The tasks associated with the gap analysis will be completed in roughly the order that they are presented above. The current objective is to analyze differences between the DoD and the VA for the purpose of enhancing chaplains' engagement with mental health services within the VA. A report describing differences and recommendations will be created. This report may be suitable for publication in various other formats. This work will be led by staff of the Durham Mental Illness Research, Education and Clinical Centers (MIRECC) in coordination with staff at the Defense Centers of Excellence (DCoE) and aided by staff at the Durham Health Services Research & Development (HSR&D) Center of Excellence, an outside research contracting group, and subject matter experts from VA, DoD, and academic institutions. Funding for the project comes from monies set aside by the DoD and VA for use in the DoD/VA IMHS, which are located at the VISN 6 MIRECC and Chesapeake Health Education Program (CHEP).

3) Comparing the provision of chaplain care in the DoD and the VA provides a unique opportunity to learn about how clinical services for the Veteran population can be improved. Because we are only considering perspectives from the DoD and the VA in the gap analysis, this analysis will not produce generalizable knowledge. The primary purpose is to make comparisons between the DoD and the VA.

4) We respectfully request that the IRB confirm that this project constitutes a quality improvement initiative and therefore does not fall under the purview of IRB research review. To acknowledge IRB agreement, please provide a memorandum indicating that the project is quality improvement.

5) A three page outline of the project is attached. Because of the quality improvement nature of this project, no further protocol has been prepared.

6) Thank you for your time and consideration of this request.

Jason Nieuwsma, PhD
Associate Director, VA Mental Health and Chaplaincy

Department of Veterans Affairs

Memorandum

Date: July 7, 2011

From: David Edelman, MD, Co-Chair, IRB

Subj: **DoD/VA Chaplains and Mental Health Quality Improvement Project**

To: Jason Nieuwsma, Associate Director, VA Mental Health and Chaplaincy

1. The project, "DoD/VA Chaplains and Mental Health Quality Improvement Project", has been reviewed by the IRB co-chair for release from further human ethics review.

2. The purpose of this project is to make comparisons between the DoD and the VA by accessing and analyzing existing data and by conducting surveys, phone interviews, and onsite local program assessments with DoD and VA chaplains and allied health professionals. Comparing the provisions of chaplain care in the DoD and the VA provides a unique opportunity to learn about how clinical services for the veteran population can be improved.

3. This gap analysis will not produce generalizable knowledge, and is considered not research. If you have any further questions or concerns, please contact me at extension 5656.

David Edelman, MD
Co-Chair, Institutional Review Board

Department of Veterans Affairs

Memorandum

Date: 9/12/2011

From: Sonja V. Batten, Ph.D., Deputy Chief Consultant for Specialty Mental Health

Subj: Surveys of Chaplains

To: Director, VA Mental Health and Chaplaincy

1. The purpose of this memorandum is to express my approval of your intention to conduct a gap analysis as a component of the DoD/VA Integrated Mental Health Strategy Strategic Action #23: Chaplains' Roles.

2. As a part of this gap analysis, there will be comparisons made between the DoD and the VA by accessing and analyzing existing data and by conducting surveys, phone interviews, and onsite local program assessments with DoD and VA chaplains and allied health professionals. Comparing the provisions of chaplain care in the DoD and the VA provides a unique opportunity to learn about how clinical services for the Veteran population can be improved.

3. I understand that the Durham VA Institutional Review Board has been made aware of this project and has determined that it is not considered research and has released the project from further human ethics review.

4. The results of this gap analysis may influence ongoing and future quality improvement initiatives. The Office of Mental Health Services looks forward to a presentation of your findings once the data is compiled.

Sonja V. Batten, Ph.D

VA FORM 2105
MAR 1989

Department of Veterans Affairs

Memorandum

Date: 7/25/2011

From: Director, National Chaplain Center

Subj: Surveys of Chaplains

To: Director, VA Mental Health and Chaplaincy

1. The purpose of this memorandum is to express my approval of your intention to conduct a gap analysis as a component of the DoD/VA Integrated Mental Health Strategy Strategic Action #23: Chaplains' Roles.

2. As a part of this gap analysis, there will be comparisons made between the DOD and the VA by accessing and analyzing existing data and by conducting surveys, phone interviews, and onsite local program assessments with DOD and VA chaplains and allied health professionals. Comparing the provisions of chaplain care in the DOD and the VA provides a unique opportunity to learn about how clinical services for the Veteran population can be improved.

3. I understand that the Durham VA Institutional Review Board has been made aware of this project and has determined that it is not considered research and has released the project from further human ethics review.

4. The results of this gap analysis may influence ongoing and future quality improvement initiatives. This Office looks forward to a presentation of your findings once the data is compiled.

A. Keith Ethridge

Keith Ethridge

Attachment

VA FORM 2105
MAR 1989

RTI INTERNATIONAL

IRB ID Number: 12911

Office of Research Protection
Institutional Review Board Notice of Approval
Federalwide Assurance No. 3331

Title of Study: Veterans' Administration Chaplains' Roles Project
Project Number: 0213005 **RTI Proposal Number** (if no Project Number)
Project Leader: Becky Lane
Project Team Member Contact (if different from Project Leader):
Source of Funding for this Study: Veterans' Administration
Date Submitted to IRB: July 21, 2011 (revised)
Level of Review *(check one)*:
Full ☐, IRB Meeting Date:
Expedited ☒, category: 7: Behavioral - surveys, focus groups, etc.

Type of Review *(check one)*:
- ☐ Preliminary review (Do not involve human subjects or data until pretest or full study is approved.)
- ☐ Pretest/Pilot Test:
- ☒ Full Implementation
- ☐ Amendment, describe:
- ☐ Add study site(s):
- ☐ Renewal
- ☐ Study Closure

IRB Approval of Special Conditions *(check all that apply)*:
- ☒ Waiver of Signed Informed Consent/Parental Permission
- ☐ Participation of Pregnant Women (**Worksheet B** submitted by project team)
- ☐ Participation of Prisoners (**Worksheet C** submitted by project team
- ☐ Participation of Prisoners in DHHS-funded studies (OHRP acknowledgement received)
- ☐ Participation of Minors (**Worksheet D** submitted by project team)
- ☐ IRB Agreement of Nonsignificant Risk Device Study Determination

Please note the following requirements:
- If **unexpected problems** or **adverse events** occur, the project team must notify the IRB.
- If there are **changes** in study procedures or protocol or any data collection materials (brochures, letters, questionnaires, etc.) the project team must notify the IRB before they are implemented.
- The project team is required to apply for **continuing review** as long as the study is active, which includes participation of human subjects or possession of human data or specimens.

Expiration Date of IRB Approval: **July 21, 2012**
(No human subjects research can occur after this date without continuing review and approval.)

Wendy Visscher
Signature - IRB Member or Chair

July 21, 2011
Date of IRB Approval

Wendy A. Visscher, PhD
Name - IRB Member or Chair (print or type)

☒ Copy sent to project leader on: July 21, 2011
☐ Entered into MIS

Office of Research Protection, Institutional Review Board
3040 Cornwallis Road, Research Triangle Park, NC 27709-2194, USA
Telephone: 919-316-3358 Fax: 919-316-3897 orpe@rti.org

RTI INTERNATIONAL

IRB ID Number: 12911

Office of Research Protection
Institutional Review Board Notice of Approval
Federalwide Assurance No. 3331

Title of Study: Veterans' Administration Chaplains' Roles Project
Project Number: 0213005 **RTI Proposal Number** (if no Project Number)
Project Leader: Becky Lane
Project Team Member Contact (if different from Project Leader):
Source of Funding for this Study: Veterans' Administration
Date Submitted to IRB: December 27, 2011
Level of Review *(check one)*:
Full ☐, IRB Meeting Date:
Expedited ☒, category: M: Minor changes in approved research

Type of Review *(check one)*:
- ☐ Preliminary review (Do not involve human subjects or data until pretest or full study is approved.)
- ☐ Pretest/Pilot Test:
- ☐ Full Implementation
- ☒ Amendment, describe: revised survey deployment procedures
- ☐ Add study site(s):
- ☐ Renewal
- ☐ Study Closure

IRB Approval of Special Conditions *(check all that apply to this review)*:
- ☐ Waiver of Signed Informed Consent/Parental Permission
- ☐ Participation of Pregnant Women (**Worksheet B** submitted by project team)
- ☐ Participation of Prisoners (**Worksheet C** submitted by project team)
- ☐ Participation of Prisoners in DHHS-funded studies (OHRP acknowledgement required)
- ☐ Participation of Minors (**Worksheet D** submitted by project team)
- ☐ IRB Agreement of Nonsignificant Risk Device Study Determination
- ☐ HIPAA Waiver of Authorization

Please note the following requirements:
- If **unexpected problems** or **adverse events** occur, the project team must notify the IRB.
- If there are **changes** in study procedures or protocol or any data collection materials (brochures, letters, questionnaires, etc.) the project team must notify the IRB before they are implemented.
- The project team is required to apply for **continuing review** as long as the study is active, which includes participation of human subjects or possession of human data or specimens.

Expiration Date of IRB Approval: July 21, 2012
(No human subjects research can occur after this date without continuing review and approval.)

Wendy Visscher
Signature - IRB Member or Chair

December 28, 2011
Date of IRB Approval

Wendy A. Visscher, PhD
Name - IRB Member or Chair (print or type)

- ☐ Copy sent to project leader on:
- ☐ Entered into MIS
- ☐ OHRP acknowledgement received for participation of prisoners in DHHS-funded studies on:_____

Office of Research Protection, Institutional Review Board
3040 Cornwallis Road, Research Triangle Park, NC 27709-2194, USA
Telephone: 919-316-3358 Fax: 919-316-3897 orpe@rti.org

Document Title: Chaplains Roles in Integrated Mental Health Strategies (IMHS), Strategic Action (SA) for Department of Defense (DoD) and Department of Veterans Affairs (VA), SA#23.

Privacy Reviewer: TMA Privacy and Civil Liberties Office

Initial Review Date: November 17, 2011; Response to initial questions received November 30, 2011; Final response to questions received December 13, 2011

Final Review Date: December 16, 2011

Disposition: Privacy Advisory Required

TMA Privacy and Civil Liberties Office (Privacy Office) Internal Review Checklist

X Thorough analysis of DMDC document

The DoD sponsor of this Survey is the Resilience and Prevention Directorate, Defense Centers of Excellence for Psychological Health and Traumatic Brain Injury (DCoE).

This analysis is based on the DMDC document (IMHS SA23 Supporting Statement for Information 11Oct11.doc provided to the Privacy Office, as modified and supplemented by the Contractor Point of Contact's (POC) November 30, 2011 response to the Privacy Office's questions received, a December 8, 2011 telephone conversation among Privacy Office contractor support representatives, the POC, and representatives of Research Triangle Institute International (RTI), and the POC's December 13, 2011 email documenting information requested during the December 8, 2011 conference call (collectively, the "Survey Documentation").

The Survey Documentation provided sufficient information to permit the Privacy Office to conduct a Privacy Act review of the online Survey of DoD chaplains described in the Survey Documentation. Although chaplains participating in the Survey will include both VA and DoD chaplains, this Privacy Act review relates only to the Survey's fielding among DoD chaplains by DCoE. The Survey Documentation does not provide sufficient information to conduct a Privacy Act review of the phone interviews that will be conducted with DoD chaplains and other health professionals, local onsite program assessments, or any surveys of Veterans and Service members regarding their utilization of chaplain services.

X Statement of purpose check

This Survey is being conducted by RTI on behalf of the DCoE and VA to measure how VA and DoD chaplain services currently differ and locate their respective shortcomings. The Survey is part of a larger DCoE and VA joint initiative called the Integrated Mental Health Strategy (IMHS). The goal of IMHS's Strategic Action #23 is to increase support of continuity in the role of the chaplain between the Services and VA and improve

identification of how to facilitate access to mental health care through collaboration with community clergy and faith communities to promote care that is consistent with the values and preferences of Veterans.

__X__ Timeframe check

The Survey fielding period among DoD chaplains is six weeks.

__X__ Beneficiaries affected check

Prospective DoD Survey respondents include all DoD chaplains on active duty (approximately 850 in the Navy, 1500 in the Army, 510 in the Air Force). Invitations to participate in the Survey will be emailed to each DoD chaplain at the chaplain's ".mil" email address. Each Survey invitation email will include a randomly assigned login ID and password to be used by the email's recipient to access the Survey online through an https website. Before answering any Survey questions, each respondent must enter the login ID and password provided in the invitation e-mail and then affirm that the respondent DoD chaplain.

__X__ Reporting by subgroup check

The maximum number of DoD participants is approximately 2,860 DoD chaplains. The smallest subgroup that will be released by the researchers is 30 respondents.

__X__ Sampling check

If the researchers create a sample of the data, it will contain responses from at least 30 respondents.

__X__ Miscellaneous/unique identifiers check

None of the Survey questions included with the Survey Documentation ask a respondent to provide a unique identifier or any other personally identifiable information (PII) or protected health information (PHI). No Survey participant information will be stored with the Survey answers. RTI personnel do not receive data that would permit them to link a Survey response back to an individual respondent.

To maximize the number of DoD chaplains participating in the Survey, reminder emails are to be sent to DoD chaplains receiving emailed Survey invitations but who have not responded or responded without completing the Survey. The RTI survey tool will track, by the unique login ID and password randomly assigned to each Survey invitation, those login IDs which have not responded or started the Survey, started the Survey, finished the entire Survey, or finished only in part. If DCoE sends the email invitations, RTI will, from time to time during the fielding period, provide DCoE lists of the unique login IDs which have completed the Survey, permitting DCoE to send a follow up Survey reminder to only those email addresses associated with a login ID not on the list of invitees who have completed the Survey. Neither the login ID used by a respondent, nor the email address in the email containing the login ID, will be linked to the contents of a respondent's completed Survey response. At the end of the fielding period, it may be possible for someone to create a list of email addresses of individuals who have

completed the Survey and email addresses for those who have not. However, it will not be possible to link an email address to a specific Survey questionnaire.

In the event that DCoE is unable to distribute emails in the manner described in the preceding paragraph, DCoE may provide the list of DoD chaplain email addresses to RTI. RTI would then manage the invitation and distribution process. If this is the case, DCoE will submit an amendment request to both the RTI and DoD IRBs detailing the requested methodology change and ways in which the data will be used and protected by RTI. DCoE will also establish a data use agreement (DUA) between DCoE and RTI detailing what data will be transmitted, how the data will be used and protected, steps for maintaining PII separately from the survey data, and how long the PII will be held by RTI before being destroyed.

X Access to survey check

In order to send a directed reminder e-mail, RTI may have access to both the database of login IDs of Survey respondents and the list of the unique login IDs assigned to the DoD chaplain Survey invitees. That information will be stored separately and compared only to determine the unique login ID's used to start or complete the Survey questions and those that have not been so used. Login IDs assigned to email invitations which have not been used in connection with a completed Survey will be used to generate periodic reminder emails to those who have completed their survey.

All data transfers to or from the Survey tool will be done via secured webpages, and responses can only be downloaded by RTI personnel who provide the correct login information. Downloaded responses will be stored on the RTI computer network, which has a firewall and requires a password for data access. Paper copies of Survey responses or data will not be created.

N/A De-identification segregated from database creation or maintenance (cannot be the same party or is a HIPAA violation) check

The Survey questions do not ask a respondent to furnish PHI. Therefore, these HIPAA-related issues do not appear to be a concern.

N/A Crosswalk collection – min. necessary *vs.* limited dataset *vs.* de-identified check

The Survey questions do not ask a respondent to furnish PHI. Therefore, these HIPAA-related issues do not appear to be a concern.

X Sponsors monitors the work of contractors check

This was not specified.

X All work product is owned by the government, if not, subject to destruction check

The data collected for this project will be destroyed five years after the project is completed.

X "Not Totally Anonymous" check
Results will always be reported in aggregate form.

N/A Telephone collection check

N/A Verify accuracy of citations check

N/A Purpose crosswalk with SORN check

N/A Privacy Act Statement is required for **collection**

X Privacy Advisory is required for **use**
A Privacy Advisory is recommended in connection with this Survey. The information included in the consent provided to respondents before completing the Survey meets the requirements of a Privacy Advisory.

Point of Contact/Program Office – Submissions Certification		
Criteria	**Completed**	**Not Applicable**
PAS Draft		X
Survey Instrument/Tool	X	
DMDC Application	X	
Any corresponding documents that would be material to the system/program.	X	

Analysis:

The purpose of the Survey is to measure how the VA and DoD chaplain services currently differ and locate their respective shortcomings. The Survey questions focus on how chaplains currently deliver spiritual care in a variety of clinical and operational settings. The Survey of both VA and DoD chaplains is part of an overall initiative to make the services provided by chaplains and allied health professionals through the DCoE and VA both better and more similar. That project is part of the VA and DCoE Integrated Mental Health Strategy (IMHS). The goal of IMHS's Strategic Action #23 is to increase support of continuity in the role of the chaplain between the Services and VA and improve identification of how to facilitate access to mental health care through collaboration with community clergy and faith communities to promote care that is consistent with the values and preferences of Veterans.

Both VA and DoD chaplains are to be invited to participate in the Survey. This analysis focuses solely on Privacy Act considerations applicable to the Survey in the context of DoD chaplains. The analysis reaches no conclusions as to VA chaplain participation in the Survey.

This Survey will be fielded exclusively over the internet. RTI and DCoE have not yet determined how to send targeted reminders to only those individuals who have not completed the Survey. Email invitations to participate in the Survey are to be sent to all DoD chaplains using their DoD email addresses. Each email invitation will include a randomly assigned unique login ID and password, together with an https link to the on-line Survey. RTI will control the Survey tool and data collected through the tool, but will not receive PII or PHI that could be used to identify a Survey respondent or link actual Survey responses to the individual respondent. Survey results will only be disclosed in the aggregate.

To participate in the Survey, a recipient of an email invitation will use the login and password included in the recipient's email invitation to access the Survey. Records will be kept of the login IDs (but not the email addresses) of the individuals staring and completing the Survey. During the fielding period, RTI will provide DCoE a list of login IDs connected with incomplete Surveys; DCoE will link those login IDs to the corresponding email address and send a reminder encouraging those who have not completed the survey to do so. From time to time during the fielding period, the login IDs of completing the Survey will be used by DCoE to create a list of login IDs used in email invitations which have not resulted in a completed the Survey. The resulting list of login IDs will be used to create a follow up email addressed to those initial Survey invitees whose randomly assigned login ID was not connected with a completed Survey, encouraging them to participate in the Survey. No further tracking or matching of a unique login IDs to e-mail addresses will occur after that a participant completes the Survey or the Survey fielding period ends (whichever occurs first). The login ID numbers and the email addresses will be maintained separately and only used together to generate email invitations and reminders.

In the event that DCoE is unable to distribute emails in the manner described in the preceding two paragraphs, it may be determined that DCoE will provide RTI a list of DoD chaplain email addresses so that RTI can manage the invitation and distribution process. If this is the case, an amendment request to both the RTI and DoD IRBs detailing the requested methodology change and ways in which the data will be used and protected by RTI. DCoE has indicated that, at that time, it will also establish a data use agreement (DUA) between DCoE and RTI detailing what data will be transmitted, how the data will be used and protected, steps for maintaining PII separately from the survey data, and how long the PII will be held by RTI before being destroyed.

> *If it DCoE determines to provide chaplain email addresses to RTI, a contractor or subcontractor of RTI, or a third party for purposes of sending email Survey participation invitations or follow up emails, this Privacy Act Review and the Privacy Office's Analysis and Recommendations set forth herein are expressly subject to the Privacy Office being provided an opportunity to conduct a Privacy Act review update of, and provide its analysis and recommendation on, the alternative arrangements for distributing Survey participation invitations and follow up reminders.*

The Survey questions do not request respondent PII/PHI. The one question that asks for additional comments or suggestions specifically reminds respondents not to include information that could compromise their anonymity.

Informed consent is being obtained from Survey respondents prior to a respondent having an opportunity to respond to the first Survey question. Prior to participating in the Survey, a respondent is informed of the risks and benefits of participating, that participation is voluntary, and they may skip any question or stop the Survey at any time.

Although the Survey responses will be stored separate from any identifying information such that linking responses to a particular individual should not be possible, RTI actively secures the information. All data transferred to or from the Survey will be done via secured webpages, and responses can only be downloaded from the server by individuals that provide the correct login information. Downloaded responses will be stored on the RTI computer network, which has a firewall and requires a password to access the data. No hard copies of the Survey or data will be created.

The Survey Documentation states that, during the course of the Survey, IP addresses of those logging into the Survey website will not be collected, no persistent cookies will be used, and the survey web server will not send cookies to determine who has or has not completed the Survey. Unique login ID numbers randomly assigned to Survey participants and provided in the invitation emails sent to DoD chaplains will be tracked, but used only for the limited purpose of sending follow up emails during the Survey's fielding period to only those DoD chaplain survey invitees who have not completed their Surveys. However, the unique login IDs are not being used after the Survey fielding period to track, identify, or otherwise provide reports to DCoE or RTI on specific email address of responding and non-responding chaplains.

TMA Privacy Office Recommendations:

The Privacy Office concludes that the collection and use of Survey responses is not part of a Privacy Act system of records. Consequently, the collection of responses through the Survey does not require inclusion of a Privacy Act Statement. Because of this conclusion, the Privacy Act Statement referenced in the DMDC document is not required in connection with this Survey or to complete the DMDC submission package.

Because respondents are not directly asked to provide PII before, after, or during this Survey, a Privacy Advisory should be sufficient. The language in the consent provided in the Survey documentation fulfills all elements of the Privacy Advisory. Before beginning the Survey, subjects are informed of the risks and benefits of participating, that participation is voluntary, and they may skip any question or stop the Survey at any time. So long as that text is provided before the first survey question, an independent Privacy Advisory is not necessary.

The Privacy Office's analysis and recommendations assume that the actual Survey documents, the methods used to solicit Survey participants, and the manner in which the online Survey is conducted are in accordance with the statements made in Survey Documentation. If any of these assumptions, or information provided in the Survey Documentation is incorrect, the Privacy Office's Analysis and Recommendations may change and may no longer be applicable to this Survey absent subsequent Privacy Office review.

APPENDIX K

VA / DoD CHAPLAIN SURVEY E-MAILS

Pre-Notification Email (to be sent from Service Chiefs of Chaplains)

Dear Chaplain Colleagues,

In a major effort to enhance the continuity and quality of care for our Service members and Veterans, the Department of Defense (DoD) and the Department of Veterans Affairs (VA) have recently launched a large-scale VA / DoD Integrated Mental Health Strategy. A key component of the VA / DoD Integrated Mental Health Strategy involves an acknowledgement and examination of the chaplain's role at the intersection of mental health issues. It is very exciting for me to see the substantive attention being paid to chaplaincy by DoD mental health leadership, and I see this as a real opportunity to strengthen integrative health care possibilities in service of our Service members.

As a central piece of the VA / DoD Integrated Mental Health Strategy on Chaplains' Roles, both VA and DoD chaplains will be asked to participate in web surveys administered by Research Triangle Institute International (RTI) who have been contracted by the VA to conduct these necessary surveys. Your feedback will be crucial to accomplishing the objectives of the VA / DoD Integrated Mental Health Strategy in constructing more optimally integrated systems of care for our Veterans and Service members, and so I strongly encourage you to complete the survey that you will receive via e-mail from RTI International.

Taking part in the survey is voluntary. It will take about 20 minutes to complete, and your answers will be kept confidential. Your name will not be associated with your individual answers and the results of the survey will be reported as group averages only. You may choose not to participate or may stop participating in the survey at any time without any problems. If you choose not to participate, there will be no penalty to you and you will not lose any benefit to which you are otherwise entitled. Your responses will be protected via the latest Internet technology. If you agree to participate, please answer all of the questions as honestly as you can; but you do not have to answer any questions that you do not want to answer. If you do not want to answer a specific question, please skip it and go on to the next question. There is a logout button on each screen which allows you to exit the survey temporarily. If you click on the logout button the survey will close and terminate the session. The survey automatically times out after 20 minutes of inactivity, but your answers will be saved and you will be able to log back in and resume the survey where you left off. Your completion of the web survey will indicate your voluntary participation.

We are hopeful that you will take the time to provide us with the information needed to allow DoD and the VA better meet the needs of military personnel and Veterans. Your participation in this study is greatly appreciated. If you have any questions about this survey, contact one of the investigators, Dr. Becky Lane at 1-800-334-8571 ext. 28490 or Dr. Jason Nieuwsma at 919-286-0411 ext. 6436. Or, if you have any questions about your rights as a study participant, you can call RTI 's Office of Research Protection (ORP) at 1-866-214-2043 (a toll-free number). Thank you for your assistance on this important project.

Sincerely,
[INSERT SERVICE CHIEF OF CHAPLAIN INFORMATION]

VA / DoD Chaplain Survey Invitation Email (to be sent by RTI)

Chaplain @LASTNAME@,

This is the follow-up e-mail to the survey invitation sent by [INSERT SERVICE CHIEF NAME]. To complete the survey, please click on the following link and enter the user ID and password provided below.

https://chaplainsurvey.rti.org/

User ID: @USERNAME@
Password: @PASSWORD@

If you do not complete the survey in one sitting, you will be able to log back in with the above user ID and password to resume the survey where you left off.

For any questions regarding the survey, please refer to the invitation e-mail sent by [INSERT SERVICE CHIEF NAME] or to the first page of the online survey. Thank you for your participation and for your service to our Service members.

Reminder Email (to be sent by RTI at Reminder 1 and Reminder 2 time points)

Chaplain @LASTNAME@,

Recently you were contacted by [INSERT SERVICE CHIEF NAME] with an invitation to participate in a survey in support of the Department of Defense (DoD) and Department of Veterans Affairs (VA) Integrated Mental Health Strategy (IMHS). If you have not yet completed the survey, or if you have completed part but not all of the survey, we invite you to complete it now by clicking on the following link and entering the User ID and Password supplied below.

https://chaplainsurvey.rti.org/

User ID: @USERNAME@
Password: @PASSWORD@

Reminder, if you do not complete the survey in one sitting, the above User ID and Password will allow you to enter back into the survey at a later date and resume from where you left off.

Your feedback will provide crucial input into the development of a more integrated system of care for our Veterans and Service members, and your participation in this study is therefore greatly appreciated. Remember that your participation is voluntary and that your answers will remain confidential. An independent organization is collecting responses to this survey, which means that your identity will not be tied to your survey responses. If you have any questions about this research, contact one of the investigators, Dr. Becky Lane at 1-800-334-8571 ext. 28490 or Dr. Jason Nieuwsma at 919-286-0411 ext. 6436. Or, if you have any questions about your rights as a survey participant, you can call RTI's Office of Research Protection (ORP) at 1-866-214-2043 (a toll-free number). Thank you for your assistance on this important project.

Reminder Email from Service Chiefs (to be sent at Reminder 3 time point)

Dear Chaplain Colleagues,

Earlier this month, I contacted you about the Department of Defense and Department of Veterans Affairs Integrated Mental Health Strategy. In service to this joint DoD-VA effort, I encouraged you to complete a web survey that is being conducted with DoD and VA chaplains. I am pleased to report that many of you have completed the survey – XX% to be precise. Thank you for your participation!

In case you have not completed the survey and do not have your User ID and Password on hand, RTI International will soon be sending reminders with this information. I would encourage you to complete the survey before it closes. Please remember that the survey is voluntary and that you can contact Dr. Nieuwsma (919-286-0411 ext. 6436) or Dr. Becky Lane (1-800-334-8571 ext. 28490) with any questions or concerns.

Thank you for your assistance on this important project.

Sincerely,

[INSERT SERVICE CHIEF INFORMATION]

Reminder Email (to be sent by RTI following Service Chiefs' email at Reminder 3 time point)

Chaplain @LASTNAME@,

This is the follow-up e-mail to the survey reminder that you should recently have received from [INSERT SERVICE CHIEF NAME]. To complete the survey, please click on the following link and enter the user ID and password provided below.

https://chaplainsurvey.rti.org/

User ID: @USERNAME@
Password: @PASSWORD@

The above User ID and Password will allow you to enter back into the survey at a later date and resume from where you left off if you do not complete the survey in one sitting. Remember that your participation is voluntary and that your answers will remain confidential. RTI International, an independent research organization, is collecting responses to this survey, which means that your identity will not be tied to your survey responses. If you have any questions about this research, contact one of the investigators, Dr. Becky Lane at 1-800-334-8571 ext. 28490 or Dr. Jason Nieuwsma at 919-286-0411 ext. 6436. Or, if you have any questions about your rights as a survey participant, you can call RTI's Office of Research Protection (ORP) at 1-866-214-2043 (a toll-free number).

Thank you for your assistance on this important project.

Final email reminder (to be sent by RTI at Reminder 4 time point)

We are writing to inform you that the survey of chaplains in the Department of Defense and Department of Veterans Affairs will be closing at the end of [INSERT MONTH]. If before the end of this month you would be willing to complete the survey, or to finish if you have completed part but not all of the survey, we would very much appreciate it. To complete the survey, please click on the following link and enter the user ID and password provided below.

https://chaplainsurvey.rti.org/

User ID: @USERNAME@
Password: @PASSWORD@

The above User ID and Password will allow you to enter back into the survey at a later date and resume from where you left off if you do not complete the survey in one sitting. Remember that your participation is voluntary and that your answers will remain confidential. RTI International, an independent organization, is collecting responses to this survey, which means that your identity will not be tied to your survey responses. If you have any questions about this research, contact one of the investigators, Dr. Becky Lane at 1-800-334-8571 ext. 28490 or Dr. Jason Nieuwsma at 919-286-0411 ext. 6436. Or, if you have any questions about your rights as a survey participant, you can call RTI's Office of Research Protection (ORP) at 1-866-214-2043 (a toll-free number). This is the final reminder that you will receive about this survey.

Thank you for your assistance on this important project.

APPENDIX L

VA / DoD Site Visit Invitation Letter

MENTAL HEALTH AND CHAPLAINCY
www.mirecc.va.gov/mentalhealthandchaplaincy/

VISN 6 MIRECC
Legacy Towers 800B
411 W. Chapel Hill St.
Durham, NC 27701
Phone: 919-286-0411 x4081
Fax: 919-416-8048

January 19, 2012

Chaplain [redacted],

In the fall of 2010, the Department of Defense (DOD) and Department of Veterans Affairs (VA) launched the DOD/VA Integrated Mental Health Strategy (IMHS). This ambitious strategy encompasses a broad array of stakeholders with the aim of "advancing an integrated and coordinated public health model to improve the access, quality, effectiveness, and efficiency of mental health services for all Active Duty Service members, National Guard and Reserve members, Veterans, and their families." To advance this mission, the DOD/VA IMHS has an entire strategic action devoted to understanding the crucial role of chaplains. As part of this strategic action on chaplains' roles, we are conducting visits to various DOD and VA facilities. **We're contacting you to express our interest in visiting the Minneapolis VA Medical Center.**

We selected the Minneapolis VA after going through a process of identifying approximately 30 VA and DOD facilities that are dispersed across the country and embody different characteristics with respect to facility size, patient population, rural/urban setting, and other features. Our hope is to learn about current pastoral care practices at your location, particularly as this care relates to issues of mental health. This is *not* an evaluation or inspection of your program. Rather, this is an opportunity for us to learn from your experience and use that knowledge to enhance services for our Veterans and Service members.

It is our hope to tour the facility and meet with chaplains, mental health care providers, other care providers, facility leadership, and any other individuals as appropriate. Your assistance in identifying the appropriate persons to meet with and in helping us to notify leadership at your facility of our intention to visit would be deeply appreciated. We have secured support and authorization to conduct these visits from Dr. Sonja Batten in the VA Office of Mental Health Services and from Chaplain Keith Ethridge at the National Chaplain Center (we can provide documentation of these approvals if desired). The site visits are being conducted by outside contractors from the University of Nebraska.

We will be in touch with you soon to further discuss the aims of our site visits and the ability of your site to participate. We will then coordinate with our contractors to assist with logistics.

Thank you for your service to our Veterans!

Sincerely,

Jason Nieuwsma

Jason Nieuwsma, Ph.D.
Associate Director
VA Mental Health & Chaplaincy
Jason.Nieuwsma@va.gov

Appendix M

VA / DoD Site Visit Interview Guide

Interview Guide – Full Version

1. **You (background; training/credentials; career trajectory)**
    - **a.** It would be helpful for me to know more about who you are. Please tell me very briefly (i.e., 1-2 sentences) about your position (what you do).
    - b. What professional training or credentials do you have that aid you in doing this work?

2. **Your job (program design; activities; pop served; service entrance)**
    - a. I'd like to get a better sense of the work you do. Please tell me what a typical work week looks like for you?
        - i. What are your day to day activities?
        - ii. Tell me what you do on a typical day.
        - iii. Tell me about the non-routine activities you are responsible for.
    - b. I would like to have a better understanding of the characteristics of the people served by mental health and chaplains here. Please tell me about who your program serves?
        - i. What makes your site unique when it comes to screening, eligibility or discharge requirements?
        - ii. Who does the chaplaincy/mental health program serve?
            1. Era of Veteran
            2. Inpatient vs. Outpatient vs. CBOCs (Community Based Outpatient Clinics)
    - c. What are the kinds of issues people bring to you?
        - i. What are the most common types of problems people bring to you?
        - ii. Are there mental health issues that you identify in your interactions with the people you serve? If so, can you describe the most common issues presented? What do you do when those arise?
        - iii. What types of problems or issues cross-over into both chaplaincy and mental health domains, and what types of issues should be exclusively in the domain of Chaplains/Mental Health? Do you perceive any boundary/turf issues that are problematic between the disciplines?

3. **Organization (reporting; physical layout; org support; other services/community including substance abuse; VA/DoD impression)**
    - a. It would help me if I could understand how you and your services fit into the overall structure here. What are the responsibilities of chaplains and mental health in this facility? How does each fit in the overall command/leadership structure?
    - b. Are there organizational charts showing command/leadership structure for chaplains and mental health professionals?
    - c. I would like to get a sense of the physical layout of the chaplaincy and mental health programs here. Please describe where you work.
        - i. Tell me about where you provide services
        - ii. How does your physical location affect your service to patients and interaction with mental health providers?
        - iii. Where would you like to be located and why?
        - iv. How does your location affect collaboration?

d. How would you describe the involvement of your area with the community?
    i. What are the most important links between your area and the community?
    ii. Do you collaborate at all with a local Vet Center? Would you like to?
    iii. To what extent do you work with local faith communities and/or clergy?

4. MH/Chaplaincy relations (state; referrals; boundaries)

a. In the course of your regular activities, do you overlap with MH?
b. I am interested in understanding the relationship between mental health and chaplaincy programs here. What are the formal and informal reporting and working relationships?
    i. How would you describe the relationship or interactions between Mental Health and Chaplaincy?
    ii. How could the relationship between MH and Chaplaincy be improved?
    iii. What influence does leadership have on the relationship between MH and Chaplaincy?
    iv. What kind of interactions with MH/CH works best for serving your clients?
    v. How often do you work with MH/CH?
    vi. How is your interaction with MH/CH supported at your facility?
    vii. Do you have standard procedures in place for referring or ordering consults?
c. How would you describe the level of understanding that Mental Health Personnel have of what you do?
    i. What should MH/CH know about what you do?
    ii. What do you think MH/CH need to know to do their job well here?
d. What would you want to know more about regarding what MH/CH staff do?
    i. What is the best way to get information about these areas to you and the people you work with?

5. Practices w/ customers/patients (staff/pts; pastoral care process; MH care process; tx tools; spiritual issues)

a. Now I would like ask for your ideas about enhancing the working relationship between mental health and chaplaincy. What benefits, if any, do you see in integrating care between chaplaincy and mental health care?
    i. Is there a model that optimally integrates issues of spirituality and mental health or health care?
    ii. Have any pieces of this type of integration been implemented here?
    iii. How does your team function?
        1. Who is on the team?
        2. How do you make referrals?
b. What practices regarding chaplaincy/mental health services are unique to your institution/facility?
    i. What would you recommend to places that might be interested in replicating what you do here?
    ii. Why does it work well here?
    iii. What is necessary to make it happen?

6. Assess & Doc (training; tools; spiritual diagnosis/assessment; ev-base impression)

a. What image(s) comes to mind when you think of spiritual assessment and/or spiritual assessment tools?
b. What education and training have you had in spiritual assessment?
c. Are there any spiritual assessment methods or tools that you are currently using?
d. When and how do you use those methods/tools?

e. Do you find the spiritual assessment methods/tools that you use to be helpful or not helpful? Why do you say that?
f. In your view, what are the strengths and weaknesses of using spiritual assessment methods or tools in chaplaincy?
g. Can you describe any evidence based practices you rely upon?
h. Do you think evidence based or best practices should be implemented in your area? How?
i. What do you think of chaplains being trained in evidence-based approaches to mental health care, such as Motivational Interviewing (MI), Acceptance and Commitment Therapy (ACT), or Problem-Solving Therapy (PST)?
j. Do you document patient/service member pastoral encounters (if so, how & what information is included)?
k. To what extent do you rely on notes from other health care providers your care for patients/service members?
l. What documentation or guidance do you rely on regarding documentation, follow-up, or interaction with chaplains? What documentation of chaplain services do you see?
m. What would be helpful for you to see with respect to documentation of chaplain services?

7. Chaplaincy/MH vision (what should know; training CH in MH & MH in CH; desire to improve & how; models; recommend)

a. Do you have any interest or hesitation in receiving clinical training in mental health issues as an enhancement to your pastoral care training?
    i. If so, would you be interested in receiving this training w/ MH providers? w/ DoD/VA chaplains?
b. Is there a model that optimally integrates issues of spirituality and mental health or health care?

Interview Guide – Short Form

Chaplaincy/MH Questions

1. What is your background and training? 2. Describe the program you work in (Organization)? 3. What do you do? What is your job? 4. What kinds of people do you serve (issues/needs)? 5. How do people get here (referral – MH/CH)? 6. How do MH/CH work together here? What's unique? Formal/informal?	7. What should CH/MH know about each other? 8. How do you work w/community/SA/SW/others? 9. CH: how assess spiritual need (MH-how use)? 10. How do you use/consider EBPs? 11. How do you document what you do/success? 12. How should MH/CH work together (model)? What other ideas do you have to improve CH/MH?

Interview (date, time place: Interviewer:

Interviewee(s) (name, rank, billet, race, gender, years in service):

Appendix N

VA / DoD Site Visit Codebook

Code Family	Confidentiality
CODE	1. CONFIDENTIALITY IMPORTANT
Brief Definition	Confidentiality of chaplains is important.
Full Definition	The privilege of confidentiality is a fundamentally important characteristic chaplaincy, and affects their relations with patients and providers.
When to use	Apply this code when reference is made to the importance of confidentiality among chaplains in their relationships or interactions with patients, peers, family members, health care providers, or command.
When not to use	Do not use this code if confidentiality is referred to without reference to its importance or impact.
Example	"Chaplains have complete confidentiality – They can't even reveal if a person came to see him so chaplains don't do chart notes unless needed."

Code Family	Confidentiality
CODE	2. MH CONFIDENTIALITY RESTRICTS
Brief Definition	Mental health confidentiality (including HIPAA) restricts what mental health can share with chaplains who are not part of the interdisciplinary treatment team.
Full Definition	Confidentiality between patients and mental health providers ensures that patient mental health information is not shared with chaplains or others who are not the patient's mental health provider.
When to use	Apply this code when reference is made to patient/mental health provider confidentiality restricting the sharing of sensitive or specific information about that patient to chaplains or others.
When not to use	Do not use this code if mental health confidentiality is referenced in general without a connection to how it restricts sharing of information.
Example	" I've tried to reach out to these providers and see who I am referring to but they don't seem to respond to me or to my phone calls, but personally I would feel more comfortable if I knew them. Some of it has to do with confidentiality and some of it has to do with HIPAA."

Code Family	Confidentiality
CODE	3. CONFIDENTIALITY EDUCATION
Brief Definition	Chaplains need education about the ethical boundaries and limits of mental health confidentiality.
Full Definition	Chaplains are in need of education or training about the nature and boundaries of confidentiality between patients and mental health professionals so they can better understand and appreciate it and its impact on patients, providers, and communication with chaplains and others.
When to use	Apply this code if reference is made to a need for education or training of chaplains on confidentiality of mental health providers and patients.
When not to use	Do not use this code if confidentiality between mental health providers and patients is noted generally without a reference for training or education of chaplains on this topic.
Example	Differences between what they do and what we do – limits on confidentiality and reporting. Providers know what the boundaries are but not sure that chaplains know the reporting boundaries.

Code Family	Confidentiality
CODE	4. MH DOES NOT KNOW CHAPLAIN CONFIDENTIALITY
Brief Definition	Mental health is unsure of what chaplains can or cannot disclose about a client.
Full Definition	Mental health providers are unsure or not clear about what types of information can be

	communicated about a patient by chaplains.
When to use	Apply this code if reference is made to mental health providers not knowing what types of information can or cannot be communicated by a chaplain about a patient.
When not to use	Do not use this code unless reference is made specifically to mental health being unclear or having mistaken expectations about the content or parameters of confidential communications about patients by chaplains.
Example	

Code Family	Confidentiality
CODE	5. COMMAND KNOWS CHAPLAIN CONFIDENTIALITY
Brief Definition	Command/Leadership is more familiar with confidentiality policy/practice for chaplains than for mental health.
Full Definition	Within DoD environments, there is a greater understanding of the dynamics and parameters of chaplain confidentiality than for confidentiality of communications with mental health professionals.
When to use	Apply this code if reference is made to DoD command having more understanding of chaplain confidentiality than mental health confidentiality.
When not to use	Do not use this code if reference is not made to relative understandings of chaplain and mental health confidentiality by command in DoD environments.
Example	Mental health needs to know level of confidentiality is different for chaplains. Non Veteran MH and chaplains don't quite understand the absolute confidentiality

Code Family	Confidentiality
CODE	6. CH CONFIDENTIALITY INCENTIVE
Brief Definition	Chaplains' strict confidentiality standards are an incentive for people to talk with them.
Full Definition	The understanding that communications with chaplains are strictly confidential is a factor that contributes to or increases the likelihood that individuals would consult with them.
When to use	Apply this code if reference is made to chaplains' enjoyment of strict confidentiality and how it contributes to their positions within military/veteran culture and settings.
When not to use	Do not use this code unless chaplain confidentiality is referenced in relation to how it impacts willingness of individuals to talk with them about issues they are experiencing.
Example	"A Vet opens up even more when vets find out he is a military chaplain. They know the military chaplain level of confidentiality is like super glue between your lips."

Code Family	Confidentiality
CODE	7. CH CONFIDENTIALITY RESTRICTS
Brief Definition	Chaplain confidentiality restricts what chaplains can share with mental health providers and can serve as a barrier to referral.
Full Definition	Strict chaplain confidentiality restricts what patient information can be shared with mental health providers, command, or others. As such, it can be a barrier to referring to mental health
When to use	Apply this code when reference is made to chaplain confidentiality restricting what can be shared about a patient without his/her permission. Also if there are references to confidentiality serving as a barrier for referrals
When not to use	Do not use this code unless reference is made to how chaplain confidentiality specifically restricts communication about a patient with others.
Example	"But a barrier is confidentiality by chaplains; they can't do patient discussions."

Code Family	Confidentiality
CODE	8. SELF REFERRAL
Brief Definition	Chaplains are able to successfully encourage self-referral by service members to access behavioral health services.
Full Definition	Chaplains are typically able to encourage patients to voluntarily seek help or disclose high risk situations they are in (e.g. suicide) to mental health professionals, command, or others in

	ways that preserve confidentiality of communications.
When to use	Apply this code if reference is made to chaplains' learning about mental health needs in confidential communications from patients, and then being able to successfully encourage them to disclose that information and seek help from mental health professionals, command, or others.
When not to use	Do not use this code if reference is not made to individuals self-referring to others after having disclosed high risk thoughts or information to chaplains.
Example	"Chaplain will encourage them to talk to others and get help – same with harm to self – continue to be by their side."

Code Family	Confidentiality
CODE	9. CONFIDENTIALITY DOCUMENTATION
Brief Definition	Confidentiality influences what can be documented by chaplains.
Full Definition	Strict confidentiality that chaplains enjoy influences what they can or cannot disclose in written documentation about a patient.
When to use	Apply this code when reference is made to chaplains not documenting all information they know about a patient in writing because of confidentiality concerns.
When not to use	Do not use this code unless written documentation is implicated and confidentiality is impacting an intentional decision to not fully document patient information.
Example	"They can't even reveal if a person came to see him so chaplains don't do chart notes unless needed."

Code Family	Individual knowledge (Formal training)
CODE	10. CPE GOOD
Brief Definition	Clinical Pastoral Education prepares chaplains to work better with mental health.
Full Definition	Chaplains who have experienced Clinical Pastoral Education (CPE) training are better skilled than those without it in working with and in mental health.
When to use	Apply this code when it is stated specifically that CPE-trained chaplains are better skilled than non CPE-trained chaplains in working with or in mental health or medical.
When not to use	Do not use this code unless CPE training is specifically cited as preparing chaplains for working with or in mental health or medical.
Example	"CH know what to expect because went through CPE"

Code Family	Individual knowledge (Formal training)
CODE	11. ARMY FAMILY LIFE GOOD
Brief Definition	Army Family Life Center training prepares chaplains to work better with mental health.
Full Definition	Chaplains who have experienced Army Family Life Center (AFLC) training are better skilled than those without it in working with and in mental health.
When to use	Apply this code when it is stated specifically that AFLC-trained chaplains are better skilled than non AFLC-trained chaplains in working with or in mental health.
When not to use	Do not use this code unless AFLC training is specifically cited as preparing chaplains for working with or in mental health.
Example	"Chaplains at the family life center have comprehensive knowledge because they are marriage and family therapists or in training for this. Some are trained therapists."

Code Family	Individual knowledge (Formal training)
CODE	12. INTEGRATION GRADUATE EDUCATION
Brief Definition	Graduate level mental health programs should include information on religion/spirituality and/or integration of chaplaincy and mental health.
Full Definition	Graduate level training for mental health students should cover the importance of religion, spirituality, and/or chaplaincy to patient care.
When to use	Apply this code when it is stated specifically that graduate training of mental health professionals should include training specifically about the role of religion, spirituality or chaplaincy in mental health care.

When not to use	Do not use this code if reference is made to training that occurs outside of formal graduate education of mental health professionals.
Example	"He did a class for psych residents on integrating spirituality into health care"

Code Family	Individual knowledge (Formal training)
CODE	12.1 BACKGROUND
Brief Definition	The background of chaplains and mental health providers allow them to provide better services or integrate with other professions
Full Definition	Mental health training of chaplains and a faith background/training of mental health providers facilitates integrated approaches. Military backgrounds of chaplains or mental health providers help them connect with active duty or veterans
When to use	References to medical or mental health background of chaplains or faith background or spirituality training of mental health facilitate integration or communication with other professions or an integrated approach to patient care. References to military background of chaplains or mental health facilitating relationship with population served.
When not to use	Do not use this code if reference is made to current training or integrated practices efforts
Example	"There are differences between mental health providers who are believers and non-believers." AND "Many chaplains are vets and vets like to talk to vets."

Code Family	Individual knowledge (Formal training)
CODE	13. MH TRAINING CHAPLAINS
Brief Definition	There should be a standard curriculum about mental health in chaplaincy training.
Full Definition	Chaplains should receive an overview about mental health in the course of formal chaplaincy training so they better understand patient conditions, and understand what mental health professionals do. Chaplains may benefit from advanced mental health training, possibly leading to certification or other credentials
When to use	Apply this code when reference is made to mental health training for all chaplains as part of a standard curriculum or for advanced training.
When not to use	
Example	"There is a one year refresher for chaplain clinicians. They already do this for CPE residents, but would be good to do for other chaplains."

Code Family	Individual knowledge (Formal training)
CODE	14. CH MH AWARENESS
Brief Definition	Chaplains currently don't have or should have a general awareness of mental health including mental health problems, treatments, and terminology.
Full Definition	Chaplains generally should have a basic working knowledge of mental health issues, principles and practices. This will assist integration and facilitate relationship building and allow chaplains to be effective team members and understanding their roles.
When to use	Apply this code if reference is made generally to chaplains not having knowledge or needing to know more about mental health issues, principles and practices. Also references to chaplains getting mental health know with implication this is good.
When not to use	Do not use this code if reference is made to chaplains needing to know about EBPs, or specific clinical skills or practices.
Example	"Chaplains should have a short course in abnormal psychology. Maybe a short study in symptoms or types of disorders."

Code Family	Individual knowledge (Formal training)
CODE	15. MH CH AWARENESS
Brief Definition	Mental health should have general awareness of chaplain practices.
Full Definition	Mental health professionals should have a general understanding of the skillsets, training, practices of chaplains, the types of issues chaplains handle, and what they do and do not do. This will assist integration and facilitate relationship building and understanding their roles.
When to use	Apply this code if reference is made to mental health not having knowledge or needing a

	general awareness and education about the skillsets, training, types of cases handled and practices of chaplains generally. Also references to chaplains getting mental health know with implication this is good.
When not to use	
Example	"Mental health should know that chaplains can help. They should know when to call a chaplain."

Code Family	Individual knowledge (Formal training)
CODE	16. JOINT SUICIDE PREVENTION
Brief Definition	Chaplains and mental health should present suicide prevention training together.
Full Definition	Suicide prevention training and education activities should be developed and presented by mental health and chaplaincy to better develop interdisciplinary ties.
When to use	Apply this code if suicide prevention training is specifically recommended as an activity that should be developed and presented jointly by chaplains and mental health working together.
When not to use	Do not use this code if other forms of behavioral health education are advocated for.
Example	"At the VA there were new directives with suicide prevention that dictated that chaplains and suicide prevention workers should work closely together. That is the only common training that I have had experiences with."

Code Family	Individual knowledge (In-house training)
CODE	17. INTERDISC TRAINING
Brief Definition	Appropriate in-house trainings should be offered to interdisciplinary teams or where chaplains and mental health train together.
Full Definition	Interdisciplinary teams should receive in-house training together on topics of importance to the team because it will increase interdisciplinary ties and relationships.
When to use	Apply this code when in-house training is referenced for formal interdisciplinary treatment teams and when chaplains and mental health do training together.
When not to use	Do not use this code if training is not referenced specifically for interdisciplinary treatment teams or when chaplains and mental health train together.
Example	"They usually trained as a team which helped team building."

Code Family	Individual knowledge (In-house training)
CODE	18. CH ATTEND MH TRAINING
Brief Definition	Chaplains should attend in-house mental health training (e.g., grand rounds).
Full Definition	Chaplains should take advantage of in-house training opportunities directed at or by mental health professionals because it will assist them in understanding the field better.
When to use	Apply this code when reference is made to chaplains attending in-house training activities directed at or by mental health professionals.
When not to use	Do not use this code for training not directed at or developed by mental health professions. Do not use this code when chaplains attend mental health training to train mental health about chaplaincy; use #20 for this.
Example	"Mental health does general quarters every Friday ... They go over general information and individual cases. They discuss information on upcoming events. They provide training for sailors. They discuss patient care...the chaplain attended these ..."

Code Family	Individual knowledge (In-house training)
CODE	19. ORIENTATION TRAINING
Brief Definition	Chaplains should be part of new employee orientations.
Full Definition	Chaplains should play a visible role in orientations of new employees. This will facilitate greater understanding of their roles and skill-sets and address potential misconceptions people may have about chaplains.
When to use	Apply this code when education about chaplains is specifically referenced in the context of training for new employees.
When not to use	Do not use this code unless new employee orientation is specifically singled out as a training

	opportunity about chaplaincy.
Example	"In hospital orientation, there is not much at all given in orientation about chaplaincy for newcomers. That needs to be improved."

Code Family	Individual knowledge (In-house training)
CODE	20. MH ATTEND CH TRAINING
Brief Definition	Mental health should be invited to attend some in-house chaplaincy meetings/training.
Full Definition	Mental health should take advantage of trainings directed at or by chaplains because it will assist them in understanding the field better.
When to use	Apply this code when reference is made to mental health attending in-house training activities directed at or by chaplains.
When not to use	Do not use this code if reference is not to chaplain sponsored/targeted training. Do not use this code when mental health attends chaplaincy training to chaplains about mental health; use #18 for this.
Example	"Mental health attended to see what strong bonds is all about."

Code Family	Individual knowledge (In-house training)
CODE	21. CH ASSISTANTS TRAINING
Brief Definition	Chaplains' assistants should have a general awareness of mental health practices.
Full Definition	Chaplains' assistants (religious program specialists, interns, administrative support, etc.) would support the work of chaplaincy and integration if they had a general awareness of or education in basic mental health.
When to use	Apply this code if reference is made to chaplains' assistants having or needing general knowledge or training in basic mental health.
When not to use	Do not use this code unless chaplains' support staff or assistants are specifically identified as needing awareness of or training in mental health generally.
Example	"Most Chaplain Assistants don't have very much knowledge. Would be good if chaplain assistant had more training on Mental health. "

Code Family	Individual knowledge (In-house training)
CODE	22. INTERDISC DOCUMENTATION
Brief Definition	Written guidance should be available at each chaplain assignment about practices and training at that location.
Full Definition	Chaplains would benefit from the existence of written guidance that identifies in-house training opportunities and integration activities with mental health. This might be particularly helpful for new chaplains.
When to use	Apply this code when written documentation is specifically recommended for chaplains about in-house mental health training and integration opportunities.
When not to use	Do not use this code unless written documentation is specifically noted or recommended for chaplains about in-house mental health training and integration opportunities.
Example	"Have a mandatory turn over or a consistent turnover binder that contains all the information in a format that is similar regardless of the billet. Then we know where to look and who to contact."

Code Family	Individual knowledge (In-house training)
CODE	23. CH COMMUNITY EDUCATION
Brief Definition	Chaplains have a key role in educating community partners.
Full Definition	Chaplains can or should have a role as liaisons with communities. They can serve as bridges to help communities better understand the culture, settings and services offered within veterans administration and DoD facilities, or to understand community needs that exist in regards to veterans, service members and family.
When to use	Apply this code when chaplains are identified specifically as assets for VA or DoD systems/institutions to facilitate increased community understanding and education of what they do and offer generally, and what community needs exist in regards to veterans, service

	members and family.
When not to use	Do not use this code if chaplains are referred to as agents of individual patient referral only.
Example	"Work between mental health and chaplaincy to enhance community network including faith community to support MH patients."

Code Family	Individual knowledge (In-house training)
CODE	24. CONFERENCES GOOD
Brief Definition	Conferences offer opportunities to further integration through networking and joint education.
Full Definition	Formal academic or professional conferences on issues pertinent to integrating mental health with chaplaincy are good opportunities for joint education of chaplains and mental health professionals.
When to use	Apply this code when conferences are referenced as opportunities to further integration and education between chaplaincy and mental health.
When not to use	Do not use this code if conferences are not specified, or if interdisciplinary integration is not the desired outcome.
Example	"Doing things together, attending things together, intentionally involving ourselves with them and them with us. I think we had more MH providers at our bridging conference. We sent out early notices to them so they could be aware of that. "

Code Family	Professional development topics
CODE	27. CASE CONCEPTUALIZATION
Brief Definition	Chaplain's knowledge of how mental health conceptualizes cases would enhance integration.
Full Definition	Chaplains are or would be better able to integrate with mental health if they had greater insight into how mental health professionals conceptualize, classify or perceive individual patients or patient episodes.
When to use	Apply this code when knowledge of mental health conceptualization or classification of patients is specifically identified as facilitating integration.
When not to use	Do not use this code if more general knowledge about mental health practices is identified as being helpful to facilitation.
Example	"Chaplains should know the rational for conceptualization of cases and be able to integrate with teams"

Code Family	Professional development topics
CODE	29. SENSITIVE ISSUES
Brief Definition	Chaplains and mental health would benefit from enhanced understanding of sensitive issues (e.g., LGBT issues, sexual assault response).
Full Definition	Both chaplains and mental health would better serve patients if they were adequately prepared to address cases which involve highly sensitive or potentially divisive issues that might implicate personal or religious convictions. This might involve developing policies, practices or trainings related to such issues that would facilitate positive outcomes, or cross-disciplinary referral for such cases.
When to use	Apply this code if mental health professionals' or chaplains' knowledge of or training related to potentially sensitive, divisive or controversial issues (e.g. abortion) is referred to as needing attention.
When not to use	Do not use this code unless highly sensitive issues are identified as needing attention as a matter of intentional training, policy development or education towards chaplains and/or mental health.
Example	"LGBT training … The presentation didn't go well because the chaplains felt it wasn't consistent with their theology and certain concepts were being forced upon them."

Code Family	Professional development topics
CODE	30. MH SPIRITUAL TRAINING

Brief Definition	Clinicians need more training and knowledge about spirituality and spiritual assessment.
Full Definition	Mental health and clinicians generally would benefit from greater understanding of spiritual needs and the importance of spiritual assessments and their results on patient care. Mental health could access the expertise of chaplains in this area
When to use	Apply this code when spirituality and spiritual assessments of patients are highlighted as topics of training/education for mental health and other clinicians. Also references to chaplains as experts and available to consult with mental health
When not to use	Do not use this code if the reference is to greater training or other types of education or to gaining more knowledge about chaplaincy in general.
Example	"It would be helpful to have more training regarding what psychologists can do in the realm of spirituality."

Code Family	Professional development topics/Integration
CODE	31. TIME/STAFF LIMITATIONS
Brief Definition	Time or staffing constraints limit opportunities for professional development or integration.
Full Definition	Both chaplains and mental health lack available time for training and professional development and integration opportunities.
When to use	Apply this code when lack of time or staff is specifically cited as a barrier to training, education and integration opportunities.
When not to use	Do not use this code if lack of time is identified as a barrier or challenge generally or to EBPs.
Example	"There is no time to do anything like additional collaboration with chaplains."

Code Family	Professional development topics
CODE	32. FUNDING LIMITATIONS
Brief Definition	Lack of funds for training limits opportunities for professional development or integration.
Full Definition	Lack of available funds to support training opportunities such as seminars or conferences, or to purchase or support training resources (journals, etc.) is a barrier that hinders professional development and integration.
When to use	Apply this code when lack of funds or budget is specifically cited as a factor that limits professional development and integration.
When not to use	Do not use this code unless funds or budgets are specifically cited as challenges for professional development and integration.
Example	"DoD has a good model for integrating chaplaincy and mental health care but it requires financial support to keep it up or enhance it beyond what it is."

Code Family	Accessibility (Accessibility and physical location)
CODE	33. BEING CLOSE
Brief Definition	Close physical proximity/presence of chaplains and mental health fosters cross-disciplinary integration.
Full Definition	Integration is enhanced by intentional physical placement or placement of chaplains and mental health professionals within close proximity. Integration is also enhanced by mental health being available to each other.
When to use	Apply this code when physical location of offices is cited as a contributing factor to integration and cross-disciplinary communication, or when being in close quarters in mission environments facilitates integration and cross-disciplinary communication. Use also if reference is made to chaplains or mental health being present or available to each other. For chaplains working with other medical programs, include references to proximity to other medical professionals and chaplains. Use also for references to being close in deployment.
When not to use	Do not use this code if the overall size of a setting is not referred to as contributing to integration.
Example	"It would be good if mental health and chaplains housed closer together"

Code Family	Accessibility (Accessibility and physical location)

CODE	34. FACILITATE ENTRY
Brief Definition	Chaplains can facilitate entry into mental health treatment.
Full Definition	Chaplains can serve as positive liaisons into mental health treatment by being physically visible or physically guiding patients to mental health offices. This makes mental health environments seem more accessible or inviting to patients.
When to use	Apply this code if chaplain presence or role is identified as an inviting or facilitating factor physically for patients to seek mental health assistance. For chaplains working with other medical programs, include references to facilitating entry to other medical programs.
When not to use	Do not use this code if physical location is cited as a factor facilitating cross-disciplinary relationship building only.
Example	"Soldiers know who the chaplain is and feel at ease with them, at least some of the chaplains. If chaplain could deal with the issue then fine, but for more serious issues like panic attack then chaplains will refer on"

Code Family	Accessibility (Accessibility and physical location)
CODE	35. FACILITY DESIGN
Brief Definition	Physical design and setting of patient environments impacts patient satisfaction and quality of interaction with providers.
Full Definition	Physical design of patient environments impacts their satisfaction and recovery. Larger spaces, meeting spaces, and calm environments are helpful, and therefore factors that can assist chaplains and mental health in working with patients.
When to use	Apply this code when physical design of patient areas are specifically noted as being positive, contributing factors on patient recovery and interaction with chaplains and/or mental health or other medical programs.
When not to use	Do not use this code in reference to physical proximity of chaplain and mental health offices.
Example	"The chapel is near the mental health area, especially the rehab unit and ASAP. It helps that patients can go to the chapel as a quiet area – meditative time."

Code Family	Accessibility (Accessibility and physical location)/Integration
CODE	36. DEDICATED CHAPLAIN
Brief Definition	Assigning/dedicating chaplains to clinical behavioral health units enhances relationships and ability to provide holistic care.
Full Definition	Intentional dedication of chaplains near or with mental health programs improves access to patients and clinicians/mental health who work with them. This serves as a positive example of direct integration of disciplines.
When to use	Apply this code when reference is made to intentional dedication of a chaplain within a mental health or other medical unit or program for purposes of integrating that chaplain into services.
When not to use	Do not use this code with reference to close physical proximity between chaplains and mental health generally.
Example	"One idea that is coming up is having either a chaplain embedded with us or one of us embedded over here at the chapel at certain times to promote understanding about what we do."

Code Family	Accessibility (Accessibility and physical location)
CODE	37. CH OPERATIONAL SETTING
Brief Definition	Chaplains supporting units in operational or foreign settings facilitate access to mental health care and promote cross-disciplinary relationships.
Full Definition	Within an operational setting (e.g. deployed in the field, at sea), chaplains and mental health or clinicians tend to work closely and well together due to close and continuous physical proximity with each other and mission priorities. The visibility and availability of chaplains in operational settings facilitates reference of service members to mental health.
When to use	Apply this code when reference is made to positive relationships between chaplains and mental health or other clinicians within the operational or field context, and the visible

	nature of chaplains and their role in connecting service members with mental health in this context.
When not to use	Do not use this code in reference to in garrison settings or VA environments generally.
Example	"But it really helped when they were deployed…He had more interaction in deployment and he got out of office and talked to them sometimes.

Code Family	Accessibility (Accessibility and physical location)
CODE	38. SETTING SIZE
Brief Definition	The size and setting of medical centers and military command environments affects access to patients and cross-disciplinary relationships.
Full Definition	The physical and bureaucratic size of the setting in which a patient or service member is (e.g. hospital setting, base, sea vessel, etc.) affects access to services and relationships between chaplains and mental health or other professional services. Larger and more complicated environments are harder to navigate and require more intentional efforts to seek and find help.
When to use	Apply this code when reference is made to the overall size or complexity of an environment as a barrier or facilitator to accessing care by a patient/service member, or a barrier or facilitator to interdisciplinary cooperation or referral among chaplains and mental health.
When not to use	Do not use this code in reference to dissatisfaction with individual office facilities or location.
Example	"The system is so big there is often a breakdown in communication."

Code Family	Accessibility (Accessibility and physical location)
CODE	39. REMOTE LOCATIONS
Brief Definition	Service gaps exist for patients or service members who live in remote communities or are deployed in remote settings.
Full Definition	Veterans or service members (e.g. national guard/reserves) who are located far from VA facilities or DoD facilities are harder to reach and/or face geographic barriers to receiving care. Obtaining services are more difficult for those who live in remote, largely rural areas or for deployed service members.
When to use	Apply this code when reference is made to geographic distance as a barrier to obtaining needed services including when service members are deployed.
When not to use	Do not use this code in reference to socio-economic characteristics of communities generally.
Example	"There were two battalion chaplains that gave him rides to different places… They worked in a post on the border – there was not much out there. Cold chow and no showers – chaplains motivated command to improve conditions."

Code Family	Accessibility (Accessibility and physical location)
CODE	40. TRAVEL POLICY
Brief Definition	Policy changes related to service coverage and travel reimbursement are needed for chaplains to better serve individuals in remote communities.
Full Definition	Funding limitations or red tape exists that restrict the abilities of chaplains to travel to patients, service members, or family to adequately serve them. Policy changes are needed to alleviate or address these barriers.
When to use	Apply this code when funding or policy limitations are referenced as restrictions to traveling to and seeing individuals in need of services from chaplains.
When not to use	Do not use this code if funding or policies are not specifically referenced as barriers to providing care to individuals in remote communities.
Example	"There is no travel pay for veterans or family to see chaplain (even though the pay will be available for them to see other clinicians) (big disconnect)."

Code Family	Accessibility (Staffing levels and accessibility)
CODE	41. LACK OF STAFF

Brief Definition	Lack of staff is a barrier to accessibility.
Full Definition	Mental health and chaplains may be short staffed and they do not have time to provide the desired level of services. Within some clinical environments, there may be few full-time chaplains and more of a reliance on part-time chaplains (contract chaplains, interns, etc.). This serves as a barrier on several levels. Part-time chaplains may not be as available as they could or should be to patients. Additionally, continuous cross-disciplinary communication and integration may be hampered by the reliance on part-time chaplains.
When to use	Apply this code when reference is made to lack of mental health or chaplaincy staff related to accessibility or providing a desired level of service. Also include references to part-time chaplain status as a barrier to either patients seeking access to services or interdepartmental or cross-disciplinary communication and cooperation among providers within that setting.
When not to use	Do not use this code if lack of staffing is related to training, documentation or learning about evidence based practices.
Example	"At this clinic – the workload is more than they can handle. There is no time to do anything like additional collaboration with chaplains."

Code Family	Accessibility (Staffing levels and accessibility)
CODE	42. HIRING PROCESS
Brief Definition	There are barriers to recruiting or hiring full-time chaplains within the VA system.
Full Definition	The process to hire full-time chaplains within the VA system is difficult and time-consuming, and results in the lack of qualified full-time chaplains within the VA.
When to use	Apply this code when the difficulty of the hiring process is referred to as a barrier to having more full-time staff chaplains in general within the VA system.
When not to use	Do not use this code in reference to limited hiring budgets, or the need to diversify chaplains in terms of faith-background, gender, or race/ethnicity.
Example	"They got a new contract chaplain to cover off hours. Tried to bring contract chaplain on full time. They are reducing staff while having more outpatient clinics."

Code Family	Accessibility (Diversity and accessibility)
CODE	43. FEMALE CHAPLAINS
Brief Definition	There is a need for more female chaplains.
Full Definition	Because the vast majority of chaplains are male, more female chaplains are needed, particularly to minister to female patients and service members.
When to use	Apply this code when a specific reference is made to a need for having more female chaplains, or deficiencies are noted related to not having enough female chaplains.
When not to use	Do not use this code in general reference to female chaplains, or general activities involving female chaplains.
Example	"The Chief of Chaplain asked if should hire female Chaplain – so he specifically sought female Chaplain."

Code Family	Accessibility (Diversity and accessibility)
CODE	43.1 FEMALE CHAPLAINS ADD VALUE
Brief Definition	Female chaplains add value to mental health or chaplaincy.
Full Definition	Female chaplains may add value to service delivery, particularly to minister to or provide services to female patients and service members.
When to use	Apply this code when a specific reference is made to the value of female chaplains.
When not to use	Do not use this code in general reference to female chaplains, or general activities involving female chaplains, or to not having enough female chaplains.
Example	"She has been able to open some of these women's eyes to choices they have. She has de-stigmatized addictions from a chaplain's perspective. She is very open, a lot of the women have had some sexual trauma. She has helped people rid themselves of a lot of their guilt and shame."

Code Family	Accessibility (Diversity and accessibility)

CODE	44. RELIGIOUS RACE DIVERSITY
Brief Definition	There is a need to increase religious and racial diversity within chaplaincy.
Full Definition	Because the vast majority of chaplains are Christian and white, there is a need to diversify chaplaincy with non-Christian and non-white chaplains to minister to a diverse population and service member base.
When to use	Apply this code when a specific reference is made to a need for having more religious or racially diverse chaplains, or deficiencies are noted related to not having enough religious or racially diverse chaplains.
When not to use	Do not use this code in general reference to a non-Christian or non-white chaplains, or general activities involving non-Christian or non-white chaplains.
Example	"4 weaknesses; I don't have a rabbi, I lost my only woman chaplain here in Topeka (but there is one in Leavenworth), and I need a native American, and Islam."

Code Family	Accessibility (Systemic and cultural issues and accessibility)
CODE	46. LEADERSHIP SUPPORT
Brief Definition	Active leadership support is critical to promote integration of chaplaincy and mental health.
Full Definition	Active and visible support for chaplaincy and mental health integration by command or institutional leadership impacts integration practices and overall institutional culture.
When to use	Apply this code when reference is made to the importance of leadership being supportive, or non-supportive, of integration efforts to the overall environment or institution.
When not to use	Do not use this code in reference to micro-level environments or programs.
Example	"If a hospital commander thinks integration with mental health is important, then it will happen. Leadership is important."

Code Family	Accessibility (Systemic and cultural issues and accessibility)
CODE	47. TURF RESISTANCE
Brief Definition	Entrenched perceptions, attitudes and turf serve as barriers to integration.
Full Definition	Historical attitudes and rivalries between chaplaincy, mental health, and other disciplines still play a role as barriers to integration.
When to use	Apply this code when reference is made to general attitudes or cultural philosophies that serve to discourage interdisciplinary integration between chaplains and mental health or other medical professionals.
When not to use	Do not use this code in reference to lack of education/training, funding, time, environmental (physical), or bureaucratic barriers to integration.
Example	"Freud despised religion. He called it infantile neurosis or something. You've got this body of literature within psychology and psycho analysis that is very hostile to religion and spirituality."

Code Family	Accessibility (Systemic and cultural issues and accessibility)
CODE	48. CH DESTIGMATIZE
Brief Definition	Chaplains can play an important role in de-stigmatizing mental health services.
Full Definition	Chaplains are generally perceived positively within military culture and with much less suspicion than mental health providers. They therefore have a potentially significant role in helping to de-stigmatize seeking help for mental health issues within military/veteran cultures and communities.
When to use	Apply this code when reference is made to chaplains facilitating de-stigmatizing attitudes or beliefs towards mental health services.
When not to use	Do not use this code in reference to chaplains working in cooperation with mental health generally, or referring patients to mental health.
Example	"There is still stigma and many active duty members would rather go to the chaplain first, then he can help them see the need for mental health and substance abuse if that is needed."

Code Family	Accessibility (Systemic and cultural issues and accessibility)
CODE	48.1 CH STIGMA

Brief Definition	Patients may be reluctant to go to chaplains because of religious stigma
Full Definition	Sometimes patients may be hesitant to participate in chaplaincy services because of history or perspectives about religion
When to use	Apply this code when reference is made to patient's reluctance to participate in chaplain programs because of beliefs about religion.
When not to use	Do not use this code in reference to chaplains destigmatizing mental health. Code these as # 48
Example	"Bias – vets think might push religion, but these Chaplains don't."

Code Family	Referrals
CODE	49. RELATIONSHIPS GOOD
Brief Definition	Professional relationships encourage cross-disciplinary referral or integration.
Full Definition	Chaplains and mental health professionals who know and are familiar with each other personally facilitates communicates, referral, and cooperation.
When to use	Apply this code in reference to the importance of having personal relationships in place that facilitates integration between chaplains and mental health or other medical professionals.
When not to use	Do not use this code in reference to formal trainings or structures that facilitate integration or referral.
Example	"We need to build trust. Trust is a very key piece. The base of any operation has got to be trust. It is not earned over night. "

Code Family	Referrals
CODE	49.1 NO RELATIONSHIPS
Brief Definition	There are no or little relationships between mental health and chaplaincy
Full Definition	Chaplains and mental health professionals do not know or are not familiar with each other
When to use	Apply this code in reference to mental health and chaplains not knowing each other, not working with each other, not referring to each other or not coordinating or integrating their practices
When not to use	
Example	"I have not done any collaborating here – when sharing cases"

Code Family	Referrals
CODE	50. CH BELIEFS
Brief Definition	Lack of knowledge or concern about how a chaplains' religious beliefs might impact a patient (e.g., anti-gay beliefs) can serve as a barrier for mental health referring to chaplains
Full Definition	Having concerns about a chaplain's religious beliefs might discourage referral of particular patients to that chaplain. For example, if it is known that a patient is homosexual, a mental health provider may hesitate to refer that patient to a chaplain if they believe that chaplain might react poorly to that patient.
When to use	Apply this code if concern or uncertainty about chaplain beliefs or that they may proselytize serve as potential barriers to referral.
When not to use	Do not use this code in reference to general perceptions about chaplain competency, or concerns about confidentiality, are barriers to referral.
Example	"The sexual orientation one is a good one, we do have a lot of that. Now we are seeing a lot of transgender people. I have to know that the chaplain will be tolerant of that. You don't want any more damage to be done."

Code Family	Referrals
CODE	51. CH KNOW REFERRAL
Brief Definition	Chaplains know to refer people to mental health if they have serious mental health issues.
Full Definition	Chaplains are trained and experienced to know during the course of counseling when to encourage referral of individuals to mental health clinicians for help.
When to use	Apply this code in reference to chaplain's being sufficiently trained or experienced to know when how to identify when an individual is in need of the help of a mental health clinician

	and not a chaplain.
When not to use	Do not use this code in situations not implicating referral for mental health needs.
Example	"Sometimes the nurse calls in the chaplain and the chaplain identifies a mental health need requiring referral."

Code Family	Referrals
CODE	52. SERVICE AVAILABILITY
Brief Definition	Availability of services impact the referral process.
Full Definition	The extent to which services and programs are available might influence decisions about whether and to whom a chaplain or mental health professional would refer that patient to.
When to use	Apply this code in reference to the perceived availability of services for individuals, and how those perceptions play a factor in referrals.
When not to use	Do not use this code if something other than the chaplain's or mental health provider's perceptions of service availability are influencing referrals for individuals.
Example	"Both mental health and probably chaplaincy are undermanned – but if chaplains had the time, it would be good if chaplains could take some easier cases."

Code Family	Referrals
CODE	53. SERVICE QUALITY
Brief Definition	Perceptions of the quality services impact the referral process.
Full Definition	How a chaplain or mental health provider perceives the quality of available services for a patient or service member might influence decisions about whether and to whom that chaplain or mental health professional would refer that patient to.
When to use	Apply this code if reference is made to the quality of an available service or program, and its impact on whether a referral to that service or program is made.
When not to use	Do not use this code if something other than the chaplain's or mental health provider's perceptions of service quality are influencing referrals for individuals. Do not use for hesitancy to refer because of chaplain values or fear they may proselytize. These should be coded under #50.
Example	"I get a sense that they don't know what they are dealing with sometimes. It may look like a marriage problem but maybe there is an underlying issue they don't recognize – like depression or a psychotic break"

Code Family	Referrals
CODE	54. REFERRALS MAINLY TO MH
Brief Definition	Patient referrals are primarily from chaplains to mental health and not vice versa.
Full Definition	The vast majority of referrals among mental health and chaplains are made by chaplains to mental health, and not vice versa.
When to use	Apply this code when reference is made to referrals of patients occurring primarily by chaplains to mental health, and not vice versa. Also use this code when reference is made to mental health not referring to chaplains.
When not to use	Do not use this code in regards to general references to referrals.
Example	"There are more chaplain referrals to mental health and substance abuse than mental health and substance abuse referrals to chaplains."

Code Family	Referrals
CODE	55. CH FOLLOW-UP
Brief Definition	Chaplains desire follow-up with patients after referral to mental health.
Full Definition	Following referral of an individual by a chaplain to mental health, that individual is typically not heard from or about again. Chaplains would like to follow-up with that individual and believe they might be helpful.
When to use	Apply this code in reference to chaplains wanting to follow-up with individuals after encouraging referral to mental health or command for assistance.
When not to use	Do not use this code unless specific reference is made to chaplains wanting to follow up

	with individuals after referral to mental health.
Example	"There needs to be more communication – chaplain could come for meetings on people they are worried about."

Code Family	Referrals
CODE	56. LEADERSHIP AWARENESS
Brief Definition	Leadership awareness of mental health needs facilitates cross-disciplinary referral and integration.
Full Definition	Structures or forums for command to identify problem cases within active duty environments helps facilitate chaplains and mental health working in an integrated fashion to address that problem case.
When to use	Apply this code when reference is made to an intentional structure or process for command to be aware of or identify problem cases, and that process assists integrated cooperation.
When not to use	Do not use this code without reference to specific process or structure for involvement of command in identifying problem cases or situations.
Example	"Once a month – mental health and chaplain and commanders at regiment – they stack them and talk about high risk people and discuss progress so battalion commander can decide if deployable of do medical board."

Code Family	Referrals
CODE	57. MEDICAL CLINICIANS REFER
Brief Definition	Medical professionals (nurses, doctors) are important sources of referral to chaplains.
Full Definition	General medical clinicians are frequent sources of referrals of individuals to chaplains.
When to use	Apply this code when a reference is made to general medicine clinicians as sources of referral to chaplains.
When not to use	Do not use this code for reference to mental health or any sort of behavioral health source of referral to chaplains.
Example	"Oncology routinely sends consults to mental health, chaplains and social work."

Code Family	Referrals
CODE	58. SOCIAL WORKERS REFER
Brief Definition	Social workers are important sources of referral to chaplains.
Full Definition	Social workers are frequent sources of referrals of individuals to chaplains.
When to use	Apply this code when a reference is made to social workers as sources of referral to chaplains.
When not to use	Do not use this code for reference to mental health or any sort of behavioral health source of referral to chaplains.
Example	"We work closely with social workers."

Code Family	Referrals
CODE	60. REFERRAL FROM ASSESSMENTS
Brief Definition	Referrals can occur through electronic information systems.
Full Definition	Assessment processes may be structured to trigger a cross-disciplinary referral to a chaplain or mental health professional depending on the patient's case.
When to use	Apply this code when reference is made to an assessment process that triggers cross-disciplinary referral through electronic information systems.
When not to use	Do not use this code unless there is reference to an electronic referral mechanism for cross-disciplinary referral within an assessment process.
Example	"The assessment is recorded in the patient care database and forwarded to chaplains for signatures."

Code Family	Referrals
CODE	60.1 INFORMAL REFERRAL

Brief Definition	Referrals generally occur through personal contact, telephone or other informal processes.
Full Definition	Although there may be electronic methods to make referrals between chaplains and mental health or other medical professionals, referrals often occur through personal contact or other informal means.
When to use	Apply this code when reference is made to an informal process that triggers cross-disciplinary referral.
When not to use	Do not use this code unless there is reference to an informal referral mechanism for cross-disciplinary referral.
Example	"Chaplains get referrals a lot but not through electronic system, but through informal process."

Code Family	Screening and Assessment (Mental Health Screening and Assessment)
CODE	61. VARIETY OF SCREENING
Brief Definition	Programs and facilities use a variety of ways to do religious/spiritual screening
Full Definition	Most medical facilities use some type of screening device to identify religious preference and if the patient wants to see a chaplain. Some respondents indicated these screening were not consistently administered either within programs or facilities or across facilities
When to use	Use for references about how screening is conducted or lack of consensus/approach about screening or application is inconsistent
When not to use	Do not use for references about spiritual assessment;
Example	"There is a common template to for assessment in the inpatient program that identifies medical history, family factors, social history. This also includes basic questions about spiritual interests and needs."

Code Family	Accessibility/Screening and Assessment (Mental Health Screening and Assessment)
CODE	62. CH CAN'T SEE ALL
Brief Definition	Chaplains cannot see everyone who requests a chaplain
Full Definition	Chaplains have limited time and may not be able to see everyone who asks to see a chaplain or who are referred
When to use	Use for references about chaplains not having time or resources to see everyone referred or screened
When not to use	Do not use for references to limited time or resources to do other things like spiritual groups or walking around seeing non-referred patients
Example	"They had a question asking if the patient would like to see a chaplain, but they deleted because just about everyone said yes, and they don't have time."

Code Family	Screening and Assessment (Mental Health Screening and Assessment)
CODE	63. VARIETY MH SP ASS
Brief Definition	Although some mental health providers assess spiritual needs, there are a variety of methods for conducting spiritual assessments in mental health.
Full Definition	Some mental health providers conduct spiritual assessments, but often there is not a consistent approach within facilities or within their discipline for how to do the assessment
When to use	Use for references about mental health providers doing their own spiritual assessment and some indication they use their own approach or there is no standard approach by program, facility, or discipline
When not to use	Do not use for chaplain spiritual assessments; do not use for assessments that are not spiritual assessments
Example	"Spiritual assessment – I ask if they attend church – then I go into it deeper."

Code Family	Screening and Assessment (Mental Health Screening and Assessment)
CODE	64. HOW INFORM TREATMENT
Brief Definition	It is unclear how mental health spiritual assessments should inform treatment.
Full Definition	Some providers thought it is unclear how spiritual assessments conducted by mental health providers would be used in developing or implementing a treatment plan

When to use	Use for references about mental health spiritual assessments only; use for any reference about not understanding how the assessment should be used
When not to use	Do not use for references about chaplain-conducted spiritual assessments
Example	"Dr. X has asked me to be on his work team through this reorganization. It appears we are working on a work plan that will aim at including a spiritual aspect to the treatment plan. I don't know how this will turn out but it appears I am in a good position to influence that."

Code Family	Screening and Assessment (Mental Health Screening and Assessment)
CODE	65. NO ASSESSMENT FOR REFERRAL
Brief Definition	There are no established protocols for collecting information that would prompt a chaplaincy referral
Full Definition	There is not a tool, assessment device, or established protocol for identifying patients/clients who could benefit from pastoral counseling and which would prompt a referral to a chaplain
When to use	Use for any reference about not knowing when to refer to a chaplain, no established protocols for referral, no tools to prompt referrals
When not to use	Do not use for chaplain referrals to mental health
Example	"We have no written guidelines for referring to chaplains (how or when). There is currently no "pop-up guidance about when to refer to chaplains like there is for other service related to positive answers on the assessment tool."

Code Family	Screening and Assessment (Chaplain Spiritual Assessment)
CODE	66. VARIETY CHAP SP ASS
Brief Definition	There are a variety of tools and methods chaplains use to conduct spiritual assessment
Full Definition	Chaplains use a variety of spiritual assessments but these may be unique to the individual chaplain, the chaplaincy program, or the facility
When to use	Any reference to the types of tools and methods used by chaplains use to conduct spiritual assessments or inconsistency in the type of assessment used by chaplains
When not to use	Do not use for mental health spiritual assessments or for screening
Example	"FICA, FACT and the 7 x 7 spiritual assessment are relied upon. There is no standardized model of spiritual assessment. We use screening questions to determine how much time we need to spend with the patient. "

Code Family	Screening and Assessment (Chaplain Spiritual Assessment)
CODE	67. CH DON'T DO SP ASS
Brief Definition	Chaplains do not routinely conduct spiritual assessments or do not do spiritual assessments for all people who could benefit from them
Full Definition	At some locations and programs, chaplains do not routinely do spiritual assessments. In some contexts, chaplains do not have the time to conduct spiritual assessments for everyone who should have one or even who is required to have one
When to use	Any reference to chaplains not doing spiritual assessments or not routinely doing them or not having time to do them for all who could benefit or who should have one
When not to use	Do not use for mental health spiritual assessment
Example	"They need to check for patient to approve taking the assessment. The assessment is not given to everyone. The goal is to give to everyone. But not meeting goal because they are too busy."

Code Family	Screening and Assessment (Chaplain Spiritual Assessment)
CODE	70. UNIFORMITY SP ASS
Brief Definition	Efforts are made to ensure uniformity in spiritual assessments
Full Definition	In some programs there has been an effort through training, policies, coordination through the National Chaplaincy center, etc to promote uniformity and consistency in how chaplains conduct spiritual assessments
When to use	Use for references to developing standard spiritual assessment tools or for policy or training efforts to improve the ability of chaplains to administer

When not to use	Do not use for mental health spiritual assessments or other activities by chaplains
Example	"The assessment was developed here but the national chaplain center said every patient had to have one, we came up with it here but it was approved by the national center."

Code Family	Screening and Assessment (Provider Consideration of Chaplain Assessments)
CODE	71. MH NOT AWARE SP ASS
Brief Definition	Providers are not aware of chaplain spiritual assessments
Full Definition	Providers are not aware that chaplains do spiritual assessment or are not aware the information is available to them
When to use	Use for any reference that mental health providers are not aware of chaplain spiritual assessments when state by provider or it's an impression of the chaplain
When not to use	Do not use for reference that they are not aware of the content because they choose not to read it; this should be coded in #72 below
Example	"Never seen chap do a spiritual assessment."

Code Family	Screening and Assessment (Provider Consideration of Chaplain Assessments)
CODE	72. MH DON'T READ CH NOTES
Brief Definition	Providers do not read or use the chaplain's spiritual assessment or notes
Full Definition	When mental health providers have access to the chaplain spiritual assessment or notes, they elect to not read or use the spiritual assessment for a variety of reasons (e.g., they don't find it useful, there are easier ways to get the information, they don't know how it relates to treatment)
When to use	Any reference to providers not reading the chaplain spiritual assessment or notes either from MH provider or perception from chaplain
When not to use	Do not use for MH doesn't know about the assessment; this should be #71 above
Example	"Chaplains can make a referral on the Centrist System, but often no one looks at their referral. The chaplain usually needs to walk the patient down to make it happen."

Code Family	Screening and Assessment (Provider Consideration of Chaplain Assessments)
CODE	73. MH READ CH NOTES
Brief Definition	Providers read the spiritual assessment or chaplains notes
Full Definition	Mental health providers or other medical professionals read the chaplain's spiritual assessment or notes
When to use	Any reference by mental health/medical or chaplains that mental health/medical reads the chaplain's spiritual assessment or notes
When not to use	Do not use if mental health says they read the spiritual assessment or notes once and they weren't useful so they didn't read them again
Example	"I know that they read my notes because I have had some of the RNs tell me that they had learned something new about a particular patient that they did not know before."

Code Family	Screening and Assessment (Provider Consideration of Chaplain Assessments)
CODE	74. INTEGRAL TO PLAN
Brief Definition	Chaplains spiritual assessments are integral to the treatment plan
Full Definition	The spiritual assessment is important and used to inform treatment planning
When to use	Use for either chaplains or mental health beliefs that the spiritual assessment conducted by chaplains is used in developing the treatment plan, mental health services, medical interventions
When not to use	Don't use if reference is just to use the spiritual assessment for pastoral counseling
Example	"At the warrior clinic, she does spiritual assessments; the team then uses the spiritual assessment as part of the overall plan and to inform treatment decisions."

Code Family	Screening and Assessment (Provider Consideration of Chaplain Assessments)
CODE	75. IMPROVE UTILITY
Brief Definition	Chaplains and providers work to improve the utility of spiritual assessments

Full Definition	In some locations, chaplains and mental health have worked to improve the spiritual assessments conducted by chaplains through improving what information is captured or by formatting in a way that is more useful or more easily accessed by mental health
When to use	Use for references about providers and chaplains jointly working on improving utility of spiritual assessments
When not to use	Do not use for efforts just within chaplaincy to improve; these can be coded in #70
Example	“The assessment tools he found on line and talked to local garrison chaplains. There was interface with unit chaplains also. They tried to develop programs to bring in spirituality components.”

Code Family	Screening and Assessment (Challenges and Suggestions in Assessment)
CODE	76. CH TRAINING SP ASS
Brief Definition	Increased training for chaplains in spiritual assessment would be helpful
Full Definition	It is desirable to have more training for chaplains in the different tools for spiritual assessment, how to administer tools, and how to use the assessment to inform what they do
When to use	Any reference to increased training for chaplain on spiritual assessment or references to trainings that were held and implication that the training was useful
When not to use	Do not use for other types of chaplaincy training or for training mental health
Example	"Chaplains need more training to effectively use assessment tools and provide counseling."

Code Family	Screening and Assessment (Challenges and Suggestions in Assessment)
CODE	77. DETERMINE INTEGRATION
Brief Definition	It would be good to have a spiritual assessment to help determine who could benefit from an integrated mental health and chaplaincy approach
Full Definition	There is not tool or assessment instrument to determine who could benefit from an integrated mental health and chaplaincy approach. It would be desirable to develop such as tool
When to use	Reference for a tool to identify who could benefit from integrated practice
When not to use	Do not use for references to assessment informing the treatment plan without reference to an integrated approach
Example	"Screenings: screen patients for those who would be good candidates for a collaborative model. We don’t have good screenings/assessments for people that would be good candidates for this type of approach. "

Code Family	Screening and Assessment (Challenges and Suggestions in Assessment)
CODE	78. SHARE INFO
Brief Definition	Chaplains would like to share information about how spiritual assessments are used in different facilities
Full Definition	Chaplains are interested in what spiritual assessment tools are used by different chaplains in different facilities and what their experiences have been in administering those assessments
When to use	Use specifically about sharing information across programs or facilities
When not to use	If reference is just to training on spiritual assessment, code under # 76; use only for chaplain administered assessment, not MH
Example	“One thing that might really be helpful is if we could have chaplain visits. I would like to go to Memphis and see what their chaplains are doing in their SUD. I would like to spend a day and see what sally is doing there as a chaplain.”

Code Family	Screening and Assessment (Challenges and Suggestions in Assessment)
CODE	79. COMMON LANGUAGE
Brief Definition	Develop a common language for assessment or practice that can be used by mental health and chaplaincy
Full Definition	Chaplains and mental health often use different types of spiritual assessments; it would be desirable to have a common assessment tool and a common understanding of terms used in assessing spiritual need

When to use	References to creating common assessment tool, common approaches, common language about spiritual assessment
When not to use	Do not use if reference is just about a common assessment for chaplains; do not use if common language or process for other than spiritual assessment
Example	"The assessment tools he found on line and talked to local garrison chaplains. There was interface with unit chaplains also. They tried to develop programs to bring in spirituality components."

Code Family	Screening and Assessment (Challenges and Suggestions in Assessment)
CODE	80. RESEARCH SP ASS
Brief Definition	There should be more research on spiritual assessments and how they might be important to patient care
Full Definition	There should be more research on spiritual assessments and how they might be important to patient care
When to use	Any reference to more research on spiritual assessment for either mental health or chaplain-administered
When not to use	Do not use for reference to research on practices other than spiritual assessment
Example	"Would like to see some better research on what is clinically relevant (in spiritual assessment) – need a larger scale study on spiritual assessment to ensure tools are empirically supported."

Code Family	Evidence Based Practices (Training Chaplains in Mental Health)
CODE	81. EBPs GOOD FOR CH
Brief Definition	Chaplains would benefit from training in mental health EBPs.
Full Definition	It is desirable for chaplains to have training in mental health EBPs
When to use	Use for any reference that MH EBP training is desirable; if they reference reasons for their belief or qualify it, these can be referenced below (all checked codes for 82-84 and 89-93 should be checked here as well)
When not to use	Do not use for general training about mental health approaches or issues
Example	"It would also be good if chaplains could learn EBPs on the mental health side."

Code Family	Evidence Based Practices (Training Chaplains in Mental Health)
CODE	82. NONTHERAPY EBPs
Brief Definition	Training in some evidence based practices such as motivational Interviewing could benefit chaplain practice because they are not restricted to therapists.
Full Definition	Training in some types of MH EBPs would be appropriate for chaplains because the practice is not intended to be delivered exclusively by psychotherapists
When to use	The type of EBP is not important here; they should reference that the EBP is appropriate because it does not require a MH credential
When not to use	Do not use if they just reference an EBP like motivational interviewing or CBT without giving a reason
Example	"MI would be good in addressing end of life issues with patients by building a trusting relationship quickly."

Code Family	Evidence Based Practices (Training Chaplains in Mental Health)
CODE	83. PREVENTION EBPs
Brief Definition	Training in prevention EBPs such as suicide prevention would benefit chaplains
Full Definition	Training in prevention EBPs would benefit chaplains because often chaplains are involved in prevention efforts or they come into contact with individuals who may benefit from a greater degree of prevention skill
When to use	Use for reference to chaplains could benefit from prevention EBP training
When not to use	Do not use for other types of EBPs
Example	"…chaplains could benefit from training in suicide prevention and safety assessment."

Code Family	Evidence Based Practices (Training Chaplains in Mental Health)
CODE	84. CREDENTIALED CH
Brief Definition	Additional training in mental health EBPs would be appropriate for chaplains who are also credentialed as mental health providers.
Full Definition	Some chaplains are trained as mental health providers and have MH credentials. For these individuals, training in MH EBPs is desirable
When to use	Use for references to chaplains with MH credentials
When not to use	Do not use for references to chaplains without MH credentials
Example	"Chaplains with mental health degrees should understand EBPs. Chaplains can do some EBPs but there needs to be appropriate supervision mechanism."

Code Family	Evidence Based Practices (Training Chaplains in Mental Health)
CODE	85. EBPs NOT HELPFUL
Brief Definition	Training on EBPs would not help chaplains very much
Full Definition	Training in MH EBPs may not help chaplains in being better chaplains or in conducting pastoral care
When to use	Use for references to EBP training would not be helpful to chaplains
When not to use	Do not use for training in MH EBPs would not be appropriate; use #86 below
Example	"It is not necessary for chaplains to know or practice mental health evidence based practices."

Code Family	Evidence Based Practices (Training Chaplains in Mental Health)
CODE	86. CH NOT THERAPISTS
Brief Definition	Mental health EBPs are not appropriate for chaplains because they are not therapists
Full Definition	Some MH EBPs would not be appropriate for chaplains because they require a credentialed therapist to use them
When to use	References to EBP training for chaplains not appropriate because they are not therapists
When not to use	Do not use for other reasons EBP training might not be appropriate or useful
Example	"I make a distinction between counseling and psychotherapy. They bring something different. I think chaplaincy and counseling gives you something different than what psychotherapy gives you with a MH provider."

Code Family	Evidence Based Practices (Training Chaplains in Mental Health)
CODE	87. NO EBP FRAMEWORK
Brief Definition	There is not a coherent framework for understanding how chaplains can best be involved with mental health EBPs
Full Definition	There is no consensus or even a coherent model for how chaplains can use MH EBPs in their work and how they should be trained
When to use	Use for references about no agreement, no models, no frameworks
When not to use	Do not use if reference is to anything other than MH EBP
Example	"There is very little in this arena from a faith standpoint. It's hard to fit religion in a scientific model. Chaplains need to frame the issue."

Code Family	Evidence Based Practices (Training Chaplains in Mental Health)
CODE	88. PASTORAL IDENTITY
Brief Definition	Chaplains need to preserve their pastoral identity as they adopt mental health EBPs or integrate with MH.
Full Definition	It may be OK to train chaplains in MH EBPs or integrate services with mental health but we don't want them to become mental health providers; they need to keep doing chaplaincy and pastoral care and not be subsumed under mental health
When to use	Any reference to EBP training and making sure this doesn't affect their unique role as chaplains; Also use for references to maintaining identity when integrating
When not to use	
Example	"Should it actually be integrated – it may not need to be integrated. We want to be careful

	about how much we do integrate these two professions."

Code Family	Evidence Based Practices (Training Chaplains in Mental Health)
CODE	89. CH ADAPT EBPs
Brief Definition	Training in mental health EBPs such cognitive behavioral therapy would benefit chaplains because they could adapt elements of these practices to chaplaincy
Full Definition	Although chaplains may not be trained therapists, they could benefit from MH EBP training, because they could take elements and adapt them to pastoral counseling (e.g., not that they would do Prolonged Exposure Therapy (PET), but they could incorporate PET) into what they do as chaplains)
When to use	References to adapting MH EBPs or it's OK for chaplains to have EBP training because they can decide how to use it, or anything that enhances skills is good
When not to use	Do not use if the reason is not there
Example	"Chaplains could be trained in time limited cognitive behavior therapy to address cognitive distortion in homeless vets."

Code Family	Evidence Based Practices (Training Chaplains in Mental Health)
CODE	90. EBP REFERRALS
Brief Definition	Learning about mental health EBPs would help chaplains make more appropriate referrals to mental health.
Full Definition	A better understanding about MH EBPs will give chaplains a better understanding of what is involved in the treatment and for whom the treatment is beneficial, thereby enabling chaplains to make more appropriate referrals
When to use	Any reference to EBP training would help chaplains refer to MH
When not to use	Do not use for other benefits of EBP training
Example	"If chaplains understand EBPs, they may better understand how to match patient needs to those EBPs and therefore make more appropriate referrals."

Code Family	Evidence Based Practices (Training Chaplains in Mental Health)
CODE	91. SUPPORT PATIENTS
Brief Definition	Learning about mental health EBPs would help chaplains explain to patients the need for treatment and provide support to patients/families in the treatment process.
Full Definition	Training about the benefits of MH EBPs and what the treatment process is like will help chaplains support patients and their families in the treatment process and as a result, chaplains may help in treatment retention and adherence
When to use	Any reference to EBP training helping chaplains support patients and families in their MH treatment
When not to use	
Example	"If chaplains understand EBPs, they may be able to explain the benefits to patients and encourage them to participate."

Code Family	Evidence Based Practices (Training Chaplains in Mental Health)
CODE	92. INTERDISC TEAM
Brief Definition	Learning about mental health EBPs would help chaplains become more knowledgeable members of interdisciplinary teams or co-lead groups
Full Definition	Training in MH EBPs can help chaplains understand better what is happening within mental health programs and as a result, chaplains can be more productive team members and participate more integrally in the program
When to use	Any reference to MH EBP training chaplains work better with mental health; use also if reference is to an best practice approach such as the recovery model or client centered care
When not to use	Do not use if not a references to an EBP or particular model
Example	"They should get more EBP and then embed themselves in the teams and watch that EBP play out in treatment."

Code Family	Evidence Based Practices (Training Chaplains in Mental Health)
CODE	93. CH LESS SEVERE
Brief Definition	Mental health EBP training enhances chaplains' ability to address less severe mental health issues, allowing MH providers to address more serious needs.
Full Definition	Chaplains and mental health could use the public health model in which chaplains could focus more on primary and secondary prevention and mental health could focus on tertiary prevention; under this model, chaplains can benefit from EBPs in secondary prevention or less severe cases
When to use	Any references to EBP training helping chaplains address the needs of individuals with less severe problems
When not to use	Do not use for primary prevention; code these in # 83
Example	"Both mental health and probably chaplaincy are undermanned – but if chaplains had the time, it would be good if chaplains could take some easier cases."

Code Family	Evidence Based Practices (Developing EBPs for Chaplains)
CODE	94. CH INTEGRATED EBPs
Brief Definition	There needs to be a major emphasis on developing EBPs for chaplaincy or integrated practice between chaplaincy and mental health
Full Definition	It would be good to develop a research base for what chaplains do and for integrated practices between mental health and chaplaincy; these practices could then be evidence based practices
When to use	References to developing EBPs or conducting research on chaplaincy or integrated practices – current or proposed
When not to use	Don't use for strictly MH practices unless chaplains are involved
Example	"The importance of understanding the spiritual needs is an EBP in making sure patient gets better. This research gives chaplains credibility with medical staff."

Code Family	Evidence Based Practices (Developing EBPs for Chaplains)
CODE	95. BOUNDARY SPANNERS
Brief Definition	Chaplains trained as mental health practitioners or researchers can act as boundary spanners and to promote a culture of integration.
Full Definition	If chaplains develop research skills or become integrally involved with researchers in conducting research on chaplaincy or integrated practices, they can work with or communicate better between mental health and chaplaincy and between researchers and chaplaincy
When to use	References to trained chaplains working across both disciplines
When not to use	Do not use just for increased research training for chaplains; this should be coded under #97
Example	"Other chaplain – infantry chaplain. – selected to be in doctoral program for pastoral counseling in San Antonio. These were boundary crossers. They could talk both languages."

Code Family	Evidence Based Practices (Developing EBPs for Chaplains)
CODE	97. CH RESEARCH TRAINING/INVOVLEMENT
Brief Definition	Chaplains need to become better trained in research and/or partner with researchers to develop chaplaincy EBPs
Full Definition	The fields of medicine and mental health have been moving in the direction of having more evidence to back up the interventions and services used; chaplaincy could benefit if chaplains increased their skills in research and developing EBPs or partnered with researchers to conduct EBP research
When to use	References to training chaplains in research methods or partner with researcher
When not to use	Do not use if training is just learning about EBPs
Example	"Chaplains need to develop expertise in research. A lot of people at the VA are doing research and this could be an opportunity for chaplains. Once the conceptual model is developed, chaplains need to be involved in planning, designing and implementing the research to test the model and develop EBPs for chaplaincy. "

Code Family	Evidence Based Practices (Developing EBPs for Chaplains)
CODE	98. MOVE TOWARD OP
Brief Definition	Chaplains need models that shift away from inpatient and toward outpatient care since this is the direction of medicine.
Full Definition	The medical world has been moving away from inpatient care to outpatient care; chaplaincy models often focus on inpatient care; to make sure chaplains have a place in the future of medicine, they should develop models for the role of chaplains in outpatient care
When to use	References to chaplains developing models for or becoming more involved in outpatient care including use of telehealth for chaplain access to outpatient clinics
When not to use	
Example	"They are required to do all the inpatient so since we are outpatient we don't get prioritized. I haven't done any direct work chaplains since we are outpatient and have had no success with consults."

Code Family	Evidence Based Practices (Challenges to Implementing EBPs with Chaplains)
CODE	99. LACK OF TIME
Brief Definition	Lack of time or staffing is a barrier in chaplains being trained in EBPs
Full Definition	Chaplains are already very busy with what they are doing. They may have difficulty finding the time to attend EBP training and in implementing EBPs if they require more time than current practices
When to use	Use for references to time as a barrier to attending EBP training or implementing EBPs
When not to use	Do not use for time as a constraint for other activities
Example	"I wish there was more time to talk to other providers about how things I do complement other clinicians work. We are all so busy that we cannot do that."

Code Family	Evidence Based Practices (Challenges to Implementing EBPs with Chaplains)
CODE	100. TIME CONSTRAINT
Brief Definition	Some EBPs are not appropriate for chaplains because they don't fit the time chaplains see vets & service personnel
Full Definition	Often, chaplains or others will only see individuals one or two times while EBPs would be more appropriate for interventions lasting more sessions or over a longer period of time; hence the benefit of training in EBPs may be diminished
When to use	Use for references to time frame of seeing individuals not being compatible with EBPs
When not to use	Do not use if not tied to time frame for seeing individuals
Example	"Not a lot of follow up with lot of guys. Keep track of monthly counseling visits but those are in aggregate. Majority only see one time and patients leave."

Code Family	Integrated Practice
CODE	102. INTERDISC TEAMS
Brief Definition	Chaplains are or could be part of formal interdisciplinary teams.
Full Definition	In some programs chaplains participate in interdisciplinary teams for patient care or broader system issues such as ethics committees or coordinating teams
When to use	Use for current or proposed practices
When not to use	Do not use if the teams do not include mental health or medical/human services; do not use if reference is to multidisciplinary groups or committees that are not IDTs; these can be coded under 104.1
Example	"She is an official member of our IDT"

Code Family	Integrated Practice
CODE	103. MH PROGRAMMING
Brief Definition	Chaplains are or could be involved in mental health programming.

Full Definition	In some programs, chaplains are actually involved in developing programs within mental health such as conducting spirituality groups
When to use	Use for references to current or proposed situations where chaplains are involved in MH programming
When not to use	Do not use for mental health care at the patient level such as participating on interdisciplinary teams; this would be coded under #102
Example	"Mondays does a faith based study that he facilitates. About 6-10 people attend this, including in-patient and out-patient. Wednesdays at 1:30 he has a weekly lecture on spirituality and recovery, covers topics such as what is spirituality, how can spirituality help you in recovery plan, shame, recovery from shame."

Code Family	Integrated Practice
CODE	104. OUTREACH
Brief Definition	Chaplains and mental health are or could be integrated in activities like outreach or working with communities to improve services.
Full Definition	In some programs, chaplains and mental health are involved in activities such as outreach to the community to inform them about how they can assist veterans or what VAs have to offer or to improve services the community can provide for active duty or vets
When to use	References to multidisciplinary activities between chaplaincy and mental health related to the community or outreach
When not to use	Do not use for integrated practices in codes #101-103
Example	"So maybe they would be a good liaison to religious leaders in the community. They could work with us to integrate people with SMI more fully in local churches."

Code Family	Integrated Practice
CODE	104.1 COMMITTEES
Brief Definition	Chaplains and mental health are or could be integrated in activities like working on multidisciplinary committees or groups
Full Definition	In some programs, chaplains and mental health are involved in multidisciplinary groups or committees such as ethics committees or groups to address specific issues such as suicide
When to use	References to interdisciplinary activities between chaplaincy and mental health related to the multidisciplinary committees or groups
When not to use	Do not use for integrated practices in codes #101-103
	"He was on a committee dealing with youth who got in trouble. Chaplains were part of the team."

Code Family	Integrated Practice
CODE	105. NO POLICIES
Brief Definition	Lack of policies is a barrier to sustained integration.
Full Definition	Often integration between chaplaincy and mental health is built upon personal relationships rather than established policy; having policies in place and support from leadership would improve sustainability of integration
When to use	References to lack of policies as a barrier or the need for policies or policies are in place that could be a model for other facilities or programs
When not to use	
Example	"The heightened sense of integration should be made more formal rather than remain informal as it is now."

Code Family	Integrated Practice
CODE	106. STAFF ROTATION
Brief Definition	Staff turnover or rotation is a barrier to sustained integration.
Full Definition	Staff turnover both planned and unplanned is a barrier to integration and good relationships;

	replacement staff do not have the history and working relationships to maintain good integration. Rotation of staff through programs may also affect integration
When to use	References to staff turnover or rotation (facility or program) and the challenges this brings to integration and working relationships
When not to use	
Example	"They tried to develop programs to bring in spirituality components. But it got lost because people were too busy with screenings . Deployments took chaplains, so lost connections. "

Code Family	Documentation (Electronic Health Records)
CODE	107. TECHNOLOGY FACILITATE
Brief Definition	Improved technology can help facilitate integrated chaplaincy and mental health documentation
Full Definition	In some places technology facilitates entering information that can be usefully shared such as spiritual assessments or treatment plans; improvements in technology could assist in improving the utility of documentation
When to use	References to technology as a facilitator and the efforts to improve technology to share records or to increase access (e.g., telehealth
When not to use	Do not use for improving content of chaplain's notes; this should be coded in #110. Do not use if chaplains don't have access to the electronic record; this should be coded as #109. Do not use if chaplains and mental health use disparate systems; this should be coded as #108
Example	"Chaplains do notes on the computerized record system (CPRS – this is a good system and the rest of the country should adopt this for EHR; VA has had this since 1995 and has tweaked to make it good)."

Code Family	Documentation (Electronic Health Records)
CODE	108. TECHNOLOGY BARRIER
Brief Definition	Technology can be a barrier to sharing information and integration
Full Definition	In some locations chaplains and mental health use different types of electronic records systems and cannot share the information electronically. In other locations, mental health has its own data system but chaplains don't use an electronic system to capture information and they don't have access to the mental health system. This prevents sharing information electronically.
When to use	References to chaplains and mental health not having access to each other's data systems or if chaplains do not have any electronic records system or other technological issues that hinder information sharing
When not to use	
Example	"ALTA (the electronic records system) – mental health uses this template for recording treatment process and outcomes, but chaplains don't use Alta."

Code Family	Documentation (Usefulness of Notes)
CODE	110. CH NOT USEFUL
Brief Definition	Chaplain notes are not useful to mental health and should be improved
Full Definition	Mental health providers do not find useful documentation by chaplains such as spiritual assessments or contact notes
When to use	References to not finding chaplain notes useful or chaplain notes could be improved
When not to use	Do not use if the barrier is technology (this relates to usefulness of content)
Example	"Having themes discussed would be nice – documenting in a medical record right now is they met with the person."

Code Family	Documentation (Usefulness of Notes)
CODE	110.1 CH DON'T DOC
Brief Definition	Chaplains don't document
Full Definition	Sometimes chaplains do not document because of confidentiality, they don't have systems that facilitate documentation, or for other reasons

When to use	References to not chaplains not documenting; if the reason is for confidentiality, also code as #9
When not to use	Do not use if reference is to chaplains not doing spiritual assessments
Example	"He does no documentation; he doesn't want a jackass attorney to subpoena his notes so he does no notes."

Code Family	Documentation (Usefulness of Notes)
CODE	111. MH NOT USEFUL
Brief Definition	Mental health notes are not useful to chaplains
Full Definition	Chaplains do not find useful documentation by mental health providers such as contact notes or treatment plans
When to use	References to not finding mental health notes useful or mental health documentation could be improved
When not to use	Do not use if the barrier is technology (this relates to usefulness of content)
Example	

Code Family	Documentation (Usefulness of Notes)
CODE	112. IMPROVE DOC
Brief Definition	Chaplains and mental health have worked or should work to improve the utility of information collected
Full Definition	In some places mental health and chaplaincy have worked to improve the content of chaplaincy or mental health documentation or the format; this could be used as a model for other programs
When to use	References for chaplaincy or mental health working to improve documentation
When not to use	Do not use is just that documentation should be improved; this should be coded under #110 or 111
Example	"The soap notes- that is what I encourage the CPE residents to use"

Code Family	Documentation (Process Metrics)
CODE	113. JOINT METRICS
Brief Definition	In some programs chaplains and mental health/medical providers jointly currently use or should use process or outcome metrics to improve quality of practices
Full Definition	Chaplains and medical or mental health providers can use process and outcome metrics to improve quality at the program level; this practice could serve as a model for others
When to use	References to collaboration in looking at process metrics
When not to use	Do not use for reviewing progress in treatment teams or for reviewing system level indicators; the later should be coded under #118
Example	"Chaplains try to do bereavement calls within two weeks of death – they reach 90% of this goal. Their scores are at the top of the VISN. The results of the surveys go to the palliative care team and to his supervisor. Not sure if supervisor uses for performance evaluation, but the interdisciplinary teams uses survey results to improve their processes including what the chaplain does."

Code Family	Documentation (Process Metrics)
CODE	114. STD MH/CHAP METRICS
Brief Definition	Some service branches or VAs have standardized chaplain or mental health metrics while in other arenas there are not standard metrics
Full Definition	Some service branches have standardized chaplain or mental health metrics while in other service branches there are not standard metrics
When to use	References to standard process or outcome metrics within a service branch, lack of standard metrics or the need for standard process metrics
When not to use	
Example	"There will be an electronic tool in the next 12 months. All Navy chaplains will track the same information. This includes marines, coast guard, navy, and both operational and

	hospital. They should have had this a long time ago. On the medical side, physicians who didn't do paper work, this was not acceptable. Now chaplains will be in the same situation."

Code Family	Documentation (Process Metrics)
CODE	115. VET RATINGS
Brief Definition	Chaplains or mental health use or could use vet/service member/family ratings to improve services
Full Definition	In some programs, chaplains and/or mental health/medical are jointly involved in administering and reviewing feedback from patients/clients or their families and using the information to improve services
When to use	Use for references to getting vet/service member/family feedback
When not to use	Do not use for getting feedback about integrated practices; this should be coded under #116
Example	"They do surveys of family members after the patient has died. The survey asks how well the chaplain provides for the spiritual needs of the family. The scores for chaplains are very good."

Code Family	Documentation (Process Metrics)
CODE	116. VET INPUT
Brief Definition	Recommend gathering information from vets/active duty about how chaplains and mental health can best integrate services
Full Definition	There should be an effort to get input from veterans and service members about how they would like to see chaplains and mental health integrate their services to best meet their needs
When to use	References to vet/service member feedback about chaplaincy/MH integration
When not to use	Do not use for vet/service member feedback about services or other things; these should be coded under #115
Example	"It would be really nice to ask the Veterans to see how they would like chaplaincy and mental health combined."

Code Family	Documentation (Outcome Metrics)
CODE	117. HARD TO MEASURE
Brief Definition	Outcomes of chaplains are not measureable and it is difficult to find measures that capture the value of chaplaincy.
Full Definition	The outcomes chaplains produce are not measurable. For example it is hard to measure the absence of bad outcomes (e.g., suicides, divorces) or certain positive outcomes (e.g., spiritual wellbeing, saved souls). It is also hard to know how chaplains contribute to these outcomes as opposed to other factors
When to use	References that it is hard to measure the value of chaplaincy
When not to use	Do not use for references that chaplains merely don't have or use outcome measures
Example	"All these things that are central to the very nature of what spirituality attends to lies outside of the scope and language. We don't have the kind of model in place that makes spiritual analysis an easy thing to assess empirically."

Code Family	Documentation (Outcome Metrics)
CODE	118. OUTCOME FEEDBACK
Brief Definition	Some chaplaincy and mental health programs are implementing or could implement formal outcome feedback processes that tracks client progress weekly
Full Definition	Some chaplaincy and mental health programs are implementing formal outcome feedback processes that tracks client progress weekly. These types of models could be used in chaplaincy, mental health or integrated programs to track and improve outcomes
When to use	Use only for formal outcome feedback processes like Scott Miller or OQ-45
When not to use	Do not use if reference is to general monitoring of outcomes
Example	"Here mental health documents progress and outcomes. Empirically validated treatments are important. They use the outcome questionnaire (OQ 45. 2 version) developed by Michael Lambert and Burlingame. They use it to identify potential treatment failures, to measure

	progress while in treatment, and for screening."

Code Family	Documentation (Outcome Metrics)
CODE	119. SYSTEM OUTCOMES
Brief Definition	Chaplains and mental health/medical/leadership are or could be involved in efforts to examine aggregate system level outcomes and develop strategies to improve outcomes
Full Definition	In some contexts chaplains are involved in efforts to review system data to develop strategies to improve outcomes such as reviewing trends in suicides or unplanned losses
When to use	Use for reviewing data at the system level; this could be separate or jointly across mental health and chaplaincy
When not to use	Do not use to code reviews at the client level or at the program level; the latter should be coded under #113
Example	"They have data showing that if sailors went to mental health from the chaplain, then they returned more often. The unplanned loss rate was largest at subpac, so did a study to determine what factor contributed to unplanned loss. Mental health was the largest factor, followed by disciplinary problems, DWIs, and other factors such as don't ask don't tell. Then they developed strategies to address these issues."

Code Family	Documentation (Documentation barriers)
CODE	121. CHAP DOC SKILLS
Brief Definition	Efforts should be made to enhance chaplaincy skills in data collection and use
Full Definition	It would be helpful to enhance chaplain skills in data collection and the use of data to better serve individuals and improve programs
When to use	Use for training data collection and use of data
When not to use	Do not use for references about training in research; these should be coded under #97
Example	"Chaplains need to have a research mentality. They need to think about how they would measure that and what would it look like. What is important for team to know?"

Code Family	Documentation (Documentation barriers)
CODE	122. TIME BARRIER
Brief Definition	Need to balance the time for documentation with the benefits and recognize time constraints
Full Definition	There is already a great deal of documentation collected. If increased documentation requirements take away from patient care, then it may not be desirable. Chaplains have limited time for increased documentation
When to use	Use for references to lack of time as a barrier and the need to balance patient contact with documentation
When not to use	Do not use when time is referenced as a barrier for other activities
Example	"While I am becoming more engaged in administrative and decision making functions I privately sort of mourn the loss of time that I love to have with the veterans themselves."

Appendix O

VA / DoD Site Visit Code Frequency Table

The following frequency table categorizes interviewees as DoD or VA and as chaplain or mental health and displays the number and percentage of interviewees who received each of the listed codes. For group interviews, we designated the interview as either "chaplain" or "mental health" based on the majority of participant affiliations (in the large majority of group interviews, participants were of the same affiliation). After removing five interviews from the Captain James A. Lovell Federal Health Care Center (since this is a joint VA / DoD facility) for the purposes of this frequency table, we coded for the presence/absence of 118 items in each of 286 separate interviews: 60 VA chaplain interviews; 80 VA mental health interviews; 94 DoD chaplain interviews; and 52 DoD mental health interviews.

Code #	Items	VA		DoD	
		Chaplain (n = 60)	Mental Health (n = 80)	Chaplain (n = 94)	Mental Health (n = 52)
Confidentiality					
1	Confidentiality of chaplains is important	4 (6.7%)	4 (5.0%)	32 (34.0%)	9 (17.3%)
2	Mental health confidentiality (including HIPAA) restricts what mental health can share with chaplains who are not part of the interdisciplinary treatment team.	1 (1.7%)	1 (1.3%)	4 (4.3%)	4 (7.7%)
3	Chaplains need education about the ethical boundaries and limits of mental health confidentiality	0 (0%)	0 (0%)	0 (0%)	1 (1.9%)
4	Mental health is unsure of what chaplains can or cannot disclose about a client	2 (3.3%)	1 (1.3%)	3 (3.2%)	4 (7.7%)
5	Command/Leadership is more familiar with confidentiality policy/practice for chaplains than for mental health.	0 (0%)	0 (0%)	1 (1.1%)	2 (3.8%)
6	Chaplains' strict confidentiality standards are an incentive for people to talk with them	3 (5.0%)	1 (1.3%)	19 (20.2%)	6 (11.5%)
7	Chaplain confidentiality restricts what chaplains can share with mental health providers and can serve as a barrier to referral.	0 (0%)	2 (2.5%)	7 (7.4%)	7 (13.5%)
8	Chaplains are able to successfully encourage self-referral by service members to access behavioral health services.	1 (1.7%)	0 (0%)	16 (17.0%)	8 (15.4%)

Code #	Items	VA		DoD	
		Chaplain (n = 60)	Mental Health (n = 80)	Chaplain (n = 94)	Mental Health (n = 52)
9	Confidentiality influences what can be documented by chaplains	5 (8.3%)	3 (3.8%)	14 (14.9%)	1 (1.9%)
10	Clinical Pastoral Education prepares chaplains to work better with mental health.	9 (15.0%)	5 (6.3%)	20 (21.3%)	2 (3.8%)
11	Army Family Life Center training prepares chaplains to work better with mental health.	1 (1.7%)	0(0%)	5 (5.3%)	3 (5.8%)
12	Graduate level mental health programs should include information on religion/spirituality and/or integration of chaplaincy and mental health.	2 (3.3%)	3 (3.8%)	1 (1.1%)	0 (0%)
12.1	The background of chaplains and mental health providers allow them to provide better services or integrate with other professions	27 (45.0%)	23 (28.8%)	26 (27.7%)	14 (26.9%)
13	There should be a standard curriculum about mental health in chaplaincy training.	3 (5.0%)	0 (0%)	18 (19.1%)	1 (1.9%)
14	Chaplains currently don’t have or should have a general awareness of mental health including mental health problems, treatments, and terminology.	32 (53.3%)	38 (47.5%)	47 (50.0%)	25 (48.1%)
15	Mental health should have general awareness of chaplain practices.	39 (65.0%)	44 (55.0%)	54 (57.5%)	35 (67.3%)
16	Chaplains and mental health should present suicide prevention training together.	1 (1.7%)	0 (0%)	1 (1.1%)	6 (11.5%)
17	Appropriate in-house trainings should be offered to interdisciplinary teams or where chaplains and mental health train together.	13 (21.7%)	18 (22.2%)	30 (31.9%)	9 (17.3%)
18	Chaplains should attend in-house mental health training (e.g., grand rounds).	8 (13.3%)	20 (25.0%)	9 (9.6%)	11 (21.2%)
19	Chaplains should be part of new employee orientations.	3 (5.0%)	3 (3.8%)	3 (3.2%)	1 (1.9%)
20	Mental health should be invited to attend some in-house chaplaincy meetings/training.	6 (10.0%)	5 (6.3%)	12 (12.8%)	5 (9.6%)
21	Chaplains’ assistants should have a general awareness of mental health practices.	0(0%)	(0%)	3 (3.2%)	1 (1.9%)
22	Written guidance should be available at each chaplain assignment about practices and training at that location.	1 (1.7%)	2 (2.5%)	5 (5.3%)	0 (0%)

Code #	Items	VA		DoD	
		Chaplain (n = 60)	Mental Health (n = 80)	Chaplain (n = 94)	Mental Health (n = 52)
23	Chaplains have a key role in educating community partners.	11 (18.3%)	11 (13.8%)	5 (5.3%)	0 (0%)
24	Conferences offer opportunities to further integration through networking and joint education.	8 (13.3%)	6 (7.5%)	6 (6.4%)	1 (1.9%)
27	Chaplain's knowledge of how mental health conceptualizes cases would enhance integration.	1 (1.7%)	4 (5.0%)	2 (2.1%)	0 (0%)
29	Chaplains and mental health would benefit from enhanced understanding of sensitive issues (e.g., LGBT issues, sexual assault response).	3 (5.0%)	3 (3.8%)	3 (3.2%)	0 (0%)
30	Clinicians need more training and knowledge about spirituality and spiritual assessment.	16 (26.7%)	19 (23.8%)	28 (29.8%)	13 (25.0%)
31	Time or staffing constraints limit opportunities for professional development or integration.	19 (31.7%)	22 (27.5%)	20 (21.3%)	14 (26.9%)
32	Lack of funds for training limits opportunities for professional development or integration.	7 (11.7%)	2 (2.5%)	2 (2.1%)	4 (7.7%)
41	Lack of staff is a barrier to accessibility.	10 (16.7%)	16 (20.0%)	12 (12.8%)	5 (9.6%)
42	There are barriers to recruiting or hiring full-time chaplains within the VA system.	6 (10.0%)	1 (1.3%)	2 (2.1%)	0 (0%)
99	Lack of time or staffing is a barrier in chaplains being trained in EBPs	6 (10.0%)	0 (0%)	0 (0%)	0 (0%)
122	Need to balance the time for documentation with the benefits and recognize time constraints	2 (3.3%)	2 (2.5%)	1 (1.1%)	1 (1.9%)
Accessibility					
33	Close physical proximity/presence of chaplains and mental health fosters cross-disciplinary integration.	13 (21.7%)	14 (17.5%)	23 (24.5%)	13 (25.0%)
34	Chaplains can facilitate entry into mental health treatment.	1 (1.7%)	6 (7.5%)	23 (24.5%)	7 (13.5%)
35	Physical design and setting of patient environments impacts patient satisfaction and quality of interaction with providers.	5 (8.3%)	3 (3.8%)	2 (2.1%)	3 (5.8%)
36	Assigning/dedicating chaplains to clinical behavioral health units enhances relationships and ability to provide holistic care.	22 (36.7%)	24 (30.0%)	11 (11.7%)	9 (17.3%)

Code #	Items	VA		DoD	
		Chaplain (n = 60)	**Mental Health (n = 80)**	**Chaplain (n = 94)**	**Mental Health (n = 52)**
37	Chaplains supporting units in operational or foreign settings facilitate access to mental health care and promote cross-disciplinary relationships.	2 (3.3%)	0 (0%)	41 (43.6%)	13 (25.0%)
38	The size and setting of medical centers and military command environments affects access to patients and cross-disciplinary relationships.	1 (1.7%)	2 (2.5%)	18 (19.1%)	7 (13.5%)
39	Service gaps exist for patients or service members who live in remote communities or are deployed in remote settings.	1 (1.7%)	4 (5.0%)	5 (5.3%)	1 (1.9%)
40	Policy changes related to service coverage and travel reimbursement are needed for chaplains to better serve individuals in remote communities.	3 (5.0%)	1 (1.3%)	1 (1.1%)	0 (0%)
43	There is a need for more female chaplains.	2 (3.3%)	2 (2.5%)	1 (1.1%)	0 (0%)
43.1	Female chaplains add value to mental health or chaplaincy.	5 (8.3%)	3 (3.8%)	0 (0%)	0 (0%)
44	There is a need to increase religious and racial diversity within chaplaincy.	3 (5.0%)	0 (0%)	0 (0%)	0 (0%)
46	Active leadership support is critical to promote integration of chaplaincy and mental health.	15 (25.0%)	18 (22.5%)	12 (12.8%)	6 (11.5%)
47	Entrenched perceptions, attitudes and turf serve as barriers to integration.	24 (40.0%)	13 (16.3%)	40 (42.6%)	11 (21.2%)
48	Chaplains can play an important role in de-stigmatizing mental health services.	1 (1.7%)	8 (10.0%)	12 (12.8%)	5 (9.6%)
48.1	Patients may be reluctant to go to chaplains because of religious stigma	3 (5.0%)	3 (3.8%)	6 (6.4%)	4 (7.7%)
Referrals/Relationships					
49	Professional relationships encourage cross-disciplinary referral or integration.	40 (66.7%)	47 (58.8%)	51 (54.3%)	26 (50.0%)
49.1	There are no or little relationships between mental health and chaplaincy	5 (8.3%)	9 (11.3%)	21 (22.3%)	12 (23.1%)
50	Lack of knowledge or concern about how a chaplains' religious beliefs might impact a patient (e.g., anti-gay beliefs) can serve as a barrier for mental health referring to chaplains	1 (1.7%)	9 (11.3%)	4 (4.3%)	2 (3.8%)
51	Chaplains know to refer people to mental health if they have serious mental health issues.	7 (11.7%)	4 (5.0%)	40 (42.6%)	10 (19.2%)

Code #	Items	VA		DoD	
		Chaplain (n = 60)	**Mental Health (n = 80)**	**Chaplain (n = 94)**	**Mental Health (n = 52)**
52	Availability of services impact the referral process.	0 (0%)	2 (2.5%)	3 (3.2%)	1 (1.9%)
53	Perceptions of the quality services impact the referral process.	1 (1.7%)	1 (1.3%)	4 (4.3%)	2 (3.8%)
54	Patient referrals are primarily from chaplains to mental health and not vice versa.	1 (1.7%)	1 (1.3%)	23 (24.5%)	7 (13.5%)
55	Chaplains desire follow-up with patients after referral to mental health.	0 (0%)	0 (0%)	11 (11.7%)	0 (0%)
56	Leadership awareness of mental health needs facilitates cross-disciplinary referral and integration.	0 (0%)	1 (1.3%)	6 (6.4%)	1 (1.9%)
57	Medical professionals (nurses, doctors) are important sources of referral to chaplains.	11 (18.6%)	5 (6.3%)	7 (7.4%)	1 (1.9%)
58	Social workers are important sources of referral to chaplains.	4 (6.7%)	2 (2.5%)	5 (5.3%)	5 (9.6%)
60	Referrals can occur through electronic information systems.	1 (1.7%)	4 (5.0%)	0 (0%)	2 (3.8%)
60.1	Referrals generally occur through personal contact, telephone or other informal processes.	15 (25.0%)	21 (26.3%)	12 (12.8%)	14 (26.9%)
Screening and Assessment					
61	Programs and facilities use a variety of ways to do religious/spiritual screening	3 (5.0%)	17 (21.3%)	4 (4.3%)	17 (32.7%)
62	Chaplains cannot see everyone who requests a chaplain	2 (3.3%)	1 (1.3%)	2 (2.1%)	0 (0%)
63	Although some mental health providers assess spiritual needs, there are a variety of methods for conducting spiritual assessments in mental health.	0 (0%)	9 (11.3%)	1 (1.1%)	16 (30.8%)
64	It is unclear how mental health spiritual assessments should inform treatment.	1 (1.7%)	2 (2.5%)	0 (0%)	1 (1.9%)
65	There are no established protocols for collecting information that would prompt a chaplaincy referral	2 (3.3%)	8 (10.0%)	5 (5.3%)	5 (9.6%)
66	There are a variety of tools and methods chaplains use to conduct spiritual assessment	32 (53.3%)	10 (12.5%)	43 (45.7%)	0 (0%)
67	Chaplains do not routinely conduct spiritual assessments or do not do spiritual assessments for all people who could benefit from them	8 (13.3%)	1 (1.3%)	8 (8.5%)	0 (0%)
70	Efforts are made to ensure uniformity in spiritual assessments	18 (30.0%)	0 (0%)	8 (8.5%)	0 (0%)

Code #	Items	VA		DoD	
		Chaplain (n = 60)	Mental Health (n = 80)	Chaplain (n = 94)	Mental Health (n = 52)
71	Providers are not aware of chaplain spiritual assessments	0 (0%)	6 (7.5%)	1 (1.1%)	5 (9.6%)
72	Providers do not read or use the chaplain's spiritual assessment or notes	5 (8.3%)	11 (13.8%)	0 (0%)	0 (0%)
73	Providers read the spiritual assessment or chaplains notes	9 (15.0%)	7 (8.8%)	2 (2.1%)	0 (0%)
74	Chaplains spiritual assessments are integral to the treatment plan	2 (3.3%)	3 (3.8%)	0 (0%)	1 (1.9%)
75	Chaplains and providers work to improve the utility of spiritual assessments	6 (10.0%)	2 (2.5%)	1 (1.1%)	1 (1.9%)
76	Increased training for chaplains in spiritual assessment would be helpful	2 (3.3%)	1 (1.3%)	1 (1.1%)	0 (0%)
77	It would be good to have a spiritual assessment to help determine who could benefit from an integrated mental health and chaplaincy approach	1 (1.7%)	1 (1.3%)	0 (0%)	0 (0%)
78	Chaplains would like to share information about how spiritual assessments are used in different facilities	1 (1.7%)	1 (1.3%)	0 (0%)	1 (1.9%)
79	Develop a common language for assessment or practice that can be used by mental health and chaplaincy	4 (6.7%)	1 (1.3%)	5 (5.3%)	0 (0%)
80	There should be more research on spiritual assessments and how they might be important to patient care	3 (5.0%)	2 (2.5%)	2 (2.1%)	2 (3.8%)
Evidence Based Practices					
81	Chaplains would benefit from training in mental health EBPs.	25 (41.7%)	36 (45.0%)	25 (26.6%)	26 (50.0%)
82	Training in some evidence based practices such as motivational Interviewing could benefit chaplain practice because they are not restricted to therapists.	11 (18.3%)	23 (28.8%)	5 (5.3%)	10 (19.2%)
83	Training in prevention EBPs such as suicide prevention would benefit chaplains	1 (1.7%)	1 (1.3%)	3 (3.2%)	2 (3.8%)
84	Additional training in mental health EBPs would be appropriate for chaplains who are also credentialed as mental health providers.	0 (0%)	1 (1.3%)	1 (1.1%)	3 (5.8%)
85	Training on EBPs would not help chaplains very much	0 (0%)	2 (2.5%)	1 (1.1%)	2 (3.8%)

Code #	Items	VA		DoD	
		Chaplain (n = 60)	**Mental Health (n = 80)**	**Chaplain (n = 94)**	**Mental Health (n = 52)**
86	Mental health EBPs are not appropriate for chaplains because they are not therapists	1 (1.7%)	10 (12.5%)	0 (0%)	6 (11.5%)
87	There is not a coherent framework for understanding how chaplains can best be involved with mental health EBPs	1 (1.7%)	4 (5.0%)	3 (3.2%)	1 (1.9%)
88	Chaplains need to preserve their pastoral identity as they adopt mental health EBPs or integrate with MH.	8 (13.3%)	11 (13.8%)	20 (21.3%)	3 (5.8%)
89	Training in mental health EBPs such cognitive behavioral therapy would benefit chaplains because they could adapt elements of these practices to chaplaincy	8 (13.3%)	6 (7.5%)	5 (5.3%)	5 (9.6%)
90	Learning about mental health EBPs would help chaplains make more appropriate referrals to mental health.	2 (3.3%)	1 (1.3%)	0 (0%)	2 (3.8%)
91	Learning about mental health EBPs would help chaplains explain to patients the need for treatment and provide support to patients/families in the treatment process.	4 (6.7%)	5 (6.3%)	2 (2.1%)	4 (7.7%)
92	Learning about mental health EBPs would help chaplains become more knowledgeable members of interdisciplinary teams or co-lead groups	2 (3.3%)	5 (6.3%)	2 (2.1%)	2 (3.8%)
93	Mental health EBP training enhances chaplains' ability to address less severe mental health issues, allowing MH providers to address more serious needs.	1 (1.7%)	1 (1.3%)	2 (2.1%)	4 (7.7%)
94	There needs to be a major emphasis on developing EBPs for chaplaincy or integrated practice between chaplaincy and mental health	5 (8.3%)	5 (6.3%)	4 (4.3%)	1 (1.9%)
95	Chaplains trained as mental health practitioners or researchers can act as boundary spanners and to promote a culture of integration.	2 (3.3%)	6 (7.5%)	6 (6.4%)	2 (3.8%)
97	Chaplains need to become better trained in research and/or partner with researchers to develop chaplaincy EBPs	4 (6.7%)	4 (5.0%)	0 (0%)	0 (0%)
98	Chaplains need models that shift away from inpatient and toward outpatient care since this is the direction of medicine.	6 (10.0%)	12 (15.0%)	1 (1.1%)	1 (1.9%)

Code #	Items	VA		DoD	
		Chaplain (n = 60)	Mental Health (n = 80)	Chaplain (n = 94)	Mental Health (n = 52)
100	Some EBPs are not appropriate for chaplains because they don't fit the time chaplains see vets & service personnel	1 (1.7%)	5 (6.3%)	2 (2.1%)	2 (3.8%)
Integration					
102	Chaplains are or could be part of formal interdisciplinary teams.	28 (46.7%)	41 (51.3%)	18 (19.1%)	18 (34.6%)
103	Chaplains are or could be involved in mental health programming.	39 (65.0%)	50 (62.5%)	23 (24.5%)	13 (25.0%)
104	Chaplains and mental health are or could be integrated in activities like outreach or working with communities to improve services.	11 (18.3%)	24 (30.0%)	4 (4.3%)	3 (5.8%)
104.1	Chaplains and mental health are or could be integrated in activities like working on multidisciplinary committees or groups.	18 (30.0%)	10 (12.5%)	21 (22.3%)	4 (7.7%)
105	Lack of policies is a barrier to sustained integration.	6 (10.0%)	9 (11.3%)	12 (12.8%)	13 (25.0%)
106	Staff turnover or rotation is a barrier to sustained integration.	3 (5.0%)	3 (3.8%)	10 (10.6%)	2 (3.8%)
Documentation					
107	Improved technology can help facilitate integrated chaplaincy and mental health documentation.	10 (16.7%)	11 (13.8%)	7 (7.4%)	4 (7.7%)
108	Technology can be a barrier to sharing information and integration.	0 (0%)	2 (2.5%)	2 (2.1%)	2 (3.8%)
110	Chaplain notes are not useful to mental health and should be improved.	0 (0%)	6 (7.5%)	2 (2.1%)	0 (0%)
110.1	Chaplains don't document.	0 (0%)	2 (2.5%)	22 (23.4%)	3 (5.8%)
111	Mental health notes are not useful to chaplains.	0 (0%)	0 (0%)	0 (0%)	0 (0%)
112	Chaplains and mental health have worked or should work to improve the utility of information collected.	4 (6.7%)	4 (5.0%)	3 (3.2%)	2 (3.8%)
113	In some programs chaplains and mental health/medical providers jointly currently use or should use process or outcome metrics to improve quality of practices.	1 (1.7%)	3 (3.8%)	0 (0%)	0 (0%)
114	Some service branches or VAs have standardized chaplain or mental health metrics while in other arenas there are not standard metrics.	2 (3.3%)	2 (2.5%)	9 (9.6%)	1 (1.9%)

Code #	Items	VA		DoD	
		Chaplain (n = 60)	**Mental Health (n = 80)**	**Chaplain (n = 94)**	**Mental Health (n = 52)**
115	Chaplains or mental health use or could use vet/service member/family ratings to improve services.	4 (6.7%)	8 (10.0%)	1 (1.1%)	0 (0%)
116	Recommend gathering information from vets/active duty about how chaplains and mental health can best integrate services.	0 (0%)	6 (7.5%)	0 (0%)	0 (0%)
117	Outcomes of chaplains are not measureable and it is difficult to find measures that capture the value of chaplaincy.	13 (21.7%)	4 (5.0%)	20 (21.3%)	2 (3.8%)
118	Some chaplaincy and mental health programs are implementing or could implement formal outcome-feedback processes that track client progress weekly.	0 (0%)	0 (0%)	3 (3.2%)	5 (9.6%)
119	Chaplains and mental health/medical/leadership are or could be involved in efforts to examine aggregate system level outcomes and develop strategies to improve outcomes.	0 (0%)	1 (1.3%)	8 (8.5%)	3 (5.8%)
121	Efforts should be made to enhance chaplaincy skills in data collection and use.	3 (5.0%)	1 (1.3%)	2 (2.1%)	0 (0%)

APPENDIX P

TASK GROUP FINAL MEETING AGENDA AND QUESTIONNAIRE

VA / DoD Collaborative Task Group Meeting
For
VA / DoD Integrated Mental Health Strategy (IMHS)
Strategic Action #23: Chaplains' Roles

Date: March 19, 2012

Location: The Fairmont Washington, DC
2401 M Street, North West
Washington, DC 20037

Meeting Background and Objectives: In 2010, the Department of Defense (DoD) and Department of Veterans Affairs (VA) launched an Integrated Mental Health Strategy (IMHS) that aims to advance a more integrated and better coordinated public health model to improve care for Service members, Veterans, and their families. As a component of this broad initiative, Strategic Action #23 has focused on how to enhance the roles of chaplains and community clergy with respect to mental health care. This meeting brings together the IMHS Strategic Action #23 Task Group to review findings from approximately one year of combined efforts on this strategic action and to collaboratively consider appropriate next steps.

Agenda:

8:00-9:00	Registration / Check-In
9:00-9:15	*Welcome*
9:15-9:30	*Brief Task Group Introductions*
9:30-10:45	*Chaplaincy and Mental Health Care: Methods, Findings, & Implications from SA #23* **Dr. Keith Meador and Dr. Jason Nieuwsma**
10:45-11:30	*Large Group Discussion*
11:30-12:45	**Lunch**
12:45-1:30	*Focusing on DoD* **Dr. Mark Bates and Dr. Jeff Rhodes**
1:30-2:00	*Toward Integration* **Dr. Keith Meador and Dr. Jason Nieuwsma**
2:00-2:15	Break
2:15-3:15	*Breakout Groups*
3:15-3:30	Break
3:30-4:30	*Large Group Synthesis*

IMHS SA #23 Final
Task Group Meeting

End of Meeting Questionnaire

1. What does successful integration of mental health and chaplain services look like? (i.e., How will we know we're successful? How do we measure it?)

2. What feedback do you have surrounding the proposed tiers for integration of mental health and chaplaincy services? What about the MHICS Certification Program? How can we optimize this program?

3. From your vantage point, what are next steps? Also, what do we still need to know?

APPENDIX Q

TASK GROUP FINAL MEETING EXPANDED TABLE

DEFINING SUCCESS
What does successful integration of mental health and chaplain services look like? (i.e., How will we know we're successful? How do we measure it?)
• Standardized curriculum for cross-training chaplains and mental health care providers.[7] • Mental health care providers and chaplains cross-refer patients, with institutionalized system in place to facilitate this.[5] • Adequate funding and staffing.[4] • Chaplain is a full, equal, and necessary member of the team.[4] • Treatment planning for Veterans and Service members is coordinated by a team that involves the chaplain.[3] • A standardized spiritual inventory is adopted among chaplains.[3] • Chaplains and mental health care providers embrace separate but complementary objectives and understand what the other does.[3] • Chaplaincy's participation in integrated care teams is reflected in progress notes.[3] • "Organic integration" in inpatient and outpatient teams. • Ongoing research paradigm that involves chaplains and mental health and produces evidence-based, outcome-oriented data. • Training extends to include civilian clergy.
INPUT ON TRAINING PROPOSAL
What feedback do you have surrounding the proposed tiers for integration of mental health and chaplaincy services? What about the MHICS Certification Program? How can we optimize this program?
• Program is needed and would be well-received.[6] • Utilize MHICS Certification Program in both VA and DoD.[3] • Tiered levels make good sense.[3] • Taking time out for full MHICS program is difficult, especially for DoD.[2] • Should come from mental health and be valued by local mental health providers. • Involve mental health providers earlier and throughout MHICS. • Identify key program instructors and providers to secure buy-in. • Consider connecting MHICS to a specialty certification and providing CEUs. • Adopt a transdisciplinary team structure. • Onsite is preferred modality over online to make trainings successful.
NEXT STEPS
From your vantage point, what are next steps? Also, what do we still need to know?
• Determine best practices for provision of spiritual care, including spiritual assessment practices and charting.[5] • Formalize curriculum model for certification.[3] • Develop learning collaborative for chaplains and mental health to build working interdisciplinary teams[3]

- Incorporated tailored versions of training into existing DoD mechanisms (e.g., chaplain schools at Ft. Jackson, Air Guard training days).[2]
- Assemble information on collaborations already in place.[2]
- Look at sub-specialty certification program coming from mental health for chaplains
- Pilot at a facility to learn about benefits and challenges.
- Incorporate joint mental health and chaplain training with CPE training in VA.
- Consider conducting portions of training online.

There were 15 task group members who completed the end of meeting questionnaire. Comments from the questionnaire are summarized in the table, with superscripts indicating that more than one task group member provided a given type of written comment (e.g., superscript of 5 means that five task group members made a similar comment on the questionnaire.)

APPENDIX R

SAMPLE AGENDA FROM BRIDGING CHAPLAINCY AND MENTAL HEALTH CARE CONFERENCE SERIES

Bridging Chaplaincy and Mental Health Care
March 8-9, 2012
Embassy Suites
Seattle, WA

Note that all sessions will be structured to include interactive components, with there being some variability in the amount of time allotted to interaction according to session content.

Day 1 Agenda	
Time	**Content**
8:00-8:20	Registration / Check-In
8:20-8:30	Welcome / Opening Prayer
8:30-9:30	*Bridging – Why do it?* **Presenter: Dr. Keith Meador**
9:30-10:30	*Etiology of OEF/OIF Problems/Combat Stressors* **Presenter: Dr. Kent Drescher**
10:30-10:45	Break
10:45-11:45	*Family Care in a New Generation of Veterans* **Presenter: Chaplain Bill Cantrell**
11:45-1:00	Lunch
1:00-2:30	*Red Flag Spiritual Issues & Moral Injury* **Presenter: Dr. Kent Drescher**
2:30-2:45	Break
2:45-3:25	*Gratitude and Acceptance: Synergies for Spiritual and Mental Health Care* **Presenter: Dr. Keith Meador**
3:25-4:25	*Acceptance and Commitment Therapy in the Context of Empirically Supported Treatments* **Presenter: Dr. Jason Nieuwsma**
4:25-4:30	**Wrap-up**

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Day 2 Agenda	
Time	**Content**
8:00-8:20	Registration / Check-In
8:20-8:30	Welcome / Opening Prayer
8:30-9:30	*Integrating Acceptance and Commitment Therapy with Chaplaincy* **Presenter: Dr. Jason Nieuwsma**
9:30-10:30	*Applying Acceptance & Commitment Therapy* **Presenter: Dr. Kent Drescher**
10:30-10:45	Break
10:45-11:45	*Acceptance and Commitment Therapy Case Studies* **Presenter: Dr. Jason Nieuwsma**
11:45-1:00	**Lunch**
1:00-2:00	*Special Topic: National Suicide Prevention Program* **Presenter: Dr. Krista Stephenson**
2:00-2:15	Break
2:15-3:15	*Special Topic: Role of the Chaplain in Treatment of Addictive Disorders* **Presenter: Dr. John Allen**
3:15-4:00	**Wrap-up / Evaluations**