

Confidentiality and Mental Health/Chaplaincy Collaboration

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Confidentiality can both facilitate and inhibit working relationships of chaplains and mental health professionals addressing the needs of service members and veterans in the United States. Researchers conducted this study to examine opportunities for improving integration of care within the Department of Defense (DoD) and Department of Veterans Affairs (VA). Interviews were conducted with 198 chaplains and 201 mental health professionals in 33 DoD and VA facilities. Using a blended qualitative research approach, researchers identified several themes from the interviews, including recognition that integration can improve services; chaplaincy confidentiality can facilitate help seeking behavior; and mental health and chaplain confidentiality can inhibit information sharing and active participation on interdisciplinary teams. Cross-disciplinary training on confidentiality requirements and developing policies for sharing information across disciplines is recommended to address barriers to integrated service delivery.

Keywords: military psychology, confidentiality, chaplaincy, veterans, service members

The role of chaplaincy in supporting mental health care and addressing spiritual needs among service members and veterans has gained significant interest in recent years. Extended U.S. military deployments beginning with the Gulf War, Operation Enduring Freedom, and Operation Iraqi Freedom have led to a

new evaluation of how chaplains can augment a response to the mental health needs of service members and veterans (Besterman-Dahan, Gibbons, Barnett, & Hickling, 2012; Drescher & Foy, 2008; Hourani et al., 2012). The relationship between combat exposure and extended deployments, and increased risk for mental

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health problems, substance abuse, and suicide, is well documented (e.g., Hoge, Auchterlonie, & Milliken, 2006; Maguen et al., 2010; Seal et al., 2009). The U.S. Department of Defense (DoD) and U.S. Department of Veterans Affairs (VA) sought improved approaches and more efficient use of existing resources to address these needs (Departments of Defense and Veterans Affairs, 2010; Department of Defense Task Force on the Prevention of Suicide by Members of the Armed Forces, 2010).

Chaplains are increasingly being asked to participate in multidisciplinary teams as part of this effort. Confidentiality has been discussed as a potential barrier to team collaboration in a variety of contexts, including sexual assault response teams (Cole, 2011), child protection (Darlington, Feeney, & Rixon, 2005), and health care teams (Miller, Charles-Jones, Barry, & Saunders, 2005; Van Liew, 2012), but there is scarce research available regarding the role of confidentiality related to chaplain participation on these interdisciplinary teams. Ethical discussions about chaplain documentation in patient charts have included pros and cons for including chaplains as team members (Loewy & Loewy, 2007; McCurdy, 2012).

There is little empirical research regarding how confidentiality furthers or hinders collaboration between chaplains and mental health providers. This study begins to fill this gap by examining the perceptions of chaplains and mental health professionals serving in operational and clinical settings within the DoD and VA. A brief review of military and VA chaplaincy and confidentiality is presented to help provide context for the results of the current study.

There is a long tradition of chaplaincy within the United States' armed forces (Bergen, 2004; R. Budd, 2002; Department of Veterans Affairs, 2013; Dorsett, 2012; Drazin & Currey, 1995). Military chaplaincy has been lauded as an invaluable and unique institution that has positive effects on morale and well-being (Crosby, 1997; Dorsett, 2012). Chaplains are trained to address spiritual needs in operational, health care, and pastoral settings by maintaining a critical frontline presence with the people they serve. Many chaplains and commentators refer to the mix of providing emotional and social support, frequent visitation, clinical pastoral counseling, or religious ministry as the "minis-

try of presence" (Crouterfield, 2009; Otis, 2009; Tinsley, 2012). Chaplains make themselves available by walking among the people they serve—in hospitals, it may be a visit to a patient room or to the staff in a ward; in the Navy, it can include providing deck plate ministry in the fleet, in training, and in the field and combat with Marines and sailors; in the Air Force, it could be walking the flight line; and in the Army, it includes serving among the troops wherever they may be.

In the VA, chaplains address the religious and spiritual needs of patients (Board of Ex-cepted Service Examiners for Chaplains, VANCC, 2012), and spiritual care is integrated into comprehensive health care for veterans (Department of Veterans Affairs, Veterans Health Administration, 2008a). VA chaplains are responsible for ensuring patients receive clinical pastoral care as desired, while simultaneously assuring their First Amendment rights to free exercise of religion and freedom from religion (Department of Veterans Affairs, Veterans Health Administration, 2008b).

Greater specialization and professionalization of chaplaincy in the military and Department of Veterans Affairs has engendered an overall trend toward more formal training and credentialing. The most visible is clinical pastoral education (CPE), which is now required by VA as a prerequisite for employment as a clinical chaplain and required by the DoD for chaplains assigned to designated hospital and medical commands (Marr, Billings, & Weissman, 2007; Snorton, 2006). Professional standards are recognized by a growing community of educational and professional associations in pastoral care and chaplaincy, such as the Association of Professional Chaplains, the American Association of Pastoral Counselors, the National Association of Veterans' Affairs Chaplains, and faith-particular entities such as the National Association of Catholic Chaplains and National Association of Jewish Chaplains (Association of Professional Chaplains, 2009, 2012; Council on Collaboration, 2004a, 2004b). Comprehensive authoritative regulations on confidentiality do not exist; instead, there is a patchwork of continually evolving guidance from VA and DoD, individual legal or regulatory texts, and differing professional, institutional, ecclesiastical, and cultural norms and practices that may share some general principles

but lack complete uniformity. Although there are differences in policy, all the U.S. armed forces recognize strict confidentiality between armed services members and chaplains as a normative and ethical obligation, and enforceable under military law (Mil. R. Evid. 503; Ortiz, 1987; *U.S. v. Isham*, 1998; *U.S. v. Moreno*, 1985).

Confidentiality requirements are different for VA chaplains. Like other VA employees, chaplains must comply with official VA confidentiality policies and other applicable federal or state regulations that shape the overall regulatory environment, and strong legal and professional obligations to protect confidentiality. This includes departmental policies such as those that govern privacy and release of information (Department of Veterans Affairs, Veterans Health Administration, 2006), receipt of confidential information (Department of Veterans Affairs, Veterans Health Administration, 2009), protected health information (Department of Veterans Affairs, Veterans Health Administration, 2008c), federal statutes such as the Health Insurance Portability and Accountability Act (2006), and confidentiality provisions pertinent to protection of veterans' benefits.

Integrating chaplaincy more closely with mental health services in military and VA environments requires careful consideration of the chaplaincy role and the issues surrounding communication between chaplains and mental health. The differing level of confidentiality among professions strongly influences what, when, and how information can be shared between mental health and chaplains. The current study explored perceptions of chaplains and mental health professionals about the role of confidentiality in DoD and VA contexts. This study was part of an initiative to examine how chaplains and behavioral health professionals can work together to improve service access and coordination for service members and veterans with mental health and substance abuse problems (Nieuwsma et al., 2012, 2013).

Method

Participants in this study were chaplains and mental health professionals working in VA and DoD sites across the United States. Approval to conduct site visits was obtained from appropriate authorities in VA and DoD. The site visits

were conducted to develop an understanding of how chaplains and mental health providers collaborate across VA and DoD. For further information on the DoD/VA site visits, see Nieuwsma et al. (2013) for description of the background and design of the study.

A total of 291 interviews (46 in group format; 245 in individual format) were conducted at 33 facilities with 399 individuals (252 males and 147 females). Table 1 shows the number of chaplains and mental health professionals interviewed by DoD, VA, and joint VA/DoD facilities. Key contacts at each of the sites (generally the chief of chaplains and chief of mental health) selected the individual participants to be interviewed after a per-site visit phone call with the team lead for that site. Chaplain interviews included chiefs of chaplains, hospital chaplains, military chaplains in operational commands, CPE supervisors and students, Army Family Life Center chaplains, staff chaplains, and contract chaplains. Behavioral health interviews included psychologists, psychiatrists, social workers, substance abuse treatment professionals, and nurses. In some sites, there was also an opportunity to interview other health care professionals and administrators with significant overlap or interaction with chaplains. Three interviewers from the University of Nebraska conducted interviews. The interview length varied from 20 min to over an hour, with the majority of interviews scheduled for 45 to 60 minutes. A semistructured interview format, approved by the institutional review board, included several open-ended questions to explore: (a) participant backgrounds and job responsibilities, (b) characteristics of individuals served and how they access services, (c) how chaplaincy and mental health work together, (d) what chaplains and mental health know about

Table 1
Chaplains and Mental Health Professionals Interviewed by Type of Facility

	Chaplains	Mental health professionals	Total
VA facilities	82	112	194
DoD facilities	111	78	189
Joint VA/DoD facilities	5	11	16
Total	198	201	399

Note. VA = Department of Veterans Affairs; DoD = Department of Defense.

each other, (e) job activities, (f) how each profession assesses spiritual needs, and (g) how documentation is shared between the professions. Approved prompts were used to clarify responses and probe ideas in more depth. There were no specific questions about confidentiality; instead, confidentiality emerged as a recurring theme related to other issues such as referral, documentation and working together as a team.

The analysis of this qualitative study relied upon a blended inductive approach that began with the team reviewing a sample of the interviews using open coding techniques that are common in grounded theory approaches to qualitative research (Charmaz, 2006; Strauss & Corbin, 1998). Researchers then employed a modified form of the constant comparative technique (Glaser & Strauss, 1967) consistent with the components of consensual qualitative research (CQR; Hill, Thompson, & Williams, 1997). The CQR approach incorporates elements of grounded theory and phenomenology, and uses a team approach to compare data across cases, and then reach consensus on the core ideas for each domain emanating from the data.

Three researchers formed the team that began the analysis by independently completing open coding of a sample of interview records to arrive at a list of major themes arising directly from the data. A coding guide was then constructed in consultation with the project sponsors, with definitions for each of the resulting 118 themes. The researchers then coded all interviews in eight rounds of coding, followed by formal discussions to refine the code definitions when agreement was not present. Obtaining intercoder agreement in this fashion is common in qualitative research. Fifteen interviews were initially coded by all interviewers; subsequently, 13 interviews were jointly coded to assess coding agreement. The team met to discuss coding questions and ensure agreement was maintained. Interrater reliability across all coded variables was calculated for approximately 10% of the interviews using Randolph's free-marginal multirater kappa (Randolph, 2005, 2008; Warrens, 2010). Raters achieved over 90% agreement and a free-margin kappa score of .8 or better (the threshold for acceptable interrater agreement) for all rounds after three initial rounds of coding (see Table 2). Confidentiality was not one of the questions

Table 2
Interrater Reliability for Coded Interviews

Review period	# Interviews	Free-marginal kappa	Overall % agreement
Round 1	5	0.79	89.26
Round 2	5	0.82	90.99
Round 3	5	0.78	89.05
Periodic testing time 1	2	0.87	93.57
Periodic testing time 2	2	0.85	92.59
Periodic testing time 3	3	0.83	91.42
Periodic testing time 4	3	0.85	92.47
Periodic testing time 5	3	0.88	94.16

asked, but was identified by reviewers as common theme during coding.

The sample size for this study was quite large for qualitative research, and the purpose was to explore rather than generalize the findings. There were some limitations to our methodology. The sample was limited to chaplains and professionals working in or with behavioral health teams in locations that were amenable to site visits. Because interviews were not conducted in sites that were reluctant to participate in the study, the sample could potentially be biased. Service members and veterans who access services from mental health or chaplains were not included in the sample, so the captured perceptions are only those of the professionals. Audio recordings were not allowed as part of this study; thus, interviewers relied upon note taking and recreation of conversations during and immediately following the interview.

Results

Participants in this study overwhelming expressed the view that collaboration between chaplains and mental health professionals provides an opportunity to improve care for veterans and service members, particularly in the intersection between mental health and spirituality; they noted that issues of confidentiality offer both opportunities and barriers to collaboration. Compared with VA participants, DoD chaplains and mental health professionals were more likely to express that (a) confidentiality of chaplains is important, (b) chaplain confidentiality is an incentive for people to talk to them, (c) chaplain confidentiality can serve a barrier to referral, and (d) chaplains are able to success-

fully encourage self-referral to mental health services.

Participants noted the obligation of chaplains to maintain confidential communications can function as a facilitator and a barrier to accessing mental health services. A common theme among participants was that chaplain confidentiality, particularly in the DoD, promotes help seeking by service members. Many participants indicated that without the assurance of confidentiality, fewer service members would seek assistance for their problems, resulting in higher rates of suicide, substance use and mental health disorders, domestic violence, and other problems. Strict confidentiality allows service members to be completely candid with chaplains, revealing sensitive issues they normally might not disclose. As one Navy chaplain indicated, “When you see me it goes to the grave. I make it clear in training—you are safe with me. I don’t discuss the case with mental health—It is sacred.” Chaplains are then able to assist the individual with their problem or to encourage them to seek additional help, such as mental health treatment.

Both chaplain and mental health participants indicated many service members with mental health and substance use problems seek assistance from chaplains rather than behavioral health professionals because of the strict confidentiality associated with chaplaincy. Because chaplains often encourage individuals to seek mental health services, chaplaincy may serve as an entry point or referral source for mental health for those who otherwise would not seek mental health services:

There is stigma with mental health services, and many active duty personnel 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; chaplains will encourage them to talk to others and get help. (Air Force chaplain)

Although the perspective that chaplains can serve as a gateway to behavioral health services was expressed by DoD chaplains and providers, this perspective was less prevalent among VA chaplains and mental health professionals. This may not be surprising, because veterans often seek health care from VA facilities through a general admissions process or through an emergency room, rather than directly through a chaplain or mental health provider. Yet even in the

VA context, some participants cited the confidentiality and trust of chaplains as an asset that allows veterans to disclose information they may be reluctant to reveal to other professionals.

Because the relationship between the chaplain and service member is modeled for veterans during their time in the service, some participants suggested that VA chaplains can serve as a conduit to mental health and substance abuse services, for example, in situations in which the veteran is receiving care at a VA facility for a medical condition, but confides in a chaplain about struggles with mental health or substance use issues.

Confidentiality can also be a barrier to accessing mental health care if the chaplain is reluctant to make a referral to mental health professionals for fear of revealing confidential information. Because of absolute confidentiality, the DoD chaplain cannot disclose information provided by the service member even if the individual is a danger to himself/herself or others. However, DoD chaplains have found a number of ways to balance the interest of confidentiality while helping service members get mental health services they may need. For example, chaplains may convince the service member to self-refer to mental health services, and, in some cases, the chaplain may even accompany the individual to mental health professionals or the emergency room; in these situations, there is no disclosure of confidential information by chaplains because the service member is self-seeking mental health services. Chaplains may get the service member’s permission to speak with other professionals or tell other professionals to “track” the individual without revealing why; although in some denominations, even this activity may be considered a violation of confidentiality. In some instances, chaplains reported they told command or the referral source that the service member was seen by the chaplain, but would not reveal any other information about the interaction. Another example frequently cited was never leaving a suicidal or potentially dangerous person alone, and arranging for the person to be watched or given time off without telling command about the specific risks known to the chaplain. For example, an Air Force chaplain talked about balancing confidentiality and getting active duty personnel the help they need: “Chaplains don’t share any-

thing, even if the person is suicidal or homicidal. You never want to break the code, but you also want to protect the person.”

Confidentiality for chaplains and mental health professionals can operate as a barrier to communication of information that could potentially improve care. For example, information obtained during mental health treatment could be beneficial to a chaplain independently working with the service member or veteran. Similarly, information revealed between a service member and chaplain could assist mental health professionals in assessing and treating them. However, both DoD chaplains and mental health professionals indicated that little sharing of information occurs between the professions. DoD chaplains particularly indicated that once they refer to mental health, little information is provided to them about the service member’s condition:

I have referred sailors who were suicidal to mental health. I will provide mental health with all the information that I had about the patient, but then the mental health provider could not provide me with any information back after seeing that particular patient. I was excluded from the equation, possibly because of a fear that HIPAA concerns would come into play. (Navy chaplain)

Some DoD mental health providers noted similar experiences when referring to chaplains. One Army social worker noted, “Once we refer to chaplains, chaplains don’t come back to us with information, maybe because of confidentiality.” A number of chaplains and mental health professionals indicated that service members may be seeing the other profession, but they would not know unless the service member voluntarily discloses it. When both professions are seeing the service member, confidentiality restrictions limit coordination of services:

Some of the issues were Health Insurance Portability and Accountability Act (HIPAA) stuff so there are some concerns about confidentiality so mental health information cannot be shared with the chaplain. There have been instances where the mental health provider and the chaplain are providing two different messages, and it is frustrating. (Navy chaplain)

Even when chaplains and mental health professionals are working in the same facility such as a VA or DoD hospital, mental health confidentiality may preclude chaplains from being included as part of the multidisciplinary team. In some sites, mental health providers were

unsure how their confidentiality requirements might affect their ability to include chaplains on interdisciplinary teams. However, in other programs, chaplains are considered integral members of the interdisciplinary team and have access to information in the medical record.

Communication between chaplains and mental health tends to be better when both professionals work in the same facility or program; however, even in this context there can be confidentiality barriers. One area affected by chaplain confidentiality is documentation. For example, some chaplains believe they should never make notes in patient records:

I don’t document. Many people with mental health problems don’t want it documented. If someone came in and said they were inclined to abuse— instantly their career is going to be gone. Even if it is supposed to be secret, someone will see it. (Army hospital chaplain)

A Navy chaplain working with Marines indicated, “I don’t keep any notes. What is written on paper is not confidential.” There is a difference between DoD and VA medical facilities in this regard. The VA requires chaplains to document their services in the medical record, whereas in the DoD, documentation, even in medical settings, often is optional for the chaplain.

Other chaplains indicated they balance the need for patient privacy with the need to provide information to other members of the treatment team. Some chaplains strike this balance by documenting information that would be useful to mental health providers but not revealing personal details of their conversation with patients:

Personally I have an issue with confidentiality. I don’t find it necessary to divulge all the details that a person may be having if it’s not specifically related to their treatment and progress. If a person was struggling with a sexual identity issue 20 years ago that is creating spiritual problems, I’m not going to put it in a note. The only time I put that in a note is if it impacts provider treatment. (VA chaplain)

Documentation for chaplains can be more complicated in DoD medical facilities in which there is an expectation of complete confidentiality, particularly when the chaplain is an integral part of the interdisciplinary team. In some cases, the spiritual assessment administered to service members is not considered confidential and can be entered in the electronic record, and

accessed and used by other team members to inform treatment decisions. For other information, chaplains may get consent from the service member to share information with team members.

Some mental health providers indicated that chaplain documentation was not as useful as it could be, possibly because chaplains are reluctant to include details in the record due to concerns about confidentiality:

The chaplain's documentation in the medical record right now is that they met with a person. If the value is to help with information and collaboration it would be nice to know the themes including resources that were offered or things they are struggling with. (VA social worker)

Some interdisciplinary teams embraced the more stringent level of chaplain confidentiality; for example, the team may ask the chaplain to talk to a patient to get a reluctant patient to reveal more information. In some integrated programs, the chaplain's office is separate from other program areas and in a private area to reinforce for patients that their conversations with the chaplain are confidential.

Participants offered a number of recommendations for improving communication between chaplains and mental health professionals while maintaining the confidentiality of information. For example, a prevalent recommendation was to provide training to both chaplains and mental health professionals regarding confidentiality requirements for each profession and to create a shared understanding of the culture of each profession.

Another recommendation was to work collaboratively to develop guidelines for sharing information between professions:

Mental health providers have HIPAA. If the patient is seeing a medical provider then mental health can talk to them about mental health but chaplains are not medical, so it would be good to figure out how to work through this [to understand what each profession can share with each other]. (Navy social worker)

Other recommendations and potential areas of concern included (a) ensuring sharing of information through referrals is balanced with maintaining confidentiality of private information, (b) communicating progress in treatment across disciplines when appropriate, (c) developing models for interdisciplinary teams that recognize the differences in confidentiality re-

quirements for the two disciplines, and (d) developing methods for documentation that improve information sharing while safeguarding privacy interests.

Participants noted that guidelines for resolving confidentiality issues between chaplains and mental health professionals should recognize differences in the roles they play in different environments. For example, in DoD, participants noted that chaplains and mental health professionals work within the chain of command and have a primary responsibility within that command structure to assess and promote fitness for duty; in contrast, the primary responsibility for mental health and chaplaincy in VA is to address the health care needs of veterans, including mental health and spiritual needs.

Discussion

The results of this study indicate broad support for improving collaboration between chaplaincy and mental health to address the needs of service members and veterans. Confidentiality is considered an important incentive, particularly for service members, to seek assistance for mental health and substance abuse issues. The strict confidentiality associated with chaplaincy likely results in individuals seeking help for their problems from chaplains, who otherwise might not access any type of care.

Attempts to frame the issue of confidentiality for chaplains and clergy in the context of health care and mental health care have been made by institutions like the VA, military services of DoD, religious denominations, and legal scholars. The complexity of the issue, differing sets of guidance, and the results of this study suggest that understanding of confidentiality by chaplains and mental health professionals impacts how these disciplines work together for the benefit of the people they jointly serve. Participants in this study offered suggestions about how this relationship could be better structured to protect confidentiality, while providing appropriate care for service members and veterans. Elements of practice and culture made collaboration possible even when confidentiality concerns surfaced in the collaboration examples provided by participants. The majority of successful practices related to overcoming confidentiality barriers in the field were not reflected in official written policies. Instead, they were

most often associated with relationships and understandings that were worked out among individuals. This was the case in both VA and DoD environments. The results from this study revealed that collaborative team processes were generally negotiated and designed by the individuals working together, rather than being guided by accepted written policy that was consistent from facility to facility.

Collaborative practices within mental health care are well documented in the literature, but less is written about how mental health and chaplains collaborate successfully, particularly in military or VA contexts. Recommendations specifically for DoD contexts have included creation of general, shared principles for collaboration within military settings (F. C. Budd, 1999), obtaining written consent for chaplains to talk with health care professionals and creating policies to guide the collaborative interactions (Howard & Cox, 2008). The results of this study confirm that confidentiality for chaplains is considered very important by mental health and chaplains serving in DoD settings. It was valued, but emerged less often, in interviews with individuals serving in VA settings. This could be due to the relative homogeneity of the VA health care environments that chaplains work in and the uniformity of expectations for chaplain service within the veterans' health care system. Although DoD has general guidance in place, each military service also provides their own direction for chaplains. This guides how and where they are placed and serve, the degree of specialization offered (e.g., Army Family Life chaplains) and the type of service required to obtain promotions (e.g., deployment, operational service vs. clinical service). Within DoD, there may be differences between the environments at operational and hospital/clinic settings that have implications for confidentiality guidance; for example, forming interdisciplinary teams may be more common and part of the culture within medical facilities in which protocols have been developed for sharing information from electronic records. On the other hand, respondents reported more natural or organic collaboration between chaplaincy and medical or mental health personnel in remote operational and combat settings.

The common feature among all military services is the shared understanding that confidentiality between service members and chaplains

is absolute. This colors what DoD mental health expects from chaplains and how chaplains interface with mental health. Within VA settings, this is not a shared understanding, so there seems to be more variance in the way VA chaplains approach collaborative work with mental health professionals. It was not uncommon to find chaplains running spirituality groups within mental health units as part of a treatment protocol within the VA, or even providing one-on-one appointments within residential treatment or outpatient treatment settings. VA chaplains usually had additional certifications to prepare them for work in a clinical environment, but this was not as prevalent with the chaplains interviewed within military services, particularly for chaplains serving in operational settings. This could help explain why confidentiality as a theme was not as emergent in VA settings as it was in DoD.

Confidentiality between service members or veterans and chaplains was often framed as an ethical obligation by the chaplain interviewees. This reflected the assumption that service members and veterans expected all communication with chaplains and with mental health to be private, without expectations of collaboration between professions. In this study, the differing interpretations of this ethical obligation is revealed by the varied approaches to documentation taken by chaplains in both DoD and VA settings. Some chaplains document selected information in patient records they believe to be relevant to treatment team members, whereas others choose not to document at all. Loewy and Loewy (2007) presented an ethical argument for limiting chaplaincy access to patient records by noting that there was an expectation of privacy when patients opt to speak to a member of the clergy. The authors advocate for separate notes for chaplains that are kept outside the regular patient record. A counterargument presented by McCurdy (2012) noted that the Association of Professional Chaplains has included chaplain documentation standards to reflect the inclusion of hospital chaplains as true members of health care teams. He supports this role but contends that chaplain conceptions of privacy and confidentiality are likely to be influenced by their role in the clinical setting and their role as a member of the clergy.

Recommendations

Table 3 provides a summary of recommendations based on results from this study. The recommendations are structured in descending order of complexity, ranging from informational sessions to become better informed about the confidentiality requirements of each profession to establishing policy that is incorporated into the standards and training of both professions.

The issue of confidentiality complicates collaboration between mental health and chaplains. Potential solutions have been posed in the form of guidelines that can be incorporated in practice and policy for both chaplains (McCurdy, 2012) and mental health professionals (Van Liew, 2012). Both authors reference the need to carefully consider what is documented about interactions and educating the service recipient about the collaboration. Data from this study confirm those conclusions and support the idea that both mental health providers and chaplains would benefit from additional information and clarification about how rules governing communication with chaplains and health information privacy laws impact information sharing between professions. The question that seems to be at the heart of confidentiality concerns is whether or not chaplains can, or should be, official members of the mental health treatment team. If the answer is “yes,” what can, and should, chaplains be expected to share about their communications with patients? Con-

versely, how should mental health interact with and include chaplains on those teams? One potential solution is to create policies that guide these relationships. Another is to tailor training programs for chaplains to prepare them specifically to work with mental health professionals and populations with mental health problems. Mental health professionals should also be prepped with information about chaplaincy and their understanding of what is confidential and sacred communication. Both professional disciplines would benefit from a shared understanding of what it means to collaborate and serve on a multidisciplinary treatment team. The expectations of team membership, documentation, and sharing should be clear in policy and reflected in practice. Confidentiality may also be understood differently by the patients, so it may be beneficial in clinical environments to have clear guidance about obtaining patient consent for collaborative team treatment protocols, particularly in military service settings.

Two areas of future research are suggested by this study. First, it is important to assess perceptions of veterans and service members about the role of confidentiality in their decisions to see chaplains or mental health professionals. This will further inform or corroborate the findings of this study which explored only the perceptions of chaplains and behavioral health professionals. Second, this qualitative study suggests the need to more broadly survey chaplains and mental health professionals in the VA and

Table 3
Summary of Recommendations

#	Recommendations
1	Share VA and DoD training resources and platforms to enhance educational opportunities including opportunities to improve understanding about the confidentiality requirements for chaplaincy and mental health.
2	Create working teams to develop guidelines for sharing information between chaplaincy and mental health in DoD and VA healthcare environments. Guidelines should be tailored to the unique environments within which mental health professionals and chaplains work
3	Develop a learning collaborative to address integrated service delivery for chaplaincy and mental health. The results of the integration model should inform appropriate balances between information sharing and confidentiality and maximize the utility of information exchange
4	Codify clear policies in both DoD and VA related to sharing information across disciplines
5	Incorporate training on confidentiality guidelines in the graduate and continuing education professional training for each discipline
6	Conduct additional research on confidentiality including a comprehensive survey of mental health professionals and chaplains and an assessment of service member and veteran perspectives

Note. VA = Department of Veterans Affairs; DoD = Department of Defense.

DoD specifically about the issues related to confidentiality. This would create more generalizable information related to perceptions and potential solutions to barriers associated with confidentiality concerns.

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