Collaborating Across the Departments of Veterans Affairs and Defense to Integrate Mental Health and Chaplaincy Services

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BACKGROUND: Recognizing that clergy and spiritual care providers are a key part of mental health care systems, the Department of Veterans Affairs (VA) and Department of Defense (DoD) jointly examined chaplains' current and potential roles in caring for veterans and service members with mental health needs.

OBJECTIVE: Our aim was to evaluate the intersection of chaplain and mental health care practices in VA and DoD in order to determine if improvement is needed, and if so, to develop actionable recommendations as indicated by evaluation findings.

DESIGN: A 38-member multidisciplinary task group partnered with researchers in designing, implementing, and interpreting a mixed methods study that included: 1) a quantitative survey of VA and DoD chaplains; and 2) qualitative interviews with mental health providers and chaplains.

PARTICIPANTS: Quantitative: the survey included all full-time VA chaplains and all active duty military chaplains (n=2,163 completed of 3,464 invited; 62 % response rate). Qualitative: a total of 291 interviews were conducted with mental health providers and chaplains during site visits to 33 VA and DoD facilities.

MAIN MEASURES: Quantitative: the online survey assessed intersections between chaplaincy and mental health care and took an average of 37 min to complete. Qualitative: the interviews assessed current integration of mental health and chaplain services and took an average of 1 h to complete.

KEY RESULTS: When included on interdisciplinary mental health care teams, chaplains feel understood and valued (82.8–100 % of chaplains indicated this, depending on the team). However, findings from the survey and site visits suggest that integration of services is often lacking and can be improved.

CONCLUSIONS: Closely coordinating with a multidisciplinary task group in conducting a mixed method evaluation of chaplain-mental health integration in VA and DoD helped to ensure that researchers assessed relevant domains and that findings could be rapidly translated into actionable recommendations.

KEY WORDS: mental health; spirituality; patient centered care; veterans; implementation research.
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INTRODUCTION

Persons with mental health problems face an array of barriers that can prevent access to health care. Among these are issues of stigma,[1] low perceived need of care,[2] inadequate healthcare coverage,[3] socioeconomic and racial healthcare disparities,[4,5] general distrust of healthcare systems,[6] and regional shortages of trained mental health care providers. [7] Additionally, many patients interpret their psychosocial functioning through a broader lens than that offered by the traditional psychiatric diagnostic model, and may perceive that mental health providers do not share their values or worldview.[8,9] For these and other reasons, a significant proportion of persons with mental health problems seek help from clergy, chaplains, or other types of spiritual care providers.[10–13]

Spiritual care providers, such as chaplains, pastoral counselors, and clergypersons, are a key part of the U.S. mental health care system,[14] and they serve particularly unique roles in caring for many veterans and service members with mental health needs. Particularly in the military where fears persist about mental health treatment potentially leading to negative career repercussions or perceptions that one is weak,[15–20]

chaplains are often considered a safer, trusted, and more confidential option.[21,22] Veterans and service members may also seek out chaplains because chaplains are able to address salient spiritual dynamics related to depression, posttraumatic stress disorder (PTSD), and other common psychiatric problems. For instance, research suggests that PTSD severity, chronicity, and treatment seeking are often interwoven with issues of guilt,[23,24] forgiveness,[25,26] religious faith,[27–29] meaning and purpose,[27,30] and moral injury.[31–33]

Recognizing that chaplains can be an important part of the mental health care systems for veterans and service members, the Departments of Defense (DoD) and Veterans Affairs (VA) advanced a focus on chaplaincy as part of developing a large-scale, coordinated, cross-departmental vision for attending to the mental health needs of veterans and service members in the post-9/11 era. This effort, termed the VA/DoD Integrated Mental Health Strategy, started in November of 2010 and was designed to run for three years.[34] Chaplaincy was one of 28 different strategic focus areas. Hence, "integration" in the present study alludes to both cross-departmental VA/DoD collaboration and cross-disciplinary integration between mental health and chaplaincy.

Integration has been defined by a variety of healthcare organizations.[35–37] The present study took a broad view of integration consistent with the World Health Organization's definition as "a concept bringing together inputs, delivery, management and organization of services related to diagnosis, treatment, care, rehabilitation and health promotion."[37] While more specified models of integration have helped to advance the implementation of multi-disciplinary care practices in systems like VA,[38–41] a broader view was adopted in the present study because of the exploratory nature of the project and the extensive variance in contexts wherein mental health and chaplain work is practiced across VA and DoD. For instance, VA chaplains work in healthcare settings and provide care almost exclusively to patients with identified health problems, while DoD chaplains work mainly in non-healthcare settings where the focus is on maintaining a resilient, fully functioning, ready military force. VA typically determines chaplain staffing needs based on a medical center's size and complexity, and while this is generally consistent with staffing practices for military medical facilities, non-clinical military chaplain staffing is dependent on numerous variables, including number of service members in a command as well as the command's mission. Complexities such as these required a robust methodological approach. The current study used a mixed methods quantitative/qualitative design to evaluate the intersection of chaplain and mental health care practices in VA and DoD, with the final aim of developing an actionable set of recommendations for better integrating mental health and chaplain services.

METHODS

The present study was conceived as a gap analysis to examine the discrepancy between current practices in chaplaincy and mental health, and a future desired state. Current practices were illuminated via quantitative and qualitative data gathering methods, and the future desired state was defined in an iterative fashion through continuous engagement with key partners. Data collection efforts in the quantitative and qualitative arms of the study were approved by appropriate authorities within VA and DoD and relevant institutional review boards.

Partnered Study Design

National leadership for the VA/DoD Integrated Mental Health Strategy selected a core team of five mental health and chaplain personnel from VA and DoD to anchor the project on chaplains' roles in mental health. The core team then identified a task group consisting of 38 members: 17 from VA, 14 from DoD, and seven from external research and academic entities. Task group members came from various disciplines—chaplaincy, psychology, psychiatry, social work, medicine, and epidemiology—and served in a range of roles, representing leadership, research, clinical, and military operational perspectives.

Task group members were involved in the stages of study design, data collection, interpretation of results, development of recommendations, and implementation of recommendations. In addition, input from the task group was systematically solicited and recorded on four different occasions: 1) a two-day kickoff meeting; 2) a two-day multidisciplinary forum that included additional subject matter experts (n=71: 27 mental health professionals, 24 chaplains, 14 affiliated health care professionals, and six other); 3) two three-month sub-task groups focused on issues of documentation, assessment, and screening; and 4) a final two-day group meeting.

Quantitative Data Collection: VA/DoD Chaplain Survey

Survey Development. Following the task group kickoff meeting, a survey was drafted and 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. Revisions at this stage included making demographic questions less precise in order to further de-identify information, and placing a subset of questions deemed less essential in a "supplemental survey" to decrease the time burden of completing the "core survey."

Survey Sample. The sample frame included all full-time VA chaplains and all active duty DoD chaplains. Part-time VA chaplains and Reserve/National Guard chaplains were not included due to their distinctiveness (e.g., part-time VA chaplains often fulfill sacramental duties while not typically being "clinical chaplains" who would participate as part of

healthcare teams), as well as difficulties contacting these populations. DoD chaplains included active duty Army, Air Force, and Navy chaplains (Navy chaplains also support the Marine Corps and Coast Guard). Of the 585 VA chaplains who were contacted, 440 completed the survey (75 % response rate). Of the 2,879 DoD chaplains who were contacted, 1,723 completed the survey (60 % response rate). The high response rates may be partially attributed to participation being encouraged by VA and DoD chaplaincy leaders and task group members. Based on consultation with VA and DoD chaplaincy task group leadership regarding known demographic characteristics of VA and DoD chaplains, the survey samples appear to be generally representative.

Survey Measures. The core survey assessed the following domains: populations served by chaplains; chaplain work settings; chaplain work activities; interaction with mental health professionals; training needs and desires; additional professional activities; and demographics. The core survey required approximately 37 min to complete (M=36.80, SD= 18.11) Surveys were completed between November 2011 and April 2012.

Survey Analysis. The main survey comparisons presented in this report are between VA chaplains, DoD healthcare chaplains, and DoD non-healthcare chaplains. 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 three-group comparisons).

Qualitative Data Collection: VA/DoD Site Visits

Site Visits Development. A series of site visits to VA and DoD facilities were planned and designed based on preliminary findings from the VA/DoD Chaplain Survey, as well as

Table 1. Demographic Characteristics from the VA/DoD Chaplain Survey of Chaplains in Healthcare and Non-healthcare Settings, n =2,163*

Characteristics	VA Healthcare Chaplains (n=440)	DoD Healthcare Chaplains (n=164)	DoD Non-Healthcare Chaplains (n=1,269)	
No. (%)	p values	No. (%)	No. (%)	
Sex				< 0.001
Male	330 (82.9)	153 (93.9)	1,206 (96.1)	
Female	68 (17.1)	10 (6.1)	49 (3.9)	
Age				< 0.001
< 45 y/o	19 (4.8)	45 (27.8)	527 (42.1)	
45–64 y/o	274 (69.0)	117 (72.2)	719 (57.5)	
≥ 65 y/o	104 (26.2)	0 (0)	6 (0.5)	
Race				0.215
White	288 (73.1)	114 (71.7)	972 (79.5)	
Black	72 (18.3)	17 (10.7)	75 (6.1)	
Asian	13 (3.3)	13 (8.2)	85 (7.0)	
Other	13 (3.3)	9 (5.7)	62 (5.1)	
Multiple	8 (2.0)	6 (3.8)	28 (2.3)	
Education/Certification				
Doctoral degree	114 (28.2)	47 (28.7)	179 (14.2)	< 0.001
≥ 3 units of CPE	290 (71.8)	134 (82.2)	297 (23.6)	< 0.001
Board Certified Chaplain	197 (49.4)	37 (23.1)	309 (25.1)	< 0.001
≥ 20 years as chaplain	173 (42.9)	41 (25.0)	277 (21.8)	< 0.001
Religious Affiliation				< 0.001
Evangelical Protestant	105 (26.1)	64 (40.3)	678 (54.5)	
Mainline Protestant	119 (29.6)	46 (28.9)	244 (19.6)	
Catholic	83 (20.6)	10 (6.3)	102 (8.2)	
Historically Black Protestant	20 (5.0)	5 (3.1)	14 (1.1)	
Other	43 (10.7)	21 (13.2)	111 (8.9)	
Multiple	32 (8.0)	13 (8.2)	96 (7.7)	
Military Experience†				
Veteran/Service member	213 (53.6)	-	-	
Rank≥O4	109 (27.4)	109 (67.7)	678 (53.9)	
Iraq deployment	29 (7.3)	113 (69.3)	860 (67.8)	
Afghanistan deployment	24 (6.0)	66 (40.5)	401 (31.6)	
Deployed in combat zone	–	54 (32.9)	243 (19.1)	
Deployed in non-combat zone	–	49 (29.9)	139 (11.0)	

*CPE*Clinical Pastoral Education*

**** Percentages in the table are based on the total number of chaplains that responded to each question. 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. For the VA sample (n=440), missing data for the above variables ranged from 36 (8 %) to 46 (10 %) cases. For the DoD sample (n=1,723), 290 (17 %) chaplains did not answer the question about the setting in which they currently serve, and so are not included in the breakdown of healthcare and non-healthcare chaplains in DoD. Participants who indicated belonging to an infrequently endorsed racial or religious category were combined into the Other category, and those indicating belonging to more than one racial or religious category were included in the Multiple category***

†Veteran/Service member refers to any history of military service, past or present (e.g., Guard/Reserve). Rank refers to highest achieved rank for veterans and current rank for active duty. Iraq and Afghanistan deployment refers to any history, past or present, of serving as part of Operation Iraqi Freedom or New Dawn (Iraq) or Operation Enduring Freedom (Afghanistan). Deployed in combat zone/non-combat zone refers to current status at the time of completing the survey

guidance from the task group. Via interviews with mental health care providers and chaplains, the site visits aimed to identify factors that contributed to or detracted from the integration of chaplain services with mental health care services.

Site Visits Sample. There are 152 medical centers in VA,[42] 56 hospitals in the military health system,[43] and over 200 military bases within the U.S. From these, a total of 33 locations (17 VA, 15 DoD, and one joint facility) 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-mental health integration; 3) geographic location; and 4) facility type (e.g., large medical center, smaller outpatient clinic). Most site visit interviews were conducted individually (n=246) and some were conducted in small groups (n=45). The majority of interviews lasted 45–60 min. In VA, interviews with chaplains included chiefs of chaplains, hospital staff chaplains, and CPE supervisors and residents. In DoD, interviews with chaplains included supervisory and staff chaplains in DoD medical centers as well as supervisory and staff chaplains in operational commands. Interviews with mental health providers included psychologists, psychiatrists, social workers, psychiatric technicians, substance abuse treatment professionals, nursing, and general medical providers who treat patients with mental health problems.

Site Visits Measures. Interviewers were two Ph.D. and one Masters level researchers who in coordination with task group members developed a semi-structured interview template. Primary domains of inquiry included: characteristics of sites; characteristics and needs of the populations being served (i.e., veterans and service members); relationships between mental health and chaplaincy (i.e., description of formal and informal cross-disciplinary relationships, interactions, and awareness of other discipline); and models of interdisciplinary collaboration (i.e., description of communication practices, joint provision of care, referral and consult practices, and professional boundaries). Site visits were conducted between January 2012 and June 2012.

Site Visits Analysis. The unit of analysis was the interview (i.e., interviews conducted in a group format were treated as one interview). The above-described interviewers initially coded interviews using the constant comparative technique[44,45] to arrive at nine major thematic families, and then developed a more complete code book with 118 separate themes/codes. To establish inter-rater reliability, Randolph's free-marginal multi-rater *kappa*[46,47] was calculated for three rounds (five interviews per round). 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. The *kappa* score was periodically calculated, and any shift in reliability was addressed through review of coding disagreements. Free-marginal *kappa* scores ranged between 0.828 and 0.883 at five periodic testing points.

RESULTS

Quantitative Findings from the VA/DoD Chaplain Survey

Demographic characteristics of chaplains who completed the VA/DoD Chaplain Survey are presented in Table 1. Compared to chaplains in DoD, VA chaplains were more likely to be female (t=6.61, p< 0.001), older (t=27.52, p< 0.001), board

Table 2. Inclusion of Healthcare Chaplains on Clinical Teams and Chaplains' Perceptions of Whether Teams Understand and Value the Chaplain's Role

Clinical Team	Member of Clinical Team			Feel Understood and Valued		
	VA Healthcare Chaplains (n=440)	DoD Healthcare Chaplains (n=164)		VA Healthcare Chaplains	DoD Healthcare Chaplains	
	No. (%)	No. (%)	p value	No. (%)	No. (%)	p value
Inpatient medical/surgical team	230 (53.2)	84 (51.2)	0.818	215 (93.5)	81 (96.5)	0.108
Inpatient psychiatric/mental health team	203 (47.0)	63 (38.4)	0.087	186 (92.1)	56 (88.9)	0.830
Substance use clinic team	148 (34.3)	38 (23.2)	0.009	141 (95.2)	36 (94.7)	0.901
PTSD clinic team	103 (23.8)	36 (22.0)	0.706	100 (97.1)	33 (91.6)	0.157
Outpatient mental health clinic team	91 (21.1)	43 (26.2)	0.162	87 (96.7)	39 (92.8)	0.506
OEF/OIF clinic team	84 (19.4)	35 (21.3)	0.537	79 (95.2)	34 (97.1)	0.626
Other mental health related team	83 (19.2)	29 (17.7)	0.740	74 (89.2)	24 (82.8)	0.894
Women's health clinic team	39 (9.0)	15 (9.1)	0.914	39 (100.0)	15 (100.0)	0.184
TBI clinic team	31 (7.2)	24 (14.6)	0.013	27 (87.1)	22 (91.6)	0.606
None	68 (15.7)	35 (21.3)	0.107	–	–	–

OEF/OIF Operation Enduring Freedom/Operation Iraqi Freedom; PTSD posttraumatic stress disorder; TBI traumatic brain injury
Respondents were first asked to select the clinical settings "in which you as the chaplain are included as a member of the care team." Only if respondents indicated being a member of a clinical team were they then asked to indicate their agreement with feeling that the team "understands and values my role as a chaplain." Percentages in the table are based out of the total number of chaplains that responded to each question. For the VA sample (n= 440), eight (2 %) chaplains did not answer the question about being a member of a clinical team, and missing data for the question about feeling understood and valued ranged from zero (0 %) to one (1 %) cases. For the DoD healthcare chaplain sample (n= 164), no (0 %) chaplains did not answer the question about being a member of a clinical team, and missing data for the question about feeling understood and valued ranged from zero (0 %) to one (1 %) cases.

certified (t=8.73, p< 0.001), to have at least 20 years of experience as a chaplain (t=6.84, p< 0.001), and to identify their religious affiliation as something other than evangelical Protestant (t=6.27, p< 0.001). Taking healthcare chaplains as a group (all VA chaplains plus DoD chaplains in healthcare settings), they were more likely than DoD chaplains in non-healthcare settings to hold a doctoral degree (t=5.69, p< 0.001) and to have at least three units of clinical pastoral education (t=25.90, p< 0.001).

Healthcare chaplains in VA and DoD were highly similar in terms of the clinical teams to which they belong and their perceptions of being valued on these teams. Healthcare chaplains in both VA and DoD were most likely to be members of an inpatient medical or surgical team (52.2 % are members in VA; 51.2 % in DoD), followed by the inpatient mental health team (46.1 % in VA; 38.4 % in DoD). When chaplains were members of a clinical team, they largely indicated feeling that the team understood and valued their role, with between 87.1 % and 100 % of VA chaplains and 82.8 % and 100 % of DoD healthcare chaplains indicating this for the nine different clinical teams listed (see Table 2).

When asked about the frequency and manners of engagement with mental health professionals, DoD non-healthcare chaplains were significantly less likely than healthcare

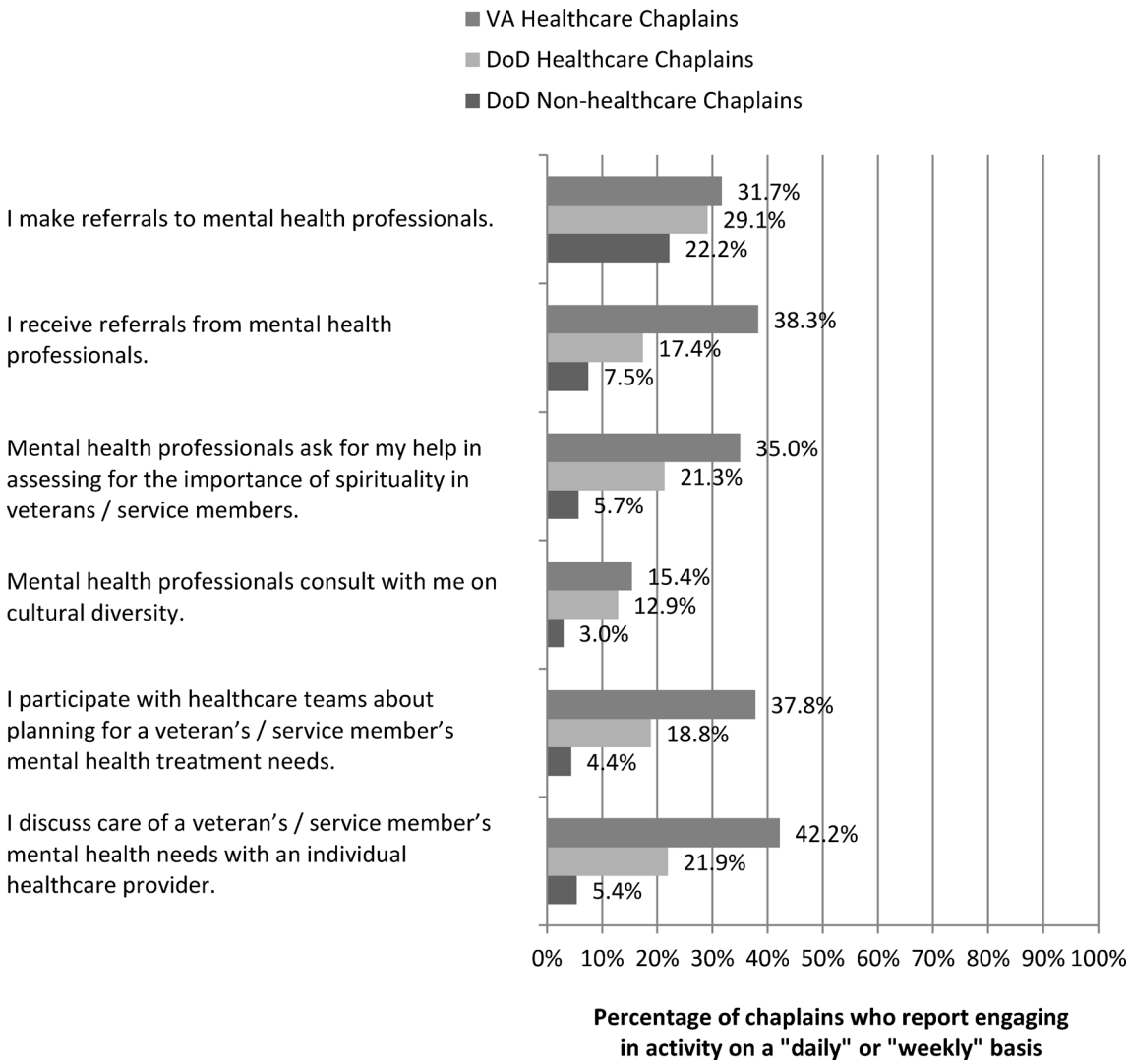

Figure 1. Frequency of chaplains' engagement with mental health in different activities scale options were: never; less than monthly; monthly; weekly; daily or almost daily. Percentages in the table are based out of the total number of chaplains that responded to each question. For the VA sample (n=440), missing data for the above variables ranged from 26 (6 %) to 30 (7 %) cases. For the DoD healthcare chaplain sample (n=164), missing data for the above variables ranged from nine (5 %) to ten (6 %) cases. For the DoD non-healthcare chaplain sample (n=1,269), missing data for the above variables ranged from 91 (7 %) to 98 (8 %) cases. DoD chaplains in non-healthcare settings were significantly less likely (p<0.001) than VA or DoD healthcare chaplains to engage in all of the above listed activities with mental health except for making referrals. VA chaplains were significantly more likely (p<0.001) than DoD healthcare chaplains to receive referrals from mental health professionals, have mental health professionals ask for help in assessing the importance of spirituality, participate with healthcare teams about planning for a veteran's mental health treatment needs, and discuss care of a Veteran's mental health needs with an individual health care provider.

chaplains in VA and DoD to engage with mental health in a variety of ways (see Fig. 1). In general, Figure 1 indicates that a relatively limited number of chaplains are regularly engaging with mental health professionals around activities such as exchanging referrals and collaboratively participating in treatment planning.

Qualitative Findings from the VA/DoD Site Visits

Demographic characteristics from the VA/DoD site visits are presented in Table 3. Because some interviews were conducted individually and some in a group format, demographics are displayed both at the level of the interview (the unit of analysis used for coding purposes) and at the level of individual interviewees. Interviews were approximately evenly split between VA and DoD, as well as between chaplains and mental health care providers. Of the 94 chaplains interviewed in DoD, 55.3 % were in non-healthcare settings, 38.3 % were in healthcare settings, and 6.4 % were Family Life Center chaplains (an outpatient pastoral counseling setting).

Overall, chaplains and mental health professionals in VA and DoD noted many of the same themes in the interviews (see Figs. 2 and 3). Both disciplines frequently noted that effective integration of services often hinges on the existence of good professional relationships. As one VA chaplain stated, "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 overnight." Mental health professionals and chaplains also 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. As a DoD chaplain said, "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."

Table 3. Demographic Characteristics from VA/DoD Site Visit Interviews and Interviewees

Interview Characteristics (n=291)		Interviewee Characteristics (n=396)	
	No. (%)		No. (%)
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)

NOSNot Otherwise Specified (This includes DoD personnel working in settings that combine military branches, e.g., Walter Reed); USMC United States Marine Corps

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 (see Interview Characteristics column). 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

DISCUSSION

Pairing intensive guidance and input from a multidisciplinary 38-member task group with the collection of extensive quantitative and qualitative data resulted in a rich understanding of the intersection between chaplaincy and mental health care in VA and DoD. Findings from the survey and site visits suggest that while VA chaplains, DoD healthcare chaplains, and DoD non-healthcare chaplains are distinct in a number of ways, chaplains from both departments frequently care for veterans and service members with mental health needs[21] and can function as important members of integrated care teams. Survey results indicate that when VA and DoD chaplains serve as members of integrated healthcare teams, they overwhelmingly feel that their role is understood and valued by the rest of the team.

However, survey and site visits findings also indicate awareness from both mental health care providers and chaplains that integration of services is often lacking. Encouragingly, providers across the spectrum generally displayed an openness to and interest in further integrating services. Regardless of departmental (VA/DoD) or disciplinary (chaplain/mental health) affiliation, the most common themes to emerge from site visit interviews focused on the disciplines needing to become more familiar with one another. Enhancing familiarity is likely to dispel many fears or misconceptions that the disciplines may have about one another, such as that negative perceptions of the other discipline and "turf" concerns prevent integration, a theme much more frequently noted in interviews with chaplains than mental health providers. Indeed, rather than feeling protective of mental health turf, one of the most frequent themes from interviews with mental health providers was that chaplains could benefit from training in evidence-based psychotherapies (importantly, many such statements qualified which psychotherapeutic approaches might be appropriate and not appropriate).

The present evaluation has a number of limitations, including that direct input from veterans and service members was not obtained, that mental health providers had input in the site visits but not in quantitative surveys, and that recommendations remain to be evaluated. Some of these limitations are being addressed in ongoing implementation work.

From Evaluation to Implementation

A key reason for partnering with the various stakeholders and subject matter experts involved in the current project was to increase the potential for rapidly translating research findings into actionable recommendations. A holistic consideration of study findings in conjunction with task group members' input helped produce the following three recommendations: 1) develop an intensive mental health certification training program to equip select VA and DoD chaplains to more effectively operate in mental health settings, collaborate with mental health providers, and care for those with mental health problems; 2) conduct a learning collaborative that brings together motivated teams of chaplain and mental health representatives to use systems redesign principles for implementing interdisciplinary practices; and 3) share VA and DoD training resources to provide broad-based, cross-disciplinary training opportunities.

These recommendations are currently being implemented with support from a VA/DoD Joint Incentive Fund grant. Early indications suggest that efforts are helping to enhance cross-disciplinary understanding. Training chaplains in appropriate, evidence-based psychotherapeutic modalities in a manner that

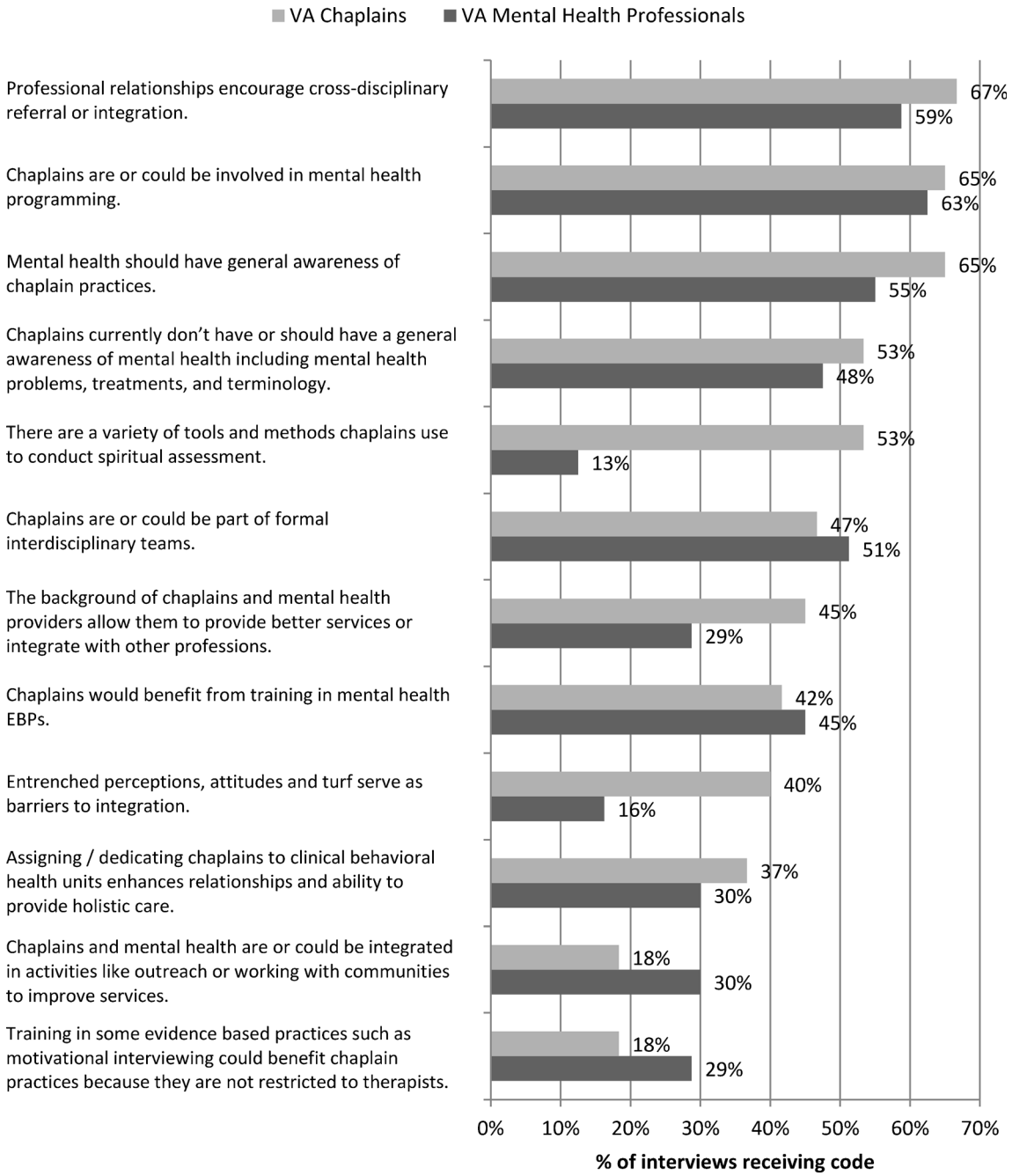

Figure 2. Common themes from VA site visit interviews. EBP=evidence-based psychotherapy. The top ten most frequently received codes for VA chaplains (n=60) and for VA mental health professionals (n=80) are included in this graph.

retains pastoral identities is important, given the barriers to mental health care that exist for many veterans and service members, such as fear than information will not remain confidential or that one will be perceived as weak. Whatever the reason for turning to a chaplain, veterans and service members need chaplains who can effectively address psychosocial problems that are within the chaplain's scope of practice and who can knowledgeably and efficiently refer to professional mental health services when needed. Conversely, veterans and service members need mental health professionals who understand what chaplains can offer and who can make appropriate referrals when indicated. Current systems redesign efforts

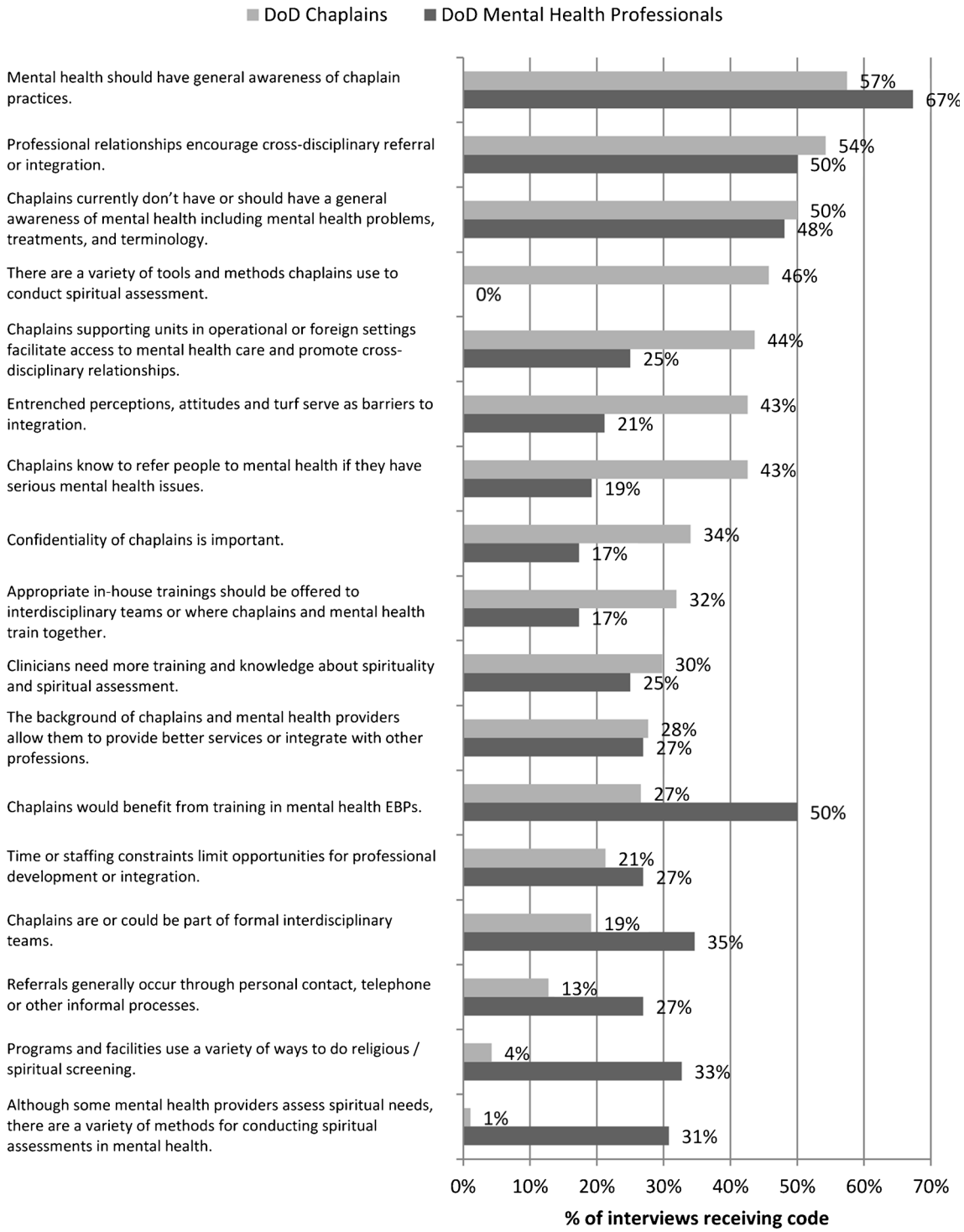

Figure 3. Common themes from DoD Site Visit Interviews EBP=evidence-based psychotherapy. The top ten most frequently received codes for DoD chaplains (n=94) and for DoD mental health professionals (n=52) are included in this graph.

provide a model and suggestions for improving integrated care practices (e.g., via improved cross-disciplinary procedures for screening, referrals, documentation, assessment, and communication), while allowing precise determination around scopes of practice and processes for cross-disciplinary collaboration to be informed by the unique characteristics of local facilities.

Partnered Evaluation: Challenges and Benefits

Coordinating efforts across multiple agencies is often difficult. There can be challenges navigating differences with respect to agencies' internal processes, authority structures, reporting requirements, values and priorities, target populations (e.g., veterans vs. service members), funding structures, domains of expertise, methods for motivating employees, and desires to collaborate. Yet, there are benefits to conducting research in close coordination with multiple partners. First, coordinating with partners can allow organizations to take advantage of previously unrecognized synergies and efficiencies. Second, engaging diverse partners can inspire constructive challenging of traditional assumptions and methods, whether those of a discipline, organization, or work group. Third, developing true partnerships creates avenues of communication and understanding that may stimulate creative endeavors beyond the originally conceived project.

Last, and most important, involving partners helps prevent research efforts from being squandered. Closely coordinating with task group members helped us ensure that we asked relevant questions in our survey and site visits. In addition, rapidly translating study findings into recommendations has allowed us to retain engagement from a significant proportion of stakeholders, thus promoting more effective and large-scale implementation. Not all health research ought to be highly partnered, as independent efforts certainly have important advantages, but spanning the research–practice divide to ensure optimal patient care requires partnership at some point.

The views expressed in this article are those of the authors and do not necessarily reflect the position or policy of the Department of Veterans Affairs, or the US government, or other affiliated institutions.

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