Chaplaincy-Mental Health Collaboration: Experiences, Discoveries, and Practical Suggestions

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Learning Objectives

1. Describe how systems redesign principles can be used to integrate mental health and chaplain services.

2. Identify six specific areas for improving the integration of spiritual and mental health care.

3. Develop an individualized approach for systematically integrating chaplaincy with mental health care.
Presentation Outline

I. Background and Rationale

II. Mental Health and Chaplaincy Learning Collaborative
   I. Methodology
   II. Findings

III. Recommendations and Conclusions
Background & Rationale
Why Integrate Mental Health and Chaplain Services?

- People who are suffering turn to clergy and/chaplains.¹,²

- Spirituality and mental health are related in meaningful ways, with particularities for service members and veterans.³,⁴

- Integration between mental health and chaplaincy is suboptimal, and much remains to be done.

References:
Recent History of Mental Health and Chaplaincy Integration across VA and DoD

**Survey**
- **(N = 2,163)**

**Site Visits**
- **(N = 33 sites)**

**Task Group**
- **(N = 38)**

**VA/DoD Integrated Mental Health Strategy (IMHS) Final Report:**

**VA/DoD Joint Incentive Fund (JIF) Final Report:**

**MHICS**
- **(N = 40)**

**Learning Collaborative**
- **(N = 14 sites)**

**Broad Education**
IMHS Methods

- **Quantitative: VA/DoD Chaplain Survey**
  - Assessed chaplain practices with respect to spiritual and mental health care
  - $M = 42$ minutes to complete
  - Response rates: 75% in VA ($n = 440 / 585$); 60% in DoD ($n = 1,723 / 2,879$)

- **Qualitative: VA/DoD Site Visit Interviews**
  - Facilities: 17 VA; 15 DoD; 1 Joint
  - Providers: 201 mental health; 195 chaplains

- **Task Group (n = 38)**
  - Employer: 17 VA; 14 DoD; 7 external
  - Professions: chaplaincy; psychology; psychiatry; social work; epidemiology; other
Perceived Understanding

- I understand the work that is done by mental health professionals.
- Mental health professionals understand spiritual work that is done with Veterans/SMs.

Perceived Valuing

- I value the role of mental health professionals.
- Mental health professionals value my role as a chaplain.

[Bar charts showing the percentage of agreement for VA, DoD HC, and DoD Non-HC for both perceived understanding and valuing.]
## IMHS Chaplain Survey: Routes to Care

<table>
<thead>
<tr>
<th>Route to Care</th>
<th>VA n (%)</th>
<th>DoD n (%)</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Veterans/SMs come to me on their own without referral.</td>
<td>295 (68%)</td>
<td>1,511 (89%)</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>I go to Veterans/SMs without them being referred to me.</td>
<td>372 (85%)</td>
<td>1,080 (64%)</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Veterans/SMs are referred to me by other professionals / their commanding officers.</td>
<td>268 (62%)</td>
<td>627 (37%)</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Veterans/SMs are referred to me by their fellow Veterans/SMs.</td>
<td>154 (36%)</td>
<td>803 (47%)</td>
<td>&lt;.001</td>
</tr>
<tr>
<td>Veterans/SMs are referred to me by non-Veteran/SM family or friends.</td>
<td>75 (17%)</td>
<td>266 (16%)</td>
<td>.731</td>
</tr>
</tbody>
</table>
IMHS Chaplain Survey: Referrals

• Chaplains making referrals to mental health
  o VA: 43% reported rarely (less than monthly or never)
  o DOD: 37% reported rarely

• Chaplains receiving referrals from mental health
  o VA: 36% reported rarely
  o DOD: 74% reported rarely
IMHS Site Visit Findings:
Common Themes from Interviews

Most common themes* to arise from interviews with chaplains and mental health professionals:

- Mental health should have general awareness of chaplain practices.
- Professional relationships encourage cross-disciplinary referral and integration.
- Chaplains currently don’t have or should have a general awareness of mental health.
- Chaplains would benefit from training in mental health evidence-based practices.

* Themes were systematically identified using a grounded theory approach following completion of interviews with 396 chaplains & mental health professionals in DoD & VA. Of the 122 themes ultimately coded for, these were among the most common.
### IMHS Task Group Input: Barriers & Solutions

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

Mental Health and Chaplaincy Learning Collaborative Methods
Using the Learning Collaborative Process to Integrate Mental Health and Chaplaincy: Systems Redesign Rationale

- Learning collaboratives have been used in healthcare since the mid-1990s to encourage improvement in care processes.
  - Based on concepts of lean management – engineering and management principle aimed at getting from current care processes to desired future care processes
  - Used to clarify the process of caring for patients (e.g., how to screen and refer appropriate patients between clinical services)
  - Utilizes local teams of clinical and administrative stakeholders who understand how things are done at their own treatment facilities
Learning Collaborative: Rationale and Process

Participants

Select Topic

Planning Group

Pre-work

Time for setting aims, allocating resources, preparing baseline data leading to the first 2 day meeting (Learning Session - LS 1).

Identify Change Concepts

LS* 1

LS 2

LS 3

*LS = Learning Session

Action period 1: adapt and test the ideas for improved system of care

Action period 2: further develop the system of care at the pilot site and spread the system to other sites &/or practitioners

Action period 3: further develop the sustain and spread

Supports

E-mail  Visits  Phone  Assessments  SharePoint  Team Reports
I. Establish chaplains as collaborators within models of integrated mental health care.

II. Improve reliability, efficiency, and usefulness of care processes by sharing information about strong practices across sites.

III. Increase timely, reliable, bidirectional access to chaplain and mental health services for Veterans and Service members with PTSD and mental health problems.

IV. Establish participating facilities as resources for other sites seeking to better integrate mental health and chaplain services.

V. Contribute to the optimization of health system performance as delineated by VA Triple Aims and DOD Quadruple Aims.

Mental Health and Chaplaincy Learning Collaborative Site Locations

Participating VA Facilities:
- V1 = Cheyenne VA Medical Center, Cheyenne Vet Center, Cheyenne, WY & Ft. Collins Vet Center, Ft. Collins, CO
- V2 = Louis Stokes Cleveland VA Medical Center, Cleveland, OH
- V3 = VA North Texas Health Care System, Dallas, TX
- V4 = Richard L. Roudebush VA Medical Center, Indianapolis, IN
- V5 = VA Pittsburgh Health Care System, Pittsburgh, PA
- V6 = South Texas Veterans’ Health Care SystemSan Antonio, TX
- V7 = James A. Haley Veterans’ Hospital, Tampa, FL

Participating DoD Facilities:
- D1 = Naval Hospital, Pensacola, FL
- D2 = Naval Hospital, Camp Lejeune, NC
- D3 = Naval Medical Center, San Diego, CA
- D4 = Army Ft. Belvoir Community Hospital, Ft. Belvoir, VA
- D5 = Army Southern Regional Medical Command, San Antonio, TX
- D6 = Army Pacific Region Medical Center, Tripler, Honolulu, HI
- D7 = Air Force Joint Base, San Antonio, TX
Site selection
December 2013 – February 2014*

Pre-work
March 10 – April 7, 2014*

Learning Session #1
April 8-9, 2014*

Learning Session #3
October 28-29, 2014

Action Period #1
April 10 – July 21, 2014*

Action Period #2
July 24 – October 27, 2014

Action Period #3
October 30, 2014 – February 13, 2015*

Sustain & Spread

*DoD teams were delayed in joining the collaborative and therefore had later dates of participation for aspects of the collaborative.
Learning Session #1 Aims: Patient Flow

Screening:
- Evaluate current practices for screening patients for spiritual and mental health issues, with the intention of strengthening existing practices and/or implementing new research-informed screening practices where none exist.

Referrals:
- Strengthen and/or develop clearly articulated processes for referring patients between disciplines, including processes to contact the other discipline, communicate the core issue, articulate a basic care plan, and close the loop.
Learning Session #2 Aims: Professional Practices

Assessment:
- Develop, improve, and / or ensure standardized use of multidimensional spiritual and mental health assessments that can contribute to making effective referrals and to providing relevant healthcare information to the other discipline.

Communication & Documentation:
- Establish regular communication practices, ideally as part of recurring integrated care team meetings, and document care and consults in a useful manner to the other discipline (at facilities where chaplain documentation of care is expected).
Learning Session #3 Aims: Interdisciplinary Relationships

Cross-Disciplinary Training:
- Champion cross-disciplinary training opportunities, at a minimum to inform colleagues about the aims of and rationale for this learning collaborative.

Role Clarification:
- Develop a better understanding of chaplain and mental health provider roles, culminating in the development of formal documentation of how mental health and chaplain services collaborate (e.g., care coordination agreement).
Mental Health and Chaplaincy Learning Collaborative Findings
Mental Health and Chaplaincy Learning Collaborative: Team Focus Areas

PDSA Activities for All Teams by Learning Collaborative Aim (as of last reporting period)

- Screening: 17
- Standardized Referral Process: 17
- Communication & Documentation: 13
- Assessment: 3
- Role Clarification: 17
- Cross-Disciplinary Training: 9

Legend:
- Green: Patient Flow
- Red: Professional Practices
- Blue: Interdisciplinary Relationships

PDSA = Plan, Do, Study, Act Cycle
Last reporting period was 4/1/2015.
Sample Flow Map: “Current State” (pre-collaborative)

<table>
<thead>
<tr>
<th>Metric</th>
<th>Baseline</th>
<th>Target</th>
</tr>
</thead>
<tbody>
<tr>
<td>80% of MH providers will receive orientation / education regarding pastoral care / services</td>
<td>0%</td>
<td>80%</td>
</tr>
<tr>
<td>Increase pastoral care consults entered by MH Trauma Service providers to Chaplain Service</td>
<td>1.33/month</td>
<td>3/month</td>
</tr>
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</table>
Sample Flow Map:
“Future State” (post-collaborative)

<table>
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<td>1.33/month</td>
<td>3/month</td>
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The relevant aims for this team were:

Aim #3 – Establish a formal screening process for active duty from mental health to chaplaincy that screens at least 80% of patients who present. Aim #4 – Establish a formal screening process from chaplaincy to mental health that screens at least 80% of patients who present.
Chaplain provided in-service to mental health providers in June, after which consults significantly increased.
Sample Screening Results

PCT Patient Response to Consult with Chaplain
(of those who screen positive for pastoral care)

<table>
<thead>
<tr>
<th>Patient Intake Month</th>
<th>% of Patients - Accepted</th>
<th>% of Patients - Declined</th>
<th>% of Patients - Deferred</th>
</tr>
</thead>
<tbody>
<tr>
<td>2014-06</td>
<td>30%</td>
<td>40%</td>
<td>30%</td>
</tr>
<tr>
<td>2014-07</td>
<td>31%</td>
<td>63%</td>
<td>6%</td>
</tr>
<tr>
<td>2014-08</td>
<td>13%</td>
<td>75%</td>
<td>13%</td>
</tr>
<tr>
<td>2014-09</td>
<td>24%</td>
<td>59%</td>
<td>18%</td>
</tr>
<tr>
<td>2014-10</td>
<td>22%</td>
<td>61%</td>
<td>17%</td>
</tr>
<tr>
<td>2014-11</td>
<td>15%</td>
<td>54%</td>
<td>15%</td>
</tr>
<tr>
<td>2014-12</td>
<td>38%</td>
<td>38%</td>
<td>25%</td>
</tr>
</tbody>
</table>

Legend:
- Accepted
- Declined
- Deferred
Learning Collaborative Key Results: Chaplain Perceptions

VA and DoD Chaplains' Perceptions of Mental Health-Chaplain Integration

<table>
<thead>
<tr>
<th>Area</th>
<th>Pre</th>
<th>Post</th>
</tr>
</thead>
<tbody>
<tr>
<td>I use a routine process to identify patients that could benefit from mental health services</td>
<td>63.3</td>
<td>64.2</td>
</tr>
<tr>
<td>I make frequent referrals to mental health.</td>
<td>43.8</td>
<td>63.5</td>
</tr>
<tr>
<td>I make appropriate referrals to mental health.</td>
<td>30.3</td>
<td>81.3</td>
</tr>
<tr>
<td>I receive frequent referrals from mental health.</td>
<td>38.8</td>
<td>52.6</td>
</tr>
<tr>
<td>I receive appropriate referrals from mental health.</td>
<td>51.9</td>
<td>54.0</td>
</tr>
<tr>
<td>I regularly communicate with mental health to improve patient care.</td>
<td>67.5</td>
<td>86.0</td>
</tr>
<tr>
<td>I have a clear understanding of how mental health and chaplain services can collaborate</td>
<td>46.7</td>
<td>59.2</td>
</tr>
<tr>
<td>I have opportunities for joint training with mental health when appropriate</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Areas of Key Aims Before and After Learning Collaborative
Learning Collaborative Key Results:
Mental Health Perceptions

VA and DoD Mental Health Providers' Perceptions
of Mental Health-Chaplain Integration

% Agree/Strongly Agree

- I use a routine process to identify patients that could benefit from chaplain services.
- I make frequent referrals to chaplains.
- I make appropriate referrals to chaplains.
- I receive frequent referrals from chaplains.
- I receive appropriate referrals from chaplains.
- I regularly communicate with chaplains to improve patient care.
- I have a clear understanding of how mental health and chaplain services can collaborate.
- I have opportunities for joint training with chaplains when appropriate.

Areas of Key Aims Before and After Learning Collaborative
Change Effort Accomplishments

- Zero agreements were in place before the collaborative; by the end, agreements were completed or in progress for 6 of 7 VA teams and 7 of 7 DoD teams.

- All teams provided/planned for educating mental health about chaplaincy and/or spirituality, and vice versa (i.e., MH→CH).

- All hospital-based teams implemented specific screening questions to be used in mental health clinics to assess potential need for referral to chaplaincy.
  - New specific process for mental health to make referral to chaplaincy were developed at 12 of 13 hospital-based team sites.

- New implementation of chaplains’ screening for mental health issues was completed at 4 of 7 DoD teams and no VA teams (appropriate due to setting characteristics).
  - New process for chaplains to refer to mental health developed and implemented at 3 of 7 DoD sites and 1 of 6 VA sites.
Recommendations and Conclusions
Learning Resources: Team Experiences

- Videos available on program website:
  - www.mirecc.va.gov/MIRECC/mentalhealthandchaplaincy/
  - Or Goggle “Mental Health and Chaplaincy”

Click on this to access learning collaborative videos
Click on this to access other videos
Recommendations

1. Map and understand the current process for screening / referring / communicating about patients between disciplines.

2. Enhance awareness of roles.

3. Develop a service agreement.
Recommendation #1: Map the Current Process

• **Description:**
  - Identify and write down the who, what, where, when and how
  - Mental health and chaplaincy identify, refer, and communicate concerning patients that may benefit from receiving care from each service
  - Process map/description should be submitted to ____.
  - Update and submit every two years.

• **Supporting findings:**
  - All participating facilities successfully mapped current processes and utilized information to improve processes of care.
  - All facilities were able to implement quality improvement processes based on understanding of current state.
Recommendation #2: Enhance Awareness of Roles

- **Description:**
  - On a recurring basis that is appropriate based on characteristics of the setting, chaplains and mental health professionals provide education to one another about what their disciplines do and can offer to patients.
  - Educational materials are available from VA Mental Health and Chaplaincy (see website for select materials) to assist in this process.

- **Supporting findings:**
  - Teams at all participating facilities conducted education activities between chaplaincy and mental health.
  - Both chaplains and mental health providers evidenced facility-level improvements in understanding how to collaborate with the other discipline (i.e., changes implemented by teams spread to the larger facility).
Recommendation #3: Develop a Service Agreement

• Description:
  o For MH&C collaborative, service agreements were 1-2 page documents generally signed by heads of mental health services and chaplain services to address topics including:
    ▪ Identifying spiritual needs among patients in mental health settings (and vice versa).
    ▪ Facilitating access to chaplain services for newly enrolled patients in mental health (and vice versa).
    ▪ Ensuring multidisciplinary awareness between mental health and chaplain services.

• Supporting findings:
  o Teams at 13 of the 14 participating sites were able to complete a service agreement.
  o See next slide for example.
Service Agreement Example

Mental Health and Chaplaincy Integration Service Agreement

Purpose
To facilitate the provision of patient-centered, holistic care to active members newly enrolled in Mental Health (MH) through the availability of pastoral care which is, where possible, integrated into the patient’s MH treatment milieu.
To facilitate improved identification of need/desire for and access to pastoral care for active duty members engaged in MH treatment.
To improve the multidisciplinary understanding of and fluency with care provided by collaborating disciplines.

Implementation
MH Service
Promote and foster understanding of pastoral care’s complimentary potential among staff.
Provide, as needed, staff education in service of the above.
Welcome and integrate chaplains to MH clinics and teams as allowed by chaplain staffing (or other) restraints.
Where possible, integrate into team assessments screening of potential need for (and the service member’s interest in) pastoral care.

Chaplain Services
As allowed by staffing, chaplains will be integrated into MH clinics and will serve as a part of an interdisciplinary team in consultative capacity.
Chaplains will assist MH service in providing education and training to staff regarding the nature and value of pastoral care for interested active duty members and the manner in which it can be integrated into MH treatment.
Chaplains will work to maintain contact and, after release is signed by member, include the member’s Command Chaplain as part of the Chaplaincy team. However, this will be done only if member explicitly asks for their Command Chaplain to be included and a release has been signed noting what information is to be disclosed.

Referrals
Active duty members will, as possible, be screened for need for and interest in pastoral care.
Active duty members who endorse a desire to obtain pastoral care will be referred to Chaplain Services via an email consult request and a signed release of information.
Active duty members received via consult will be scheduled and seen by Chaplain Services, with feedback to the team or clinic being provided as appropriate to patient’s concern over confidentiality within the team and by the need to integrate care in service of the service member’s recovery goals.

This service agreement will be reviewed annually by MH and Chaplain Services.

Initiated: [date]  Last Reviewed: [date]

_____________________________  __________________________
[name]                       [name]
Department Head, Mental Health  Command Chaplain
Conclusions

- Because in many locations there is a substantial gap between mental health and chaplain services, improvement efforts in many places may need to focus first on establishing basic building blocks before moving on to making improvements in other domains.

- Global recommendations for integrating mental health and chaplain services must be able to accommodate variations in the local characteristics and capacities of different facilities and providers.

- Patients (including service members and veterans) commonly endorse having mental and spiritual problems when asked, and continued efforts are merited with respect to further developing and refining approaches to screening, referrals, and treatment.
Questions?

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