

Developing Innovation in Spiritual Care Education: Research in Primary Health and Social Care

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January 2013

ACKNOWLEDGEMENTS AND THANKS

We would like to thank the many people who have made this research both possible and successful. Without their hard work we would have had no data on which to base the findings, nor recommendations, of this research.

We are grateful for the good will and honesty of all healthcare chaplains, and especially those who helped devise the Assets Framework, and for the willingness of the health and social care practitioners who readily gave their time so that we could include their perspective.

The steering group, which included Ewan Kelly, Isabel Smyth, Wilma Reid, Jane Cantrell and Sandra Falconer, has been both challenging and supportive: pointing us in the direction of useful people to talk to, helping us to develop lines of inquiry and commenting on the draft report. Anne Richardson has given us invaluable administrative back-up throughout.

We remain responsible for the drafting of this report and any errors or omissions.

CONTENTS

Executive Summary

1	Background	9
2	Methodology	10
3	The Context of Health and Social Care	11
3.1	<i>Person Centred</i>	11
3.2	<i>Prevention</i>	12
3.3	<i>Assets Approaches to Health Improvement</i>	12
4	How does spiritual care promote health and wellbeing?	13
5	What do Chaplains do to promote Spiritual Care?	14
6	Developing the Assets Based Approach to Spiritual Care Framework	16
6.1	<i>Spiritual Health of Individuals</i>	16
6.2	<i>Spiritual Health of Communities</i>	18
6.3	<i>Spiritual Health of Organisations</i>	20
7	What do other health and social care practitioners do to promote spiritual care?	21
7.1	<i>Individual</i>	21
7.2	<i>Community</i>	22
7.3	<i>Organisational</i>	22
8	Research Evidence	23
8.1	<i>Social Capital interventions and outcomes</i>	23
8.2	<i>Meaning Making Interventions</i>	23
8.3	<i>The Lothian Chaplaincy: Patient Reported Outcome Measure (PROM)</i>	24
8.4	<i>Community Chaplaincy Listening: Phase 2 Evaluation</i>	24
8.5	<i>Scottish Borders Stroke Study</i>	25
8.6	<i>Making Use of Evidence</i>	25
9	Ideas for Collaborative Research	26
9.1	<i>What is different about the way chaplains provide spiritual care?</i>	26
9.2	<i>Listening</i>	26
9.3	<i>Developing Spiritually Resilient Communities</i>	27
9.4	<i>Working with faith communities</i>	28
9.5	<i>Development of organisational spirituality</i>	28
10	Learning and Development Needs of Chaplains	29
10.1	<i>New role</i>	29
10.2	<i>Organisational Development Training</i>	30
10.3	<i>Values Based Reflective Practice</i>	30
10.4	<i>Understanding of the context in which health and social care practitioners work particularly in relation to assets based approaches to health improvement</i>	31
10.5	<i>Competency Framework</i>	32
11	Learning and Development Needs of Health and Social Care Practitioners	32
11.1	<i>Understanding Spiritual Care and Making the Links</i>	32
11.2	<i>Targeting particular health and social care practitioners sectors</i>	33
11.3	<i>Bereavement Care</i>	34
11.4	<i>Undergraduate and Post-Graduate Studies</i>	35
12	Conclusions	36
	References	37
	Appendices	39

EXECUTIVE SUMMARY

Spirituality is as relevant for the non-religious as it is for the religious because it is about the fundamental meaning of being human¹ (Malcolm Goldsmith 2011)

Process

In December 2011, Interfaith Scotland in partnership with NHS Education for Scotland (NES) Chaplaincy Training and Development Unit, appointed us to undertake a 10 month secondment which aimed to promote greater awareness:

- amongst those working in primary health and social care of the potential of spiritual care to support health and wellbeing within communities and
- within the chaplaincy community of the issues facing those working in primary health and social care, the common challenges and the areas of shared interest

The research involved: individual interviews, with 31 health and social care practitioners including policymakers, educationalists, managers and front-line staff from the statutory and voluntary sector; in depth interviews with 11 chaplains and critical conversations with many others at conferences and chaplaincy meetings. We also attended relevant events, including two chaplaincy conferences and the Joint Improvement Team meeting on faith and older people and took up informal advisory roles on related initiatives.

We invited 'champions', a purposeful sample of chaplains whom we identified as already being innovative in their practice, to a workshop during which we asked them to scope what chaplains do and how they think it impacts on health and well being. From this we put together the draft framework defining an Assets Based Model of Spiritual Care, which we tested out in subsequent interviews with chaplains and health practitioners, and used as the basis both for highlighting research gaps and identifying learning needs.

Recommendations

We found a lot of innovation in the practice of spiritual care; some of it pioneered by chaplains, some by faith communities and some by health and social care practitioners. Some of it was called spiritual care, some of it was called person-centred, asset based, holistic or compassionate care. Some of our interviewees in health and social care were excited by the idea of more integration between chaplaincy and health and social care practitioners to promote greater health and wellbeing; others struggled to disconnect spiritual from religious care and that led to suspicion. Some chaplains can see the potential of solidifying the connections between their work, and the health and wellbeing of individuals and communities; others feel anxious and bewildered.

Much of what is needed in order to deliver real person-centred and holistic care is about getting out of our silos and working across boundaries. We made 3 recommendations, which are about integration.

Common frameworks such as the Asset Based Approach to Spiritual Care can help practitioners to understand each other's contribution to a set of common spiritual, health and wellbeing outcomes.

Joint Training. Joint locality based training of chaplains and health and social care practitioners from across sectors on the meaning of spiritual care, the links with person-centred and asset based

¹ Goldsmith M (2011) Spirituality and Personhood in Dementia. Ed Albert Jewell

approaches and how it can be provided systemically, is likely to achieve a lot more than competency based training within silos.

Action Research. Many of the ideas for research could be undertaken collaboratively across sectors, using an action research methodology, which involves both practitioners and people using the service as co-researchers. This would enable the learning to be not only richer, but person-centred and applicable immediately.

The Context of Health and Social Care

Patient Centred: Since 2007 Scottish Government policy has been moving in the direction of a mutual NHS where patients are treated as partners in their own healthcare.

Prevention: Running alongside the person centred approach, is a complementary movement in health improvement towards the prevention of ill-health rather than the treatment of disease. At the same time in response to the changing demographic in Scotland and the continuing pressure on the public purse, there is a renewed emphasis on **treating people at home** and in their communities.

Assets Approaches to Health Improvement: Dr Harry Burns, Chief Medical Officer suggested (in his Annual Report 2009) that our approach to health improvement in Scotland needs to have at its core an effort to discover the assets within communities on which we can build health, both individually and communally.

Spiritual care, chaplaincy and the promotion of health and wellbeing

We based our research on the assumption that spiritual care improves health and wellbeing. At the same time we sought to find evidence to test this assumption and to highlight the areas where further research needs to be undertaken.

Although not confident with the terminology, most chaplains find many parallels between person-centred and asset based approaches and their own approach, although the emphasis on building networks and developing communities is new for some. However, there are challenges. Many chaplains are uncertain and even suspicious about aspects of their evolving role. At the same time most health and social care practitioners are unsure both of what chaplains do and how this relates to person centred support, and of their own role in providing spiritual care.

At the same time, whilst we are beginning to be able to demonstrate that 1:1 spiritual care contributes to overall health and wellbeing in an acute or psychiatric hospital setting, we have much less evidence to demonstrate the efficacy of spiritual care outside this setting.

Developing the Assets Based Approach to Spiritual Care Framework

The 'chaplaincy champions' were asked to identify what they do now, what feels new and creative about what they do, and what more they could be doing to promote health and wellbeing.

Their responses were grouped into three categories:

- work with individuals either in hospitals or in the community to promote individual resilience
- work with groups, mostly in the community to promote community resilience
- work with organisations to promote organisational resilience

Logic models were drawn up for each of the 3 categories. These models detail inputs, processes and short, medium and long-term outcomes. One of the strengths of the model is that it does not specify the context in which spiritual care is delivered. This allows chaplains and health and social care practitioners to locate it in their own setting whether that be, for example, mental health, palliative care, community care or bereavement care.

What do other health and social care practitioners do to promote spiritual care?

We heard throughout the secondment of examples of person-centred, holistic and compassionate care undertaken by health and social care practitioners of all descriptions. These examples would have much in common with the spiritual care provided by chaplains, and there are numerous examples of community projects supporting individuals to find meaning and purpose in their lives. Most of these were taking place outside the statutory sector and were unconnected with the work of chaplains. Many did not regard their work as contributing to spiritual care.

Faith communities too are making a very positive contribution to the health of local communities. Being fluent in the languages of both healthcare and faith communities healthcare chaplains are ideally located to be a bridge between the faith communities and public agencies.

Research Evidence

There is now beginning to be strong evidence for the efficacy of 1:1 chaplaincy interventions both within the acute sector and in the community. A brief literature search also reveals other evidence, which can be used to support the case for the health and wellbeing outcomes of spiritual care interventions. These include: when spiritual care is delivering social capital outcomes, which include: people feeling happier and better in themselves and increased confidence and self-esteem, there is a direct link, through social capital research, with improved wellbeing and resilience.² There is also evidence to show that interventions, which help people to discover meaning and purpose have a beneficial effect on health. Much of this comes from the palliative care sector but is increasingly being found in literature around cancer care. Research carried out within the Scottish Borders Stroke Study³ found that the majority of stroke patients felt that their spiritual health was important or very important to their overall wellbeing. However here is still some concern about whether all this evidence is being used wisely.

Ideas for Collaborative Research

As chaplains evaluate the impact of their 1:1 work, whether it be in the acute sector or in the community we can begin to answer the question, what difference does it make? As we make more of the links between what chaplains do and the care they offer, and the new move in health and social care to more person-centred practice, other questions are raised such as: what do chaplains do that is different from other health and social care practitioners and what is their role in providing spiritual care in relation to other health and social care practitioners?

Answering these questions might involve research, for instance about the impact of spiritual care interventions by other practitioners, it also requires some strategic conversations between those responsible for workforce planning and development within NES. It would lead to greater clarity and

² Cote, S. Healy T. (2001) The Wellbeing of Nations. The role of human and social capital. Organisation for Economic Co-operation and Development. Paris
NHS Health Development Agency 2004: Social Capital for Health: issues of definition, measurement and links to health, London

³ Devenny B 2005 Spiritual Responses to Sudden and Progressive Disabilities: Recommendations for the systemic integration of spiritual awareness into health and social care

could lead to the development of spiritual care competencies for both chaplains and other practitioners in acute and community settings. Greater role clarity and an appreciation of the subtle differences in focus in delivery of spiritual care will help practitioners to understand and support one another's work

Developing Spiritually Resilient Communities

The assets based model of health improvement seeks to address alienation and to transform communities through working with the resources they offer rather than focusing on their deficits.

Our assumption is that spiritual care interventions can play a key role in this approach, not only through 1:1 listening located in community settings, but also through working with community groups and community workers, enabling them to support the development of meaning, purpose and a sense of coherence for many individuals feeling isolated or lost.

This assumption is being tested out Kevin Franz, NHS Chaplain, in a small piece of action research in the Kingsway Flats and the findings will be written up early in 2013. However there is definite need for more research on spiritual care interventions in the community, both those undertaken by chaplains and those which are undertaken by other health and social care practitioners.

We need to know more about how to develop the spiritual health of communities, whether they be communities of interest or geographical communities, and about how spiritual health contributes to the overall health of communities and to community resilience. In the same way that the Go Well programme aims to investigate the impact of investment in housing, regeneration and neighbourhood renewal on the health and wellbeing of individuals, families and communities, we need to find out what impact an investment in spiritual (rather than religious renewal) would have on the health and wellbeing of individuals, families and communities.

Working with faith communities

We know that many faith communities are involved in work to promote health and wellbeing and indeed that much of the pastoral care work which chaplains do now, had its roots in faith communities. More work needs to be undertaken to examine what faith communities are currently doing, what impact it has and how it could complement the spiritual care work undertaken by chaplains and other health and social care practitioners.

Development of organisational spirituality

The Chief Medical Officer himself has highlighted the fact that although we have compassionate staff we may not have a compassionate system for them to practice in. The report describes several initiatives that are designed to address and/or challenge aspects of the culture within the NHS and to support the promotion of organisational spirituality.

There is a key opportunity to contribute to emotional and spiritual intelligence and strong values based practice by embedding 'Values Based Reflective Practice' in health and social care settings across Scotland. It will be important to carry out ongoing research into how Values Based Reflective Practice, delivered and facilitated by healthcare chaplains, gives practitioners the inner capacity to deliver compassionate care.

Learning and Development Needs of Chaplains

It became increasingly clear throughout our research that, although some chaplains are at the forefront of defining a new role within health and social care, and are excited by the parallels between their approach and the asset based and person-centred approaches now being advocated in health and social care, even they are struggling with the pace of change. Many others are continuing to work the way they have always done and feel threatened by the new developments.

Training and action learning using the Asset Based Approach to Spiritual Care Framework as an anchor will help to elicit case studies to further illuminate how chaplaincy practice is evolving, what difference it is making, and where the areas of tension remain. Other areas where we identified training needs include: values based reflective practice; understanding the policy and practice changes in health and social care and working systemically within organisations.

Learning and Development Needs of Health and Social Care Practitioners

The term spiritual care was unfamiliar to most of our interviewees and they struggled to connect spiritual care with the existing practice of health and social care practitioners. Once the connection between person-centred and spiritual care, was understood, there were some interviewees, who knew of many practitioners who were undertaking at least some aspects of spiritual care, but under a different name such as: being person-centred, holistic or compassionate care. Others, felt that although a few did it naturally, many practitioners either didn't have the time or the skill to provide spiritual care.

However the majority of our interviewees in health and social care, either themselves did not know what chaplains did, or were convinced that the practitioners they worked with would not know. This finding is borne out by other research:

So, even if they were identifying spiritual needs, it is unlikely that many practitioners would know who to refer people to. Nurses need to be able to pick up the signs of spiritual ill-health and a discussion of spiritual care should be included when planning workforce development around person-centred practice.

There are strong foundations to build on. In March 2009 the educational tool *Spiritual Care Matters: An Introductory Resource for all NHS Scotland Staff*⁴ was launched. Over 7,500 copies have been widely circulated within healthcare and university settings in Scotland and beyond. Evaluation is showing that it is making a positive impact and recommends that training should be rolled out with better integration with health and social care priorities such as the Healthcare Quality Strategy 2010.

Particular areas which should be addressed include: targeting those practitioners who have exposure to a wide range of patients in the community including GPs, Practice Managers, Allied Health Professionals and care staff in residential homes and focusing on including spiritual care in Undergraduate and Post-Graduate Studies.

⁴ The document can be downloaded from www.nes.sct.nhs.uk/spiritualcare/publications/

1 BACKGROUND

In December 2011, Interfaith Scotland in partnership with NHS Education for Scotland (NES) Chaplaincy Training and Development Unit, appointed The Craighead Institute and Ian Stirling, Chaplain at Ayrshire Hospice, to undertake a 10-month secondment dedicated to Developing Innovation in Spiritual Care Education.

The secondment was conceived as a response to the huge changes in the way that health and social care is being understood and delivered in Scotland as new developments such as coproduction, asset based interventions, the 2020 Workforce Vision and the integration of service provision get underway. These changes impact on the delivery of spiritual care, which has traditionally focused on providing support for individual patients, their carers and staff in acute crisis situations in secondary care.

The secondment brief stated that:

Innovation informed by relevant research is required in order to help chaplains work in new and creative ways to best impact on the promotion of health and wellbeing of individuals, families and local communities rather than primarily focusing on crisis management in institutional settings.

Our work included research and critical conversations, with both NHS chaplains and health and social care practitioners from a wide variety of disciplines.

We viewed the secondment as a piece of action research in itself, meaning that as we interviewed people we aimed to inform them about new thinking and practice, either in chaplaincy or in health and social care, and to inspire transformative practice. For instance the interview between Ian Stirling and Iain MacRitchie evolved into a published⁵ article, which we hope will be widely read by practitioners and academics and go on to influence the delivery of spiritual care.

The aims of the secondment were to promote greater awareness:

- amongst those working in primary health and social care of the potential of spiritual care to support health and wellbeing within communities and
- within the chaplaincy community of the issues facing those working in primary health and social care, the common challenges and the areas of shared interest

As our final outputs we aimed to produce:

- new ideas for collaborative research to inform best practice in developing spiritual wellbeing in community settings based on a process of listening and engagement
- a learning needs analysis of both chaplaincy and health and social care practitioners which informs the development of educational resources and opportunities designed to promote individual and collective wellbeing in communities

At our first team meeting we agreed on the following outcomes for the research:

- that we influence the education of future chaplains and health professionals (through the ideas for collaborative research and training needs analysis initially)
- we, the steering group and through them policymakers have a greater understanding of how chaplaincy contributes to health

⁵ MacRitchie, I. 2012 'Lessons for Chaplaincy from a Management Secondment' *Scottish Journal of Healthcare Chaplaincy* Vol 15 (1) p3-9; Appendix 6.

- there is a greater understanding of the new model of spiritual care both within chaplaincy and within health and social care in different sectors

2 METHODOLOGY

Our team comprised of 3 consultant researchers from the Craighead Institute: Ian McKenzie, Duncan Wallace and Jo Kennedy, working with Ian Stirling. Team members were selected on the basis of their experience and their existing networks within NHS Chaplaincy and Health and Social Care.

The research involved: individual interviews, with a wide range of health and social care practitioners, and chaplains; and group meetings, mostly with chaplains. We also attended relevant events, including two chaplaincy conferences and the Joint Improvement Team meeting on faith and older people. In addition, Ian Stirling took up a role as an informal advisor on initiatives such as the community ward proposals in Ayrshire and Arran, the compassionate community ambassador at Ardgowan Hospice and exploring organisational spirituality with the family care team in Children's Hospice Association Scotland.

At our first research team meeting in January 2012, we agreed:

- who we wanted to impact which included: all chaplains, policymakers and educators in health and social care
- who would be able to inform us about the research gaps which included: chaplains and researchers in health and social care
- who would be able to inform us about learning needs which included: chaplains and educators in health and social care

We allocated interviews to individual team members and decided to take a 'snowballing' approach with the first round of interviewees, asking each interviewee to recommend further people to interview.

Our aim in the first round of interviews was to find out more about:

- existing good practice in promoting spiritual health, both by chaplains and health and social care practitioners
- how the contribution of chaplaincy to health and wellbeing was understood by chaplains themselves and others

We used a semi-structured questionnaire, which is attached as Appendix 1.

In June 2012, we invited 'champions', a purposeful sample of chaplains whom we identified as already being innovative in their practice, to a workshop during which we asked them to scope what chaplains do and how they think it impacts on health and well being in the short, medium and long term. From this raw material we put together the draft framework defining an Assets Based Model of Spiritual Care, which is explored later on in this report and forms Appendix 2.

We tested out the validity of the framework in subsequent interviews with chaplains and health practitioners and used it as the basis both for highlighting research gaps and identifying learning needs. The questionnaire for the second round of interviews is included as Appendix 3.

In total we interviewed 31 health and social care practitioners, including policymakers, educationalists, managers and front-line staff from the statutory and voluntary sector. We

conducted in depth interviews with 11 chaplains and had critical conversations with many others at conferences and meetings. A full list of all those we interviewed is attached as Appendix 4.

In January 2012, a steering group was set up for the secondment which included: Wilma Reid, Head of Learning and Workforce Development, NHS Health Scotland, Jane Cantrell, Programme Director, Community Nursing (NES), Sandra Falconer, Policy Manager, Scottish Government Health and Social Care Directorates as well as Isabel Smyth, Chair of Interfaith Scotland and Ewan Kelly Programme Director for Healthcare Chaplaincy and Spiritual Care (NES). Four steering group meetings were held throughout the life of the secondment to review progress and guide the emerging direction of the research.

3 THE CONTEXT OF HEALTH AND SOCIAL CARE

3.1 Patient Centred

Since 2007 with the discussion about Better Health, Better Care and the subsequent Better Health, Better Care: Action plan (NHS Scotland 2007) Scottish Government policy has been moving in the direction of a mutual NHS where patients are treated as partners in their own healthcare.

The *Healthcare Quality Strategy for NHS Scotland* (Scottish Government, May 2010) cites person-centredness as one of its' 3 Ambitions and talks of providing the '*best possible care compassionately and reliably*'.

*. . . our approach will be designed to be: **Patient-based**: reflecting the uniqueness of the individual, their experience of their health, illness and healthcare, and enabling them to share in decision-making about their care, to manage their own health . . .*

The National Person-Centred Health and Care Programme is a framework to support the delivery of the person centred aims and ambitions of the Quality Strategy, using a focused improvement approach to support the testing, reliable implementation and spread of interventions and changes that are known to support health and care services and organisations to be truly person-centred. The high level aim of the Programme is that, by 2015, health and care services are more person-centred as demonstrated by improvements in care experience, staff experience and in co-production. The launch and first learning session was held 20 and 21 November 2012 and the Health and Social Care Alliance (The Alliance) recently received funding from the Scottish Government Health and Social Care Directorates to support the co-production work stream of the Person-Centred Collaborative. This will include support for the further development and co-ordination of the People Powered Health proposal.⁶

The Patient Rights (Scotland) Act 2011 passed by the Scottish Parliament in February 2011, gives all patients the right that the healthcare they receive will:

- consider their needs;
- consider what would most benefit their health and wellbeing
- encourage them to take part in decisions about their health and wellbeing, and provides them with information and support to do so.

⁶ People Powered Health and Wellbeing: Shifting the Balance of Care. September 2012

The Act also required Scottish Ministers to publish a Charter of Rights and Responsibilities which summarises the existing rights of patients using the NHS in Scotland. The Charter⁷, published in October 2012 (Scottish Government, 2012), includes a right to request support to access NHS services and this includes access to support from a hospital chaplain.

3.2 Prevention

Running alongside the person centred approach, is a complementary movement in health improvement towards the **prevention of ill-health** rather than the treatment of disease. The new NHS Health Scotland Strategy: *A Fairer Healthier Scotland* names as one of three short-term goals: 'stronger support for action for prevention and better, fairer health'.⁸

At the same time in response to the changing demographic in Scotland and the continuing pressure on the public purse, there is a renewed emphasis on **treating people at home** and in their communities, encapsulated in the NHS Scotland initiative, Shifting the Balance of Care and the Scottish Government's Change Fund.

The *Commission on the Future Delivery of Public Services* (Christie Commission 2011) suggested that irrespective of the current economic challenges, a radical change in the design and delivery of public services is necessary. Future public services must be "built around people and communities, their needs, aspirations, capacities and skills, and work to build up their autonomy and resilience"⁹. It called too for a new culture with a focus on prevention and early intervention; on 'assets' rather than deficits; and for new collaborative relationships to enhance outcomes and build resilience.¹⁰

3.3 Assets Approaches to Health Improvement

There is a growing recognition within NES, and more widely within the health profession in Scotland, that many individuals present problems to the health service, which do not have a medical solution. In addition some medical problems such as obesity, addiction and poor mental health are more effectively treated with social as well as medical interventions.

The 'After Now' website launched by Phil Hanlon, Professor of Public Health at the University of Glasgow and others, details some of the health challenges facing our society currently, and advocates a much more integrated approach to wellbeing than we have had in the past, one which takes into account social and spiritual needs as well as economic and medical ones.

Health improvement draws substantially on practice from community development which emphasises the importance of personal development opportunities for individuals, supporting communities to organise themselves around their own priorities and focusing on the areas where people are most disadvantaged. The work of Jim Dyers, a community organiser in Seattle and the Assets Based Community Development model pioneered by John McKnight at the University of Chicago, are being seen as inspirational because they enable individuals to turn round their own wellbeing and the wellbeing of their communities.

Dr Harry Burns, Chief Medical Officer (CMO) started off a debate on assets based approaches to health in his Annual Report of 2009. In this he posits, quoting Jimmy Reid speaking in 1971, that

⁷ The Charter <http://www.scotland.gov.uk/Publications/2012/09/2252>

⁸ A Fairer Healthier Scotland: Our Strategy 2012-2017. NHS Health Scotland

⁹ Christie Commission, 2011; p.26

¹⁰ See also Deacon, 2011, GCPH, 2011.

many of Scotland's major health problems are caused by alienation, which comes from people lacking a sense of meaning and purpose in their lives. Instead of the current deficit model, which drives most of our statutory service provision, he believes our healthcare system should focus on salutogenesis – or the art of keeping healthy. This approach is already well established in the voluntary and community sector.

At its core, salutogenesis asks:

- *What external factors contribute to health and development?*
- *What factors make us more resilient (more able to cope in times of stress)?*
- *What opens us to more fully experience life?*
- *What produces overall levels of wellbeing?*¹¹

The CMO suggests that our approach to health improvement in Scotland needs to have at its base an effort to discover the assets within communities on which we can build health both individually and communally:

*An assets approach to health and development embraces a positive notion of health creation and in doing so encourages the full participation of local communities in the health development process.*¹²

Assets approaches have been common in community led health practice for a long time, but up to now have had a limited impact on mainstream health interventions. The Chief Medical Officer's interest has sparked debate about how such approaches could change the way health improvement is conceived and delivered in Scotland. Over the past two years, further efforts have been made to implement an assets based approach to tackle some of Scotland's most fundamental and persistent health issues such as obesity and alcohol abuse in areas such as Onthank in Kilmarnock. The Directors of Public Health have been debating how these asset-based initiatives could be both rigorously evaluated and made more mainstream.

4 HOW DOES SPIRITUAL CARE PROMOTE HEALTH AND WELLBEING?

We based our research on the assumption that spiritual care improves health and wellbeing.

'Patients and physicians have begun to realise the value of elements such as faith, hope and compassion in the healing process.....a more holistic view of health that includes a non-material dimension, emphasising the seamless connections between mind and body.' (World Health Organisation 1998)¹³

At the same time we sought to find evidence to test this assumption and to highlight the areas where further research needs to be undertaken.

Spiritual Care Matters (2009) defined spiritual care as follows:

¹¹ Morgan A and Ziglio E 2007. Revitalising the evidence base for public health: an assets model.

¹² Annual Report of the Chief Medical Officer, Scotland. 2010

¹³ *The then Scottish Executive echoed this holistic definition of healthcare in guidance issued under HDL(2002) 76 by describing spiritual care as "an integral part of the healthcare offered" and that spiritual caregivers (chaplains) are "members of the professional care team". Revised guidance issued under CEL (2008) 49 in November 2008 also reflects this view.*

Spiritual care is that care which recognises and responds to the needs of the human spirit when faced with trauma, ill health or sadness and can include the need for meaning, for self worth, to express oneself, for faith support, perhaps for rites or prayer or sacrament, or simply for a sensitive listener. Spiritual care begins with encouraging human contact in compassionate relationship, and moves in whatever direction need requires.

Whilst both Spiritual Care Matters and the Cochrane Review ¹⁴ (2012) are clear that all NHS staff have a role in providing spiritual and pastoral care, chaplains are seen as specialists.

The NHS Chaplaincy Consensus Statement (2010), included as Appendix 5, also emphasizes the connection between attention to spiritual needs and overall health and wellbeing:

Best practice in 21st Century healthcare attends to the whole person – the physical, mental, social and spiritual aspects of human living. When emotional and spiritual needs are addressed, service users and staff experience a greater sense of wellbeing in dealing with ill- health

In their research paper *What do Chaplains Do?* (2007), John Swinton and Harriet Mowat, highlight the changing nature of the role as it responds to the changes in religious belief, spiritual practice, and the health and social care context. They conclude:

One of the primary tasks for the chaplain within the multi-disciplinary team is as the marketer of a spiritual ethos, which has the potential to transform and re-humanise a healthcare system which is often lacking in such aspects. (p.9)

There is a clear link between the provision of spiritual care and the art/science of keeping healthy or salutogenesis, for which we will examine the evidence in Section 5.1.

5 WHAT DO CHAPLAINS DO TO PROMOTE SPIRITUAL CARE?

During our research we interviewed several NHS staff who were very clear about the importance of chaplains in providing a level of holistic care to patients which other staff are simply unable to deliver, both because they don't have the requisite level of skill, and because they don't have the time to listen for long enough.

The particular skills the members of the Department of Spiritual Care bring are from their required education and experience which enable them to help people consider the 'big' questions about life, death, suffering, the origin of the universe, life after death, etc. which so many face when given diagnosis of ill health, bad news, or they wish to celebrate hope of recovery. (NHS Tayside: Spiritual Care Strategic Framework 2010).

'A focus on spirituality forces us to ask different questions and in answering these questions we begin to care differently.' Professor John Swinton, Centre for Spirituality, Health and Disability, University of Aberdeen

The essence of what chaplains offer – generic spiritual listening - can be described as active non-judgemental listening that creates a 'dynamic holding space' which the patient, the storyteller, can

¹⁴ Candy, B., Jones, L, Varagunam, M., Speck, P., Tookman, A. and King, M. 2012 Spiritual and religious interventions for wellbeing of adults in the terminal phase of disease Cochrane Database of Systematic Reviews Issue 5

use to talk about the present and to revisit and reinterpret events from the past, and in so doing maintain their story or create new possibilities, even a new sense of hope, for the future.

Another way to look at this would be to say that chaplains are already specialists in person-centred care. Not only that, but their day to day work involves supporting individuals to develop a sense of coherence and find meaning and purpose in their lives at times of alienation and distress. This work underpins the assets approach, which is attempting to find new ways of tackling the underlying social problems which result in the loss of health and wellbeing for individuals and communities.

In their recent study on Assets in Action (GCPH August 2012), Jennifer Maclean and Valerie McNeice identify the following principles underlying an asset-based approach.

Principles of an asset based approach:

- Start with what is working and what people care about
- Work with people – “doing with”, rather than “doing to”
- Help people to identify and focus on the assets and strengths within themselves and their communities, supporting them to make sustainable improvements in their lives
- Support people to make changes for the better by enhancing skills for resilience, relationships, knowledge and self-esteem
- Support the building of mutually supportive networks and friendships which help people make sense of their environments and take control of their lives
- Shift control over the design/development of actions from the state to individuals and communities

Although not confident with the terminology most chaplains find many parallels between person-centred and asset based approaches and their own approach, although the emphasis on building networks and developing communities is new for some.

We can conclude therefore, that most chaplains are already experts in person-centred practice and are adopting an assets approach.

One interviewee, a senior NHS employee, told us that because of the changing priorities within the NHS in terms of patient care, *‘the time for chaplaincy is now’*.

However there are challenges. If we accept that spiritual care contributes to overall health and wellbeing, there are many people who have no access to this, both because generic NHS staff struggle to provide it, and because chaplains are mostly located within acute or psychiatric hospitals. Many chaplains are uncertain and even suspicious about aspects of their evolving role. At the same time most health and social care practitioners are unsure both of what chaplains do and how this relates to person centred support, and of their own role in providing spiritual care.

At the same time, whilst we are beginning to be able to demonstrate that 1:1 spiritual care contributes to overall health and wellbeing in an acute or psychiatric hospital setting, and we go into this in more detail in Section 5.1, we have much less evidence to demonstrate the efficacy of spiritual care outside this setting.

In order to clarify exactly what it is chaplains do and how that contributes to the health and wellbeing of individuals, communities and organisations working in health and social care, we worked with chaplains to develop and test out an Assets Based Approach to Spiritual Care Framework.

Developing such a framework was also recognised as important in the NICE systematic review of spiritual care at the end of life (2011), which recommended the development of:

‘a clear framework, underpinned by established theory, within which practitioners can locate their own professional orientation and work context’. (Recommendation 3)

6 DEVELOPING THE ASSETS BASED APPROACH TO SPIRITUAL CARE FRAMEWORK

The ‘chaplaincy champions’ met in June 2012 and were asked to identify what they do now, what feels new and creative about what they do, and what more they could be doing to promote health and wellbeing.

Their responses were grouped into three categories:

- work with individuals either in hospitals or in the community to promote individual resilience
- work with groups, mostly in the community to promote community resilience
- work with organisations to promote organisational resilience

Logic models were drawn up for each of the 3 categories. These models detail inputs, processes and short, medium and long-term outcomes. The challenge inherent in the logic model is to demonstrate the ‘theory of change’ i.e. that the activities undertaken by chaplains lead to the outcomes they identify.

The Framework took as its starting point the Social Capital Health and Wellbeing Planning and Evaluation Toolkit developed by Edinburgh Health Inequalities Standing Group in 2009. One of the advantages of using this is that the short-term outcomes identified in the toolkit have been matched with medium and long-term health and wellbeing benefits through mining international research studies on the impact of increasing social capital. So, where the short-term outcomes in the Assets Approach to Spiritual Care Framework correlate with those in the toolkit, the evidence for health and wellbeing impact is strong. However spiritual care is not only about developing social capital and there are gaps in the evidence base, which we discuss in Section 10.1.

The following sections go through each part of the framework in some detail to establish what chaplains actually do and how it contributes to the health and wellbeing of individuals, communities and organisations.

One of the strengths of the model is that while it identifies inputs and processes it does not specify the context in which spiritual care is delivered. This allows health and social care practitioners to locate it in their own setting whether that be, for example, mental health, palliative care, community care or bereavement care.

6.1 Spiritual Health of Individuals

We are not human beings seeking to be spiritual rather we are spiritual beings striving to be human. (De Chardin)¹⁵

¹⁵ de Chardin, T 2008: The Phenomenon of Man.

The logic model starts with inputs, and currently chaplains are the only inputs in each model. This is a limitation and reflects the early stage of development of the Asset Based Model of Spiritual Care. It is envisaged that as the model develops, other health and social care practitioners who have an input into the delivery of spiritual care will be integrated into the model. For example there is considerable evidence supporting the role of GPs, psychiatrists and psychologists, nurses, care assistants and social workers in the delivery of spiritual care but it has been beyond the scope of this secondment to comprehensively examine all the evidence and locate them in the model.

Processes

This section outlines what activities chaplains are undertaking to promote spiritual care. Fundamental to what all chaplains do is 1:1 **listening and accompanying**, both in acute and community settings.

Margery Collin, NHS Chaplain in Forth Valley defines this as spiritual listening:

‘. . . we bring something more than therapy and counselling. The added dimension is the type of presence and being very present – the connecting of the soul... this is spiritual holding; spiritual listening because it is connected to the transcendent.’

Meaning making interventions in psychiatric, palliative and cancer care in particular, support patients to connect both with themselves and with others and rediscover **a sense of meaning and purpose**.

‘. . .it is the quality of presence . . . One cannot over estimate the value of offering ‘time’ ‘peace’ ‘security.’ There is a great power structure in a mental health hospital – because most are under the Mental Health Act. . . . Chaplains are not part of the regime ‘I know nothing except what you tell me therefore I invite you to tell me as it is.’ (Kevin Franz, NHS Chaplain at Gartnavel Psychiatric Hospital)

Much of a chaplain’s work comes at times of loss, when spiritual issues such as social isolation, loss of control and loss of self-worth are often present. Some of their work involves supporting families and staff to devise **rituals or rites of passage**, which enable people to let go of a loved one.

‘If a baby is ill or has died midwives need (the chaplain) to be a wordsmith... to take the pain and translate the pain into words.’ (Mark Evans, Chaplain NHS Fife)¹⁶

Similarly an audit of when chaplains are called in out of hours in NHS Greater Glasgow & Clyde revealed that the most common situations are as follows:

- where a patient is approaching the end of their life and family / friends are requiring spiritual care
- patients are being cared for using an end of life care pathway, where an assessment of spiritual needs is required and a referral to the chaplaincy service is encouraged
- neo-natal loss, where there is a request for a naming ceremony, or a blessing ceremony.

Taken together, these comprise over 60% of out of hours calls to the chaplaincy service. Chaplains, therefore, are regularly responding to people in extremely emotional circumstances, where a death has happened or is about to happen.

¹⁶ Evans, M. 2012 Exploring midwives’ understanding of Spiritual Care and the role of the Healthcare Chaplain within a maternity unit. MSc Dissertation University of Glasgow

Outcomes

Chaplains identified what they see as the immediate difference they make to people. This includes a sense of meaning and motivation to cope; a belief in their own capacity; finding life manageable and a belief in their own coping resources; more positive feelings about life; recognition of the ability to grow through suffering & trauma; enhanced self esteem, self confidence and sense of dignity; peace, contentedness and connectedness.

In the medium term they thought these led to: resilience; a stronger sense of coherence, purpose and control; a sense of wellbeing; improved physical and mental health and better self-management.

The anticipated long term outcomes were: stronger, safer and healthier communities and decreased rates of; suicide, alcohol and substance abuse, violence, depression, obesity and prolonged bereavement disorder.

Margery Collin spoke of the impact on one woman she worked with who had had 30 years in an abusive marriage and has now been on her own for 8 years, concerned about her 5 children, 3 of whom have a learning difficulty. When she first met her she was on medication for several physical and mental health issues. Now she is off her anti-depressants and finding a new life. The chaplaincy support was a catalyst and a human connection: *'encouraging her to be a person, valued, with higher self-esteem...all her story is safe'*.

Kevin Franz NHS Chaplain in Gartnavel Psychiatric Hospital in Glasgow, talks of being a bridge into community for people with mental health issues. *'In order to keep folk in the community the chaplain becomes a bridge after discharge. Roles are similar to those of the crisis team, but they have the power of detention. We meet in neutral space and they bring themselves - empty handed and not boundaried by hospital walls. When I am with people the social/ environmental and family dimensions are as important as the inner mental health journey'*.

Kevin works 1:1 in communities, but he has also taken on a new role providing support to a community health project, which is explored in the next section.

6.2 Spiritual Health of Communities

The second logic model within the framework looks at how chaplains promote the spiritual health of communities through working with community groups, health and social care practitioners within communities and faith groups.

The only inputs in our model so far are chaplains, although we are well aware that there are many other health and social care practitioners working on the spiritual health of communities.¹⁷

The activities chaplains are undertaking, or would like to undertake, include: mapping and developing community assets in relation to spiritual health; supporting community groups and health and social care practitioners working in communities to deliver spiritual care; facilitating hope and recovery groups for people with mental health issues; facilitating mindfulness groups; engaging

¹⁷ See Kennedy, J and McKenzie, I: *The Search for Meaning and Purpose in Communities*. NES. March 2012 for examples of community projects addressing meaning and purpose.

with faith groups; developing secular community rituals and rolling out training related to Spiritual Care Matters.

The immediate outcomes include: health practitioners and community members are more confident in promoting resilience and a sense of coherence through addressing issues relating to spiritual health e.g. hopelessness, isolation, loss, alienation and faith groups are more active in addressing issues of spiritual health in communities.

In the medium term this should lead to: community resilience, cohesion and solidarity and more people experiencing inequality being able to influence decisions that affect their lives and communities.

In the long term this should lead to stronger, safer and healthier communities and greater community influence and control.

Most of this work is new for chaplains. In Tayside, the chaplaincy team have acknowledged this by commissioning a development programme to support them with a variety of parallel change initiatives. They are collectively mapping the assets of their community, and analysing where and how to intervene most effectively to support the building up of a sense of coherence and community resilience. Examples of this include developing spiritual care champions in a new mental health outreach unit, developing chaplaincy volunteers in the community and developing reflective practice with staff in a community hospital.

Kevin Franz, has recently started a short term project working 0.5 days a week in Kingsway Health and Wellbeing Centre, which is seeking to improve the health of asylum seekers and the indigenous population in the Dumbarton Corridor.

The aim of the project is to explore what it means to promote the spiritual wellbeing of a community, how best to do this and what impact it has on the local population.

So far Kevin has been attending the pensioners' group and the walking group. He is also making links with NHS staff outside the project and with faith communities. It is too early to assess the impact of his work but he is certain that he is exploring a different role.

at the moment I'm spending a little time each week in a scheme of tower blocks in Scotstoun, near the Clyde. It's one of the most deprived and down-trodden communities in Glasgow. The toxic mix of unemployment, drug and alcohol abuse, violence and human despair make it, on the face of it, a challenging place to conceive of community. With the support and encouragement of NES I'm reflecting on what spiritual care might look like in a community setting. The people in Kingsway Court are helping me think again about what makes for human resilience, what builds a caring, a healthy community. I feel marginal there, de-skilled. I feel I go empty-handed. I'm learning a huge amount about what it means to be human...in my mental health chaplaincy role I listen; there I craft relatedness...'

Blether¹⁸ is an informal group of people living in and around Tain and Invergordon, which meets to talk about spiritual wellbeing. It emerged out of a talk about psycho-neuro-immunology (the study of the interaction between psychological processes and the nervous and immune systems of the human body) which looked at how belief/faith supports the immune system.

¹⁸ Blether (www.blether.info) is facilitated by Fire.Cloud, with funding provided by NES

Blether is an example of a collective expressive space that builds community resilience. The group meets six weekly bringing issues that are on their minds, and deciding democratically what they will collectively reflect on. They have learned together how to listen and care about one another by talking through spiritual questions and ideas that are important to them.

‘... real conversation is becoming less and less a part of our lives. In a world which is often confusing or worrying, most of us don’t get many opportunities to explore with others how we really feel about what we are seeing and experiencing, to rediscover ‘what lifts our spirit’ and or to discover the strength of ‘being in it together.’ (Blether participant)

6.3 Spiritual Health of Organisations

This part of the model looks at how chaplains are supporting spiritual health through developing organisational resilience in health and social care.

The only inputs so far are chaplains, although again we are aware that there are many other health and social care practitioners, and even organisational development consultants involved in similar work.

The activities chaplains are undertaking include: workforce and organisational development; service development in particular areas e.g. stroke management; Critical Incident Stress Management; structured mediation; “Healthy Working Lives” type initiatives and Values Based Reflective Practice with groups of practitioners.

The immediate outcomes of activities to promote organisational health include: stronger more innovative multidisciplinary teams, work teams and organisations; creative outcome focused partnerships and improved attendance at work.

In the medium term this should lead to: stronger more resilient organisations which reflect their values base both internally and externally; staff retention; negotiated shared interest interventions e.g. social prescribing, peer support, co-production and outcome based commissioning, personalised/self-managed care, community development to tackle health inequalities.

In the long term this should again lead to stronger, safer, healthier communities.

The ETHoS project was born following research into the spiritual needs of stroke patients and their carers. Supported by the NHS Lanarkshire Managed Clinical Network for Stroke, the aim of the project was to develop a spiritual awareness and greater understanding of the holistic needs of patients and carers, post stroke.

What has evolved is an approach to training and service development, which supports frontline staff and managers in making the important transition to a truly person-centred, collaborative, community based service.

In order to integrate spiritual care systemically into the service, the knowledge and skills required were identified and integrated into the overall core competency framework for stroke within the Managed Clinical Network. General and in-depth training modules were developed and piloted to support the identified competencies. Along with this, physical environments of care were examined from a spiritual care perspective to suggest ways of creating a more holistic environment for

patients, carers and staff. Suggestions were made for means of a more intentional approach to supporting self-care. Finally a form was designed to aid in delivering a more personalised care.

In Appendix 6, Roddy McNidder, Chaplain in NHS Ayrshire and Arran explains the Critical Incident Stress Management work that he and the chaplaincy team have developed in the hospital in which they work and Blair Robertson, Paul Graham and Kevin Franz describe Mindfulness Meditation for NHS staff at Inverclyde Hospital.

Both these interventions are examples of how chaplains are seeking to promote and support the spiritual health of organisations.

7 WHAT DO OTHER HEALTH AND SOCIAL CARE PRACTITIONERS DO TO PROMOTE SPIRITUAL CARE?

By the end of this secondment, we had heard, in one way or another, from almost all the spiritual care chaplains working in Scotland, and consequently have a clear idea both about how they are working currently and how they aspire to work.

However, there are thousands of health and social care practitioners working in both the voluntary and statutory sector. We were reliant on a brief literature search and our interviews with 31 policymakers, educationalists and practitioners from across the statutory and voluntary sector to give their overview. Although the picture is therefore, necessarily partial, there were some interesting findings and some further lines of inquiry to pursue. The next section provides a few examples of holistic care, which included aspects of spiritual care, carried out by health and social care practitioners. We go on to discuss some of the issues in providing this care.

7.1 Individual

We heard throughout the secondment of examples of person-centred, holistic and compassionate care undertaken by health and social care practitioners of all descriptions. These examples would have much in common with the spiritual care provided by chaplains.

Mark Evans explored the interface of midwives and chaplains in a maternity unit and found that *'all participants were clear that Spiritual Care was part of midwifery care'* They could give examples of spiritual care; rooted in their own personal experiences and in their clinical practice, as is shown in these words of comfort after a death in the unit:

"I said it to that young girl 'when this has all passed, grieve for these babies, you are going to go on and have a good and full life .., these babies will be your first born, and they will never be forgotten".

Participants described the relationship between a midwife and the woman they care for as a key manifestation of spiritual care.

Julie Mann and Aileen Meek of Scottish Huntingdon's Association were clear that *'Everything we do is spiritual care – we couldn't take spiritual care out of what we do'*

We heard too of health and social care practitioners, many of whom have told their story as part of the support programme for Spiritual Care Matters, who understand the spiritual care available

through chaplaincy and other faith communities and refer patients and community members to it, when necessary.

One assets based initiative which is located in the statutory sector, took as its inspiration an Alaskan approach in which spirituality is integral to the holistic care offered. Dr Margaret Hannah, Deputy Director of Public Health in Fife has been working with colleagues in a GP practice in Buckhaven, an area where the population has a high level of medical and social problems. The GP practice is adopting a model of care based on the approach the Fife team saw adopted in Alaska, which treats the whole person rather than simply the presenting medical issue.

7.2 Community

NES commissioned Jo Kennedy and Ian McKenzie to carry out a piece of research into the Search for Meaning and Purpose in Communities in January 2012. The research found numerous examples of community projects supporting individuals to find meaning and purpose in their lives. Most of these were taking place outside the statutory sector and were unconnected with the work of chaplains. Many did not regard their work as contributing to spiritual care.

*the search for meaning and purpose in communities is happening all around us in Scotland, in both formal and informal ways. It is undertaken both by individual practitioners and by groups working in the community.*¹⁹

There are many examples too of faith communities making a very positive contribution to local communities.

Examples enumerated in the report Faithful Endeavours,²⁰ include:

- The 'Toy Box' project initiated by the Quaker community supports offenders and their families in Barlinnie Prison
- The Glasgow Central Mosque collaborates with Glasgow City Council in caring for older people)
- Community Learning is supported by the Cranhill Community Project in Glasgow
- The Orbiston Neighbourhood Centre exists for local people and offers childcare, elderly care, befriending, community café, training opportunities and daily worship.

In the foreword to the report Martin Johnstone writes *'The importance of acknowledging, valuing and harnessing that contribution is perhaps even more important at a time of increasingly limited public resources.'* He continues to say that much work goes on *'under the radar'* and calls for a stronger relationship between faith communities and public agencies.

There are barriers to effective partnerships between faith communities and public agencies; a need to build working relationships, for training and the sharing of information and resources. Being fluent in the languages of both healthcare and faith communities, healthcare chaplains are ideally located to be a bridge between the faith communities and public agencies.

7.3 Organisational

¹⁹ Kennedy, J and McKenzie I: The Search for Meaning and Purpose in Communities. NES. March 2012.

²⁰As part of the Scottish Government's Better Community Engagement Programme a collaborative report was produced in 2011 by Faith in Community Scotland and the Scottish Community Development Centre, entitled 'Faithful Endeavours: How public agencies and faith communities can work better together'.

Hospices are often at the forefront of providing spiritual care in innovative ways. Alison Bunce, who comes from a nursing background, is a member of the Senior Management Team and Director of Care at Ardgowan Hospice. She describes how in 2007 the hospice began working on organisational spirituality through a review and change process. A philosophy group was formed which included representatives from all areas of work to explore how to identify values and bring them to life.

We wanted to live our values; talk about them and build every activity on our values...

Internal initiatives included using the values in key meetings, displaying them throughout the hospice, creating a song and a booklet and devising a new appraisal process around them. Now they are taking their work out into the community into schools and care homes employing a compassionate community ambassador with the aim of making Inverclyde a 'compassionate county'.

8 RESEARCH EVIDENCE

There is now beginning to be strong evidence for the efficacy of 1:1 chaplaincy interventions both within the acute sector and in the community. Much of the research for this has been done in Scotland itself through *the Lothian Chaplaincy: Patient Reported Outcome Measure* and the evaluation of the Community Chaplaincy Listening Service.

A brief literature search also reveals other evidence, which can be used to support the case for the health and wellbeing outcomes of spiritual care interventions.

8.1 Social Capital interventions and outcomes

Throughout this report we have argued that there is a strong link between spiritual care and person-centred, holistic or compassionate care. Founding the Assets Based Approach to Spiritual Care Framework in the Edinburgh Social Capital Toolkit enabled us to see the links between the provision of spiritual care and the development of social capital, which, in this case, is mostly undertaken by community health projects. When spiritual care is delivering social capital outcomes, which include: people feeling happier and better in themselves and increased confidence and self-esteem, there is a direct link, through social capital research, with improved wellbeing and resilience.²¹

8.2 Meaning Making Interventions

'He who has a why to live for can bear almost any how' (Friedrich Nietzsche)

There is also evidence to show that interventions, which help people to discover meaning and purpose have a beneficial effect on health. Much of this comes from the palliative care sector but is increasingly being found in literature around cancer care.

Meaning making interventions encourage dying patients to find meaning and purpose in their lives right to the end. Increased meaning and spiritual well being enhance patients' ability to cope with pain, lowers depression, lowers their desire for hastened death and their sense of hopelessness. Meaning making gives patients a new story to live by²²

²¹ Cote, S. Healy T. (2001) *The Wellbeing of Nations. The role of human and social capital.* Organisation for Economic Co-operation and Development. Paris
NHS Health Development Agency 2004: *Social Capital for Health: issues of definition, measurement and links to health*, London

²² Breitbart, W., Gibson, C., Poppito, SR. and Berg, A. 2004

*Cancer patients with a high degree of meaning in their lives, ..., are able to tolerate severe pain symptoms more than patients with a lower scoring of 'meaning and peace'. Patients with a high sense of meaning reported high satisfaction with their quality of life, despite pain and fatigue.*²³

Meaning making interventions are also relevant to those who are bereaved. The experiences people have, and the care people receive, at or around the time of the death of a loved one affects the grieving process. Therefore good spiritual care at the time of death - assisting people to say goodbye, to find closure and to have any religious needs addressed – is an important contribution to the wellbeing of the bereaved.

'There is a range of evidence that the way those who have been bereaved experience the events around the time of death will influence the trajectory of their grief journey. Where health services get it right, showing empathy and providing good quality care, bereaved people are supported to accept the death, and to move into the grieving process as a natural progression. Conversely if the health services get it wrong, then bereaved people may experience additional distress, and that distress will interfere with their successful transition through the grieving process, with implications for them, those around them and for the social economy of the nation.' (Shaping Bereavement Care, 2011)

8.3 The Lothian Chaplaincy: Patient Reported Outcome Measure (PROM)

The PROM is a project designed to generate evidence for the efficacy of specialist spiritual care. It is particularly interesting because it looks at the link between what chaplains themselves do (the processes outlined in the Assets Approach to Spiritual Care Framework) and the outcomes, either short or medium term. It also examines the relationship between the difference chaplains themselves think they make and the difference as reported by patients.

The PROM has been piloted with 39 patients from the acute sector in Edinburgh. Initial results are overwhelmingly positive with patients reporting that as a result of chaplaincy interventions, they could be more honest, their anxiety lessened, they had a better perspective, things were more under control and they had a sense of peace.

The measurement tool developed in Lothian can be used for all 1:1 chaplaincy interventions. Although some of the language needs to be reconciled, there is clear link between the outcomes found by patients in the Lothian study and those identified by chaplains in the workshop to develop the Assets Approach to Spiritual Care Framework. These outcomes can also clearly be linked to improved health and wellbeing.

In her preface to the research report Dr Harriet Mowat wrote:

This report is a powerful testament to the value of healthcare chaplaincy as it provides spiritual care for patients in the Scottish NHS. ...In Community Chaplaincy Listening and PROM we have overwhelming evidence from both quantitative and qualitative research traditions that chaplains impressions of their interventions closely correlate with patient impressions. This is person-centred care. Not every healthcare profession can boast this degree of coherence.

8.4 Community Chaplaincy Listening: Phase 2 Evaluation

'When you are listened to you discover yourself.' (John Swinton)

²³ Brady, MJ., Peterman, AH., Fitchett, G., Mo, M., and Cella, D. 1999 'A case for including spirituality in quality of life measurement in oncology' *Psycho-oncology* Vol. 8 pp417-428

Eight health boards across Scotland are delivering Community Chaplaincy Listening. Fifteen listening chaplains are working in 18 GP practices and between them saw a total of 250 patients over the 11 months from Sept 2011 – July 2012. The programme is currently being evaluated by Dr Harriet Mowat and Dr Suzanne Bunniss.

Their findings to date show that chaplains provide a patient centred listening intervention which results in reported change in behaviour. Patients report an increased sense of wellbeing. This has the potential to reduce the need for GP consultations, to positively affect the subsequent consultations between the patient and GP and may contribute to appropriate use of medication for depression and subsequent reduction in medication. Chaplains help patients find coping mechanisms for life's difficult issues within themselves that may not change the situation, but help change the response to it. Patients themselves recommended the service without exception:

I went in suicidal, I came out with hope (patient)

8.5 Scottish Borders Stroke Study

Research carried out within the Scottish Borders Stroke Study²⁴ found that the majority of stroke patients (66%) felt that their spiritual health was important or very important to their overall well being. The same questionnaire revealed that a low percentage of patients, less than 6%, felt that they had received spiritual support from the health care service.

The research identified a process of spiritual recovery associated with sudden onset disability caused by stroke. Transformational coping is a vital step in the journey of recovery undertaken by stroke patients and their carers in terms of regaining their sense of wellbeing. This process of growing through experience, towards well being, can be supported and facilitated through a relationship of mutuality, respect and compassion and the use of active listening.

My grief for the life that I knew and what it might become was profound...The therapeutic value of the environment helped in my recovery...I had space to think, to heal, to regain my spirit. I was still 'ME', with another set of priorities, but I was still same old 'ME' - Marianne Rowan, Lanarkshire Stroke MCN, Patient Carer Group

'By acknowledging the grief associated with illness and recognising the inner spiritual strength and resilience within humanity, we can support people more fully. A holistic ethos of care supports self-care and the personal quest for well being.

8.6 Making Use of Evidence

There is still some concern about whether the evidence is being used wisely. In 2005 substantial investment was made in the Scottish Borders Stroke study²⁵. This became one of the best examples of evidence for the efficacy of spiritual care. However four years later neither spiritual care nor chaplaincy were mentioned in the Scottish Government's Stroke Care plan (SG 2009 *Better Heart Disease and Stroke Care Action Plan*), an example of the struggle at every level to integrate and embed spiritual care within health and social care policy.²⁶

²⁴ Devenny B 2005 Spiritual Responses to Sudden and Progressive Disabilities: Recommendations for the systemic integration of spiritual awareness into health and social care

²⁵ *ibid*

²⁶ See - Iain Macritchie SJHC 15 (1) 2012

9 IDEAS FOR COLLABORATIVE RESEARCH

9.1 *What is different about the way chaplains provide spiritual care?*

The European Association of Palliative Care (EAPC) spiritual care taskforce, highlights the importance of starting with the needs of the patient. EAPC has a working definition of spiritual care and the assumptions behind it, but has identified other priorities for research, which have got unanimous international support. The three core areas proposed are:

- identifying patients' spiritual needs
- evaluating specific spiritual care interventions
- using conversation models to empower staff to deliver spiritual care²⁷

As chaplains evaluate the impact of their 1:1 work, whether it be in the acute sector or out in the community we can begin to answer the question, what difference does it make?

However as we make more of the links between what chaplains do and the care they offer, and the new move in health and social care to more person-centred practice, other questions are raised such as: what do chaplains do that is different from other health and social care practitioners and what is their role in providing spiritual care in relation to other health and social care practitioners?

A recent text book, *Spiritual Care for Healthcare Professionals*:²⁸ reflecting on clinical practice speaks of how *'the core skills of a healthcare chaplain include enabling others to articulate their sense of spirituality, acting as a resource for staff and volunteers in their assessment and delivery of spiritual care and encouraging healthcare professionals to develop their self-awareness and competence with regard to spirituality and spiritual care.'*

Although this might involve research, for instance about the impact of spiritual care interventions by other practitioners, it also requires some strategic conversations between those responsible for workforce planning and development within NES.

Questions that need answering include:

- What spiritual care are chaplains expected to provide both in acute and community settings?
- What spiritual care are other health and social practitioners expected to provide in these settings?
- What is the relationship between the two – do chaplains have a training/mentoring role with other practitioners in health and social care?

Beginning to answer these questions would lead to greater clarity and could lead to the development of spiritual care competencies for both chaplains and other practitioners in acute and community settings. Greater role clarity and an appreciation of the subtle differences in focus in delivery of spiritual care will help practitioners to understand and support one another's work. Appendix 7 is broad competency framework that could be populated in a consultative process.

²⁷ Selman, Young, Stirling ,Leget, Vermandere, 2013.

²⁸ Gordon, Kelly and Mitchell 2012

9.2 Listening

The evaluation of the Community Chaplaincy Listening service has thrown up some interesting questions around listening. How do chaplains do it? How is this distinct from the way other health and social care practitioners do it, and particularly counsellors? Some chaplains including Marjory Collins, cited earlier in this report, and John Swinton, are clear that it is different, others are not so sure. And those clients interviewed as part of the CCL evaluation don't seem concerned. GPs might be willing to take whatever listening support is easiest to access.

'An extra resource would be welcome - an extra load on the practice would not' (Dr Margaret Craig, Deepend Practice GP)

But it would be helpful to keep gathering evidence and information from chaplains themselves, from those they are listening to and from fellow health practitioners on where the overlaps are and what is distinct.

9.3 Developing Spiritually Resilient Communities

In his 1971 speech Jimmy Reid described communities where people feel alienated. The assets based model of health improvement seeks to address this and to transform communities through working with the resources they offer rather than focusing on their deficits.

Our assumption is that spiritual care interventions can play a key role in this approach, not only through 1:1 listening located in community settings, but also through working with community groups and community workers, enabling them to support the development of meaning, purpose and a sense of coherence for many individuals feeling isolated or lost.

This assumption is being tested out Kevin Franz, NHS Chaplain, in a small piece of action research in the Kingsway Flats and the findings will be written up early in 2013. The action research is exploring how spiritual care can contribute to health and wellbeing through working with groups and through staff, rather than focusing on 1:1 interactions, in an area where health inequalities are a real issue. And as part of that to explore what the role of a chaplain is in the community, what unique skills he brings and how they complement those of other health and social care practitioners. The Asset Based Approach to Spiritual Care Framework is being tested out through this action research.

However there is definite need for more research on spiritual care interventions in the community, both those undertaken by chaplains and others, such as the Blether project and the Compassionate Community Ambassador, which are undertaken by other health and social care practitioners.

We need to know more about how to develop the spiritual health of communities, whether they be communities of interest or geographical communities, and about how spiritual health contributes to the overall health of communities and community resilience. In the same way that Go Well²⁹ aims to investigate the impact of investment in housing, regeneration and neighbourhood renewal on the health and wellbeing of individuals, families and communities, we need to find out what impact an investment in spiritual (rather than religious renewal) would have on the health and wellbeing of individuals, families and communities.

Again, this could be part of a bigger initiative examining the impact of person-centred care.

²⁹ cf. www.gcph.org.uk

9.4 Working with faith communities

We know that many faith communities are involved in work to promote health and wellbeing and indeed that much of the pastoral care work which chaplains do now, had its roots in faith communities. More work needs to be undertaken to examine what faith communities are currently doing, what impact it has and how it could complement the spiritual care work undertaken by chaplains and other health and social care practitioners. The action research to support the work of Kevin Franz in the Kingsway Flats should lead to some findings on how to link with local faith communities. The challenge is that many faith communities are acting independently so the linking will need to take place at a grassroots level. However there are some national initiatives. Liaising with the Chance to Thrive initiative, run by the Church of Scotland, which is supporting 8 communities in Scotland's poorest areas to promote wellbeing across the community, would be a good place to start.

9.5 Development of organisational spirituality

Dr Suzanne Bunniss, specialist in chaplaincy research, who is currently evaluating the impact of spiritual care education on the perceptions and practice of healthcare staff in Scotland, thinks the 'aspirational' Healthcare Quality Strategy (2010) describes 'a highly emotionally and spiritually intelligent NHS'.

The Chief Medical Officer himself has highlighted the fact that although we have compassionate staff we may not have a compassionate system for them to practice in. Other interviewees also commented on how spiritual care with its emphasis on the whole person works against the culture of the NHS.

This was recognised as an issue in the *Learning Needs Analysis to Support the Implementation of Person-Centred Care* undertaken by Blake Stevenson in 2011. The report quotes one interviewee, who had recently received hospital care saying:

"compassion is seen as a luxury not a priority and so there is less time for it".

This report describes several initiatives including those in NHS Lanarkshire, NHS Ayrshire and Arran and NHS Glasgow and Clyde which are designed to address and/or challenge aspects of the culture within the NHS and to support the promotion of organisational spirituality. All these initiatives have strong theoretical roots, have been designed to promote good practice within NHS performance management frameworks, and have been shown to be highly effective through evaluation on site. Such initiatives will need to continue to be evaluated to examine how they promote a 'spiritually intelligent NHS'.

There is a key opportunity to contribute to emotional and spiritual intelligence and strong values based practice by embedding 'Values Based Reflective Practice' in health and social care settings across Scotland. This builds on innovations within a variety of professions, Chaplaincy, Medicine, Nursing, Midwifery and Allied Health Professions, all of which highlight the need for reflective practice, self-awareness, and leadership. It could also contribute to the change to more person-centred, holistic and assets based practice being undertaken by health and social care practitioners.

Self-awareness, understanding and managing "self" in the work context, reflective practice, technical competence and a clear professional identity are identified as essential elements of professional and inter-professional practice. Maintaining professional boundaries when engaging with patients and

service users in highly emotional contexts is also recognised as important, while not losing the essential elements of a caring relationship.’³⁰

Ros Moore, the Chief Nursing Officer advocates that *‘professionalism provides nurses, midwives and allied health professionals and patients, service users and carers, with much needed continuity in the face of an ever-changing system and an “internal compass” to guide them in challenging circumstances.*

Chaplains have already identified a real role for themselves in this area. It will be important to undertake ongoing research into how Values Based Reflective Practice, delivered and facilitated by healthcare chaplains, enhances this ‘internal compass’ and gives people the inner capacity to deliver compassionate care.

10 LEARNING AND DEVELOPMENT NEEDS OF CHAPLAINS

As part of our secondment we were asked to identify the learning and development needs of chaplains as they undertake their evolving role, and of health and social care professionals, in relation both to understanding the role of chaplaincy and their own role in providing spiritual care.

Our approach involved in depth interviews with chaplains and with practitioners responsible for policy and workforce development within NES, Scottish Government, and the Higher Education Sector.

It became increasingly clear throughout our research that, although some chaplains are at the forefront of defining a new role within health and social care, and are excited by the parallels between their approach and the asset based and person-centred approaches now being advocated in health and social care, even they are struggling with the pace of change. Many others are continuing to work the way they have always done and feel threatened by the new developments.

The introduction of a draft version of our Asset Based Approach to Spiritual Care Framework at the Chaplaincy Conference in September 2012 was greeted in the main, with bewilderment and some frustration. Although there were other factors at play, we took it as a clear indication that more work needs to be done with chaplains to prepare them for, and accompany them in, a new and challenging environment.

10.1 New role

Chaplains themselves have been on a journey in the past few years. Many of the current workforce started their lives within churches or other faith communities and have moved from a religious to a secular setting as they took up roles within the health service. Part of this shift required a move from providing religious to generic spiritual care. Now this role is being seen as not only theirs, but the responsibility of all health care staff. And there are ambiguities about where their role ends and another practitioner’s begins. Capacity issues are an increasing concern. Currently many chaplains hear the call to work differently, as a request to do more work with less resources.

Greater clarity at a strategic level will help chaplains to clarify their understanding of their new role but it will also need to be worked at in context by lead chaplains and their teams.

³⁰ Health Professions Council 2012 Professionalism in nursing, midwifery and the allied health professions in Scotland

Training and action learning using the Asset Based Approach to Spiritual Care Framework as an anchor will help to elicit case studies to further illuminate how chaplaincy practice is evolving, what difference it is making, and where the areas of tension remain.

The formation of new chaplains will need to incorporate the new understanding of their role and work is already underway to review this programme.

Professor John Swinton is clear that chaplaincy as a profession or discipline, like other professions, needs a clear theoretical basis. Given the changing context, he asserts that they can no longer work primarily from a theological perspective and that narrative becomes key. They need to be clear about what is distinctive in what they offer, and he suggests that this lies in the way they work with people. He describes their approach as “*hearing and holding*” – high quality listening that creates a holding space that enables people to maintain and create their own stories. Advanced communication and listening skills was highlighted as a training need for many chaplains.

Maureen O’ Neill and Kevin Franz both talked of chaplains as *bridges*. We could also see them as *linguists*, who can interpret the traditional values and themes of spiritual care, into the public language of a secular values based health and social care community.

A specific example of this is how ‘theological reflective practice’, which speaks particularly to the healthcare chaplaincy community and keeps alive the link with faith communities, has been translated into ‘values based reflective practice’ which is a public and philosophical language embraced by all in health and social care.

Bruce Rumbold³¹ describes how the essential original ‘spiritual care’ component of palliative care has been translated into the concept of ‘compassionate communities’. So a pattern is emerging of how the core essence of spiritual care is being translated into terms that all health and social care practitioners can identify with.

10.2 Organisational Development Training

Chaplains are being called upon to work more collaboratively than they ever have before, and to work strategically, deciding where to put their energy for maximum impact. Other training needs we identified were:

- leadership styles, how to analyse and understand them, and adopt different ones to suit different situations
- Systems thinking and processes for working strategically with systems. Because they are so person-centred, chaplains haven’t traditionally thought of how to work across a whole healthcare system. This should help with capacity issues, supporting chaplains to work where to put their energies into making a difference rather than simply being reactive.

10.3 Values Based Reflective Practice

Values Based Reflective Practice is becoming a core component of the new role chaplains are taking up within the NHS to support staff and promote an organisational culture, which can sustain the challenge of providing truly person-centred care. Many chaplains will need to develop their skills in facilitating this work.

³¹ Rumbold B: Models of Spiritual Care in Oxford Textbook of Spirituality in Healthcare (2012)

10.4 *Understanding of the context in which health and social care practitioners work particularly in relation to assets based approaches to health improvement*

Just as health and social care practitioners need to gain a greater understanding of spiritual care, chaplains need to understand the context in which their new role is evolving more clearly. This would include understanding the roles other health and social care practitioners play in promoting healthy communities. Much of this is captured in the learning resource *Community-Led Health for All*,³² which outlines the benefits of community-led, assets based approaches to health improvement and could be used as the basis for information/training sessions involving cross-sector teams.

One of our interviewees, Iain MacRitchie, previously Lead Chaplain for NHS Highland, learnt about the context of health and social care through undertaking an 18 month secondment as Rehabilitation Coordinator for the board area.

In November 2010, he returned to full time Chaplaincy, working now as Mental Health, Learning Disability and Community Chaplain in the Inverness area. While the work as Rehabilitation Coordinator had its own goals in the delivery of the Adult Rehabilitation Framework for NHS Highland, the underlying principles are proving to be of huge significance to the ongoing work of Chaplaincy. Iain put into practice the lessons learned from the Adult Rehabilitation Framework:

What this means is continually asking, 'Am I working collaboratively? Am I working preventatively? Am I promoting and supporting self-management and reducing the need for acute care? Am I working with groups?'

An article in the *Scottish Journal of Healthcare Chaplaincy* 15 (1) Iain examines how the insights of the secondment influenced his understanding of the role and practice of healthcare chaplaincy and the delivery of spiritual care. The conclusion is below but the whole article is included as Appendix 6. Iain's learning provides a template for all chaplains as they move towards a more collaborative community based model of delivering spiritual care.

...what I am suggesting may not be anything new to those of us currently working in chaplaincy and spiritual care, but it needs to be articulated and worked out in practice so that the service where we work can see that we have changed. This involves:

- *Making a difference as part of the healthcare team (and measuring the difference we make and talking it up)*
- *Being a bit more outcome focussed and a bit more confident about articulating these outcomes (e.g. I am clear that when people connect with their inner spiritual resources that this has a hugely beneficial effect on recovery and rehabilitation)*
- *Helping people to realise their own assets*
- *Genuine multi-disciplinary team working*
- *Developing and nourishing community through working with groups*
- *Developing a creative interface with faith communities*
- *Engaging allies (e.g. Allied Health Professionals, the Voluntary Sector, Churches and faith communities)*

The benefits are for all, not least the patients and clients whom we seek to serve. New circumstances call for new ways of working and the health service simply will not be able to resource the future

³² *Community Led Health for All: Developing Good Practice. A Learning Resource. Scottish Community Development Centre and NES. 2011*

demographic with current practice. Not only can chaplaincy adapt to this change, it can also be a resource for change within the health service itself.

The benefits are also for chaplaincy. This new model of working will reduce isolation, increase team working, put energy and time into the spiritual care aspects of motivating health and wellbeing earlier in the process, lend chaplaincy's voice to the shaping and implementing of policies, encourage and nourish community, and demonstrate the unique contribution of chaplaincy with increased confidence.

10.5 Competency Framework

The chaplaincy role in delivering spiritual care in communities is evolving. As we learn more about how it is evolving and the skills needed to undertake it, the current competency and capability framework³³ for healthcare chaplains needs to be revised. Ideally the revised document would include additional requirements for knowledge and skills, new capabilities on measures and outcomes, chaplaincy to the community and a new section on audit and research.

A complementary competency and capability framework could be written for other health and social care practitioners. This piece of work would strengthen the interface between specialist and generalist who are working together to deliver spiritual care.

11 LEARNING AND DEVELOPMENT NEEDS OF HEALTH AND SOCIAL CARE PRACTITIONERS

11.1 Understanding Spiritual Care and Making the Links

Spirituality is as relevant for the non-religious as it is for the religious because it is about the fundamental meaning of being human³⁴ (Malcolm Goldsmith 2011)

The term spiritual care was unfamiliar to most of our interviewees. Many went straight to discussing how to support connections with churches or faith groups as sources of support, or alternatively to concerns about patients being evangelised. This meant they struggled to connect spiritual care with the existing practice of health and social care practitioners.

Many staff reported that prior to attending the workshops they mis-understood Spiritual care to mean religious care. Feedback after each of the workshops indicated that staff had learnt the differences (and similarities) in the terms and could recognise that the provision of high quality healthcare incorporated Spiritual Care. (report on Spiritual Care Matters with AHPs)³⁵

Once the connection between person-centred and spiritual care, was made and understood, there were some interviewees, and this was particularly true of the third sector, who knew of many practitioners who were undertaking at least some aspects of spiritual care, but under a different name such as: being person-centred, holistic or compassionate care. Others, felt that although a few were doing it as part of their own natural way of working, many practitioners either didn't have the time or the skill to provide spiritual care.

³³ NHS NES 2008 Spiritual and Religious Care Capabilities and Competencies for Healthcare Chaplains

³⁴ Goldsmith M (2011) Spirituality and Personhood in Dementia. Ed Albert Jewell

³⁵ SPIRITUAL CARE MATTERS: ALLIED HEALTH PROFESSIONALS WORKSHOPS: FINAL REPORT FROM THE SOUTH EAST REGION: September 2010

Staff don't have time to have a real conversation.. but they could put a marker around spiritual health and get in touch with someone else to refer them to... (interviewee)

However the majority of our interviewees in health and social care, either themselves did not know what chaplains did, or were convinced that the practitioners they worked with would not know. This finding is borne out by other research:

Other healthcare professionals and healthcare managers do not know what chaplains do (Dr Harriet Mowat)³⁶

So, even if they were identifying spiritual needs, it is unlikely that many practitioners would know who to refer people to.

Jane Cantrell, Programme Director for Community Nursing at NES and Jane Harris, Programme Manager for Modernising Nursing in the Community for the Scottish Government both felt that it was real issue for nurses working in the community.

'those that have a personal connection with the Church often feel more comfortable talking about spirituality but many nurses are frightened of raising these issues... '

They were clear that spiritual care is an integral part of being person-centred and that nurses need to be able both to pick up the signs of spiritual ill-health. They felt that a discussion of spiritual care should be included when planning workforce development around person-centred practice.

There are strong foundations to build on. In March 2009 the educational tool *Spiritual Care Matters: An Introductory Resource for all NHS Scotland Staff*³⁷ was launched. Over 7,500 copies have been widely circulated within healthcare and university settings in Scotland and beyond. In order to maximise the utilisation of *Spiritual Care Matters* and develop the spiritual care education of pre and post registration healthcare professionals, in clinical and academic settings, eight small projects across Scotland, were awarded £3,000 each. These projects, which adopted an innovative variety of methodologies, reported their activity at a national conference in May 2010. An evaluation is currently being carried out of the impact of such education on spiritual care practice and is due to report by the end of 2012.

Preliminary sightings of the findings show a positive impact, which is borne out by an interim report carried out by Allied Healthcare Professionals of four of the projects which received awards. This report made a series of recommendations, one of which was that the training should be rolled out with better integration with health and social care priorities such as the Healthcare Quality Strategy 2010.

11.2 Targeting particular health and social care practitioners sectors

The different practitioners within health and social care all have important roles to play in supporting the delivery of spiritual care. It was not within the scope of this secondment to be able to connect with all of them, but we have highlighted a few issues in relation to the training and development needs of practitioners who seem to have a particularly significant role to play.

³⁶ PROM report reference

³⁷ The document can be downloaded from www.nes.sct.nhs.uk/spiritualcare/publications/

GPs and Practice Managers

GPs are a crucial first point of contact for many people. They are very well aware of how many people come to them with problems, which have no medical solution but could be well addressed by social or spiritual support. The GPs involved in the Community Chaplaincy Listening pilot are very appreciative of the service offered. A minority of them are beginning to access ALISS a search engine which helps them understand the assets available to promote self-management in their community. However most GPs find it impossible to keep up with the forms of social and spiritual support which are available in their communities. Practice Managers could be a crucial point of contact. Marion McCleod, Practice Manager Lead at NES, felt that Practice Managers were a core group who would need training so that they can play a part in disseminating information about spiritual care and the opportunities available to access it. She welcomed the suggestion of a short briefing paper, explaining what spiritual care is, outlining the links with person-centred and holistic approaches to care and highlighting opportunities such as the Community Chaplaincy Listening Service.

Allied Health Professionals

Allied Health Professionals include practitioners such as psychologists, speech and language therapists, art therapists etc. Many of them have already shown a keen interest in Spiritual Care and have attended training on spiritual care matters. Psychologists are an important group to liaise with particularly as they are currently developing learning and support materials on managing long term conditions.

Support Workers and Volunteers

Gill Walker, Educational Projects Manager within NES with a specific responsibility for overseeing the integration of health and social care for older people, highlights the vast number of support workers employed by the voluntary and private sectors who have the most contact with older people. They need to be reached, either directly or through team leadership and supervision. She has developed a model for analysing the learning needs of the workforce which includes both asset based working and holistic care.

Maureen O'Neill, Director of Faith in Older People, was clear that Spiritual Care Matters had made a big difference:

structurally a lot is in place, which is good... but it is difficult to make it the norm...

She felt that there was a huge need for spiritual care and values based reflective practice in residential homes, where the culture is redolent with loss of meaning and purpose. She identified in particular the need for rituals around death in these secular settings, and for many the lack of connection with faith communities around them:

Healthcare chaplains could have a bridge building role...

Both Irene Oldfather from the Health and Social Care Alliance and Jim Pearson from Alzheimer's Scotland also highlighted the lack of person-centred and spiritual care on Continuing Care Wards in hospitals.

11.3 Bereavement Care

The Scottish Government produced Shaping Bereavement Care – a framework for action (2011) and it highlights the importance of person centredness, patient safety and clinical effectiveness, the key drivers within the Healthcare Quality Strategy.

Bereavement care has long been a speciality of chaplaincy. But Shaping Bereavement Care recognises the very wide range of staff that will in the course of their day to day work have contact with people who have been bereaved. It recommends there that NHS Boards should: develop a planned and consistent approach to bereavement awareness, training and education, which should be available, at appropriate levels, for all staff. (Recommendation 6)(Chapter 4)

To assist in the development and delivery of appropriate training and education NHS Education Scotland should: explore the development of training and education resources to support health boards in the task of training staff across the workforce in bereavement awareness and bereavement care. (Recommendation 10)(Chapter 4)

To help support the delivery of these recommendations the Scottish Government provided funding to CRUSE for the development of training programmes in bereavement care for staff.

11.4 Undergraduate and Post-Graduate Studies

The NICE review reports a paucity of empirical evidence focusing on the education and training of the workforce and recommends training and education in spiritual care to be incorporated into the teaching curricula of health care professionals. This view was backed up several of our interviewees.

The review states that this should be supplemented by a wider range of learning opportunities and training programmes at different career stages. Again this is a view backed up by all of our interviewees.

Whilst on the whole spiritual care is not covered in training health and social care practitioners at an undergraduate level, Dundee University³⁸ and the University of the West of Scotland (UWS), offer robust modules in Spiritual Health, based on Spiritual Care Matters. The Thistle Foundation up until 2011, ran an HEC in Person-centred Approaches at Queen Margaret University, which included modules on understanding self and active listening.

At Glasgow Caledonian University, Beth Seymour describes the philosophy behind her courses on spiritual care –

'All work in spiritual care education is about character and qualities. Nurses work on their own inner spirituality and health to gain capacity to empower others. We open up preconceptions; disentangle the spiritual from religious; become aware of the difference of own beliefs and those of the patient, conscious that there is no requirement to assume another's life stance. During our modules we try to free up ideas and practices; encourage nurses to create the environment for spiritual care. Always aiming for spiritual literacy; spiritual wisdom; spiritual intelligence. Encouraging nurses to become confident in themselves to provide spiritual care; be able to suspend disbelief; conscious that there is never a right or a wrong unless breaking morals or virtues; and develop self.'

Elaine Stevens, who lectures at the University of the West of Scotland and Ayrshire Hospice, notes that nursing has become an increasingly '*task based system*' e.g. dressings and syringe pumps. There is no time for an asset based approach because of the '*quick in and quick out*'. In an attempt to address this she has drawn on a new model for psychological care: 'SAGE & THYME' and is testing this with new care assistants who are working in a community setting with the Ayrshire Hospice. The model offers a framework, which embraces an asset based model care.

Training of this sort needs to be made more widely available to health and social care practitioners.

³⁸ MacTaggart, I. et al 2012 Learning about Spiritual Care. It Matters Scottish Journal of Healthcare Chaplaincy 15

12 CONCLUSIONS

During the course of this secondment we found a lot of innovation in the practice of spiritual care; some of it pioneered by chaplains, some by faith communities and some by health and social care practitioners. Some of it was called spiritual care, some of it was called person-centred, asset based, holistic or compassionate care. Some of our interviewees in health and social care were excited by the idea of more integration between chaplaincy and health and social care practitioners to promote greater health and wellbeing. Others struggled to disconnect spiritual from religious care and that led to suspicion. Some chaplains can see the potential of solidifying the connections between their work, and the health and wellbeing of individuals and communities, others feel anxious and bewildered.

There are areas which are beginning to be quite well researched such as the impact of spiritual care interventions undertaken by chaplains with individuals and other areas, particularly as chaplains move into community and organisational spirituality, where it would be helpful to know a lot more about the difference particular interventions make.

Several learning and development needs were identified for chaplains and for health and social care practitioners.

Much of what is needed in order to deliver real person-centred and holistic care seems to be about getting out of our silos and working across boundaries. We make three final recommendations, which are about integration.

Common frameworks such as the Asset Based Approach to Spiritual Care can help practitioners to understand each other's contribution to a set of common spiritual, health and wellbeing outcomes.

Joint Training. Joint locality based training of chaplains and health and social care practitioners from across sectors on the meaning of spiritual care, the links with person-centred and asset based approaches and how it can be provided systemically, is likely to achieve a lot more than competency based training within silos. There are several training initiatives already in development, which could provide an opportunity for joint working. These include the proposal submitted to the Scottish Government by the Health and Social Care Alliance on People Powered Health and Wellbeing and the paper outlining NES' strategic direction for education, training and workforce development to support the Scottish Government's ambition for person-centred health and care.³⁹

Action Research. Many of the ideas for research described in Section 8, could be undertaken collaboratively across sectors, using an action research methodology, which involves both practitioners and people using the service as co-researchers. This would enable the learning to be not only richer, but person-centred and applicable immediately.

³⁹ led by Jane Davies, Educational Projects Manager in October 2012

REFERENCES

Brady, MJ., Peterman, AH., Fitchett, G., Mo, M., and Cella, D. 1999 'A case for including spirituality in quality of life measurement in oncology' *Psycho-oncology* Vol. 8 pp417-428

Breitbart, W., Gibson, C., Poppito, SR. and Berg, A. 2004

Candy, B., Jones, L, Varaganam, M., Speck, P., Tookman, A. and King, M. 2012 'Spiritual and religious interventions for wellbeing of adults in the terminal phase of disease', *Cochrane Database of Systematic Reviews* Issue 5

de Chardin, T 2008: *The Phenomenon of Man*.

Chief Medical Officer for Scotland. 2010. *Annual Report*.

Devenny B 2005 *Spiritual Responses to Sudden and Progressive Disabilities: Recommendations for the systemic integration of spiritual awareness into health and social care*)

Edinburgh Health Inequalities Standing Group (2009): *Social Capital Health and Wellbeing Planning and Evaluation Toolkit*.

Evans, M. 2012 *Exploring midwives' understanding of Spiritual Care and the role of the Healthcare Chaplain within a maternity unit*. MSc Dissertation University of Glasgow

Goldsmith M (2011) *Spirituality and Personhood in Dementia*. Ed Albert Jewell

Gordon, Kelly and Mitchell 2012: *Spiritual Care for Health Professionals*.

Health and Social Care Alliance. (2012) *People Powered Health and Wellbeing*.

Health Professions Council 2012 *Professionalism in nursing, midwifery and the allied health professions in Scotland*

Holloway M, Adamson S, McSherry W, Swinton J, *Spiritual Care at the End of Life*. NICE Systematic Review 2011.

MacRitchie, I. 2012 'Lessons for Chaplaincy from a Management Secondment' *Scottish Journal of Healthcare Chaplaincy* Vol 15 (1) p3-9; Appendix 6

MacTaggart, I. et al 2012 'Learning about Spiritual Care', *It Matters Scottish Journal of Healthcare Chaplaincy* 15

McClellan J and MacNeice V (2012), *Assets in Action*. Glasgow Centre Population Health.

Morgan A and Ziglio E 2007. *Revitalising the evidence base for public health: an assets model*.

Mowat, H., Bunniss, S. and Kelly, E. 2012, *Community Chaplaincy Listening Phase 2 Executive Summary*

NES. March 2012. *The Search for Meaning and Purpose in Communities*. Kennedy, J and McKenzie I.

NES (2011). *Learning Needs Analysis to Support the Implementation of Person-Centred Care*. Blake Stevenson

NES (2009)) *Spiritual Care Matters: An Introductory Resource for all NHS Scotland Staff*

NES (2008) *Spiritual and Religious Care Capabilities and Competencies for Healthcare Chaplains*

NHS Health Scotland : A Fairer Healthier Scotland: Our Strategy 2012-2017.

Rosseau, P. 2000 'Spirituality and the dying patient' *Journal of Clinical Oncology* Vol. 8 pp2000-2002

Rumbold B 2012: 'Models of Spiritual Care' in *Oxford Textbook of Spirituality in Healthcare*

Scottish Community Development Centre and NES. 2011: *Community Led Health for All: Developing Good Practice. A Learning Resource*.

Scottish Community Development Centre and Faith in Community Scotland (2011): *Faithful Endeavours: How public agencies and faith communities can work better together*.

Scottish Government (2011): *Report on the Future Delivery of Public Services*.

Scottish Government (2009), *Healthcare Quality Strategy for NHS Scotland*

Scottish Government (2007), *Better Health Better Care*

Scottish Government (2002), *Spiritual Care in NHSScotland*

Scottish Government (2008), *Spiritual Care*

Scottish Government (2011), *Shaping Bereavement Care*

Scottish Government (2012), *The Charter*

Selman L, Young T, Vermandere M, Leget C, Stirling I, 2012 on behalf of the EAPC Spiritual Care Taskforce

Snowden, A., Telfer, I., Kelly, E. R., Mowat, H., Bunniss, S., Howard, N., & Snowden, M. A. (2012). *Healthcare Chaplaincy: the Lothian Patient Reported Outcome Measure (PROM). The construction of a measure of the impact of specialist spiritual care provision*.

Spiritual Care Matters: Allied Health Professionals Workshops: Final Report from the South East Region. September 2010

Vermandere, M., Choi, Y-N., De Brabandere, H., Decouttere, R., De Meyere, E., Gheysens, E., Nickmans, B., Schoutteten, M., Seghers, L., Truijens, J., Vandenberghe, S., Van de Wiele, S., Van Oevelen, L-A and Aertgeerts, B. 2012 'GPs' views concerning spirituality and the use of the FICA tool in palliative care in Flanders: a qualitative study', *British Journal of General Practice* October e718-724

APPENDICES

APPENDIX 1:

A new model of Spiritual Care - area of inquiry interview guidelines

Background

NES is looking to develop a new model of healthcare chaplaincy that will promote and provide holistic spiritual care in community settings e.g. the Community Chaplaincy Listening (CCL) action research project which offers patients in GP surgeries the opportunity to tell their story to a trained listener from an NHS department of Spiritual Care.

We are keen to explore existing and developing models of practice that may be examples of “models of the future” that we can learn from, and would like to learn more about the approach you are using and the work you are doing.

- How did you get started?
- Can you describe your model/conceptual framework
- What problem you are trying to solve?
- What difference you are hoping to make?
- Who is providing the care/service?
- What local assets have you been able identify and use to support the service?
- Do you think it is a healthcare role?
- Does/could the chaplain have a role in this?
- What impact are you seeing now and would like to see in the future?
- How much is the idea of a sense of coherence or integration a part of it?
- Who else do you think we should speak to?
- What should we read to find out more?

APPENDIX 2:

Asset based approach to Spiritual Care Framework: developing individual assets

This part of the model looks at how chaplains (or other professionals) contribute to individual health and wellbeing through 1:1 work

Inputs	Processes	S T Outcomes	M T Outcomes	L T Outcomes
Chaplains	Person Centred Spirituality – discovering and developing individual assets through: <ul style="list-style-type: none"> • 1:1 listening and accompanying in acute and community settings • meaning making therapies for people with mental health issues • developing rituals and rites of passage 	<ul style="list-style-type: none"> • motivation to cope • belief in own capacity • belief in coping resources • positive feelings about one’s life • ability to grow through suffering & trauma • self esteem and self confidence • enhanced sense of dignity • contentedness/peace • connectedness 	<ul style="list-style-type: none"> • Resilience • Sense of coherence • Sense of purpose • Sense of control • Sense of wellbeing or life satisfaction • Improved physical and mental health • Self managed care 	<ul style="list-style-type: none"> • Stronger , safer and healthier communities • Decreased rates of suicide, alcohol and substance abuse, and violence, depression, obesity, prolonged bereavement disorder

Asset based Approach to Spiritual Care Framework: developing capacity within communities and other professions

This part of the model looks at how chaplains have more of an impact on community health and wellbeing through working with community groups, health and social care practitioners within communities, and faith groups, to address spiritual health.

Inputs	Processes	S T Outcomes	M T Outcomes	L T Outcomes
Chaplains	Community Spirituality <ul style="list-style-type: none"> • mapping and developing community assets in relation to spiritual health • Supporting community members/staff to deliver spiritual care • Facilitating hope and recovery groups for people with mental health issues/dementia • Engaging with Faith/Church groups • Secular community rituals • Mindfulness groups • Training for staff in Spiritual Care Matters 	Health practitioners and community members more confident in promoting resilience and a sense of coherence through addressing issues relating to spiritual health e.g. hopelessness, isolation, loss, alienation Faith groups more active in addressing issues of spiritual health in communities	Community resilience Community cohesion Sense of community and solidarity More people who experience inequality influence decisions that affect their life or community	Stronger, safer and healthier communities Community influence and control

Asset based Approach to Spiritual Care Framework – developing organisational assets

This part of the model looks at how chaplains support spiritual health through developing organisational resilience.

Inputs	Processes	S T Outcomes	M T Outcomes	L T Outcomes
Chaplains	Organisational Spirituality <ul style="list-style-type: none"> • Workforce and organisational development • Critical Incident Stress Management • Structured mediation • “Healthy working Lives” type initiatives • Values Based Reflective Practice with staff groups 	Stronger more innovative multidisciplinary teams, work teams and organisations Creative outcome focused partnerships Improved attendance at work	Negotiated shared interest interventions e.g. social prescribing, peer support, co-production and outcome based commissioning, personalised/self-managed care, community development to tackle health inequalities Value based organisations Staff retention	Stronger, safer and healthier communities

APPENDIX 3:

Towards an asset based model of spiritual care – interview guide

Background

NES is looking to develop a new model of healthcare chaplaincy that will promote and provide holistic spiritual care using an asset based approach.

Taking an asset-based approach involves mobilising the skills and knowledge of individuals and the connections and resources within communities and organisations, rather than focusing on problems and deficits⁴⁰.

Current examples include:

- the Community Chaplaincy Listening (CCL) action research project which offers patients in GP surgeries the opportunity to tell their story to a trained listener from an NHS department of Spiritual Care, and
- the Kingsway Ct chaplaincy support project where community members and project staff are being supported to explore issues of spiritual wellbeing e.g. hope, identity, resilience, meaning and purpose within a group setting, and to build their skills in enhancing the spiritual wellbeing of the community.

We are keen to explore how chaplaincy/spiritual care can link with and support existing and developing models of practice in community settings.

Context:

Our working assumptions are based on the following extracts from the NHS Spiritual Care Guidance:

- Spiritual care in the NHS is given by all members of staff and by carers and patients, as well as by staff specially appointed for that purpose
- The majority of healthcare takes place in the community. Therefore spiritual care, (alongside other health and social care disciplines) must find its place in settings other than hospitals
- NHS Boards are therefore encouraged to develop new ways of providing spiritual care to health service users in community settings
- NHS Boards should encourage (Chaplain's) co-operation with other AHPs and to work as members of the multi professional healthcare team whenever possible

Areas to be explored:

Given the above, and recognising that an asset based model of spiritual care assumes that a wide range of health and social care workers, community members and volunteers are needed to promote, encourage and develop spiritual wellbeing at individual, community and organisational/institutional level -

- Can you describe your model of practice/way of working?
 - explore how the model/service is delivered and the extent to which it identifies, connects with and uses/builds on service user/local people's and community assets
- How do/would you see spiritual care being delivered in your context?

⁴⁰ Asset-based approaches to health improvement, NHS Health Scotland, Debbie Sigerson and Laurence Gruer, Oct 2011

- What learning and development needs do you think your staff/volunteers may have around spiritual care giving?
 - explore issues of information/knowledge, skills, confidence development etc and current practice development approaches, supervision, peer support, multidisciplinary team working etc
- What support would your staff/volunteers need to undertake their role in promoting and developing spiritual wellbeing
- How do you think this approach fits with other initiatives taking place within the NHS and Social Care (e.g. personalisation/self managed care agenda, co-production etc)

Key findings of our research to date:

- The crucial role chaplains do already and could play in the new understanding of health & wellbeing dis-ease which is being explored in healthcare
- The radical nature of some work already going on within chaplaincy e.g. Tayside, Inverness and Ayrshire
- The need to develop an understanding of the interface between chaplaincy and faith communities locally and perhaps nationally
- The need to write up new and innovative practice – a definition of ‘spiritual listening’ - the secondment is being a trigger to chaplains to do this in the SJHC
- The contribution that chaplains could make to facilitating values based reflective practice with health professionals
- The interest from health practitioners both at community and policy level in working with chaplains and the notion of spiritual health
- recognising that spiritual care is embedded in a secular/healthcare institution (professionalised) - and the challenges lie in equipping it to go forward from there and to resist slipping back into its religious/church cultural roots
- needing to continue to "professionalise" - undertake more research, learn the language of outcomes etc
- the importance of building on Spiritual Care Matters - seen as a key document - we need to use the language it uses
- the emerging new role - the likelihood of a need for chaplains to take on an enabling role given the capacity issues as the model develops and moves further into community settings - i.e. supporting trained listeners to deliver much of the face to face work; developing supervision, mentoring, action learning group type roles and settings, with direct referrals to chaplains for particular cases (e.g. those with religious concerns/needs etc)
- need to make connections with other practice models/theories of change - person centered approaches and to make more explicit connections with co-production, asset based approaches (as above re logic model)
- need to bring chaplains with us - many are challenged by the prospect of community settings, co-production, asset based approaches etc - and to identify gaps and training/learning needs etc

“Principles of Spiritual Care Services

The present policy of the Scottish Government Health Department (CEL (2008) 49) states that the following basic principles should underpin all spiritual care services provided or funded by the NHS in Scotland. They should:

- Be impartial, accessible and available to persons of all faith/belief communities and none and facilitate spiritual and religious care of all kinds, as required.
- Function on the basis of respect for the wide range of beliefs, lifestyles and cultural backgrounds found in the NHS in Scotland today.
- Value such diversity; never be imposed or used to proselytise.
- Be a significant NHS resource in an increasingly multicultural society.
- Be a unifying and encouraging presence in an NHS organisation.
- Affirm and secure the right of patients to be visited (or not) by any chaplain, belief group/religious leader or spiritual caregiver.
- Acknowledge that spiritual care in the NHS is given by all members of staff and by carers and patients, as well as by staff specially appointed for that purpose.⁴¹

“The majority of healthcare takes place in the community. Therefore, spiritual care must find its place in settings other than hospitals. This is perhaps most clearly seen in mental health services where fewer people require in-patient care. Consequently, several mental health chaplains are working in day centres and in the community as well as in their local hospital. This will increasingly be the norm as Community Health Partnerships become major providers of health care.

NHS Boards are therefore encouraged to develop new ways of providing spiritual care to health service users in community settings.⁴²

NHS Boards should encourage (Chaplain’s) co-operation with other AHPs and to work as members of the multi professional healthcare team whenever possible

⁴¹ Spiritual Care Matters

⁴² CEL (2008) 49

APPENDIX 4:

Interviewees/Conversations

Health Professionals

Alison Bunce, Director of Care, Ardgowan Hospice
Jane Cantrell , Programme Director, Community Nursing, NES
Margaret Craig, GP Deep End Practice, Possil
Vicki Cunningham, GP Practice Manager, Fife
Margaret Hannah, Deputy Director of Public Health, NHS Fife
Jane Harris, Scottish Government, Programme Manager, Modernising Nursing in the Community
Anne Hendry, National Clinical Lead for Quality, Scottish Government
Julie Mann, and Aileen Meek, Scottish Huntingdon's Association
Marie Curie Information Project – Ayrshire and Arran
Marion McCleod, Practice Manager Lead, NES
Esther Murray, trainee psychologist, Ayrshire and Arran
Catriona Ness, Organisational Development, NHS Tayside
Diana Noel-Paton, Chief Executive, The Thistle Foundation
Irene Oldfather, LTCAS
Jim Pearson, Deputy Director, Alzheimer's Scotland
Gerry Power, National Lead for Coproduction and Community Capacity, Joint Improvement Team, Scottish Government
Liz Ferguson, Ripple Project, Edinburgh
Beth Seymour, Lecturer Glasgow Caledonia University
Susan Shandley, AHP Practice Education Coordinator, NES
Elaine Stevens, Nursing Lecturer University of the West of Scotland
Lorna Taylor and Alex Curran, GPs, Conan Doyle Practice, Edinburgh
Gill Walker, Educational Projects Manager, Reshaping Care for Older People, NES
Craig White – psychologist, Ayrshire and Arran
Jim White, STEPS, Glasgow South East CMHT
Wilma Reid – Head of Learning and Workforce Development, NHS Health Scotland

Health and Chaplaincy

Suzanne Bunniss, Director of Firecloud
Maureen O'Neill, Director, Faith in Older People
Morag Sievwright, Project Manager, Faith in Throughcare
John Swinton, Chair in Divinity and Religious Studies, Aberdeen University

Chaplaincy

Almost all chaplains were consulted through conferences and informal conversations but in-depth interviews were conducted with:

Margery Collin, NHS Forth Valley
Mark Evans, NHS Fife
Kevin Franz , NHS Greater Glasgow and Clyde
Ian MacRitchie, NHS Highland
David Mitchell, lecturer at Glasgow University
Sheila Mitchell, NHS Ayrshire and Arran
Gillian Munro, NHS Tayside

Jim Simpson, NHS Grampian
Lynda Wright, NHS Fife

APPENDIX 5:

Chaplains consensus statement

Best practice in 21st Century healthcare attends to the whole person – the physical, mental, social and spiritual aspects of human living.

When emotional and spiritual needs are addressed service users and staff experience a greater sense of wellbeing in dealing with ill-health.

Chaplains are employed as part of NHS Scotland multi-disciplinary teams. Their primary responsibility is to promote the spiritual wellbeing of healthcare communities and all who are part of them – patients, carers, staff and volunteers – 24 hours a day, 7 days a week by:

- Engaging in a therapeutic listening, talking and being present with people in difficult times. In doing so chaplains:
 - Affirm that fear, anxiety, loss and sadness are part of the normal range of human experience in healthcare;
 - Establish trusting relationships in which others can explore hard questions relating to morality, meaning and identity;
 - Help them to (re)discover hope, resilience and inner strength in times of illness, injury, loss and death.

- Helping individuals, families and communities in health care to mark significant moments in life and death using ritual and in other meaningful ways.

- Resourcing, enabling and affirming healthcare colleagues in their delivery of spiritual care – supporting them in reflecting on their own spirituality and that of patients and their carers.

- Meeting the particular needs of all in the healthcare community in relation to religion and belief by promoting creative links with faith and belief groups.

- Helping staff reflect on the relationship between their personal stories, including their values, beliefs, experiences and sense of vocational fulfilment, and the shared story of their workplace. The interface of the two influencing: behaviours, attitudes, decision making and wellbeing.

APPENDIX 6:

Case Studies

Community Chaplaincy Case Study

In May 2009, after 11 years as Lead Chaplain for NHS Highland, Iain Macritchie started work as the Rehabilitation Coordinator for the board area. This was to be a two year secondment, the aim of which was to embed the recommendations of the Rehabilitation Framework (SCOTTISH EXECUTIVE HEALTH DEPARTMENT (SEHD) 2007 *Co-ordinated, integrated and fit for purpose: A Delivery Framework for Adult Rehabilitation in Scotland*) in the practice of the health board, local authorities and voluntary sector agencies with respect to all aspects of rehabilitation.

In November 2010, he returned to whole time Chaplaincy, working now as Mental Health, Learning Disability and Community Chaplain in the Inverness area. While the work as Rehabilitation Coordinator had its own goals in the delivery of the Adult Rehabilitation Framework for NHS Highland, the underlying principles are proving to be of huge significance to the ongoing work of Chaplaincy.

An article in SJHC 15 (1) examines how the insights of the secondment influenced his understanding of the role and practice of healthcare chaplaincy and the delivery of spiritual care.

Upstream preventative care, asset based approaches and self-management

All of these areas have important messages for chaplaincy as well as having aspects which could well use the kinds of interventions healthcare chaplains give routinely. For example, “motivational interviewing” in vocational rehabilitation is what chaplains do when asking patients to consider what gives their lives meaning and purpose, what inspires them, what gives them a reason to live. ‘Mindfulness’, ‘relaxation’, ‘group support’ as components of *inter alia* rehabilitation, falls prevention, re-ablement and self-management are also activities with which chaplains are familiar.

Current Context & issues

Iain put into practice the lessons learned from the Adult Rehabilitation Framework. What this means is continually asking, ‘Am I working collaboratively? Am I working preventatively? Am I promoting and supporting self-management and reducing the need for acute care? Am I working with groups?’

Team Working

I learned that Chaplaincy is not alone in feeling alone! Many of the healthcare staff I met during my secondment spoke of their desire to be more connected with the MDT and to work more collaboratively with colleagues across sectors. Now that I am back in chaplaincy, I find myself using some of these connections, particularly with Allied Health Professionals working in Mental Health and Learning Disability and using their own policy ‘Realising Potential’ to get more involved with the MDT. (SG 2010 *Realising Potential: An Action Plan for Allied Health Professionals in Mental Health*). I recognise that I am fortunate in terms of following a chaplain who had already embedded this way of working in his daily practice and that nearly 19 hours of my working week are allocated to the community and local community mental health teams.

I try to ensure that every area of my work has at least one group activity associated with it that patients or clients can access. In New Craigs Hospital there are ‘First Things’ (morning prayers for staff and patients and an opportunity to be quiet and to ‘centre’ at the start of the day), Sunday services and fortnightly worship on the ward caring for patients with dementia. I am also involved in

the Creative Writing Group which I facilitate alongside an occupational therapist and a speech and language therapist. In the Royal Northern Infirmary Community Hospital there is a weekly Sunday service and 'Mind the Gap', a multi-disciplinary group of staff, reflecting on practice. In the community there is 'Churchlite' (like 'Church' but without the heavy bits) for community clients, where I am helped by a CPN and volunteers who are also community service users.

Each of these areas of group work enables me to use skills learned during theological training in terms of the imaginative use of space, visual aids, liturgy and poetry, images, music, spoken and sung words etc, in order to facilitate good healthcare outcomes (and good spiritual care outcomes within that) such as the building of community, the discovery of meaning and purpose, the encouragement of gifts and abilities, and a sense of connectedness to inner and outer resources for recovery and rehabilitation.

Upstream Working

I am constantly challenged to go 'further upstream' with people (see SEHD 2007 p18), as with the client who has been asked by a nurse, using good CBT techniques, to list alternatives open to him whenever he feels like ending his life. The client listed a number of good options including contacting *inter alia* his CPN, a neighbour, Breathing Space, Samaritans. In discussion with the nurse, I realised that all of these measures involved reaching out to other people and that we could go further upstream to address this individual's capacity to be at ease with himself and, through mindfulness or prayer or whatever other method the patient owned, we could show him his own inner resources to help deal with acute periods of isolation.

Asset Realisation

Another area of application would be in number of times I would see a patient or client, especially clients in the community. I am more intentional now in pointing out from the first contact that these visits will be limited in number (say, six to eight). I invite the patient to discuss early on in the process what he or she would want to achieve in our times together (recognising that 'outcomes' might change in the process) and find that this sharpens the focus of discussions and increases the outcome of supported self-management. Conversations are predicated on the knowledge that I am not necessarily going to be around in the long term future and that we are about identifying the patients existing assets (including, and perhaps especially, his or her spiritual strengths) and utilising these.

This becomes especially important in bereavement care where I find myself resisting the tendency to pathologise grief (with beliefs like 'It hurts, so something must be wrong!') and helping the individual to realise inner strengths (such as faith, life stance, philosophy etc) and outer resources (such as community, family, volunteers etc). Most of all, I am keen not to become the person to whom everyone in Mental Health and Learning Disability is referred simply because they are bereaved. I really do not have the capacity for that. What I try to do is to work with staff and individuals to normalise grief and to allow it to follow its natural course.

Cross-agency working

Every now and again, I find myself taking a spot check. How many non-NHS agencies am I involved with? This would include Social Workers, MHOs, police, home carers, care home staff and voluntary sector workers such as those employed by the Highland Homeless Trust or Cruse or Acorn Listening Service. And, within the NHS, how many non-Chaplaincy staff am I engaged with. This would include AHPs, CPNs, TIs, doctors, nurse, ancillary staff, managers etc. (SG 2010 *Realising Potential*)

If, as chaplains, we are not engaged with others in the care of patients and clients, we run the risk of deserving the old stereotype of being lone works, accountable to no one, and therefore, for all anyone knows, quite expendable. Increasingly, the question is being asked within healthcare, 'What difference does this part of the service make?' Following my secondment, I am convinced that the

more chaplaincy engages with others in the work of healthcare the more of a difference we will be seen to make.

Contributing to what's hot

I believe in chaplaincy that we miss many opportunities to promote ourselves through not being aware of current policies and issues in the NHS and, therefore, not contributing to the shaping of the future service. We cannot complain if chaplaincy is sidelined if, when opinion is solicited for a policy-in-the-making, we do not speak up. It was truly soul-destroying working as a Rehabilitation Coordinator and seeing, again and again, lists of NHS and local authority staff who might be engaged in service delivery, with no mention of chaplains, especially where I knew that chaplaincy and spiritual care would have a hugely positive contribution to make. (e.g. SEHD 2007 p22)

Further to this, some policies, even although they do not explicitly mention chaplaincy, represent an open door for chaplaincy to walk through, e.g. 'Realising Potential' within Mental Health and Learning Disability. (SG 2010 *Realising Potential*)

My experience is that managers and senior staff whose job it is to implement these policies, are unlikely to have chaplaincy at the forefront of their minds when doing so. It means that it is all the more necessary for us as chaplains to take these policies to managers and demonstrate how we can be of help in delivering them.

New ways of being a Chaplain

In conclusion, what I am suggesting may not be anything new to those of us currently working in chaplaincy and spiritual care, but it needs to be articulated and worked out in practice so that the service where we work can see that we have changed. This involves:

Making a difference as part of the healthcare team (and measuring the difference we make and talking it up)

Being a bit more outcome focussed and a bit more confident about articulating these outcomes (e.g. I am clear that when people connect with their inner spiritual resources that this has a hugely beneficial effect on recovery and rehabilitation)

Helping people to realise their own assets

Genuine MDT working

Developing and nourishing community through working with groups

Developing a creative interface with faith communities

Engaging allies (e.g AHPs, the Voluntary Sector, Churches and faith communities)

Making an impact within the NHS by offering a chaplaincy voice and resource to hot- topics e.g. 'Realising Potential', 'Gaug Yersel', 'Rehabilitation Framework', 'Health Works' etc, etc, etc.!

Benefits

The benefits are for all, not least the patients and clients whom we seek to serve. New circumstances call for new ways of working and the health service simply will not be able to resource the future demographic with current practice. Not only can chaplaincy adapt to this change, it can also be a resource for change within the health service itself.

The benefits are also for chaplaincy. This new model of working will reduce isolation, increase team working, put energy and time into the spiritual care aspects of motivating health and wellbeing earlier in the process, lend chaplaincy's voice to the shaping and implementing of policies,

encourage and nourish community, and demonstrate the unique contribution of chaplaincy with increased confidence.

Organisational Spirituality Case Studies

Critical Incident Stress Management (CISM) is a comprehensive staff support structure and represents an integrated 'system' of interventions, which are designed to help prevent, assess the impact of, and alleviate the potentially harmful psychological reactions that so often accompany a traumatic incident. CISM, however, is more than just a technique or indeed a system of well integrated interventions. It is a philosophy and a belief in the importance and value of members of staff.

"It is the integration of all the diverse elements of a trauma support programme, so that care is delivered to those who need it, when they need it and where they need it, which is one of the greatest challenges facing responsible employers into the next century"⁴³

The provision of CISM within an integrated structure serves a number of interconnected purposes:

- *Preparing staff for the possibility of traumatic incidents occurring*
- *Enabling effective and timely support during and after incidents and the rapid resolution of problems*
- *Heightening awareness and acceptance of reactions to stress and trauma, including realistic understanding about the frequency of severe and prolonged reactions*
- *Raising awareness of the support programme to ensure staff and managers know how to seek support or further information about reactions to trauma*
- *Ensuring that members of staff feel supported in both the short and long term*
- *Minimising short term distress and long term disability*
- *Facilitating return to effective work*
- *Educating employees and management about the effects of trauma and how to give day to day support to colleagues⁴⁴*

Blair Robertson, Paul Graham and Kevin Franz describe another approach to promoting organisational health:

Mindfulness Meditation for NHS Staff at Inverclyde Royal Hospital

Aim: *To develop and establish a means of introducing colleagues to the benefits of mindfulness practice which in turn will support the person-centred agenda for colleagues, patients and their carers.*

Background: *Based upon easily accessible elements of the Mindfulness based stress reduction (MBSR) course, a four session Introduction to Mindfulness course was created, piloted with a group of GG&C chaplains and revised in light of feedback. Some of the key drivers were: 'provide easy-to-use tools', 'be open to all grades', 'aligned to Core Dimensions of the NHS Knowledge and Skills Framework' and 'able to be replicated in different settings.'*

Approach: *The lunchtime class was advertised in the IRH Chaplaincy Bulletin, and was supported by posters and information leaflets distributed in Staff rest areas. The leaflets provided some 'what is mindfulness?' information and outlined how Mindfulness connected to the Key Service Framework*

⁴³ Richards, 1997 p 325

⁴⁴ British Psychological Society Report, 2002

Core Dimensions. There was a good deal of interest shown across various disciplines with 10 colleagues signing up for the first batch of classes, with 14 more interested if they were held on a different day.

Course Outline: *The course consisted of four 30-minute classes held on Tuesday lunchtimes from 28th Aug - 18th Sept 2012. Each class involved exploration of Mindfulness; mindfulness practice (awareness and short meditations); and enquiry with attendees about the experience of practice during the class and the previous week.*

Feedback: *Attendees were asked to complete a basic, anonymous feedback form. This was to gather some personal info about the dept & grade; rating of pre-class info, environment; content and pace of each class. It also sought to assess if mindfulness had had an impact on any of the core dimensions and their personal objectives of attending the course. Nine responses were received.*

*All scoring was out of 10 (1=very poor through to 10=excellent)
Scoring of the pre-class info & environment (seven aspects) had average score of **9 out of 10**.
Scoring of the course content, tone & pace (seven aspects) had average score of **9 out of 10**.*

KSF Six Core Dimensions:

The following aspects of each core dimension were assessed:

- 1. Communication:** *encourages non-judgmental acceptance which develops relationships*
- 2. Personal & People Development:** *Kindness to self and a desire to grow*
- 3. Health, Safety & Security:** *Clearer recognition of environment*
- 4. Service Improvement:** *Cultivating a different relationship with daily experiences*
- 5. Quality:** *Increased awareness and energy to become more effective*
- 6. Equality & Diversity:** *Treats others with dignity and respect*

All respondents had noticed an impact on core dimensions 1,2 and 6.

Seven respondents had noticed an impact on core dimensions 3 and 4.

Six respondents had noticed an impact on core dimension 5.

Current Situation: *The second four-week class is almost finished. It was over subscribed before any publicity was sent out. This was mainly due to a change of day (Wednesday) to accommodate the 14 who couldn't attend the first class, and also enquiries made by colleagues of those who attended the first course. There are already colleagues enlisted for the next course in early 2013.*

APPENDIX 7:

Learning and Training Needs for Healthcare Chaplains

NES/UKBHC Spiritual and Religious Care Capabilities and Competences for Healthcare Chaplains	Learning needs	Training needs
<p>Capability 1.1. Knowledge and skills for practice: The chaplain continually develops and updates his or her knowledge of spiritual and religious care, current policy, and research evidence relevant to chaplaincy services, and uses this to promote and develop effective, evidence-based practice</p>	<p>Government policies – quality strategy; person centred care; re-enablement</p> <p>Definitions?</p> <p>Healthcare Language - how do you describe forgiveness in secular language?</p> <p>Theological basis -</p>	
<p>Capability 1.2. Practicing ethically: The chaplain maintains and develops his or her knowledge of culture, diversity, ethical, professional and legal theory and frameworks. This knowledge is used to support interactions with individuals using chaplaincy services.</p>		
<p>Capability 1.3. Communication skills: The chaplain maintains and develops the communication skills necessary for the spiritual and religious care of individuals and groups.</p>	<p>Active listening</p> <p>Advanced communication skills</p>	
<p>Capability 1.4 Education and training: In response to identified needs the chaplain contributes to internal education and training</p>		

programmes and external voluntary and healthcare groups.		
Capability 2.1. - Spiritual assessment and intervention: The chaplain, in partnership with the individual and the healthcare team, assesses the spiritual needs and resources of the individual and their family/carers and responds with interventions which can include referral to other internal and external care providers.	Asset-based approach Screening and assessment tools What interventions work?	
Capability 2.2. Religious assessment and intervention: The chaplain, in partnership with the individual and the healthcare team, assesses the religious needs and resources of the individual and his or her family/carers and responds with interventions which can include referral to a faith community or belief group representative.	Asset-based approach	
Capability 2.3. Outcomes and evaluation: The chaplain can evaluate outcomes	PROMS	
Capability 3.1. Team working: The chaplain recognises and works to promote the place of chaplaincy within the chaplaincy team, local multidisciplinary teams and the wider healthcare team.		
Capability 3.2. Staff support: The chaplain builds working relationships with members	Values based reflective practice	

of staff and volunteers and responds to requests for personal and professional support.		
Capability 3.3. Chaplain to the hospital or unit: The chaplain is aware of his or her role in the hospital or unit's major incident plan and responds to staff issues and events that need a communal recognition and action.	Organisational spirituality Values based reflective practice	
Capability 3.4 Chaplain to the local community: The chaplain is aware of his or her role in contributing to the health and wellbeing of the local community	Asset based model of spiritual care	
Capability 4.1. Reflective Practice: As part of the process of continuing professional development the chaplain demonstrates the ability to reflect upon practice in order to develop and inform his or her practice.	Using self in spiritual care Value based spiritual care	
Capability 4.2 Audit and Research: The chaplain is research aware and research literate		

Learning and Training Needs For Healthcare Practitioners

NES Spiritual Care Capabilities and Competences for Health & Social Care Practitioners	Learning Needs	Training Needs
<p>Capability 1.1. Knowledge and skills for practice: Continually develop and update knowledge of spiritual care, current policy, and research evidence relevant to one's own discipline, and use this to deliver effective, evidence-based practice.</p>	Spiritual Care Matters	
<p>Capability 1.2. Practicing ethically: Maintain and develop knowledge of culture, diversity, ethical, professional and legal theory and frameworks. This knowledge is used to support interactions with individuals using health and social care services.</p>		
<p>Capability 1.3. Communication skills: Maintain and develop the communication skills necessary for the spiritual care of individuals, groups and the wider community.</p>		
<p>Capability 1.4. Education and training: In response to identified needs the chaplain contributes to internal education and training programmes and external voluntary and healthcare groups.</p>		
<p>Capability 2.1. - Spiritual assessment and intervention: In partnership with the individual and the health & social care team,</p>		'Ars Moriendi'

assesses spiritual needs and resources of the individual. Offer effective evidence based interventions, or if necessary refer on.		
Capability 2.2. - Religious assessment and intervention: In partnership with the individual and the health & social care team, assesses religious needs and resources of the individual. Offer effective evidence based interventions. This may include referral to a faith community.		
Capability 3.1. Team working: Promote spiritual care within local multidisciplinary teams and the wider health and social care community.		
Capability 3.2. Staff support: Builds positive working relationships with members of staff and volunteers.		
Capability 3.3. Organisational spirituality: Support the development of organisational spirituality		
Capability 4.1. Reflective Practice: As part of the process of continuing professional development demonstrate the ability to reflect upon practice in order to develop and inform practice.		

