Delivery of spiritual care in HBCCC from the community and faith based pastoral care teams

Aim of paper: Identifying and fulfilling the need for community spiritual care engagement with HBCCC units

Introduction

Spiritual Care Matters was produced as an introductory resource for all NHS Scotland staff through NHS Education for Scotland (Levison 2009). The steering group that worked on this document included consultants, bereavement coordinators, chaplains and university lecturers all of whom agreed that a learning resource was needed to underpin the provision of spiritual care in the National Health Service (NHS) in Scotland. The resulting publication was testament to Levison's nine years in developing a national Healthcare Chaplaincy and Spiritual Care service. Because this service became integral to the NHS, many local ministers became part of the teams offering the service as well as attending to their own parishes. Over the years, with diminishing numbers of ministers, and increasing sizes of parishes (Church of Scotland Ministries 2016 1.2.2.2. / 1.2.2.3) the original hospital based teams lost that community input, instead training chaplains with different skillsets to suit the needs of patients and the specialist knowledge required in hospitals.

Levison and his team wrote their guidelines (2005) insisting 'that the NHS must offer both spiritual and religious care with equal skill and enthusiasm'. Far from squeezing out the religious needs of patients Levison (2005) brought together the religious faith and spiritual care in 'encouraging human contact in a compassionate relationship (p6).'

In 2015 the then head of the spiritual care team in Lothian Health Board, Scotland, became concerned that the gradual reduction in hours allotted to the team was having an adverse effect on the spiritual care in nine hospital based complex clinical care (HBCCC) units in the area. He brought together a working group to develop a rationale for increasing the team's

resources, by studying the effects that the lack of spiritual care knowledge and education had on both staff and patients. He postulated that the staff on those units required education to enable them to deliver spiritual care themselves. The subsequent research can be found in Aird and O'Neill's paper (2017) which concluded that education of all staff was key to the delivery of spiritual care to patients on these units. Recommendations included bringing together the plethora of spiritual care education as a directory, which would be available for those who are involved in offering spiritual care to patients. As a sub conclusion the Aird, O'Neill (2017) paper noted that there was a lack of community involvement, yet where it did exist there was mutual benefit.

The study also found that community involvement was integral to the social needs of patients who were confined to bed or a very small space within a ward. Few areas visited had regular engagement from the local community. This short paper seeks to address these recommendations, acknowledging the fact that other community agencies, including faith based organisations, should be involved in discussions delivering spiritual care in HBCCC.

Spiritual Care

Spiritual care can be defined in the words of the Purple Bicycle Project (Mowat and Swinton 2018):

'Spiritual care acknowledges the presence and importance of such things as joy, hope, meaning and purpose as well as the reality of disease, suffering, disappointment and death. This means that spiritual care is much broader than any one faith or religion and is of relevance to everyone. The Spiritual task is to offer friendship, comfort and hope to each other in ways that are meaningful to the individuals concerned.'

Mowat and Hunter (2014) cite the definition of chaplain from the dictionary of pastoral care and counselling which:

'… refers to a clergyperson who has been commissioned by a faith group or an organisation to provide a pastoral service in an institution, organisation, or governmental entity. Chaplaincy refers to the general activity performed by a chaplain, which may include crisis ministry, counselling, sacraments, worship, education, help in ethical decision-making, staff support, clergy contact and community or church coordination.'

Ordained ministers are generally appointed to a parish which could be one, two or three charges depending on the geographical area. But as the definition above points out, the 'charge' could be anything from a shopping centre to a church to a hospital. It largely depends on the area in which the minister or celebrant wishes to specialise.

Baldacchino (2015) describes a hospital chaplain as one who is an expert in clinical pastoral education giving help with theological beliefs and conflicts but may also go under the title of Pastor. Others (Barber and Parkes 2015) describe the spiritual care team or the chaplaincy team as a necessary member of the health service for the wellbeing of mental health. The spiritual care teams in health boards have immense specialist knowledge of counselling for various needs such as bereavement of a child, death and dying. However, this does not exclude a minister visiting a member of their parish who happens to be in hospital. Equality and diversity ensures person centred care, treating people according to their needs. Spirituality is an integral part of a person's wellbeing, giving meaning and value to life, enabling them to better cope with illness (Levison 2009). Therefore if this means that an enabler from the community aids that process it is important to involve that person.

Spiritual care teams have been on the decrease in most health boards over the past ten years (Kelly 2012) although anecdotally the overall compliment within teams has remained static (Aird, O'Neill 2017). However, this only accentuates the recognition that reducing spiritual care team hours will increase the work load and minimize the areas that are covered by members of the team. Distilling these teams requires managers to look elsewhere for the ability to fulfill the long-standing guidelines, although the Aird and O'Neill (2017) study discovered that most managers were not aware of either guidelines or resources available to them.

In the SEHD HDL (2002) report it was recommended that the NHS provide healthcare chaplaincy services at the rate of one session for every 25-30 beds and spiritual care education for all NHS staff. However, with reduction in staff teams and a lack of education in spiritual care for ward staff, this recommendation is becoming harder to fulfill.

In 2008 a conference was held at Dunblane House between the Churches and chaplaincy teams in the NHS due to concern that chaplaincy was being excluded from the health care team. It was made very clear at this conference that NHS Scotland and Scottish Government were continually updating guidelines to ensure that religious care of patients would have a place 'within the NHS's wider spiritual care approach'. Collaboration and partnership between the religious and spiritual care groups was encouraged within a working relationship, fostered by those on the Spiritual Care Development Committee. This conference noted that it was important for ordained members of the community to continue to have a role within the NHS as 'they remained the most effective conduit for provision of religious care' and some were duly appointed to be members of the spiritual care teams. Ten years later NHS spiritual care teams are made up of ordained and non- ordained chaplains who have trained for this specialised role within the healthcare services. This is generally to

the exclusion of religious, denominational chaplains who may have previously visited patients in hospital freely under their role as a faith based person in the local parish. Due to the implementation of the Data Protection Act 1998, if a patient now wishes to have a religious member of the public visit it would be through a request to the ward staff. While this has safeguarded the privacy of a person, it has unintentionally marginalized those who would wish their religious needs to be met and are unable to access them due to the nature of t heir illness. There is provision however, for any member of the public who wishes to become a volunteer with the spiritual care teams to do so.

It was pointed out by the Rev Dr Idris Jones, Primus of the Scottish Episcopal Church that 'chaplaincy carried out reluctantly or plain badly is better ended and left alone.' So whereas previously it was automatically assumed that an ordained minister would take on responsibility for the local hospital visiting regardless of their desire to do so, the new guidelines had changed this. Instead, those who took on the role of hospital chaplain did so with adequate training and appropriate skills and knowledge.

The issue discovered through the Aird and O'Neill Study (2017) was that requests made by patients for a specific denominational minister were rarely answered. This appeared to be due to an overburdened spiritual care team and no contact details for the local ministers. Occasionally when there were details, or when a patient presented details the minister also had little time to deal with the request or as one nurse famously said:

The minister said I don't do death and dying – check this ref.

This conference recognised that church going has declined and therefore the need for denominational ministers of faith is not so acute as it once was, but the issues of spiritual care still remain. This is because there is more of a recognition that addressing spiritual issues increases the well being of patients in hospital. Church going has indeed declined in Scotland over the last thirty years from 4,100 congregations to 3,700 in 2016 (Jaquet 2018). Although it is not clear whether these numbers include independent churches or the established churches (Scottish church census 2016). During the research carried out by NES (2009) it became clear that reduction in church or faith congregations did not necessarily correlate with the 'need to know.' In other words, a desire to have life questions answered and a willingness to talk about spiritual concepts.

Spiritual care and religious or faith care differ – Kaur et al has the description of both.

Needs of the patients in HBCCC

Since 2002 the Scottish Government (SEHD 2002) has recognized the importance of spiritual care for the well-being of all people but particularly those who receive health care within the NHS sector. Wallace (2011) maintains that 'spiritual wellbeing leads to a better quality of life' regardless of faith or no faith, because religion does not necessarily mean spirituality. The spiritual care teams seek to ensure the soul comfort of all patients and staff who require this specialised service, regardless of their culture, creed, faith or no faith.

The search for meaning, particularly at the end of life, affirmation of life and a sense of value and self- awareness increase healing and attitude to crises in life. While this becomes the premise of all health care workers to address, there is a place for those who are specialised in the knowledge of faith and religion to be able to draw along side those who have a wish to address these issues perhaps in the final days of life.

Levison at the conference said that all people have an equal right to have their needs met and so the providence of a spiritual care team was designed with this in mind. All people of faith and no faith could access spiritual care a 24/7. However, in practice for the HBCCC in the Aird and O'Neill study this was not the case. Placed as they are on the margins of the city geographically miles apart it would be impossible to deliver this 24/7 service to all the patients in these units. The numbers could be around 450 patients a good number of whom will be in the end stages of life. This would require hours of being in each unit offering support to not only the patients and relatives but also to the overworked staff some o f whom were in tears during their interviews for the Aird and O'Neill study (2017). Yet Levison was clear that the NHS having taken on the spiritual care teams, now had 'a clear responsibility to serve the spiritual and religious needs of the patients and the staff. '

Kaur et al (2007) produced a fine resource for looking at the context for providing religious and belief care in 21st century hospital settings. They quote the WHO as recognising the connection between mind, body and spirit; William Bloom who sees the interconnection and presence of spirit in mind and body. The questions that each individual might have in life such as why am I here? What is life all about? Why is there suffering? All have a right to be answered is such as way as to present to the individual a choice to choose a personal option.

Community involvement findings from study/studies

Need to know who those people are on the community who are willing to be engaged with patients. Levison (2005) looked at the chaplaincy collaborative, recognising that volunteers from all interested agencies would be important to the success of spiritual care teams in hospital. He suggested that links be made with other organisations in healthcare chaplaincy providing support to NHS teams and therefore to the patients. In reality, the faith- based teams in the community largely stepped back, and the experience of the Aird, O'Neill study (2017) was that rarely did nurses see local ministers or priests visit their units.

Levison (2005) freely admitted that there were significant differences to the ways of working in Healthcare to community chaplaincy. He therefore organised workshops as a way of addressing these differences to enable enhanced awareness of the need for structured

spiritual care The differences between religious and spiritual care: .'Religious care is given in the context of the shared religious beliefs, values, liturgies and lifestyle of a particular faith community; spiritual care is usually given in a one to one relationship, is completely person centred and makes no assumption about personal convictions or life orientations. Spiritual care is not necessarily religious. Religious care, at its best, should always be spiritual.'

Jaquet's study (2018) involved similar methods to the Aird and O'Neill (2017) study although employed a mixed method approach conducting interviews in care homes across four health boards. This allowed for a wider spread and replication of results. However, the recommendations of this study were remarkably similar to the previous Aird and O'Neill study. That 'Scottish Government should recognise the importance of including the spiritual dimension in policies affecting older people and more importantly ensure consistent implementation across relevant policy areas.'(p40) It is the implementation that has consistently caused the greatest dilemma to all stakeholders involved in spiritual care. Dilemma: How do you create community within HBCCC unit -in effect a locked place? Who do they call on with confidence, to provide comfort with competence? How does the community engage with patients in the face of death?

The Aird and O'Neill study (2017) used the methodological approach of appreciative inquiry (Cooperider and Whitney 1998) which allowed the interviewees reflective space, not to change what was but to instead discover what could be. Although all members of the team were given the opportunity to be a part of the study, only 29 interviews were conducted partly due to time limits on the units and researcher's time. Given the 14 Health Boards across Scotland the researchers acknowledged that this was a very small sample and questioned the replicability of the study. It was noted that the study did not interview any chaplains or any of the spiritual care team, although they were consulted before, during and after the study. Some of the interviewees felt that responsibility for this specialised care lay with the spiritual care team, but on closer questioning it was not because they felt this was their domain, but rather because they themselves did not have the ability or knowledge to deal with some of the challenges and questions they were being asked by patients.

It seems from the guidelines available from the last 15 years that although various stakeholders across the country have defined spiritual care; recognised the need for spiritual care as part of the person centred wellness; provided centres of education through NES; spiritual care teams and the Scottish Government, no single agency has taken on the responsibility of standardised education for those who are the forefront of patient care delivery.

With the best will in the world there does not appear to be enough time for spiritual care teams to deal with the individual challenges presented to them across their enormous geographical location. To offer the kind of compassionate, listening care that takes time to

enable critical questions to be answered in an unhurried way requires training and time away from an already squeezed nursing team. In theory the most obvious members of staff to offer spiritual care would be those that have the most to do with the patients, for their work has an immediacy of availability. It may be possible for the units to provide spiritual care with the specialist knowledge of the spiritual care teams in the background when required.

Another solution is to use other well-placed agencies to provide the spiritual care within the health care sector such as community groups; interfaith groups and other caring organisations. Those closest to the patients are doctors, nurses and health care assistants, who according to Aird and O'Neill (2017) recognise the need for spiritual care as part of person centred wellness, but due to time constraints and the challenge between choosing necessary tasks and critical conversations veer on the side in which they have the greater knowledge and the immediacy of physical needs of the patient.

As one nurse put it:

N2 We give out tea, biscuits, meals but never spiritual care – it always has the last priority, the lowest priority.

However, time management is a learnt skill and as this piece of research pointed out, many critical conversations are carried out while the tasks are being undertaken – such as washing or bed changing. The research from this study identified issues of knowledge gaps such as the ability to answer critical questions – where am I going? am I going to die and what happens then? I want to see a minister. If the unit is geographically distant then seeing a member of the spiritual care team may not be an option, and there will probably not be someone available. The nursing care team in this survey admitted that they did not have the knowledge and skills to confidently provide spiritual care and so the one who falls into this gap is the patient. This was substantiated by the RCN survey (McSherry 2010) to all 85,000 members of the RCN, of which just over 4,000 responded (1% of total members), showing that 79.3% of respondents agreed that spiritual care training was both insufficient and inadequate.

Community involvement supported the regular staff not only in social activities but also in the emotional attachment that is inevitable in units which are family orientated. Sometimes the community help is not always as helpful as it could be:

There used to be a visitor who brought in a dog which the patients loved but she doesn't come any more. The same applied to music but there is a view that the patients are too frail to enjoy these things.

There used to be a service here but it stopped because the patient group felt it was not needed. It was the decision of the minister not to come in anymore. Ministers felt that the patients didn't need it either.

The voluntary input of community care from various people such as priest, nuns; ministers or groups were all seen as positive resources. In fact, it did not seem to matter who they were, provided they were people who cared enough to give up time to support both patients and staff.

There aren't many volunteers on a regular basis but they are important as it is an opportunity to give patients specific time.

One unit manager realised the extent to which volunteers could be a significant addition to the team and allotted funds to attract external groups.

There was a sense of frustrated resignation at the need to provide spiritual care but being unable to grasp at faint possibilities because of barriers from time, accessibility and the external decisions made by those other than the patients or staff.

Churches only come to the home if requested by an individual but (I feel) that being able to talk about 'faith' for some people was important and there is a need.

Sometimes a priest or minister comes but this is dependent on the families. Other wards where there are higher functioning patients' activities are offered. Because of the capacity of the patients in this ward it is difficult to design activities except on a one to one basis occasionally. Hand massage is enjoyed.

The provision or not of community involvement highlighted the vast differences to be seen within one very small geographical area. It was evident that all five groups, chaplaincy, community, patients, relatives and staff wanted to take advantage of these resources in varying degrees but were unable to do so due to lack of finances; time; knowledge or inability to gauge the appropriateness within the unit.

Jaquet's paper (2018) recommended that the Scottish Social Services Council (SSSC) and NES should highlight the importance of spiritual care to colleges which offer SVQs and nursing qualifications. Given FIOP's previous work in online courses and NES's abundance in educational resources there is no lack of learning routes.

Pastoral care guidelines from theological colleges

This merely examines a few colleges of faith and a brief look at no faith- based learning in order to look at the possibility of engaging with them in widening their college briefs in pastoral care. Ministers of the faith generally gain their theological degrees of divinity in

order to practice in a church or other area. Some people are lay preachers and take on the pastorate of an independent church or perhaps as a ministry team leader in areas such as pastoral care. In keeping with the aim of the paper we have examined the need for community engagement in HBCCC and now we look at ways in which we can fulfill that need by entering into discussion with those who have a desire to care for the people within their ‘’parish’.
This would include those in faith and non-faith based communities.

Jaquet recommendation 10.10 suggested that faith communities should consider how to further strengthen links with local care homes building on existing work in pastoral care and practical assistance, also sharing learning when addressing spiritual cares needs of patients – in particular those with dementia also Consider the value of volunteers and befrienders from faith communities, consider capacity building in faith communities to enable them to better understand the needs of people living with dementia.

Scottish Episcopal: Diocesan: an ordained minister will be well informed about, and actively engaged with, the priorities for mission and ministry of the diocese in which they serve. This will include learning about and reflecting upon trends in social and spiritual needs that are seen across the diocese, and how churches are responding to these in partnership with each other and external bodies.

An aim of the ETS according to their prospectus is to: ‘facilitate in conjunction with apprenticeships in local churches – the development of ministry skills and Christian character. These are crucial for both men and women as they engage in ambassadorial ministries in a world crying out for human love and care shaped by ministries that are themselves vocational, spiritual and Christ like in character. ‘

Baptist union have a college on the UWS campus in Paisley – difficult to navigate website or to find prospectus. Pastoral care is mentioned as part of the training but no specifics. No statement of pastoral care aim.

The last Roman Catholic seminary in Scotland closed at the end of the last century and now potential priests must go to Rome to train. Their initial training period helps them to understand ‘ that diocesan priesthood, which is the ultimate goal of this formation, is characterised above all by a life of service to the Christian community, and is rooted in a spirituality of service to that community. To help develop that spirituality and to express it most fully, *Pastores Dabo Vobis* (#31) says that all priestly formation should be placed in the context of - and be inspired by - an “essential and undeniable ecclesial dimension” of priesthood. Even if our priests might work in "one-man-parishes", it is essential that they have developed a strong sense that they are not "lone workers", but rather servants of a community, either the local parish or parishes where they work, or the wider Church itself of which they are representatives, witnesses and servants.’

It is difficult to find their prospectus but this aim says clearly they are to serve the community.

There are five Islamic colleges in Scotland. The compulsory units are as follows:

Introduction to Islamic Studies will introduce students to Islam, its history, important personalities in the early history of Islam, the development of Islam, its main sources and basic teachings. The students will also be introduced to the skill of transliterating for correct pronunciation of some Arabic/Islamic terms. On successful completion of this unit, students should know the basic teachings and the main sources of Islam. In addition, students will be able to understand some of the similarities and differences between Islam and other religions.

Islamic Core Sources and Approaches will give students a comprehensive understanding of the Islamic core sources and approaches. They will be introduced to the different sciences developed within Islamic studies from exegesis (*tafsir*) to Islamic law (*fiqh*) and principles of jurisprudence (*usul al-fiqh*). On successful completion of this unit, students should know the different methodological approaches developed by Muslim scholars within the Islamic tradition.

Islamic Ethics (*Akhlaq*) has always been an intrinsic and fundamental part of Islamic thought, manifested in both Muslim jurisprudence and Islamic theology. This unit will look at the centrality of ethics in the Islamic core sources and how early and classical Muslim scholars have conceptualised it. Modern debates about the significance of ethics in Islamic core sources will be critically examined.

Women and Islam is a lively subject used by those in both the Islamic and western worlds. It is a subject often used by critics to portray Islam as a misogynistic and oppressive religion. In their arguments, their first point of reference is the plight of Muslim women in many Islamic societies. The advocates of women's rights in Islam encourage differentiation between the teachings of Islam and diverse cultural practices.

Research Methodology in Social Sciences and Islamic Studies is designed to strengthen students' critical thinking while writing or reading scientific research, to familiarise students with theories and the practical application of research methodology, methods, design and strategy while conducting a research proposal. The unit also includes aspects of methodology of Muslim scholars in searching for the truth by considering the revealed knowledge of the Qur'an and Sunnah, evidence from *iltizam*and *qiyas* (logic) or even disputed sources.

- Arabic as a Foreign Language (SCQF 5)
- Arabic as a Foreign Language (SCQF 6)
- Arabic as a Foreign Language (SCQF 7)
- Arabic as a Foreign Language (SCQF 8)
- Arabic as a Foreign Language (SCQF 9)
- Arabic as a Foreign Language (SCQF 10)
- Islamic Economics and Finance (SCQF 11)
- Islamic Commercial Law (SCQF 11)
- Applied Islamic Banking and Insurance (SCQF 11)
- Islamic Accounting and Auditing (SCQF 11)

From non-faith based learning bases:

Humanism at St Andrews: 'Humanism is an approach to life based on reason and concern for humanity. Humanists believe that moral values are founded on human nature and experience alone. A belief in God or the idea of life after death is not accepted.

Humanists aim to live full and meaningful lives and try to help others do the same. The fundamental moral principles of Humanism are freedom, tolerance and happiness.'

No college of learning for atheism – lobbying only.

Scottish secular society aims to help those in need around us regardless of faith or no faith, although their philosophy and belief is similar to those of the humanists.

Other community groups which have a history of engaging with HBCCC

Resources which were available:

- Talking mats – most did not know these existed. We approached the talking mats group in Stirling and they admitted that there was no spiritual care component (apart from a church picture) but would like to work with us to address this. None of the units used these as a resource.
- Advice for last rites in various faiths seemed to be lacking, although there is a resource book for this in Lothian, many did not know it existed. Only one unit actually had this to hand.
- Intranet help – this is in a very basic form and did not appear to be detailed enough to deal with the challenges and issues of various faiths. Only one unit had used the intranet and then went on to use the internet as they did not find enough information on the intranet.
- Resource Folder: There was a resource folder in one area that the nurse knew of, but felt it was too black and white and that the softer issues of spiritual care was missing, although this could not be articulated. One unit, unable to find anything for spiritual care resources, developed their own leaflet with contacts in and around the unit.
- Music in Hospitals – this was only available in one unit but appeared to be available in other wards surrounding the HBCCC units.
- End of life care plan which included spiritual care - One unit had an end of life care plan that they had developed which included spiritual care.

- Chaplaincy or spiritual care teams -There was evidence of notices pinned up in one unit – if you need a chaplain get in touch, but the interviewees at this unit did not mention they had seen this.

- Mobile friendly, smelling gardens that were risk managed. This was in the planning stage in one of the units, seven of the other units had some form of outdoor area, but one unit was unable to use any outdoor area due to different agencies using the same building.

- Rotation of Churches together, taking services in different homes. Only one unit had organised spiritual services taking place on a regular basis from external faiths.

- Therapets - used by one unit

- Massage: head; hand and Indian - used by two units

- Community Volunteers/befrienders - some were free and some required payment, both at the behest of the unit manager, requiring administrative organisation. Three of the units used these.

Conclusion

It seems that with the advent of NHS spiritual care teams, the community based ordained communities have been paralysed by a sense of not feeling needed within hospitals, lack of knowledge about the spiritual or religious needs of the patients; lack of time themselves and the burden they have in parish affairs. Yet it is this interfaith community that could go some of the way to solving the inability of most other agencies to implement spiritual care in HBCCC and other places of care.

Recommendations from this paper

1. For the authors to engage with the faith and non- faith colleges to include spiritual care of patients or residents in care homes within their syllabus.
2. For the authors to engage with agencies that provide social interaction to people in care and provide a spiritual care learning base to enable and empower their communication.

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