SPIRITUAL AND PASTORAL CARE SERVICES
WITHIN SOUTH AUSTRALIAN PUBLIC MENTAL HEALTH FACILITIES

A research report compiled on behalf of

Chaplaincy Services SA Inc

for submission to the

Mental Health Unit, SA Health

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Background

Following discussions between the Mental Health Unit (MHU), SA Health and Chaplaincy Services SA Inc (CSSA) it was agreed that information of a comprehensive nature was required to further consider the provision of spiritual and pastoral care services within South Australian (SA) public mental health facilities. This report responds to this need by addressing specific objectives regarding chaplaincy and spiritual care in mental health care in SA.

The primary purpose of this project is to ascertain benefits and outcomes of mental health chaplaincy in specified public health locations and determine an appropriate model of service delivery that is adequately resourced and maintained.

The Report

The research findings support the assertion that there are benefits of spiritual care to mental health patients and that spirituality and/or religion is an important consideration in a patient's mental health care needs. Such consideration is consistent with the *South Australian Mental Health and Wellbeing Policy* and the recovery model of care intended to empower a person toward recovery and well being. A holistic approach to care would include the spiritual dimension of an individual. A spiritual assessment identifying the individual needs of a patient and utilised to inform a plan of care has potential positive outcomes for the individual and therefore mental health services.

The research also supports the view that the chaplain is the preferred professional to provide spiritual care. This was reflected in literature reviewed and patient and staff surveys. In addition to attending to spiritual care needs, the role of chaplain extends to spiritual assessments, participation in multidisciplinary team meetings, discharge planning and community support following discharge. The findings of this report also support the need for development of specific guidelines and policies for the provision of chaplaincy services within SA public mental health facilities.

There have been several methods adopted to ascertain appropriate benchmarks for chaplaincy staffing levels, with some specific application to mental health chaplaincy. However, further

research and analysis is required to ensure a cost effective staffing model for the provision of spiritual care is developed for the SA Health Mental Health Unit. Currently there are 2.0 fte designated chaplaincy positions spanning across four sites which are solely resourced by the Church organisations that place chaplains in those positions.

There are consistent components that are considered minimum training, qualifications, experience and certification requirements to work as a professional chaplain. These include a degree qualification in religion or theology, a unit of Clinical Pastoral Education and two years practical experience. These requirements correlate with requirements for certified membership with Spiritual Care Australia. Endorsement from the chaplaincy candidate's faith tradition or belief group is also a consistently recommended requirement. Currently there are no specified training pathways for specialising in mental health chaplaincy or a consistent accountability framework.

Recommendations

Implementation of the following recommendations will enable further development of mental health chaplaincy and contribute to positive outcomes in patient care and the provision of efficient spiritual care services that are professional, holistic and accessible.

It is recommended that:

a) The *Recovery* model of care be further promoted and applied in mental health care units with consideration to spiritual/religious needs of individual patients being incorporated into their healthcare plan.

b) MHU work cooperatively with CSSA to identify and/or develop a Spiritual Assessment tool for inclusion in standard admission procedures and considered in care plans for all patients being admitted to mental health units of SA public hospitals.

c) MHU work cooperatively with CSSA to develop the role of mental health chaplain in the conduct of spiritual assessments of mental health patients.

d) MHU work cooperatively with CSSA to formally develop a position description for the role of mental health chaplain.

e) MHU work cooperatively with CSSA to develop protocols for referral procedures to chaplains in mental health units of SA public hospitals.

f) The role of chaplain is formally recognised within the multidisciplinary team of mental health units of SA public hospitals and that chaplains participate in case conferences and discharge planning.

g) MHU work cooperatively with CSSA to develop a strategy for broader recognition of chaplains in the provision of spiritual care of mental health patients.

h) MHU work cooperatively with CSSA to formally develop policies and guidelines for patient spiritual care as part of MHU service provision consistent with the *South Australia's Mental Health and Wellbeing Policy*.

i) MHU fund a pilot project to be conducted in cooperation with CSSA for the placement of chaplains at designated acute mental health units in SA public health facilities to:

    i. determine time given to episode of care and other role requirements in order to develop bench marks for chaplaincy staffing levels in mental health units of SA public hospitals

    ii. further define and develop the job and person description for the role of mental health chaplain

    iii. ascertain specific benefits of and feasibility for a community service model of mental health chaplaincy within the SA mental healthcare system

    iv. identify gaps in training, qualifications and experience for mental health chaplaincy

    v. develop an appropriate performance, accountability and reporting framework for mental health chaplaincy

j) MHU provide funding for the appointment of a Spiritual Care Coordinator of mental health chaplaincy services for the development and coordination of spiritual care services within the MHU.

k) SCA certified membership be recognised as the minimum requirement for training, qualifications and experience in order to be engaged as a chaplain working within the MHU.

l) MHU identify and/or develop additional training modules to provide specialist education and professional development for mental health chaplaincy.

m) Documentation of current endorsement of good standing in accordance with the requirements of a chaplain's faith tradition or belief group is required to practice as a mental health chaplain.

n) CSSA explore benefits and disadvantages of establishing a register of approved mental health chaplains.

SPIRITUAL AND PASTORAL CARE SERVICES

WITHIN SOUTH AUSTRALIAN PUBLIC MENTAL HEALTH FACILITIES

RESEARCH REPORT

1. Background:

From July 2008 to November 2010 there have been a series of discussions between the Mental Health Unit (MHU), SA Health and Chaplaincy Services SA Inc (CSSA) (formerly HC4 – Heads of Christian Churches Chaplaincy Committee) to consider the provision of spiritual and pastoral care to the South Australian public mental health sector. It was agreed that further information was necessary to ascertain the current status of mental health chaplaincy in order to provide for considered strategic planning in the provision of this specialised service.

The MHU provided a grant to CSSA to conduct this research and to address particular objectives.

2. Objectives:

The primary purpose of this project was to ascertain benefits and outcomes of mental health chaplaincy in specified public health locations and determine an appropriate model of service delivery that is adequately resourced and maintained.

Specific objectives were:

- To clearly identify current staffing levels and funding sources for the provision of chaplaincy services within South Australia (SA) public mental health facilities.

- To ascertain the specific benefits of spiritual and pastoral care to patients, families and staff within SA public mental health facilities and identify shortfalls in these services where they occur.

- To determine realistic benchmarks for chaplaincy staffing levels within SA public mental health facilities.

- To develop a funding model to meet the recommended benchmarks for the provision of chaplaincy services within SA public mental health facilities.

- To identify training needs, competency levels and accountability processes in order to establish guidelines, standards and structures for the provision of chaplaincy services within SA public mental health facilities.

3. Introduction:

Pastoral and Spiritual Care services are readily accepted within SA metropolitan public hospitals. Historically these services have been provided by chaplains placed through their respective Churches, which continues to be the current arrangement. CSSA is the representative body which coordinates the placement of ecumenical chaplains and liaises with SA Health for the cooperative delivery of spiritual and pastoral care in public hospitals. There are various structures, models and funding arrangements currently in place, including direct arrangements with a number of public hospitals for the provision of these services.

Mental health chaplaincy has been recognised to a lesser extent and any services within this particular area of healthcare are minimal and are completely resourced by individual Churches. There is relatively little information regarding mental health chaplaincy within the Australian context. Therefore information has largely been sourced from overseas, in particular the United Kingdom (UK). This project has been a vast undertaking endeavouring to meet the objectives of the research proposal, which has drawn upon a broad range of resources and research in order to speak to the local SA setting.

4. Method:

Literature review

Literature searches where conducted using Medline, PubMed, and CINAHL data bases in English. Search terms included *pastoral care, spirituality, religion, chaplain, mental health, mental illness, hospital services*. While there were many articles and journals that recognised the need for spiritual care within the health system it was very difficult to find articles that related to chaplaincy, spirituality and religion and mental health. For example, searching Medline using the above terms identified 144 articles. Of those five were related to chaplaincy and mental health. There were no articles relating to the Australian context in regards to chaplaincy and mental health. Other literature was found by hand search and known sources within the field. A comprehensive reference list is provided at item13.

Surveys

Quantitative and qualitative surveys were conducted of patients, staff and chaplains from within SA public mental health facilities. Questionnaires for these groups appear as appendices 1, 2 and 3 respectively. Survey results are contained within the body of the report in the form of tables and recorded comment. Patient surveys included a *Contact* group and a *Control* Group. The *Contact* group consisted of those who were currently in-patients of an acute mental health unit within a SA public hospital and had contact with a chaplain. The Control group consisted of those who were currently in-patients of a mental health unit within a SA public hospital and had **not** experienced the services of or had contact with a chaplain during their current period of admission. For the Control group, this did not preclude contact with a chaplain in another setting or during a previous experience. There were a total of 68 participants, 28 in the Control group and 40 in the Contact group. Patient surveys were conducted at the following locations:

- Wards 1G and 1H at Lyell McEwin Hospital (LMH)

- Woodleigh House at Modbury Hospital (MOD)

- Crammond Clinic at The Queen Elizabeth Hospital (TQEH)

- Glenside Hospital Campus (GHC)

There were 31 responses received from staff working within the area of mental health care. Surveys were sent to all metropolitan acute mental health units in SA. However, in order to ensure confidentiality, the particular locations from which the responses were received cannot be ascertained.

Four chaplains were interviewed who, at the time of the interviews, were working in the area of mental health in SA public hospitals. The locations in which these chaplains are/were employed include LMH, MOD, TQEH, GHC and Oakden Older Persons Mental Health Service. The chaplaincy role at TQEH has since been discontinued.

Other sources

Information was also drawn from the internal sources of CSSA and included existing reports, documents and operational arrangements.

5. Spirituality and religion – definitions and perceptions

Literature

It is recognised that there may be confusion between various terms that encompass spirituality and religion. The term "spirituality" can define a broad field that extends beyond religion and can include a range of alternative faith and secular beliefs (Parkes & Gilbert, 2011, p. 4).[1] Cornah (2006, p. 26) notes that there is theoretical recognition of a distinction between spirituality and religion and that either can be practiced without the involvement of the other. The terms are not mutually exclusive in that people can be both spiritual and religious, while some may consider themselves spiritual but not religious (Hilbers, et al., 2007, p. 1). Spirituality and religion may also intertwine with culture. With the onset of a crisis there may be movement across cultures, religions and faiths, and from belief to unbelief and back to belief (Parkes and Gilbert 2011, p. 5)[2].

The following definitions are provided from literature within a healthcare context.

Spirituality

Speck (2005, p. 28) defines spirituality as, "...a vital essence of our lives that often enables us to transcend our circumstances and to find new meaning and purpose, and that can foster hope." Spirituality may include the sense of one's place in the universe but is not necessarily clearly identifiable or given any religious label (Parkes and Gilbert, 2011, p. 4). Haynes, et al., (2007, p. 2) state that spirituality, "...relates to how we find meaning and connection, and the resources we use to replenish ourselves and cope with adversity. Spirituality may be part of religious practices or another shared belief system, or something entirely personal and self developed."

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[1] Parkes and Gilbert note that words such as "faith" and "belief" can be included in the language associated with spirituality and religion.

[2] Parkes and Gilbert are referring to the UK multi-cultural context at this point.

Cornah (2006, p. 6) identifies a number of common themes found in literature to describe various elements of spirituality that include:

a) a sense of purpose

b) a sense of 'connectedness' – to self, others, nature, 'God' or Other

c) a quest for wholeness

d) a search for hope or harmony

e) a belief in a higher being or beings

f) some level of transcendence, or the sense that there is more to life than the material or practical, and

g) those activities that give meaning to people's lives.

Spirituality becomes a means through which meaning is sought and can be influenced by a range of factors including age, gender, culture, political ideology and physical or mental health (Cornah, 2006, p. 6). Given the individual nature of spirituality, it is difficult to find an all encompassing definition (Haynes, et al., 2007, p. 2). However, in citing Bassett et al., Smark (2009, p. 20) notes that spirituality is an inner motivator and essence of a person which makes it a significant factor in recovery of mental illness.

Religion

Religion has a more structured appearance. Hilbers, et al., (2007, p. 1) suggest religion may be considered an institutional form of spirituality which involves shared beliefs and practices integrated into the socio-cultural life of a faith community. They note that religion, "... is considered to be more structured, formal, rooted in tradition and doctrine, with rituals taking place in a shared community of practice. In contrast, spirituality is generally perceived as more fluid, eclectic and individual". Religion may be viewed as the way in which people organise their way of relating to the sacred and transcendent and is characterised by a faith leader, sacred texts and definitive understanding of God, a higher power and/or moral codes, conduct and ethics (Parkes and Gilbert, 2011, p. 4). Haynes, et al., (2007, p. 2) add, "Most religions are understood to have traditional beliefs and practices relating to healthy living, illness and death".

Adherence to a given religious group does not imply rigidity in one's expression of faith or belief system. However, in providing pastoral care it is important to meet the person at their point of need.

It becomes a significant factor when attending to those of a particular religious community that their story remains unique and they are understood as individuals. (Healthcare Chaplaincy Council of Victoria (HCCVI), 2011, p. 49).

Patient perceptions

Survey responses from patients of mental health units in SA provided insights in relation to spirituality and religion, and their self understanding. The majority of those surveyed in both the Contact and Control groups expressed some form of spirituality or religion (see Table 1). Of the responses recorded only 7.9% (n = 6) indicated that they were neither spiritual nor religious.[3] Within the Contact group those who saw themselves as predominantly spiritual (n = 19: 38.8%) notably exceeded those who identified themselves as primarily religious (n = 3: 6.1%). This difference is not as distinct in the Control group. However, those who view themselves as spiritual (n=7: 25.9%) still exceed those who identify with being religious (n = 5: 18.5%). In both groups a significant number identified with being spiritual and religious (n=33: 43.4%).

Table 1 –

How do you see yourself? (Question 5 – Appendix 1)

	Religious	Spiritual	Religious & Spiritual	Not Religious or Spiritual	Undecided	No Response	Total
Control group	5	7	11	3	1	1	28
Contact group	3	19	22	4	1	0	49
Total	**8**	**26**	**33**	**6**	**2**	**1**	**77**

Respondents gave varying answers when asked to differentiate between religion and spirituality and its meaning for them (Survey Question 4, Appendix 1). Those within the Control group identified aspects of ritual and doctrine associated with religion. Themes that referred to conflict between religious ideologies were also noted. Views regarding spirituality were expressed in more individual and personal terms compared to understandings of what religion meant. The Contact group displayed similar impressions. Religion was generally associated with organisation, structure, community, church, beliefs and common understandings. Spirituality was understood in terms of

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[3] Given the nature of the question (spiritual and/or religious) it is apparent that more than one response was recorded by some among those surveyed in the Contact Group.

personal experience, values, inner strength and meaning, a means of finding inner calm and peace. While there was an overlap of language used by both groups in their personal understanding of the difference between religion and spirituality, there was a general distinction made between the two. Overall, 96% (n = 65) of respondents made a distinction between religion and spirituality.

Patient responses also highlight the shifting nature of spirituality and religion. The majority of those surveyed in both groups (n = 41: 60%) had undergone a change in their beliefs during their lives (see Table 2). From the Contact group 52.5% (n = 21) recorded they had a change in their beliefs and 71.4% (n = 20) of the Control group had altered their beliefs.

Comments received from the Contact group suggest respondents have adopted a broader and more adaptable perspective on spirituality without a legalistic adherence to religion. It appears that a more personal spirituality has been taken up, which for some has been influenced by a significant event involving grief or trauma. Similar explanatory comments came from the Control group. There had been a shift from organised religion and its perceptions of legalism toward pursuits of meaning and purpose. There were also indications that those who had previously held an agnostic view moved to belief in God or a higher power.

Table 2 –

Have your beliefs changed during your life time? (Question 7 – Appendix 1)

	Yes	No	No response	Total
Control group	20	8	0	**28**
Contact group	21	15	4	**40**
Total	**41**	**23**	**4**	**68**

Observations

   a) There is a high level of consistency between understandings of spiritual and/or religion found in the literature and those received from survey respondents.

   b) The issue of spirituality and/or religion is a significant dimension of self understanding and identity, and therefore influential in the individual's perception of themselves and their existence.

c) According to survey responses, spirituality appears to be a more dominant theme than religion. Spirituality has a more personal focus whereas religion is viewed in terms of structure, organisation, established ritual and group practice.

d) Faith and belief tends to change during the course of one's life and, as noted by some respondents, is known to be influenced by critical life events involving grief or trauma.

e) From survey respondents it appears there is a shift of emphasis from religious affiliation to personal spirituality.

6. Spirituality, religion and health care:

Literature

Harding, et al, (2008, p. 100) note that since the 1990s there has been a surge in the number of published articles regarding spirituality in healthcare and a rising interest in literature from healthcare professionals. The field of psychology has seen articles in spirituality increase while articles pertaining to religion have declined. Speck (2005, pp. 29-30) cites several studies conducted between 1987 and 2004 that identify beneficial outcomes for recovery when spirituality and religion are considered. These demonstrated that spirituality affects morbidity rates, quicker recovering from burn injuries, longer survival rates from cancer, ability to cope more effectively and decreased instances of depression. The importance of spiritual beliefs in regards to mental health was also noted.

Within the Australian context the HCCVI conducted an extensive review of literature pertaining to spiritual care from the pastoral care, medical and nursing fields. Findings from this review indicate that there is correlation between attention given to patient religion or spirituality and health benefits. Drawing on a study by Pembroke published in 2008, it was noted that, while some caution needs to be exercised, there is clear evidence that religious involvement influences positive health outcomes when other (medical care) factors have been provided (HCCVI, 2009, p. 21). Spiritual Care is also seen as a necessary component of person-centred care within the field of nursing (HCCVI, 2009, p. 23).

Vandecreek and Burton (2001, pp. 82-83) note that issues of spirituality – questions of purpose and meaning – come to the fore when illness occurs and institutions should not ignore this dimension of the individual in the daily provision of care. The concern here is that such institutions risk becoming

"biological garages where dysfunctional human parts are repaired or replaced"[4] without due consideration for the whole person. Stempsey (2011, p. 347) supports this view and asserts that healthcare professionals should provide holistic care which recognises the spiritual dimension in all people, which is often disrupted by illness.

Correlation between spirituality, religion and mental health is given particular consideration in the following section.

7. Spirituality, religion and mental health:

Literature

Swinton (2001, p. 57) suggests that it is important to recognise the difference between curing and healing. Curing is the ability of medicine to bring about the absence of illness or the reduction in symptoms. Healing is the ability to give people the opportunity for recovery, which includes spiritual aspects. Recovery is distinct from fixing biological processes or reversing the symptoms of illness. Rather, for progression toward mental health, the person should be enabled to find meaning within trial and joy that will allow them to retain their humanity in the midst of both experiences. Swinton asserts that it is meaning and purpose that will empower the individual in the midst of trauma and suffering. Therefore mental health care will also entail relational and spiritual dimensions in which meaning and hope will assist a person to cope with their problems. Healing is thereby intricately connected with spirituality and the spiritual quest.

Kelly and Gamble (2005, p. 246) also consider the definition of recovery and note that it may have a variety of meanings. It may not mean that suffering or illness has been removed. Rather it may involve personal development in the midst of living with mental illness. From literature that Kelly and Gamble cite, recovery can take on individual experiences which provide a level of empowerment rather than being subject to purely medical interventions. Anthony (1993, pp. 527-528) sees recovery in terms of a personal and unique process of change which leads to a satisfying, hopeful and contributing life even with the restraints of living with illness. Anthony notes, "Recovery involves the development of new meaning and purpose in one's life as one grows beyond the catastrophic effects of mental illness". It is asserted that a recovery-oriented mental health system has the potential to not only reduce impairment, dysfunction, disability and disadvantage, but to provide more meaning, purpose, success and satisfaction in one's life (Anthony, 1993, p. 530).

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[4] Vandecreek and Burton citing Gibbons & Miller (1989) "An Image of Contemporary Hospital Chaplaincy", *The Journal of Pastoral care*, 43 (4), pp.355-361.

Cornah (2006) has undertaken a literature review on the impact of spirituality on mental health and its implications for recovery. In summary she found that spirituality and religious beliefs are associated with positive outcomes in relation to depression and depressive symptoms, levels of anxiety and stress, post-traumatic stress disorder (PTSD) and schizophrenia (Cornah, 2006, p. 2). Cornah also identifies a growing number of voices from service users, survivors and carers of those with mental illness that assert mental health and spirituality are intrinsically linked and that there should be multi-discipline communication on this issue. A survey conducted by the Mental Health Foundation affirms the positive place of spiritual or religious beliefs for service users. The role of these beliefs for individuals included, "...guidance; a sense of purpose; comfort; grounding; the allowance of expression of pain and the development of an inner love and compassion for others" (Cornah, 2006, p. 9)

Drawing on analysis of informant narratives, Sells et al., (2006, p. 10) have cited spiritual pursuits as helpful for personal recovery. Spiritual interactions have offered hope to persist amidst mental illness and the belief that strength and support can be found from an external source, such as a "higher power". Spiritual support from one's religious community was also identified as necessary in recovery and it was thought that spirituality also helped to provide balance, ultimately leading to recovery. Smark (2009, p. 20) cites the personal experience of Marcia Murphy who wrote of her own mental illness. Murphy contends that combining spiritual beliefs with medication gave clarity of thought, which then provided a basis of support for her recovery. Spirituality is thereby considered a positive strategy to help individuals cope with personal challenges. Smark further draws on research by American psychologist Natalia Yangarber-Hicks who conducted an empirical study on the relationship between religious coping styles and recovery. It was found that those who believed they had a collaborative relationship with God were more prepared to be actively involved in their recovery than those who had a passive relationship with God.

Blanch (2007, pp. 255-256) notes that a psychiatric diagnosis does not preclude the deepest yearning of an individual for a meaningful and purposeful life. According to Blanch, mental health consumers/survivors have stated that to understand one's problems in religious or spiritual terms can be a highly influential alternative to solely a biological or psychological framework. In light of a pessimistic outlook that confronts people with mental illness, when considering the challenging and daunting path of recovery, reframing the situation in spiritual terms may be viewed with optimism, particularly in relation to spiritual development. Citing Australian professor of psychological medicine David Clarke, Smark (2009, p.23) notes that people with mental illness need to rediscover meaning and purpose in order to sustain recovery.

Galek and Porter (2010, pp. 62-63) have analysed a number of studies which consider the relationship between religious belief and threat perception. They deduced that, based on one's view of the world, be it good or evil, anxiety levels of a given individual may be significantly influenced. One study (by Inzlicht, McGregor, Hirsch and Nash) found that belief in God correlated with reduced anxiety, specifically as it related to assessment of social threats. An individual's perception of a loving and benevolent God or positive intervention from God could lead to reduced anxiety. Therefore Galek and Porter concluded that religious beliefs may be a significant factor in understanding the relationship between religion and mental health.

In citing Koenig et al., Reeves and Roberts (2009, p. 8) note, "More than 700 studies have examined the relationship among religion, well being, and mental health, with nearly 500 of them demonstrating a significant positive association between religion and better mental health, greater well being and lower substance abuse". Koenig et al. concluded that,

> In the majority of studies, religious involvement is correlated with well-being, happiness, and life satisfaction; hope and optimism; purpose and meaning in life; higher self esteem; adaptation to bereavement; greater social support and less loneliness; lower rates of depression and faster recovery from depression; lower rates of suicide and fewer positive thoughts about suicide; less anxiety; less psychosis and fewer psychotic tendencies; lower rates of alcohol and drug use or abuse; less delinquency and criminal activity; and greater marital stability and satisfaction (Cited in Reeves & Reynolds, 2009, p. 8).

The Department of Health (UK) affirm the value of spiritual belief in supporting people with mental illness towards recovery, asserting such support is well attested. Koenig et al., is again cited whereby a review of 101 studies found that 65% reported significant positive relationship between a measure of religious involvement and lower rates of depression or depressive symptoms, anxiety and hopelessness. Further, a meta-analysis of 147 studies involving almost 100,000 subjects found that religious involvement was also associated with reduced depression particularly for stressed populations. (Department of Health (UK), 2011b, p. 37)

Fallot (2007, pp. 262-263) cites a number of studies in which a significant number (80 -95%) of people with mental health related problems indicated that spirituality or religion was helpful or a source of comfort and strength. She cites a survey of in-patients conducted by Baetz, Larson Marcoux, Bowen and Griffin in 2002, which found those who engaged in either formal religious practice or personal spirituality were associated with less depressive symptoms. Moreover those who attended worship were seen to have lesser current stays in hospital and increased life

satisfaction. Fallot further notes that individuals in recovery who self identified themselves as spiritual or religious reported higher levels of psychological well-being. Gilbert & Watts (2006, p. 22) conclude that people who enter any form of mental health service need to be assured that their spirituality is being given appropriate attention. Gilbert (2007, p. 21) asserts, "Users of mental health services and survivors have been very clear that they wish to be viewed as whole persons, living in complex environments, and that their spirituality is a vital part of their identity – that sense of self."

Russinova and Blanch (2007, p. 248) strongly endorse the positive influence of spirituality on recovery outcomes and the inclusion of spiritual approaches to be included in clinical practice and person-centred systems of care. They also assert that recovery-oriented systems of care encompass more than clinical treatments or in-patient services for whole of person considerations, "...finding housing, friends, a job, a role in the community, and something to believe in may be the most essential ingredients in healing".

Parkes and Gilbert (2011, p. 7) have identified a diversity of people whose spirituality is considered important to healthcare:

a) Those with a practising religious faith, who may wish to discuss its relationship to their illness, or to access and express services, rituals and festivals related to the faith whilst in hospital or care.

b) Those who have previously had a religious faith but have since moved away from it – they may be prompted to re-visit and re-explore it due to illness and crisis.

c) Anyone searching to find meaning in their illness and life situation; purpose in life as a result of their illness and hope for their future recovery.

d) Anyone whose coping mechanisms involve ritual and religious practices; belief in a higher power or force; any expression or hobby they consider to be spiritual in nature.

e) Anyone who welcomes the support of a faith community.

f) Those who wish to express personal pain.

g) Those who wish to deepen their compassion for others.

h) Those who are suffering complex symptoms of psychosis that may have confusing religious elements.

Patient surveys

Survey responses from in-patients were consistent with the correlation between spirituality and mental health asserted in the literature. Questions asked (as per Tables 3 and 4) sought to distinguish between general perceptions and personal experience of the interrelation between spirituality/religion and mental health. A significant majority of both the Control (n = 25: 89%) and Contact groups (n = 38: 95%) believed that beliefs affect people's health (see Table 3). This equated to 93% (n = 63) of all respondents holding this view. The response was not as strong when applied to personal experience of health and spirituality/religion (see Table 4). However, the majority (n = 41: 60.3%) of total respondents still maintained that religious or spiritual beliefs impact their health.

Table 3 –

Spiritual and/or religious beliefs can have an effect on people's health? (Question 1 – Appendix 1)

	Yes	No	Undecided	Total
Control group	25	2	1	**28**
Contact group	38	0	2	**40**
Total	**63**	**2**	**3**	**68**

Comments received that conveyed a positive impact on personal health in both the Control and Contact groups referred to aspects of hope and resilience, peace and strength amidst ill-health, and a positive outlook which helps when dealing with illness. Comments conveying a negative impact on personal health were also evident and related to aspects of guilt in failing God's instruction and insufficient faith amidst ill health.

Table 4 –

Do you think your beliefs have an effect on your health? (Question 8 – Appendix 1)

	Yes	No	Undecided	Total
Control group	18	5	5	28
Contact group	23	10	7	40
Total	**41**	**15**	**12**	**68**

The majority of both groups also supported the view that spiritual/religious beliefs influence how people view their health and illness (see Table 5). Approximately 71.5% (n = 20) of the Control group believe that an individual's beliefs impact the manner in which their health and illness is viewed. A lesser proportion than the Control group, but still greater part of the Contact group also supported this perspective. There was no significant difference in comments recorded by respondents from both groups. Respondents referred to the influence that spiritual/religious beliefs has on the attitude that one adopts in dealing with illness. This can include notions of guidance, strength of faith, positive outlook for a positive recovery, optimism for the future, respect for life and God's plan or providence. A few comments alluded to a correlation between religious adherence and wellbeing.

Table 5 –

A person's spiritual and/or religious beliefs influence how people view their health and illness? (Question 3 – Appendix 1)

	Yes	No	Undecided	No Response	Total
Control group	20	5	2	1	**28**
Contact group	26	6	7	1	**40**
Total	**46**	**11**	**9**	**2**	**68**

The extent to which spirituality and/or religion becomes more important when a person is unwell was also recorded as prominent by respondents from both groups (see Table 6). 68% (n = 19) of the Control group and 55% (n = 22) of the Contact group supported the view that when in a state of ill health spirituality and/or religion came to the fore in one's priorities. Only 13% (n = 9) of total respondents clearly disagreed with this question. 25% (n = 17) of total respondents were undecided on the question.

Table 6 –

Spirituality and/or religion becomes more important when a person is unwell? (Question 2 – Appendix 1)

	Yes	No	Undecided	No Response	Total
Control group	19	4	5	0	**28**
Contact group	22	5	12	1	**40**
Total	**41**	**9**	**17**	**1**	**68**

The majority of respondent comments recorded in relation to Table 6 indicated that spirituality or religion provides a point of reference, strength, guidance and/or support amidst personal trauma and upheaval.

Staff surveys

Staff (n = 31) were also asked similar questions to those put to patients. Of those responses received 96.8% (n = 30) believed that spiritual or religious beliefs have an affect on people's health, especially their mental health.[5] Comments recorded (n = 9) in relation to this question indicated that spiritual and/or religious beliefs can be a means of additional support, hope and comfort, either through the beliefs themselves or in a practical way through friendship, a chaplain or faith community. Some expressed concern that spiritual/religious beliefs can escalate psychotic or delusional episodes.

Similarly, the majority of staff respondents (n = 20: 64.5%) believed that spirituality or religion becomes more important when a person is unwell or experiencing illness. Only two respondents disagreed, with the remainder (n = 9: 29.0%) being undecided. Comments recorded (n = 14) varied regarding whether the manner in which spirituality or religion becomes prominent during a period of illness was positive or negative. Spirituality/religion could be a positive means by which one could cope during a period of distress. However, ill health can also cause one's beliefs to be called into question, according to the survey respondents. The view was also expressed that the manner in which a person may respond could vary from individual to individual.

Again, there was strong support for the view that spiritual or religious beliefs influence how a person views their health. 74.2% (n = 23) supported this view with 19.4% (n = 6) of respondents being undecided. Comments recorded (n = 10) in relation to this question varied. Some indicated an uncertainty about the question (n = 4), while others (n = 4) indicated a connection between spiritual/religious beliefs and health benefits either as a requirement for or consequence of the beliefs.

Chaplain interviews

The chaplains interviewed indicated that from their experience people's spiritual and religious beliefs affect their recovery by giving them hope and a sense of peace amidst turmoil. Their faith can be a point of stability among the inconsistencies of behaviour and responses that often come with mental illness. A belief in God has been observed to offer people reassurance that they are not

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[5] The one respondent who did not answer yes to this question recorded the response as undecided.

alone in the midst of ill-health. It was expressed that one's spirituality is an adhesive that helps with personal cohesion and provides a source of encouragement to work toward recovery. The chaplains interviewed suggest that when a patient is heard and understood it helps reduce fear and anxiety.

A patient's particular religious affiliation may also provide them with a link to a church or faith community, which is an added support toward recovery. While being part of a faith community may be difficult as a result of mental illness, it is believed to be an integral part of the patient's recovery resources. Reading of sacred texts and prayer also provides a means of connectedness, peace and reassurance.

Observations

a) Recovery as a focal concept of mental health care takes into consideration broader issues of well being beyond medical treatment of the mental illness. That is, recovery gives attention to the whole person and whole of life issues amidst mental illness, which can lead to personal growth and a means of coping with mental illness. At this point spirituality and religion are significant considerations in the provision of health care.

b) Evidence supports the view that spirituality/religion is a positive factor in the provision of mental health care and that patients want their spirituality validated and considered as part of their treatment and recovery.

c) Spirituality and/or religion having a negative influence on mental health also requires consideration in the patient's healthcare plan.

d) There was no marked difference in responses from the Control and Contact groups. The majority of both groups affirm the influence of spirituality and/or religion in relation to health and illness.

e) There is strong affirmation from staff working within mental health units that spirituality is a significant factor in relation to health and illness.

f) From observations of the chaplains interviewed the experience of being heard and understood is a positive contributor to recovery.

g) Support from a faith group or other community group is considered important in recovery.

h) Spiritual/religious beliefs play a significant part in coping and how patients view their mental illness.

8. Public policy

Literature

The World Health Organisation (WHO) has developed a holistic and person-centred approach to health care which recognises human rights within the context of health care. Access to spiritual and religious support is considered a necessary human right whereby patients with mental health disorders should be free to exercise or practice his/her religion or belief, to which full respect should be given (WHO, 1996, p. 31). WHO guidelines further stipulate that a mental health facility should be resourced equally as any other health establishment and that appropriate professional staff are available to meet the therapeutic needs of each patient (WHO, 1996, p. 34). Again from a person-centred perspective of health care, WHO advocates "Access to psychological and spiritual support during the care experience" (WHO, 2007, p. 39). This WHO document cites principles of the Bhutan government policy of person-centred care in which the significance of spirituality and religion for patients and health practitioners is recognised (WHO, 2007, p. 74).[6]

The National Health Service UK (NHS) has a long history of incorporating the religious and spiritual needs of people into their health care planning and implementation. Consequently guidelines have been established to ensure the provision of spiritual and religious care, including those who do not profess any particular faith (NHS, 2003, p. 5). More recently, to comply with equality standards, the UK Department of Health have developed guidelines that will also ensure that the role of religion or belief is understood within the context of healthcare (NHS, 2009, p. 5). Specifically, within the context of UK health policy, local services should give consideration to religion or belief as a necessary part of assessment for those with mental illness. It is recognised that religion and belief are important factors in giving explanation to mental illness whereby language and conceptualisations affect engagement between an individual and services provided. This in turns impacts upon positive treatment and care outcomes (Department of Health (UK), 2011a, pp. 21-22).

The former National Institute for Mental Health in England (NIMHE)[7] developed a Guiding Statement on Recovery within the context of mental health. In its definition of recovery the NIMHE recognised six meanings which together suggested a process whereby there is a change in orientation and

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[6] This issue is cited in the context of Bhutanese principle of "Gross National Happiness" which places people at the centre of development and is the focus of health care and education service delivery within the country.

[7] NIMHE has since been superseded by the National Mental Health Development Unit (NMHDU) which has developed a number of strategic documents in the provision of mental health services and outcomes. See www.nmhdu.org.uk/, viewed 15 February 2012.

behaviour in an individual from a negative experience of trauma toward reclamation, restoration and control of one's life toward wellbeing and a meaningful life. It was asserted, among the guiding principle for the delivery of recovery-oriented mental health services, that service users will experience recovery more quickly when a number of elements are considered, one of which being spirituality (NIMHE, 2005).

Citing the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO)[8], VandeCreek and Burton (2001, p. 83) highlight the fundamental right which patients have to receive care that respects and gives consideration to their spiritual values. They further note The Canadian Council on Health Services Accreditation, which states that spiritual and religious needs are to be considered when developing a service plan.

South Australia's Mental Health and Wellbeing Policy 2010-2015 recognises the need for person-centred care that considers the spiritual dimension of the individual and that care is tailored to his or her needs in a manner that is respectful and culturally sensitive (Department of Health (SA), 2010, p. 4). The policy also espouses the principle of 'recovery' which focuses on, "...an improved level of wellbeing and a renewed sense of identity, purpose and meaning in life in the presence or absence of symptoms of illness" (Department of Health (SA), 2010, p. 5).

Patient Surveys

From the patient surveys there was strong support from both the Control and Contact groups for the MHU to provide a service for the spiritual needs of patients while in hospital (see Table 7).   The majority of both the Control (n = 23: 76.7%) and Contact (n = 31: 77.5%) groups gave support to the belief that spiritual care is a responsibility of the mental health system.

Comments from the surveys indicate that providing spiritual care services to patients would assist recovery, support patients' families, offer a sense of hope and provide necessary spiritual nurture. Comments from both groups (n = 2: 2.6%) that did not support MHU providing spiritual care services indicated that they were either agnostic or 'new age pagan' and did not believe this service would benefit them.

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[8] JCAHO accredits and certifies more than 19,000 healthcare organisations and programs in the United States (see The Joint Commission (2012), *About the Joint Commission*, www.jointcommission.org/about_us/about_the_joint_commission_main.aspx, viewed 15 May 2012

Table 7 –

Should the Mental Health Service be providing a service for people's spiritual needs while in hospital? (Question12 – Appendix 1)

	Yes	No	Undecided	No response	Total
Control group	23	2	3	0	28
Contact group	31	1	5	3	40
Total	**44**	**3**	**8**	**3**	**68**

Staff Surveys

Staff were also asked whether the MHU should provide a service for the spiritual needs of people while in hospital. The majority (n = 26: 86.7%) of respondents supported the need for this service. The remaining respondents either disagreed (n = 2: 6.7%,) or were undecided (n = 2: 6.7%). Written responses further elaborated on the need for the provision of a spiritual care service. Particular comments focussed on the role of spiritual care at the time of admission where patients can most often experience distress. It was also suggested that involvement from a chaplain could assist with shorter in-patient stays and reduce the involvement of community mental health teams following discharge. It was noted that while the service should be offered it was up to the individual to take it up. Generally, staff indicated that a spiritual care service was necessary and beneficial to both patients and staff.

Observations

a) It is well recognised by the WHO and healthcare services in UK, USA and Canada that spiritual care is to be included as part of the healthcare provided, including mental health care.

b) Spiritual care within the context of mental healthcare in UK is recognised to the extent that policies and guidelines have been developed to ensure this aspect of care is given specific consideration.

c) The MHU, SA Health has adopted a *Recovery Model* of mental health care as part of its formal principles and policy of care, which takes into consideration a holistic approach to patient care, including spirituality.

d) The majority of patients and staff believe MHU is responsible for the provision of spiritual care in SA mental health facilities.

9. Chaplaincy roles and models

Literature

The role of chaplain in the literature reviewed is quite varied. However, it is generally associated with the provision of spiritual care. This can be understood as a role that facilitates service users to regain a sense of connection, hope and purpose (Parkes & Gilbert, 2011, p. 6). According to HCCVI (2011, p. 51), "Chaplaincy is a form of professional pastoral ministry requiring the skills to provide pastoral, religious and spiritual care in a range of diverse healthcare settings." Jacobs (2008, p. 15) notes that spiritual care in the context of healthcare can take on a variety of meanings but tends to encompass support for those who, in the midst of suffering, are grappling with issues of identity, meaning and purpose. Jacobs adds that while various caregivers can provide spiritual support, the chaplain is deemed the healthcare professional who responds to this need. Mohrmann (2008, p. 18) similarly asserts that spiritual care is not necessarily confined to the role of a professional chaplain, just as teaching is not confined to the role of a teacher, but recognises the role of hospital chaplain as a specialised professional entrusted with the task of spiritual care. While other clinicians may offer spiritual care, the chaplain is a specialist in attending to the patient's pursuit of meaning in the midst of suffering and crises.

De Vries et al., (2008, pp. 23-24) use the language of "translation" when identifying the role of chaplain. In this capacity, a chaplain may be sought by a patient, family member, nurse or physician to interpret a given situation. Chaplains can take a whole of person approach and ask questions that consider the life of the patient outside the immediate medical condition. "... chaplains are skilled at translating patients' experiences and sources of meaning in real time, allowing medical teams to better understand the person they are treating". Carey and Cohen (2008, p. 27) refer to a number of literature sources within Australia which suggests that some physicians recognise the importance of spirituality in clinical practice and that chaplains have an effective role in assisting a patient's health and wellbeing. Reeves & Reynolds (2009, p. 9) note that while clinicians are encouraged to support spiritual dimensions of care and related religious practice, more often than not, professionally trained chaplains should be involved.

Research within the Australian healthcare settings indicates medical, nursing and allied health staff value chaplaincy and pastoral care services. Holmes and Carey (2005, p. 4) state, "There has been an increasing recognition and valuing of chaplains as professional members of the healthcare team and

of the importance of religious and spiritual wellbeing in the provision of holistic health care within the Australian context."[9]

Mowat (2008, p. 59)[10] refers to a survey of mental health professionals and general practitioners regarding their view on the delivery of spiritual care. Of those who responded, 50% believed that mental health professionals were not the most suitable people to assess and provide spiritual care. This was particularly expressed by doctors. However, 20% of nurses believed that they were best placed to give spiritual care. In regard to mental health chaplaincy in the UK NHS, chaplains are expected to respond to the needs of service users regardless of age, gender, culture, religion, disability or sexual orientation. Chaplaincy within this mental health context is regarded as an important resource that should be utilised (Merchant & Wilson, 2010, p. 596).

It is posited that mental health professionals should exercise caution when attending to a person's unique belief system. Consideration should be given to calling upon an expert practitioner to assist in understanding an individual's belief or cultural context. This can further assist in the recovery process and be integrated into other positives aspects of the self (Longo & Peterson, 2002, p. 336). Gilbert (2008, p. 4) notes that while spirituality and religion are generally helpful, these dimensions of an individual can take an unhelpful or disruptive turn. In these instances, spiritual and pastoral care teams can assist in clarifying the nature of the disruptive episode. This role of the chaplain can extend to identifying the difference between delusional behaviour and spiritual experience, and even working collaboratively with faith communities to distinguish between belief system and aberration.

It is recognised that faith plays a major part in a patient's decision making and coping with illness. Healthcare professionals would be prudent to refer patients to chaplains to assist in treatment issues. Neglecting to do so, "... creates a professional gap in patient care that leaves patients without guidance and counsel regarding religion, spirituality, and related issues" (Galek et al., 2007, p. 374). A literature review conducted by Proserpio et al., (2011, p. 669) suggests that patient referrals for pastoral care may vary according to the perspective of healthcare professionals and how important the role of chaplain is viewed. It is considered valuable for staff to give their views on the circumstances of how and when patients should be referred to a chaplain. It is advisable that protocols be developed for patient referral to the chaplain. Orton (2008a, p. 116) notes that

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[9] Holmes & Carey support their assertion by citing research conducted at a number of Australian hospitals in New South Wales, Victoria and Queensland.

[10] This document is a scoping review of research commissioned by NHS (UK).

standards for the provision of chaplaincy services commonly require written protocols for referral of patients or family members to pastoral care services.

The place of spiritual assessment is significant in providing holistic mental health care. Addressing spiritual dimensions of a patient is deemed important to the consumer and asking how they would like spirituality and religion to be included as part of their personal goals and care provision is highly relevant (Fallot, 2007, p. 265). To consider spirituality and religious beliefs during assessment will endorse the importance of these dimensions to mental health. The significance of understanding spiritual and/or religious beliefs in guiding spiritual assessment is supported in a study conducted by Russinova and Cash. It is asserted that an understanding of spirituality and/or religion can influence the quality of relationship a clinician has with an individual (Russinova and Cash, 2007, pp.282-283).

However, there are potential barriers that may hinder obtaining an individual's spiritual history, which may need consideration by those working in and planning mental health services. These relate to lack of time and training, discomfort with the subject matter, one's competency to conduct such a task, concern about imposing beliefs on the service user and a deficiency in interest or awareness of the assessor. Further questions arise over who, when and how such assessments should be conducted (Cornah, 2006, pp. 28-29). In this regard, Russinova and Cash (2007, p. 282) have identified descriptors that may provide guidance to mental health practitioners in conducting, "...better informed and sensitive person-centred spiritual assessments of the clients they serve." Further, Parkes and Gilbert (2011, p. 15) cite the development or utilisation of spiritual assessment tools among the spiritual care and chaplaincy resources in the UK mental healthcare system.

Holmes and Carey (2005, pp. 4-5) cite research conducted at the Royal Children's Hospital in Melbourne which found strong support for the role of chaplain. Medical, nursing and allied health staff experienced positive interactions with hospital chaplains and believed it is importance for chaplains to be consistently available for patients. It was considered that hospital chaplains should be engaged as part of the hospital system rather than be called upon at short notice from an external source, such as a local parish. Reasons cited for supporting this model of chaplaincy services included meeting a number of needs:

1. Providing religious and psycho-social support to patients and staff through the mechanisms of 'religion', 'faith', 'God' and 'Church'

2. Providing specialist skill and support to families and staff particularly at times of death and grieving

3. Providing an input into the 'hospital environment' in terms of:

    a. ethics,

    b. being a community link,

    c. providing a non-diagnostic communication role within the hospital,

    d. assisting/facilitating staff team work, and

    e. alleviating emotional discomfort for staff, patients and their families within a complex and sometimes frightening institution.

VandeCreek and Burton (2001, pp. 86-88) note that the role of chaplain involves a diverse range of interactions with patients and families, professional staff, volunteers, and members of the community. It is recognised that while no single chaplain may be able to meet every function, a number of aspects of the role have been identified. These include:

1. When religious beliefs and practices are tightly interwoven with cultural contexts, chaplains constitute a powerful reminder of the healing, sustaining, guiding, and reconciling power of religious faith

2. Professional chaplains reach across faith group boundaries and do not proselytise.

3. Chaplains provide supportive spiritual care through empathic listening, demonstrating an understanding of persons in distress.

4. Professional chaplains serve as members of patient care teams

5. Professional chaplains design and lead religious ceremonies of worship and ritual

6. Professional chaplains lead or participate in health care ethics programs

7. Professional chaplains educate the healthcare team and community regarding the relationship of religious and spiritual issues to institutional services

8. Professional chaplains act as mediator and reconciler in the healthcare system

9. Professional chaplains may serve as contact persons to arrange assessment for the appropriateness and coordination of complementary therapies

10. Professional chaplains and their certifying organisations encourage and support research activities to assess the effectiveness of providing spiritual care.

Orton (2008a, pp. 115-116) refers to a "parochial" model of chaplaincy service. This is largely faith based and has been dependent upon visiting clergy or volunteers. This is generally reflective of the situation in Australia whereby pastoral care services have arisen out of a given local historical context and is particularly evident within acute hospitals in the SA metropolitan area where there are various staffing, funding arrangements and operational models (Chaplaincy Services SA Inc, 2011). A major deficiency of the parochial model is that spiritual care is primarily given to those of a given faith tradition. Those without a particular faith tradition tend to be overlooked which thereby neglects the holistic needs of individuals who do not have structured systems of spiritual support. A model of spiritual care that considers people, regardless of their spiritual inclinations or religious affiliations, is asserted to be a more patient-focused model of spiritual care (Orton, 2008a, p. 116).

Patient surveys

When asked whether chaplains are able to provide for the spiritual and religious needs of patients while under the care of the MHU, the responses were strongly in the affirmative (see Table 8). Majorities in the Control (n = 23: 76.7%) and the Contact groups (n = 30: 75.0%) held the view that chaplains were well placed to provide this service.

Table 8 -

Do you think Chaplains are able to provide for people's spiritual needs? (Question 13 – Appendix 1)

	Yes	No	Undecided	No response	Total
Control group	23	3	2	0	**28**
Contact group	30	2	5	3	**40**
Total	**53**	**5**	**7**	**3**	68

There were minimal written responses from the Control group. While a few respondents expressed concern that chaplains were not adequately trained in the area of mental health, the majority commented that chaplains were competent and capable to work within acute mental health units. Comments from the Contact group were strongly supportive of the role of a chaplain and identified a number of beneficial functions that they offer. These included listening, understanding, having time to be available, being able to talk about issues that cannot be discussed with other staff, helping people become closer to their faith, providing extra support and care, not judging or condemning and helping individuals obtain comfort and peace.

A majority of respondents from both Control and Contact groups also indicated that they would welcome a visit from a chaplain (see Table 9). Approximately 57% (n = 16) of the Control group would like a chaplain to visit them and 75% (n = 30) of the Contact group wanted a chaplain to visit them.

Table 9 -

Would you like to be visited by a Chaplain? (Question 9 – Appendix 1)

	Yes	No	Undecided	No response	Total
Control group	16	5	7	0	**28**
Contact group	30	4	5	1	**40**
Total	**46**	**9**	**12**	**1**	**68**

One response from the Control group indicated concern that a chaplain would impose religion upon them ("...they just quote the Bible at you..."). However most of the Control group saw chaplains as providing a valuable role through offering spiritual support and comfort, and facilitating spiritual reflection and religious practice.[11] Comment from the Contact group saw the benefits of a chaplain as someone who can assist the individual beyond medical services by offering understanding and support for spiritual dimensions of one's mental health care. Additionally, aspects of faith and belief are more readily supported, confidentiality and spiritual perspectives are respected, and there is focussed recognition of an individual's spirituality and religion within the context of mental health care. Overall, both groups saw chaplains as offering support, respect, and someone who would pray with patients and listen to their concerns without judgment.

Where respondents had previously been visited by a chaplain, there had again been an overall positive response (see Table 10). Approximately 57% (n = 16) of the Control group found a chaplain's visit helpful. 67.5% (n = 27) of respondents from the Contact group believed the chaplain's visit was helpful. Two respondents from the Contact group who did not find a chaplain's visit helpful noted reasons of a lack of understanding on the part of the chaplain or that the individual's faith community were better placed to meet their spiritual needs. The majority of respondents cited reasons for chaplaincy benefits similar to that stated at Table 9. Given the nature of the Control group it is expected that there is a greater number of 'undecided' or 'no response' from the

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[11] One comment made specific reference to the value of an Islamic Imam.

respondents. However, this does not preclude or assume that they had not previously come in contact with a chaplain.

Table 10 –

Have you found a visit by a Chaplain helpful? (Question 10 – Appendix 1)

	Yes	No	Undecided	No response	Total
Control group	16	2	4	6	**28**
Contact group	27	4	6	3	**40**
Total	**43**	**6**	**10**	**9**	**68**

Staff surveys

Staff (n = 31) were also surveyed on their views and experience of chaplains in mental health settings. 83.9% (n = 26) of respondents thought that chaplains are able to provide for the spiritual/religious needs of people while under the care of the MHU. The remaining 16.1% (n = 5) were undecided. Written responses expressed strong support for the role of chaplain in a mental health setting having observed various benefits for the patient. These include providing trust, comfort, confidentiality, availability and accessibility and the unique opportunity in speaking to someone on matters of spirituality. Suggestions were also made that the chaplain in this field would require specific mental health training and alternative spiritual leaders may also be required, dependent upon the individual's particular faith/religious need.

71.0% (n = 22) of staff respondents had called a chaplain for a patient at some time. From the few (n = 6) written comments most referrals had come at the request of the patient. One comment from an atheistic perspective endorsed the role of the chaplain:

> "I make this comment from the perspective of an atheist. I have observed the ability of a chaplain to provide comfort to people in crisis in both the mental health and military (medical services) environments. I might add that the Australian military do not even query the need of pastoral care because it objectively works in supporting individuals in time of individual need."

Of those staff who called a chaplain for a patient, 87.0% (n = 20)[12] had found the service helpful. The remaining 13.0% (n = 3) were undecided. Written responses indicate that staff had observed positive responses in patients. Among the responses observed, patients appeared to be validated,

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[12] There were 23 respondents to this question. Eight (8) respondents skipped the question.

calm, settled, valued, supported, had reduced anxiety and increased confidence. One comment of note:

> "Objectively, the chaplains have frequently been able to calm troubled clients. This reduces the need for medication and nursing/medical staff interventions and helps reduce admission time. I am sure the chaplains themselves do not look upon their services in this way but this is the outcome of their involvement on a ward."

Chaplain interviews

The chaplains interviewed indicated a range of roles that they perform. These include:

a) Provide a listening ear which encompasses hearing patients' stories, their pain and frustration.

b) Provide spiritual and pastoral support, and help address spiritual needs.

c) Help clarify who/what God is to the patient and ascertain implications for their wellbeing.

d) Help reframe aspects of spirituality or religion which may assist personal growth and foundational matters of spirituality as it relates to personal difficulties of patients.

e) Help establish links for patients' with community networks and be involved in discharge planning.

f) Offer religious services, sacraments and prayer.

g) Provide various resources to assist with relaxation and stress reduction such as playing music.

h) Conduct practical activities such as cooking and craft with a view to building trust and relationships.

i) Assist with goal setting where appropriate.

j) Be an independent listener and support outside of the clinical field of doctors and nurses. In this capacity the chaplain acts as a "non medical" person with whom patients can unravel their thoughts and feelings without being considered delusional while feeling safe and being taken seriously.

k) Develop relationships with and offer support to staff.

l) Develop relationships with and offer support to patients' families/carers.

m) Provide support to patients/clients in the community with a view to preventing readmission and demand on the hospital system.

n) Provide advocacy and practical support in relation to government services, housing and other referrals.

o) Develop programs to support people with mental illness connect with local churches and/or community groups – offer ongoing support following discharge.

The chaplains interviewed also identified a range of topics which patients talk about during interaction:

a) Who or what is God? What God is like to the client and often conversation regarding links between childhood experience and perceptions of God.

b) Issues of grief and loss as a result of mental illness which may include family, relationships, children, loss of faith, stigma of illness, isolation.

c) Issues of what brings meaning, forms values and provides peace.

d) Issues of forgiveness, guilt, remorse and judgement of God.

e) Issues of fear and uncertainty, taking into consideration questions of heaven and hell.

f) Issues relating to "demons" and "witchcraft" or delusions of being God and/or Jesus.

Observations

a) Within the literature reviewed there is no identifiable model for the delivery of mental chaplaincy, rather guiding principles.

b) While there may be reference to the "parochial" model of pastoral care within Australia hospitals there is no consistent model of chaplaincy service. This is particularly relevant for mental health chaplaincy.

c) The "parochial" model does not meet the needs of those whose spiritual/religious beliefs are outside of those religious traditions who provide chaplaincy services.

d) The role of the chaplain is both diverse and complex and is considered a valuable part of the clinical team in the healthcare system.

e) The role of chaplain is unique and the chaplain is best placed to bring the specialised level of service to patients, families and staff.

f) Given time, expertise and availability, the chaplain is best placed to fulfil the task of spiritual assessment.

g) The majority of patients from both the Control and Contact groups supported the view that chaplains are able to provide for people's spiritual needs.

h) Those patients who had the experience of a chaplain had found it helpful and the majority of the Control group was also welcoming of a chaplain's visit and supportive of the chaplain's role.

i) Staff working in mental health units strongly supported the role of chaplain and had observed that the involvement of a chaplain had been seen as helpful.

j) The chaplain can maintain a role of independence from the medical team while having the capacity to work closely with clinical staff who are involved in the provision of mental health care.

k) The chaplaincy service contributes to a holistic approach that allows the patient to feel valued amidst the diagnosis and trauma of mental illness.

l) Chaplaincy services have a role in discharge planning and providing support to service users in the community with a view to reducing readmission and demand on other mental health community services.

10. Staffing levels and funding sources

Literature

From the literature reviewed there are various approaches to determining chaplaincy staffing levels. Traditionally these have been in the form of chaplain-patient or chaplain-bed ratios. VandeCreek et al., (2001, pp. 292ff) undertook a study of chaplains employed in various institutional settings in the US. From this analysis it was determined that there was an average of 1.20 chaplains per 100 patients employed in psychiatric hospitals.[13] VandeCreek et al., acknowledge that while the number of chaplains per 100 patients offers some guidance for chaplaincy staffing, it does not necessarily

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[13] The sample size for the category of psychiatric hospitals was fifteen (15).

reflect "best practice" and may indicate the extent to which chaplaincy is valued in given institutions. It is suggested that the chaplaincy profession would benefit from determining the use of chaplaincy time, visit structure and the impact on patient outcomes.

Wintz and Handzo (2005, pp. 4-5) have provided a summary of bench marking ratios from overseas chaplaincy settings stemming from 1988 to 2005. These chaplain to in-patient/bed ratios vary from 1:50 to 1:100 and relate to hospital in-patient beds but do not specifically consider mental health facilities. Wintz and Handzo also assert that while ratios may be helpful, they are not intended to be a "one size fits all". Rather each institute should consider its own specific needs and the various factors that influence the institutional mission and strategic goals. Data relating to the chaplaincy activity should also be considered in determining staffing levels. The Association of Professional Chaplains (APC) in the US (APC, 2009) supports the view of Wintz and Handzo and endorses a process in which a chaplaincy service is established based on quality rather than ratios alone.

The NHS (2003, pp. 27-29) have developed a framework for calculating chaplaincy-spiritual care time to determine staffing levels. One unit of chaplaincy is allocated per 35 beds which equates to 3.5 hours of chaplaincy time. One unit is also allocated for every 500 Whole Time Equivalent (WTE) staff. Mental health services are given specific consideration allowing for up to 19 additional units of chaplaincy, dependent upon particular roles and responsibilities, including management. This framework is to be applied within best practice guidelines which the NHS has established.

The *Caring for the Spirit* NHS project (NHS Chaplaincy Collaboratives, 2007) gathered data from 15 different chaplaincies, including mental health chaplains, to determine what a typical week involved. The results from the different chaplaincies were averaged to provide an overall profile. There was a total of 37 hours and 40 minutes hours recorded for mental health chaplaincy in a typical week. The survey findings note that the average duration of an episode of chaplaincy-spiritual care in acute care was half that of mental health (14 minutes in acute care compared to 28 minute in mental health).

Within the Australian context, Holmes and Carey (2005, pp. 17-18) conducted a review of chaplaincy staffing levels within metropolitan health and aged care services in Victoria. Taking into consideration data collected and staffing levels overseas, it was recommended that a conservative ratio be set in Victoria health care facilities of one chaplain to 270 beds, and that this ratio be increased by the calculation of additional time units based on staff numbers, specialist units and

other responsibilities. The report further recommended that all public health care facilities having 270 beds or more fund the placement of a full-time Pastoral care coordinator.[14]

Still addressing the Australian context, Boddé (2008, p. 8) notes that ratio formulas alone do not capture the array of specialised areas within chaplaincy, such as mental health, and the complexity of roles within the field. Therefore, more empirical methods should be adopted that consider time per task.

Chaplaincy staffing levels in SA mental health facilities

A review of chaplaincy staffing levels and funding across SA metropolitan hospitals was conducted in 2011.[15] At that time, allowing for volunteer (in-kind) contributions, SA Health provided approximately 17.54% ($298,182) of funding for chaplaincy services and a further 19.06% ($323,995) was received directly from hospitals. Church organisations resourced the remaining 63.39% ($1,077,489).[16] Of the total chaplaincy outgoings, approximately $1,290,986 was applied to 17.7 fte chaplaincy positions across nine public hospitals. These included Flinders Medical Centre (FMC), Lyell McEwin Hospital (LMH), Modbury Hospital (MOD), The Queen Elizabeth Hospital (TQEH), Repatriation General Hospital (RGH), Royal Adelaide Hospital (RAH), Women's and Children's Hospital (WCH), Gawler Health Service (GHS) and Glenside Campus. There is 0.8 fte allocated to the role of Executive Officer, CSSA.

These figures predominantly remain current. However, there has since been a variation to the level of mental health chaplaincy service provided. At the time of the 2011 chaplaincy review, of the 17.7 fte chaplaincy positions, there was 2.5 fte designated to mental health chaplaincy. These included 1.0 fte located at LMH, 0.5 fte at TQEH and 1.0 fte at Glenside Campus. Since that time the 0.5 fte at TQEH has been discontinued. Chaplaincy services to mental health wards at FMC, RGH and RAH are provided as part of the chaplaincy services to the broader hospital. Designated mental health chaplaincy services (currently 2.0 fte) would account for 8.5% of total hospital chaplaincy outgoings, which is essentially funded directly by Churches. There is no designated funding from SA Health for mental health chaplaincy.

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[14] The appointment of a Pastoral care coordinator is implemented on a pro-rata basis for health care facilities that have less than 270 beds.

[15] Information for this review was gathered from Churches who are members of Chaplaincy Services SA (CSSA). Information was also sourced from CSSA records that relate to service agreements with SA Health and grant funding from individual public hospitals.

[16] This figure includes an estimated $387,600 from in-kind volunteer hours and a further $21,080 in volunteer related administration expenses.

Chaplain interviews

Chaplains interviewed provided information regarding designated employed time given to their respective mental chaplaincy roles and the source of funding

- LMH (wards 1G and 1H) – 19 hours per week which is provided through the Uniting Church of Australia (UCA)(SA Synod).[17]

- TQEH (Crammond) – 19 hours per week (half time) was funded through a local UCA church and church trust.[18]

- Glenside, James Nash House and Oakden Mental Health aged care – 20 hours per week – funded by the Catholic Archdiocese of Adelaide.

Most chaplains would work in excess of these hours and includes preparation, planning, training and development of services

Chaplains interviewed expressed a desire for:

a) recognition as a member of the multidisciplinary team

b) additional training for mental health chaplains

c) MHU to provide funding for mental health chaplaincy in each hospital in order to be more available to patients.

d) resources for community based chaplaincy programs to assist in reduction of readmission.

e) education of staff regarding the role of chaplain in order to help address misperceptions and the importance of spirituality for beneficial health outcomes for service users.

f) practical and accessible arrangements for patients to attend religious services, particularly at Glenside Campus.

g) increased recognition of chaplains in mental health settings.

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[17] At the time the interview this chaplain was in acting in relieving capacity at 0.5 fte on wards 1G and 1H at Lyell McEwin Hospital. Ordinarily this is a 1.0 fte position which also includes 0.5 fte community based mental health chaplaincy.

[18] As indicated, this service is no longer provided.

Observations

a) There is no consistent or established model to determine benchmarks for mental health chaplaincy staffing levels.

b) Indicators suggest that time required per episode of mental health chaplaincy care is approximately twice that of general acute care services.

c) There is no designated funding for mental health chaplaincy in acute hospitals in SA.

11. Mental health chaplaincy training, qualifications, experience and accountability requirements

Literature

Within the broad context of medical education, WHO (2007, pp. 53-56) promotes a "patient-centred" approach which includes consideration for psychosocial aspects of care, and ethical issues in service delivery and communication. A number of competencies have been developed to complement existing ones that will assist healthcare professionals in this regard. These include organising care around the patient ("patient-centred" approach) and to communicate effectively with patients and other stakeholders[19] for improved health outcomes. The intent is to provide trainees and healthcare practitioners with knowledge, attitudes and skills that extend beyond physical aspects of health to include mental, emotional, social and spiritual dynamics.

Regarding chaplaincy, there are a number of sources from UK, USA and Australia regarding capabilities, competences, training requirements, qualifications and standards of practice. It is recognised that there is a distinction between *competence* and *capability*. In citing Fraser and Greenhalgh, the NHS Education for Scotland (NHS EFS) (2008, p. 7) refer to the difference in these terms:

- **competence** describes what individuals know or are able to do in terms of knowledge, skills and attitudes at a particular point in time;

- **capability** describes the extent to which an individual can apply, adapt and synthesise new knowledge from experience and continue to improve his or her performance (also cited in HCCVI, 2011, p. 6).

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[19] Stakeholders include other health care providers and communities.

The NHS EFS (p. 8) have developed in partnership with the National Institute for Mental Health England and the Sainsbury Centre for Mental Health Joint Workforce Support Unit and in conjunction with the NHS University, ten essential capabilities for healthcare chaplaincy. These capabilities have been adapted from the mental health setting to reflect core values for chaplains and are presented in a framework under four main domains[20]. These domains are:

1. Knowledge and skills for professional practice

2. Spiritual and religious assessment and intervention

3. Institutional practice

4. Reflective practice

HCCVI (2011, pp. 5-7) has also developed a capabilities framework for pastoral care and chaplaincy. The intent of this framework is to clarify for chaplaincy and pastoral care professionals the qualities and capacities needed for this particular field of work and the qualifications required to work competently and cooperatively in the healthcare environment. The HCCVI framework provides for five levels[21] of practice across five areas of capability. These areas of capability are:

1. Personal

2. General Workplace

3. Pastoral Care practice

4. Theological/Spiritual reflection, and

5. Team and accountability

Various training, qualifications and experience requirements have been developed both overseas and in Australia in order to identify appropriate levels of competency for professional chaplaincy practice. The Chaplaincy Academic and Accreditation Board in the UK proposed that to apply for an entry level position as a chaplain it was required that the candidate hold a basic university degree or equivalent, had completed three year's experience of pastoral care and one unit of Clinical Pastoral

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[20] For a full description of these domains – capabilities and practice learning outcomes/competencies – see NHS Education for Scotland (2008), *Spiritual Care Capabilities and Competences for Healthcare Chaplains*, pp. 12-26.

[21] For a detailed explanation of the level see HCCVI), (2011), *Capabilities Framework for Pastoral Care & Chaplaincy 2011*, pp. 7-8. A full description of the capabilities is found in pp. 9-46 of the same document.

Education (CPE)[22]. Specialist training in areas of acute care, mental health, palliative or paediatric care would be made available (Orton, 2008b, p. 8).

The Multi-Faith Group for Healthcare Chaplaincy (MFGHC) in the UK is currently developing a regulatory framework for chaplains as part of its Regulation of Healthcare Chaplaincy Authorisation and Chaplaincy Project.[23] It is proposed that in order to join the register of healthcare chaplains the candidate is required to provide documentation of current endorsement of good standing in accordance with the requirements of his/her faith tradition or belief group. The candidate is also to have completed an appropriate period of study in accordance with requirements agreed by the relevant authorising body, and provide evidence of a commitment to continuing learning (MFGHC, 2012).

In 2004 the Council on Collaboration established *Common Standards for Professional Chaplaincy* as certification requirements for a professional chaplain in the US. Qualifications and experience for certification include an undergraduate degree from an accredited college, university or theological school, a graduate level theological degree from a similar institution and a minimum of four units of CPE. The candidate for certification must also provide documentary evidence of current endorsement of good standing in accordance with the requirements of his/her faith tradition (Association of Professional Chaplains, 2004).

The HCCVI capabilities framework identifies requirements for a Level 2 chaplain or pastoral carer who has been in a professional role for approximately two years and is functioning as an autonomous professional, able to identify and initiate a response to the spiritual and religious needs of individuals, their families/carers and staff. Training in pastoral care at this level would include 20 hours of professional individual supervision, 120 hours of peer group supervision, 400 hours of clinical placement (including 200 hours of pastoral practice) and 120 hours of reflective writing. It is also expected at this level that the chaplain or pastoral carer would have completed a Bachelor Degree level qualification in theological studies or a Bachelor Degree in another discipline and a Graduate Diploma in Theology or Religious Studies. Theological/spiritual competence should ideally

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[22] CPE is an action reflection model of education and formation for the practice of pastoral care. Each CPE Unit involves 400 hours of supervised learning in a pastoral care setting of the student. See Association of Supervised Pastoral Education in Australia (ASPEA), (2011), *About CPE*, Available at www.aspea.org.au/cpe.php, viewed 10 May 2012.

[23] At the time of writing this report it appears that the *Regulation of Healthcare Chaplaincy Authorisation and Chaplaincy Project* is an ongoing project which is yet to be finalised.

be grounded in one's own faith tradition, with demonstrated openness to other traditions in order that spiritual resources of others can be recognised and valued (HCCVI, 2011, pp. 7, 27, 44-46).

Level 3 within the HCCVI capabilities framework describes a senior professional who is able to move into a specialist role, such as mental health. A person practicing at this level would have at least five years experience in a professional pastoral care role, with regular professional supervision. In addition to the training requirements described for Level 2, it would be expected that there would be a *FURTHER* 10 hours of professional individual supervision, 60 hours of peer group supervision, 200 hours of clinical placement (including 100 hours of pastoral practice) and 60 hours of reflective writing *AND* evidence of high level integration of identity and practice as a pastoral carer. A person at Level 3 would be expected to participate in relevant on-going professional development and encouraged to undertake post-graduate studies in Pastoral Care or a related discipline (HCCVI, 2011, pp. 7-8, 44-46).

The training, qualifications and experience of individuals deemed to be at HCCVI Levels 2 and 3 would meet the requirements of Certified Membership and Advanced Certified Membership respectively with Spiritual Care Australia (SCA) (HCCVI, 2011, pp. 7-8). SCA is a national association of practitioners in chaplaincy, pastoral care and spiritual services that operates within the context of multi-faith and multi-cultural Australia and is concerned with ensuring excellence in the practice of pastoral care (SCA, 2009). Chaplaincy Services SA Inc is an organisational member of SCA and endorses and recommends certified membership for its ecumenical chaplains.

It is expected that the following professional accountabilities would apply to all chaplains working within the SA public hospitals:

- Comply with SA Public Sector Code of Conduct and Code of Fair Information Practice within the workplace and in the public domain

- Behave consistently in accordance with hospital guiding principles, workplace values and directions

- Participate in any performance management system

- Adhere to the provisions of relevant legislation, policies, procedures, instructions and guidelines

- Comply with all Occupational Health and Safety provisions policies and strategies which result in a healthy and safe work environment

- Ensure learning and development relevant to the role remains current

- Maintain strict confidentiality regarding any information regarding client/patient, personal staff information, human resource and financial information and information of strategic importance to the Hospital.

There are several stakeholders who are involved in the accountability arrangements of chaplains working within SA public hospitals. Where an Ecumenical Coordinating Chaplain (ECC) is appointed by CSSA the ECC is accountable to:

- The General Manager in matters of daily practice and in accord with the protocols and guidelines of the Hospital

- CSSA in matters of team development, professional standards and conduct

- The Chaplaincy Supervisor (or denominational equivalent) of their religious denomination in matters of faith and discipline

Those chaplains currently working within the area of mental health in SA would be accountable to the hospital administration and their religious denomination as outlined above. The mental health chaplain may also work as part of an ecumenical chaplaincy team coordinated by an ECC. However, there are currently no consistent accountability protocols in the provision of chaplaincy services within SA public hospitals, including mental health chaplaincy.

Observations

a) While there may be some variation between training, experience and qualifications requirements for healthcare chaplains in UK, US and Australia, there are consistent elements of these requirements. These include:

    i.   A degree level qualification in theology or religious studies

    ii.   A minimum of one unit of CPE or its equivalent

    iii. Endorsement from the chaplaincy candidate's faith tradition or belief group

    iv.   Registration with or certification from a recognised peak body.

b) Currently there are no specialist training requirements identified for mental health chaplaincy in SA.

c) There are currently no consistent accountability protocols for mental health chaplaincy in SA public hospitals.

12. Conclusion and recommendations

The literature review and the surveys conducted validate benefits of spiritual care to mental health patients. Spirituality and/or religion are important considerations in the provision of a patient's mental health care. There are demonstrated positive outcomes when this dimension of patient care is given attention. Spiritual care has particular relevance within the context of a *Recovery* model of mental health care, intended to empower a person toward recovery and wellbeing. *Recovery* therefore necessitates a holistic approach that embraces a patient's spirituality. Spiritual assessment becomes a significant component of the admission process and should extend beyond questions of simple religious affiliation. A specific tool is required in order to conduct an extensive spiritual assessment of a patient at the time of admission that contributes to a patient's healthcare plan.

The chaplain provides a unique service in attending to the spiritual care of patients experiencing mental illness. This role provides specialised and independent support to the patient while making a valid contribution to the multidisciplinary team. While the provision of spiritual care is not confined to the chaplain, literature reviewed and surveys conducted indicate that the chaplain is the preferred professional to provide this service. There was strong support from patients and staff surveyed affirming the positive influence that a chaplain has in the provision of patient care. The presence of chaplaincy services does not assume that this service is necessary for all patients but primarily where there are particular spiritual/religious needs or where a specific patient request is made. This service may extend to involvement with discharge planning and ongoing support in the community following discharge. Literature reviewed, together with the majority of patient and staff opinion, indicates that it is the responsibility of the MHU to provide this service. The literature reviewed also supports the development of specific guidelines and policy for spiritual and religious care in the mental healthcare system. Establishment of a job and person description for the position of chaplain, together with protocols for chaplaincy referrals, will consolidate the role and its identity within the mental healthcare system.

A number of benchmarking methods have been posited as appropriate for determining mental health chaplaincy staffing levels. While there are variations to the methods considered it has been determined that the average time for an episode of mental health chaplaincy is twice that of acute care chaplaincy. Ultimately more empirical methods should be adopted. Further information is

required to accurately determine appropriate benchmarks for chaplaincy staffing levels in SA mental health services.

There are currently 2.0 fte chaplains designated to work in mental health units in SA public hospitals. These chaplains are placed and fully funded by their respective Church organisations. SA Health provides no direct funding for the provision of mental health chaplaincy.

When compared with requirements overseas, there is also some variation in the training, qualifications, experience and certification of professional chaplains to work in a healthcare setting. HCCVI have developed a capabilities framework which identifies five levels of practice, which correlate with certified membership with SCA, the national association of practitioners in chaplaincy and is concerned with ensuring excellence in the practice of spiritual care. As such, SCA provides a helpful national reference for the requirements of a person to work as a professional spiritual care practitioner. The key components for chaplaincy practice include tertiary qualifications in theology or religion, a minimum of one unit of CPE, a minimum of two years experience and endorsement from the chaplaincy candidate's faith tradition or belief group. There are no specific pathways for specialist training in mental health chaplaincy. Feedback from patients, staff and chaplains all expressed to varying degrees a desire for chaplains working in the field of mental health to receive specialist training for this role. A specific accountability framework for chaplains working within a mental health setting requires further consideration.

While this report has made significant findings in response to the objectives set for the research proposal, further assessment and analysis is required to ensure that a model of chaplaincy is developed that is consistent with the needs of the SA mental healthcare context. To this end a pilot program resourced by MHU and conducted in cooperation with CSSA would provide a validated basis to further develop a mental health spiritual care service. Such a pilot would also identify key performance indicators, measurable outcomes, cost/benefit integrity and service efficacy in relation to impact upon length of in-patient stay and readmission occurrence. It would be equally legitimate to ascertain the value of community based mental health chaplaincy.

In light of these findings the following recommendations are made:

a) The *Recovery* model of care be further promoted and applied in mental health care units with consideration to spiritual/religious needs of individual patients being incorporated into their healthcare plan.

b) MHU work cooperatively with CSSA to identify and/or develop a Spiritual Assessment tool for inclusion in standard admission procedures and considered in care plans for all patients being admitted to mental health units of SA public hospitals.

c) MHU work cooperatively with CSSA to develop the role of mental health chaplain in the conduct of spiritual assessments of mental health patients.

d) MHU work cooperatively with CSSA to formally develop a position description for the role of mental health chaplain.

e) MHU work cooperatively with CSSA to develop protocols for referral procedures to chaplains in mental health units of SA public hospitals.

f) The role of chaplain is formally recognised within the multidisciplinary team of mental health units of SA public hospitals and that chaplains participate in case conferences and discharge planning.

g) MHU work cooperatively with CSSA to develop a strategy for broader recognition of chaplains in the provision of spiritual care of mental health patients.

h) MHU work cooperatively with CSSA to formally develop policies and guidelines for patient spiritual care as part of MHU service provision consistent with the *South Australia's Mental Health and Wellbeing Policy*.

i) MHU fund a pilot project to be conducted in cooperation with CSSA for the placement of chaplains at designated acute mental health units in SA public health facilities to:

    i. determine time given to episode of care and other role requirements in order to develop bench marks for chaplaincy staffing levels in mental health units of SA public hospitals

    ii. further define and develop the job and person description for the role of mental health chaplain

    iii. ascertain specific benefits of and feasibility for a community service model of mental health chaplaincy within the SA mental healthcare system

    iv. identify gaps in training, qualifications and experience for mental health chaplaincy

    v. develop an appropriate performance, accountability and reporting framework for mental health chaplaincy

j)   MHU provide funding for the appointment of a Spiritual Care Coordinator of mental health chaplaincy services for the development and coordination of spiritual care services within the MHU.

k)   SCA certified membership be recognised as the minimum requirement for training, qualifications and experience in order to be engaged as a chaplain working within the MHU.

l)   MHU identify and/or develop additional training modules to provide specialist education and professional development for mental health chaplaincy.

m)   Documentation of current endorsement of good standing in accordance with the requirements of a chaplain's faith tradition or belief group be required to practice as a mental health chaplain.

n)   CSSA explore benefits and disadvantages of establishing a register of approved mental health chaplains.

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Appendix 1

Spirituality and Chaplaincy Services within the Metropolitan Public

Mental Health Facilities in South Australia

Spirituality and Religion Questionnaire

There are 13 statements and/or questions on this form. Please tick [ ] one box for each answer

Tick **Yes** if you agree with the statement

Tick **No** if you disagree

Tick **Undecided** if you are not sure or if there are circumstances that influence your answer

There is space after each question for you to explain your answer or tell us more. You do not have to write in the space, but it may help us to understand your answer better.

1. **Spiritual and/or religious beliefs can have an effect on people's health**
   Yes **[ ]** No **[ ]** Undecided **[ ]**

   Why?...

2. **Spirituality and/or religion becomes more important when a person is unwell**
   Yes **[ ]** No **[ ]** Undecided **[ ]**

   Why?...

3. **A peson's spiritual and/or religious beliefs influence how they view health and illness**

   Yes **[ ]** No **[ ]** Undecided **[ ]**

   Why?...

4. **Please complete these two sentences:**
   For me, religion means...

   For me, spirituality means..

5. **How do you see yourself?**

		Religious	Not religious
Religious [ ]	Spiritual [ ]	and Spiritual [ ]	or spiritual [ ]

6. **How would you describe your beliefs?** Please tick the box or boxes that describe you best.

Aboriginal-Traditional		**[ ]**
Buddhism		**[ ]**
Other Eastern Religions		**[ ]**
Christianity:	**Catholic**	**[ ]**
	Orthodox eg. Greek/Serbian/Russian	**[ ]**
	Protestant eg. Anglican, Baptist, Uniting Church	**[ ]**
	Other (please specify)	**[ ]**

Hinduism	**[ ]**
Islam/Muslim	**[ ]**
Judaism	**[ ]**
New Age, Nature Religions, Pagan	**[ ]**
Personal Spirituality, not necessarily connected to a religious group	**[ ]**
Agnosticism (ie. uncertainty about the existence or nature of God)	**[ ]**
Atheism (ie. certainty that there is no God)	**[ ]**
Other (please specify)	**[ ]**

7. **Have your beliefs changed during your life?**   Yes **[ ]** No **[ ]**
    Please tell us more about your answer so we better understand:
    ....

8. **Do you think your religious or spiritual beliefs have an effect on your Health**

    Yes **[ ]** No **[ ]** Undecided **[ ]**

    Why?..

9. **When I stay in hospital I would like to talk to a chaplain or pastoral care Worker?**

    Yes **[ ]** No **[ ]** Undecided **[ ]**

    Why?..

Appendix 1 (cont)

**10. If you have been visited by a chaplain or pastoral care worker.
Have you found it helpful?**

     Yes **[ ]** No **[ ]** Undecided **[ ]**

Why?..

11. When it comes to religion and spirituality I would like:
....

12. Do you think we (the mental health service) **should be providing a service for people's spiritual and/or religious needs while in hospital?**

     Yes **[ ]**   No **[ ]**   Undecided **[ ]**

     Why?...

13. Do you think that Chaplains are able to provide for people's spiritual religious need while under the care of the public mental health service?

     Yes **[ ]**   No **[ ]**   Undecided **[ ]**

     Why?...

Patient Questionnaire version 1, dated 5 April 2011

Appendix 2

**Spirituality and Religion Questionnaire for
Staff working in the Public Mental Health sector**

There are 7 statements and/or questions on this form. Please tick [ ] one box for each answer

Tick **Yes** if you agree with the statement

Tick **No** if you disagree

Tick **Undecided** if you are not sure or if there are circumstances that prevent you from answering the question

There is some space after each question for you to explain your answer or tell us more. You do not have to write in the space, but it may help us to understand your answer better.

1. **Spiritual or religious beliefs can have an affect on people's health, especially their mental health?**
    Yes **[ ]**   No **[ ]**   Undecided **[ ]**

    Why?...

2. **Spirituality and or religion becomes more important when a person is unwell, or experiencing illness?**
    Yes **[ ]**   No **[ ]**   Undecided **[ ]**

    Why?...

3. **A person's spiritual or religious beliefs influence how they view health and illness**
    Yes **[ ]**   No **[ ]**   Undecided **[ ]**

    Why?...

4. **Do you think we should be providing a service for people's spiritual   and/or religious needs while in hospital?**
    Yes **[ ]**   No **[ ]**   Undecided **[ ]**

5. **Do you think that Chaplains are able to provide for people's spiritual religious need while under the care of the public mental health service?**
    Yes **[ ]**   No **[ ]**   Undecided **[ ]**

6. **Have you called a chaplain for a patient while in the mental health service?**
    Yes **[ ]**   No **[ ]**   Undecided **[ ]**

7.   **If you have called a chaplain for a patient, did you find the service helpful?**
    Yes **[ ]**   No **[ ]**   Undecided **[ ]**

Appendix 3

Spirituality and Religion Survey
for Chaplains

There are several questions that we would like to ask you regarding your experience working as a chaplain with people who experience mental illness, their families and friends and staff.

1. **What is your role as a chaplain to people who experience mental illness? What specific services do you provide? (listening, counselling, worship/ritual, other activities)**

2. **What amount of your time is spent in the area of mental health?**

3. **What are some of the spiritual and/or religious issues that people speak to you about?**

4. **How do people's spiritual and/or religious beliefs affect their recovery? Could you please give us some examples?**

5. **How is your position funded?**

6. **What improvements would you like to see for the spiritual care of people in the public mental health sector?**

7. **What would you like to see happen in regards to chaplaincy and mental health?**