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SYNOPSIS

Is there a role for faith communities in the provision of spiritual care in health?

Il y a-t-il une place pour les soins spirituels dans les soins de santé?

Introduction

The central role of faith communities (religious traditions) in the provision of chaplaincy in health care cannot be denied. Numerous studies have traced the history of chaplaincy in the United Kingdom [1], United States of America [2], and Ireland [3]. In each of these places chaplaincy care has emerged from the responsiveness of the faith communities to the religious needs of patients in hospitals, and the role of clergy and authorised faith representatives has been integral to the provision of this ministry. How then do we arrive at a time when the involvement of the religious traditions could be brought into question? Each of the historical narrativies identifies seismic shifts that have happened over the decades, which have impacted the nature and understanding of chaplaincy. Meg Orton (2008) sought to discuss and compare some of the transformations that have occurred across countries in response to these shifting paradigms [4]. More recently in 2018, Reverend Richard Tessmer Leadership Lecture Steve Nolan stated, 'Chaplaincy care has historically been—and to a large degree remains—religiously affiliated. The key challenge concerns whether chaplaincy care can accommodate itself to the reality of our altered context' [5]. Chaplaincy has sought to remain relevant through changes that have come from both internal and external shifts. Internally there have been changes in language—chaplaincy, pastoral care, spiritual care; changes in providers—clergy, women, lay people, non-religiously affiliated; changes in employers—churches, hospitals, institutions; and the consistent move towards the professionalization of spiritual care. Externally the changes have manifested through the ascendance of the bio-medical model in health care and the subsequent challenge from the psycho-social model; various incarnations of health reform; the emergence of the spirituality in health care movement; and changing cultural and religious demographics. This is by no means an exhaustive list and serves only to highlight the context in which the continuing role of the faith communities in the provision of spiritual care is questioned. This paper seeks to address this question through the lens of the Australian experience in the hope that this might shed some light, (or pose further questions), for those in other countries exploring models of spiritual care and how it can meet the needs of current and future generations. As this is written from the Australian experience, the term 'spiritual care' will be used, rather than chaplaincy or pastoral care. Likewise, the term 'spiritual care practitioner' will be used to denote the spiritual care provider employed by the health institution. The term 'chaplain' is reserved for those who are employed and authorised by their faith community.

Table 1 ABS Religious Affiliation Census Data 2016.

	1996	2006	2011	2016
Anglican	22%	18.7%	17.1%	13.3%
Catholic	27%	25.8%	25.3%	22.6%
Other Christian	21.9%	19.3%	18.8%	16.3%
Other Religions	3.5%	5.6%	7.2%	8.2%
No Religion	16.6%	18.7%	22.3%	30.1%

The Australian Context

Religion and Spirituality

Australia has a population of 24.9 million people living across six states and two territories. Table 1 shows the most recent religious affiliation census data from the Australian Bureau of Statistics (ABS) [6]. This illustrates the increasing religious diversity within the Australian population and the rise of theproportion of the population who identify as 'no religion'.

For the first time in 2016, 'no religion' was the largest cohort and there are growing numbers of people who identify as 'spiritual but not religious' at 14% nationally [7]. The research undertaken by McCrindle Research in 2017 provided more meaningful data than the ABS census by tightening the identifying criteria used. By identifying the 'spiritual but not religious' group as a separate category, the overall numbers of those who identified as Christian went from 61% in the 2011 census to 45% in the McCrindle study (the results of the 2016 census were not available at the time of the McCrindle report).

In December 2017, the final report from a Royal Commission into Institutional Responses to Child Sexual Abuse was published. The stories of abuse have been heartbreaking, and the stories of the institutional responses have served to reinforce for people the harm that can be done by religious institutionsand raised questions about institutional credibility. The debate on same-sex marriage in 2018 further strengthened public opinion about how out of touch and irrelevant religious institutions are. The public voice

of religious institutions can be met with ambivalence at best and outright hostility at worst, and the admittance of religious representatives into health care settings can no longer be taken for granted.

Health Care in Australia

Health care in Australia is funded and administered by several layers of Government and supported by private health insurance arrangements. Nationally the Australian Government is primarily responsible for health service funding; regulation of health products, services and workforce; and national health policy leadership. The States and territories are primarily responsible for the delivery and management of public health services and the regulation of health care providers and private health facilities. The public system is supplemented by optional private health insurance for hospital treatment and for ancillary health services provided outside a hospital. As has occurred elsewhere, there is an increasing shift towards a focus on person-centered care and a move towards capturing data related to patient reported outcomes and patient experience rather than reports of patient satisfaction alone. There is a greater emphasis placed on quality and safety in health care which is reflected in the accreditation standards for hospitals—the National Safety and Quality Health Service Standards. These have a distinctive clinical emphasis that has been a change from previous standards, that prior to 2011 were more accommodating of spiritual care. It is an interesting dichotomy with the emphasis on patient experience on the one hand and on the other, having clinical aspects emphasised as being the most important contributors towards quality and safety.

Spiritual Care in Australia

Spiritual Care Australia (SCA) is the national professional association for chaplains, pastoral care workers and spiritual care practitioners working in any sector in Australia. However, spiritual care provision in health care is state based and so there are various models in operation across the country from professional spiritual care practitioners employed directly by health services to chaplaincy provided by faith communities (usually the Christian Churches) either in a paid or voluntary capacity. The faith community appointed Chaplains have dual accountabilities to both their faith community and to the health service. There is also a wide range of models involving volunteers (both faith community appointed and hospital appointed) and student interns in Australia. The Catholic Hospitals in Australia employ a pastoral care workforce across their hospitals who work as members of the multidisciplinary health care teams and they therefore have the most consistent professional approach to the provision of spiritual care. The language used for providers includes chaplains, pastoral care workers and spiritual care practitioners—these terms are used in different ways nationally. There are no consistent standards for education/training (although Clinical Pastoral Education is still recognised as the most common pathway into spiritual care). Research in the Australian context has been limited, although there have been some signs of progress in recent years. SCA launched the National Standards of Practice in 2014 but these have not been implemented consistently nor are they mandated or referenced in health policy [8]. In 2017, a national consensus conference was held in Australia to identify opportunities for a nationally consistent approach to spiritual care. Outcomes from a national survey 2016—2017, and from the conference have been published previously [9,10]. One of the policy statements from the consensus conference states: ''Faith communities are recognised as partners in the provision of spiritual care''. What this means,in reality, remains unclear.

Faith Communities and Spiritual Care

Given the complexity of the Australian spiritual care landscape, this paper will discuss the involvement of faith communities in the state of Victoria only. The experience in Victoria has some similarities to other states (e.g. New South Wales and South Australia where state government funding has also been provided to faith communities through a state based organization) but is very different from others (e.g. Queensland and Tasmania where state government funding has never been provided in this way). However, the faith communities have been involved in the provision of spiritual care in health care in every state and territory in varying capacities. In Victoria, the Christian churches have been in receipt of government funding since the mid-1950s, initially in recognition of the significant contribution made by the churches to the provision of chaplaincy in public hospitals. This funding is paid to an organization, in its present incarnation called Spiritual Health Victoria (SHV), which then disburses the funding to the faith communities based on the most current ABS census figures. In the mid-70s hospitals began to directly employ 'Pastoral Care Coordinators' which initiated conversations around boundaries and identity, similar to those occurring in North America at the time [2]. Are chaplains church representatives or are they health professionals? To whom are they accountable? Should they have access to medical records and sensitive patient information? Are they members of the health care team? Over the decades the internal and external shifts described in the introduction above have kept many of these issues alive. In 2008 SHV undertook a project to answer the question, ''Who is responsible for spiritual care in Victorian metropolitan public hospitals?'' [11]. The project involved eight metropolitan hospitals and interviews were conducted with six Pastoral Care Coordinators, five hospital management representatives, and four faith community Chaplaincy Coordinators. Due to the small number of interviews conducted ($n = 15$), a number of faith communities had concerns that the findings were skewed and so the report was never published. However, the report noted that there was agreement among interviewees about the significance of the role of the Pastoral Care Coordinator and that a non-sectarian pastoral care service delivery model was needed to be defined as ''pastoral care that was not affiliated with or limited to a specific religious tradition'' [11 p17]. With the growing numbers of Pastoral/Spiritual Care Coordinators in Victorian hospitals,SHV established a Spiritual Care Management Network in 2002 to give the coordinators a common voice in the movement towards establishing spiritual care as a health profession and distinguishing themselves from church appointed chaplains. In 2010 funding began to be disbursed to faith communities other than the seven Christian denominations who were the original members of SHV, with the ensuing need to formalise

a multi-faith approach to spiritual care. Over this period of time, SHV developed the first Capabilities Framework for Chaplaincy and Pastoral Care (SHV, 2009), and went on to develop the Spiritual Care Minimum Dataset Framework [12], the Towards Best Practice: Spiritual Care in Victorian Health Services Framework [13], and finally a new Capability Framework for Spiritual Care Practitioners in Health Services based on a national health workforce resource and the Victorian framework for allied health [14]. One consequence of this ongoing move towards professionalization was the recognition of spiritual care as an allied health discipline by the Chief Allied Health Advisor in the Victorian Department of Health and Human Services (DHHS) in 2016. In the meantime questions about the quality of care being provided by the faith communities in receipt of government funding began to be raised by the DHHS. This paralleled the move in health care towards value over volume [15]. In response SHV developed a credentialling framework that required faith communities receiving funding through SHV to develop and implement a credentialling process as one of the requirements for ongoing funding [16]. A significant issue faced by the faith communities is the varying capacity they have due to differences in experience, size and infrastructure. Many of the smaller faith communities are new to the spiritual care field, while the major Christian denominations have long histories of providing chaplaincy and, as reflected by Cadge (2018) do not want to let go of 'their personal histories, identities and religious traditions' [2 p8]. The smaller faith communities are mostly reliant on volunteers and respond to the needs of their own faith community members mostly on a referral basis. Maintaining adequate records of spiritual care provision is a challenge for these communities. The larger Christian denominations employ chaplains to major hospitals, and these chaplains are seen as members of the spiritual care team often providing spiritual care in an inclusive capacity. They may be assigned specific wards or units where they are available to all patients and staff. While this model provides additional resources to the spiritual care department, the chaplains continue to have dual accountabilities and this raises a number of questions around responsibility and professional identity. There is also concern that hospital management and government remain oblivious to the true volume of spiritual need within health care and are not held responsible for ensuring adequate and realistic funding and resources from a trained and competent workforce. It can be too easy in this context for health services and government to frame spiritual care as ''religious care'' and therefore the responsibility of the faith communities. In 2017 SHV's accountability was moved from the DHHS to a new agency set up by the Victorian Government to respond to issues of quality and safety. Safer Care Victoria acknowledges the significance of spiritual care and the contribution of the spiritual care practitioners employed within health care services as integral members of the health care team. However, Safer Care Victoria continues to raise questions about the value and quality of the contribution of the faith communities in receipt of Government funding. In response to these questions, SHV commenced a partnership with La Trobe University (Melbourne, Australia) in 2018to undertake research that will commence in 2019. In line with current health care concerns, this research will address the question of the faith communities' contribution in the context of the identified spiritual needs of the patient and patient reported experience and outcome measures.

An agent for the Church or . . .

In his 2018 lecture, Nolan calls for spiritual care practitioners to reflect on and question their relationship with their faith communities as the primary source for professional identity. He poses the question, ''Am I first of all an agent of the Church or an activist for the Kingdom and Jubilee?'' [5]. The question of professional identity is important and needs to be addressed on an ongoing basis by spiritual care practitioners, although those who do not come from a Christian tradition would want to reframe the language used by Nolan. The question also needs to be reframed by the spiritual care sector as a whole. Spiritual care is no longer an ''agent of the Church'' nor of the faith communities. It is no longer enough either, to describe spiritual care as having a ''multi-faith approach'' and to believe that this language is inclusive of the diversity of beliefs, values, practices, and traditions found in our complex societies. If spiritual care is no longer a representative of the Church, what is the alternative? An agent of the Church or.? Spiritual care has worked to maintain its relevance, value, and place in health care by being responsive to the movements in health care [2], so has spiritual care (and its practitioners) become an agent of health care? Some may think this is indeed the case, arguing that spiritual care is at risk of losing its soul and selling out to the health care system. But those engaged in the field are committed advocates for bringing whole-heartedness, soul, and spirit into health care. Finding new words for the second half of Nolan's question is important—what is the ''or''? Perhaps spiritual care and spiritual care practitioners are activists for ''the spirit'', that impulse alive in every human person towards transcendence. The concept of transcendence has traction across religious and non-religious explorations of spiritual care practice and needs further consideration in the field [17,18]. If spiritual care is ''an activist for the spirit'' the primary focus must be on the person and we find ourselves in the place where spiritual care has always been exemplaryin person-centered care.

An Emerging Model

Given all of the above, is there a role for faith communities in the provision of spiritual care in health and what might that look like? While the cultural and religious demographics continue to change, there remains a high proportion of the population in Australia who claim a religious affiliation. Of this cohort, there will be people for whom that impulse towards transcendence is expressed through the beliefs, values, practices, and traditions of their religion. There are a number of assumptions that can then be made (and often are):

- That a person with a religious affiliation will have spiritual needs related to matters of their religious affiliation.
- That their spiritual needs can only be met by someone from their own religious tradition.
- That they want to see someone from their own religious tradition.
- That their spiritual needs are met when they receive care from someone of their own tradition.

These assumptions have not been tested and there is no evidence at hand to support or to contradict these assumptions, thus the need for research in this area. As Swift reports, ''The church entertains and promotes the idea that it is reaching into areas of need, but little evaluation seems to have been done on whether this effort is in any way effective or indeed valuable'' [1]. The emerging models for spiritual care clearly need to be able to respond to the spiritual needs of the diverse population and David Savage (2019) suggests that the question of identification become more inclusive of religious, non-religious, and spiritual possibilities [19]. The person-centered nature of spiritual care highlights the skills, formation, and competencies required of spiritual care practitioners if they are truly to work as specialists in this field to enable and facilitate responsiveness to the identified spiritual needs of patients. When those needs require the ministry of someone from the patient's own faith tradition it is the role of the spiritual care practitioner to expedite that ministry. This may or may not need to occur in the health care setting, depending on the urgency of the circumstances. Spiritual care practitioners, at least in the Australian context, need to engage more in discharge planning and referrals into the community. The emerging model in Australia acknowledges spiritual care as a shared responsibility within health care [10,20]. Spiritual care practitioners employed by health services are specialists working alongside their health care colleagues as activists for the spirit and they are representative of the religious, non-religious, and spiritual diversity of the Australian population. The faith communities provide faith specific care as agents of their religious tradition and in response to the identified spiritual needs of people. The extent, value and place for this care is yet to be fully investigated and integrated so that faith communities can truly become partners in the provision of spiritual care. This is the intention of the research to be undertaken by SHV in partnership with La Trobe University commencing in 2019. The research will address the following questions:

- When patients nominate a specific faith affiliation do they want their spiritual needs met by someone from their own tradition?
- When they receive care from someone of their own tradition are their spiritual needs met?
- What model of spiritual care is needed in light of the answers to the first two questions?

Conclusion

Through an exploration of the Australian experience and context, this paper addresses the ongoing role of faith communities in the provision of spiritual care in health care. There is an increasing distinction between spiritual care practitioners as activists for the spirit and representatives of faith communities as agents of their faith traditions. While it can be expected that for people with a religious affiliation the ministry of someone from their own faith community may be important, the assumptions that are made about this need to be addressed through further research. The role and contribution of faith communities need to be mapped as part of the emerging model for spiritual care. Clarity about roles and responsibilities can only support the inclusion of spiritual care as an essential part of person-centered health care.

Disclosure of Interest

The author declares that she has no competing interest.

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