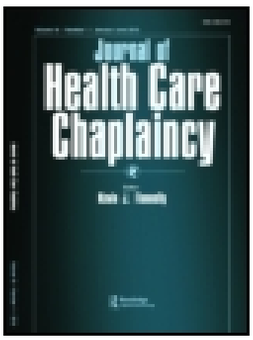

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Professional development for spiritual care practitioners: a program review

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ABSTRACT

Professional development is a crucial aspect for further successful progression of an individual's skills and effective function in their role. It is also a compulsory part of registration for most professionals in the health care sector. This article reports on the evaluation of a monthly professional development program, specifically for spiritual care practitioners, offered over the period 2017–2019 by Spiritual Health Association (Victoria, Australia) and its partners. Many common themes such as motivation, culture, purpose and areas for improvement have been identified and are further examined. Recommendations such as greater emphasis on the professionalism in the sector, broader inclusions of sessions across culture and ethnicity and the development of cross disciplinary communication skills are made for the future of this program.

KEYWORDS

Chaplaincy; education; professionalisation; professional development; spiritual care

Introduction

Professional development is a crucial element of professional practice. As spiritual care is increasingly being recognised in the health care sector as an essential element of person-centred care (Gordon et al., 2018; Tan et al., 2020; Timmins et al., 2018) the requirement for professional development equally applies. This is expressed within the Spiritual Care Australia (2020) registration standards for professional spiritual care practitioners. Manley, Martin, Jackson, and Wright (2018), for example, reveal that professional development is significant in upgrading skills for improved professional practice, as well as delivering effective and best possible patient care. This was also demonstrated in an earlier evaluation of our professional development program for spiritual care practitioners (Wong & Tan, 2017).

Bhatnagar and Srivastava (2012) indicate that keeping up to date with continuing professional development has resulted in enriching employability, maintained self-confidence and job satisfaction. Other studies have also emphasised the importance and value of on-going education and training for spiritual care practitioners (Cadge et al., 2019; Fitchett, Tartaglia, Dodd-McCue, & Murphy, 2012). It can be concluded that professional development in spiritual care is essential for spiritual care practitioners within health care teams.

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Table 1. Outline of an average month's agenda.

Time	Program item
9.30 AM	Morning tea
10.00 AM	Announcements—Collaborating organisations
10.15 AM	Reflection—Keeping in mind the multi-faith affiliations of participants
12.15 PM	Colloquium—Presented by a speaker who has specialised knowledge and experience in a particular area of spiritual care provision
1.00 PM	Lunch
2.00 PM	Facilitated Reflection Groups—Further small group discussion of the topic presented on the day.

The purpose of this report is to evaluate a professional development program, produced by Spiritual Health Association, in collaboration with their partners Spiritual Care Australia (SCA-Victoria) and the Association for Supervised and Clinical Pastoral Education in Victoria (ASACPEV), for spiritual care practitioners which were conducted over the period 2017–2019.

Arrangement of professional development sessions

The professional development sessions with education and facilitated discussion groups were offered eight times per year, between March and November with a break in July. This included a morning and afternoon session. The program was organised by a working group that included spiritual care practitioners. Each year topics were selected from among those suggested on evaluation sheets by participants of the previous year's program and any other particular issue arising in the sector. Any suggestions for appropriate speakers for a particular topic were also considered by the working group.

The sessions noted within this report were held at different public and private hospitals and medical facilities. These were attended by spiritual care practitioners from within metropolitan and regional areas of the state of Victoria (Australia). At times other staff such as nurses, doctors and allied health staff from the site at which the program was presented, who had been alerted by the site spiritual care manager about a program of possible interest, also attended. Overall attendance over the three years covered in this report ranged from 30 to 38 people per session. The total number of evaluation forms received during this period was 498, which included 22 sessions, representing an approximate 67% response rate.

Table 1 outlines the agenda of the average month. A broad range of topics was included in the colloquium program. Some examples, from the twenty-two topics presented during the evaluation period included: secular symbols and images as carriers of spiritual strength, recognising and pastorally responding to elder abuse, compassion fatigue and self-care, latest research in spiritual care, assessing and responding to trauma, understanding voluntary assisted dying legislation in Victoria, ethical decision making and a multifaith panel discussing rituals in death and dying from different traditions.

Methods

This report is based on evaluation forms distributed and completed by participants at each session, enabling consideration of the program's effectiveness and areas for

Table 2. Gender of participants by year of attendance ($N = 474$).

Year	2017	2018	2019	2017–2019
Male	36 (21.3%)	27 (17%)	31 (21.2%)	94 (19.8%)
Female	117 (69.2%)	122 (76.7%	111 (76%)	350 (73.8%)
Other	16 (9.7%)	10 (6.3%)	4 (2.7%)	30 (6.3%)
Total	169 (100%)	159 (100%)	146 (100%)	474 (100%)

Note: Not all ($n = 24$) participants identified their gender.

improvement. They were invited to complete these and place them into a collection box before leaving the session (see Appendix A: Evaluation form). The data collected from these forms included demographic information, quantitative data (utilising a standard Likert Scale) and qualitative data in the form of responses to semi-structured questions. The latter were thematically analysed by the corresponding author, and three assistants, with any differences in analysis resolved by discussion.

The results presented represent the data from the participants who not only attended the professional development but also filled out this optional evaluation form. These relate to the morning program only. These data encompass results from the 2017 to 2019 professional development programs, however, an earlier report was completed and published (Wong & Tan, 2017) evaluating the data from previous years (2013–2016).

Results: quantitative data

Quantitative data were collected as per the evaluation sheet (Appendix A). These included gender, religious affiliation, place of work, qualifications, registration type, overall satisfaction with the program along with specific evaluations of parts of it. Qualifications and registration type were poorly responded to and are no longer on the currently used evaluation form and so it was decided to exclude them from this report. The remaining factors are reported below.

Gender

Table 2 indicates gender identity of those who attended and completed the evaluation forms This was included to assess if there was any change in gender balance of attendees in a sector traditionally dominated by females. The "other' category is included as a recognition that not all participants identify as either male or female. Across the three-year period the overall average percentage of participants were female (73.8%) with the next largest category being male (19.8%) and then "other" (6.3%).

Religious affiliation

Table 3 provides a framework of the program participants religious backgrounds/affiliations as self-reported and described by the participant in the blank space provided. No suggestions of options were made. This program arose from a Christian foundation and by far the larger group of attendees identified as having a Christian background. However, every effort was made to keep the program inclusive. The reflection time, for

Table 3. Religious affiliation (if any) ($n = 479$).

Religion	2017	2018	2019	Total 3 years
Christian	59 (33.5%)	55 (35.5%)	48 (32.2%)	162 (33.8%)
Baptist	17 (9.7%)	11 (7.1%)	9 (6%)	37 (7.7%)
Uniting Church Australia (UCA)	11 (6.3%)	7 (4.5%)	1 (0.7%)	19 (4%)
Multifaith	2 (1.1%)	4 (2.6%)	1 (0.7%)	7 (1.5%)
Catholic	37 (21%)	30 (19.4%)	28 (18.8%)	95 (19.8%)
Anglican	6 (3.4%)	13 (8.4%)	11 (7.4%)	30 (6.3%)
Church of Christ	6 (3.4%)	1 (0.6%)	1 (0.7%)	8 (1.7%)
Non-denominational	1 (0.6%)	1 (0.6%)	2 (1.3%)	4 (0.8%)
Buddhist	5 (2.8%)	2 (1.3%)	11 (7.4%)	18 (3.8%)
Eco-spiritualist	2 (1.1%)	2 (1.3%)	1 (0.7%)	5 (1.7%)
Lutheran	9 (5.1%)	6 (3.9%)	6 (4%)	21 (4.4%)
Mormon	1 (0.6%)			1 (0.02%)
Spiritualist	3 (1.7%)		3 (2%)	6 (1.3%)
Non-duality	1 (0.6%)	1 (0.6%)		2 (0.4%)
Not applicable	15 (8.5%)	15 (9.7%)	15 (10%)	45 (9.4%)
Secular		1 (0.6%)		1 (0.2%)
Islam		2 (1.3%)	2 (1.3%)	4 (0.8%)
Women's way earth medicine		1 (0.6%)		1 (0.02%)
Undecided	1 (0.6%)	2 (1.3%)	7 (4.7%)	10 (2.1%)
Presbyterian		1 (0.6%)	1 (0.7%)	1 (0.02%)
Greek orthodox			1 (0.7%)	1 (0.02%)
Hindu			1 (0.7%)	1 (0.02%)
Total	176	155	149	479

Note: Not all participants ($n = 21$) identified their religious affiliation.

example, was inclusive (apart perhaps from the major religious festivals), rather than one based exclusively in Christian theology or any other religious belief base.

While changes to the program, relating to a more inclusive approach to content and presentation did meet some challenges from some long-time participants, the strong ethos of multiculturalism and inclusiveness of the providing organisation, now known as Spiritual Health Association, enabled this progress to proceed and continue to grow. It is interesting to note that a large proportion of those with Christian background chose to describe themselves as Christian rather than use a denominational identification.

Professional context

While this program is directed predominantly towards the health care sector some participants' place of work was in prisons or with faith community congregations. Table 4 outlines the place of work by year and total across three years.

Evaluation of the program

This specifically included a measure of 1–5 indicating overall satisfaction with the program, relevance to spiritual care, interest in the topic, quality of the presentation and experience of reflection time. These data are recorded in Table 5.

It is interesting to note that in all categories 2018 scored the lowest of the three years. This is possibly accounted for by some internal organisational issues occurring that year and in the planning period preceding it. In all categories 2019 was the best year. While still good (averaging above 4 on a 1–5 scale), the relatively lower scores in relation to

Table 4. Place of work ($n = 498$).

Year	Public hospital	Private hospital	Aged Care facility	Mental health	Other	Total
2017	87	27	26	10	26	176
	49.4%	15.3%	14.8%	5.7%	14.8%	
2018	85	32	13	6	25	161
	52.8%	19.9%	8.1%	3.7%	15.5%	
2019	89	31	16	4	21	161
	55.3%	18.3%	9.9%	2.5%	13%	
Total	261	90	55	20	72	498
	52.4%	18.1%	11%	4%	14.5%	

Note: Some participants work across more than one facility

Table 5. Experience of the program.

Year	Overall satisfaction	Relevance of topic	Interest to participant	Quality of presentation	Quality of reflection time
2017	4.48	4.57	4.53	4.47	4.00
2018	4.40	4.47	4.48	4.43	4.01
2019	4.57	4.72	4.62	4.61	4.24
Over period	4.48	4.59	4.54	4.53	4.11

the reflection is probably indicative of the discomfort experienced by some participants by the move to a more inclusive reflection and one that was not specifically Christian.

Results: qualitative data

The results of three open-ended questions on the evaluation form i.e., the "main reason for attending" and then two separate comment sections where participants were able to comment on any part of the professional development program provided the qualitative data.

Four key themes were identified through the analysis which is (1) motivation for engagement; (2) areas for improvement; (3) culture/purpose and (4) recommendations. These are illustrated below with examples taken directly from the evaluation forms.

Motivation for engagement

The most common reason given for attendance was networking and building partnerships. Several participants used phrases such as: "*Enjoyed the opportunity to network*" (P471).

A number of participants indicated that they were more motivated and likely to engage with speakers who showed passion and utilised stories to highlight their points:

> [The] Speaker got the balance right between storytelling, research and evidence and that hard to describe sense of grace and possibility, (P5)
>
> … But sensitivity and experiences are essential; (P293)
>
> "Fabulous, entertaining, thought provoking and relevant speeches" (P187), "His presentation embodied passion, compassion and deep/wide reading and experience" (P406)

As well as having an engaging speaker, an interactive presentation was another important selling point with the participants:

> Love the integration of creative activities into the curriculum by SHV, (P112)
>
> Very interesting, presenters relaxed and interactive manner engaging and affirming we can't be experts, (P293)
>
> It was good being interactive. She was well able to draw on many on the challenges and clarify about the advocacy of the patients within ethically challenging context. (P419)

Most of the feedback relating to the morning reflection was positive:

> Morning reflection provided space for self-care and nurture (P272) and
>
> Excellent depth and reminder of the necessity of self-care and reflection. (P115)

Many of the topics discussed allowed for further discussion or learning and challenged many participants in a positive manner:

> A wonderfully stimulating discussion that enabled us to truly reflect upon our own role in pastoral/spiritual care as we considered ethical decision making; (P405)
>
> Appreciated the thoroughness of the preparation. Very well paced delivery. Excellent distinguishing of shame and guilt. Really helped to have healthy responses to shame and guilt identified. Take home is so very beneficial for example - that shame and guilt essential elements for healthy human development. That we need to hear them not numb them. Tendency has always been to attempt to assure these difficult emotions. A light bulb moment to see this differently. (P397)
>
> Challenging and necessary. A lot of very deep, important points to be fully understood. (P184)

Areas for improvement

Some participants however thought that there was a lack of depth in some presentations while others found themselves "out of their depth":

> There are still many grey areas; (P222)
>
> I was happy for a little more depth - deep ecology practices beyond my scope! (P282)

The utilisation of real-life examples were looked upon favourably but also some felt that a bit more discretion should have been applied:

> Personal stories – were very powerful; (P22)
>
> If people gave examples/stories it helps illustrates there points better; (P158)
>
> Little more confidentiality from 'speakers', for example, not name dropping/naming and shaming people; (P65)
>
> Appreciated the opportunity to have questions answered but would have appreciated more of the actual presentations to be about how it works on the ground; (P48)
>
> A great model of spiritual knowledge and strength. His awareness of the issues was also presented in a way we could apply to our pastoral care practice. (P31)

Some participants felt there should be more awareness of other cultures/religions that may be represented as the program aims to be inclusive of all regardless of culture or religious affiliation:

> Get frustrated when prayer is Christian centric. (P414)

Culture and purpose

Participants indicated that they were given the opportunity to see how they could implement aspects of the speaker's presentation, not only in their professional work but in everyday life:

> So good to have the focus on the supervised relationship, yet the way the speaker presented gave us plenty of scope to reflect on the ways our resistance to change applies to all aspects of our lives. So relevant; (P318)

> Spoke from a place of heart as well as spiritual authenticity. Information was relevant and applicable and felt we could take away what was presented and investigate information in the pastoral care setting. (P25)

Having the chance to have the prayer/reflection time allowed many of the participants to appreciate the purpose of both spiritual care and professional development:

> I loved the reflection time - didn't want it to end, really enjoyed the meditative colouring and the images - I especially loved their reflections, the mirroring which was very suggestive of the mirroring and empathy we do. (P121)

> Beautiful reflection and options for all, so I really appreciated the diversity/choice/music and sacred space to reflect on my own path, dignity and value. (P429)

The opportunity to hear many different cultural/religious/spirituality approaches and how they can impact an individual's work was also much appreciated:

> Valuable insights, like the broader spirituality focus. (P23)

> Good to hear three different traditions approach to pastoral care. (66)

> Perfectly balanced but different approaches to a very contemporary issue for health care professionals. Important information for our sector - but also could offer our allied health friends much as well. (P373)

Another participant, however found the impact of the unfamiliar confusing:

> Some faith - traditions turn conventional wisdom on its head. (P222).

Recommendations

Some participants suggested that it was important to increase the opportunities for understanding a variety of traditions and how they can utilise the knowledge within any workforce:

> Encouragement to explore other wisdom traditions; (P148)

> Really appreciated learning different perspectives from different traditions. Good to know some of the traditions if I come across them. (P446)

Learning more about important and current issues and how they are addressed, was helpful to participants in addressing these topics within their own practice:

> Need to be careful of our prejudices/judgements towards perpetrators. Need much more sorrow and compassion in this respect. Much wisdom needed. Need to underline the importance of referral. (P87)

The importance and value of learning about what other countries have done was also raised.

> Would have been good to include a pastoral care perspective on the issue from USA/ Canada. (P217)

It was suggested that highlighting the importance of continual professional development and education programs, from the very beginning of an individual's career, should be emphasised more:

> It was very interesting topic and interactive. I did find it interesting that the nurses don't have a clear understanding of what pastoral care is; (P467)

> A bit anxious regarding unready people beginning this work. Good to hear professional presenters. (P358)

Many participants had questions following on from the presenter's discussion about the future of spiritual/pastoral care and its relationship with other allied health professions:

> Good explanation of complexity, sad to hear. Lack of social work PC having to pick this up. What does this mean for future PC? (P83)

There have also been a number of occasions, both verbal and written, when participants, or potential participants have expressed a desire to access professional development via webinars or by on-line streaming. Distance of travel from workplace to site of the training, along with the challenges of being available during working hours at work sites which are mostly lacking in appropriate staffing levels for spiritual care practitioners are the main reasons for these requests.

Discussion

Several areas of interest featured significantly across the data analysis, both quantitative and arising from the four main themes identified in qualitative data analysis.

Religion and gender of attendees

There has been a slight increase in the percentage of males attending during the period of this evaluation, with there being 19.8% overall compared to 19.1% in the earlier evaluation (Wong & Tan, 2017). In 2017 another option of "other" was also added to the evaluation form. The recent study showed a decrease in the percentage of females attending, from an overall of 80.9% in 2013–2016 (Wong & Tan, 2017), down to 73.8 in 2017–2019. The dominance of females attending the program is reflective of gender ratios within the sector as indicated in a state-wide survey which showed that from a sample of 92 responses 21% were male and 79% female (Spiritual Health Association, 2019).

The data in Australian Bureau of Statistics (ABS) 2016 Census (2017) demonstrated a notable variation in the percentage of people who identified as being Christian across age groups. For under 18s, there was 48.4%, for 18–34s there was 39.4%, 50.4% for 35–49s, a 59.5% for 50–64s and for 65+, 70.3% of Christians. In terms of 18–34s it has shown a balance between the number of Christians and no religion, 39.4% and 38.7%

respectively. While age was not recorded in our current evaluation, these ABS data may have significance in planning future programs with the probable trend of younger people engaging in spiritual care and the on-going change in the mix of ethnicity in the overall population of Australia.

In the previous study Wong & Tan, 2017), within the first two years only three people were completing the evaluation who identified with a religion other than Christianity. This number did slowly increase in 2015 and 2016 however with there being 10 and 12 in each year respectively. This is an important improvement and reflects the movement towards a more inclusive professional development program, regardless of religious affiliation or none. One example of changes in the program in the last few years towards this end has been the introduction of a reflection time, which is not targeted to a specific religious affiliation, but conducted in a way that is inclusive and can be embraced by all. Across the years of 2017–2019, apart from the increase in the number of participants who identified as something other than Christian affiliated, the number of such groups rose from seven in the earlier study (Wong & Tan, 2017), to ten in the current one—further evidence of reaching a broader audience.

Speaker topics

It was noted that in the 2017–2019 data there was little to no overlap of topics presented in the previous three years, although some could be considered as sub-topics of the same broader area. The diverse range of topics illustrates a broader understanding of the nature of spiritual care and a more inclusive approach to its practice and hence the need for professional development that challenges participants across a broader base of knowledge and experience.

As a part of the evaluation process, participants were given the chance to evaluate and make comment on the day's program. The categories of evaluation included "relevance to spiritual care," "interest to you," "presentation" and "morning prayer and reflection." These data are recorded in Table 5. Commonly the reflection section was ranked the lowest, with notable reasons given that the participant felt it was too Christian focused or simply that the reflection was not as important to some participants as the speaker's topic.

The ranking of scores overall from 2017 to 2019 improved as the years went on. It was notable that the topics aimed at specific processes and how to implement them were ranked higher, as were those that involved diversity such as openly discussing and acknowledging different beliefs and the different ways these impact how situations are addressed.

Interestingly the lowest-ranked topic was in 2017 and was entitled "latest research in spiritual care." This is reflective of a need for cultural change within the sector regarding the importance of research in spiritual care to support evidence-based practice. An international study into attitudes to research amongst chaplains/spiritual care practitioners (Snowden et al., 2017) found that those who regarded research as important and read relevant research papers regularly were significantly more likely to have post graduate qualifications and to have been involved in research in some way. In the light of this data, there has been an increase in some countries in training in research literacy (Transforming Chaplaincy, 2020) as well as encouraging practitioners to become

engaged in research as part of their regular scope of practice. It also emphasises the importance of continuing to include research-related topics in the program as well as in other avenues of professional development for the sector.

Networking

Throughout the evaluations, a major reason for participation was networking and eagerness to meet other individuals working both within the hospital system and in other areas such as prisons. The opportunity for networking has been particularly important as a reason to participate, as many spiritual care practitioners either work alone within their workplace or in very small teams. Forret and Dougherty (2004) suggest that networking is taking place when an individual aim to build relationships which will support them in their future through the advancement of their careers. It has also been identified as having other benefits such as supporting the enhancement of professional and personal opportunities such as developing networks (Wolff & Moser, 2009).

There is a degree of conflict between the motivation to attend being networking and the only practical way to participate for some being webinars. With the demands of time and resources, it is likely that in the future both options may need to be offered to increase opportunities for participation in professional development.

Culture

In order to deliver effective patient care, Deodhar and Muckaden (2015) state that recognition of our own spirituality and worldview is required. Equally, as Cioffi (2005) suggests, one would hope that practitioners would express a willingness to learn about the patient's culture (ethnicity and religious expression) and what brings meaning and purpose to them. Participants in this professional development program evaluation indicated that they gained valuable insights into a broader focus of spirituality.

Culture, especially specific religious rituals at significant turning points in life, is extremely significant to patients and their lives in relation to health and illness and consideration of treatment options (Fukuyama & Sevig, 2004; Omeri & Malcolm, 2004). This was also appreciated by participants of this study as reflected in many comments on their interest in and appreciation of more knowledge and understanding about practices and beliefs that are different from their own. Professional development programs in relation to spiritual care can be very significant in enabling practitioners to understand the differences and relationship between religious beliefs and cultural practices (O'Brien, Kinloch, Groves, & Jack, 2019) and so it is important that such programs cover a range of topics along religious, existential, psychological and social domains.

Motivation

A number of other motivations for participation in the professional development program were identified by participants which were also consistent with reports in the literature. The desire by practitioners to become more aware of spiritual health in a broader community than just that of their own faith background was also identified in

a study by White (2000). The need for spiritual care practitioners to be culturally competent to deliver basic spiritual care to all patients regardless of background, and hence be educated to do so was expressed by participants of this program and has also been discussed by O'Brien et al. (2019).

Omeri and Malcolm (2004) reported that nurses believed that acknowledging their strengths and weaknesses and reflecting on these is critical. A similar view is reflected in the comments by participants in our program. In other studies, both nurses (Cioffi, 2005) and physicians (Fukuyama & Sevig, 2004) spoke of a desire to understand patients' needs by being aware of their cultural and religious backgrounds and expressed concern that their failure to do this would impact on the quality of care they offered.

Self-care for health professionals was another expressed motivation for participation in the professional development program. This is also supported by Deodhar and Muckaden (2015) who clarify that self-care is a buffer between productive work experience and satisfaction on the one hand and compassion fatigue and burnout on the other.

Areas of improvement

`As already stated there was both support for greater and broader education and understanding of the diverse cultural, religious and non-religious needs of the general population both by the participants of our program and as discussed in the literature (Cioffi, 2005; Fukuyama & Sevig, 2004; Omeri & Malcolm, 2004; White, 2000). While this process has begun it will be important that it is maintained and expanded in the professional development program as the needs of patients and staff change.

Another area of need for on-going improvement and development is the field of cross disciplinary communication and decision sharing between members of the care team—including spiritual care practitioners. This further development has also been supported in the literature (Jeanne Wirpsa et al., 2019; O'Brien et al., 2019).

Some participants believed that they would benefit from a greater depth of discussion on some important and topical areas of education. This is supportive of the view expressed by Deodhar and Muckaden (2015) who conclude that it is of great importance for practitioners to have a high level of understanding of spiritual care and its delivery to patients. However, while maintaining a good standard of professional education, it will need to be kept in mind that some other participants of our program felt that some areas of discussion had put them out of their depth. This is possibly a reflection, to a degree, of the changes occurring in education pathways and expectations for professional spiritual care practitioners as the sector moves towards professionalisation of spiritual care practitioners. These levels are not always met by some who have been in their role for a long time. Professional spiritual care providers, as equal partners in care with other health care professionals, seems to be the way of the future.

In the future consideration will need to be given to providing more broadly accessible programs through the use of modern technology, thus allowing greater flexibility for participation by spiritual care practitioners and other health care professionals interested in furthering their understanding of the role of spiritual care in the health care system. Some international professional education providers in the spiritual care sector such as Transforming Chaplaincy (2020) have taken a lead in this area.

As the trend towards greater diversity amongst spiritual care practitioners continues, e.g., age, cultural and spiritual background, there will be a need to consider other factors in the provision of professional development and the collection of evaluation data. Some examples may be using tools such as Survey Monkey to collect and collate data as well as promoting the program more broadly utilising electronic methods such organisational newsletters and staff bulletins.

Limitations

Several limitations of this data have been identified. Completion of the evaluation forms was not compulsory and not everyone who attended the program completed and returned a form. The evaluation forms did not collect data about the type of registration the participant had (i.e., casual, institutional or individuals who had registered for the whole year program). There would be variations in the regularity of attendance of the different types of registrants which may have influenced their experience of and commitment to the program. Information about age and cultural identity of participants was also not collected so no comparisons can be made between subgroups based on those two criteria. In spite of increased diversity amongst the participants, the majority of participants are of Christian religious affiliation, making it difficult at times to move away from a Christian orientated program, particularly in the reflection times.

Conclusion

The professional development program as provided over the period 2017–2019 has continued to offer valuable education and support to spiritual care practitioners but has also demonstrated an increased diversity in both the backgrounds of those participating, and in the topic areas which have been considered appropriate and relevant to this education process. It is apparent that in order to further increase accessibility and provide relevance for the professional approach to the provision of spiritual care, changes will need to be made in the mode of presentation looking particularly to more on-line availability. These programs will need to continue to expand the opportunities for education that are more inclusive of diversity both within the profession and within the population they serve. To cater to the ongoing trend towards a professionalised workforce, this program will also need to include exploring some topics at greater depth and education relating to interdisciplinary communication within health care services.

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Appendix A

Spiritual Health Victoria

PD PROGRAM EVALUATION FORM

1. GENDER: _____

2. RELIGIOUS / FAITH / SPIRITUAL IDENTITY (IF ANY): _____

3. (a) HIGHEST EDUCATIONAL QUALIFICATION (IF ANY)? *(Please circle)*

Certificate/s Diploma/s Degree/s Post graduate (Masters / Doctorate)

(b) DISCIPLINE: *(e.g., Theology, religious studies, nursing, etc.)*

_____

4. DO YOU HOLD / HAVE YOU HELD ANY PROFESSIONAL REGISTRATIONS? *(Tick all that apply)*

Spiritual Care Australia ____

ASACPEV ____

Other (*please specify*): _____

5. WHAT IS YOUR CURRENT PROFESSIONAL ROLE? _____

6. (a) WHERE ARE YOU CURRENTLY EMPLOYED? *(Please tick all that apply)*

Public hospital ____

Private hospital ____

Aged Care facility ____

Mental Health ____

Other … (*Please specify*) _____

(b) HOW MANY YEARS HAVE YOU BEEN WORKING THIS AREA? _____

7. WHAT WAS THE MAIN REASON YOU ATTENDED THIS MONTH'S PROGRAM?

_____-

____

FOR THE FOLLOWING QUESTIONS, PLEASE USE THIS SCALE:

*(**1** = Very Dissatisfied; **2** = Dissatisfied; **3** = Not Sure; **4** = Satisfied; **5** = Very Satisfied)*

8. HOW WOULD YOU RATE THIS MONTH'S EDUCATION SESSION?

a.	Overall	1	2	3	4	5
b.	Relevance to Spiritual Care	1	2	3	4	5
c.	Interest to you	1	2	3	4	5
d.	Presentation	1	2	3	4	5
e.	Morning Prayer and Reflections	1	2	3	4	5

ANY COMMENTS? *(Please continue on following page)*

COMMENTS:

_____-
_____

9. PLEASE DO GIVE SUGGESTIONS ON RELEVANT TOPICS AND/OR SPEAKERS FOR FUTURE

EDUCATION SESSIONS:

TOPIC(S):

POTENTIAL SPEAKERS:

10. IS THERE ANYTHING ELSE YOU WOULD LIKE TO ADD?

_____-
_____

Thank you for taking the time to complete this