FROM CHAPLAINCY TO SPIRITUAL CARE: TURNING POINTS FOR AN EMERGING HEALTH PROFESSION

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ABSTRACT

OBJECTIVES

National standards in Australia acknowledge the significance of spiritual care in the provision of holistic care, understanding that peoples' beliefs and values impact their experience and health outcomes. While spiritual care has been provided in Australian hospitals for many decades little attention has been given to changes in the workforce and the implications for quality of care. This study aimed to further understanding of the key influences and mechanisms for change to ensure safe and high-quality spiritual care provision in Australia by a qualified and credentialed workforce.

METHODS

This study used a qualitative case study design which included interviews and analysis of archived records. Narrative analysis produced an extensive organisational case study from which a timeline of key changes significant to the spiritual care workforce was constructed to inform this paper.

RESULTS

There have been movements towards a professional spiritual care workforce, but progress has been slow, and inconsistency persists across Australia. Five key influences were identified that provide a basis for future progress: the need for evidence, cooperation amongst stakeholders, investment by government and health service management, and leadership and advocacy from spiritual care peak bodies.

CONCLUSIONS

Attention to historical turning points enables understanding of the influences for change. These can become opportunities for health management to further progress towards a qualified and credentialed spiritual care workforce able to deliver safe and high-quality spiritual care.

KEYWORDS

quality and safety, spiritual care, workforce, hospitals

INTRODUCTION

There is a long history of spiritual care provision in Australian hospitals and yet little has been published on the changes to models of care over these decades, and the implications of these for the quality of care received by patients, families and staff. One publication was identified that details the history of chaplaincy in two hospitals in Brisbane [1] and serves to illustrate the inconsistent approach to spiritual care when contrasted with the state of Victoria. In Brisbane, hospital chaplains have remained religiously identified and solely employed by faith communities, a model reinforced by the recently released *Framework for the Integration of Spiritual Care in Queensland Health Facilities*. [2] In contrast, Victoria has increasing numbers of spiritual care practitioners from a diverse range of backgrounds employed directly by health services and working as members of the multi-disciplinary team. [3] Qualified and credentialed spiritual care practitioners are an expectation of the Victorian model. [4] The question of professional identity of those providing spiritual care continues to garner international attention and should be of interest to health management with responsibility for ensuring high standards of care. [5, 6] The expectation for spiritual care is apparent in current Australian standards, [7, 8] and pastoral care is included as a common health profession in the Health Professionals and Support Services Award 2020. [9] Yet there is no national agreement on the workforce required to deliver this care and spiritual care continues to be provided by a range of people with varying skills, competencies and accountabilities. To date, evaluation of this workforce in Australia has been limited. [10, 11] Confusion is further exacerbated because the roles and scope of practice for different providers are not adequately defined. [12] These variations pose a risk to the quality of spiritual care and the safety of those receiving this care. This should be of concern to the spiritual care sector, and to the health service management and governments responsible for providing safe, quality health care. Spiritual health is one of the domains of care, [13] and it is therefore incumbent upon governments and health services to ensure equitable access to safe, quality spiritual care. Endorsement and recognition of qualified and credentialled spiritual care practitioners as health professionals would be a significant first step in this process.

This paper contributes to this goal through the analysis of data from a case study of an organisation based in Victoria. In writing of the difficulties of addressing health workforce issues, Boyce (2008) acknowledges the 'benefit of looking back before rushing forward'. [14] The data covers nearly seven decades and provides a rich source from which to understand the key turning points that have led to progress in Victoria, and to posit the steps required to reach a nationally consistent approach to recognition and endorsement of a professional spiritual care workforce.

METHOD

The data for this paper come from a larger project involving the development of an extensive case study of Spiritual Health Victoria (since 2019 known as the Spiritual Health Association). Case study research is a qualitative method involving the exploration of "a real-life, contemporary bounded system (a case)…over time, through detailed, in-depth data collection involving multiple sources of information". [15]

The development of the case study was informed by three sources of data.
1. Hard copy records from organisational archives 1955-2006
2. Electronic organisational records 2006-2018
3. Interviews with 17 participants.

Data Collection

Data were collected through two main methods:
1. Documentation (hard copy and electronic): archival records held by Spiritual Health Victoria (SHV) included minutes of meetings, letters, publications, conference proceedings and annual reports. Permission to access organisational records was sought and granted from the Chair of the Board of Spiritual Health Victoria.

2. Narrative Interviews: A letter or email inviting participation was sent to past SHV committee members; hospital executives; and Government personnel with a Participant Information Statement included with the letter/email of invitation. Potential participants were invited to contact the researcher to participate and signed consent was received prior to the commencement of the interview. Ethics approval to conduct interviews was received from La Trobe University, Melbourne, reference number HEC18055. Seventeen narrative interviews were conducted using an unstructured, in-depth form and followed a

narration schema as described by Jovchelovitch and Bauer. [16] All interviews were audio recorded.

Data Analysis

Narrative analysis can be applied to both archival materials and interviews [17, 18] thus providing converging lines of inquiry in a triangulation allowing a full description of the case. [19] Transcripts were made of all narrative interviews. Data were analysed with a focus on providing a chronological ordering of events. Data were entered into Excel spread sheets and timelines created for each decade to highlight significant transitions. Multiple sources of data enabled cross checking of factual information and enabled a thick description to be developed to 'help facilitate understanding of a culture'. [20] For this article only data relevant to the spiritual care workforce are presented. Key changes were identified from the timelines created for each decade to construct a timeline from the 1950s to 2010s.

RESULTS

The key changes identified in the data of significance to the spiritual care workforce in Victoria (and in some cases more broadly in Australia) since the 1950s are provided chronologically in Table 1 below.

TABLE 1 KEY CHANGES SIGNIFICANT TO THE SPIRITUAL CARE WORKFORCE FROM 1950-2019

DECADE	KEY CHANGES RELATED TO THE SPIRITUAL CARE WORKFORCE	YEAR
1950s	1. Key church leader influenced by the model of full-time chaplains employed by the National Health Service (NHS) in the United Kingdom.	Mid-1950s
	2. Key church leader influenced by the Clinical Pastoral Education (CPE) method used to train hospital chaplains in the USA.	Mid-1950s
	3. Government agrees to a request from the churches to provide a grant towards the costs incurred by them employing chaplains in hospitals	1955
	4. Churches Advisory Council (CAC) (Hospital Chaplains) formed to advise Victorian Government	1956
1960s	1. CPE flourishes leading to increased numbers of trained chaplains.	1960s
	2. Increased numbers of chaplaincy appointments by the Christian churches supported by the Government grant.	
1970s	1. Increasing acknowledgment of the specialist and integral role of the hospital chaplain by the CAC	(1972, 1973)
	2. Establishment of the Interchurch Chaplaincy Committee of Victoria (ICCV) to advocate for Interchurch Chaplains (those able to work across denominational boundaries)	1974
	3. Australian Health & Welfare Chaplains Association (AHWCA) commenced (chaplains increasingly seeing themselves as distinct workforce)	1974
	4. Two Victorian hospitals directly employ full-time chaplains	1975, 1978
	5. First strategic seminar held including key Government stakeholders, hospital executives and chaplains raising profile of growing field of chaplaincy	1979
1980s	1. ICCV produced a paper, *The Interchurch Chaplain* and *Standards and Procedures for Appointment of Full-time Chaplains in Hospitals and Institutions*	1983
	2. Second strategic seminar held including key Government stakeholders, hospital executives and chaplains. Questions raised about the difference between chaplains employed by	1983

	health services and those employed by the churches and the challenges of creating a team concept among persons with different employers	
	3. Noted the movement from chaplains seen as 'outside visitors' to 'integral part of the staff'	Seminar 1983
	4. Noted the setting up of Pastoral Care Departments within hospitals, with some hospitals funding positions	Seminar 1983
	5. CAC produced a *Statement of Policy for Chaplaincy in General Hospitals* recognising the model of full-time chaplains as the most appropriate way to provide ministry in a major hospital and outlining the need for specialist training	1983
	6. Increased emphasis on accountability with expectation of chaplaincy reported data at Austin Hospital	1986
	7. Australian College of Chaplains formed to increase professionalisation	1987
1990s	*1.* Revision of the 1970s *Standards and Procedures for the Appointment of Full-time Chaplains in Hospitals and Institutions*	1990
	2. ICCV consolidate Inter-church role by strengthening chaplains' accountability through issuing of Interchurch Authorities	Mid-1990s
	3. Department of Health & Community Services invite ICCV to enter into Health Service Agreement for first time	1994
	4. ICCV influenced by USA, begin to discuss need for interfaith focus	1997
	5. ICCV hold first strategic planning day to set future directions	1999
2000s	1. Seeding grants made possible through increase in Government funding and these used to establish ecumenical chaplaincy coordinating positions in partnership with hospitals	2000
	2. WHO ICD-10AM Pastoral Care Intervention Codes launched in Australia	2001
	3. Pastoral Care Coordinators Network (PCCN) established creating representation from hospitals to liaise with Heads of Churches. PCCN voice expectation of hospital participation in appointments of chaplains to hospitals	2002
	4. Healthcare Chaplaincy Council of Victoria Inc (HCCVI) (formally ICCV) appoint CEO to raise profile of work of chaplaincy and pastoral care across health services	2002
	5. Government funds HCCVI research and report produced recommending model of Pastoral Care Coordinators in every hospital and directly employed by the hospital	2006
	6. First meeting of state chaplaincy bodies in Australia to discuss national direction	2006
	7. Chaplaincy and pastoral care included in the Victorian Department of Health *Policy & Funding Guidelines* for health services	2007
	8. HCCVI publish *Capability Framework for Pastoral Care and Chaplaincy*	2008
	9. HCCVI meet with Department of Human Services (DHS) to discuss recognition of pastoral care as allied health professionals	2008

	10. HCCVI develop *Guidelines for Volunteers* in consultation with PCCN	2009
	11. HCCV publishes *Guidelines for Writing in Patient Notes*	2009
	12. AHWCA votes to wind up and become Spiritual Care Australia – the professional association for chaplains, pastoral and spiritual carers	2009
2010s	1. Interchurch Authority program discontinued in light of: the increasing need for spiritual care to be provided for people of a wide range of spiritual identities and; revision of the Capabilities Framework to include capacity for providers to respond to this reality	2011
	2. HCCVI hosts consultation on a framework proposing full integration of pastoral care in health services. Consultation attended by Government representatives, health service representatives and other key stakeholders	2012
	3. Spiritual Care Australia publish *Standards of Practice*	2013
	4. HCCVI becomes Spiritual Health Victoria (SHV)	2014
	5. Department of Health set new KPIs for SHV to include: credentialling guidelines for faith appointed chaplains, guidelines for best practice, consistent data collection and a focus on patient outcomes	2014
	6. *Spiritual Care Providers (Faith Community Appointed) Credentialling Framework* published by SHV	2015
	7. *Towards Best Practice: Spiritual Care in Victorian Health Services Framework* and *Spiritual Care Minimum Data Set Framework* published by SHV	2016
	8. *Capability Framework for Spiritual Care Practitioners in Health Services* published by SHV	2016
	9. Department of Health and Human Services moves towards recognition of spiritual care as an allied health profession	2016
	10. *National Guidelines for Spiritual Care in Aged Care* published by Meaningful Ageing Australia in partnership with SHV	2017
	11. National Consensus Conference held to agree a nationally consistent approach to spiritual care	2017
	12. ICD-10AM/ACHI/ACS Spiritual Care Intervention Codes revised 10th edition published	2017
	13. Commencement of research partnership with La Trobe University to investigate the contribution of spiritual care to patient outcomes	2018
	14. SHV becomes Spiritual Health Association (SHA)	2019
	15. *Spiritual Care in Medical Records: A Guide to Reporting and Documenting Spiritual Care in Health Services* published by SHA	2019
	16. *Guidelines for Quality Spiritual Care in Health* launched by SHA (revised and published 2020)	2019

Interview data confirmed two key workforce transitions that can be seen in the chronological ordering of events above. The first describes the service received by patients and is a movement from a narrowly focussed to a more broadly available service. This is a transition from chaplaincy to spiritual care. "It's my thoughts about what should have

been happening at the time *[1990s]*, was a move from chaplaincy, which I think is a confused word, but from pastoral care to parishioners, into spiritual care for whoever wants it." (Interview 08).

The second focuses on those providing the care and the locus of accountability, recognising a shift from those seen as external providers to intrinsic members of the health care team. This could be described as a transition from religious representatives, accountable to their religious bodies, to healthcare professionals with direct accountability to the hospital. "I think we have transitioned from a place where spiritual care was seen as an extension of pastoral care, or a place to organize the last rites and funerals, to now being an essential element of the healing and wellness process." (Interview 04)

"So, I think historically we've gone from a sort of individual, probably not so connected spiritual care, to a connected care, more a part of the clinical care team…" (Interview 09).

DISCUSSION

Looking back provides some insight into the complexities of spiritual care provision over the decades. It is important to acknowledge the societal changes that have occurred throughout the period under investigation: greater immigration and changing demographics, increasing secularisation along with increased mistrust of institutions, and the impact of globalisation. All of these have had an influence on the structure and practice of spiritual care, but a thorough exploration of this is outside of the scope of this paper. Whilst acknowledging the broader context within which this discussion takes place, the focus of this paper is to explore what can be learnt from the case study presented.

Table 1 demonstrates that transitions have occurred across the time span covered and yet full integration of spiritual care practitioners as valued members of the multi-disciplinary health care team, envisaged by leaders in the field in the 1970s and 1980s, has yet to be realised. The incremental change illustrated in Table 1 is in keeping with the concept of evolution in the policy process, providing some encouragement that there is slow progress towards acceptance of a professional spiritual care workforce, at least in Victoria. [21] The two identified workforce transitions were reinforced by the interview data, noting changes

over time in understandings of the nature of the service being delivered and of the providers and their accountabilities. The data demonstrate key turning points at each decade, and these can increase our understanding of what is needed for change and become opportunities to take us forward. Turning points in narrative analysis as described by Denzin, are moments of transition, interruption and tension. [15] It is possible to identify in the data a number of influences for these turning points:

1. *Attention to international models and research*: Evidence and engagement with international colleagues has informed understandings of best practice and guided development of key documents. This has been crucial to the identified workforce transitions impacting delivery of service and providers of care.
2. *Cooperation between the churches*: Collaboration by the original cooperating churches laid the foundations for innovation. Their willingness to engage with emerging evidence and with the broader changes in society created the context for new initiatives. This also ensured the increasing diversity of stakeholders' voices gathered 'around the table' to influence and shape progress in the field.
3. *Government support and investment*: From the beginning, the development and growth of spiritual care in the health sector has been dependent on support and investment by Government in research, education, advocacy and service delivery.
4. *Investment from health service management*: Recognition by health service management of the value and contribution of spiritual care to patients' health and wellbeing has enabled the shift towards an integrated workforce.
5. *Leadership and advocacy from the spiritual care peak bodies*: The data illustrates the significant role of leadership and advocacy by the spiritual care peak body in Victoria specifically, whilst recognising the role of other national peak bodies. This work has fostered and enabled the influences listed above and led to growth in the sector.

These influences continue to support progress towards a professional spiritual care model in Victoria, but this has not been the case nationally and the move towards a nationally consistent approach has been slow, even though the contribution of spiritual care to enhanced quality and safety in health care has been established. [22] A national spiritual care peak body needs to identify the

competing interests of stakeholders at a national level as an initial step in the policy process, recognising that progress is more likely if the policy goals are shared at state, territory and federal levels. [23] Ongoing tensions between church employed and health service employed models of spiritual care can become opportunities for further progress if tensions are understood as turning points in the process. In fact, these tensions became even more apparent as the health system coped with the COVID-19 pandemic. COVID-19 has been a major interruption and may provide a significant turning point for spiritual care. International research exploring the impact of the pandemic on spiritual care practice showed that in Australia, the workforce provided through the churches, faith communities and volunteers were stood down. The spiritual care practitioners employed by health services who were identified as being more professional (this was measured by three criteria: higher level of qualification, members of a professional association, and receiving regular professional supervision) were more likely to have contact with COVID patients and seen as essential. [24] In response to COVID-19, decisions were made that highlighted the variations that continue to exist within the spiritual care workforce and reinforced that quality and safety of care is associated with qualified and credentialled spiritual care practitioners. This experience could be a catalyst for the next transition in spiritual care at a national level and the next step in the evolution of spiritual care. Many health services across Australia continue to rely on faith community representatives, church appointed chaplains and volunteers to provide spiritual care. Practices during COVID-19 demonstrated that this is no longer sustainable nor compatible with quality and safety of care, and health service management will need to invest in spiritual care as part of their multi-disciplinary workforce planning. This has implications for the education and training of the required workforce. Continued leadership and advocacy by spiritual care peak bodies is needed to formalise the certification process for qualified and credentialled spiritual care practitioners and to ensure key government and health service personnel across Australia have the evidence and information required to garner their support and investment.

CONCLUSION

This article calls for governments and health service management across Australia to endorse and recognise qualified and credentialled spiritual care practitioners as health professionals in response to growing evidence. Attention to the historical turning points in the development of spiritual care enables understanding of the influences for change that include: the need for evidence, cooperation amongst stakeholders, investment by government and health service management, and leadership and advocacy from spiritual care peak bodies. The challenge in such a complex and competing health policy environment is to identify a window of opportunity that will once again put this issue on the policy agenda. The interruption of COVID-19 may provide a turning point that creates this window of opportunity for further evolution towards an integrated professional model of spiritual care in Australian health services.

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