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CODESIGN OF AN INCLUSIVE, CONTEMPORARY SPIRITUAL CARE MODEL

HEALTH LEADER'S FORUM

'What Was Said' Report

SPIRITUAL HEALTH ASSOCATION

25 October 2022

TABLE OF CONTENTS

INTRODUCTION

OVERVIEW

On 25th October 2022, 26 representatives from across the health sector, in Australia and abroad, met to support the codesign of a contemporary spiritual care model. The two-hour workshop formed part of a six month, independently facilitated engagement process to address the following remit:

REMIT

The central question of our work together is:

We have a responsibility to care for the whole person when they are in hospital - this includes their spiritual needs. Research tells us that responding to spiritual needs improves health outcomes, including quality of patient experience and healthcare safety.

How do we make quality, safe spiritual care accessible in our hospitals?

PROJECT ROADMAP

INITIATION	IDEAS FOR THE MODEL	DRAFTING THE MODEL	FEEDBACK ON THE DRAFT	REFINING THE MODEL	MODEL READY TO PILOT
AUGUST/ SEPTEMBER	OCTOBER	NOVEMBER	DECEMBER	TBC	2023
Get key elements of the project agreed upon and initiate the engagement	Build the partnership with leaders and other key stakeholders to help solve the remit	Use input provided by stakeholders to draft the model	Consider gaps in the model and areas for improvement	Present the draft model Gain a sense of support for the draft model and final suggestions	Hand model over to Spiritual Health Association for piloting
Desktop review Interview key leaders Refine project scope	Leader forum #1 Interviews	Draft the model	Survey Interviews	Leader forum #2	Project debrief

*Further detail on the project is available in the Strategic Engagement Plan

The session objectives were:

- To understand the issues, risks and opportunities behind the need to create a contemporary spiritual care model
- To consider international best practice
- To hear attendee ideas for an achievable, contemporary model
- To keep attendees informed of next steps

PARTICIPANTS

Over 50 people were invited and 26 were able to attend. The target audience for the workshop was intended to be people who understand and can influence governance in hospitals, as well as people who work in the sector (including in research and education) and those who have lived experience of spiritual care.

NAME	ROLE	ORGANISATION
Anna Halafoff	Associate Professor of Sociology	*Deakin University*
Bhagyashri Chitale	Spiritual Care Provider	*Hindu Council of Australia*
Bishop Genieve Blackwell		*Anglican Diocese of Melbourne*
Briana Bass	Chief Allied Health Officer	*Safer Care Victoria*
Cheryl Holmes	CEO (project team)	*Spiritual Health Association*
Colleen Williams	Acting Social Work Manager and Spiritual Care Manager	*Monash Health*
Cuong La	Research & Policy Leader (project team)	*Spiritual Health Association*
Gawaine Powell Davies	Past Chair	*NSW Civil chaplains advisory committee*
Hannah Friebel	Member	*Advisory between Experience and Committee*
John Capper	Principal	*Stirling Theological College*
Jude Boyd	Allied Health Director	*Eastern Health*
Karen Pack	Deputy Chair SCA board	*Spiritual Care Australia*
Kristen Yates-Matthews	Director Partnerships and Engagement	*Bass Coast Health*
Luke Bowen	Director Patient Safety & Clinical Excellence (and board of SHA)	*Austin Health*
Martin Chadwick	Chief Allied Health Professions Officer	*NZ Office of the Chief Clinical Officers*
Mary Ringstad	National Coordinator for Pastoral Care.	*Calvary Health Care*
Michael Hertz	Manager - Spiritual Care	*Royal Perth Bentley*
Nancy Hermsen	Manager - Spiritual Care	*Central Adelaide Local Health Network*
Rev Heather Topp	Buddhist Hospital Chaplain	*Buddhist Council of NSW*
Richard Egan	Researcher	*New Zealand University of Otago*
Sarah Connolly	Manager Social Work	*Royal Children's Hospital*
Stephen Delbridge	President	*Australia & New Zealand Association for Clinical Pastoral Education*
Terry Masson (they/them)	Senior Project Manager for Gender Equality and Diversity	*South Australian Department for Health and Wellbeing (DHW)*
Tracey Sheldrick	Acting Allied Health Operations Manager | Allied Health and Continuing Care	*Bendigo Health*

Observers from the project team:

- Angie Dalli, Senior Policy Advisor/Partnering with Consumers, Australian Commission on Safety and Quality in Health Care (OBS)
- Christine Hennequin, Quality and Development Leader, Spiritual Health Association (OBS)
- Craig Exon, Manager- Spiritual Care, Alfred Health (OBS)
- Nick White, Archdeacon for Diocesan Partnerships, Anglican Diocese of Melbourne (apology)

OPENING QUESTIONS

Three opening questions were posted to the group.

20 participants answered each of these questions

Q1 Select the options that best describe which hats you are wearing today...

35%	Work within/manage a spiritual care team	*7 participants*
30%	Hospital executive/senior leader	*6 participants*
30%	Academic	*6 participants*
25%	Religious representative	*5 participants*
10%	Past or prior consumer of spirtual care	*2 participants*
10%	Other	*2 participants*

Q2 How well do you understand the way spiritual care is delivered in Australian hospitals?

10%	Thorough understanding	*2 participants*
45%	Good understanding	*9 participants*
45%	Limited understanding	*9 participants*
0%	Not at all	-

Q3 How comfortable are you with the way spiritual care is currently organised and governed in hospitals?

0%	5. Completely comfortable	-
10%	4. Quite comfortable	*2 participants*
55%	3. Borderline, I flip between comfortable and uncomfortable	*11 participants*
25%	2. Quite uncomfortable	*5 participants*
0%	1. Not at all ucomfortable	-
10%	I do not know it well enough to say	*2 participants*

AGENDA

TIME	ITEM
10.00AM	**Welcome** Acknowledgement of country, purpose of the session, agenda & introductions.
	Project context and personal consumer perspective Why is change needed? Spiritual Health Association CEO, Cheryl Holmes OAM presented project context and reflections on her consumer experience.
	Dilemmas facing health care Consider key trends in spiritual care research that indicate the need for change and consider implications for our health services.
	Essential elements of best practice – international perspective Associate Professor Richard Egan, presented on what health services can do to efficiently and equitably provide spiritual care.
	Ideas for consistent best practice in Australia Based on the information we have understood earlier in the session, attendees were invited to discuss and share ideas for what should be consistent across health services, for spiritual care provision, in Australia.
	Next steps Final reflections on the forum and next steps.
12.00PM	**Close**

INFORMATION TO SUPPORT THE DISCUSSIONS

Attendees were given contextual information to support their conversations.

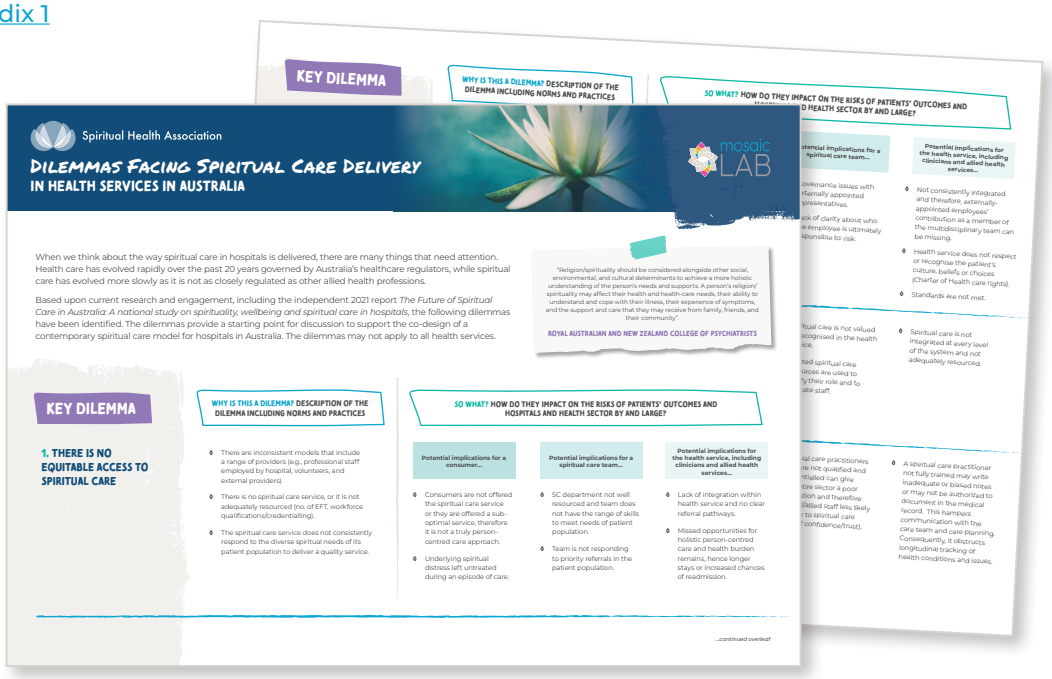
PROJECT CONTEXT AND PERSONAL CONSUMER PERSPECTIVE

Cheryl Holmes OAM

- Earlier this year my brother was admitted to a palliative care ward. While I was there with other members of the family someone opened the door, went up to the bedside and said, "Hi I'm XXX from pastoral care. I'm here to provide emotional support". They stood talking to my brother (part of his condition means he is confused). After a few minutes they turned to the family and repeated what they had said to my brother by way of introduction. They then took their leave. After 20 years of advocating for spiritual care, this personal experience where there was no mention of the spiritual domain, once again brought home to me why we need to improve our services.
- Depending on where you are in Australia, you will have different experiences of spiritual care.
- Your care may be delivered by spiritual care practitioners employed by the hospital you are attending who are integrated as members of the multi-disciplinary team
- Or, your care may be delivered by a volunteer
- Or, your care may be delivered by a local faith representative
- Or, your care may be delivered by a chaplain employed by a faith community but working as part of the hospital spiritual care team.
- Or, your care may be provided by another member of the healthcare team.
- Or you may not have access to spiritual care at all.
- Unwarranted variations have been identified as a key risk to quality and safety.
- We need to recognise that the level of variation in spiritual care across hospitals in Australia is a risk to the quality and safety of spiritual care being provided to people in our hospitals.
- In 2017 a national consensus conference was held *Enhancing Quality & Safety: Spiritual Care in Health* – outcomes were principles for design and delivery of spiritual care and policy statements. These informed SHA's Guidelines for Quality Spiritual Care in Health. But there has been no mandate for implementation. Lack of investment and recognition of the professional spiritual care workforce.
- WHO recognises that wellbeing is made up of four dimensions of health: physical, mental, social and spiritual health.
- Cannot provide person-centred care, cannot provide holistic care if the spiritual dimension is excluded.
- This year launched research report *The Future of Spiritual Care in Australia: A national study on spirituality, wellbeing and spiritual care in hospitals*. Survey of 2501 Australians and four focus groups across generations.
- Australians recognise the link between spirituality and wellbeing. Australians reported that receiving spiritual care made them feel confident in their treatment process (85%), supported by others who listened to their hopes and fears (84%).
- 54% of Australians said they would want to receive spiritual care in the future (and this was led by younger generations).
- Can we work together to ensure that peoples' spiritual needs are recognised and attended to as part of providing comprehensive care? Can we work together to ensure that they receive spiritual care that is of high-quality and is safe, no matter where they are receiving care?
- That is the goal of this co-design project and we are grateful for your willingness to be part of creating a contemporary model for spiritual care in Australia.

DILEMMAS IN SPIRITUAL CARE

See Appendix 1



ESSENTIAL ELEMENTS OF BEST PRACTICE – INTERNATIONAL PERSPECTIVE

Associate Professor Richard Egan - Department of Preventive & Social Medicine, University of Otago - Aotearoa, New Zealand

Richard's presentation is available on the Spiritual Health Association website.

RESULTS

DILEMMAS – WHAT STANDS OUT?

Attendees were invited to discuss the 'dilemmas document' (see Appendix) which summarised four key dilemmas facing spiritual care. Insights from the group are captured below.

DILEMMA 1

There is no equitable access to spiritual care

- Solutions - improving definitions to incorporate spiritual care needs into overall health and well-being
- Branding as something other than pastoral or other words with religious connotations
- At intake into healthcare some inconsistencies around questions asked around religion / spiritual care needs
- Challenge for patients to understand how to access spiritual care services
- Mental health and physical health spiritual care supports are not integrated
- We agree - Some spiritual beliefs may be less represented related to the way services are designed and funded. Overall lack of consistent pathways for determining spiritual care needs.
- Challenge of navigating different health service processes, requirements. How do faith-based organizations/ spiritual care providers find this information? No common approach or process.
- What does equitable access look like? Are there industry standards that make this measurable?
- What defines equitable e.g. offered or integral?

DILEMMA 2

The current model of funding is not meeting contemporary needs

- It is our responsibility to make ourselves irreplaceable
- Some funding to churches to fund visiting practitioners that attend health services (inter faith and specific faith)
- How could we measure impact and outcomes better to grow services
- Different between state, and organisations
- There is very limited and consistent government funding - therefore there are no enhancements and retention within workforce, nor equity within salaries and condition
- How to reflect the needs of the whole person

DILEMMA 3

Spiritual care is not accepted as an integral part of whole person care by all healthcare providers, administrators, and governments

- Evidence-based practice is an important aspect to show value, impact and outcomes to improve the person/patients care
- Spiritual carers who lack clarity about their role, or work in a siloed way, are not seen (by other health professionals) as having something worthwhile to contribute
- Important here to note that there are many Australians who are 'spiritual but not religious' but we should not assume that all people want a spiritual component to care as some are very strongly non-religious and non-spiritual - this needs to be acknowledged also
- Often spiritual carers do not understand their place within a multidisciplinary team, and aspects of spiritual care are carried by other allied health professionals who are listening, and attending to, client needs
- Greater understanding of spirituality more generally and its ongoing significance in Australia is needed
- COVID has opened the door to more acceptance of spiritual care in the hospital setting - both for patients and families but also for our depleted, exhausted staff. Spirituality provides hope.
- There needs to be designated specialist spiritual care practitioner roles - rather than included or dismissed as part of every other allied health role. 'If its everyone's responsibility, its no-ones responsibility.'
- Mental health reform agenda in Victoria expresses a motivation and commitment to future of person centred and holistic care. This will never be achieved without spiritual care contributions.
- Not even understood or appreciated

DILEMMA 4

Health services do not have clarity about the role and credentials of spiritual care practitioners nor about the scope of spiritual care practice

- Credentialing and governance of practitioners from a range of different backgrounds and employment types can be challenging
- Needs to be some minimum standards for skills and training
- Consistent implementation needed
- Differences between religious care and spiritual care
- There is very limited consistency or access to across the board education around the evidence base for spiritual care practice
- Need better education for staff managing spiritual care about what spiritual care means
- Need for best practice guidelines, vigorously promoted within our organisations

OTHER

Do any other major dilemmas come to mind that weren't in the list?

- The principles of cultural safety can be applied to spiritual care, LGBTIQA+ care, racial based care - the approach is relevant to all :)
- The history of colonialism and colonisation and the ongoing generational and contemporary trauma for Australian and Torres Strait Islanders requires a trauma informed approach and recognition
- It needs to be a spiritual model of care - not a religious model of care
- Lack of understanding more generally of what spirituality is and its ongoing significance in Australia - First Nations spirituality, religious spirituality, holistic spirituality (spiritual but not religious) - this means that spirituality is not taken as seriously as it should be in many aspects of Australian society - including spiritual care in healthcare
- Education pathways--CPE, hospital protocols and culture, academic beyond theology
- No recognition of contribution to staff wellbeing/ where does this fit?
- Managing the legacy of historical spiritual abuse, such as around issues of gender and sexual orientation. (Consider trauma-informed care.)
- Lack of clear understanding in community as to what is Spiritual Care

IDEAS FOR THE SPIRITUAL CARE MODEL

Attendees considered all the presented information in pairs before joining larger groups to define their top ideas, in response to the question:

What do you suggest should change in spiritual health care delivery and governance?

Once all ideas were added, attendees could select up to three of the ideas that they felt would be most beneficial to focus upon initially (see votes column).

DILEMMA	SUGGESTIONS FOR CHANGE	VOTES
DILEMMA 1 There is no equitable access to spiritual care	We need specialist mental health spiritual care practitioners who are trained and supported to work in the public mental health sector. Their work needs to build on the existing Recovery Model and expand to support a biopsychosocial-spiritual approach. Lived experience voices and leadership must be included and integrated as we look towards this expansion.	2
	Focus on multi-faith/ interfaith approach- e.g. visual symbols to represent various faith traditions, first nations - illustrating neutral ground of safety.	2
	Inadequate funding restricts access to appropriate spiritual care.	1
	Suggestion about screening tool for spiritual need, including spiritual distress- can be completed by any member of the multidisciplinary team.	0
	Typically, EFT does not match patient numbers- instead promote what Spiritual Care can offer, then triage and prioritize referrals within the available resource.	0
DILEMMA 2 The current model of funding is not meeting contemporary needs	Find the intersection of where we are all coming together on the work e.g. in disability, diversity, healthcare.	3
	Wildly radical government system redesign to increase funding at all levels for all health outcomes - we spend $1 today to spend $10 next week, and we are just running downhill, juggling, while on fire.	1
	Advocacy to improve willingness to commit resources.	1
DILEMMA 3 Spiritual care is not accepted as an integral part of whole person care by all healthcare providers, administrators, and governments	Development of standard scope of practice of our discipline, and uniform definition of spirituality and spiritual care.	4
	Find ways to define and communicate spirituality to help people understand the broad scope of spirituality.	2
	Foreground long history and significance of spirituality in Australia - First Nations, holistic (non-religious) and religious - informed by academic research/studies.	2

...continued overleaf

DILEMMA	SUGGESTIONS FOR CHANGE	VOTES
DILEMMA 3 Spiritual care is not accepted as an integral part of whole person care by all healthcare providers, administrators, and governments *(continued)*	Spirituality is often associated with biophilia/reverence for nature and/or the arts - so stressing the importance of nature-based and art-based (material and aesthetic) practices in spiritual care.	1
	How to define impact, value and outcomes.	1
	Decoupling of faith and spiritual care - a more spiritual rather than religious based approach to ensure inclusivity.	1
	Marketing to workforce and patients as spiritual care unclear to many people.	1
DILEMMA 4 Health services do not have clarity about the role and credentials of spiritual care practitioners nor about the scope of spiritual care practice	Establish robust credentialing and capability processes (e.g. CCC framework).	9
	We need very clear educational pathways and evidence base for practitioners.	5
	Spiritual Care needs a 'rebranding'- to better represent inter faith, inclusivity and contemporary healthcare and move away from historical concerns including religious trauma and links to colonisation.	5
	Spiritual care practitioners/leaders need to be included in management and governance within health care services - also supported to be integrated within multidisciplinary teams and across the broader spiritual care workforce.	2
	Break down state based (including NZ) systems into a more unified approach.	1
	Establish education pathway to become SC that includes healthcare component - referrals, diversity.	1
	Development of specialists and generalists.	0
OTHER	We need a more diverse spiritual care workforce which provides equitable pathways for people with diverse faith or cultural backgrounds to engage with the workforce, also considering pathways for people who have experienced religious trauma to contribute to the future leadership of spiritual care. E.G. for implementation could include a scholarship program for people from marginalised communities or who have experienced challenges - Missionary Sisters at University of Divinity are great for example.	2
	Dilemmas output from today.	0
	Focusing on lack of financial resources can be counter-productive. We need to demonstrate our value and funding will follow.	0
	Active and enthusiastic inclusion.	0
	Consider where spiritual care is already offered within workforce and be thoughtful about making it a specialisation so as to not fragment care (in hospitals, and in the community). Spiritual care is considered a value within allied health profession.	0
	Understand the difference between competence and cultural safety.	0

ADVICE TO THE PROJECT TEAM

After closing the workshop, attendees had the option to provide any final words of encouragement or advice to the project team:

Continue to consult very broadly, especially amongst the more 'traditional' providers of spiritual care. There is a lot of experience and wisdom there, and many people continue to think of spirituality through a religious lens.

Trauma informed care must consider and integrate religious trauma. The spiritual care profession has the opportunity to address this within training and delivery of services.

We need more consumer / lived experience voices involved in codesign, and to consider: how could these people be allies for our work?

Something for consideration within future developments is that within coproduction approaches across the mental health sector, there is a big focus on asking the question: who is most impacted by this issue/topic? Therefore... how can we centralise and privilege these voices in the codesign efforts moving forward? How are connecting with marginalised communities?

I'd like to see more scoping research across the current offerings, grassroot, health care and community initiatives (including multicultural, First Nations, lived experience, interfaith) that are offering some form of spiritual care atm. This wisdom should be considered and not excluded from spiritual care research, or isolated from the professionalisation agenda.

Spiritual Health Association may want to consider the parallels currently occurring between the professionalisation of the Spiritual Care workforce and the (Mental Health) Lived Experience Workforce (n.b. Vic current reform agenda). Also consider this workforce may present an ally for the future progression of spiritual care - and the importance of lived experience perspectives embedded within future workforce scoping, training, development and leadership. Anton Boison is our role model in this space.

Keeping up respectful and engaging conversations around spiritual care and its role/contribution to health. Identify points of support in government and funding structures.

Consultation with all current spiritual care practitioners in health care settings.

Happy to share the successes we are experiencing within Royal Perth Bentley since the launch of the centre for wellbeing and sustainable practice (Michael Hertz).

Thanks for a clear process. Happy to be further involved.

To quote J Michael Straczynski - "Understanding is a three edged sword: your side, their side, and the truth.

The co-design methodology is important and engaging with but also outside of the spiritual care networks is critical to making any changes in the way spiritual care is viewed and embedded in healthcare. I think it is also to be mindful of the complexity of the language including what was is used today. It did at times confuse the issues for me. There were lots of very complex concepts and language around religion, ideologies there is the risk of making things too complicated. The challenge will be agreeing on a simple message about what spiritual care is, to find a way to show the value and impact on patient care and experience and communicate in a way that engages people from all backgrounds. Be mindful of embedding health literate practices. Thanks for the opportunity to participate. When there was discussion about music and art note than in healthcare services will be more familiar with art, horticulture and music therapies and may well group them as creative therapies that would most likely sit under allied health - these will have a therapeutic focus by nature.

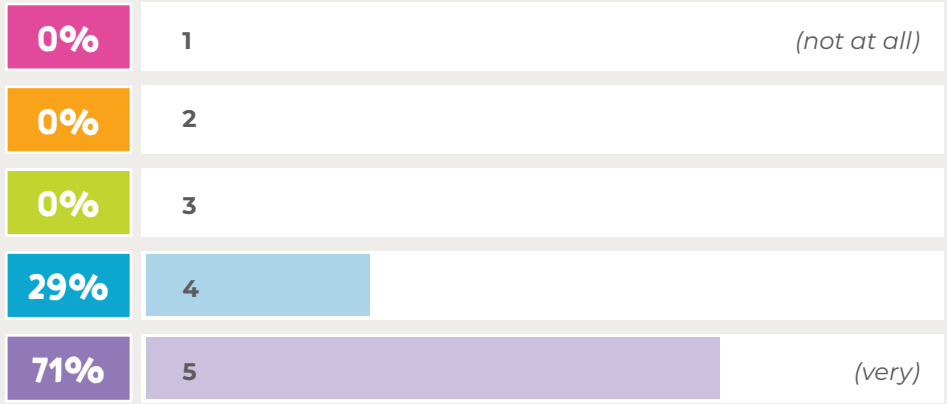
EVALUATION

FEEDBACK SURVEY

How fair and balanced were the facilitators in their approach?

Answered: 14

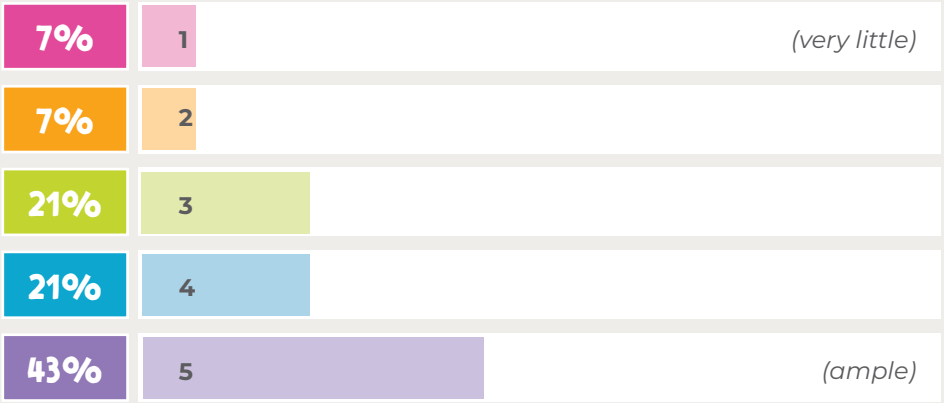
Skipped: 0



How much opportunity did you have to contribute and be heard at this event?

Answered: 14

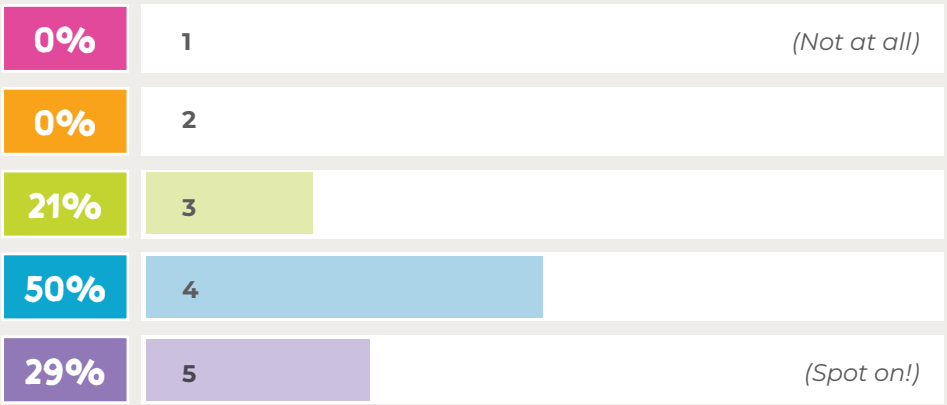
Skipped: 0



How well did we meet the outcomes/ outputs of this event together?

Answered: 14

Skipped: 0



What did you like most about this event and why?

- User friendly and focused
- The recognition of and discussion about the place of spiritual care in health and the multiple struggles from every side to integrate and value this aspect of holistic care
- Well timed overall with appropriate times in each task -- more to say but enough said
- Meeting the range of people who participated
- Break out rooms and group map tool - great facilitation
- Well facilitated
- The brain storming solution focused
- Interactive, everyone had opportunities to contribute
- Increased awareness of work being done in the profession
- Breakout rooms
- The inclusion and hearing the different point of views
- Learning from others
- Very skilfully run

What did you dislike most about this event and why?

- The diversity was great and could have been more.
- Connecting with such a diverse range of people and ideas. Excellent (brief, focussed) input from Richard.
- Lack of health leadership and government representation for the full session. Participants not remembering what is “out of scope”. Perhaps a reminder in breakout rooms would have been important.
- Not enough time! But it was also really good to begin the process with a 2hr really focused & participatory concise workshop discussion.
- Not enough time
- My audio was not working well- likely to be fault at my end

What improvements could be made for future events?

- All ok
- Trivially, mute all participants on return to main session if someone is going to speak -- I think you did quickly when needed. It was a very smooth session.
- As above regarding scope of project. How can we get the funders to commit to being in the room?
- Longer time
- Facilitators in discussion group and longer time

Any Other comments?

- Need to keep momentum in this daunting project
- Happy to be further involved
- Great to have two facilitators who were both well up to speed and who worked well together.
- I was an observer and it was good to have that role and to hear the discussions. Felt like jumping in at times! Tricky.
- Thank you for a dynamic workshop

Spiritual Health Association

DILEMMAS FACING SPIRITUAL CARE DELIVERY IN HEALTH SERVICES IN AUSTRALIA

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When we think about the way spiritual care in hospitals is delivered, there are many things that need attention. Health care has evolved rapidly over the past 20 years governed by Australia's healthcare regulators, while spiritual care has evolved more slowly as it is not as closely regulated as other allied health professions.

Based upon current research and engagement, including the independent 2021 report *The Future of Spiritual Care in Australia: A national study on spirituality, wellbeing and spiritual care in hospitals*, the following dilemmas have been identified. The dilemmas provide a starting point for discussion to support the co-design of a contemporary spiritual care model for hospitals in Australia. The dilemmas may not apply to all health services.

> "Religion/spirituality should be considered alongside other social, environmental, and cultural determinants to achieve a more holistic understanding of the person's needs and supports. A person's religion/spirituality may affect their health and health-care needs, their ability to understand and cope with their illness, their experience of symptoms, and the support and care that they may receive from family, friends, and their community".
>
> ROYAL AUSTRALIAN AND NEW ZEALAND COLLEGE OF PSYCHIATRISTS

KEY DILEMMA

1. THERE IS NO EQUITABLE ACCESS TO SPIRITUAL CARE

WHY IS THIS A DILEMMA? DESCRIPTION OF THE DILEMMA INCLUDING NORMS AND PRACTICES

- There are inconsistent models that include a range of providers (e.g., professional staff employed by hospital, volunteers, and external providers).
- There is no spiritual care service, or it is not adequately resourced (no. of EFT, workforce qualifications/credentialling).
- The spiritual care service does not consistently respond to the diverse spiritual needs of its patient population to deliver a quality service.

SO WHAT? HOW DO THEY IMPACT ON THE RISKS OF PATIENTS' OUTCOMES AND HOSPITALS AND HEALTH SECTOR BY AND LARGE?

Potential implications for a consumer...

- Consumers are not offered the spiritual care service or they are offered a sub-optimal service, therefore it is not a truly person-centred care approach.
- Underlying spiritual distress left untreated during an episode of care.

Potential implications for a spiritual care team...

- SC department not well resourced and team does not have the range of skills to meet needs of patient population.
- Team is not responding to priority referrals in the patient population.

Potential implications for the health service, including clinicians and allied health services...

- Lack of integration within health service and no clear referral pathways.
- Missed opportunities for holistic person-centred care and health burden remains, hence longer stays or increased chances of readmission.

...continued overleaf

KEY DILEMMA	WHY IS THIS A DILEMMA? DESCRIPTION OF THE DILEMMA INCLUDING NORMS AND PRACTICES	SO WHAT? HOW DO THEY IMPACT ON THE RISKS OF PATIENTS' OUTCOMES AND HOSPITALS AND HEALTH SECTOR BY AND LARGE?		
		Potential implications for a consumer...	Potential implications for a spiritual care team...	Potential implications for the health service, including clinicians and allied health services...
2. THE CURRENT MODEL OF FUNDING IS NOT MEETING CONTEMPORARY NEEDS	◊ The provision of spiritual care in many hospitals does not align with international best practice. In many cases, the delivery of spiritual care continues to be based upon historic models of funding and administration, and the quality of the service provided often remains unquestioned. Hence, the unwarranted variation is known as a key risk to quality and safe care. ◊ The bio domain (focus on physical rather than psycho-social-spiritual) of care dominates the delivery of health care. ◊ Funding for spiritual care should align with other disciplines in health services to enable equitable access.	◊ Consumers are confused about the service provided and by whom. ◊ The service can be perceived as only for religious people rather than inclusive of all. ◊ Patients do not receive holistic care i.e. all dimensions of healthcare.	◊ Governance issues with externally appointed representatives. ◊ Lack of clarity about who the employee is ultimately responsible to: risk.	◊ Not consistently integrated and therefore, externally-appointed employees' contribution as a member of the multidisciplinary team can be missing. ◊ Health service does not respect or recognise the patient's culture, beliefs or choices (Charter of Health care rights). ◊ Standards are not met.
3. SPIRITUAL CARE IS NOT ACCEPTED AS AN INTEGRAL PART OF WHOLE PERSON CARE BY ALL HEALTHCARE PROVIDERS, ADMINISTRATORS, AND GOVERNMENTS	◊ Internationally, spiritual care models were developed primarily by the chaplaincy/spiritual care professional associations, whose voices/ perspectives dominate spiritual care models in healthcare. Not all stakeholders have been represented within a co-design approach. ◊ Research has demonstrated that integrating professional spiritual care practitioners into healthcare directly enhances patients' overall expressions of satisfaction with the care they receive at a hospital.	◊ All dimensions of healthcare are not addressed for the consumer. This can impact decision making, coping and health outcomes.	◊ Spiritual care is not valued or recognised in the health service. ◊ Limited spiritual care resources are used to justify their role and to educate staff.	◊ Spiritual care is not integrated at every level of the system and not adequately resourced.
4. HEALTH SERVICES DO NOT HAVE CLARITY ABOUT THE ROLE AND CREDENTIALS OF SPIRITUAL CARE PRACTITIONERS NOR ABOUT THE SCOPE OF SPIRITUAL CARE PRACTICE	◊ There are industry standards for spiritual care practitioners which are not used by all hospitals. ◊ Some hospitals credential visiting volunteers. Some of these have access to patient notes, others do not. Most commonly the volunteers are affiliated with a religious institution such as a local church who want to provide spiritual care to their congregation while in hospital, but they may also visit other patients by request, or by 'cold calling'.	◊ Consumers may be visited by someone who has not undergone the necessary training to ensure socially, emotionally, and culturally, safe and professional provision of spiritual care. ◊ The top barrier to spiritual care is 'Not feeling comfortable sharing personal details with someone I don't know' [1].	◊ Spiritual care practitioners who are not qualified and credentialled can give the entire sector a poor reputation and therefore clinical/allied staff less likely to refer to spiritual care (lack of confidence/trust).	◊ A spiritual care practitioner not fully trained may write inadequate or biased notes or may not be authorized to document in the medical record. This hampers communication with the care team and care planning. Consequently, it obstructs longitudinal tracking of health conditions and issues.

1. The Future of Spiritual Care in Australia: A national study on spirituality, wellbeing and spiritual care in hospitals, McCrindle 2021

PLEASE NOTE: This report has been prepared by MosaicLab on behalf of and for the exclusive use of Spiritual Health Association (SHA).

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MosaicLab is a Victorian-based consultancy that specialises in community and stakeholder engagement, facilitation, negotiation, strategic planning and coaching.

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