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Service user views of mental health spiritual and pastoral care chaplaincy services

Emily Wood, Sally Ross, Julian Raffay and Andrew Tod

Abstract

The aim of this research was to study the needs of mental health service users using Spiritual and Pastoral Care and to further inform an upcoming feasibility study to investigate spiritual care provision. Semi-structured interviews were conducted with mental health inpatients to assess their views of their spiritual strengths and needs. Framework analysis was based on the analysis used in a previous study with consideration for emergent themes coming from a more diverse population. Thirteen participants reflected different faiths and denominations. Overall, participants held religious views of the definition of spiritual care but highly valued the pastoral aspects of being listened to by a compassionate person with time to be with them. Some specific religious needs were highlighted. Most participants supported extending the chaplaincy provision. Key themes from a previous study recurred with the participants. Service users valued chaplaincy for chaplains' skill in listening and providing choice, in that the option to engage in religious or spiritual practice was available but not pushed.

Keywords: Mental health, recovery, spiritual care, service user experience, chaplains

Introduction:

Most NHS Trusts provide a chaplaincy or spiritual and pastoral care (SPC) department to support service users with the spiritual needs arising from admission to a health service and staff with the emotional labour of working in the health service (Swift, 2015). Until recently these departments have been primarily composed of Christian staff, with a remit to provide support across people of all faiths and none. Most chaplaincies now have access to staff and

volunteers from diverse backgrounds. The aim is usually to reflect the local population's demographics.

Chaplaincies have received renewed organisational interest in the light of the Equality Act 2010. This requires trusts to consider patients' 'protected characteristics', one of which is 'religion or belief' (Equality Act, 2010). Chaplaincies provide various services including leading religious worship, providing religious rites to those who cannot leave hospital, pastoral care, and listening to people who need to talk.

Background

In 2015, members of the research team completed an original study in Mersey Care NHS Foundation Trust (FT) to investigate what service users thought about the Trust's SPC department (Authors et al., 2016a; Authors et al., 2016b). In that study the key themes arising are listed and briefly explained below:

- The meaning of spiritual care
- Benefits of the SPC department
- The role of religion
- Qualities of a 'good' chaplain
- Who talks to chaplains and when?
- Chaplains and the multidisciplinary team (MDT)

Key themes from Mersey Care NHS study:

(1) The meaning of spiritual care

Participants defined 'spiritual' as including religion, but recognised it as broader. Participants valued talking to people with time to listen and who appeared to understand their situation. Service users tended to have a 'whole person' view of healthcare in which mind, body and spirit all needed to be addressed.

(2) Benefits of the SPC department

The services provided by the SPC team that participants found helpful included religious services such as Holy Communion, pastoral care, helping people find hope, and self-worth. People talked about why they were helpful. For example, people talked about the social side of services and the fellowship provided, that feeling part of a community, valued, and loved was important.

(3) The role of religion

Participants reported about how they saw God and described God's grace as a healing power that helped them.

(4) Qualities of a 'good' chaplain

Many of the qualities were general 'good staff member' qualities, including compassion. Others were more chaplaincy-specific, for instance 'walking with God'. There were different opinions about whether life experience or formal training as clergy was most important.

(5) Who talks to chaplains and when?

The participants felt that almost everyone will benefit from seeing a chaplain at some point. It was emphasized that chaplains needed to be available to those with no religion as well as those with religious faith. It was suggested it would be helpful for chaplains to see all new inpatients as soon as possible after admission to let them know the services available and make them feel more comfortable.

(6) Chaplains and the multidisciplinary team (MDT)

There was some disagreement over whether chaplains should be separate from the MDT or part of it (Franz, 2019). Some felt that chaplains should be separate to maintain a confidential

service. Others felt by integrating them into the team, the importance of spiritual care and the need to include it in routine healthcare would be highlighted.

Summary and previous study limitations

From these interviews, we concluded that participants considered spiritual care to be of vital importance to their well-being and recovery. That is, spiritual care can provide a source of hope, meaning and motivation to engage with other treatments, often combined with the belief that God is supporting the service user. Our findings suggest that healthcare professionals should not underestimate its impact (Authors et al., 2016a; Authors et al., 2016b).

One limitation of the previous study however was the participant's demographics. Almost everyone interviewed was Christian with an even split between Roman Catholics and Anglicans. Although reflective of the area it was not representative of the UK. Sheffield and Liverpool are economically similar but differ significantly in their religious make up (see Table 1) (ONS, 2013).

Table 1

Religious identification in England from the UK census report (2011)

Region	Population	Christian	Buddhist	Hindu	Jewish	Muslim	Sikh	Other	None/ Atheist	Not stated
UK	N	%	%	%	%	%	%	%	%	%
England	53,012,456	59.4	0.5	1.5	0.5	5.0	0.8	0.4	24.7	7.2
Liverpool	466,415	71.0	0.4	0.5	0.5	3.3	0.1	0.2	17.7	6.2
Sheffield	552,698	52.5	0.4	0.6	0.1	7.7	0.2	0.4	31.2	6.8

Liverpool had the highest percentage of people who identified as Christian compared to any other county in England (74%). Sheffield on the other hand had one of the highest percentages of people saying they had no faith or were atheists. It also has a much larger

percentage of people from other faiths, particularly Islam, although not as high as many other major cities (e.g., Manchester 16%, Birmingham 22%). The different religious landscape suggests that the spiritual needs of people receiving care in Sheffield may be different from those in Liverpool.

Aim

This project sought to improve the Spiritual and Pastoral Care (SPC) provided to service users in mental health settings by investigating if the findings from Mersey Care are replicable and therefore, can be considered suitable for broader implementation. Despite considerable professional, political, and user-led interest in spiritual and pastoral care, chaplains have been hampered by the lack of funding to provide a research evidence base to improve their working practice (Jankowski et al., 2011; Mowat, 2008; Pesut et al., 2016; Snowden et al., 2013). SPC teams have been criticized for a lack of efficacy research (Handzo et al., 2014; Paley, 2007). As the face of chaplaincy changes, it is essential to listen to service users' voice to ensure it continues to provide a service that is valued and useful.

Methods

Chaplaincy staff attended the ward to let service users and staff know of the research aims and methods and requested volunteers to contact them after the meeting. Chaplaincy staff approached potential service user participants and invited them to take part in the project. Purposive sampling was used to seek service users from black and minority ethnic communities, and non-Christian faiths were represented.

Chaplains offered a clear and straightforward explanation that the research was entirely voluntary and involved a semi-structured interview lasting from 10-60 minutes. Chaplains informed potential participants of the proposed content of the interviews, that participants would be recorded, and that any data would be anonymous. Participants were

told that matters discussed in the interview would not have any direct bearing on their care, but that the researchers intended to use overall findings to improve the service.

Participants were provided with a copy of the Participant Information Sheet, which included their right to withdraw from the research. Participants were given a minimum of a days' notice to make an informed decision. Nursing staff on the wards were aware of the study and its content. Interviews were audio-recorded and took place in a private room. Participants signed a consent form before recording commenced. The interview schedule is in the appendix. For details on the development of the interview schedule please see Authors et al. (2016a).

Before the interview commenced, participants were told the research's purpose and aims. Participants received guidance about how they could withdraw consent at any point. All participants had capacity to consent and gave informed consent to be in the research and for their data to be used in the write up. Consent forms were signed in the presence of a researcher, countersigned and kept in the main study site file.

Interpretation and analysis of findings

It was anticipated that up to 20 interviews would be needed for data saturation. The interviews were transcribed and analysed using the Framework Analysis method (Srivastava & Thomson, 2009). The Srivastava and Thomson (2009) framework analysis involved five steps: familiarisation, identifying a thematic framework, indexing, charting and mapping and interpretation (see Table 2).

Table 2

Stage	Description
1) Familiarisation:	Getting to know the transcripts of the data, becoming immersed in it.

2) Identifying a thematic framework:	Central to the framework analysis is the concept that although the research questions were designed around a priori issues, and these may form some of the key themes, it is also possible for unexpected themes to emerge from the data.
3) Indexing:	Identifying portions of data that correspond to specific themes and coding these appropriately.
4) Charting:	Indexed data is now removed from the transcript and placed in charts of corresponding themes linking key portions of data.
5) Mapping and interpretation:	Analysing key characteristics of the data set.

The Quirkos software package (Quirkos Limited, 2019) was used to help with data handling. The Framework used was the outcome of the thematic analysis from the previous study (Authors et al., 2016a) to see if responses here covered similar ground or new themes.

Inclusion and exclusion criteria

Service user participants were (i) Service users in receipt of inpatient services from Sheffield Health and Social NHS Trust, (ii) able to give informed consent, (iii) sufficiently fluent in English. We aimed to ensure recruited service user participants were additionally reflective of: (iv) the client group that the ward is intended to serve, (v) demographic spread as compared with the catchment area of the ward/unit, (vi) a sample of psychiatric conditions (vii) diversity in attitudes to spirituality, (viii) ages within the service.

The Criteria used for exclusion were: (i) Participants lacking capacity to consent (as described in the Mental Capacity Act 2005 Code of Practice); this was assessed by ward staff independent of the research team, (ii) under the age of 18, (iii) service users for whom participation in the research is likely to prove distressing. This was assessed by ward staff independent of the research team, (iv) service users who would require an interpreter (due to financial and time constraints).

Reflexivity

The researchers are Christian chaplains (JR and SR), and an academic (AT) with constructivist backgrounds, and a mental health nurse (EW) with a critical realist background, identifying as 'spiritual but not religious'. This diversity allowed the team to challenge assumptions and discuss preconceptions. Most of the participants knew SR or one of the other chaplains well but EW conducted all the interviews and was previously unknown to the participants. This aided the neutrality of the research, one of the key components of rigour (Cypress, 2017; Lincoln & Guba, 1985). This study was in part set up to test the applicability and consistency (two other components of rigour) and the fit (Morse & Singleton, 2001) of the theory developed from the first study (Authors et al., 2016)

Results

We interviewed 13 people from SHSC (see table 3). Our target for recruitment was to ensure data saturation was reached rather than to recruit a specific number of participants. However, for practical purposes we estimated the need for 15-20 participants at the start of the research (Guest et al., 2006). Saturation was achieved at 13 participants. Subjectively most participants seemed more acutely unwell than those from the Mersey Care study. This resulted in shorter interviews with more extraneous material included and less detail on primary issues.

The same framework as Mersey Care was used but only coded to 53 of the 110 nodes from the Mersey Care interviews. There were no new nodes.

Table 3:

Participant characteristics

Characteristic	Participants	Totals
Gender	Female	5
	Male	8
Ethnicity	White British	8
	South Asian/ British Asian	4

	African	1
Age	20-29	2
	30-39	2
	40-49	7
	50-59	2
Religion	Muslim	3
	Atheist/ agnostic	2
	Christian	7
	Mixed background	1
Ward	Open acute	5
	Secure	3
	Rehab	5

Certain key themes from the Liverpool study were regularly repeated in Sheffield. Spiritual care was seen almost exclusively through the lens of religion.

> it's about religion and care means looking after your needs while you're in hospital P9

However, one of the most important things the chaplains did was listen. Chaplains listen and are friendly and talking to a chaplain helps.

> It's someone to listen to you, you know, good or bad and you know, lift your mood and always give you that hope that there is light at the end of the tunnel P7

Many participants considered that chaplains should be kind, compassionate and approachable, empathic and understanding and take a genuine interest in their service users.

> [She] takes a genuine interest P11

> [She is] really kind, compassionate P3

Chaplains assist people in religious observance. This was mostly about prayer but also providing religious texts and rosaries or information about local religious communities.

> Because they pray for me and that … I don't know, it helps me, it makes me feel better P1

> I do like that she gave me an inspiration prayer but that was fantastic the little inspiration prayer. She gave me a little wooden cross that I usually carry in my bag P5

One person also stated that the chaplains protected the ward (including staff and services users) from 'evil spirits'.

> This is the ward…chaplaincy…[is] protecting it from evil spirits. P2

One person also said the Imam helped him 'be a good Muslim' which in turn helped his mental health.

> I talk to the Imam, he tells me what is Muslim about it, so I can be a good Muslim P10

Most people felt the chaplain should have a lot of training and be very knowledgeable about faith. For most people this meant ordination but not exclusively.

> On the whole, if someone said they believed I'd be willing to talk to them, but I'm reassured to know that the chaplain has given her life to this and I'm more comfortable with that. P13

A 'Holy person' was generally acceptable but some people wanted to see a representative from their own religion.

> No, it has to be a vicar. P1

It was felt that chaplains should not try to impose religion on people, however. Only one person felt this had happened and that there was '*too much Jesus*' at a Christmas service. A recurring theme was one of choice and that chaplains offered a service (such as prayer) but did not push the issue.

> [She] will say 'do you want me to pray?' She will ask me that and I can say no or yes. For me I like to finish like that, so I say yes. P13

Suggestions for improvement

When it came to suggestions for improving the chaplaincy many of the comments were around time and access to chaplains – participants wanted to see them more often.

> more chaplains or at least chaplaincy assistants would be helpful P2

Other suggestions included more readily available religious texts, chaplaincy assistants and a DVD introduction to chaplaincy services for those who couldn't read or were too ill to concentrate on written material.

> When I was a patient in the 80's they would has Gideons Bibles because that's what they started doing isn't it, giving bibles in hotels and American places. They don't do that now, they don't leave or give you this bible and I think it's because of multi-faith and I think part of that has been lost because of that. But I don't think it would be a bad idea if they were, maybe a Psalms and a New Testament or a book in the cupboard at the back. If staff said, if they can't put them in rooms, if they say to a guy who's a Muslim, we've got a Koran, or to a Christian we have a book of Psalms if you want one. That would be nice because then you can access to a bible and they'd be for everybody. P13

Other ideas included meditation, including longer meditations and Buddhist meditations, more readily available access to people from other faith backgrounds, more information about available services, explanations about why things are done the way they are (in context this appears to be about why certain rituals are done when they are done or why certain ritual words are said).

> at the Buddhism workshop it was like forty-five minutes to an hour meditations which to clear your mind for that long it's just something else P3

When should chaplains be introduced to service users?

Every one of the participants felt they had been too unwell at admission to see a chaplain immediately and a week or two later would have been the right time. Most did acknowledge that others might want to see someone immediately, and two gave examples of detox service users who might want an earlier service and a Muslim friend who was not allowed to pray so needed to see someone straight away.

> It's too much on top of everything else when you first come on to the ward. It's best to wait until you've been on the ward a bit. Because you're poorly and you can't be bothered, and you can't communicate properly. P1

Only one person said they felt comfortable talking to ward staff about 'well-being'. Several participants suggested that having a chaplain to 'guide' the rest of the MDT would be helpful, mainly where there were questions around religious delusions.

> having the chaplains around might help guide the nursing staff and the doctors P2

Discussion

In comparison to Mersey Care, Sheffield participants had a purely religious definition of spiritual care but talked less about religious needs. Although prayer was a big need, there was much less emphasis on other religious rites such as confession and communion. There was also no mention of the need to see chaplains on a specific day. Both of these could reflect the reduced numbers of Roman Catholic participants in Sheffield.

For both Trusts, participants repeatedly talked about the chaplains listening and the need to be a good listener. However, other than this and significant theological training, Sheffield participants did not identify the wide range of skills and personal qualities needed for chaplains reported in Liverpool. In a recent study of University students views of their

chaplains, the main characteristics of a good chaplain were that they were approachable, open and non-judgemental, had integrity of faith, were a good listener and were compassionate (Aune et al., 2019). This is very closely aligned to both our studies in mental health services and suggests these may be universally desirable characteristics for chaplains. This also mirrors characteristics for other health professionals (Forrest et al., 2000).

There was no suggestion of who chaplains should or shouldn't see in Sheffield. As for timing they agreed that a week or two after admission would have been the best time for them to be approached but recognized that this was likely to be an individual preference, and some may need chaplaincy support sooner. Like Mersey Care, participants thought that seeing the chaplains was very helpful to their recovery and they would like to see them more often.

The suggestion of having a chaplain in MDT meetings was less controversial than in Mersey Care. Many thought it was a good idea although predominantly to aid the other clinicians and provide them with guidance on religious beliefs rather than support for the service user directly.

This study on its own is small and limited to one Trust, but when taken in comparison with the original study in Liverpool and new research in the University sector (Aune et al., 2019), a picture emerges of the expectations of chaplaincy services. A set of universally desirable characteristics for chaplains to personally aspire to (approachable, open and non-judgemental, had integrity of faith, a good listener and compassionate) and service that offers both religious (e.g. prayer) and pastoral (e.g. listening) components.

Implications

Although chaplaincies are small departments, their impact for service users can be immeasurable. Chaplaincies should be included in evaluations of Trusts and explorations of the services they offer are vital to ensure a small resource is targeted effectively. Their small

size makes it easy for them to adapt and respond to change/research. As such, they stand to make a disproportionate contribution to other disciplines.

Limitations

A limitation of the present study is that some of the differences may be attributable to the specific priorities, cultures, and personnel in the two SPC departments. Like much similar research, we have assumed that professionals are interchangeable. However, chaplains as well as service users are likely to reflect their demographic. This will be true not just of their denominations but also of the specific local variations, cultures, and assumptions. A separate study might be considered regarding the impact of approaches to chaplaincy on service user uptake.

Conclusions

The two studies (Sheffield and Liverpool) provide evidence that many service users consider that access to the chaplaincy supports their recovery.

Most service user participants had a purely religious understanding of the role of chaplains but at the same time the key task they reported as most helpful was ‘listening’. This corroborates the Mersey Care mental health study and recent work in Universities.

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Ethics approval and consent to participate

Ethical approval for the data collection was granted by the NHS Research Ethics Committee proportionate review subcommittee (16/WA/0320) on 05/10/2016.

Appendix A: interview schedule

What do you understand by chaplaincy and spiritual care?
In what way do you think the chaplaincy and spiritual care department can help you at this time?
Have you been seen by a chaplain?
How was that for you?
What was good about the experience, what could have been better?
What else would you like the chaplaincy and spiritual care department to offer?
When do you think it is most important to have access to a chaplain (on the ward, in community, at admission, at discharge or at any other time?)
Do you think it is important that a chaplain is theologically trained (e.g. a degree in religious studies) or is an ordained person (i.e. is a trained Priest or Imam etc) or would you be happy with an interested lay person with people skills?
How important is it to you that a chaplain is of a particular faith or denomination within that faith?
What do you think are the personal qualities that a chaplain needs to have?
Do you think the chaplains should be part of your care team (with the nurses and doctors) or separate from them?

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