Mental health chaplain views of practice and service development: A qualitative analysis

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Abstract

Chaplains from a mental health service in the North of England were interviewed about the role of chaplains currently and potential service developments. Interviews were analysed by thematic analysis.

Results from the thematic analysis led to the identification of four main themes: (1) professionalization of chaplaincy, (2) access to service user notes systems, (3) Trust resources and (4) day-to-day chaplaincy.

Chaplains felt there was a need for greater professionalization and accountability within the profession. Chaplains see themselves as mental health professionals but feel that many of their non-chaplain colleagues do not. They felt that chaplaincy was seen as an add-on service by some staff. Chaplains were divided on record keeping in service user notes. Although most were generally in favour for reasons such as safeguarding service users, risk and evidencing practice, there was also acknowledgement of potential problems, specifically time concerns. There was a discussion about what chaplains do, whether they provide spiritual or religious care or both. Although most agreed they primarily provide religious care, there was an acknowledgement that there needed to be more promotion of spiritual care. This would make the service more accessible to the 'spiritual but not religious' service users.

Background

In 2015, research was commissioned to discover the spiritual and religious needs of mental health service users in the North of England and whether the current system was meeting those needs (1,2). Service user views revealed a high level of satisfaction with the spiritual and pastoral care team. Service users wanted and received a mix of religious (for example, faith-based services), spiritual (providing a source of hope) and pastoral (someone to listen) input. Respondents suggested several changes to the service. Some were not possible to accommodate (such as vastly expanding the service) but others were (such as the way information about the service was conveyed). However, before any changes were made it was important to fully assess the service at present.

Following this research, the UK Board of Health Care Chaplaincy's audit tool (3) was used to investigate compare the NHS Trusts' spiritual and pastoral care department with the national recommendations. In general, the Trust performed well although some specific issues were highlighted. The Trust has a well-resourced chaplaincy in comparison to many other mental health Trusts in the UK but still falls short of staffing recommendations by at least a full time chaplain. Still greater investment would be required to support a true community chaplaincy. There were also concerns that the chaplains were not seen as an integral part of the multi-disciplinary team as they have no access to service user notes and cannot document the care they provide. There were other aspects of the audit that the service did not meet but some of the chaplains also questioned the guidance's relevance to mental health Trusts. For example, the recommendation to make referrals to community faith organisations; given the vulnerable nature of the patient group and the stigma associated with mental health careful assessment of individual needs must occur before any information can be transferred. To complement the audit and the research with service users, the Trust's chaplains were interviewed to gauge their opinions on some of the finding and the direction of this developing service.

Methods

As part of Chaplaincy service evaluation, seven chaplains were interviewed to gain their views on some of the more controversial aspects uncovered in the audit and research. Access to the interviews was restricted and managers were not able to access the audio or transcriptions to allow the chaplains to speak freely and make any criticisms necessary. Chaplains were also informed that they

did not need to answer any question, participation was voluntary and they could withdraw if they wished to do so.

Attempts were made to interview all chaplains within the Trust. Nine chaplains were approached, but seven were interviewed, one paid chaplain was not interviewed as they were so part-time that the interview would have taken their allocated time for a two week period and one chaplaincy volunteer was unable to attend. Two of the chaplains were from the management team. The chaplains interviewed covered the majority faiths and denominations represented in the Trust demographics. They included Roman Catholic, Methodist, Church of England and Muslim chaplains.

The interview schedule is in the appendix. All interviews were recorded and then transcribed. Thematic analysis was used to identify, analyse and describe patterns within the data (4,5). Nvivo 11 software was used to aid data management.

Results

The thematic analysis led to the identification of four main themes: (1) professionalization of chaplaincy, (2) access to service user notes systems, (3) Trust resources and (4) day-to-day chaplaincy.

Professionalization of chaplaincy

Five of the seven chaplains interviewed were a member of at least one of the national chaplaincy organizations. However, most thought they were the only one who was and at least two were considering whether or not to renew as membership had not been as helpful as they had hoped. One of these chaplains was affiliated to more than one organisation. One had been a member but the organisation had lost the fees he had paid. There were clear examples of how membership of a professional organization had been helpful to individuals. One explained that membership of the College of Healthcare Chaplains came with access to the profession's journal and membership of Unite, the Union. Another said how it had helped in a training session with other health professionals.

'I did some ethics training and we compared the different documents that were available from you know, there was a psychologist there, there was an OT there, there were some nurses there and I brought my stuff in as well and we sat and compared those different accountability things that had. It

is useful to be able to show that, to be able to demonstrate that, I'm accountable too. I'm not just walking around being a hippy spirituality person.'

This idea of chaplains as healthcare professionals was echoed by several chaplains.

'I work in spirituality, religious care, spirituality all that, the consultant is the consultant, a nurse, an OT, we are all mental health professionals.'

This is particularly important as some chaplains do not currently feel that they are viewed with this level of parity by some other members of the multi-disciplinary team.

'I think [having clinical oversight] puts us very much as part of the care team for the patient, rather [than] the freaky hippy dippie outsider, who doesn't know anything about anything. So, which is how I sometimes feel here'

Negatives of membership included the way continuing professional development is organised.

'You only get points for certain things, so if you go on something they organise it will say at the bottom, this is worth some many CPD points which is a nonsense to me……. what is more important, the actual points or the content of what you do?'

One of the key purposes of professional registration is to add a layer of accountability to staff, some of the chaplains also pointed out they are accountable to the Trust, via their contracts of employment, and also to their faith group, as part of being ordained. However, they also said that these tended to be more about not doing anything wrong rather than providing guidance on how to do it right.

There was a sense that the current situation of voluntary chaplaincy registration and several organisations which you can register with is not helpful.

'the principle of one organisation would begin to command a great deal more respect from chaplains. I think that given that its requirements are not excessive I think it is entirely reasonable that chaplains should be registered and be able to be held to account.'

<u>Access to Service user notes</u>

This topic was highly controversial but was linked to certain aspects of professionalization. Although most chaplains were in favour of being able to read and write in service user notes, it was acknowledged that this would pose some challenges.

Reasons given in favour of chaplains having access to notes were:

Risk issues:

'it kind of identified risks…, I got a sense of their history, before I saw a patient.'

'it isn't just because of the violence or you know whatever, I think it's because of trigger words, trigger things. I have incidents where I've talked about something to a patient and later a staff member has said oh that's one of his issues.'

Demonstrating holistic care:

'we need to update you know the notes to say oh a chaplain's been, gave them Bible, said a prayer? Does that not show holistic care, is that not evidence for that?'

'I think if I can evidence that I see 30 people a week well actually I am a valuable part of this team. You know or I give communion to 15 people a week, 60 people a month, if we evidence that well, that is positive.'

Parity of esteem:

'it made the other professionals see me as a grown up professional and their equal.'

Safeguarding:

'I think it is important …..now we have the PREVENT agenda in place'

'God forbid, if something happened to a patient and the last person he had seen was a chaplain, you know, that's not recorded ok. You have chaplains who work in the community, you've got lone working, he or she sees a chaplain and then something happens to that service user, who was the last person they've seen, but there is nothing in the notes'

Reasons given against chaplains having access to notes were

Time:

'If so and so wants to see you, I've got to sit down, I've got to find time to read and that takes time out of the time I've got to speak to them….Plus then I've got to write it up afterwards which takes up more of my time.'

Prejudging:

'It also means that I may prejudge what they are going to say.'

However,

'I know it's about that prejudgement thing but I think as a professional that shouldn't really come onto our radar.'

However, these two chaplains may have been talking about slightly different issues. The first was worried about "second guessing" what the service user may say or need whilst the second was talking about judging the person based on their diagnosis (or in secure services, their index offence).

Another concern was that some other health professionals now seem to spend more time writing notes than being with service users and all staff were keen to ensure Chaplains did not end up in that position:

'People desperately want to be that human compassionate person but then they've got shedloads of paperwork, it's a tension'

Some were also concerned it would affect their relationships with service users:

'At the same time, one of the reasons we have those relationships, is because people know we are the only people in there who do not take notes.'

At the very least, the chaplain should be given a handover when they arrive on the ward:

'*I think one thing for the protection of all is that risk information should be, should probably be available or if not that there is a reasonable hand over when a chaplain comes on the ward. Otherwise, a chaplain maybe at risk they may inadvertently put the service user at risk through being unaware of some of the issues. I am also aware that with certain psychotherapeutic interventions if*

the chaplain is unaware of them or certainly if there is any behaviour modification type stuff going on, the chaplain can well and truly screw it up by being naïve to it.'

However, although relying on handovers did work for some chaplains, many found ward staff too busy to provide a thorough handover and many expected the chaplains to have looked in the notes and to be able to write up anything that came up during a spiritual care sessions.

'staff will say to me, "what you can't get on to [notes system]" and I go "no" and they go "what, just go to your manager and get it" and I have to say "no we are not allowed" and they say "what do you mean you're not allowed", "we are not able" and they are quite shocked that we are not.'

The issue here is that if nursing staff assume, wrongly, that chaplains have access to the notes and therefore should be aware of what is in the notes, they may not realise that a handover is required The chaplain may not be told the information they need to protect themselves and safeguard the service user.

Trust resources

In general, chaplains were pleased with the Trust, especially when it came to training. Despite a limited training budget, the service had managed to support chaplains to do a variety of courses and this was appreciated. Two chaplains noted that they would appreciate a training course on working with people with personality disorder and that hospital-specific training on standard operating procedures (SOPs) might be useful, particularly in the secure units where things need to be done in a very specific way. Chaplains sometimes felt that SOPs had been changed but they were not properly informed. In general, they felt that if you identified a course that was beneficial to your work, you would be supported to attend

Chaplains based in the Trust's Secure Division felt that they had excellent office and chapel space. Chaplains in other areas struggled in some respects. One key issue was the Trust policy of moving all staff to hot-desks. This meant there was no confidential space for chaplains to talk to people. This was not too bad for service users as they could generally been seen in their room on the ward but it was a problem if staff or carers needed to speak to a chaplain.

'I think chaplains should have an office because I think the staff want to talk to me …, I've had a number of staff on the ward we've snuck into a room to talk to me and I know they are uncomfortable because people can see them.'

Given that part of the chaplain's remit is to provide spiritual care for staff as well as service users this appears to be an omission on the part of the Trust. Whilst there are bookable rooms available, these are often booked up in advance and a chaplain does not always get advance notice that someone is in difficulty and requires time.

Another need for dedicated office space is reflection.

'I need somewhere that I can just go to stop and reflect, because we need to do reflective practice, because if you don't you just become part of this machine, the quickness, the business and it's just like a conveyor belt of people and you never reflect on what you are doing'

Another is for preparation work

'I think in terms of doing any concentrated work or preparation it's actually quite hard. Erm, when you know someone else is desperate to get on the computer and you are thinking, I've got two hours of work yet to do. You just feel like you can't do it there'

Although some hospitals have good faith room facilities, some do not

'On Christmas Eve, I celebrated communion in the sluice room, I celebrated it in the phone room, I celebrated it in the corner of a ward, which in some respects was lovely because people were just kind of drifting over and joining in but if you had no interest in faith that is not really helpful for your recovery and if you are feeling paranoid, the fact that there is someone sat there chuntering on about God in the corner of the room really isn't very helpful either so. Erm, you know I think having some sort of dedicated space, certainly somewhere like [this] would be really helpful'

The other key issue regarding resources was the chaplains themselves. Many chaplains are part-time and they generally felt they did not have enough hours in the day to complete their roles. Some reported regularly staying late to make sure they got round everyone.

'they said they only time you can do it is 5.45 on a Monday which meant I had to stay late but that is what I have done so they can have their choir and I just added a cup of tea in if we have got time, but mostly we do have time.'

This is also an issue when it comes the timing of religious services, for example, Christian services on a Sunday and Muslim Friday prayers. With only one Muslim chaplain, only one hospital can have Friday prayers on site. Currently due to the faiths of most people on the ward, this is not a problem but if any other hospital were to have a number of Muslims admitted this service could not be provided given the current make up of chaplaincy. Similarly, chaplains in this Trust are currently only contracted to cover Monday to Friday so the only Christian services on a Sunday are provided by volunteers, only in the secure hospital.

Were the Trust to provide Sunday services, the layout of hospitals across the city will continue to make that difficult. Numerous different wards at numerous sites across the city, means it would be almost impossible to provide weekly Sunday services.

<u>Day to day chaplaincy</u>

The final key theme was about what chaplains do, who they see, and how they work. There was some discussion of the differing aspects of spiritual care and religious care and whether a chaplain was the 'spiritual care provider' or 'the vicar'. Being 'the vicar' was not necessary a negative thing

'I do like the fact that when I am asked to be a vicar, I can be a vicar. So in my previous trust I couldn't even pray with patients. I wasn't allowed to wear a cross because it was so generic I was told off for wearing a cross never mind a dog collar (laughter). So I think what I want is something in between, I want, when patients need me to be that faith representative I can be that, but for the patients who would never identify with a specific faith I want them to feel that I am able to serve them and work with them too.'

In fact, in certain parts of the Trust, particular secure services, it was very important to have the vicar figure

'I think it is helpful to have a Catholic service, to have a Protestant service, to have you know Muslim prayers on a Friday because actually that is all they have access to. That is all some of them will have access to for the rest of their lives, so, it is more important there.'

However, there was a sense that, if the chaplain was regarded as the vicar, this might make the service inaccessible for those who are spiritual but not religious.

'At the moment when I walk on the ward I am the vicar. Erm, and I think that does limit our usefulness to those patients who do identify as spiritual but not religious.'

One participant brought up the issue of chaplaincy provided by the Trust for community service users. Although this is something the service will consider on a case by case basis, it is not part of their core work due to insufficient staff to cover the size of the community teams. It is also often thought of as the remit of the Churches and faith communities to provide community based spiritual and religious care.

'I would also like recognition that we ought to be functioning more in the community context than we are in in-patient. You know we have got no more than 800 inpatients and we have 35000+ service users in the community. Now arguably you could say I suppose that is the role of local faith communities but a substantial amount of our work is not terribly specific about faith. It is around helping people to self-identify as spiritual beings I think. Rightly or wrongly and for very good reasons in fact [people] have walked away from organised religion but in so doing they have to a large extent lost the vocabulary about which to talk around spirituality and therefore to identify themselves as spiritual beings. So I think therefore, their ability to maintain a good spiritual health is poorer, so I think we do very basic work around that, hopefully enabling people to make choices for themselves which would be hugely beneficial in the community…… I mean, at times of mental health crisis, there's all sorts of questioning that goes on and the last, even if you are part of a faith community, person you might want to discuss that with is your local priest…….. Similarly, people that we come into contact with will have had very negative experiences of organised faith and therefore how that's teased apart is quite a delicate art.'

One area that was talked about frequently was the makeup and direction of the chaplaincy team. Over the past six years, there has been an almost complete change in personnel with several changes

in the last year. Chaplains were positive about the changes and thought the direction of the service was good

'I think we have become a bit more proactive, since [manager] arrived.'

'I think the change I would make is what is happening. Is that we are growing as a team, I think we need to keep that very much flagged up, that we are a team, that we are colleagues, that we are working together'

However, it was acknowledged that the transition had at times been very difficult.

'I just worked extra hours and did things like that, only because it was, I felt responsible at that time, they were interviewing for someone. It hadn't worked out, you know the way it goes and then it takes a long time for the DBS [Disclosure and Barring Service check] to come through and all that and the other. It was a struggle but I got there. I didn't want to let the chaplaincy down; I didn't want to let all these people down who had no one.'

Although some wondered about the practical issues of regular team meetings, such as part time staff getting to them and whether staff who work in very different environments can really provide peer supervision for each other, in general the move to a more integrated team approach was welcomed.

'I think what we are trying to do now, because we work as a secure division whereas before it was chaplains over the wall, because we are working as a team we are seeing each other more regularly. More meetings, more supervisions erm, yeah I think it's, I'm happy with the way it is going'

One other recent talking point in the service is the use of volunteers. The Trust has set the service a target to recruit volunteers but there is some reticence to engage with this. Partly this is again an issue of time. Particularly in secure settings volunteers cannot just walk around the unit, they must be escorted and this often means a chaplain has to be with them and as such cannot do anything else at that time.

'[Volunteer] is not key cleared so as soon as he comes in a 5.15pm, I'm with him then … so that is a couple of hours out of my day'

There is also the question of getting the 'right' volunteers

'Trust itself wants each department to have a number of volunteers so I think that is another development to the team, so we need to make sure we get the right people who can offer the right spiritual and pastoral care.'

Some volunteers who already come to the Trust provide an Evangelical Christian service

'It was suggested that because of the sorts of people they are they shouldn't be coming in. But I did say but according to the data we have a number of people in our community who identify as evangelical or charismatic and I'm not and therefore they are meeting a need in a way that I'm not.'

On the subject of the way chaplains work, one subject echoed the interviews undertaken with service users in the summer of 2015in comparison with prison chaplaincy.

'I have also worked in the prison service... It is actually a statutory requirement for each prisoner, every single prisoner to meet a chaplain on admission, and also on discharged. So I think it is important to have some sort of formality in place.'

Several secure service patients had spoken about how helpful it is to see a chaplain immediately on admission. It is often a frightening and disconcerting time for people; to know that the service is available, even if you do not need it just then, can be helpful.

Other chaplains talked about engaging with service users, both within the intervention itself and to involve people in the design and direction of the chaplaincy service. A key element to this was letting people know what services are available. This is similar to the prison comparison, which is very much about early engagement. It also relates to the service user interviews in the summer in which some people said they did not know what services were available and did not know how to find out.

A key element in engaging service users was the ability to give time and not rush people.

'people say to me, I'm so sorry you haven't got time and I say no if I haven't got time then I'm doing something wrong, that is my job to actually give you time, to hear your story to share our story together.'

Discussion

Four main themes arose from the interviews with chaplains: the professionalization of chaplaincy, access to service user notes systems, impact of Trust resources and day-to-day chaplaincy.

The spiritual and pastoral care department is a small Trust-wide service providing spiritual and religious care to service users, carers and staff members. There is a positive feeling among members that the direction of the team is proactive and helpful. There are some key points that divide opinion both within chaplaincy and within the Trust. The primary issue here is access to clinical records. Other issues include the differentiation of spiritual care and religious care and whether chaplains should be generic or for a specific faith group. Although some questioned why it has to be an either/or situation, a middle ground where chaplains can give religious care or spiritual care as and when it is needed was preferred. Given NHS financial limitations it is likely that spiritual care departments will need to be innovative to survive, chaplains in the Trust felt that they could bring ideas to their management team and those ideas would be considered, they are also well supported in training.

The NHS guidelines for chaplaincy (6) lay out the key components for effective chaplaincy. They state it is essential that chaplains have access to the facilities and data they need and an ability to audit their work so they are accountable to the Trust. Without access to clinical notes for recoding interactions with service users and contributing to risk assessment this cannot be done. Whether or not the chaplain had access to office space and faith rooms depended on the setting in which they worked. The chaplains did have a lead chaplain, written descriptions of the service available on paper and online for staff and service users and a recognised method of assessing need. Development and appraisal processes were good and the availability of pastoral supervision was improving with a change in management.

Limitations

Limitations in the analysis arise as the researcher is not a chaplain and may have had other priorities in analysing the interviews. Another limitation is that it was not possible to have someone cross check the coding of the transcripts, as the only people able to do this would have been the chaplaincy managers and this would have potentially made it difficult for chaplains to speak as freely as they needed to. Finally comparisons to the literature are difficult to make for this study. Although there are increasing numbers of research papers published on healthcare chaplaincy the views of chaplains on their role are scarce.

Conclusions

Most chaplains favour accessing clinical notes on the grounds of safeguarding, risk, and demonstrating the worth of chaplaincy.

Most chaplains welcome the move to professionalize chaplaincy and for chaplains to be recognised as an accountable profession.

Chaplains provide a wide range of spiritual care and religious care interventions.

Trust-wide buildings and policy need to acknowledge the work chaplains perform and that given their remit to work with staff as well as service users, hot-desking is not a suitable way of providing access to IT and confidential spaces.

Recommendations

1. It would be helpful for chaplains to have access to clinical notes, the same as other professionals within the care team. However, genuine thought must be applied to the practice of record keeping ensuring it is time and cost effective.
2. Chaplains need to be able to provide both spiritual care and religious care where appropriate. Whilst for some service users it is very important to be able to see 'the vicar', it is vital that chaplains are seen as spiritual care providers so they can engage with the 'spiritual but not religious' population.
3. Future building developments within the Trust should take into account the unique nature and needs of chaplains.
4. The professionalization of chaplaincy (and development of professional accountability) needs to be done with care to ensure it is not overly onerous and does not put people off coming to chaplaincy.

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Appendix

Interview schedule

What thoughts do you have on the Spiritual and Pastoral Care service?

How do you assess spiritual strengths and needs in a new referral?

- Do you think a formal assessment tool would be helpful?

What do you think the advantages and disadvantages are to not having access to the service user's notes?

- Do you think you should have access to read and write in service user notes?

Do you feel you have the time and resources (office/quiet room space, access to IT/comms, enough hours in the day) to do your job in the way you would like to do it?

- What do you need to do it better?

Do you think the Trust provides you with the training you need?

- If it were possible what training would you like to receive? (MH, chaplaincy, other)

Do you feel you have the clinical/professional supervision you require?

Do you think you have the pastoral support you require? (from the Trust or elsewhere)

Are you aware of the UKHBC 'code of conduct for healthcare chaplains' and 'spiritual and religious care capabilities and competences for healthcare chaplains'?

- If yes, do you think they are helpful?

If you could make any change to your practice, what would it be?

If you could make any change to the department, what would it be?