Spiritual Health Association

Dilemmas Facing Spiritual Care Delivery
in health services in Australia

mosaic LAB

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

2. THE CURRENT MODEL OF FUNDING IS NOT MEETING CONTEMPORARY NEEDS

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

- 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.

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...
• 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