



Brotherhood
of St Laurence

Working for an Australia free of poverty

Spiritual care and spiritual poverty in aged care

An investigation into current models of spiritual care in
high and low care residential aged care facilities
and implications

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Summary

The Brotherhood of St Laurence Vision

As the current Vision of the BSL states: ‘Established during the Great Depression, the BSL was the vision and creation of Fr Gerard Tucker, a man who combined his Christian faith with a fierce determination to end social injustice. The BSL has developed into an independent organisation with strong Anglican and community links. Today we continue to fight for an Australia free of poverty.’ Fr Tucker affirmed the Judeo-Christian teachings of personhood in his ministry by recognising the dynamic interaction between one’s body, mind and spirit in the context of one’s social relationships and physical environment. Across our society today, poverty is recognisable in the many, often interrelated, forms of material poverty, social poverty, spiritual poverty and communal poverty.

The project – its history and basics

Within the BSL of the last decade, debate has often raged over the organisation’s involvement in aged care. There are obvious difficulties trying to balance a genuine and distinctive (and longstanding) BSL presence in the field against the ongoing challenge of finding the enormous resources to support it. Again and again, however, three factors have prevailed in the debate:

1. We cannot contemplate a fight against poverty which excludes work in aged care.
2. We cannot abandon those people and facilities that have been at the core of the BSL throughout its existence.
3. The particular history of the BSL gives us unique opportunities to add value to our involvement in aged care—for example, well-developed interactive relations with our ‘clients’, our research and advocacy capacities, and our treasured past and present ‘bank’ of staff and volunteers with strong church and other community connections and compassionate worldviews.

The upshot is that high-quality aged care will be at the heart of the strategic work of the BSL for as long as anyone can contemplate.

A number of people associated with the BSL, on the Board and at every level, have been concerned that this expressly renewed commitment to aged care should stimulate a continuing review and upgrade of services. In conjunction with the Rev’d Joanne Hall’s appointment as part-time Chaplain to the Tucker Settlement in July 2001, she was invited to undertake a project building on the BSL’s pastoral record to review services and find ways to make them more wholistic, not least in the area of spiritual care. Her work was to be overseen by a Project Management Committee.

The first fruit of her labours was the report *Honouring the soul* (2002), which reviewed pastoral care specifically at the Tucker Settlement. It made clear that more needed to be done, not only there but throughout the BSL.

The task of this report

Subsequently, the Project Management Committee decided to pursue further the Board’s earlier mandate of reviewing chaplaincy and related services, and the development of wholistic care for the Brotherhood of St Laurence aged and community care service.

Under the guidance of the Committee, Joanne Hall, as the Chaplain/Project Officer (Aged Care) was asked to commence a research project with the threefold aims of:

- surveying and identifying spiritual care models and practices currently offered in high and low care aged care settings
- revealing implications for the development of best practice in intentional, integrated, and wholistic spiritual care suitable for the particular clientele and vision of the BSL and the unique requirements of each facility
- sharing of major learning with participant facilities and the wider aged care sector.

Methodology

The research design was structured to:

- document the present ways a variety of external for-profit and not-for-profit aged care facilities were approaching issues of spirituality and pastoral care for their residents, resident's families/care network, and staff, and how these facilities imagined best practice
- document how the BSL'S own four very different facilities were approaching issues of spirituality and pastoral care and what their preferences for improvement might be
- draw implications from the analysis of the research and review of the literature for:
 1. development of spiritual care in the sector
 2. consideration within the unique context of the BSL aged care facilities.

Over the months of October 2003 to March 2004 arrangements were made to interview at each of the four BSL facilities and 12 external facilities. Interviews typically lasted an hour and a half, consisted of up to four staff or volunteers nominated by each facility and were informally standardised by the researcher's use of a topic checklist. The material was then collated using a matrix system and themes and models of spiritual care were analysed.

Findings in the literature

Across an international paucity of literature relating to articulated models of spiritual care provision and other related research a number of points were made:

- It takes a change in a facility's understanding and culture to incorporate fully such spiritual care practices as to enable all residents' spiritual needs to be addressed.
- The paucity of articulated models and related research is, to some degree, due to a history of reluctance on the part of primarily Judeo-Christian representative bodies to initiate or welcome scrutiny and research of spiritual care provision and practices
- A pattern of discrepancy was found in resource placement, with professional pastoral care and education units being largely hospital, welfare and industry based in comparison with the under-serviced aged care sector.
- The need was identified for further funding, research, and development, in the specific area of spiritual care of the ageing in long-term care settings embracing, but going beyond, faith-based or religion-focused models of pastoral care.

Related literature that informs the development of best practice in spiritual care attends to questions such as:

- Why develop spiritual care for the ageing in long-term care?
- Who benefits from spiritual care in the long-term aged care sector?
- How can we evolve spiritual care in an integrated wholistic and professional way, allowing for individual reading and exploration?
- How may we address the specifics of spiritual care and its relevance and/or practice in particular client situations such as mental health and palliative care?

Findings in the research

Models of spiritual care and facility characteristics

Spiritual Care Worker position titles and roles varied across facilities. Those formally appointed to this position had generally completed some specialist training to prepare them for work in the field of pastoral care. See Table A below.

Table A: Models identified by key person responsible for spiritual care

Model	Key person responsible
1	Organisation Spiritual Care Worker
2	Facility based Spiritual Care Worker
3	Lifestyle Coordinator
4	All Staff

Guided by the level of professional resources available, and who was ultimately responsible for spiritual care, four models were identified as currently in place across the range of 16 low and high care facilities and are shown in Table B below.

Table B: Current models of spiritual care in low and high care residential aged care facilities

Care level	Model 1	Model 2	Model 3	Model 4
Low	3	2	2	1
High	1	1		
High/low	2	2	2	
Total facilities N=16	6	5	4	1

Description of models and structure of spiritual care

Model 1

Findings indicated that church-affiliated, larger organisations with multiple facilities were more likely to have an appointed organisation level Spiritual Care Worker. Both high and low care client groups were represented across these facilities. These Spiritual Care Worker roles often included other related areas of responsibility within the organisation and, although available for individual provision of spiritual care to ageing residents, were more likely to have indirect involvement at facility level through a Lifestyle Coordinator. In addition, their role may have included annual facility memorial services. In Model 1, the Lifestyle Coordinator had primary responsibility for identification and assessment of spiritual needs, documentation, development and review of the spiritual care plan, and developing and facilitating appropriate responses to ageing residents' identified spiritual needs.

Model 2

Findings indicated a range of service providers utilised this model. They had diverse affiliations, low and high care clients, and often, specific needs related to the facility's general resident profile. These facilities had a formally trained and appointed facility-based Spiritual Care Worker. One facility in this group also had an organisation level Spiritual Care Worker to whom the facility-based Spiritual Care Worker was accountable. Findings indicated facilities utilised the Spiritual Care Worker in a range of different ways reflecting the unique, identified needs within each facility. A notable strength in this model was the spiritual care worker being facility-based, giving residents, family, and staff access to someone known, either formally or informally. An additional strength in this model was that the spiritual care worker at facility level had clear responsibilities designated, particularly identification, assessment, and direct provision of spiritual care to ageing residents. As in Model 1, the Lifestyle Coordinator was responsible for documentation. The Spiritual Care Worker liaised with the Lifestyle Coordinator to communicate residents' ongoing spiritual care needs and facilitate appropriate responses.

Model 3

Findings indicated that there were limited similarities in facilities using this model. Each facility had its own particular client profile. All had low care residents, two also had high care. For-profit and not-for-profit, as well as small, medium, and large facilities were represented in this model.

Findings in two facilities indicated the development of access to external pastoral support in the form of local clergy, parish volunteers, and an honorary chaplain. In another facility, staff perceived the appointment of a Dementia Coordinator, whose role included supporting residents and families, as a commitment to general pastoral care. In this model the Lifestyle Coordinator had the major responsibility for identification, assessment, documentation, and facilitation of spiritual and religious care for the residents. In addition, and mostly informally, all care staff participated in the spiritual care of residents.

Model 4

Findings indicated only one of the 16 facilities required all staff to be responsible for initial assessment, with additional information from the Lifestyle Coordinator's assessment. All staff members were also responsible for facilitating spiritual care and appropriate resources, documentation, ongoing identification of spiritual issues and care planning.

Strengths and weaknesses of models

Across the 16 facilities research findings indicated that the person most commonly responsible for the initial assessment, ongoing identification of spiritual issues, facilitation of appropriate response and service provision to the resident, as well as documentation, was the Lifestyle Coordinator. A resident's spiritual profile, while interrelated, is not the same as a resident's social profile. The social profile gathered by workers includes religious affiliation and practices but this in no way provides care planners with an understanding of the resident's spiritual perspective or current spiritual state. A further potential gap in spiritual care provision exists where a resident has no stated religious affiliation. These comments are particularly relevant to *Models 1 and 3*.

Although *Model 1* facilities had a trained Spiritual Care Worker at the organisation level it is difficult to ascertain the influence their role directly had within a facility in relation to accuracy of assessment, quality of spiritual care provision, development of resources, as well as documentation and funding. In addition they also had other roles within the organisation which would have limited availability for identification of resident spiritual issues or direct care to residents from a trained pastoral worker. Most *Model 3* facilities, while having no trained worker on staff, were supported by local clergy, parish volunteers, and other community links. While reliance on external providers is common to all models an issue might arise if this was a loosely structured arrangement. Identification of residents' spiritual needs, and responses to them, would be dependent on the facility's relationship with clergy and other external resources, and subsequent access and availability, as well as interest in, and understanding of, both ageing and spiritual care. An important consideration in all models (especially *Models 1, 3 and 4*) is the knowledge and personal aptitude of external resources with regard to the specific spiritual needs of the ageing and spiritual issues arising within the aged care context. There is a risk that spiritual care provision may be ad hoc, and potentially inadequate or inappropriate.

In *Model 2*, the facility based Spiritual Care Worker was responsible for the initial assessment and direct provision of spiritual care and then liaised with the Lifestyle Coordinator who was responsible for documentation. This model had the potential to ameliorate concerns related to the initial assessment of the spiritual state, including where there was no stated religious affiliation or stated spiritual perspective. It also offers residents access to a trained pastoral worker who, as a staff member, was a familiar and regular presence on site. However, the weakness of this model was in the area of documentation of spiritual care issues and provision, as well as future care plans, all of which appeared to be the responsibility of the Lifestyle Coordinator. It is unclear why the facility based Spiritual Care Worker was not responsible for documentation.

One facility in *Model 2* had a facility based Spiritual Care Worker who was accountable to, and supervised by, an organisation level Spiritual Care Worker. Although this provided an appropriate professional structure for the facility based spiritual care worker it remains difficult to ascertain how this might improve the quality of spiritual care documentation, or enhance the knowledge of spiritual care and its practice, for the Lifestyle Coordinator. Accountability and supervision in

spiritual care practice is important and includes practice related to competent assessment, documentation, and care planning, as well as the development of appropriately responsive spiritual care resources and related funding.

Where all staff were required to participate in the spiritual care of residents, especially *Model 4*, it would appear necessary to consider the diversity of views and personal understandings of spirituality and spiritual care among staff. Without a shared understanding and adequate guidelines the spiritual care provision could result in inconsistent or inaccurate assessment, ad hoc, inadequate or inappropriate provision of spiritual care to the ageing person, and potentially compromise residents' spiritual health and well-being.

Notable points:

- Organisation level Spiritual Care Workers were also engaged in a range of 'other' peripheral organisation tasks.
- Both initial and ongoing assessment was the responsibility of a trained spiritual care worker in only five facilities.
- The documentation of spiritual needs and the care responses were not the direct responsibility of Spiritual Care Workers in these five facilities.
- Of the five facilities with a designated Spiritual Care Worker on site, only one had supervision within the organisation.
- No pre-requisite specialist training in spiritual care was provided to other staff responsible for this area.
- No consistent pattern of external resource development was evident: generally resources had been cultivated and developed by individual facilities and were dependent on in-facility knowledge of spiritual care and availability of members of local religious institutions.
- There is no evidence from this research to support a blanket assumption of adequate knowledge and training with regard to current external spiritual care resources to aged care.

It is unclear from this investigation whether all external and appointed spiritual care workers were paid or required to meet minimum standards of training. This raises issues of the appropriateness and quality of spiritual care provision available to residents and families. It further raises issues of accountability and supervision, for both the organisation and the practitioner, and importantly, the question of access to training and the development of guidelines.

Facility knowledge and understanding of spirituality, spiritual needs and pastoral care

Aged care guidelines related to spiritual care

When considering the development and provision of spiritual care it has been important to take into consideration Resident Classification Scale 3.8 Cultural and Spiritual Life (DHA 2004d). The RCS 3.8 is further informed by guidelines for Professional Nursing Practice in aged care through the Documentation and Accountability Manual, Chapter 2, which has specific (and limited) criteria for assessment, 2.2.2 d. Spiritual State (DHA 2004a). The emphasis on documentation and care provision associated with the aged care standards and current funding arrangements increase the risk of less than competent identification and assessment of spiritual care needs. With a new Aged Care Funding Instrument (ACFI) to be introduced next year, the emphasis would be on identification and assessment of resident needs and care planning.

Identification and assessment of spiritual needs are influenced by, and ultimately depend on, the subjective knowledge and understanding of facility staff. In turn, this knowledge and understanding also influences care planning, the development of resources, and the practice and provision of spiritual care.

This research revealed a wide variety of understandings of spirituality, spiritual needs, and pastoral care expressed across the 16 facilities. This diversity is highlighted by the fact that there is no single understanding common to all 16 facilities. The most common shared understandings related to pastoral care (For more detail about the understandings expressed, refer to Appendix 3).

This research indicates the aged care sector may rely too heavily on the personal knowledge and understanding of staff in relation to the practice and provision of spiritual care. It also suggests an over-reliance on mainstream churches to provide spiritual care resources. The findings further suggest an underlying assumption of the 'church' volunteer having knowledge and expertise in the practice and provision of spiritual care for the ageing. This reliance, particularly in conjunction with the suggested underlying assumption, has the potential to contribute to spiritual poverty, communal and social isolation, and subsequent negative health outcomes. For those residents already disadvantaged or marginalised, and admitted to residential aged care, spiritual care may be even more important to their health and well-being. An increased risk exists in the absence of spiritual care or in the practice of inappropriate or harmful spiritual care.

Implications for the BSL

The particular context of the BSL includes a vision that upholds the individuality and dignity of each person; seeks to alleviate poverty, socially, materially and spiritually; and to strengthen local communities. Facility based clientele are generally socially and financially disadvantaged, often have poor social skills, poor support networks, limited education, and dual or multiple physical and psychiatric diagnoses.

Across the four facilities a different emphasis on spiritual care existed between low and high care, different resources and networks were available in each community; and each facility had a slightly different culture and ethos. Common to each facility was the variability of staff understanding and potential contribution to the provision of spiritual care. In the broader context the following implications may also have relevance to other BSL aged care services e.g. CACPS. Reflecting on the context of the BSL development of best practice in spiritual care would involve it being articulated, integrated, intentional, and wholistic.

BSL 'in-facility' development of an integrated, intentional, wholistic spiritual care program suggest best practice will depend on competent identification and assessment of spiritual issues, and the spiritual state, of the ageing person and those in their care network. This in turn will depend on the knowledge and skills of facility staff and resident/care network engagement. This implies:

- a shared understanding that spiritual issues, needs, responses, may contain, but are not limited to religious affiliations
- welcoming, facilitating and supporting the contributions of care staff, family/resident care networks, general and spiritual care volunteers and community contacts
- maximising facility ethos, procedures, and unique environment, to facilitate spiritual care
- developing opportunities for residents to contribute, as well as receive, spiritual care
- a review of aged care worker position descriptions in relation to spiritual care responsibilities
- position descriptions and pre-requisite training for external professional and volunteer spiritual care providers
- opportunities for training, education, and ongoing development of aged care workers in the area of spiritual care with the ageing
- consideration of staff, family and volunteer spiritual needs, some of which may be appropriately responded to at the facility level
- staff development opportunities for self-care strategies and the personal spiritual resources needed for work within an environment dealing with increasing frailty and death in conjunction with other aspects of human suffering

- proactive collaboration and the fostering of creative, and possibly financial, partnerships with community faith groups/organisations and their members, as one important external resource for spiritual care.

In addition:

- the development of basic training and education programs in the area of spiritual care with the ageing for BSL aged care workers and spiritual care volunteers
- BSL development of guidelines and professional standards for assessment, documentation, and care planning, direct care provision, specialist services, accountability and supervision, in the area of spiritual care with the ageing
- adequate funding allocated to the development of spiritual care in aged care.

The last three points have broader implications for the BSL in the context of Mission and advocacy in the wider sector, including both Federal and State Governments. It is also noted that the relationship of the BSL and the Anglican Church offers a unique opportunity for the BSL to contribute to the responsible development of this area of care.

Issues for the aged care sector

The research findings indicate or imply the need for:

- a shared understanding that spiritual issues, needs, responses, may contain, but are not limited to religious affiliations
- review of aged care worker position descriptions in relation to spiritual care responsibilities
- basic training in spiritual care and practice related to the ageing and increased personal awareness of spiritual resources for Nursing staff, Personal Care Workers, and those providing activities, e.g. Lifestyle Coordinators
- promotion and development of training for spiritual care volunteers representing local and varied religious groups
- promotion of advanced training focusing on the spiritual themes of ageing, identification, assessment, and documentation requirements, including Clinical Pastoral Education opportunities, for parish clergy, chaplains and professional spiritual care workers
- engagement with religious institutions, and those representing the arts, environment, and family/care networks to identify the roles they can play in responding to the particular spiritual needs of the ageing
- advocacy for an adequate government funding base for the integration and provision of spiritual care in order to maintain the integrity of our care of the ageing
- promotion of further research into spiritual care models in aged care and their application to the spiritual needs of particular resident groups and relationships with the community

Introduction

The history and influence of the founder of the BSL, Fr Gerard Tucker

In 1946, the G.K. Tucker Settlement at Carrum Downs moved from providing low cost rental housing to poor families, to providing housing for older people who were financially disadvantaged. In 1956, in his booklet 'The best is yet to be', Fr Tucker confidently proclaimed that old age could be a thoroughly satisfying and happy experience when the right environment was provided. In developing elderly persons' cottage accommodation, and later the Collins Court Hostel and an onsite hospital, Fr Tucker endeavoured to provide an environment where the elderly:

- could feel secure
- have spiritual, emotional and practical support close at hand
- could enjoy friends nearby
- could have the opportunity to engage in meaningful and satisfying activities.

Fr Tucker aimed to contribute to the independence of the elderly person by allowing them to have security, dignity, and a sense of control over their own lives. Meaningful interdependence between the residents and the then community was made possible because the original community was an isolated country setting. Fr Tucker's insight that people not only have physical and psychological needs but also social and spiritual needs, gives us an historical link to the more modern concept of integrated wholistic care, most fully imparted in the setting of a caring community. While Fr Tucker innately understood the value to individuals and society of fostering interdependent resilient communities, the concept of creating healthy communities is now overtly promoted and seen as vital by the BSL in assisting to eradicate aspects of material, social, spiritual and communal poverty. When a community embraces the needs of a marginalised group, the community's capacity, health, and resilience are subsequently enhanced.

The BSL now

Over the years, amongst developments across all aspects of poverty prevention and eradication, aged care services and corresponding advocacy have grown and continue to be an integral aspect of the BSL's commitment. Services continue to target financially and socially disadvantaged older persons residing in the inner city of Melbourne and the Mornington Peninsula. Services include ILU accommodation, boarding house accommodation, CACPS packages and four residential services (3 low care and 1 high care). Additional services include specialist day centres for the city dwelling elderly, the intellectually disabled, and those with a dementia, as well as dementia specific respite services. It is the spiritual care facilitated in both high and low care facilities that is the focus of this report, although general findings may also be relevant to, for example, the future provision of spiritual care in community based programs.

The research task

A previous review, *Honouring the soul* (2002), assessed the availability of pastoral care for residents of the GK Tucker Settlement both within the Settlement and in the rapidly growing suburb of Carrum Downs. Following this the Project Management Committee then desired to continue the Board's earlier mandate of reviewing 'chaplaincy and related services and the development of wholistic care for the Brotherhood of St Laurence aged and community care service'. (See Appendices 1 and 2)

In 1997 Federal Government reforms were implemented in the existing Hostel and Nursing home sector. Now with the successful uptake of the reforms, particularly around residential living standards and clinical and nursing practices, it was noted that the sector was shifting focus to critique the less emphasised and funded 'quality of life' issues in the reforms, notably for this research, the provision of spiritual care. Hence it was timely for the Project Management

Committee to instigate a study of spiritual care provision in high and low care residential aged care facilities. The task, represented by this report, was delegated to the BSL Chaplain/Project Officer (Aged Care).

The research context

Since the introduction of the 1997 Australian Federal Government reforms in high and low care aged care facilities, provisions for meeting the needs of the residents 'spiritual life' have been included under Standard 3: Resident Lifestyle, specifically 3.8 Cultural and spiritual life; and the expected outcome is 'Individual interests, customs, beliefs and cultural and ethnic backgrounds are valued and fostered' (Aged Care Standards and Accreditation Agency 2003).

This research has taken into account the emphasis on documentation and care provision current guidelines and funding have encouraged. However, with the potential introduction (in 2006) of the new Aged Care Funding Instrument (ACFI) an increased emphasis on identification and assessment of 'needs' would be required to achieve available aged care funding. Within this context, and with potential opportunities presented by these changes, this research considers both aspects.

Rather than limiting understanding of one's 'spiritual life' to 'religious beliefs', the Committee decided to take a broader view of what contributes to, and promotes, a healthy spiritual life for the ageing person in long-term care. As spiritual care is also interrelated to many of the other Standards and areas of assessment, it is suggested that using an intentional, integrated and wholistic framework for spiritual care will best meet residents' needs. When employing such a framework, spiritual care goes beyond an ad hoc, and potentially limiting, emphasis on facilitating religious beliefs, practices and interests to incorporate a broader perspective. This perspective would include addressing the spiritual challenge of finding meaning, value, purpose, and integrity, in the latter stage of one's life, and in the context of one's community. A multi-disciplinary, and community approach may best support this framework for the provision of spiritual care, as the total person in their social and environmental context is critical to the wholistic care approach. It would also include taking into account the resident's psychological attributes, access to support, the effects of mental and physical health, illness and anticipated death, and the contribution of their social support network and community connections. From a spiritual perspective, inclusion of these additional factors is considered essential for facilitating a resident's spiritual well-being, which is an integral part of total well-being.

This approach is further determined especially necessary as residents, having moved beyond the acute health system of medically orientated care, have entered the high or low care 'home' where they may spend their last days. It is with this informed spiritual perspective, and understanding of the complexity of spiritual care, that the limited nuances of the current standards, and their corresponding lack of direct funding, can be brought into critique.

The four BSL facilities have traditionally had access to different levels of community and organisational religious support, however, no in-house ethos related to spiritual care has previously been developed. This research will also offer a timely critique of existing practices for the development of best practice in spiritual care for the BSL aged care services.

Terms and benchmarks used in the literature review and research

The terms intentional, integrated and wholistic

Intentional: used to emphasise that each resident has broad and complex spiritual needs. Unless the approach to spiritual care is intentional and comprehensive even obvious needs in the religious domain may be responded to in a variable and ad hoc way. The identification of spiritual issues and needs is necessary to provide equity of access to all residents with regard to the opportunity to maximise their spiritual well-being in this challenging last phase of life.

Integrated: used to propose that spiritual care, at its best, can be a fully incorporated and equally important component of a facility's approach to care planning with residents, residents' families/support networks and also of facility staff. This approach ensures that spiritual care is not relegated to the 'private arena of life', or seen as an optional extra, determined simply by stated religious affiliation. The community and other agents of spiritual care can also participate in an intentional and defined role.

Wholistic: used to refer to the multiple dimensions of interrelated needs each resident has and the affect on total well-being, which includes their spiritual well-being. Needs are more fully met when the complexity of psychological, social, physical, and spiritual needs, including the need to be a valued member of the community, are consistently addressed across the multiple environments and relationships in which a resident engages. In addition this word, and its spelling, complement the image of a unified whole rather than the image of a person in some way lacking or being empty.

From a spiritual perspective, to emphasise that we are all 'whole' human beings is particularly important for the care of those suffering from a dementia and other cognitive or physical losses. Due to our society's general tendency to elevate productivity and youthfulness, some consider the person with a dementia to be 'not at home' or almost non-human. Our society tends to emphasise having an intact mind, and an intact body, to define a human person's value, so to name the person with a dementia as a 'whole person' could be viewed as a radical step against societal trends. Regardless of the type of loss, the human person is not diminished. They do not lose their personhood, dignity or value. A spiritual perspective of the human person recognises that their deficits do not define who they are. The human person is more than the sum of their individual parts.

The terms spirituality, religion, pastoral care and spiritual care

Due to the long-held Anglican associations of the BSL combined with the Christian background of the researcher, the terms spirituality and pastoral care were used throughout the initial project in 2002. The word spirituality was proposed rather than the word religion, as the former is understood to be inclusive of religious beliefs and practice and speaks more generally to a pluralistic society. It also acknowledged the spiritual dimension of the human condition and subsequently engages with each person's fundamental search for meaning, value, and purpose in life, encompassing their constructs and experiences of the transcendent.

The term pastoral care recognised the Judeo-Christian origins of the term and the history and source of current developments toward professional requirements for the practise of intentional care of the human spirit. This can be seen in the parish community, the acute hospital, and other settings. However this term, because of its historically Judeo-Christian origins and theistic orientation, may be alienating to some. In response to observations of trends in the literature, internationally and locally, and with consideration of terms used by government, as well as acknowledgment of our increasingly secular and pluralistic society, the researcher now affirms the differentiation between the terms pastoral care and spiritual care. The continued use of the term pastoral care will be in its Judeo-Christian context or when it is the term of choice by other authors and practitioners cited. The use of the more inclusive term spiritual care will be used in other circumstances throughout the report and defined as follows:

Wholistic, life-giving, intentional care of the human spirit in the context of the individual's life journey through transitions encompassing grief and joy, loss and gain, the search for meaning, and the maintaining of fruitful relationships with self, others and the transcendent 'other'.

Size of facilities

No government sizing is standardised in the sector. This research project has therefore allocated an arbitrary measure, as shown in Table 1, accommodating the range of facilities approached and selected for interview as follows:

Table 1: Facility size

Facility category	Number of beds
Small	≤ 50
Medium	51 – 110
Large	111 – 300

Note: The tasks undertaken in this project have only been partly completed, and will depend on the BSL and others in the field to bring them to fruition.

Review of spiritual care in the literature

A literature search, with international scope, was conducted. Limited material was found directly addressing:

- articulated models of spiritual care provision
- related research in high and low care aged care settings.

Considering that the provision of spiritual care in aged care is in its early stages of evolution this literature review will consider the existing material and move toward a consideration of further literature that may inform best practice under the following headings:

1. Why the development of spiritual care for a fulfilling old age may be important?
2. Who might benefit from spiritual care in the long-term aged care sector?
3. How spiritual care may be developed in an integrated wholistic and professional way?

A small amount of literature relating to specific ethnic or cultural and religious groups is available. Literature dealing with specific applications of spiritual care, its relevance, and/or practice, can also be found in the areas of:

- mental health, particularly depression and dementia
- spiritual care in relation to the life/health transitions of ageing, including multiple losses
- spiritual care in relation to dying and death, bereavement and palliative care

Until the more recent advent of secularism and multi-religious societies, the term ‘pastoral care’ was most commonly used and still has considerable currency with authors ministering, and writing, out of a Judeo-Christian or humanitarian context. Throughout this literature review, the term ‘spiritual care’ may be used unless a particular author bases comment on ‘pastoral care’.

best practice in spiritual care provision in aged care cannot be directly discussed as its development worldwide is embryonic. Given the paucity of specific material in the area it appears that for many years, locally or facility provided spiritual care has been understood as largely a private matter, related to religious needs only, and generally not regarded highly enough by State or Federal governments, mainstream Christian churches, or the aged care sector, to attract even modest funding for research or development.

The concept that the human person had specific spiritual needs was formally articulated in America when the *White House Conference on Aging* defined spirituality in the inaugural Spiritual Well-Being Section in 1971. This section focused on a person’s inner resources, particularly, ... ultimate concern, the basic value around which all other values are focused, the central philosophy of life – whether religious, antireligious, or nonreligious – which guides a person’s conduct, the supernatural and nonmaterial dimensions of human nature ... (Moberg, 1971, cited in Moberg, 2001, p10).

Since this time, there has been a slow development around three identified concepts:

- The spiritual dimension of the human condition continues to be a substantial dynamic in human life regardless of religious affiliation.
- There are specific spiritual tasks of ageing.
- Consequently, aged care service providers have a professional obligation to facilitate the spiritual well-being of their residents.

Academic rigor in the area has only been visible in the USA since the very early 1990s. In Australia the study of the spiritual needs of the aged has only become of academic interest, mainly from nursing, palliative care and pastoral care studies, over the past 5–7 years.

Characteristics of models of spiritual care provision, pastoral care and research relevant to high care and low care residential settings

The acute hospital sector has traditionally been the most common place of employment for chaplains and professional pastoral care workers. Therefore it is not surprising that, historically, most literature arises from that context. This medical location of care subsequently informed and shaped the professional practice of pastoral care, including the development of standards and education.

Beyond the acute hospital context, the literature search by Carey (1999) acknowledges the long held tradition of chaplaincy services in policing and prison institutions, the defence forces, commercial industries, and educational institutions. His work further identifies a similar need in aged care facilities. He posits that the majority of literature in Australasia, the USA, and Britain, arises from the acute hospital context as a consequence of the common driving forces of case mix funding and economic rationalism. Frequently reviewed topics covered across the acute hospital sector are:

- the acceptance of chaplains by patients, families, and staff
- analysis of chaplaincy roles, both traditional and innovative, and including ethical input and staff counsel
- the positive contribution of chaplains to enhancing patients' health and well-being
- the positive interrelationship between religiosity and health
- the growth, since the 1970s, of the professionalisation of pastoral care, particularly, and primarily, through the worldwide growth of the Clinical Pastoral Education training movement
- the need for further empirical research to develop quality measures of efficacy and patient satisfaction.

The absence of material covering any aspect of chaplaincy in the aged care field gives Carey a reason to leave us with the rhetorical question: Why is this so? Thinking laterally, Carey suggests one way of bridging the gap between acute hospital provision of pastoral care and provision to the ageing in the wider community could be to link the existing supply of services in the hospital sector to the needs of the aged recently discharged from hospital. He suggests that follow-up pastoral care visits after discharge from hospital and into an aged care facility could benefit the elderly person.

The Our Lady of Consolation (OLOC) Aged Care Facility's pilot residents' survey on pastoral care indicated that the majority of residents were very affirming of the provision of pastoral care services (Mulder & Carey, 1999). Although the research design was biased to residents able to read, comprehend, and write independently, the overall study confirmed a number of pastoral care quality indicators. Carey identifies the OLOC pilot research as 'groundbreaking' in overcoming the resistance that many chaplains and the church often had with regard to being open to the scrutiny of research in pastoral care. The valuable directions identified by the study, in which further research is needed, particularly pointed to the need for research skills in health care chaplaincy.

It appears that since 1999 pastoral care departments, aged care facilities, and government – the stakeholders Carey identified as needing to commit to the provision and research of pastoral care practice in the aged care sector – have done little in the area. To the researcher's knowledge, the most recent journal article has been McCoy (2003) who offered a non-empirical, non-critical, descriptive article entitled 'The joys and difficulties of establishing a distinctively Christian nursing home'. The continuing paucity of literature to date reflects:

- the lack of federal government funding directed to resources for quality spiritual care in aged care facilities
- the institutional, financial and human resource pressures in largely, religiously affiliated, not-for-profit facilities who do choose to provide quality spiritual care in their facilities

- the general attitude of a society that views religious matters as private, along with a corresponding tendency of elected governments not to give priority and equity to the spiritual dimensions of quality of life issues in aged care settings
- the lack of research funding from government, community, church, and educational institutions, combined with a lack of recognition for the academic and professional development required to provide quality spiritual care services to the aged
- scarce support for, or availability of, training in qualitative and quantitative research methods for existing spiritual care practitioners.

Overall only two articles of any substance discussing spiritual care were found. The first article to use the term 'spiritual care' appears to be an American retrospective article. Tomsic (1998) reflects on 12 years of experience moving from a traditional model of providing pastoral care in a Roman Catholic, 297-bed, long-term aged care setting. The traditional model took the form of religious care through priestly and sacramental care being provided for the 86 per cent of residents who were Roman Catholic. In addition, religious sisters offered support, to those who were in need, seriously ill, or near death. In 1986 a Pastoral Care Department was established and its Director oversaw spiritual care being 'integrated with the good physical, emotional, and psychological care that was already present to achieve the best possible quality and sanctity of life in its final stages' (Tomsic, 1998, p.42–44). This article articulates the goal of an integrated, wholistic, team approach, and acknowledges that all residents, whether of the majority religion or not, require spiritual care. In addition to an individual's religious practices, the approach recognised all residents had a need to discuss what gave their life meaning, including their relationships and feelings.

Initiating the new model involved the Director of Pastoral Care developing a policy and procedures manual, educating staff in pastoral support skills, and an interdisciplinary team. The Pastoral Care Department developed roles in ethics and advocacy with staff and residents, and provided Catholic and ecumenical liturgies for the physically and cognitively able and those with a dementia. By 1996 the Department had grown to 6 EFT, and included one priest, two religious sisters, and three lay people. Of these, four had certification with the National Association of Catholic Chaplains. Documentation developed over time, as did a commitment to cover the facility seven days a week from 8am to 5pm and, in recognition of the need for ministry to families, to 8pm three days a week.

The second article was a paper by Elizabeth MacKinlay and presented at the Pastoral Care and Spirituality of Ageing Seminar in Melbourne in November 2004. MacKinlay's article elucidates the importance of pastoral care as an aspect of spiritual care. Coming from the perspective of how parishes may contribute to the pastoral care needs of the various ageing populations in their communities, MacKinlay identifies three current models of pastoral care engagement. This engagement functions at its best when pastoral care and spiritual care are not viewed as an optional extra, but are built into the main mission statement and actioned right through resident and community based care. All three models presuppose, and emphasise, a team approach, the contribution of clergy, and the potential contribution of nurses as pastoral carers. The clergy are identified as having particular skill in providing for ritual and sacrament, pastoral counsel and spiritual direction through life transitions and loss, confession and the pronouncement of God's forgiveness, and reconciliation.

1. Parish-based model: The parish forms the focus for care. The team engaged with the community, including clergy, possibly a parish nurse and pastoral visitors, are based in a parish administrative structure that includes appropriate education for all levels of staff.
2. Model based on the aged care facility: The resources of the aged care organisation provide infrastructure for service provision. This model avoids duplication of services. Where services are offered outside the organisation knowledge of the organisation assists the smooth operation of services. With this model the links between community, parish and aged care facility are enhanced.

3. **Collaborative venture between parish and aged care facility:** The place of pastoral care in the total package of care is clearly acknowledged and serviced by facility and parish joining in partnership to provide best practice. The knowledge base of facility based specialist aged care chaplains is used to optimise pastoral care, while the human resources of the parish are utilised, providing a real service component.

MacKinlay emphasises the need for education, professionalism and accountability. However, when discussing scientific (empirical) outcome measures she does view them as a suitable lone measure for assessing success and outcomes in pastoral care. Assessment of pastoral care outcomes and practice in the aged care sector is another area to be developed.

These five articles reveal the limited nature of current research internationally and in Australia, the evolving use of the terminology 'pastoral care' and 'spiritual care', and the historic prevalence of the Judeo-Christian, and religious approach to the interest, funding and scope of spiritual care provision to the ageing.

Why develop spiritual care for the ageing in long-term care?

Relevant theories of personhood, theories of ageing and Christian theology

In the current environment, and with the development of spiritual care models in its infancy, those shaping policy have a serious responsibility. There exists a unique opportunity to choose the values, attitudes, and methods, that will not only contribute to best practice, but will actively contribute to the betterment of our wider social fabric.

Constructs of personhood are not discussed in relation to the aged care literature even though they are very evident in our society. Consequently, from a more wholistic perspective, it would seem reasonable to reject the limitations of a biological/mechanical view of personhood that perceives the ageing body to be like a clock winding down. This view invites ageism, an illness/deficit orientation, and may be readily aligned to the limitations of a clinical medical model of care. A functional view also proves inadequate as a person's worth is related to societal determinations of productivity. Here 'productivity' and 'doing' are valued over 'being'. Again this invites limiting and negative attitudes towards ageing and contributes to the promotion of an economic rationalist approach to funding.

In the spirit of the Judeo-Christian and humanistic heritage a positive foundation for the development of spiritual care models could occur when using a wholistic and more organic view of personhood. Here the dynamic interaction between one's body, mind and spirit is captured in the context of one's social relationships and physical environment. The person is seen as an integrated whole, and not totally diminished by the decline of any one aspect. Mastering this view enables us to respect the individual complexity of each person, recognise their essential spirit, their coping mechanisms and strengths, and their flexibility and capacity for change and learning. This wholistic and organic perspective invites positive attitudes to ageing, challenges stereotypes, and promotes the older person's capacity and ability to live a fulfilling life in the face of losses, and the inevitability of death, in the context of a loving and supportive community.

When reviewing theories of ageing, and critiquing their usefulness, a wholistic view of personhood enables us to include the place of spirituality. Moberg (2001) in his review of eight current western theories of ageing suggests that theories of ageing offer us complementary, rather than alternative, perspectives to choose from.

Monotheistic religions across the world, along with many other religious and philosophical traditions, affirm the value and status of the elderly within the faith community and beyond. This affirmation is at times at odds with a western secular tradition that appears to offer limited respect to the ageing and negligible opportunity for the discovery of meaning at this stage of life. A single

lens of ‘ageing and decline’ promotes stereotypical attitudes and influences the aged care sector’s development of service provision. McNamara (1999), in his discussion of attitudes to ageing in Australia, identifies and describes the ambiguous experience that human ageing involves.

...(A) downward curve involving diminishment, pain, suffering, loneliness and isolation and an upward curve of growth and development characterised by a developing self-encounter, a greater and deeper expansion of relationships with other persons and a more direct meeting with God. (McNamara, 1999, p.45).

Christian theology traditionally finds meaning and opportunity in both trajectories of ageing. It views both trajectories as journeyed with a God who continues to be in solidarity with those who are suffering and gives life a ‘sacred ground’ for meaning. For an older person facing the task of discovering ‘final meaning’ it is more often their vulnerability and dependence that facilitates the work of meaning making. This occurs in the context of the ageing person holding and facing both the positive and negative aspects of their human relationships and their relationship with God.

Psychosocial development

Having a robust spirituality assists the task of ageing. When talking about the value of spiritual care for the ageing it is vital to have a comprehensive understanding of the psychosocial tasks of ageing. Pioneering work by Erik Erikson (1968) in the 1950s described the psychosocial stages we typically go through across the life cycle.

Erikson’s theory proposes that one’s identity and coping skills gradually build at each life stage. How each person responds to the life challenges before them at any one stage can be a help or hindrance to future development and well-being. Erikson’s stages are commonly experienced as sequential. However, Erikson posits the opportunity exists to successfully resolve the conflict, or task of each stage, and achieve one’s fullest potential, by revisiting and reworking the developmental stage of an unsuccessful outcome and this can occur in any sequence over a lifetime.

When originally constructed, Erikson’s final stage corresponded to the 65+ age-group. With advances in medical care supporting a person’s health and activity level longer, this stage may not be faced until a decade or so later. Many people have the potential to live well into the nineties. In this current context, Vaillant’s (2002)* insights from the Harvard Longitudinal Studies, also warrant inclusion in Table 2 below.

Table 2: Stage tasks and corresponding virtue outcomes

Adult stage tasks	Virtue
Identity vs. role confusion	fidelity
Intimacy vs. isolation	love
*Career consolidation vs. emptiness	
Generativity vs. stagnation	care
*Keeper of the meaning vs. fossilisation	
Integrity vs. despair	wisdom

Many people being admitted into long-term aged care would be in one of the last three stages. If not already in process, the very admission to care can bring about movement towards the final challenging task of achieving integrity. For Erikson, this relates to the acceptance of one’s lived life, with all its ambiguities, a sense of the world and one’s place in it, and a valuing of the very substance of one’s own experiences in spite of mental or physical decline. This also includes, for many, a robust spirituality that supports the ageing person’s ability and capacity to find contentment in ‘being’ rather than in ‘doing’.

Spiritual tasks and the process of ageing

Especially in this final stage of life the psychosocial dimension has many spiritual elements as the ageing person reminisces, reviews their life, and makes meaning of their past, present and future. Providing an environment where a resident’s attributes and skills can be nurtured, deficits supported, and potential for growth facilitated, allows them to live as fully as possible until death.

To achieve integrity, wisdom, acceptance, and the lively peace of mind of the last stage, requires an environment that supports the spiritual dimension of the ageing person. While ‘religion’ is the most common domain considered MacKinlay (2004) identifies three other domains through which an individual may commonly express their spirituality. An individual may focus on one domain, or alternatively, express a unique and personal spirituality through any combination of the four domains of religious commitment, relationships, the environment, and/or the arts.

Applicable to the four spiritual domains, MacKinlay (2001) identifies six spiritual themes of ageing (see Table 3). MacKinlay’s model assumes the context of community and is interactive across elements.

Table 3: MacKinlay’s six spiritual themes and tasks of ageing

Spiritual themes of ageing	Spiritual tasks of ageing
1. Self-sufficiency and vulnerability	Transcending loss and disability
2. Finding hope beyond, and over and against, fear	Affirming and maintaining hope
3. Relationships rather than isolation	Establish intimacy with others and a sense of God or transcendent ‘other’
4. Wisdom and final meanings rather than a sense of life amounting to nothing	Commitment to revisiting and reworking one’s past, for the purpose of searching for, and discovering, final meaning for one’s life superseding ‘provisional meaning’ and current spiritual state
5. Search for ‘ultimate meaning’ (beyond final meaning) in life	Identifying the source that acts as a primary resource and inspiration for life
6. The response to a personal experience and sense of ‘ultimate meaning’	Finding a way to express that response

Prior to MacKinlay’s work, Howard Clinebell (1984) identified nine human spiritual needs. Most can be accommodated in MacKinlay’s model. The spiritual themes of ageing identified by MacKinlay also point to the need for competent assessment. Subsequent, appropriate responses to the spiritual care needs of the ageing person would require competent provision of spiritual care. However, Clinebell placed particular emphasis on the need to find paths to reconciliation and forgiveness; a more intentional emphasis on maintaining a healthy self-esteem and self respect; and specifically identified the contextual need of a caring community for spiritual tasks to be achieved.

In addition, Clinebell’s specific emphasis on the importance and value of community connectedness fits well with the BSL vision. Communal poverty may well be a significant contributing factor to spiritual poverty. There is more than adequate research evidence to support the implications of social isolation for mental health and well-being.

Well-being, life satisfaction and spiritual well-being

Articulating a wholistic approach to total well-being in managed care and preventative health strategies, Hilsman (1997) uses the following description:

Total well-being means a combination of relative vigor in bodily functioning, resilience in emotional self-care, satisfaction in social contexts, and fulfilment in the spiritual arenas of life. (p.2)

Moberg (2001) also affirms high levels of religiosity and spirituality are correlated positively with life satisfaction, health, healing and well-being. With particular relevance to those with chronic medical conditions Seidl (1993) defines spiritual health as ‘that aspect of our well-being which organises the values, the relationships, and the meaning and purpose of our lives’ (p.1). Underpinning this definition is the assumption that spiritual well-being is not static and growth and change are possible. While characteristics of general adult spiritual health have been defined they are of limited value as they don’t focus on the particular life stage of the ageing resident and the spiritual tasks of that period. However, they do indicate the general application of spiritual care, and its provision to residents in both the high and low care sector, as being beneficial in relation to enhanced health and well-being.

Who benefits from spiritual care in the long-term aged care sector?

Benefits to residents generally and specifically

When spiritual care was provided by a facility the quality of care and benefits were usually informally assumed. Given the material presented in this review one could expect that the provision of integrated wholistic and intentional spiritual care to residents would ensure the following observable benefits:

- The psychosocial and spiritual challenge of achieving integrity rather than falling into despair would be supported and facilitated.
- The individual’s progress when encountering the spiritual themes of ageing would be facilitated and resourced.
- Residents would be validated through reminiscence, their relationships with staff, family, social and community members, as they experienced themselves as loved, being needed, and having something to contribute.
- Residents’ religious practices would be enabled and opportunities for faith development offered.

Of particular relevance to the clientele of the BSL is literature that may enhance the provision of spiritual care to those who have been potentially homeless, and come with a history of psychosocial and/or financial disadvantage. Fry (2000) compared the effects of psychosocial factors (e.g. social resources, income and negative life events) with the effects of existential factors (e.g. religiosity, spirituality and personal meaning) as potential predictors of well-being in samples of community residing and institutionalised older adults. Results indicated that involvement in formal religion, participation in spiritual practices, importance of religion, degree of comfort derived from religion, sense of inner peace with self, and accessibility to religious resources were not only significant predictors of well-being for the combined sample but was strongest for the institutionalised elders. Key to these findings for the institutionalised elderly was their easy access to religious services and spiritual supports.

The findings revealed that in spite of difficult psychosocial circumstances, together with failing health, and other losses associated with ageing, where residents had easy access to existential resources, engagement with these resources also had a mediating affect on depression, anxiety, and the distressing aspects of old age. Given the psychosocial, educational, and cognitive variables, and often multiple diagnoses, of this group, Fry suggests that engagement in meaning making and discovering aspects of spiritual coping may need to be stimulated and reinforced by facility staff in concert with, and maximising, the resources of, pastoral care professionals.

A study by Krause (2004) examined the effects of lifetime exposure to traumatic events upon life satisfaction of older adults. He found that emotional support in the over-75 age group offset the effects of lifetime trauma and the stress buffering properties of emotional support were particularly evident in the 85+ age group. While a number BSL residents in this category are younger than 75 years of age, the research does challenge the reader to think further about what conditions would need to be in place for the ameliorating effect of social support to be effective for this younger age

group. The social benefits of personal and community engagement through religious and spiritual contacts were affirmed. However, there appears to be no literature on the modes of emotional and spiritual support that may be most suitable for often largely non-verbal, and socially challenged residents with low self esteem, and few, if any, personal emotional supports. Spiritual issues arising around the residents' sense of security and need for belonging as well as the unique and often pressing ministry opportunities for funeral planning and celebration are also lacking in the literature. This is especially relevant to the BSL and offers an avenue for further research.

In other specialist areas, some literature revealed the particular role and benefits of spiritual care in particular resident circumstances such as:

- multiple losses and transitions of older age
- past trauma, grief and bereavement
- mental health, particularly depression and dementia
- palliative care
- need for particular religious practices
- church membership, and the ability/inability of the wider church or local parish to respond or offer inclusion in the faith community

Benefits to staff

As the personal, communal, and economic benefits have been recognised over the past decade, providing various forms of staff support in the acute hospital sector has become the norm. The type of support offered can generally be grouped into five categories:

- in relation to acute trauma (critical incident debriefing)
- routine clinical situation (ward group debriefing)
- area or career related mentoring
- psychological (employee assistance programs and counselling)
- spiritual (confidential counsel from member of hospital pastoral care department).

In relation to care and support of nursing home staff, Pullman and James-Abra (2001) recognise the distinctive and unique emotional and spiritual demands of the long-term high care environment. Nursing and care staff are having to increasingly deal with specialised technical procedures, the pressure to accept frailer residents, sparse carer/resident ratios, negotiating complex ethical situations, often in a context of lower salaries (than other comparable environments) and high staff turnover. They also discuss differences occurring across the continuum of caring relationships from an 'extreme professional relationship' to an 'extreme familial relationship'. The first is characterised by professional detachment and more commonly seen in an acute hospital context. The second is characterised by a high degree of connection and involvement in the lives of those being cared for. Also present in the continuum of caring relationships, is the emphasis on 'curing' within an acute care setting and 'caring' in high level care environments. In addition, a difference is noted in the way clients are referred to as 'patients' in the acute hospital system, and 'residents' in long-term, high and low level care environments.

As nursing home residents can reside there for months or years, staff naturally become more intimately involved with residents' lives. At worst this kind of relationship might speak of over-involvement on the part of the staff member and a corresponding lack of autonomy for the resident. The authors consequently argue that pastoral care and ethical support should be available to staff particularly because of the long-term familiarity of the relationships.

A particular ongoing stress for carers, emphasised in lone high care facilities, is their repeated experience of the death of residents. Knight (1999) makes reference to allied studies on retention rates of nursing assistants that show that death is the number one reason for leaving their employment. However, it appears this is not only the experience of repeated death with people they had come to know, but also the lack of acknowledgement within the system regarding the grief

they may experience on the death of an individual or accumulated grief over time. Knight argues that facilities have a responsibility to help staff deal with death at a personal level as well as a clinical level and that a fulltime chaplain in every nursing home could alleviate the problem. Given that neither occurs as the norm, she critiques a system that denies both. Knight advocates for death education to be available to all staff, and the benefits to staff and residents of regular facility based memorial services, as well as the availability of spiritual resources/materials for staff self care.

In arguing for the place of spirituality, as it contributes to total well-being in preventative health strategies and managed care, Hilsman (1997) reminds his readers of the power of the mind/body connection:

Competent spiritual caregivers believe that attending to the concerns of a person's inner life, when combined with established regimens of medical diagnosis and treatment, is likely to increase patient satisfaction and motivation for self-care, as well as unlock personal energy to enhance healing from the medical complaint. (p.3)

He also contends that attending to individuals' unresolved grief, and the degree of acceptance of their own mortality, health care costs could be reduced. He notes: 'Effective self-care and shorter recovery times are directly linked to positive self-esteem, strong connections with friends and family, a satisfying social and community life, and a positive regard for transcendent forces' (p.4).

Alongside the possible cost effectiveness of quality spiritual care provision for ageing residents in long-term care would be the practical benefits to care staff of more contented and independent residents who have had opportunities to maximise their spiritual health and well-being. Further research confirming that quality spiritual care was cost-effective might encourage greater development and provision of spiritual care. It could also contribute to improving the working environment for staff as well as the living environment for residents.

Benefits to family

A great deal has been written about the general and spiritual needs of carers in the community but again this appears to be an area not researched in the context of long-term aged care. Across all disciplines, care workers speak colloquially of the extensive amount of time given to supporting families and resident care networks. These workers have recognised the benefits to residents of this indirect support. The availability of spiritual care support appears to be particularly appreciated during times of:

- transitions in care, e.g. location change due to increased care needs, hospitalisation, changes in mental/physical health
- family conflict
- visiting, or caring for, a loved one with dementia and/or depression
- coping with the long haul of visiting a failing relative
- terminal care, death, bereavement aftercare.

At a weekend intensive, 'Ethics and self care in bereavement work' at the Monash Centre for Grief Education in June 2005, Wayne Lynch presented the concept of 'spiritual fatigue'. Based on the premise that unmanaged, unhealthy stress precedes burnout, he suggests that, in addition to physical fatigue and psychological fatigue, spiritual fatigue may be a less recognised contributor to burnout. He suggested themes that may indicate spiritual fatigue such as: doubting self-worth; experiencing doubt about personal values, beliefs, morality, ethics; feelings of resentment or guilt; frequent blaming of self or others; being haunted by change; questions about relationships, lifestyle and work. These are themes that may arise in carer relationships in residential care. The risk of spiritual fatigue may be reduced, for residents, families, and staff, with the availability of appropriate spiritual care.

Benefits to community and society

The benefits to community and society of spiritual care in aged care do not appear to have been formally researched. However spiritually aware communities may foster social inclusion of the elderly in care. The general community has considerable capacity for forging lasting links related to religion, relationships, the environment and the arts – the four domains of spiritual expression. One obvious example of capacity in relation to the spiritual domains of religion and relationships is the faith community. A web of communal relationships has the potential strengthen the spiritual thread in the fabric of society through increased awareness, involvement and spiritual engagement. In addition, the contribution of spiritual well-being to total well-being for both residents and staff may reveal positive aspects of the ageing experience. In time, this may in turn contribute to a more wholistic societal understanding of ageing, particularly of persons with a condition such as dementia.

The development of best practice in spiritual care also allows an agency, such as the BSL, to work towards the full integrity of their vision and mission. In addition it promotes continuous improvement and the broader intention of federal government requirements in caring for ageing members of our community. Research in this area would offer a unique opportunity for a range of professional disciplines, community groups, agencies, and government departments, to participate in the building of an age-friendly society and strengthen the spirit of community in Australia.

How might spiritual care be developed in an integrated, wholistic and professional way?

Integrated spiritual care

Integrated spiritual care is multifaceted. MacKinlay (2004) reminds us that, ‘Spiritual care/pastoral care is not an optional extra, but needs to be built into the main mission statement’ (Seminar 2004). The care model of a facility influences the integration of spiritual care. A multidisciplinary team approach, partnership with community providers, and ‘primary’ resident care models can all enhance integration.

One model in development is the ‘Being Alive’ Program at the BSL low care facility Sumner House. With a resident group that has complex needs, and often poor social skills, Sumner House bases its philosophy on the fundamental well-being of residents:

Our key focus is for residents to be at the very centre of decision making which enables them to maintain their sense of identity, continue their lifestyle choices and interact with the community. (Mundy, Van Dueren & Heywood, 2004).

Residents have taken a variety of roles, including involvement in the operation of Sumner House, putting on a play, and responsibility for small interest groups, with backup from staff. Homely routines involve residents alongside the primary care offered. Staff/resident barriers are also reducing through the experience of bunking together at camp. The Being Alive program shows that:

...with time, support and a reason, residents can make choices and decisions about their life and home in a meaningful way. By understanding their past of loneliness and isolation, we have worked through and continue to work on empowerment for all of our residents and staff. (Mundy et al 2004).

Conceptually this type of program lends itself to the integration of spiritual care due to its emphasis on resident well-being, individuality, self-determination, and empowerment, all of which strengthen the in-house connections and links with the local community.

Wholistic spiritual care

Wholistic spiritual care addresses the complex inter-related needs of the whole person and promotes engagement and growth in the domains of religion, relationships, the environment, and the arts through which a person may express their spirituality. In promoting a spiritual wellness paradigm across long-term care facilities, Anderson (1998) points to a wholistic approach by considering the various elements that make up a resident's 'core identity'. Indeed, 'spiritual wellness is a process, a faith journey grounded in the mission and values of a community' (Anderson 1998, p.1). Wholistic spiritual care is individualised and multidisciplinary. Staff members in touch with their own core identity are more able to develop supportive pastoral connections with residents, even when assisting residents with personal care.

Nursing theorists, particularly over the last 10 years, have begun to reclaim the potential for a role in assessing and addressing spiritual needs as part of a wholistic approach to nursing care. Historically, nurses were generally expected to assume this responsibility as an aspect of good nursing care.

Nursing theorists who have written extensively about the role of nurses in the provision of spiritual care are Hudson (1994), Hudson & Richmond (2000) and Ronaldson (1997). In order to harness the skills of all staff, this trend could be encouraged, especially if comprehensive spiritual care training became standard in nursing education. This expansion of the professional role by some nurses does raise a question with regard to where the growing profession of Personal Care Workers would place their involvement and education in spiritual care. This issue is increasingly important given the higher ratio of personal care workers to registered nurses currently working in the aged care system.

Professional integrated wholistic spiritual care

Spiritual care staff ratios, funding sources and training.

Variations in the provision of spiritual care exist by default in many facilities due to esoteric, and often inconsistent, understanding of the 'spiritual life'. Limited access to in-house and community resources, including volunteers, combined with the fact that currently this area of care is inadequately funded, too often leaves aged care services unable to competently identify or assess spiritual needs or provide an appropriate level of professional spiritual care. At present those facilities employing any type of Spiritual Care Worker are largely dependent on obtaining supplementary funding from the 'charitable dollar'.

The literature indicates that where professionally trained spiritual care workers are employed there is great variety in their roles and training. In some cases there is concern among chaplains that the additional administrative or other duties are limiting their availability in the actual work of spiritual care. (Hinrichs, 1999c, cited in Moberg, 2001) The involvement of general staff, or the community, also varies considerably. It appears that no Australian research has taken place in the sector to consider what best practice ratios of spiritual carer to residents in long-term care might be. Hinrichs (1999a, cited in Moberg, 2001) recommends a ratio of one full-time chaplaincy position for every 150 residents in intermediate care (equivalent to our low care) and one full-time chaplaincy position for every 75 residents in skilled care (equivalent to our high care). A professional spiritual care worker would direct care provision across the facility, enabling care to be intentional and individualised. However, adequate and diverse coverage can only be provided when skilled professionals are supplemented through the involvement of other staff and volunteers.

For spiritual care to be integrated across disciplines, with the leadership and resources of professionally trained spiritual care providers, a multi-tiered educational approach is needed for all involved. It appears that literature across all disciplines about spiritual care education is lacking, with the exception of some non-core training offered in some nursing degrees. It also appears that in Australia required formal training in this area for Personal Care Workers and Lifestyle Co-

ordinators is non-existent. It is worth noting recent developments such as the current Diversional Therapy course which offers an optional study component that looks at the spiritual needs of a resident receiving palliative care.

Lasting change can only occur if education and a basic understanding of spiritual care across all disciplines can be shared, articulated, and no longer an optional extra. In theological institutions specific training for those who would like to specialise in community or facility based spiritual care of the ageing is also limited. In addition Clinical Pastoral Education opportunities offered across the Australian aged care sector are exceedingly limited. However, the establishment in 2001 of the Centre for Ageing and Pastoral Studies in Canberra is perhaps indicative of the recognition of a growing need for spiritual care provision appropriate to the spiritual issues associated with ageing and the aged care sector in Australia.

Parish based, community based and in-house volunteers

A considerable amount of general literature supports the view that the social, spiritual, and economic benefits of keeping an aged care resident connected with their family, friends and communities of choice are extensive. Visitors, and more specifically for this investigation, suitably trained and selected volunteers, who are regularly involved in the life of a resident can support and facilitate the ageing person's connection with their previous life experience and networks. Through the volunteers' gift of time and friendship, residents can experience increased self-esteem. Generally, volunteers are more available than staff to spend this important one-on-one time with residents and provide emotional, spiritual, social, and leisure support.

While many volunteers may inadvertently provide some form of spiritual support to a resident, specifically trained, and supervised, spiritual care volunteers have an invaluable contribution to the spiritual well-being of the ageing person in residential care. These designated spiritual care volunteers will have varying levels of training depending upon the standards required by their auspicing body, for example, the local church or synagogue, or in some cases, a facility that recruits, trains, and supports them.

Unfortunately many churches are neither theologically equipped nor sufficiently educated in the area of ministry to the ageing, to respond to their needs. In addition, both human and financial resources contribute to this shortfall of spiritual care provision. Fears about ageing and dementia in society are often reflected in the church, and result in a lower priority for ministry with the elderly. Ordained and lay volunteers from different faith communities have a vital role in residential long-term care facilities. However, unless guidelines and competency standards for spiritual care are determined and directed by the facility the spiritual needs of those residents who have no religious inclination may be ignored.

Another approach, advocated by MacKinlay (2000), suggests Christian churches offering pastoral care focus not just on looking after their own but model the theology that every person is valuable, at every point in their lives, because they are made in the image of God. This perspective could also have the benefit of affirming the contribution of the recently retired retirees in a given congregation who could be suitably trained in ministry to community and institutionalised residing elders. This approach widens the scope of responsibility beyond church members alone to any older resident who may appreciate a pastoral contact. With a widening of scope comes the need for an articulated theology of presence, rather than conversion. In addition this would require highly developed pastoral skills, interpersonal communication skills (particularly associated with listening), and an adequate level of knowledge and competency related to interfaith sensitivities and the spiritual tasks of ageing.

While facilities auspiced by faith communities are known to occasionally provide in-house training, literature is scarce and resources few. Where facility based recruitment, training, and ongoing support for spiritual care volunteers is possible, this method may offer improved continuity and better outcomes for residents and volunteers. In this facility context, review,

ongoing education, and quality assurance processes are more likely to be in place. The opportunity exists for further development of training programs designed for volunteers wishing to minister within the aged care sector.

Accountability and quality assurance

Accountability guidelines and quality assurance tools are yet to be developed for the professional delivery of spiritual care in high and low level aged care. This reflects a lack of funding for professional spiritual care and the subsequent, largely ad hoc, approach to spiritual care in conjunction with the sector's reliance on community based clergy and occasional volunteers. Australian chaplains, with strong historical foundations in the hospital sector, combined with a higher level of denominational and hospital funding, interfaith support, and the initiative of the Australian Health and Welfare Chaplains Association, followed international trends in 1998 in publishing when the first edition of Health Care Chaplaincy Standards.

The document is contextualised for the acute hospital environment, and the medical model, but does give some helpful structure to possible future development of standards and competencies for the delivery of spiritual care across the aged care sector. The document presents a key purpose, key roles, units of competence and competency elements which could then be used for establishing a chaplaincy service, determining chaplaincy occupational standards, constructing competency-related educational programs, defining job and departmental responsibilities and performance review. An element alluded to, but not fully explained, is the need for spiritual care workers to recognise the formal need for, and put into place, a system of spiritual and psychological support. This would include self-care strategies such as regular spiritual direction and professional supervision.

As a part of the National Palliative Care Program, in May 2004 the Australian Government Department of Health and Ageing launched the *Guidelines for a Palliative Approach in Residential Aged Care* (DHA 2004b). Although the involvement of chaplains, clergy and spiritual/pastoral care workers is advocated, no standards or competencies are suggested for this professional group. The document gives guidance to the basic training in spiritual care required by aged care staff, including competencies and standards in spiritual care, and is especially relevant to all staff involved in palliative aged care. The Guidelines are to be introduced to the residential aged care sector during Stage 2 of the project which is expected to commence in September 2005.

Spiritual assessment

The literature reveals some discussion about the value of comprehensive professional spiritual assessment and intervention as well as the quality of assessment across disciplines. It appears very few assessment resources are available and only meagre discussion considering the type of comprehensive, but easily administered, assessment that may be suitable for nursing and other care team staff to use in the absence of a trained spiritual care worker.

Spiritual assessment is not just a fact finding mission designed to maintain the status quo of the resident, but rather an evaluative process of discerning the spiritual strengths and difficulties a resident may have, in order to provide an 'appropriate, restorative response' (Ramsay, 1998; Friberg, 2001 in Moberg 2001, p184). Fitchett (1993a, 1993b) suggests that spiritual assessment is a dynamic process, both perceptive and interpretive, and that 'caregiver strategy can only be as good as the underlying rationale that supports and informs it' (pp.185–186).

Just as only brief religious information is obtained in the typical Australian admission interview, Friberg (2001) refers to the limitations of the common practice in the USA of simply asking new residents or their relatives to fill in a religious census card stating religious preference; indications for clergy contact; desire to attend worship services, receive the sacraments, maintain contact with a faith community; and preferences at the time of death. Frequently in Australia this information would be supplemented by a resident lifestyle profile; however, depending on the spiritual

development and awareness of the staff person obtaining the information, issues relating to spirituality may not be further explored. He notes that where trained spiritual care workers are not employed, which is often the case, the implementation and coordination of spiritual care is left up to an activity officer or volunteer services director.

In Australia, the Centre for Ageing and Pastoral Studies is currently developing assessment tools that would eventually be available on their website. Through an initiative of the palliative care sector in aged care, in the previously mentioned *Guidelines for a palliative approach in residential aged care* (2004), a team approach and regular review of the spiritual assessment are advocated. Suggestions for a conversational approach to determine spiritual needs are also made. Of importance in any assessment is the use of language that is relevant to the age and era of the resident, to make them feel at ease, and engage them. The Guidelines include the following possible questions borrowed from Hicks (1999), to assist in the assessment of spiritual needs:

- How are you in yourself?
- What is your source of hope and strength?
- What are your spiritual needs?
- Are there ways we might help with your spiritual needs or concerns?

They further suggest the assessor look out for:

- social isolation
- depression
- a resident's questioning around the meaning of their existence
- a resident seeking spiritual assistance
- a resident attending spiritual services
- religious items.

An initial assessment, with adjustments as the resident's situation changes, may be all some facilities can provide. Fitchett (1993a, cited in Moberg, 2001) advocates that spiritual assessment is best positioned in a wholistic approach alongside six other areas: medical, psychological, psychosocial, family systems, ethnic/cultural, and societal. He further gives a breakdown of seven components to be considered within the spiritual assessment.

MacKinlay (2001) offers an alternative structure. Her work identifying six spiritual themes of ageing across the four domains of religion, nature, the arts, and relationships, offers a strong, and perhaps more readily understood structure on which to base assessment. MacKinlay's approach also calls for a broad wholistic understanding, and for a variety of resources to be available to the spiritual care practitioner in response to the individual needs of each resident, as well as to specific groups of residents. Common across the international literature is the importance of further funding and educational resources to ensure equity of access, quality and individualised spiritual care.

Approaches, methods and modalities of spiritual care

Most widespread in the western world is the Judeo-Christian model of pastoral care which is commonly practised in hospital, welfare, military and penal systems. The Health Care Chaplaincy Standards state the key purpose of pastoral care as: 'Within a wholistic approach to health to enable individuals and groups to respond to spiritual and emotional needs, and to the experiences of life and death, illness and injury, in the context of a faith or belief system' (p.4). Primary aspects of care for the individual and their community include opportunities for worship and religious expression, pastoral care, spiritual counsel and spiritual direction. In addition, the pastoral worker is a resource for ethical, theological and pastoral matters. This system of care has largely been promoted and financially supported by the major Christian denominations, with some support from government sectors. Professionals in this field of care tend to be auspiced by their religious group. In addition to theological training, in Australia, Clinical Pastoral Education has been chosen as a practical training component. The strengths of CPE training include developing clinicians' pastoral listening skills, responses, and capacity for theological reflection and personal spiritual growth. While predominantly verbal in its communication style, CPE does not provide formal training in

pastoral counselling, nonverbal communication skills, or broader forms of spiritual expression such as different forms of prayer, meditation and visualisation. Also absent is formal training in social science, including research methods.

Alongside the pastoral care/chaplaincy approach of the major Judeo-Christian faiths, has been the development of the profession of Pastoral Counsellor. Pastoral counselling, which grew out of the CPE movement, became institutionally formalised in the US in the 1960s with the establishment of the American Association of Pastoral Counselors (Wicks, Parsons & Capps, 1993). In Australia, a professional association for pastoral counsellors was established in 1998. Known as the Australian Association of Spiritual Care and Pastoral Counselling, it is a constituent organisation of the Psychotherapy and Counselling Federation of Australia (PACFA). Full members are trained practitioners who have completed tertiary studies including theology, religious and spiritual perspectives, ethics, counselling skills, social sciences and supervised clinical practice fieldwork. Practitioners have formal training enabling the practice of spiritual care, including ethical decision making, and in addition, professional pastoral counselling and research. Various tertiary courses are available and practitioners are more likely to be in private practice or employed in institutions, occasionally aged care facilities, for their counselling skills.

The influential work of Victor Frankl, the founder of Logotherapy, is observed in some pastoral counselling approaches and highlights the importance of competent identification and assessment with regard to the spiritual dimension of a person's life. As Frankl (1987) stated:

A man's concern, even his despair, over the worthwhileness of life is a *spiritual distress* but by no means a *mental disease*. It may well be that interpreting the first in terms of the latter motivates a doctor to bury his patient's existential despair under a heap of tranquilizing drugs. It is his task, rather, to pilot the patient through his existential crises of growth and development. (p.104)

Frankl's approach is of particular relevance to ageing, as it emphasises the motivational force of finding meaning in one's life and maintains 'profound commitment to the human being as an irreducibly spiritual creature' (Kimble & Ellor, 2001, p.9). Frankl's work has also been influential in affirming the various sources of meaning a resident with dementia still has available in spite of cognitive loss (McFadden, Ingram & Baldauf, 2001). Currently, specialities in spiritual care practice are emerging in the areas of palliative care, dementia, and depression.

In Australian aged care homes, between 40% and 60% of high care residents, and between 25% and 51% of low care residents, are shown to be depressed. These alarming findings from research commissioned by the Australian government contributed to the Challenge Depression campaign. While surveys did not directly focus on spirituality, Fleming, the campaign project director, hypothesised that an analysis based on the commonly used Geriatric Depression Scale question 'Do you feel that your life is empty?' would provide insight into the type of person who may benefit from spiritual support. The results indicated that residents who responded 'no' to this question were more likely to have a healthy spiritual life and less likely to be depressed. Those who self-assessed their lives as empty were more likely to be filling their time with non-meaningful activity and more likely to be depressed.

Fleming also quotes research indicating religious commitment is associated with a reduced incidence of depression and a quicker recovery from depressive illness for the elderly, and inversely related to suicide risk in 13 of 16 studies reviewed. He points out that in Australian aged care homes, less emphasis and funding is given to the assessment of spiritual need and provision of spiritual support than is given to diversional activities. For those less interested in engaging, or re-engaging, in a formal spiritual life, Fleming emphasises the need for appropriate engagement, not diversion, in re-establishing and maintaining the resident's sense of meaning and purpose in life. This engagement, spiritual at its core, opens up opportunity for collaboration between spiritual care workers and those coordinating and providing activities.

MacKinlay (2002) notes in relation to the psychosocial and spiritual tasks of ageing that one aspect of depression can be a crisis of meaning. She cites Baker's (2000) research which found that the prevalence and degree of depression could be reduced by an intentional 30-minute pastoral care visit. Where the research did not continue with long-term pastoral care visits, follow-up assessment showed an increase in depression. Best outcomes were noted when pastoral care strategies were introduced once the severely depressed mood of clinical depression was improved through the pharmacological treatment. A crisis of meaning may also be directly connected to a crisis of faith.

In light of the psychospiritual and social value of meaning making in old age, a modality applicable to most residents' state of being is one of engaging residents privately, or in a group, in the process of reflecting on their life. In the midst of constant losses and the drive to construct meaning at this stage of life, reminiscence has many beneficial effects. Depending on the context, it may be recreational, offer psychosocial engagement and, when used with sensitivity and training, may be a strong tool for the spiritual care worker and their spiritual ministry with the resident. MacKinlay (2001) reminds us that reminiscence is generally helpful to the older person as it offers a relaxed and enjoyable way of engaging in the ultimately spiritual task of meaning making and is therefore empowering. While the benefits of spiritual validation, spiritual growth, and opportunity for the healing reconstruction of memory are great, reminiscence in general, and more specifically intentional life review, are not without risks. These modalities must be engaged in with care, demonstrate sensitivity to traumatic events in the resident's life, and should only be engaged in if appropriate emotional, psychological and spiritual resources are available for follow-up when required.

Methodology

Under the guidance of the Project Management Committee, the Project Officer was directed to commence a research project with the threefold aims of:

- surveying and identifying spiritual care models and practices currently offered in high and low care aged care settings
- revealing implications for the development of best practice in intentional, integrated and wholistic spiritual care suitable for the particular clientele and vision of the BSL and the unique requirements of each facility
- sharing major learnings with participating facilities and the wider aged care sector.

The research design was structured to:

- document the present way a variety of external for-profit and not-for-profit aged care facilities were addressing issues of spirituality and pastoral care for their residents, residents' families/care network, and staff, and how these facilities imagined best practice.
- document how the BSL's own four very different facilities were addressing spirituality and pastoral care and what their preferences for improvements might be.
- draw implications from the analysis of research data, and literature review, for:
 1. development of spiritual care in the sector.
 2. consideration within the unique context of the BSL aged care facilities.

Research design

Initially 15 not-for-profit and three for-profit facilities were canvassed by letter and phone to ascertain their interest in participating in the research. Facilities were confined to metropolitan Melbourne and reflected the industry contacts of the BSL at the time. A wide range of not-for-profit facilities were approached but, coincidentally, none happened to be auspiced by local government or service clubs. Out of the 18, only one indicated no interest in participating. In order to contain the research, a representative selection of 10 not-for-profit and two for-profit facilities, in addition to the four BSL facilities, were asked to participate.

Facilities received a letter explaining the scope and purpose of research. Ethical and confidentiality issues were discussed and management was requested to nominate up to four staff and/or volunteers to participate in an hour's in-depth interview to be held, at a time nominated by them, at their facility. Residents were not invited to participate, as their inclusion would have involved suitability screening and complex confidentiality issues. Organisation consent forms were signed, by the appropriate authority, at each facility, all participants signed personal consent forms, and a contact person was nominated by each facility.

Interviews were scheduled from October 2003 to March 2004. Due to the lively interest of each group, interviews often lasted up to one and a half hours. Groups had one, two or four participants, typically including an organisational Chaplain, Pastoral Care Worker (if available to the facility), local clergy, Facility Manager, Nurse Unit Manager, Personal Care Workers, Activities Officer/Diversional Therapist (or student trainee) /Lifestyle Coordinator, and general and pastoral care volunteers.

A topic checklist was used to ensure that, while each interview session was autonomous and allowed for the uniqueness of each facility to be highlighted, the same subject matter was covered. Very brief notes were taken at each interview and all interviews were taped for the purpose of typing up first stage thematic analysis of each facility, after which all tapes were destroyed.

Findings were analysed using a matrix system to identify major themes, similarities and differences across the facilities.

The same interview and analysis process was used with the four BSL facilities. However, in addition, for these four BSL facilities, a confidential Residents and Relatives Questionnaire was circulated to gain feedback on resident/relative perceptions, current and prior experience of spiritual support and pastoral care, and what people's desires might be. Questionnaires were distributed by the Chaplain or Activities Coordinator, on a self-select basis to cognitively able residents only, and to interested relatives.

Ethical issues and confidentiality

The BSL Research and Policy Planning Group vetted the ethical dimension of the project design before commencement, ensuring that it complied with the BSL social research ethics policy (May 2003).

Participants were assured that no personal identifying information would be used and that the intellectual material gained from the research would remain the property of the BSL. Notification was also given that the typed interview data would be kept in a locked cabinet by the BSL for a period of two years.

Role of the Project Management Committee

The Committee gave direction and professional support to the Project (see Terms of Reference Appendix 2). The Project Officer reported to the Committee and progress was monitored and discussed by them.

Role of the Project Officer

In addition to undertaking the research, the Project Officer, as BSL Chaplain (Aged Care), had priestly and pastoral responsibilities across various services in the BSL Aged and Community Care Service. Subsequently she was known by and ministered in a professional capacity to various degrees across the four participating BSL sites. Hence in the four BSL interviews the Project Officer was not only the researcher but, as BSL Chaplain, also a participant and contributor to the interviews. While staff member participants were aware of, and consenting to, the situation it is acknowledged that this dual role may have influenced those interviews in undetermined ways.

Summary of main findings

Demographic and contextual analysis

Facility type, size, and characteristics

In total 16 facilities were visited, 14 not-for-profit and two for-profit (fp). Table 4 shows the distribution across facilities of care level and size.

Table 4: Facility type and size

Care level	Size		
	Small	Medium	Large
Low	8		
High	1		1
High/low		3	3
N=16	9	3 (1fp)	4 (1fp)

Table 5 shows the total number of facilities in each care level and a range of characteristics found across the 16 facilities.

Table 5: Facility characteristics

Care level	No. of facilities	Part of larger organisation	Single facility	Faith/cultural affiliation	Socially/financially disadvantaged clients
Low	8	7	1	7	7
High	2	1	1	1	1
High/low	6	4	2	4	

Models and characteristics of spiritual care provision

By determining the person/s most professionally responsible for this aspect of care in the facility four models of spiritual care provision were identified across the 16 facilities. Table 6 below shows the number of facilities subscribing to a particular model as well as organisational and facility infrastructure supporting spiritual care provision. The table assumes formal education and training in spiritual care and its practice for designated Spiritual Care Worker positions.

Table 6: Structure of spiritual care service provision

Model	No. of facilities	Key person Organisation Spiritual Care Worker	Key person In-facility Spiritual Care Worker Assessment & provision	Key person In-facility Spiritual Care Worker Document Care Plan	Key person In-facility No specialist training Assessment & provision	Key person In-facility No specialist training Document Care Plan
Model 1	6	6	0	0	6	6
Model 2	5	1	5	0	0	5
Model 3	4	0	0	0	4	4
Model 4	1	0	0	0	all staff	all staff

Model 1

Findings indicated that church-affiliated, larger organisations with multiple facilities were more likely to have an appointed organisation level Spiritual Care Worker. Both high and low care client groups were represented across these facilities. These Spiritual Care Worker roles often included other related areas of responsibility within the organisation and, although available for individual provision of spiritual care to ageing residents, they were more likely to have indirect involvement at facility level through a Lifestyle Coordinator. In Model 1 the Lifestyle Coordinator had primary responsibility for assessment of spiritual needs, documentation, development and review of the spiritual care plan, and facilitating an appropriate response to the identified spiritual needs of the ageing resident.

Structure of spiritual care service provision model 1

Depending on local resources and identified facility needs the organisation level Spiritual Care Worker might be called on:

- for one to one counsel for residents/care network
- to lead religious services
- to network with clergy
- to officiate at funerals and organisational memorial services
- to maintain professional networks and standards
- to provide staff support to each facility.

They might have other related roles in the organisation, e.g. project officer. They might also have responsibility for:

- general oversight of spiritual care services across facilities
- training and support for pastoral care volunteers
- and/or be involved in-facility staff education in areas such as pastoral care and grief and loss
- chairing a pastoral care committee, bringing together representatives of staff volunteers and visiting clergy to discuss common concerns
- planning facility memorials.

In addition all care staff formally at times, but more often informally, support the residents' needs for spiritual care.

Model 2

Findings indicated that a range of service providers with diverse affiliations, low and high care clients, and often specific needs related to the facility's general resident profile, utilised this model. These facilities had a formally trained and appointed facility based Pastoral Worker. Facilities utilised the Spiritual Care Worker in a range of different ways reflecting the unique needs identified within each facility. A notable strength in this model was the spiritual care worker being facility based, enabling residents, family, and staff access to someone known, either formally or informally. A further strength was that the spiritual care worker at facility level had clear designated responsibilities, particularly the assessment and direct provision of spiritual care to ageing residents. An additional strength for one facility in this group was the organisation level Spiritual Care Worker to whom the facility based Spiritual Care Worker was accountable. As in Model 1, the Lifestyle Coordinator was responsible for documentation. The Spiritual Care Worker liaised with the Lifestyle Coordinator to communicate residents' ongoing spiritual care needs and appropriate responses.

Structure of spiritual care service provision model 2

The facility based Spiritual Care Worker generally worked extensively alongside the facility Lifestyle Coordinator and had specific responsibilities around:

- the residents' spiritual care assessments
- the provision of spiritual care for all residents
- availability to residents' family or care network
- availability to staff.

In some cases they made a separate spiritual care assessment alongside the social profile done by the Lifestyle Coordinator. Usually the Lifestyle Coordinator was responsible for documentation. In addition, they might:

- conduct liturgical/sacramental services
- liaise with local clergy
- provide one on one spiritual counsel to residents, families and staff
- provide support and advice around bereavement, transition and terminal care issues
- be available to conduct or assist at funerals
- conduct facility memorial services
- develop spiritual care protocols
- be involved in education of personal care staff

The hours worked varied from 12 hours per week to full time and some also had other roles in the facility. In addition all care staff – formally at times, but more often informally – support the residents' needs for spiritual care.

Model 3

Findings indicated that there were limited similarities in facilities using this model. Each facility had its own particular client profile. All had low care residents, two also had high care. For-profit and not-for-profit facilities, as well as small, medium, and large facilities, were represented in this model. Findings in two facilities indicated the development of access to external pastoral support in the form of local clergy, parish volunteers, and an honorary chaplain. In another facility, staff perceived the appointment of a Dementia Coordinator, whose role included supporting residents and families, as a commitment to general pastoral care. In this model the Lifestyle Coordinator had the major responsibility for identifying, assessing, documenting and facilitating the spiritual and religious care of the residents. In addition, and mostly informally, all care staff participated in the spiritual care of residents.

Structure of spiritual care service provision model 3

Generally the Lifestyle Coordinator had the major responsibility to:

- identify and assess spiritual care needs
- document
- and implement responses to the spiritual and religious care needs of residents
- and liaise with clergy

Facilities relied on external local religious and spiritual care resources from clergy and church volunteers. In addition, all care staff at times formally, but more often informally, support the residents' needs for spiritual care.

Model 4

Findings indicated only one of the 16 facilities required all staff to be responsible for spiritual care.

Structure of spiritual care service provision model 4

This meant that all staff took responsibility for:

- initial assessment of spiritual needs, with additional information from the Lifestyle Coordinator's assessment, and facilitating spiritual care and appropriate resources
- documentation and care planning
- ongoing identification of spiritual issues.

In Model 4, community links with local clergy were developed as spiritual needs were identified and general volunteers from the local council Volunteer Visiting Program visited residents.

These findings indicate that most commonly, across all models, the person directly responsible for initial assessment of a resident’s spiritual state and needs, ongoing identification of spiritual issues, facilitation of appropriate response and service provision to the resident, as well as for documentation, was the Lifestyle Coordinator.

Other variables

Facility auspice and vision/philosophy

Table 7 shows that, overall, 12 facilities were auspiced directly by or acknowledged an affiliation with a religious/faith/cultural tradition.

Table 7: Facility auspice

Auspice	No of facilities
Christian tradition	9
Faith/cultural tradition	3
Charity sector	2
Commercial sector	2

Of these 12 auspiced/affiliated facilities only five overtly expressed the influence of their affiliation and mission/vision statement. Table 8 shows the model used by these facilities and the number of facilities using each model.

Table 8: Influence of affiliation

Model	Overt expression	No. of facilities using model
Model 1	1 (pastoral approach/ facility ethos)	6
Model 2	3 (influence of affiliation)	5
Model 3	1 (influence of affiliation)	4
Model 4	0	1

In addition, of 16 facilities, six facilities expressed a commitment to wholistic care and five facilities expressed a vision that encompassed integration and/or participation in the life of the local community.

All facilities had pertinent themes in their mission/vision/ethos/philosophy statement supporting the provision of spiritual care services, such as:

- valuing each unique person and maintaining their options, dignity, and rights
- creating a caring compassionate community
- providing an environment of quality care within a wholistic ethos, and offering life enhancing opportunities

Facility focus and client characteristics

Across the 16 facilities, while in most women far outnumbered men (60–80% of residents), findings also indicated various client groups were a particular focus for a facility. These groups included:

- (2) general care to anyone who had an appropriate ACAS assessment
- (1) religious and cultural, including specific dietary requirements
- (1) cultural and linguistic requirements
- (1) disabled, intellectually and visually impaired

- (3) dementia specific care
- (8) financially, socially, physically, emotionally disadvantaged (2 for men only)

The following variables for resident characteristics were specifically identified and allocated to three categories. While these characteristics may exist in more facilities, Tables 9, 10, and 11 show the number of facilities identifying and naming the following variables in addition to any stated denominational affiliation or particular spiritual and religious beliefs.

Table 9: Cultural and ethnic variables

Stated variables	No. of facilities
Multicultural/ethnic	7
Multilingual	4

Table 10: Diagnostic variables

Stated variables	No of facilities
Dementia	7
Psychiatric diagnoses, including schizophrenia and personality disorders	4
Dual/multiple physical and psychiatric diagnoses	3
Intellectual disability	3*
Sensory impairment	4
Depression	1

*includes 1 facility with a number of clients under 65 years

Table 11: Psychosocial variables

Stated variables	No of facilities
Isolated, socially challenged	5
Poor social support/care networks/family	4
Poor cognitive abilities	3
Cognitive and behavioural problems	2
Singles	2
Migration or issues related to traumatic life experience	3
Poor communication skills	2

Proportion of concessional residents

Across the sixteen facilities, 50 per cent catered for the most socially and financially disadvantaged residents. Nine facilities maintained a 35–80 per cent proportion of concessional residents. The remaining seven facilities maintained a higher proportion of 91–100 per cent of concessional residents. The latter group represented five organisations and as Table 12 below shows the distribution across the range of models.

Table 12: Facilities with different proportion of concessional residents by model

Model	Percentage of concessional residents	
	35– 80%	91–100%
Model 1	3	3
Model 2	2	2
Model 3	3	2
Model 4	0	1

Range of other services on site and offered by the parent organisation

Twelve facilities, representing nine organisations, offered either health sector services or additional aged care services which could be utilised.

Ageing in place

Most staff from low care facilities, while they spoke about the facility ‘being the residents’ home’, acknowledged that comprehensive ‘ageing in place’ which provided terminal care could not always be offered due to staffing constraints. This related to staffing levels, as well as access to, and availability of, professional skills required to provide the full and appropriate range of palliative care services to meet client needs.

Dimensions of spiritual care

Range of religious traditions and spiritual perspectives

Across the 16 facilities six religious traditions and spiritual perspectives were identified: Hinduism, Buddhism, Islam, Judaism, Christianity and agnosticism. In one facility that named Christianity, eight Christian denominations were identified. The most common resident mix was represented by six facilities whose residents were predominantly identified as Christian.. In some facilities up to 50 per cent had no stated religious affiliation, faith tradition, or spiritual perspective, and had been assessed and recorded as ‘nothing’, ‘no preference’ or ‘has own spirituality’.

Access to a dedicated worship or quiet space

Table 13 indicates the types of space available to for spiritual care and support.

Table 13: Facility spaces available for worship or privacy

Space type	Description	No. of facilities
Space available for worship and private devotions	• on-site dedicated worship space	3 facilities
	• on-site parish church	1 facility
	• access to parish church or chapel	2 facilities
Space available for private devotions and family privacy during palliative care	• designated small ‘quiet room’	5 facilities
Space available for worship services	• communal lounge	8 facilities

Of the eight facilities in the last group, three also had additional space available for private devotions and family privacy during palliative care.

Access to a local parish church was viewed as positive in maintaining faith community links but difficult for those with mobility problems. A parish church on site promoted ease of access and community connectedness for those who utilised it. Where an on site dedicated space was available the feedback was unanimously positive, in terms of access and usefulness. For some worship in the lounge was perceived as informal and welcoming. Staff spoke favourably when small ‘quiet rooms’ were multipurpose, adaptable for use by different faiths, and offered easy access for residents, their families, local clergy and others

One issue raised was that the ‘lounge’ was often not big enough for large communal gatherings such as a memorial service. For other facilities, adapting a lounge presented difficulties such as not being private, interruption of other residents’ social environment, risk of worship service being disrupted due to socialising residents or the sound of cleaners vacuuming, which was distracting, and impacted on the capacity for intimacy. When there was no alternative space for residents to use, staff spoke of residents possibly feeling unable to leave when in other circumstances it would

not have been their wish to attend a worship service. Also named was the need to move furniture and that was viewed as a complex occupational health and safety issue.

Understandings of spirituality, spiritual needs and pastoral care

Members of each facility's discussion group expressed a variety of views and understandings of spirituality, spiritual care and pastoral care. They were so diverse across all models that no 'typical' correlation was found to exist. (See Appendix 3 for the full range of responses by defined item in the three categories.)

Identification and assessment of a person's spiritual state and spiritual needs were influenced by, and ultimately depended on, the subjective knowledge and understanding of facility staff. In turn, assessment guided the development of resources and provision of spiritual care.. See Appendix 3 for the full range of responses by defined item in the three categories.

The diversity of understanding was highlighted by the fact that there was no single understanding common to all 16 facilities, in spite of eleven facilities having access to a 'trained spiritual care worker'. Of the terms explored, 'pastoral care' was clearly the most familiar – but even there, the most widespread understanding was expressed by staff from only eight facilities out of a possible 16. This suggests the potential for inconsistency and inaccuracy in the identification and assessment of spiritual needs in aged care. The responses are summarised

Spirituality

The most common understandings of spirituality encompassed existential meaning making and a person's core identity. For example,

- people in seven facilities expressed an understanding of spirituality as: the deepest meaning, gives value and hope, and allows the resident to make sense of their life in the final stages; this is in tension with the reality of ageing and loss

Spiritual needs

The most commonly expressed understandings of spiritual needs embraced a more wholistic perspective, for example:

- 6 facilities expressed understanding:
 - a) spiritual needs encompass the needs of the whole person
 - b) spiritual needs are part of wholistic care
 - c) spiritual needs may include religious needs but also the broader relationship between a resident's physical, mental, emotional, and spiritual well-being, their mind, body and soul

Pastoral care

Most familiar to interviewees was the language of pastoral care, with the general understanding held that it was limited to religion, predominantly Christian, and should be primarily provided to residents by the church or faith representatives. The most common understandings of pastoral care included:

- 8 facilities:
 - a) pastoral counsel in response to life events
 - b) liturgical and sacramental rites
 - c) provision of pastoral services by church/faith authorities through ordained or lay representatives.
 - d) primarily an expression of religious support.

Across the 16 facilities, findings related to pastoral care understanding pointed to the diversity of care staff understanding underpinning the identification of spiritual needs and influencing care provision and practice. Pastoral care across facilities included:

- having a variety of care staff, volunteers and clergy available, with a system of referral for further expertise
- spiritual life review
- personalised one-on-one care in addition to group worship
- use of symbol, ritual, music, food and the senses
- awareness specific pastoral needs could be triggered by events such as birthdays, religious celebrations such as Christmas, anniversaries or the death of a resident, family/staff member or friend, or remembering prior traumatic experiences.

General observations from interviews and findings on staff understanding of spirituality, spiritual needs, and pastoral care related to a need (and in some cases desire) for increased knowledge. These observations include:

- Interviewees either had a strong understanding of what spirituality and spiritual needs may encompass, or found it a challenging, yet stimulating, concept to think about.
- Some responses were very narrowly focused and even when an interviewee's expressed understanding of spirituality went beyond religion, this was not always translated into practice in the facility.
- Pastoral care requires sensitivity to a resident's preferred communication style.
- Pastoral care could involve personal and confidential issues.
- Pastoral care needs of families (if recognised) are more often considered than the pastoral care needs of those with a dementia.
- No facility considered pastoral care support as a dimension of the care plan for a resident with depression.

These findings suggest that the aged care sector may be over-reliant on, and over-confident about, the personal knowledge and understanding of staff in relation to the practice and provision of spiritual care. Such over-reliance holds the potential to contribute to spiritual poverty which may lead to communal and social isolation and subsequent negative health outcomes. In the case of those already on the margins socially and communally prior to admission to a residential aged care facility, the provision of spiritual care may be even more critical to their health and well-being.

With regard to the additional interview and analysis process used with the four BSL facilities for a confidential Residents and Relatives Questionnaire, it had been anticipated that non-staff assistance would be available to assist those with visual or writing difficulties. Unfortunately a very poor uptake, and poorer return rate, resulted. This may have been due to a number of difficulties such as:

- the complexity of the questionnaire requiring a level of education most cognitively able residents didn't have
- the fact that many residents have some cognitive impairment
- the fact that non-staff assistance could not readily be arranged
- the practicalities of connecting with a resident's care network or family when many residents don't have such visitors or their visits are out of hours.

Consequently the little material that was gathered was not statistically viable nor was it possible to draw out any consistent or major themes.

Spiritual care wish list

BSL staff interviewed identified specific needs related to the provision and practice of spiritual care. The spiritual care 'wish list' indicated current areas of BSL staff interest and/ or concern for:

- those with a dementia and their families
- complex transition issues, including death, guilt, family conflict, challenging behaviour.

The staff expressed a desire for training to:

- increase understanding about pastoral care
- develop skills for primary spiritual care provision
- increase general knowledge related to grief and loss, funeral directors, psychology.

Staff requested:

- more skilled volunteers for one-to-one spiritual care for residents
- dedicated worship space; quiet space for overnight stays; closed-off larger lounge for religious services; designated quiet space (in particular, they mentioned the pros and cons of Fitzroy chapel; desire for quiet space at Sumner House)

Considerations re volunteers included:

- promotion of pastoral care volunteer program
- development of community partnerships
- development of a team of volunteers to work with the chaplain (while acknowledging that attracting volunteers to this sector is challenging)
- volunteers' limitations related to OH&S regulations.

General comments related to 'homeliness' of facility and external resources:

- 40 residents a good size
- difficult to get support from local denominations – too busy/'you have a chaplain'
- would like residents to be able to go to local churches of choice
- local Anglican input invaluable – needs to be better resourced and acknowledged by BSL.

Discussion

The findings of this investigation into current models of spiritual care provision in residential aged care reveal a diversity of infrastructure, understanding, internal and external spiritual care resources, and subsequent provision of spiritual care within individual facilities. In addition the literature review reveals the paucity of documentation on models of spiritual care in aged care. The following discussion will comment on the strengths, weaknesses, and relevant issues raised by each model identified. It will also comment on the findings related to the spiritual care understanding, knowledge and skills base in residential aged care facilities and supporting community resources. Finally it will suggest possibilities for best practice future directions, particularly regarding further research.

A comparison of the infrastructure of models identified with models in the literature review indicates that most facilities aspire to MacKinlay's (2004) model of a collaborative venture between parish and aged care facility, where 'the place of pastoral care in the total package of care is clearly acknowledged and serviced by facility and parish joining in partnership to provide best practice'. However in only five facilities was 'the knowledge base of facility based specialist aged care chaplains ... used to optimise pastoral care, while the human resources of the parish are utilised, providing a real service component'.

Across the 16 facilities, research findings indicated that the person most commonly responsible for the initial assessment, ongoing identification of spiritual issues, facilitation of appropriate response, service provision to the resident, and documentation, was the Lifestyle Coordinator. A resident's spiritual profile is not the same as a resident's social profile, though they are interrelated. The social profile gathered by workers includes religious affiliation and practices but this in no way provides care planners with an understanding of the resident's spiritual perspective or current spiritual state. The professional knowledge and personal capacity of staff to identify and assess spiritual needs is fundamental to the development of best practice. A further potential gap in spiritual care exists where a resident has no stated religious affiliation. These comments are particularly relevant to *Models 1 and 3*.

Although *Model 1* facilities had a trained Spiritual Care Worker at organisation level, it is difficult to ascertain their influence within a facility in relation to accuracy of assessment, quality of spiritual care provision, development of resources, as well as documentation and funding. Most *Model 3* facilities, while having no trained worker on staff, were supported by local clergy, parish volunteers, and other community links. While reliance on external providers is common to all models, issues might arise if this is a loosely structured arrangement. Residents' spiritual needs, and responses to them, would depend on the facility's relationship with clergy and other external resources, and subsequent availability, as well as their interest in, and understanding of, both ageing and spiritual care. The risk is ad hoc, inconsistent identification and assessment of spiritual needs, and inadequate or inappropriate spiritual care responses.

In *Model 2*, the facility based Spiritual Care Worker was responsible for the initial assessment and direct provision of spiritual care and then liaised with the Lifestyle Coordinator who was responsible for documentation. This model has the potential to ameliorate concerns related to the initial assessment, including where there is no stated religious affiliation or stated spiritual perspective. It also offers residents access to a trained pastoral worker who, as a staff member, is a familiar and regular presence on site. However, the weakness of this model is in the area of documentation of spiritual care issues, provision, and future care plans, all of which appear to be the responsibility of the Lifestyle Coordinator. It is unclear why the facility based Spiritual Care Worker is not responsible for documentation and this would be worth further exploration.

One facility in *Model 2* had a facility based Spiritual Care Worker who was accountable to, and supervised by, an organisation level Spiritual Care Worker. This provided an appropriate

professional structure for the pastoral worker, although there is no evidence that this translated into improved spiritual care documentation, or enhanced the knowledge of spiritual care and its practice, for the Lifestyle Coordinator. Accountability and supervision in spiritual care practice include practice related to documentation and care planning, as well as the development of spiritual care resources and achieving funding.

Where all staff are required to participate in the spiritual care of residents, especially *Model 4*, it is essential to consider the diversity of views and personal understandings of spiritual care among staff. Without a shared understanding and adequate guidelines, the spiritual care provision may result in inconsistent or inaccurate assessment, ad hoc, inadequate or inappropriate provision of spiritual care to the ageing person, and a compromising of residents' spiritual health and well-being. Intentional care of the human spirit cannot be developed in a facility without some basic shared understanding and staff with an ability to at least identify a spiritual need and facilitate an appropriate response or referral.

It is unclear from the findings whether all appointed spiritual care workers are paid. In the case of both external and internal spiritual care workers it is also unclear whether they are required to meet a minimum standard of training. The findings are also unclear regarding issues, at both organisation and facility level, around accountability, professional supervision, and the development of guidelines for spiritual care practice. These issues are raised for future investigation.

Roles and skills required in relation to models

The skills and knowledge needed to perform the range of functions required by the different models of spiritual care varied greatly. Only two models acknowledge the need for specialist skills. In *Model 1*, in addition to professional knowledge and skills in spiritual care, knowledge of spiritual issues and the ageing process, management, research, volunteer recruitment and training, staff support, and more would be required. *Model 2* presents similar requirements. However spiritual care workers in *Model 2* have less organisation/management duties and more direct care opportunities in the facility improving both access and quality in relation to spiritual care provision.

Shared understanding at facility level

The findings related to understandings around spirituality, spiritual needs, and pastoral care raises some considerations. The fact that not one consistent understanding is evident across all facilities suggests that serious commitment to this area of care has not occurred in the aged care sector. With such inconsistency we might ask, how can we know that spiritual needs are being identified? And subsequently, how relevant or limited are the resources each facility is developing? In addition, there appears to be an absence of any collegial and systematic endeavour by mainstream churches to develop this area for the ageing in care.

Position descriptions in the aged care sector generally include some requirement to provide spiritual support to residents and their families. The findings of this investigation suggest that a review of knowledge and understanding of spiritual care and the spiritual themes and tasks of ageing may well reveal a lack of consistent competence across the aged care sector.

The findings of this investigation highlight the importance of developing training for aged care workers that has a capacity to engage them in this area of learning without imposing a particular religious view. The aged care workforce is culturally diverse and religiously pluralistic – as are residents and families. Frequently terms such as spiritual awareness, spiritual awakening, spiritual well-being, spiritual health, spiritual development, or spiritual growth, are now used in daily language. There are other, not so familiar, terms that apply to the spiritual state such as spiritual malaise, spiritual distress, spiritual crisis, spiritual fatigue, spiritual vacuum, spiritual identity, or spiritual rigor mortis – these terms relate to spiritual poverty and may have some relevance when caring for the ageing. Spiritual care needs to be understood across a range of disciplines, cultures and religions. It is also important, for this discussion, to remember the vocational dimension of

spiritual care provision. There may be some workers who have neither the interest nor the aptitude for this area of care and this is an important consideration with regard to the quality of spiritual care and benefits to residents.

Best practice in spiritual care would promote a broad perspective with regard to non-physical care in aged care. It is clear from the findings that there is no explicit and consistent standard, or foundation, for spiritual care training in our multicultural and religiously pluralistic Australian society. The development of local, spiritual care training program options may support and enhance the learning of facility staff and facilitate the integration of this new shared knowledge into care practice. Psychogeriatricians and mobile aged psychiatry services have provided an essential mental health resource for ageing members of the community. The social model of care with its emphasis on lifestyle has been a welcome compliment to medical and clinical nursing care in aged care in recent years. Social profiles, psychosocial assessments, caseworkers, and clinicians have contributed greatly to enhancing the quality of life of many ageing people, including those with a dementia, in both residential and in-home care programs. In conjunction with the myriad of variables found across the facilities investigated one cannot ignore the dilemma faced by aged care workers when required to accommodate such complexity in assessment, care planning, and care provision. Spiritual care for aged care workers would encourage the development of self-care strategies enabling and strengthening their capacity for care within the facility environment.

Frankl (1987) made clear that spiritual distress is not a mental disease – it is a spiritual issue and needs to be identified and responded to as a spiritual issue. While spiritual care, pastoral counselling, or pastoral psychotherapy may be an adequate and appropriate response, it is in the best interests of the client for this to occur within the context of professional consultation with the care manager and/or a resident's medical doctor. It is also important to consider the skill level of spiritual support resources and possible interventions, particularly when in conjunction with a medical diagnosis of clinical depression and/or medication. With the high incidence of depression found in facility residents, and in light of the fact that depression is not a normal part of ageing, the competent provision of spiritual care has the potential to contribute to increased quality of life, better mental health, and overall enhance resident well-being. This particular issue offers scope for research.

In conclusion, best practice may require a facility based, trained spiritual care worker who is appropriately placed to develop an in-facility spiritual care program and provide direct assessment, care, and care planning. It is important for spiritual care positions to be integrated into a multidisciplinary approach to wholistic care enabling and ensuring competent assessment, as well as care planning in spiritual care, and ethical input when required. Particular consideration of external resource development could be done in consultation with a Lifestyle Coordinator to maximise community links and strengthen facility integration of spiritual care. In addition to the in-facility spiritual care worker, for the large organisation with multiple facilities, a coordinator of spiritual care at organisation level would enable the maintenance and development of continuous improvement across all facilities and provide a structure for supervision and accountability. Another approach might be the development of 'teams of spiritual care professionals', experienced in care of the ageing, and available to a number of facilities in a particular geographic location.

In conjunction with these possibilities basic spiritual care training for aged care workers and potential spiritual care volunteers could be offered. Any movement towards best practice will need to begin with the identification of a resident's spiritual needs. best practice might also include an emphasis on research for continuous improvement. However, consideration of best practice remains speculative unless adequate funding is made available and further research is done.

The findings of this investigation point to a need for the development of pilot service delivery programs, based on competent identification and assessment of spiritual needs and care planning, which concurrently include pilot training programs for staff, and subsequent evaluation. The findings further offer a point of departure for such pilot programs. With a high incidence of

depressive symptoms evident in those ageing in residential aged care facilities, the findings of the Challenge Depression Project and the imminent introduction of the Aged Care Funding Instrument (particularly ACFI 9: Depression), provides an opportunity to professionally integrate spiritual needs identification and assessment into care practice and care planning. Finally, knowledge of human spiritual needs combined with intentional care of the human spirit is a fundamental aspect of wholistic care. Intentional care of the human spirit acknowledges, and gives a place to, the spiritual dimension of the human person.

Implications

For the sector in general

Aged care guidelines related to spiritual care

It is important, when considering the development of spiritual care to take into consideration the policies and standards of the Australian Government. Regardless of whether funding guidelines place the emphasis on documentation, care provision, care planning, or identification of needs, one cannot document what one has not identified. With regard to spiritual issues and needs arising for the ageing person in care, the application of guidelines for Professional Nursing Practice in aged care is informed by the Documentation and Accountability Manual, Chapter 2, and has particular criteria outlined under 2.2.2 d. Spiritual State (DHA 2004a). The assessment criteria for this area suggest limited knowledge and understanding of the spiritual needs of the human person. The subsequent absence of commitment to funding, development, and research in spiritual care in the aged care sector is therefore not surprising. At worst the criteria contribute to the risk of spiritual poverty, and negative health outcomes, for the ageing in care.

General areas for consideration:

- spiritual issues, needs, responses, may contain, but are not limited to religious affiliations
- aged care worker position descriptions in relation to the identification and assessment of the spiritual needs of the ageing person, spiritual care planning and provision
- basic training in spiritual care and practice related to the ageing and increased personal awareness of spiritual resources for Nursing staff, Personal Care Workers, and those providing activities e.g. Lifestyle Coordinators
- promotion and development of training for spiritual care volunteers representing local and varied religious groups
- promotion of advanced training focusing on the spiritual themes and spiritual needs of the ageing, including Clinical Pastoral Education opportunities, for parish clergy, chaplains and professional spiritual care workers
- engagement with religious institutions, and those representing the arts, environment, and family/care networks to identify the roles they can play in responding to the particular spiritual needs of the ageing
- advocacy for an adequate government funding base for appropriate, competent assessment and response related to the spiritual needs of the ageing in care
- promotion of further research into spiritual care models in aged care and their application to particular resident groups and relationships with the community

For the BSL and its facilities

Implications for the BSL relate to the:

- effectiveness of the current BSL structure (model 1) for assessment of spiritual needs and delivery of appropriate and timely spiritual care to the ageing
- reviewing of aged care worker position descriptions especially related to expectations to identify and assess spiritual needs, or provide spiritual care and spiritual support to residents in the facility
- spiritual care needs of residents' families/friends
- ability of staff to identify/assess spiritual needs
- level of knowledge and skills of facility aged care staff for the development and direct provision of spiritual care, including spiritual themes and tasks in ageing
- level of knowledge and skills of facility aged care staff to develop adequate and appropriate internal and external resources for the provision of spiritual care

- spiritual care training needs of BSL aged care staff
- spiritual needs of aged care staff/volunteers
- development of BSL policy and guidelines for spiritual care practice in BSL residential care facilities including accountability and supervision
- consideration of spiritual needs and spiritual care practice associated with clients of other BSL aged care services
- advocacy and in the wider aged care sector, government, church and others to promote the development of standards for the specific practice of spiritual care in aged care
- promotion and enabling of further research

Issues arising related to models and future development of spiritual care:

- spiritual issues, needs, responses etc., may contain, but are not limited to religious affiliations
- careful consideration of 'wish list'
- the position of a BSL Spiritual Care Worker could involve coordination, training and supervision needs across more than one facility
- specific skills in addition to general spiritual care and support skills would be important for this position (may also include research skills)
- resident/families/staff access to direct support from adequately trained facility Spiritual Care Worker offers regular, familiar presence, increases potential for establishing effective spiritual care relationships
- depending on the number of residents and identified spiritual needs a facility based Spiritual Care Worker may be employed part time with specific in-facility functions and development of external spiritual resources
- importance of accountability and supervision guidelines for all professional Spiritual Care Workers and any general staff involved in spiritual care of residents
- early development might include promotion of continuous improvement related to guidelines and training standards for the practice of spiritual care to the ageing
- importance of facility based Spiritual Care Worker(s) being a part of the multi disciplinary team with specific responsibilities
- specific knowledge of the ageing process, psychosocial development theory, spiritual needs of the ageing, in addition to general training in spiritual care and support skills, would be important for a Spiritual Care Worker position in aged care (may also include research skills)
- an alternative could be to utilise the lifestyle coordinator position and require additional knowledge and training in spiritual care development and provision however, requirements for supervision or staff support related to the provision of spiritual care (including ethical input) may be inadequately met at facility level
- there was an identified need for consistent, shared knowledge, development and training of aged care staff/volunteers at facility level
- development of any model for spiritual care would require management support and encouragement, particularly at facility level, to enable the integration of a new and shared understanding
- in addition further research, especially in facility trials and evaluation of pilots, would engage the participation of staff in the development and integration of spiritual care in their facility – this could be viewed as a supportive intervention for organisational change as it would encourage facility staff to take some ownership of the program and potentially ameliorate any resistance

Postscript

At the completion of this report it was noted by the Project Committee that the concept of 'faith', and the research into faith stage development done by James Fowler (1984), had not been explored. The following is a brief overview for further consideration in relation to spiritual care and spiritual poverty in aged care.

Pia Sim,

29 September 2005

Research into faith stage development across the lifespan by James Fowler (1984) integrates the insights of human developmental stage theories, particularly Erikson, Kohlberg, and Piaget. Fowler tells us faith is not only dynamic, it is a universal human experience. He also makes a distinction between the structure of faith (stages and ways of knowing) and the contents (beliefs) of faith.

Fowler (1984) investigates faith, as a generic and inherent dimension of the human condition, and its development across the lifespan. Key findings identified (pp.48–75):

- There are seven stages of faith: primal, intuitive-projective, mythic-literal, synthetic-conventional, individuative-reflective, conjunctive, and universalizing.
- Faith stages are not 'attained' or 'realised' – they are 'a way of being on pilgrimage' and 'not primarily matters of the *contents* of faith'.
- Each 'stage' is qualitatively different and widens the 'inclusiveness of the circle of those who count as neighbour'.
- Many people 'equilibrate' at stage 4 (which generally develops around adolescence) and subsequently 'move through the life cycle with a set of tacitly held, strongly felt, but largely unexamined beliefs and values'.
- Faith stage transitions alter the structure of one's knowing and valuing.

People often say they have faith in 'the system', 'the medical profession', 'in God', 'in a higher power' – faith in 'the contents'. In faith stage development theory, faith is the inherent '*something indestructible*' that holds what we believe to be 'a centre of value, an image of power, or a story that transcends us as individuals and binds us together with others' (Fowler, 1991, p.102). Human life, so often marked by suffering and struggle, may present a 'crisis of faith'. This happens when the contents of faith no longer make sense or sustain us in life. Faith stage development theory suggests that we try to discover and create new meaning from the contents (beliefs) that no longer sustain us as we previously understood them. A 'crisis of faith' can occur in conjunction with life transitions related to age/stage development, situations, circumstances, events, persons, and issues of loss.

The 'contents' of faith shape and inform attitudes, thoughts, and behaviours, toward self, other, God, and the world, to become an expressed and articulated spirituality. 'Religious' faith includes spiritual practices such as regular contact with a 'community of believers', participation in the rituals, liturgies and sacraments of the tradition e.g. Judaism, Hinduism. Spirituality is the practice of faith. This leads to consideration of, for example, Aboriginal spirituality and the importance of reflection on questions such as: Do older indigenous Australians experience a 'crisis of faith' when unable to discover or create new meaning from their beliefs?

Faith, as a dynamic human developmental process, is experienced across the lifespan and across cultures. It is a critical factor influencing both *care recipient* and *caregiver* and warrants consideration in relation to spiritual care and spiritual poverty in aged care.

Appendix 1 Project brief

REVIEW OF CHAPLAINCY AND RELATED SERVICES AND THE DEVELOPMENT OF HOLISTIC CARE FOR BROTHERHOOD OF ST LAURENCE AGED AND COMMUNITY CARE SERVICES

The Aged and Community Care area of the Brotherhood wishes to undertake a pilot 12-month action–research project aimed at establishing agreed models to provide appropriate holistic care for all aged residents in accommodation and community care centres provided by the Brotherhood.

The project will focus on the following concerns and possibilities:

- How best can residents be encouraged and supported, whatever the nature of their spiritual experience, commitment and journey?
- Which dimensions of holistic care of residents are integral to the job descriptions of existing staff? How might these be better evoked? Are there specific forms and aspects of personal ministry needed to achieve such care that are beyond the capacity or duties of existing staff? From what source might these be found: generalist or specialist clergy? designated professionals? trained volunteers? within or outside the facilities or both?
- What relationship can/should exist between the residents and staff of the Brotherhood’s facilities and the surrounding churches (particularly but not only Anglican or ecumenical Christian ministry groups), local bodies of whatever faith, and other relevant community-based providers of aged care services?
- Doing a definitive mapping exercise of current provision for holistic care in all accommodation centres, delineating areas of potential gap and under-provision, overlap or duplication.
- Giving attention to the major issues around death and bereavement, e.g., establishing appropriate funeral policy guidelines; developing protocols for handling concerns about funeral expenses for residents and other users of aged care services who do not make any provision for such costs.
- Consulting with other Melbourne-based aged care agencies (whether secular, religious or Christian) and undertaking a brief literature search to ensure that relevant models from elsewhere are reviewed.

In the development of an appropriate model it is vital that the process be informed by the Brotherhood’s vision and mission statement, and specifically the ‘one for the many’ criterion, so that the results will be relevant beyond the specific circumstances and needs of this project.

Appendix 2 Project Management Committee terms of reference

PROJECT MANAGEMENT COMMITTEE

REVIEW OF CHAPLAINCY AND RELATED SERVICES AND THE DEVELOPMENT OF HOLISTIC CARE FOR BROTHERHOOD OF ST LAURENCE AGED AND COMMUNITY CARE SERVICES

Terms of reference of the Project Management Committee

- 1 To provide advice, support, feedback and guidance to the chaplain/project officer who will be undertaking the review process.
- 2 To assist the chaplain to identify issues and possible solutions with regard to;
 - a) the best way in which all service users (residential and community care) can be encouraged and supported across the full range of their personal experience and needs, including their faith journey;
 - b) the nature of the relationship between the Brotherhood of St Laurence service users, the surrounding parish churches (particularly but not only Anglican or ecumenical groups), local communities of whatever faith, and other relevant community based providers of aged care services,
 - c) the current and future requirements of holistic care in Brotherhood of St Laurence Aged and Community Care Services. This would also focus on identifying areas of overlap with other services and under-provision or gaps in service provision.
- 3 To provide comment and direction as recommendations emerge, and to formulate strategies and timelines which address the issues identified.
- 4 To provide advice and guidance to the chaplain on the consultation process, in particular the individuals, groups and organisations that should be consulted and the process needed.
- 5 To assist in identifying sensitive or potentially sensitive areas and to offer counsel in developing effective strategies to deal with them.
- 6 To develop a communication strategy with the chaplain for outcomes and implementation.

Appendix 3 Understandings of spirituality, spiritual needs and pastoral care

Members of each facility's discussion group expressed a variety of views and understandings traversing the following range:

In descending order of frequency expressed across all interviews spirituality was conceived as:

- (7 facilities) what it is that is of deepest meaning, that gives value and hope and allows the resident to make sense of their life in the final stages and is in tension with the reality of ageing and loss
- (4 facilities) the passion that gives a resident a reason to live; it is whatever they identify as important: what makes them tick, their individuality
- (2 facilities) often of a religious nature which is very important but you still have spiritual needs even if you are not religious
- (2 facilities) that it is different and personal for everyone; and can encompass cultural, religious, social, culinary and musical aspects of the person's life
- (1 facility) if the person is non-verbal it may be expressed in their activities/behaviours
- (1 facility) reflecting an individual's identity and choices
- (1 facility) belief in a higher being; source of power, a force, an energy, outside of oneself
- (1 facility) beliefs/preferences, including but not necessarily religious
- (1 facility) beliefs about life beyond
- (1 facility) including one's spiritual strengths, for example the wisdom of learning to cope with difficult situations
- (1 facility) expressing being part of a community; unity with others, connectedness and belonging

In descending order of frequency, and expressed across all interviews, spiritual needs were summarised in the following ways:

- (6 facilities) they encompass the needs of the whole person and need to be seen as part of wholistic care; not just including religious needs, but also the relationship between their physical, mental, emotional and spiritual well-being; their body, mind, and soul
- (4 facilities) they are different and personal for everyone; and can encompass cultural, religious, social, culinary and musical aspects of the person's life
- (2 facilities) care for the inner self
- (2 facilities) staff also have spiritual needs and this is an expression of our shared humanity
- (2 facilities) are able to be met through activities or responses to behaviour if the person is non-verbal in their spiritual expression
- (1 facility) include a sense of enquiry, searching, seeking and growing
- (1 facility) are about finding empowerment to express needs, rights, and individuality

In descending order across all facility interviews, pastoral care was understood as:

- (8 facilities) primarily an expression of religious support; liturgical, sacramental, or religious counsel through life events, emanating from the church through ordained or lay representatives
- (7 facilities) part of wholistic care and responsive to the individual (they are the driver)
- (4 facilities) also relevant to those without a belief system, may be provided by staff, family, care network, or at times, a designated chaplain
- (4 facilities) supporting the person finding meaning in their life
- (3 facilities) general staff being engaged in pastoral care but it is the specific responsibility and expertise of the Pastoral Care Coordinator/Chaplain/Worker who has more dedicated time for one-to-one pastoral/spiritual care provision

- (2 facilities) that it is different to a friendly visit, because the intention is to connect with the spirit of the other person and is confidential: the Chaplain has expertise in connecting with the person's spirit, their essence
- (2 facilities) difficult to differentiate from emotional care even when ordained clergy provide it
- (2 facilities) part of a person-centred and gospel values approach
- (2 facilities) each person's need for pastoral care is individual and can encompass their need to maintain human dignity, their emotional spiritual or physical needs; whatever it is that they need
- (2 facilities) being there; listening, both for residents and families who are often in a state of continuous grieving
- (1 facility) helping prepare the resident, and their relatives and friends, to accept the reality of death and the end of life in as positive a way as possible
- (1 facility) that a variety of different people (i.e. staff, volunteers, ordained, lay) required to provide for the needs
- (1 facility) arising out of an attitude of charity and hospitality
- (1 facility) supporting the 'battery' that energises the person's passion; that keeps them going in life
- (1 facility) allowing the person to express their cultural/religious life in as full and particular way as they may desire
- (1 facility) that it can be a listening presence for life review
- (1 facility) the importance of someone being 'available' one to one when the person wants to talk about their past trauma or what is on their minds at that time so that the moment doesn't pass
- (1 facility) incorporating the power of symbol and food
- (1 facility) including provision of specific religious/sacramental needs, but also includes the social side – being a loved and valued member of a community
- (1 facility) affecting well-being and personal identity
- (1 facility) with regard to dementia sufferers, pastoral care is about what gives them fulfilment
- (2 facilities) has 2 dimensions: the religious aspect; and the social, emotional and spiritual; and can change especially when faced with terminal care
- (1 facility) is most effective one to one
- (1 facility) may be more needed at the time of particular anniversaries, e.g. birthdays, Christmas, as these are times when memories are prompted
- (2 facilities) can be provided through activities and practical support especially when the person is non-verbal

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