Mental Health Chaplains: Practitioners' perspectives on their value, purpose and function in the UK National Health Service

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Abstract: There is limited research into the value, purpose and function of Mental Health

(MH) Chaplains. Yet they are employed within National Health Service Trusts in the UK.

Eight MH Chaplains were interviewed to explore how they see their value, purpose and

function. The data were analysed using interpretative phenomenological analysis (IPA). The

data reveal the relational and spiritual/existential accompaniment nature of their work, which

is of transformative value, and which requires MH Chaplains to be able to offer 'hospitality'

and to work at relational depth which is akin to working with the spiritual dimension of clients

within counselling. Other roles include: religious care; offering a visible presence; running

groups; training; advocacy; connecting with other services; community liaison; committee

work; and staff support.

Keywords: Mental Health; chaplaincy; chaplain; purpose; function; counselling

Introduction

Morrow and Matthews (1966) defined the role of Mental Health (MH) Chaplaincy as being that of 'conducting worship services' and 'offering pastoral religious counselling'. By the change of the century, the role of the MH Chaplain had grown exponentially, with MH Chaplains offering: empathic listening for those who want to relate experience to faith; a reference resource for culturally competent care; a means of access to appropriate spiritual practices and resources; care for people in loss and bereavement; connections with faith communities; advocacy for patient, carer, staff and the organisation; knowledge of spirituality for coping, recovery and well-being; a partnership for dialogue regarding religious and spiritual matters; and complementary hermeneutics for human purpose, values and identity (Sunderland 2008, pp.121-128). More recently, Eagger, Richmond & Gilbert (2009, p.202) have stated that MH Chaplains take patient referrals, conduct spiritual assessments, run support groups and build opportunities for pastoral care – all of this delivered by a highly motivated workforce, but with little, or no, specialised training (Gubi & Smart 2013).

The role of MH Chaplains remains unclear, broad, and changing. Yet, there is limited research into their value, purpose and function (e.g. Carey & Del Medico 2013; Gubi & Smart 2013) whilst being employed within several National Health Service (NHS) Trusts in the United Kingdom, where the importance of working with the spirituality of MH patients has been acknowledged as crucial in Mental Health care (Gilbert and Nicholls 2003; Mental Health Foundation 2002; Swinton 2000). The aim of this research is to tentatively ascertain what the value, purpose and function of a MH Chaplain is, through the perspectives of MH Chaplains.

Method

A thematic analysis was conducted of eight participants' descriptions of their value, purpose and function as MH Chaplains. Participants were chosen from those who responded to an advertisement in 'The Newsletter of the Mental Health Resource Group of the College of Health Care Chaplains' (Winter 2012/2013: 6). The selection process was conducted on a

first-come, first-serve, basis. Interviews were semi-structured and were digitally recorded and transcribed. Written consent was gained at the interview stage and after each participant had read a copy of the transcript of their interview, to verify its accuracy. Interviews were conducted in a public, but confidential space, following lone-working procedures. Ethical approval was granted by the University of Chester. Participants were able to withdraw at any time without prejudice. The data were stored electronically and encrypted, and will be destroyed after five years in keeping with the Data Protection Act (2000). The researchers (one of whom is a Lead MH Chaplain, and the other is a Professor of Counselling who is an ordained priest) were keen for the participants' voices to be heard and represented in the thick data. Therefore, the data were analyzed using interpretative phenomenological analysis [IPA] (Smith, Flowers & Larkin 2009). To protect anonymity, the participants were coded to denote gender (F/M), and then given a number. The data regarding interviewees' role and purpose were divided into three superordinate themes: Contextual; Role; Characteristic. These were then divided into nineteen subordinate themes (see Table 1).

Findings

Table 1: Role, purpose and function of MH Chaplains

Superordinate Themes:	1.	Contextual	2.	Role	3.	Characteristic
Subordinate Themes:	1.1	Gender	2.1	Religious care	3.1	Different from other services
	1.2	Religion	2.2	Being alongside	3.2	Above and beyond
	1.3	Affiliation	2.3	Visible presence		
	1.4	Length of Experience	2.4	Running groups		
	1.5	Training	2.5	Encompassing diversity		
	1.6	Employer	2.6	Training		
			2.7	Advocacy		
			2.8	Connecting with other services		
			2.9	Community		
			2.10	Committee work		
			2.11	Staff support		

Superordinate Theme 1: Contextual:

Subordinate Theme 1.1: Gender: Six of the participants are female (F1, F2, F3, F4, F5, F6), and two are male (M1, M2).

Subordinate Theme 1.2: Religion: Seven of the participants are Christian (F1, F2, F3, F4, F5, F6, M2), and one is Muslim (M1).

Subordinate Theme 1.3: Affiliation: Of the seven participants who are Christian, three are ordained and licenced Priests of the Church of England (F2, F4, M2); three are ordained Ministers in the Methodist Church (F1, F5, F6); and one is a Quaker Elder who is 'of good-standing' in her Meeting (F3). The Muslim participant is a lay person from the Shia faith (M1), who is under the guidance of an eminent Shia Imam.

Subordinate Theme 1.4: Length of experience: The length of experience as a MH Chaplain for each participant is: F1, four years; F2, seven years; F3, three years; F4, thirteen years; F5, twenty-four years; F6, six years; M1, fifteen years; M2, twelve years.

Subordinate Theme 1.5: Training: Not one of the participants had any initial, formal, specific, recognised, training for MH Chaplaincy before they started their Chaplaincy work. 'Training' for the participants consisted of: training for Ordination (F1, F2, F4, F5, F6, M2) plus attendance on a number of short courses, day seminars, and at conferences, and 'conversations' with other MH Chaplains (F1, F2, F3, F4, F5, F6, M1, M2). Ordination training for F6 included clinical training for Chaplaincy (although not specifically MH Chaplaincy). As well as training for ordination: F1 had trained as a Person-Centred Counsellor prior to ordination, and then undertook a week's training in MH Chaplaincy after she had been involved with Chaplaincy for a year. F1 appreciated her 'Clinical Supervision' as an important place of training; F2 had undertaken an introductory course for new Chaplains and undertaken a placement in a psychiatric hospital during her ordination

training; F4 had undergone courses in basic listening skills and had helped out at a 'Listening Service' in her theological college. She had also undertaken a week's course as a Health Care Chaplain (which had only one session on Mental Health). However, she later undertook a Postgraduate Diploma in Spiritually, Health and Social Care which she found useful; F5 had regular, on-going, spiritual direction which she found helpful to her work; M2 had undertaken an 'Introduction into Health Care Chaplaincy' and 'An Introduction into MH Chaplaincy' which was put on by the Trust that he was working for. He then undertook a Master of Theology degree in Health Care Chaplaincy, which, although not specifically in MH Chaplaincy, provided a forum in the assessments and research dissertation, to reflect on his experience in MH Chaplaincy. Of those who were not ordained: F3 had undertaken a Certificate in Health and Social Care Chaplaincy, and was completing her Master's degree in Health and Social Care Chaplaincy; M1 used his Clinical Supervision as his primary training, but otherwise had no formal training. He had come into MH Chaplaincy through being an established faith representative who was known to a Chaplain.

Subordinate Theme 1.6: Employer: All of the participants are employed as MH Chaplains: F1, F2, F4, F5, M1 & M2 work full-time within various NHS Trusts; F6 works part-time within an NHS Trust; and F3 is full-time within a private, Christian-affiliated Hospital which takes NHS patients.

Superordinate Theme 2: Role:

Subordinate Theme 2.1: Religious care: Although spiritual care is often identified as being important in policy documents, the Chaplains were keen to identify religious care as something they offered, alongside spiritual care:

> *"…we are the ones who can offer prayer, blessings, reading religious scriptures, and make sure Ramadan is kept and Divali is noticed… the religious care aspect of communion… celebration of festivals"* [F1].

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"I make sure regular worship is available, so at Christmas and Easter we have services. I'm also responsible for funerals" [F3].

Subordinate Theme 2.2: Being alongside: Offering a transformative, relational, presence was the largest theme to emerge from the data. M1 very much saw his role as one of servanthood:

"I feel that the essence of chaplaincy is servanthood. To serve patients in whichever way one can. To encourage them to remember that they too are people who can recover, serve a useful function and be valued… I just know I must be of service to them, I must do it and do not want to stop doing it" [M1].

Other Chaplains described the transformative presence that they offer as: *"…sitting alongside people; being with people, with staff, with carers, with service users"* [F1]; as enabling people to go *"to the core of their humanity… We talk about meaning and purpose… We're not there to sort it out, but what I am there to do is to hold it… to meet that person in their despair and just be with them."* [F3]; as offering compassion and forgiveness, which can often get overlooked in other aspects of the Health Service [F4]; as offering hope through 'presence': *"just sticking with it, and trying to be there with them at those darkest places.... To sit with somebody in a conversation, to acknowledge how impossible it all is. And that person and I share something that is very human";* and the opportunity to connect with people at a very deep level *"which doesn't happen in other forms of chaplaincy actually"* [M2].

Subordinate Theme 2.3: Being a visible presence: Offering a visible caring presence on the wards was part of F2's work: *"To actually go out on wards on a more regular basis and just simply to be there, just spend time getting to know the patients who are there and seeing how their needs might be better catered for"* [F2].

Subordinate Theme 2.4: Running groups: Several Chaplains ran creative, therapeutic-type groups and activities such as meditation groups, love and kindness groups, or spiritual exploration groups [F2].

"We made a temporary labyrinth last year, and we've mown a permanent one in one of the hospital lawns. That's a personal interest but I see it as having huge spiritual benefits. Patients walk the labyrinth, sometimes in conjunction with some other form of therapy. It feels a little on the edge, but for me it feels absolutely right to be using an ancient spiritual practise, bringing it into a hospital setting… The gardening project is something that I've been involved with which I see as being very beneficial. It encourages patients to do gardening. So we might be talking, or we might be tree-planting with patients. So it's the kind of job where I can bring my whole self into the job" [F3]*.*

"We used to run some groups in the community, exploring your spiritual side… that was an opportunity for people to do what they might not be able to do anywhere else…, in a safe and open environment, explore these things" [F4].

Subordinate Theme 2.5: Encompassing diversity: Many of the Chaplains (e.g. F1, F4, F5) valued the opportunity to learn about other faiths, and to find common ground, or spiritual resources, from each tradition to enable better support and accompaniment:

"What are the underlying spiritual questions for somebody when they are experiencing psychosis? Or what are the common experiences spiritually for people when they are profoundly depressed and isolated from God? And actually, what resources do all traditions have to help to relieve some of the distress, or to enable a chaplain to be there alongside people in the midst of it?" [F1].

Subordinate Theme 2.6: Training: Several Chaplains offered training as part of their role (e.g. F1, F2, M2):

> *"I felt very much part of my role was in developing awareness-type training for communities outside of the mental health world, because they would realise that a lot of people in their communities, be they faith communities or whatever, perhaps were engaging with mental health services in some way or another, or they had people there and they just didn't know how to deal with them"* [M2].

Subordinate Theme 2.7: Advocacy: Being an advocate at a number of different levels for MH patients was seen as an important part of the role by some (e.g. F1, F4, F5):

> *"Being a voice - whether that's a voice that not necessarily challenges the status quo, but kind of offers an alternative view to the status quo, or can… wants to have some input into policy-making, and wants to be an advocate for spiritual care of service users. So, there is a kind of campaigning element there… I am passionate about service-users being take seriously, their spirits being heard and informing services and the provision of the care they receive…"* [F1].

Subordinate Theme 2.8: Connecting with other services: In the NHS trust that F1 worked for, *"the Chapel is being used for art and music therapies three times a week"* [F1]. In this way, the Chaplaincy is integrated into the wider hospital provision.

Subordinate Theme 2.9: Working in the community: Some of the MH Chaplains worked in the community supporting others with MH problems, or educating others about MH difficulties (e.g. F1, F6).

"Also to be a link to local religious communities, religious leaders and others in the communities that have a stake in mental health care and that goes two ways and I do a lot – and I lived on partnerships so the NHS, my secondary mental health partners with the local church to do meditation, mindfulness, not just for service users but for the community so we become a point where service users find their way back into the community, but not in an open house, but in a structured, evidence based way" [F6].

Subordinate Theme 2.10: Committee work: F2 and F6 contributed to, and sometimes chaired, NHS Trust committees.

Subordinate Theme 2.11: Staff support: Many of the Chaplains regarded the support of staff to be an important part of their role (e.g. F5, F6):

"Often it's quite young nurses within the profession, or whatever, who are just coming in. I give them a bit of support in what they doing, and have an appreciation of what they are doing" [F5].

"I like being able to do the one-to-one, the pastoral work that comes from my colleagues – occupational therapists, to consultants, to social workers – I like that very much. I like being a support to them" [F6].

Superordinate Theme 3: Characteristics

Subordinate Theme 3.1: Different from other services: Many of the MH Chaplains valued the reality that they were seen as being able to offer something different, yet complimentary, to other aspects of the NHS (e.g. F1, F3, F5, M2]:

"We are part of the service, but I think we are often perceived by the staff, carers and service users not to be quite part of the service. What I call 'betwixt and between

places… therefore people give us an enormous amount of trust, which I think is a very deep privilege, and very humbling what people entrust to you. And they think they trust us because they have perceived us to be fully imbedded in the system and yet not… it's quite a difficult thread really" [F1].

"It's about sharing that space… being with that person in that place of despair. Other disciplines can't do that, because there is an outcome they need to address. I had a situation where there was a woman who had tried to hang herself several times that day, and she just told me her story, and with tears in her eyes she just talked and talked, and I did absolutely nothing. I was just there with her. I was just present. That's a typical chaplaincy story, of not talking - just listening. But it's more than just listening, it's a deep encounter with an individual and I think that's very particular" [F3].

"They [the patients] *are receiving endless instructions on what they must do next. And the idea that somebody can come and enjoy their company without an ulterial motive, but simply to be with them. I find that very fulfilling. And they do really respond tremen dously to that"* [F5].

"It's a kind of deep, spiritual, personal level there is that engagement. It doesn't happen in general health, and I kind of realise now that massive difference. They [the rest of the NHS] *don't engage with people on those levels at all…"* [M2].

"It's about a person being a whole person and provision of a space that is different than the every other space of the professional healthcare professions are providing. So, what OT's are providing, psychologists, doctors, nurses, they are all equally valid. I am not saying we are specialist in… or what we are doing is the best. It's not that - but that's what they are offering - and what I think the mental health chaplain brings to that multidisciplinary team is a kind of, to the team, but also for service users, is always,

always about the person themselves. You know, what is this person saying about what is happening for them at the moment? How are they making sense of what's going on for them? It's about their identity - who they are. Yes, we need to know can they manage it, but when they go home, what are their skills in terms of cooking all these other things? The OT, yes we need. There might be some psychological help and tools. Yes, obviously medication is a big one, and of course they need nursing care. But I think the one thing we could keep on bringing is space and time, and I think we are very lucky to be able to that. But we can do that, we can sit down with somebody for an hour and just say: 'how you doing today?' And we haven't got to… we haven't got the agenda that we've got to go through. So at the end, you know, we will be able to find out, are they able to cook or what their personal hygiene is like, or are they taking their medication? You know it's something about the creation of that space to sit with another person: 'how is it going, you know… what's going on for you?' How you start the conversation… and I think we became part of a kind of, you know, doing that for staff as well. You know actually, you know, staff just having opportunity to say who they are, and what their concerns are. What they are bringing to work from their home situation. Or their worry about the unemployment and the cuts, or their pressure they being put under with the paper, or from up-above, or staffing issues, or whatever it is… I think and with carers of course, I mean carers, just the strain and stresses… Really none of the people I mentioned would not be able to sit for an hour with a Carer, unless they are being asked to make an assessment. Whereas we are going without the agenda. Just being alongside people. And it sounds incredibly easy, but in fact it requires all of us, ourselves, to do that. Every part of ourselves to do that, particularly. I have been listening to some pretty harrowing stories, and I think there is... mental health chaplains are… it's a very strange place, that we, that we kind-of, that we are placed in" [F1].

Subordinate Theme 3.2: Above and beyond: Many of the Chaplains saw their role as going 'above and beyond' that which many other roles in the Health Service would do (e.g. F1, F3) :

"I got to see somebody in a group. She said, "Oh I really wanted to show you something… Where I used to live… Where I was evicted from… Really… and she said three years previously. It was behind us, but then she said you know we haven't got the time to do that, so we checked the staff and they said, yeah, and as we walking out of the hospital, across the cemetery, and she just said: "I am so angry". And I said, "is it not going so well, kind of thing". She said we were given a poem. I forgot what the name of the poem was... She said it was about 'you can be whoever you want to be. You could dream the dreams you want to dream, and you just have to believe in yourself'. And she said afterwards the OT on her ward kind of pulled her on the side and said they were going out. 'I really hope that poem, you know, kind of helped you today, because you are really bright. And you have got great potential, and if you just believe in yourself, you know you would be ok'. So we are walking, and she said: "How am I meant to be believing in myself?" I have lived where we going now, which is this block of flats near xx , a very good location. And it was a house that have left the legacy that it used to be there for the needy and vulnerable in xx. Long story how she ended up there, but she did end up there. She had a room, shared kitchen, shared bathroom, library facility and study. She lived there for thirteen years, and then a property developer came along and approached the housing association. It was all sold to a private landlord who developed it in a very prime place in xx [location name] and they were all evicted. Huge injustice! And she is now in a really grotty tower block, so far away. This was part of, part of, not the sole reason of deterioration of her mental health. And, so she is now unemployed, she lost her job, she lost her home. She is on housing benefits, and the problem of housing benefits. She suffers from paranoia, whole range of things, but what she was saying to me, 'I have spent thirteen years

putting my life back together after very difficult circumstances. I had a job, I have a place, and I thank God for all those things, every day. I used to walk across the park and I used to thank God for all the gifts he has given me. It's hard going but I got my life back together as a healthcare assistant, etc, etc. and these things, what have I done wrong? What, why is God angry with me? My OT just say, 'you got to believe in yourself and dream whatever you want to'. That's sort of powerful talk of those who have nothing. My choices are absolutely limited. How am I going to get into work?"' And what I am saying is it is the chaplain who is the one who hears that. You know, where else, you know, or who else would she have said those things? Would she have expressed the anger, both with God, with the system and with the OT? I think it might be an example of what mental health chaplaincy is. Because, would you come and see where I was evicted from, you know? I could check with the staff if that was ok, you know. What time she would be back and things. I could go around. Who else would have done that, telling of the story - and of course I have no answers… but the hope is that she feels that somebody has heard her anger with the talk. I think maybe that's what the purpose of mental health chaplaincy is…" [F1].

"Quite a lot of patients have been with us for a long time with no family. So we'll put on the funeral, we become the family. We do the flowers and we do the tributes. We had a family who wanted the patient's funeral at the hospital, so I was able to work with the undertakers and organise the funeral. So on paper one of the main purposes of the job is taking funerals… The family will ask for a memorial. Sometimes we'll decide to put on a memorial. I'm becoming more confident in taking responsibility for those, both planning them and putting on a memorial service, without a minister being present. Staff will contribute and do tributes, and we've got a marvellous music therapist, so we make our own memorial services and they can be very beautiful. We always try to do it in a way that is relevant to that patient. So they are all quite different. What they have in common is that they are very person-centred really. There's nothing off the shelf

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because there isn't a shelf. They're crafted for that individual. My role extends to

organising memorial stones as well" [F3].

Discussion

Moving beyond Morrow's and Matthews' (1966) limited view of MH Chaplaincy, the data reveal that advocacy [F1, F4, F5], offering religious care that encompasses diversity issues [F1, F2, F3, F4, F5], running groups [F2, F3, F4], facilitating training on issues of spiritual care [F1, F2, M2], working with community [F1, F6], and taking part in committee work [F2, F6] are all tasks of MH Chaplains. These are reflected in more recent literature (e.g. Sunderland 2008). However, the most significant function that the MH Chaplains [M1, M2, F1, F3, F4, F5] expressed, was the transformative presence that they offer when 'being alongside' folk who are struggling existentially (or spiritually), and who need to talk 'meaningfully'. Mental Health chaplains straddle two philosophical paradigms in attempting their role - the theological/spiritual and the secular. This is different from the outcome-base, or evidence-base, paradigm otherwise utilised within the National Health Service. Their theological paradigm enables them to see 'true listening is one of the highest forms of hospitality' (Nouwen, 1976, p.89).

> "...the kind that does not attempt to change people but to offer them space where
>
> change can take place... Hospitality is not a subtle invitation to adopt the lifestyle of
>
> the host, but the gift of a chance for the guest to find his own... Healing means first of
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> all the creation of an empty but friendly space where those who suffer can tell their
>
> story to someone who can listen with real attention..." (Nouwen, 1976, p.88).

Some of the moving accounts offered above, testify to the loving care and attention given to patients through the careful, attentive organisation of personalised funerals [F3], to giving time to hear a patient's anger with God [F1], and to hearing the darkest facets of the soul that often accompanies depression. Being able to receive the 'personhood' of the patients, in these ways, through attentiveness, presence and listening, is redemptive (McFadyen, 1990,

pp.113-150). This is arguably akin to the therapeutic concept of being alongside someone at 'relational depth' (Mearns and Cooper 2005), or to working with clients' spirituality (Gubi 2015; Pargament 2007; West 2004) in Counselling and Psychotherapy. Yet, few MH Chaplains had training in the accompaniment of others at such depth, other than in basic listening skills. F1 had *"training to be a Person-Centred Counsellor that was actually a very good training for mental health Chaplaincy. Those are the skills that I draw on all the time in the provision of spiritual care"* [F1]. Sunderland (2008) underemphasises this most important aspect of MH Chaplaincy by stating that MH Chaplains offer 'empathic listening for those who want to relate experience to faith'. The experiences stated in the data indicate the need for MH Chaplains to have ability to journey into some 'dark places' as a receptive, compassionate, affirming, forgiving, acknowledging, connecting, visible presence, and as a presence of hope - not always explicitly in connection with faith. They are required to have an enormous capacity for empathy and resilience. MH Chaplains offer a complimentary healing presence to those with, or without, faith, that other services are unable to offer due to the constraints of time, and who are caught-up in the milieu of meeting outcomes and target measurements. This presence makes a qualitative difference to the service users, as they offer a different level of compassionate care, over and above what the rest of the NHS seems able to give. For F3, this offering of caring humanity went into the provision of meaningful, personalised funerals and rituals at times of intense vulnerability. This caring is also extended to the support of other staff - an aspect of a Chaplain's role that is missing from previous literature.

Conclusion:

One limitation of this research is that this is a small-scale study which reflects the experience of a small number of participants who chose to participate (and which may not be representative of a larger sample of MH Chaplains). Another is that it does not shed any light on roles and functions that we might have expected to be present, e.g. the 'prophetic' nature of spiritual care within the NHS, multidisciplinary working, partnerships with Faith

communities, the challenge and opportunities of multi-faith teams, the importance of partnerships and networks, and the role as understood within the wider organisation. Nevertheless, this qualitative study does illuminate the value, purpose and function of the MH Chaplains who took part in the study. The data reveal that MH Chaplains offer an important, but different, level of care to MH service users, which is complimentary to that offered by other NHS care provision. Their role and function includes: advocacy; offering religious care that encompasses a diversity of faith and spirituality issues; running 'therapeutic' or educative groups that sometimes use spiritual resources and which give an opportunity for accompaniment; facilitating training on issues of spiritual care to staff of community groups; working with community; and taking part in committee work. However, their more important value that makes a qualitative difference to patient care is in their role in existential and spiritual accompaniment of service users, and in supporting staff, which other services seem unable to offer. *"Chaplains are wanting chaplaincy to become more of a reco gnized health care profession, rather than it being the local vicar popping-in"* [F2]. The training to enable this important role of 'hospitality' seems inadequate for most of the MH Chaplains, and yet the ethical creativeness of the participants to have obtained what training they could to support them in this valuable role, is praiseworthy. However, this small scale study clearly demonstrates a need for training and development of scope of practice. Whilst their role is different to that of counsellors, greater training in accompaniment at relational depth and in working with clients' spiritual issues would be beneficial for the depth of existential/spiritual accompaniment that they encounter. Financial strictures within the NHS and changing practice developments have brought challenges to MH chaplaincy, yet the value of their work seems important at a human, redemptive and transformative level.

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