

Chaplaincy and Mental Health Services - towards an integration of care

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One of the few research projects to have focused on NHS hospital chaplains reports widely divergent views regarding its service. On the one hand, chaplaincy is described as being 'utterly essential'¹, a view supported by comments reporting that it is a discipline surfing along 'on the crest a wave'.² On the other hand, it has also been described as being 'benignly superfluous' and as a profession that is 'still wrestling with issues of nature and purpose'.¹ The more positive perspective is backed by increased levels of NHS investment in chaplaincy. Consequent upon funding, which is heading towards £14 million, there has been a significant surge in numbers of appointed whole-time hospital chaplains. Despite such encouragement however, not only is there no mention of the spiritual and religious dimension to patient care in the NHS Handbook, but the chaplaincy service in general fails to get a mention. Perhaps this suggests that what appears to chaplaincy as a 'wave' in reality generates not even a ripple on the surface of the NHS organization as a whole. It is hardly surprising that chaplaincy for many in the NHS, not least psychiatrists, often figures little in their thinking. So then, how many chaplains are there? How are they organized? Where are they located? What do they do?

Historical background

As the established church, the Church of England has historically always dominated the chaplaincy scene and continues to do so. Recent statistics state that 277 (83%) of present-day whole-time chaplains are Anglican; the rest are made up of 46 Free Church (13.8%), 8 Roman Catholic (2.5%) and finally Muslim (0.3%). From a historical perspective, it was Archbishop Fisher, the incumbent Archbishop of Canterbury in the 1940s, who ensured that chaplaincy was integral to the National Health Service as it came into existence. When the 1946 Act became effective on the 5 July 1948, it allowed for the appointment of approximately 28 whole-time Anglican chaplains who were predominantly employed in the London Teaching Hospitals. Information derived from the Hospital Chaplaincy Council (HCC), which links chaplaincy to the General Synod, the ruling body of the Church of England and also to the Department of Health, states that the first increases came in 1951 when the decision was taken to appoint whole-time chaplains to hospitals with more than 750 beds. Since Psychiatric Hospitals tended to be the larger type of NHS institution, this decision impacted especially on mental health service provision. The first chaplaincy guidelines were published in 1959, coinciding with the first Mental Health Act. A second handbook was produced in 1967 by the Birmingham Regional Health Board, which set out in a more systematic manner, duties and terms of reference for chaplains. The 750-bed rule came to an end in 1969, producing a steady rise in chaplaincy whole-time appointments - 1970 (65), 1973 (100), 1978 (150), 1988 (227). Entering the 21st century, the HCC reports a more recent surge in appointments bringing the total to around 350 w/t NHS chaplains.

During the half-century since the inauguration of the NHS, it goes without saying that there have been many changes, not least the welcome incorporation of women into a previously male-dominated scene. If the need to become an inter-denominational service in order to ensure a broad-based Christian representation also marked a past change in social attitudes, then a more recent one has been the need to address the implications of a 'patient-centred' multi-cultural healthcare environment. Not least for

chaplainship this involves responding to 'the incredible diversity of beliefs and worldviews in our global village'³ and therefore to develop a chaplainship service that is multi-faith in nature and operation. Achieving inter-denominational partnership was achieved and is maintained through cooperation between HCC and corresponding chaplainship bodies representing the Roman Catholic (Churches Committee for Hospital Chaplainship) and Free Churches (Health Care Chaplainship Board of the Free Church Council).

Although it is apparently not so easy to arrive at accurate figures, there are likely to be in the region of 4500 part-time chaplains evenly divided between the three Christian groupings. Nonetheless, while there are approximately 66 Rabbis and between 20-25 Imams providing sessional support to hospital patients, the emergence of a Joint Multi-Faith National Consultation and its formal recognition has followed a somewhat pedestrian pace.¹ One further chaplainship body of importance is the College of Health Care Chaplains (CHCC) to which any NHS chaplain may belong irrespective of denomination or creed. Originally two groups providing fellowships for chaplains representing the medical and psychiatric domains respectively, it now provides a focus for chaplainship information, debate and training, as well as offering Trade Union membership via the MSF (or Amicus as it has become recently). There are also special interest groups that focus on particular aspects of the service, not least one that brings together mental health chaplains, called the Chaplainship Mental health Resource Group.

The role of NHS Chaplains

Although the following observation is directed primarily towards mental health chaplainship, the views expressed are equally applicable to chaplains in a more general sense. It is suggested that:

'Chaplains have a vital role to play in the spiritual care and the discernment of spiritual experiences. They bring specific expertise of religions and spirituality and as such, are in a perfect position to make a major contribution to the process of care assessment'.⁴

The author goes on to highlight his reasoning behind this statement; firstly, chaplains are in a position to provide multi-disciplinary teams with vital information; secondly, chaplains can, and do, spend long periods of time with service users; finally, chaplainship is a conduit into appropriate religious or faith communities. Such positive comments seem perceptive and are likely to be accepted as accurate by a majority of chaplains. However, from her research critique of 'service models' and 'performance assessment' in just five London hospitals, Orchard calls into question Swinton's more appreciative description. Orchard suggests levels of difficulty around fundamental issues, which raise doubts about the 'professional' status of chaplainship since her data 'discerned the absence of a firm foundation for the professional practice of hospital chaplainship and an inadequate level of post-basic training' (p.151).

Among other issues that were highlighted by the research was a considerable divergence in how chaplains view their role and task. Some argue for a focus of attention on individual patient needs or for a strategic focus on staff needs; still others believe that it should be concerned with a wider organizational and social dimension. The first approach⁵ is called into question elsewhere as illustrative of the failure of chaplainship to address 'issues of power, justice, inequality and human rights'.⁶ Although my own perspective, informed as it is by social scientific insights, is sympathetic to the latter view, it is nonetheless open to the argument that these two apparently competing perspectives may simply reflect the difference between what has been called the 'privatisation of religion' as distinct from the 'public influence of religion'. Following this line of thought it has been argued that 'in so far as privatisation refers to the rise of pluralistic and voluntary religion among individuals, the basic structures in modern global

society encourage it. These structures, however, do not in themselves undermine the possibility of publicly influential religion'.⁷

Inter-disciplinary contacts and cooperation

Given the intra-disciplinary challenges that confront chaplaincy, it might seem an inopportune moment to suggest that our two professions, despite the undoubted overlap in our concern to enhance patient care, should enter into some form of dialogue. For the following reasons I would offer a contrary view.

1. Reflecting on what she offers as a constructive critique of chaplaincy, Orchard¹ comments that serious efforts 'need to be expended in demonstrating to other healthcare professional what chaplains are bringing to the bedside that is therapeutically effective, rather than simply edifying' (p.151). Such efforts clearly require forums that provide opportunities to engage in worthwhile dialogue as well as in joint education initiatives and research projects.
2. Two incidents from my own experience come readily to mind that illustrate the need for practical cooperation. A genuine nursing concern for a dying patient was not matched by an equally sensitive cultural awareness. A young Buddhist woman, who had refused any form of pain-relief because of her beliefs, was confronted with the threat of being placed on a section. The trauma arising from the ensuing hiatus was the spark that ignited a five-year research program and my own doctoral thesis.⁸ (see footnote)
3. The second very recent incident followed from the request of a senior consultant psychiatrist to provide a religious assessment of a patient. It had been comparable requests that had provoked a collaborative effort that led to the production and publication of a guide for assessing the religious and spiritual aspects of people's lives.⁹ From my contact with the patient, it became clear that the religious language and ideas he expressed were not part of some kind of delusional state; rather, his articulated world-view had been acquired from long-term contacts with a fundamentalist yet perfectly legitimate charismatic Christian group. Despite twelve years of regular admission to psychiatric establishments, when this patient's case notes arrived from outside the locality, reference was made neither to his fragmented religious cultural background, nor to his subsequent extensive Christian contacts. This was particularly surprising, not just because of the nature of his personal tragedy but also because of his expressed view that 'the only time my life had meaning was when I was part of a Christian fellowship'. He also observed as he leafed with considerable interpretative sophistication through my Bible, 'I only have the scriptures to give me hope in my suffering...what else would I have to live for?'
4. While the prescriptive nature of the National Service Framework and the demands of Clinical Governance place heavy pressures on healthcare professionals, they also present at least one area of possible practical cooperation. Within the Care Plan Approach (CPA) a genuine platform for multi-disciplinary interaction can be identified under the heading of holistic care, which includes 'spirituality'. At this point in the CPA there is a designated and legitimate boundary point at which we can meet and enter into a dialogue that is practically based, as and when it stems from an expressed patient need. This type of approach can also link medicine and pastoral care, where the former is an

approach that is inclined towards narrative-based medicine¹⁰ and when the latter is akin to a pastoral initiative described as being one which ‘sprang from a conviction that there were other ways of doing theology apart from reading books and that a study of the “living documents” of humans in crisis would provide insights of pastoral importance’.¹¹

Footnote: An analysis of six user forum/collective empowerment initiatives, then compared to one that focused on individual empowerment - the work of the Brighton Patient Advocate. The accumulated data provided a basis for questioning whether either approach was able to influence local policy decision-making and offered signposts towards the potential for a genuine form of ‘discursive democracy’ in the NHS. Theoretical validation was derived from the sociological and philosophical insights of Jurgen Habermas, one that views all knowledge as socially constructed (this includes religious knowledge) and places language at the heart of both ontological and epistemological endeavours.

Conclusion

Reflection on some of the more critical aspects of my observations might appear to suggest that I am pessimistic about the future of chaplaincy. Quite the reverse is true. I know that chaplaincy offers a rich resource of experience that may be undervalued but will not be readily undermined. Given the highly dedicated women and men in chaplaincy who retain a sense of vocation in their work, there is every reason to suppose that there is sufficient experience and competence to meet on-going challenges. It may seem secondly that I am suggesting that chaplaincy needs psychiatry, especially the encouragement and support of the Spirituality and Psychiatry Special Interest Group of the Royal College, rather more than the reverse. This observation is only partially accurate since I would also posit that medicine could benefit from chaplaincy experience as it confronts comparable and overlapping critical theoretical and practical challenges. Among these are challenges from thinkers such as Foucault¹² (power/knowledge); Lupton¹³ (medicine and culture); Good¹⁴ and Lindebaum & Lock¹⁵ (medical anthropology); Kleinman¹⁶ (narrative perspectives); Habermas¹⁷ (modernity, communicative action and rationality, and complementary validity claims). In addition, while recent research into the spiritual and religious dimension of care by both the National Schizophrenic Fellowship and the Sainsbury Foundation suggest that the spiritual and religious dimension is an area of genuine concern to users and widely felt to be ignored, to their detriment. Still others regard religion with no less suspicion than medicine, arguing that it can be charged with disempowering service users consequent upon their normative stance in body politics and because of their disciplinary powers within society.¹⁸

In view of all this, I am suggesting that there are eminently good reasons both for extending joint cooperation and for developing opportunities for shared learning in a context of mutual respect.

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Biography

The Rev Dr. (Geoffrey) Stuart Johnson was ordained in the Church of England some forty years ago. Over the first twenty years, Stuart served in suburban, rural and mining community churches in England, in black community church projects in the USA, in a wide range of social projects in Israel and for almost ten years in Taiwan and Singapore, where cross-cultural religious and social interests became embedded in his pastoral and theological thinking. The subsequent twenty years has been spent as an NHS hospital chaplain - whole-time chaplain to Horton Hospital, Epsom (1984-90), whole-time managing chaplain to the two Brighton NHS Trusts (1990-2000) and part-time (retired) chaplain to the mental health unit of South Downs Health NHS Trust. Stuart has acquired accreditation as a lecturer in Further Education, also having wide experience and training as an individual and group therapist, and has become increasingly committed to patient-centred research projects. He was recently appointed as a reviewer with the Commission for Health Improvement.

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