

HEALTHCARE CHAPLAINCY IN SCOTLAND AND THE UK: A LOOK BACK TO THE FUTURE

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Abstract: As the Scottish Journal of Healthcare Chaplaincy heads toward its 10th anniversary year retiring joint editor David Mitchell reflects on the changes that have taken place in the arena of healthcare chaplaincy during that time. Looking at Scotland and the wider UK scene the author acknowledges the considerable developments, changes and frustrations that have impacted on chaplaincy and have guided its course to the present day. Acknowledging the fears of individual chaplains, faith communities and belief groups, the author outlines a positive vision for the future that could allay these real fears. A vision that sees the development of standards, competencies and professional registration as a clear strategic direction and one earthed in the professional chaplaincy organisations. The author concludes that the continuing development of healthcare chaplaincy in Scotland is a model that could have a positive and guiding influence on the development of chaplaincy throughout the UK.

Key words: Chaplaincy, professional organisations, professional registration, standards,

Introduction

I remember being ordained into my first parish and being terrified to discover there was a 45 bed hospice in the parish and the previous minister had been chaplain. It was a great relief to discover that in the vacancy the neighbouring minister had been appointed and would continue to be chaplain. Three years later I found myself sitting in the Matron's office and remember her words "I'd like you to be chaplain, not because you're the local minister, I just think you're someone our patients could talk to."

As we move into an era where chaplaincy is likely to become a registered healthcare profession an era of standards, competencies and the knowledge skills framework (Department of Health, 2004) there is a risk that the common sense of attracting the right people will be lost, yet that would be to doubt the credibility of a developing profession that through its three professional organisations has its feet firmly on the ground and knows what its about.

We have come a long way since the creation of the College of Health Care Chaplains (CHCC) and the split over trade union status that saw the creation of

the Scottish Association of Chaplains in Healthcare (SACH), and since then the Association of Hospice and Palliative Care Chaplains (AHPCC) in Scotland has become a branch in its own right rather than a regional UK group. The pain and distrust of the early years has been replaced with a spirit of genuine co-operation and the creation and support by the three professional organisations of the Chaplaincy Academic Accreditation Board (CAAB) which offers real potential for the future of healthcare chaplaincy in the UK.

Healthcare Chaplaincy in Scotland: Small is beautiful

There are two significant yet related events that have catapulted healthcare chaplaincy and spiritual care forward in Scotland:

1. Scottish Executive Health Department Letter (2002) 76 Guidelines on Chaplaincy and Spiritual Care in the NHS in Scotland (NHS HDL 76, 2002)

2. The creation and staffing of the Healthcare Chaplaincy Training and Development Unit now under NHS Education for Scotland (NES).

The HDL instructed NHS Boards to develop and implement spiritual care policies and a local plan for spiritual care services, and the Healthcare Chaplaincy Training and development Unit was there to support the Boards and facilitate discussions and progress.

If we reflect on why these two events have been so crucial and effective it comes down to size: Scotland is a relatively small country and makes its own decisions regarding healthcare. The working group preparing the HDL was representative of the NHS, faith communities, belief groups, healthcare chaplaincy professional organisations and the Scottish Executive, all able to sit round a table, talk to each other and come to agreement. Small in this instance is beautiful.

Healthcare Chaplaincy in the UK

From chaplaincy colleagues in England, Wales and Northern Ireland the regular response is "how do you manage to get things done in Scotland?" The answer is short: we talk to each other and come to agreement. There is a real sense of frustration in England in particular with the plethora of organisations claiming to speak for healthcare chaplaincy:

The Healthcare Chaplaincy Council of the Church of England (HCC), the Multifaith Group for Health Care Chaplaincy (MFGHCC), Yorkshire and the Humber Strategic Health Authority (YHSHA), and the chaplaincy professional organisations CHCC and AHPCC and also CAAB. As an outsider looking in the problem is clear, there is duplication of work and a host of historical personal agendas. There are clear conflicts of interest with individuals in office on a number of groups and some groups who claim to speak for chaplaincy appear to have no working chaplains in their number. The bottom line is there can be little hope for a way forward if this plethora of groups won't meet together in the same room to talk with each other.

Wales is different yet again with the Welsh assembly and its developing structures and experiences of chaplaincy as is Northern Ireland where generic

chaplaincy is almost unheard of, except in hospices, and denominational chaplaincy is the norm.

These observations aside there is some remarkable work being done that has the potential to have a profound and positive influence on healthcare chaplaincy throughout the UK. The ongoing work of *Caring for the Spirit* (SYSHA, 2003), the Health Care Chaplains Code of Conduct (AHPCC, CHCC, SACH, 2005), continuing professional development, clinical supervision, accreditation of training (CAAB, 2005, 2006) to name but a few. However, until the groups sit down together and talk to each other Healthcare Chaplaincy will look to be in disarray and professional registration will be difficult at best if not impossible.

The influence of palliative care

In recent years palliative care chaplaincy has been able to develop and integrate itself in its field and has developed a clear structure, guidelines and standards for its hospice and palliative care chaplaincy services.

Again size is important: palliative care is a small specialty within a much larger healthcare system. Independence is also a contributing factor: there is freedom and flexibility in independent hospices to develop services that are focused on the patient and their family and bend the structures to suit. It is also significant that palliative care chaplaincy has long been considered part of the multidisciplinary team, and spiritual care understood as being much more than religion.

The AHPCC as a professional organisation has been proactive in co-operating with and being represented on a considerable number of national and local working groups. As a result there are in place mandatory clinical standards for palliative care in Scotland and national guidelines in England that both include chaplaincy and spiritual care as core elements (CSBS, 2002; NICE, 2004). Following on the AHPCC has developed and revised national standards for hospice and palliative care chaplaincy services and working with Marie Curie Cancer Care has endorsed Spiritual and Religious Care Competencies for Specialist Palliative Care. The competencies acknowledge that all healthcare professionals can and do provide spiritual care, however, the competencies also set out the expertise of chap-

laincy, and expertise that chaplains have long been struggling to put into words that other healthcare professionals will understand (MCCC, 2003).

The influence of this work has gone far beyond palliative care chaplaincy. In Scotland NES is in the process of piloting standards for NHSScotland Chaplaincy Services based on a revision of the AHPCC (2006) palliative care standards (Levison and Bullock, 2006). In Europe there is also recognition that palliative care is on the current agenda and could be used to take chaplaincy forward. The European Network of Healthcare Chaplaincy in its drive to raise the profile of healthcare chaplaincy in Europe has looked to the example of palliative care chaplaincy in Scotland with its clear standards and competencies and has recommended it as an example of good practice for use throughout Europe (ENHCC, 2006).

Again it would seem size matters: when people sit down and talk together development is not only possible, it flourishes.

The present: A challenging but exciting time.

There are some who view the current status and thinking of healthcare chaplaincy as a concern or a threat. In particular the increasing professionalisation of chaplaincy is seen as a negative influence. Some fear that part-time chaplaincy will be a thing of the past, local relationships will be lost, that spiritual care will become more secular and exclude the Christian denominations in favour of a diluted multi-faith focused care, and that Church authority over its clergy working as chaplains will be challenged. These are real and legitimate concerns. However, there is another view.

The professionalisation, developing structures and standards for chaplaincy services could in fact strengthen the role of part time chaplains and the role of the faith communities and Christian denominations in particular. They also have the potential to protect patients from unwanted visits, protect them from the damage that can be done from inappropriate chaplaincy appointments, and those who seek to use the vulnerable to vent their theology and for proselytising or 'bringing back to faith' (Gordon, 2000).

Standards have come a long way since the Sails standards of 1993 which made good reading but were impossible to audit in their entirety (CHCC, et al., 1993). Modern chaplaincy standards are written in a language that health boards and chaplains understand and come complete with audit tools. Some fear they will be held to account by standards. Why not? Other professions are accountable, why should chaplaincy be different? The other side to that particular coin is that standards can be a powerful tool when chaplaincy services are being reviewed: standards that can't be met are often the best argument for additional resources or changing practices: Healthcare services want to demonstrate they are meeting standards and they are accountable if they are not.

Perhaps the most positive development at present though is the improved communication and co-ordination of the three chaplaincy professional organisations AHPCC, CHCC and SACH. These groups represent and are the voice of those working as chaplains and have clear and open agendas. Add to that the work of CAAB which is innovative and consultative and there is a good foundation laid for the future.

Healthcare Chaplaincy: What of the future?

Is this the realm of the crystal ball or the shifting sands of time? No, there are signs and work in progress that suggest a clear and strategic path.

The registration of chaplaincy as a healthcare profession is coming, though will likely be a further 10 year process. By that time CAAB, with the support of the three professional organisations, will have established continuing professional development, clinical supervision and accredited education for chaplains all of which will be a requirement for newly appointed chaplains. Through cooperation with the Yorkshire and the Humber Strategic Health Authority and the development of Caring for the Spirit (SYSHA, 2003) there will also be a clear and defined career structure that will attract graduates from different disciplines into chaplaincy.

In Scotland the HDL 76 (2002) will be revised or developed into mandatory national standards for Spiritual Care through NHS Quality Improvement Scotland. The NES (2006) Standards for NHSScot-

land Chaplaincy Services will be in place and spiritual care competencies for NHSScotland will be created. All chaplains will be directly employed by the NHS, the number of whole-time appointments will increase, part-time chaplaincy will be alive and well, and the faith communities and belief groups will be working in liaison with local spiritual care services.

In the wider UK and in England in particular the debate will have moved on. The office bearers in the plethora of organisations will have changed and the air will be cleared. The groups will sit together and talk together and agree a way forward. One option then would be to look to Scotland and see a working model to follow or more likely see a working model that could be adapted to suit the practices of chaplaincy that by its Anglican influence is more sacramental than that in Scotland.

As the Scottish Journal of Healthcare Chaplaincy moves towards its 10th year in circulation through its articles and comment it has recorded and contributed to considerable debate and development in healthcare chaplaincy in Scotland and further a field. Exciting, challenging and hopeful times are ahead and the journal will continue to record and help shape that future. As to how many of the predictions made above come into being we will have to wait and see and that will be up to the journal editors to report in 10 years time when the Scottish Journal of Healthcare Chaplaincy looks to celebrating its 20th year.

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