A literature review exploring the integration of minority faiths and beliefs within NHS hospital chaplaincy.

To what extent are the spiritual, religious and pastoral care needs of all patients, staff and other service users being met?

Paul Hurst

A dissertation presented for the degree of
Masters of Arts in
Humanistic and Existential Pastoral Care

Submitted: Winter 2020

Dedication

To Penny

Acknowledgements

I would like to thank Dr Paula S. for being my supervisor, pilot, guide, and academic midwife. Having had no idea of the importance of a supervisor at the start of this dissertation, I was in no doubt by the end. My thanks also to Sasha, Mackay and other staff at the NSPC, fellow students Clair, Demelza, Josh and especially Dr Louie software advice.

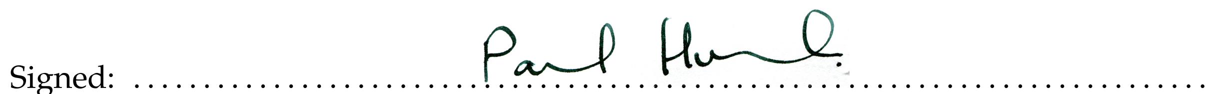
I am grateful to my friends and colleagues in the NRPSN, including Dr David, Jo, Lindsay and Simon, for their helpfulness and information. Thanks also to Rev Dr Chris S., Prof Jim M. and Rev Dr Steve N. for their contributions to PSR literature, and for being so open and helpful when contacted.

Thanks also to MTW fellow volunteers, chaplains Nicola and Stephen and the Library staff.

Declaration

I, Paul Hurst, declare that this thesis, entitled *A literature review exploring the integration of minority faiths and beliefs within NHS hospital chaplaincy* and the work presented herein are my own, and have been generated by me as the result of my own original research. I confirm that:

- this work was done wholly or mainly whilst a candidate for a research degree at this University;
- where any part of this thesis has previously been submitted for a degree or any other qualification at this University or any other institution, this has been clearly stated;
- where I have consulted the published work of others, this is always clearly attributed;
- where I have quoted from the work of others, the source is always given. With the exception of such quotations, this thesis is entirely my own work;
- I have acknowledged all main sources of help;
- where the thesis is based on work done by myself jointly with others, I have made clear exactly what was done by others and what I have contributed myself;



Abstract

Aims of the research

This dissertation aims to explore the integration of minority faiths and beliefs within NHS hospital Chaplaincy. Revised guidelines in 2015 confirmed the right of all patients, relatives and staff members to receive appropriate pastoral, spiritual and pastoral care. There is an increasing divergence between the British public and organised religion, while hospital chaplaincy departments are largely staffed by paid and volunteer Christians. This research provides an opportunity to study the extent to which the 2015 guidelines have been implemented.

Research

Conventional and 'grey' literature sources were studied in an indicative narrative review, using the researcher's experience in pastoral care. Potential personal biases in the researcher were identified and noted, along with the steps taken to minimise them.

Summary of the main findings

There was conflict noted between the historical role of chaplain and that of the hospital PSR carer. A parallel split between the British public and the Church of England was highlighted. At times, the language used within NHS PSR excluded those with a minority worldview, and the structures of chaplaincy departments also present challenges to their integration. In general, departments have not used the opportunity to connect online with those with minority beliefs or faiths.

Recommendations

Surveys of the British public would enable assessment of their current PSR requirements and allow the formation of a structure to meet these needs most appropriately, probably using the internet to expand and improve the scope of the service provided. The language used within hospital chaplaincy literature requires scrutiny regarding the potential impact directly on service users, and indirectly through the shaping of the care provided. Modern Hospital websites could be used more effectively to communicate with those holding minority worldviews.

Key Words Pastoral care, chaplaincy, integration, nones, non-religious, multi-faith, faith and none

Contents

Preface 1

1 Introduction 2
1.1 NHS hospital chaplaincy . . . 2
1.2 Theoretical approaches in chaplaincy . . . 4
1.3 Personal bias and corrective action . . . 7

2 Methodology 9
2.1 Choice of review approach . . . 9
2.2 Review approach . . . 10
2.3 Review Methods . . . 11
2.3.1 Conventional literature research . . . 11
2.3.2 Potential public impressions of chaplaincy departments, 'grey' literature search . . . 12
2.4 Limitations to the literature review methods used . . . 14
2.5 Ethical dimensions of conducting this literature review . . . 15

3 Findings 16
3.1 Current faiths and beliefs held by the British public . . . 18
3.1.1 Census . . . 18
3.1.2 Surveys . . . 19
3.1.3 Research on faith and belief in the UK . . . 21
3.1.4 Research on 'nones' in the UK . . . 21
3.2 NHS PSR responsibilities . . . 24
3.2.1 Legislation . . . 24
3.2.2 Codes . . . 25
3.2.3 NHS chaplaincy guidance . . . 26
3.3 Anglican chaplaincy . . . 28
3.3.1 The Church of England . . . 28

3.3.2 Anglican perspectives of chaplaincy . . . 29
3.4 NHS PSR care . . . 32
3.5 Healthcare Chaplains . . . 34
3.6 Potential impressions of chaplaincy departments . . . 37
3.6.1 Overview . . . 38
3.6.2 Page heading . . . 39
3.6.3 Inclusivity of pictures used on PSR websites . . . 40
3.6.4 Text . . . 41
3.6.5 Facilities . . . 42
3.6.6 Outreach . . . 43
3.6.7 Summary of potential impressions of chaplaincy departments . 44
3.7 Summary of Findings . . . 44

4 Discussion **46**
4.1 Differences in the role of chaplaincy regarding the integration of minority beliefs and faiths . . . 47
4.2 The impact of language in the integration of minority faiths and beliefs within hospital chaplaincy . . . 48
4.3 Structural and organisational disconnections . . . 49
4.4 Engagement with those holding minority beliefs and faiths . . . 50

5 Conclusions **52**
5.1 Reflexive exploration . . . 52
5.2 Strengths and limitations of the study . . . 53
5.3 Future research . . . 53

References **55**

Preface

> In conclusion, rigorous self-reflection will be essential for the development of a new model of healthcare chaplaincy in a pluralistic society. In finding the courage to be unafraid to question or even throw away the mould and to challenge the established ways of doing things, new possibilities are invited ... The profession and the people it seeks to care for will be best served by the perception of this situation as an opportunity, rather than a threat. It is an opportunity to design a truly inclusive practice of Spiritual Care that will be nurturing to all
>
> —Mirabai Galashan, *From Atheists to Zoroastrians...*

CHAPTER 1

Introduction

1.1 NHS hospital chaplaincy

Most of us will enter a hospital at some time in our lives, be it as a patient, visitor or employee. Since its establishment in 1948, the National Health Service (NHS) has recognised spiritual as well as physical needs requiring hospitals to appoint chaplains and maintain chapels (Cambridge University Hospitals, 2019). The United Kingdom (UK) is currently a partial theocracy with a state religion and 26 seats reserved for Anglican 'Lords Spiritual' in the House of Lords. As such, Chaplaincy posts were previously reserved for Anglican ministers on the assumption that a majority of patient would share this faith (Cambridge University Hospitals, 2019).

The needs of the non-religious to receive pastoral support are now supported by equality legislation (Equality and Human Rights Commission, 2010; European Court of Human Rights, 2010), where religion, and the lack of religion, are given equal status. In 2015, revised chaplaincy guidelines (Swift, 2015b) highlighted the obligation for NHS trusts to provide spiritual and religious care in a way that meets the needs of all service users. Changes in communities regarding beliefs and faith are also recognised and accepted, with an acknowledgement that chaplaincy support should be available to all when needed.

A shift in the relationship between organised religion and the British public (Woodhead, 2016) noted how traditional attitudes of church leaders regarding sexuality and gender issues has resulted in a growing rift. Changes have also been observed in self-identification regarding faith or belief (Natcen.ac.uk, 2019). With declining numbers of Anglicans, and increasing numbers who are non-religious, the latter are now in the majority.

The dominant role played by Anglican clergy in hospital chaplaincy raises concerns regarding compliance with the laws and guidelines above, especially regarding the

ability to understand and provide appropriate PSR care for those who hold different values and beliefs. A 'one-up' chaplaincy model of pastor and flock from the same faith tradition seems less suitable for providing care, respectfully and non-judgmentally for all worldviews. Successful integration of minority beliefs and faiths is of considerable importance in the provision of chaplaincy care.

A recent report by the Network for Pastoral, Spiritual, and Religious Care in Health (O'Donoghue, 2020) (NPSRCH) also covers inclusion within NHS pastoral, spiritual and religious (PSR) care. Rather than repeating the research recently carried out, the report has been drawn on as another resource, developing on the work done. The opportunity has been taken to add fresh insights.

The term 'chaplaincy' was used generically in the 2015 guidelines (Swift, 2015b) to describe all spiritual, religious and non-religious care and the convention has been followed in this dissertation, together with the acronym PSR (Pastoral, Spiritual and Religious) to provide variety. The NPSRCH report (O'Donoghue, 2020) highlighted concerns over the use of the words 'Chaplain' and 'Chaplaincy' however, and the term 'spiritual' may have different meanings for some compared to the definition used in the Swift report (Swift, 2015b). Similarly, the disadvantages of using the term 'none' have been explored by Savage (2018).

Healthcare chaplaincy involves person-centred care, provided in response to the wishes and needs of the service user (Swift, 2015b). While churches and other faith and belief organisations provide information publicly regarding their views, aims and the services they provide, the voices of service users, especially of those with minority worldviews, can be harder to hear. To gain insight from their perspective, help build up a more precise overview and identify patterns in the data, it was necessary to draw creatively on a wide range of material rather than employing a more formal scoping or systematic review methodology.

An indicative narrative review was carried out, drawing on personal experience in pastoral care to select appropriate methods and material. Due to the rapidly changing demographics regarding belief and faith, and the significant implications for working procedures and provision of care following the 2015 chaplaincy guidelines (Swift, 2015b), research has been focused mainly on literature following the updated guidelines. Differing demographics and working practices in other UK countries have also been taken into consideration when identifying appropriate sources. Rather than using the word 'inclusion' in the research question, the author chose 'integration' ('to combine two or more things in order to become more effective' (Integration, n.d.)),

hoping that chaplaincy teams will include all worldviews equally, constructively drawing on different perspectives for the benefit of every service user.

The research followed a 'clean sheet' approach to identify a best working practice, person-centred PSR model that would address the needs of all service users, including those with minority worldviews. Census and survey data were examined, together with research exploring the group who self-identify as 'none' when defining their faith. Starting with a focus on the needs service users felt appropriate to the patient-centred spirit of the 2015 NHS Chaplaincy Guidelines (Swift, 2015b). The work of NHS chaplaincy staff is regulated and informed through legislation, professional codes of conduct and national guidelines; these are identified and summarised regarding relevance to minority faiths and beliefs. By identifying both the potential PSR needs of the population, including those with minority faiths and beliefs and the laws, guidelines and codes establishing the care they are entitled to, it is possible to construct a model for NHS PSR care that is equally open to all.

As well as identifying the information needed to determine what a truly integrated model of NHS PSR care would look like, the structure currently in place was also explored. The research revealed that different concepts of chaplaincy exist, resulting in tensions for healthcare chaplains. These conflicts were studied, together with their potential impact on minority belief and faith service users, by highlighting the Anglican foundations of chaplaincy, the nature of NHS PSR care and information obtained regarding the experiences of healthcare chaplains.

Literature was also sought to provide insight into how largely autonomous trusts deliver PSR care locally. While studying the literature would inform patients about the PSR care they should expect to receive, they are more likely to base their expectations on an online search of the hospital they will attend. Data provided by Humanists.UK was used in a 'grey' literature study. An initial 356 potential NHS England hospitals were identified and searched for online, with others being added later. Chaplaincy web pages were codified regarding the inclusion of minority faiths and beliefs based on their page heading, picture, wording, facilities and outreach.

1.2 Theoretical approaches in chaplaincy

Hospital chaplaincy previously relied on Christian theological underpinnings; however, the 2015 guidelines (Swift) require a broader perspective to meet all pastoral,

spiritual and religious needs. Patients, relatives and staff members with other faiths will have their religious structures and practices which need to be integrated; and religious support seems clearly inappropriate for those who do not follow a faith. This dissertation is part of a course aimed at helping to meet PSR needs of the non-religious by providing pastoral care from humanistic and existential perspectives, the latter having its roots in philosophy – 'a search for understanding of essential questions of human knowledge and existence' (van Deurzen & Kenward, 2005).

With many of those coming into a hospital facing existential challenges such as death, long term illness and sudden and drastic changes to their lives from sickness and injury, existentialist counselling could be appropriate and effective (van Deurzen & Adams, 2016; van Deurzen, 2012; Yalom, 2020). Non-religious chaplains are however required to be able to 'distinguish between pastoral support and formal counselling and ensure that those you support understand the type of support you are offering' (NRPSN, 2018, p. 4). There is a further requirement:

> 'Pastoral support involves establishing relations and engaging in practices in situations where people are vulnerable, and there is an imbalance of power. Pastoral relations can, therefore, go wrong, and they have the potential to be damaging or harmful. You must, therefore, exercise your role with sensitivity, discernment, and within ethical boundaries' (NRPSN, 2018, p. 2).

Chaplains are not sought out and chosen by a client seeking change. There is no contact, treatment plan or guaranteed uninterrupted private time together and possibly no more than a single encounter. Rather than counselling, the role is one of 'concord and support' (Munnings, 2016, p. 3). Any theological or philosophical system used must provide appropriate and sensitive support, 'Compassion should always inform chaplaincy practice and is a key outcome of the patient's experience of the service being provided' (Munnings, 2016, p. 10). The NHS can succumb to a 'tick-box' culture (Francis, 2013), tempting classifications of faith and belief from options provided in advance. Discovering the worldviews and needs of individual patients rather than relying on assumptions founded in theology or philosophy can enable chaplains to offer support for those with minority beliefs or faiths. Whatever the background of a chaplain, they will need to engage with patients using the patient-first approach described by Swift (2015b) who warns that:

> 'Poor communication skills; pastoral insensitivity; or a failure to identify

> essential elements of the patient's belief system may all create potentially serious risks for both the patient and the organisation. (Swift, 2015b, p. 25).

The Humanistic, person-centred approach of extending empathy, congruence and unconditional positive regard (Rogers, 1995) can be very effective in a time when more of us seek to find a personal faith or belief (Sigal, 2019). A Humanistic model for pastoral support is already in place with training, support, supervision and paid chaplains in post. In the view of the first Humanist managing chaplain appointed, 'The main difference is that we put a person's values, morals, and worldview at the forefront of how we interact with a patient.' (Humanists UK, 2019, p. 1) with the person-centred focus clarified:

> 'Our method of care relies of simply listening, questioning, and providing feedback... The underpinning value of humanist pastoral care is that we empower somebody to come up with their own solutions by being listened to. We find that often, patients have never been able to share their story with somebody who takes the the (sic) time and patience to so sit with them. It's a very simple but powerful approach. (Humanists UK, 2019, p. 1).

As well as identifying the relevance of humanistic psychology in pastoral care, Savage (2018) notes how existential counselling could help those in institutions who suffer 'loss, isolation, death, grief and anxiety' (2018, p. 63). Humanistic and existential therapies sometimes draw on the same sources. There are notable differences between the two approaches, as the humanist psychologists 'Maslow and Rogers also tend to downplay the tragic dimensions of existence, arguing instead that human beings have an innate tendency to actualise their potential and to grow'(Cooper, 2016, p. 86-87). Described as being 'the most individualistic and optimistic of the existential therapies' (Cooper, 2016) existential-humanistic therapists approaches include many humanistic techniques, including Roger's core conditions (1995).

Existential and Humanistic therapies also share the use of phenomenology (Cooper, 2016). In bracketing their personal views and beliefs, therapists attempt to discover the worldview of their client, shifting the focus on to them, and their needs (Tilney, 1998). Existential therapy can vary according to the therapist, including the extent of 'knowing' or 'Un-knowing', and 'Directive' and 'Non-directive' in their approach (Cooper, 2016). Relational existential-phenomenological therapy as developed by Spinelli has an 'Un-knowing' and 'Non-directive' approach which can help 'clients

descriptively explore their worldviews and their lived experiences so that they can come to understand more about the disparities and disjunctions that might be related to their dilemmas and difficulties' (Cooper, 2016, p. 155). As such, therapists experienced in this approach may find it easier to adapt to a role as a hospital chaplain (subject to remaining aware of the different roles noted above).

Healthcare chaplaincy has expanded from the original theological underpinnings, now drawing on the person-centred traditions in philosophy, psychology and therapy. Able to offer care for those with minority worldviews, those with a faith are also supported if they wish, most of us just need 'a damn good listening to' at times. As noted above and by Savage (2018), the functions of pastoral care and counselling are however overlapping yet separate skills. Standing and competence in one do not, however, confer authority to practice automatically in the other, the role of all hospital chaplains is principally to extend compassion (Swift, 2015b) rather than seeking either cure or conversion.

1.3 Personal bias and corrective action

Despite best intentions, conscious and unconscious personal views and biases can affect research. Knowing the background and life choices of a researcher can help reveal these. This section may help readers identify any blind spots or distortions in the search process, literature chosen and interpretations made.

Childhood experiences, including the imposition of Catholicism, resulted in wariness and distrust of adults, a focus on self-reliance and a struggle for autonomy. Openly rejecting my parents' faith as soon as this felt safe (late teens), and leaving home as soon as financially possible, I built a lifestyle with the maximum of enjoyment and few responsibilities. During this period, faith, belief or philosophy seemed to have no import or relevance.

A medical scare in my late 40's led to introspection, a review of my life, and the realisation of regret at not having gone to university. After an Open University psychology degree, a desire to focus more on interaction with individuals led to a post-graduate diploma in psychotherapy and counselling. Interested in extending the remit of therapy to those unable to travel to me or find the fees, pastoral care felt like the next step to take.

The arguments of Miller, Duncan and Hubble (1997) struck a chord that still

resonates. They suggest that therapy, at its heart, is not complicated, and successful outcomes owe much to the methods and core conditions of Carl Rogers (1995). I have experienced the effectiveness of extending congruence, empathy, and unconditional regard to clients and hospital patients, both religious and non-religious.

Further education, self-reflection and therapy during training led to feelings of empowerment, as well as the realisation and processing of suppressed childhood emotions. The continuing public revelations of abuse, and in particular the attempts by religious organisations to discount, deny and hide them still result in feelings of anger – although focused on the present, rather than the past. Now identifying as a Secular Humanist, working and talking with Christian colleagues in a hospital chaplaincy team has brought a realisation of similarities in ways of working, and a shift to understanding others by their actions and individual thoughts, rather than through membership of a group.

Perhaps it was the childhood influences that led to a bottom-up, person-centred attitude, with a bias towards actions and practicalities rather than theory resulting from the experiences of firstly self-employment, then from being a director of limited companies. I currently feel the role of chaplaincy staff to be one of spiritual, ethical, moral and emotional support and suggest that the therapy guideline of always considering 'what is right for the client at that time' equally applicable to encounters with patients. When pressed to sum up an aim in life, I came up with a perhaps simplistic motto of 'making good things happen, and bad things stop'.

Given the above, and past experiences as the NRPSN South-East coordinator, the potential exists for bias favouring a non-religious, Humanistic perspective. A discounting or exclusion of minority faiths could also occur, lost in the broader establishment vs atheist debate. The need to bracket off my personal views as far as possible is recognised, and a reflexive section is included in the conclusions chapter. Although it felt more natural to write reflexive passages in the 1st person, to help maintain an academic perspective, a 3rd person narrative is used for the body of the dissertation.

CHAPTER 2

Methodology

2.1 Choice of review approach

This dissertation seeks to review the integration of different faiths and beliefs within NHS England hospital chaplaincy. Following revised chaplaincy guidelines (Swift, 2015b) and demographic changes to the point where those with no religious belief are in the majority (Natcen.ac.uk, 2019) it is essential to explore how well the existing Anglican chaplaincy teams have adapted to meet the worldviews and beliefs of others. Conducting a narrative literature review allows different research to be compared and contrasted, such as the doctoral theses studying the experiences of Anglican (Kyriakides-Yeldham, 2017) and minority faith (Bryant, 2018) chaplains, while also using 'grey' literature to explore the extent of integration experienced by service users.

As a Humanist pastoral carer with experience over three and a half years, the researcher was already aware of some relevant specialist literature available. The decision to use an indicative narrative approach did, however, raise the risk of bias, particularly considering the author's beliefs, as well as the difficulty in replicating online searches due to the nature of algorithms evolved to individual users. The specialist nature of healthcare chaplaincy simplified finding relevant information, although the different strands uncovered led to the use of sub-sections proving useful (Figure 2.1, below).

2.2 Review approach

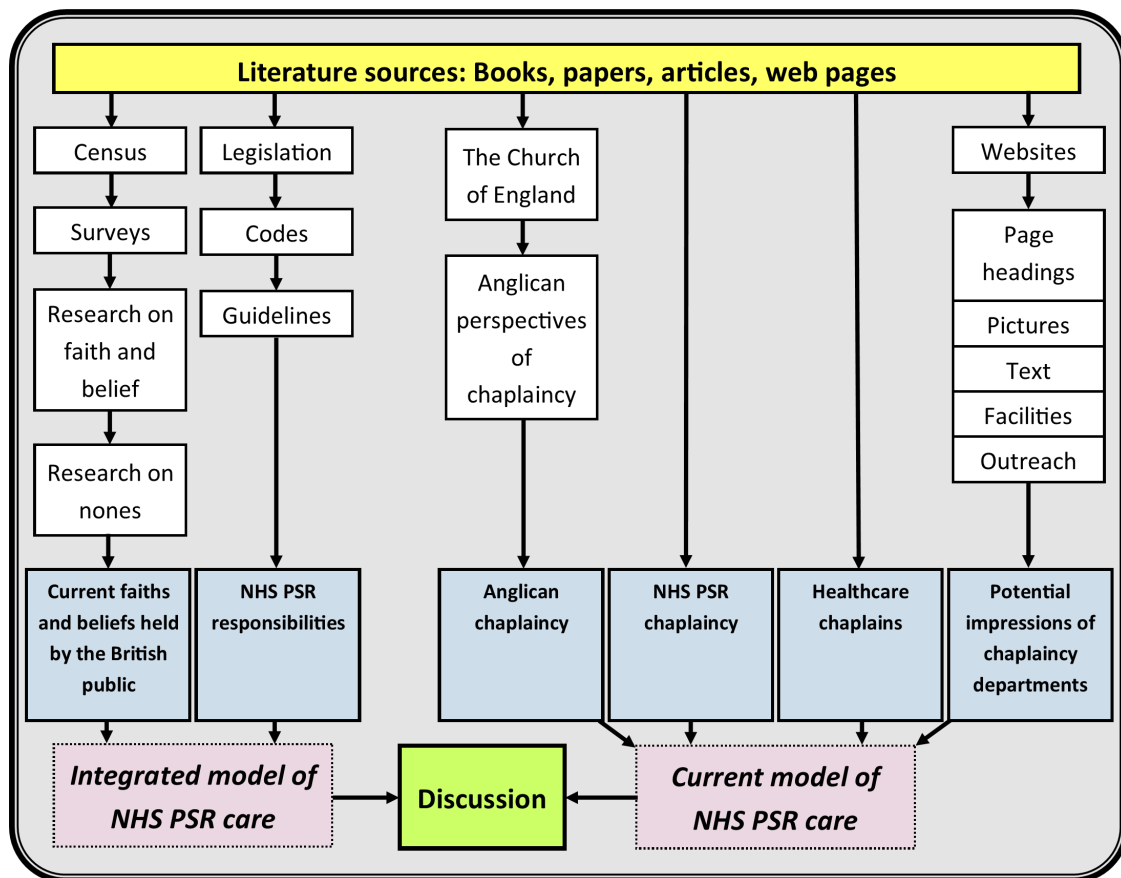


Figure 2.1: Overview of research

The research started with two questions – 'What PSR framework would meet the needs of all service users?', and 'What system do we currently have?'. Using literature already found and general online searches, a framework was constructed identifying different dimensions, evolving with new sections and sub-sections added as necessary to categorise the findings (Figure 2.1, above). A pragmatic and tailored approach was taken to identify material relevant to each section. Where appropriate, a critical appraisal of empirical research was carried out using CASP (2018). The researcher identified six dimensions of literature as important for obtaining sufficient information for this exploration of the integration of minority faiths and beliefs within NHS hospital chaplaincy.

i) Current faiths and beliefs held by the British public

ii) NHS PSR responsibilities
iii) Anglican Chaplaincy
iv) NHS PSR care
v) Healthcare chaplains
vi) Potential impressions of chaplaincy departments

2.3 Review Methods

As well as the information held already, found serendipitously through the BACP 'Thresholds' journal (Freeth et al., 2017) and advertising (Savage, 2018) or in the news (Church of England, 2019; Sherwood, 2020; Church of England, 2020), a literature review was conducted using printed and online material. A 'grey' literature study of hospital chaplaincy websites was also undertaken to explore the potential impressions formed by the British public regarding hospital chaplaincy.

2.3.1 Conventional literature research

Initial searches were conducted online through Google and Google Scholar to gain an overview of the research area, with structured searches undertaken as detailed below once a pattern had emerged. Online searches were conducted as necessary during research to check potential areas for study. As a chaplaincy, and particularly healthcare chaplaincy are fairly specialist areas, it was possible to identify, obtain and read the relevant handbooks and guidebooks.

Search terms used
Searches for material relating to minority faiths and beliefs within NHS PSR revealed the terms 'minority faiths and beliefs', 'spirituality', and 'non-religious' to be too general. The terms 'chaplaincy', 'pastoral care', 'spiritual care' 'multi-faith', and 'all faiths' were used, with 'non-religious', and 'minority faith' finding the most appropriate material. All terms were checked on the academic sites, with only the last two used if there were more than 250 or so possible items on any of the first six terms. The same procedure was used for the professional journals, due to their specialist nature, only the terms 'non-religious' and 'minority faith' were used. Where particular areas of interest came up, google scholar was used for checking specific topics (i.e. 'challenges to 2011 census religion question'). A 'snowballing' technique was adopted, with the

references for each new source checked for new potential material. Searches did not extend back past 2015, due to the change in working practice resulting from the new guidelines (Swift, 2015b). No exclusion terms were used in the searches; all potential articles and reports were checked individually for relevance to the research question.

Academic Journals
The researcher had access to the 'Health and Social Care Chaplaincy' online archives, 14 articles were identified as having a potential relevance for later research; nothing was recognised for this project. Searches in the 'Journal of Health Care Chaplaincy' identified 451 potential articles, with copies of the three relevant (Nolan, 2016, 2019; Schuhmann, Wojtkowiak, van Lierop & Pitstra, 2020) being obtained through the Tunbridge Wells hospital library.

Academic Web searches
Two academic sites were used, Academia.edu and Researchgate.net. Searches on the first revealed 254 titles on 'non-religious chaplaincy'. Seven of these were for 'Minority faith chaplaincy' and 54 for 'Multi-faith chaplaincy'. When filtered for relevance to this project, one remained (Hewson & Crompton, 2016) although this source had already been identified. Researchgate.net netted 46 titles, under 'non-religious' with a single paper potentially useful for later projects.

Chaplaincy Handbooks
As a chaplaincy is a specialist field, it was possible to identify 11 relevant handbooks either from experience, references in other publications or searches online. Those released after the revised guidelines (Swift, 2015b) were given preference. The differences between healthcare and non-healthcare chaplaincy were noted and respected, regarding how the data was used.

2.3.2 Potential public impressions of chaplaincy departments, 'grey' literature search

While legislation, rules and guides define the NHS PSR care that should be available, delivery of the service is in the hands of individual hospital trusts. The experiences of individual service users cannot be explored through traditional literature sources. Without this information, it is hard to understand the extent to which minority beliefs

and faiths have been integrated, resorting to 'grey' literature provided a way to fill this gap.

The information on websites is not accidental but chosen, as such, it can be seen as the way a chaplaincy department has decided to present itself. For patients, relatives and friends who wish to know more about the spiritual, pastoral and religious care available at a hospital, websites can provide current information and host downloadable guides to the services and facilities available. These can be accessed by those away from home or searching on behalf of patients elsewhere. While lacking the academic rigour provided by using conventional sources, this aspect of the review represents the information more readily available to the general public while allowing a broad overview – the first impression gained on how well a hospital will meet their PSR needs.

Due to the individual nature of search algorithms and the level of personal interpretation required, this research method presents risks regarding both reproducibility and bias. Hospital websites were, however, usually among the top few entries when searched for using the methodology detailed below, it seems unlikely that the experience of others will be much different. The coding used has also been provided (Figure 2.2 below), including examples for each section, and should prove usable by others. It is believed that this is the first time this approach has been used; the researcher is open to correction or suggestions for changes and alternatives. Despite the challenges, it was felt that the potential benefits of this approach justified its use.

The research was based on a list of hospitals created by Humanists UK based on NHS data to sort hospitals into regional areas. During the study, 14 additional facilities were found and added, and one removed when substantial evidence of its closure was found. In all, 356 hospitals were identified over the nine English regions. Data was collected over 41 days, with results stored in an Excel spreadsheet. Five alterations to the nature of the data collected were made over this period as the researcher became more familiar with the material, and previous work was revised accordingly.

Searches were undertaken through Google by typing in the hospital name followed by 'chaplaincy' and were limited to the first page of results. Where multiple links were found, including PDF documents and generic NHS 'Facilities' pages, these were also viewed. Data from these different sources were combined where necessary. Non-NHS third party pages were not included in the study, even if the highest-ranking result, the only one found for that hospital or non-hospital pages using wording implying that that they were the official chaplaincy page.

Information was coded to identify the extent of integration in the five areas studied; examples are given below:

	Heading	Picture	Wording	Facilities	Outreach
Inclusive	Pastoral and spiritual care - chaplaincy	Secular design, sculpture, etc.	Inclusive of all backgrounds, beliefs, etc	Spiritual space for any belief	Other faith, belief representatives
Insufficient or conflicting	Chaplaincy	Picture unrelated to chaplaincy	Unclear from wording	Faith room available for all	Unclear from wording
Faith-centric	Chaplaincy for all faiths and none	'All faiths and none' logo	All faiths, people of no faith	Room for all faiths and none	Your local faith leader
Faith only	Faith centre	Montage of faith-themed images	Working across faith boundaries	All faiths prayer room	Local faith communities
Selected faiths or beliefs	Chapel and mosque	Multi-faith logo	We are here for all (*specified faiths)*	Chapel and prayer room	Main World religions
Single faith or belief	Chapel	Single faith, belief represented	We are here for all (*single faith)s*	Chapel	Specified faith contactable

Figure 2.2: Examples of codes used

2.4 Limitations to the literature review methods used

Hospital web sites varied greatly, with no standard layout, differing levels of information provided, broken or missing links and freestanding PDF files identified independently during searches. Hospital sites sometimes also contained conflicting information or redundant pages. Those hosted on the leading trust site did not always appear directly in searches but were found through generic NHS hospital 'Facilities' pages. Although these can contain a small hyperlink link at the top, this option was not always utilised or was sometimes broken. It was not possible to find information on nearly a ninth of the hospitals identified.

The single researcher involved holds non-religious beliefs. As well as the potential for unintentional personal bias, he may have been overly cautious at times, overcompensating in an attempt to remain neutral. It is also possible that his background helped in identifying issues that may not be so apparent to someone with a different belief background. The data and analysis have not been peer-reviewed.

2.5 Ethical dimensions of conducting this literature review

The quality of literature reviews will be affected by the relevance and accuracy of the source material selected, and the ability of the researcher to remain as neutral as possible. With NHS hospital chaplaincy being a specialist and easy to define field, the significant sources of information are relatively easy to identify either directly, or through existing sources. To counter potential personal bias, the researcher remained aware of the spirit of cooperation and professional respect within academic research in this subject.

The use of 'grey' literature, with the attendant risks of subjective interpretation, was only adopted when it became apparent that it was the most effective way to gather information that would otherwise be unavailable. Examples of pictures, wordings and working practices have been used where they indicate more effective ways of integrating PSR care for all service users. No personal details or images were reproduced. All data used for the 'grey' literature review is in the public domain.

As a white, older male, the author sought to remain aware that potential chaplaincy service users come from many different faith and belief perspectives, some radically different in their practices. Equally, when conducting research, especially on minority faiths and beliefs, it is necessary to leave the comfort of a personal world view. The very people at risk of exclusion may be the least likely to have their voice heard or their spiritual needs understood, they may be shut out or discounted by language, status, access or cultural comprehension. While conducting the reviews of both academic and public domain non-academic literature respectfully, the researcher will, however, address challenges revealed in the data.

CHAPTER 3

Findings

To understand the extent of integration of minority faiths and beliefs within NHS hospital chaplaincy, it was decided to avoid relying on a single perspective, especially one rooted in the status quo. While laws, rules and guidelines relating to integration may exist, this does not guarantee that they will be adopted, or have the desired effect. Many hospital chaplains feel disconnected from the main body of their church regarding their role with regard to those with different faiths and beliefs (Swift, 2014; Kyriakides-Yeldham, 2017) and, as detailed below, the terms 'chaplain' and 'spirituality' have multiple meanings which can lead to the exclusion or discounting of service users with minority worldviews. Imbalances in the staffing and functioning within chaplaincy teams appear evident to some (O'Donoghue, 2020), yet not to others (Williams, 2020), again hampering the inclusion of all patients and staff.

Areas of literature explored

This chapter arranges the findings of the review of literature into six sections. As detailed below, these include 'grey' literature sources as well as perspectives from those providing hospital chaplaincy care. Together,they provide a broad perspective regarding the integration of minority faiths and beliefs within NHS hospital chaplaincy.

The British public

The NHS is open to all UK citizens equally, regardless of race, age, gender, faith or belief. In order to provide an effective and inclusive service for all, it is necessary to understand what these variables may be. Just as hospitals will need relevant data to plan medical services, ranging from births to hip operations, so it will also require information to provide appropriate chaplaincy care. This can be gained through studying census, surveys and academic research in this area.

NHS PSR responsibilities
The NHS is obliged to follow general employment, public safety and equality legislation. There are also general professional standards and codes of conduct for all staff, as well as those relating specifically to the provision of PSR care. In addition, there are also professional guidelines providing more detailed and current clarifications.

Anglican chaplaincy
Hospital chaplaincy has its roots in the Church of England, with the majority of the paid and unpaid hospital chaplaincy staff still coming from this tradition. Where churches mainly focus on congregations who choose to come to them for spiritual support, chaplaincy staff are external agents with a service to offer to all. It is necessary to understand these differing roles, particularly following the 2015 chaplaincy guidelines(Swift, 2015b) and their relevance to the integration of minority faiths and beliefs.

Healthcare chaplaincy literature
As well as the official codes and guidelines, literature is available relating to the provision of hospital chaplaincy care. These are important not only to understand how all worldviews are supported, but to check for instances where minority faiths and views are being included or excluded through the use of language, access to physical spaces, appropriate staff or in any other way.

Healthcare chaplaincy
Hearing the views and experiences of individual chaplains and pastoral carers provides insights into the practical realities of their role, their working practices and the language they use regarding service users with minority faiths and beliefs. Studies and papers on chaplaincy staff provide a different perspective relating to the research question.

Potential impressions of chaplaincy departments
Organisations will be judged to a greater or lesser extent by the public images and messages they present. Potential service users from minority faith or belief backgrounds may feel excluded or welcomed by what they read in chaplaincy department literature, and decide in advance of hospital visit to avoid or make use of any PSR care available. For many, if not most of us, the easiest way to gain information is via

the internet. The study below indicates the extent to which chaplaincy departments engage with the public online.

3.1 Current faiths and beliefs held by the British public

Chaplaincy departments exist to meet the pastoral, spiritual and religious needs of the British public. As the Country has moved from a single, dominant faith to embracing a multitude of spiritual, faith and philosophical worldviews, it is important to understand the current demographics in order to provide an equitable service open to all faiths and beliefs. Confusion can result when studying census and surveys regarding the British public to the different countries and areas within Great Britain. Health care in the United Kingdom is provided through four regional groups, with England, Scotland, Wales and Northern Ireland having separate organisations and working practices. The term 'NHS' is used the government to denote cover in England, with the other areas adding a prefix or suffix to differentiate themselves. This dissertation covers NHS hospitals in England; data covering wider areas are identified accordingly.

3.1.1 Census

This section uses the largest scale survey of the British public in order to explore how they self-identify regarding belief or religion. A census is conducted every 10 years by the Office for National Statistics, with the last held in 2011. Covering the populations of England and Wales, this data is used by the NHS when formulating policy on NHS PSR care (Office for National Statistics, 2011b). Question 20 asked 'What is your religion?' (Office for National Statistics, 2011b, p. 8), following the clarification that any reply was voluntary, eight options were provided allowing participants to choose 'No Religion', alphabetically between Christian, Buddhist, Hindu, Jewish, Muslim and Sikh or 'Any other religion'. Those selecting the last option were allocated 17 boxes for their response.

Of the 53,012,546 people surveyed in 2011, nearly 60% answered 'Christian', with nearly 25% identifying as non-religious (Office for National Statistics, 2011a). Doubts were raised however regarding the accuracy of the survey. Allowing the head of the

household to complete the Census on behalf of presumably younger family members may have led to an under-reporting of nones, (Lancaster University, 2016), especially when considering the differences noted below. Woodhead (Woodhead, 2017) also emphasised the importance of framing the research question, suggesting that asking 'what is your religion?' is a leading question. A challenge has also been made regarding the influence of cultural identity and social affiliation and the potential under-representation of nones (Humanists UK, 2015).

3.1.2 Surveys

With a continuing decline of the Church of England since the mid 1980's (Brown & Woodhead, 2016) the numbers recorded eight year years ago in the last census may also have changed. More current information is however available through British Social Attitudes (Natcen.ac.uk, 2020) surveys, which seek to explore the experiences of those living in Britain by interviewing 3000 participants a year, chosen by random probability sampling. Survey Nº 36 (Natcen.ac.uk, 2018) included a study on religious identity in Britain for the period between 1983 to 2018. Information obtained regarding minority faiths and beliefs is provided below.

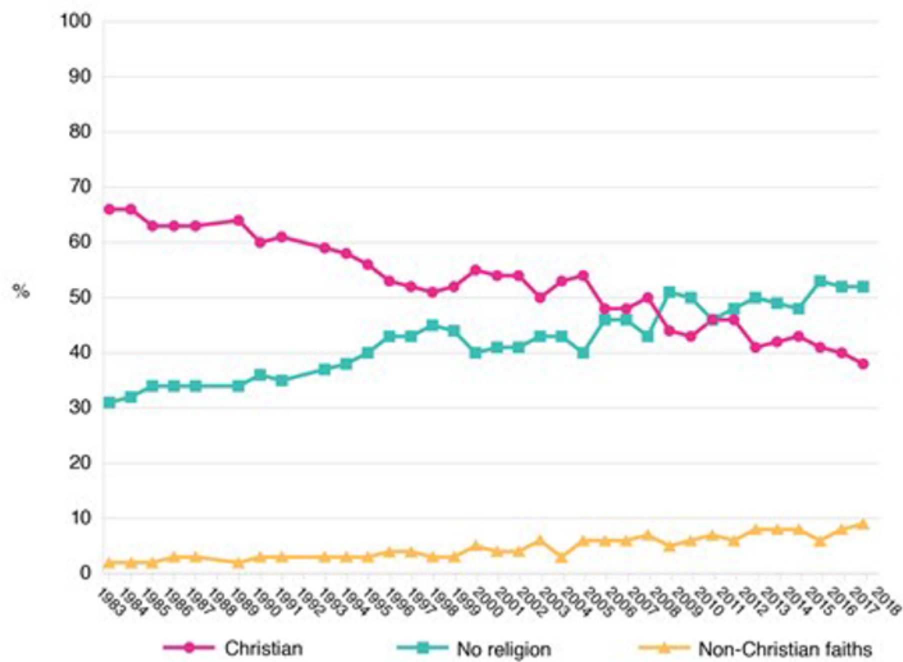


Figure 3.1: Decline of religion in Britain from 1983 to 2018 (Natcen.ac.uk, 2018)

The above is reflected in data collected for Great Britain by the Office for National Statistics regarding 'Annual Population Survey and the Labour Force Survey' (Office for National Statistics, 2018). During the years 2010 to 2016, the percentages for all Christians fell from 70 to 55, while the non-religious rose from 20 to 34. The numbers for other faiths increased over this period from 10% to 11%. Research on the members of Christian churches in the UK between 2005 to 2010 (Brierley, 2011) slightly reflected the trend, with a fall in membership from 12.3% to 11.2% within these dates.

Data from the BSA (Natcen.ac.uk, 2017) also provides a breakdown of faith and belief by age group. While 53% of all participants identified as having no religion, the figure rose to 71% for 18 to 24-year-olds. Similar results were found in a report (Bullivant, 2018) composed with data from the European Social Survey, with information from both ESS Rounds seven (2014) and eight (2016) surveys combined increasing the sample size. The study found 70% of 16 to 29-year-olds identify as non-religious, with 22% as Christian and 8% with other religions. With relevance to the future of PSR care, only 1% of 18 to 24-year-olds identify as Anglican.

3.1.3 Research on faith and belief in the UK

The census and surveys above identify affiliation to a religious organisation but not the intensity of that allegiance. They also do not recognise those holding an alternative worldview. Bulk data collection through box-ticking also limit options, Catholics and Protestant Christians, and Shia and Shiite Muslims can practice their faiths in very different ways. Although the 2011 census (Office for National Statistics, 2011b) did provide a limited option for self-identification regarding belief or faith, this complicated and personal subject benefits from a more profound analysis. The BSA data (Natcen.ac.uk, 2017) above suggests that the majority of the British population are non-religious, but this does not automatically define them as having no spiritual belief. Research is needed to gain a more in-depth insight.

3.1.4 Research on 'nones' in the UK

Research by Woodhead provides comprehensive insights into the world view of nones:

> On the whole they do not much care for religious leaders, institutions and authorities, but they tolerate them. While many nones say that it is acceptable for religious leaders to speak out on various topics, they also say that they take no notice at all of what they say (Woodhead, 2016, p. 250).

It was also found that 'nones dislike being preached at and told what to do; they prefer to make up their own minds' (Woodhead, 2016, p. 251), and that while nones have similar views on economics and politics, they tend to be more cosmopolitan - especially when compared to Anglicans (Woodhead, 2016). Regarding ethical issues, nones share a general British strong support of individual freedom – just more passionately, with a strong focus on the right of self-determination. Sharing a similar liberal attitude with ordinary Anglicans on 'hot' issues such as same-sex marriage, abortions and assisted dying both these groups find themselves at odds with 'Muslims, members of conservative evangelical Christian denominations and Anglican and Catholic Bishops' (Woodhead, 2016, p. 252). Tolerant to public religion, nones reject classification or labelling, wanting to establish a unique identity (Woodhead, 2016).

This reluctance to be labelled extends to descriptions such as 'atheist', 'secular, 'Humanist', or even 'spiritual'. Woodhead (2017) suggests that, based on 2013 data, 67% of nones are neither spiritual nor religious (NSR), as are 48% of the rest of the population. The contrast with the 2011 census findings (Office for National Statistics,

2011b) was noted by Todd (2015a) although the validity of the Census has been criticised from different perspectives (above).

No reference appeared to be available for the citation 'Source: Woodhead/YouGov 2013', (Woodhead, 2017, p. 255), however a search of the YouGov site for 2013 revealed two papers (YouGov / University of Lancaster Survey Results, 2013a, 2013b) with the same research questions. Combining the data suggests that less than a third of the population identify as spiritual and/or religious, while just under half of the population choose an identity that rejects being labelled as either spiritual or religious. This has a relevance to not only potential census and survey questions, but also the language used in chaplaincy literature, if nearly half of the population reject the terms 'spiritual' and 'religious', how will they relate to a 'Pastoral, Spiritual and Pastoral Care' department?

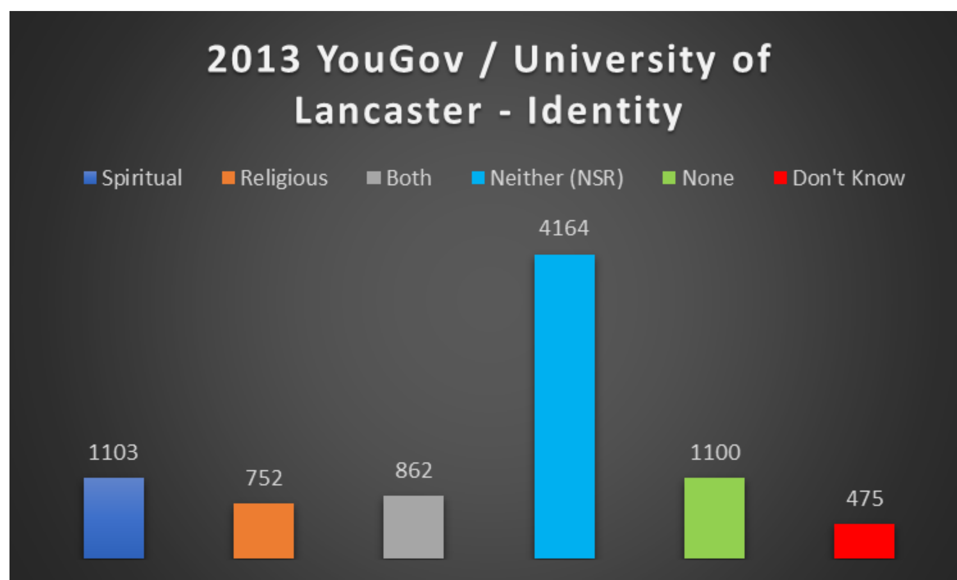


Figure 3.2: Combined 2013 data on religious identity

Data collected in 2017 (Bullivant, 2017) provides a more up to date and detailed picture of those identifying as none. Of this group, 3.1% were categorised as having high religiosity and praying at least monthly. A further 11.5% either had high religiosity or prayed monthly. Within the remaining balance of 85.4%, 40.3% of the group is not religious at all and do not pray.

A similar breakdown of the religious group is not available to show the commitment of their religiosity. This total could have clarified the extent to which faith is held as a 'social' construct. Both this data and the findings of Woodhead (YouGov / University

of Lancaster Survey Results, 2013a, 2013b; Woodhead, 2016, 2017) do show that simple box-ticking does not cover all the traditional categories of belief and faith, as well as the significant number of the population who identify as NSR.

This broader perception of faith and belief is reflected in the way that many chose to mark significant events in their lives. Previously, chaplaincy teams were able to provide baptisms and funeral services in the formats familiar in ordinary life, Woodhead suggests that nones are open to the idea of religious content in celebrations and ceremonies while rejecting the dogmatism of the past (Woodhead, 2017). The growth of Humanist and other non-religious services has reached the point where, in 2016, civil marriages outnumbered religious ones by three times (Office for National Statistics, 2016). Many nones do engage in religious and spiritual practices and rituals personal to them, including praying; they want to take control, rather than be led or directed (Woodhead, 2017). It seems probable that appropriate and effective PSR care for nones will need to encompass and support their input.

Accepting the current demographic picture noted by Woodhead (2016), Atherstone (Atherstone, 2016) suggests that the changes resulted from young people being more honest than their grandparents and parents. In acknowledging their lack of faith, rather than accepting a social identity, the youngsters demonstrate integrity in their attitude to religion. This integrity is reflected in Woodhead's view (2016) that the term none does not indicate a void or absence. The term instead shows a decision to choose a moral and spiritual identity that is in tune with a liberal worldview of personal freedom, individuality and inclusion, and which they do not perceive as being available from the formal, historically based structures of the past.

In later research, Woodhead (2016) confirmed that nones, rather than believing in nothing, have robust codes regarding personal ethics. Believing in self-autonomy for all so long as no one else is hurt in the process, they refuse to be labelled as religious, even if they do believe in a God or gods. They share a common trait with the majority of the population – including many who do have a faith – in that 'they consult their conscience, reason and intuition rather than relying on an external authority or friends and family'(Woodhead, 2017, p. 253). For those who do have a faith, travel, modern media, cultural and social changes in retail, politics, education and improvements in diversity and equality have all helped to nurture the growth of alternative sects and sub-sects (Woodhead, 2017).

Later research suggests that self-identification is contextual, dependant on how the person wishes to be seen by the person they are talking with. 'Non-religious'

is seen as a moderate, more gentle alternative to the more confident description of 'atheist' 'which often comes across as being quite aggressive' (Lee, 2015, p. 135). The dominant role of the concept of 'religion' has also been challenged regarding the lack of suitable terms to express non-participation, 'religion is an exclusive category that has been allowed to masquerade as an inclusive one' (Lee, 2015, p. 196-7). Rather than a simple difference between the presence or absence of a faith, understanding the latter requires 'recognizing-sometimes more clearly, sometimes for the first time-a number of prior questions about the nature, variety and pervasiveness of non-religion' (Lee, 2015, p. 185).

3.2 NHS PSR responsibilities

Having identified the potential PSR need of the population, it seemed logical to explore the obligations of the NHS to provide appropriate care to those with minority beliefs and faiths. All paid and volunteer NHS England staff are required to follow legal, professional and local working procedures, including those relating to the provision of chaplaincy care. The sections below detail the relevant legislation, professional codes and guidelines. While the latter two may have an element of discretion subject to the ethics involved in individual cases, the obligations imposed by law are less fluid. Local practices will vary between trusts; the sections below focus on the obligations common to all staff.

3.2.1 Legislation

The laws recognising and confirming the PSR requirements of patients and other service users have evolved and been reinforced over time, covering both the nature of individual needs and the availability of suitable staff to provide them. Rather than attempt to engage with this material from an untrained perspective, the relevant statutes are identified below. Legal practitioners may be able to identify other potentially relevant legislation; uncertainty remains at the time of writing regarding the future relevance and force of European Union legislation, and the potential loss of protection for those with minority faiths and beliefs.

The Human Rights Act (2019) confirmed citizens' fundamental freedoms and rights, with Section 13 covering those relating to those of conscience, thought and religion, requiring that public authorities act in a way compatible with these rights. In 2006,

three commissions tasked with policing diversity and equality were replaced with a new one with a focus on equality and human rights (Equality and Human Rights Commission, 2010). Section 44 of the 2006 act covered religion and belief; this was repealed and replaced by section 10 of the 2010 act (Equality and Human Rights Commission, 2010) which confirmed the protected characteristics of all beliefs and faiths, also conferring the same status to the lack of belief or faith. Article nine of the European Convention on Human Rights (European Court of Human Rights, 2010) again recognised the equal status of belief or the lack of either, and the right to teach, practice and change faith or belief with the constraints of public order, safety, and the rights and freedoms of others.

3.2.2 Codes

As with other professions, the conduct of members is regulated by codes of conduct. Breaches of these can lead to sanctions up to the loss of membership (and therefore, employment). These codes provide ethical guidance allowing staff to respond appropriately in often unique situations. Staff have some freedom in carrying out their duties, but must be able to justify their decisions and actions – including those affecting service users with minority beliefs and faiths, who are entitled to equal care and respect.

Although there are multiple chaplaincy groups and organisations, the Code of Conduct for Healthcare Chaplains (UKBHC, 2014) developed by the UK Board of Healthcare Chaplains (UKBHC) in conjunction with other healthcare organisations is also used by the College of Health Care Chaplains (CHCC). It is also used, with minimal changes as the foundation for the code of the Non-Religious Pastoral Support Network (NRPSN). It is a requirement for all professional PSR staff to comply with the UKBHC code. Adherence to the sections regarding minority belief and faith will have a significant impact regarding their integration within NHS hospital PSR care.

The Code of Conduct recognises the difference between, but equality of, faith and belief and requires respect for 'the rights of individuals, belief groups and faith communities to hold their values, traditions, beliefs and practices' (UKBHC, 2014, p. 7). There are requirements to 'not impose your values, beliefs or practices on those in your care; or fail to respect their beliefs, values or spiritual interests' (UKBHC, 2014, p. 8). Chaplaincy staff are also required to 'respect the autonomy of those in your care including their freedom to make decisions contrary to your beliefs, practices or advice'

(UKBHC, 2014, p. 9). The role of colleagues from different belief groups and faith communities in working together to provide appropriate care is also recognised.

3.2.3 NHS chaplaincy guidance

Guidelines are provided for the provision of Chaplaincy care, promoting good practice and 'promoting excellence' (Swift, 2015b, p. 1). These are subject to review and revision over time to reflect changes in society and the NHS and to encompass new legislation. Although confidential draft copies of the 2019 revised guidelines have been circulated (the researcher had a minor role in their development) they have not been finalised and made public at the time of writing. Those issued in 2015 (Swift, 2015b) remain in force, these refer to the 2010 Equality Act (Equality and Human Rights Commission, 2010), and provide fresh guidance regarding PSR care for all, regardless of belief or religion.

As with the UKBHC Code of Conduct (UKBHC, 2014), a patient-centred, inclusive tone is used throughout, with specific reference made to the equality of faiths and beliefs. In the Executive summary, the term 'Chaplaincy' is defined as applicable to the provision of pastoral, spiritual and religious care as well as the staff involved. Spiritual care is noted as including a wide range of areas, including support during recovery, mortality issues, religious and non-religious convictions, practices and rituals, significant relationships and broader questions concerning the experience and exploration of faith and belief. The 2006 Equality act (Legislation.gov.uks, 2006) is cited in support of this integrated position, the summary concludes with a confirmation that the NHS is 'focused on ensuring that all people, be they religious or not have the opportunity to access pastoral, spiritual or religious support when they need it' (Swift, 2015b, p. 6).

These views are reinforced throughout the guidelines, with the changing demographics of the population regarding beliefs, cultures and religions recognised, and the requirement that 'critically the experience of patients and carers is enhanced by ensuring either religious or non-religious pastoral support is available' (Swift, 2015b, p. 7). The need for appropriate support for particular beliefs or faiths is recognised, as well as the right of those receiving care to not experience it as either proselytising or insensitive. The provision of non-religious spiritual and pastoral support is recognised as a requirement for 'best practice'. Minority faiths are not mentioned in section four (Staff and Organisational support), (Swift, 2015b, p. 11), although section five (Key

Components for an Effective Chaplaincy Service), (Swift, 2015b, p. 12) does refer to the provision of facilities such as storage for religious items and running water.

Many PSR hospital visits are carried out by volunteers who are selected and then trained locally. All are expected to be aware of and follow the UKBHC Code of Conduct (UKBHC, 2014) – including the sections relating to minority faiths and beliefs. The guidelines also note there may be volunteers from local minority belief and faith groups to provide appropriate support and advice. These volunteers are required to be in regular contact with their belief, or religious community.

Managing chaplains are reminded of the obligations under the European Convention on Human Rights (European Court of Human Rights, 2010) and the Equality Act (Equality and Human Rights Commission, 2010) towards those with a minority faith, belief, or different worldview. The importance of gathering and storing details regarding belief or creed are noted, as well as the need to check both these details, and the experience of service users knowing about and using the services available – including agreed PSR outcomes. The importance of considering those without a belief or religion when planning or employing staff is also highlighted. Chaplains and PSR teams are encouraged to engage with 'inter-faith groups and other relevant patient forums, including those that are non-belief and non-religion.' (Swift, 2015b). While noting regional differences and challenges, the need for the provision of a suitable area for prayer, meditation, tranquillity and similar uses, is recognised to meet human rights and provide equality.

Further information in support of the guidelines is available online from NHS England. The 'NHS England Chaplaincy Guidelines 2015: Equality Analysis: Promoting Excellence in Pastoral, Spiritual and Religious Care' (Durairaj, 2015) download again highlights the need for PSR to reflect the changing population demographics regarding faith and to be aware of the legally protected rights of all regarding beliefs and faith. In addition to providing data regarding religious affiliation of the population, concerns expressed regarding religious connotations of the terms 'Chaplaincy', and 'Chaplain' are noted and addressed. The lack of data regarding the belief or religion of chaplains and the challenge this presents in ensuring that the belief and faith requirements of all patients are highlighted,

3.3 Anglican chaplaincy

As the traditional provider of chaplaincy staff in hospitals, schools, universities and prisons, the Anglican tradition has shaped the language, character and settings of NHS PSR care. Anglican NHS chaplains have a responsibility to both the Church and their employer. The broader discussion regarding the role of chaplaincy can present challenges to both the provision of healthcare chaplaincy and the general public perception of the title. With an increasing majority rejecting formal religion (Woodhead, 2016, 2017), a failure to differentiate NHS PSR care from other forms of chaplaincy and the language and attitude of the Church of England can lead to a disconnection between chaplaincy departments and potential service users.

3.3.1 The Church of England

In a document available online (Church of England, 2017), the Church of England outlines a clear vision of reform and renewal for the future. The report recognising falling levels of attendance, calling for the message to be taken to the people in order to reverse the decline by gaining new disciples. There is reference to evangelising at random and planned encounters and profound moments in life, as well as the claim that the church is still there when nobody else is willing to help (Church of England, 2017, para. 11).

The Church of England website has a page specifically for healthcare chaplaincy (Tony Kyriakides, 2020), confirming that care is available to all, as required by the revised guidelines (Swift, 2015b). The tension resulting from holding the role of both priest and healthcare provider is noted, as well as the specialist nature of the work, the need to be adaptable and flexible and the freedom to be creative and innovative in sacramental, liturgical and pastoral ministry that can provide enjoyment (Tony Kyriakides, 2020, para. 1). The page is a personal account, mentioning to friends made from other faith communities, in an interfaith partnership. Healthcare chaplaincy is described as focusing on 'health, healing and wellbeing; on suffering and theodicy, therapeutic practice and Christian ethics, mortality and pastoral care, as well as 'wounded healers' and reflective practice' (Tony Kyriakides, 2020, para. 1).

The traditional role of the Anglican Church has led to arguments being made for its sole, or majority responsibility for the provision of pastoral care (Ryan, 2015; Stewart-Darling, 2017). This view has been challenged (Savage, 2018; Galashan, 2015), with

Galashan (2015) pointing out the benefits of having pastoral care provided entirely by the non-religious. These views are discussed later.

The friction described between regular Anglicans and their leaders (Woodhead, 2017) was illustrated in early 2020, following the release of a statement regarding the sexual conduct of same and different-sex couples, admitting that 'a substantive gap (had) emerged between the Church's understanding of marriage and that of the State.' (Church of England, 2019, para. 3), and instructing clergy to follow church teachings regardless of their personal feelings. The resulting internal criticism by about 800 clergy and 2,200 others who felt disappointment and anger (Sherwood, 2020) led to an apology for the hurt and division caused but not a withdrawal of the original statement (Church of England, 2020). This friction could lead to an increasing strain for Anglican chaplains attempting to reconcile both roles.

A report released later in 2020 by the Ozanne Foundation also highlighted the rift between church leadership and membership (2020). Although Anglicans lag behind the three-quarters of the general British population supporting the right of members of the same sex to marry, just under half do agree, rising to all but a third for those under 50. Calling for acceptance of this reality, and a change in attitude to reflect rapidly changing public views, the report expresses interest in finding out how this issue will be addressed in the forthcoming 'Living in Love and Faith report' (Ozanne Foundation, 2020).

3.3.2 Anglican perspectives of chaplaincy

As well as handbooks and guides for the provision of NHS PSR care (Bull et al., 2015; Baxendale et al., 2015; Freeth, 2017; Savage, 2018; Pattison et al., 2015; Swift, 2014), there are those written from a Christian perspective covering chaplaincy in other areas (Seeley, Ryan, Whipp, Bradley & Williams, 2017; Slater, 2015), which reveal differences in perceptions of the role. The decrease in church numbers has been recognised by the Church, with Todd (2017) noting how the evangelising drive in response has prioritised mission over chaplaincy's primary role of care. The shift for mission to focus on recruitment, and ministry on evangelisation, is raised by Caperton (2017), who expresses concern that 'the Church of England had been panicked into adopting a missionary agenda by grim church attendance figures and wider attitudinal research portending terminal institutional decline' and argues that it is wrong to instrumentalise ministry or mission for growth (Caperon, 2017).

The role that inclusive spiritual rituals can still play, as well as the challenges to a religious chaplain in a secular society, has been highlighted (Slater, 2015). Confirming that participation in a religious group is up to the individual, she also identifies how fundamentalist faiths have led to a climate of hostility and suspicion, citing their practice of proselytising. Rather than using chaplaincy as a vehicle to gain access for recruitment, she suggests instead that chaplains go to the places where people are to provide support, listen respectfully and to 'engage in genuine dialogue with a diverse society'. Such an approach could provide insights about human needs and desires in the process (Slater, 2015).

This approach is practised as a Christian only model. Rooted in theology and intentionally focused on 'the call to discipleship of the Christian community' (Slater, 2015, p. 101) professional and relational skills are used to 'respond creatively and faithfully to the challenges and opportunities that context presents as part of the Church's ecology of mission' (Slater, 2015). Todd (2017), considers that 'for the Christian chaplain, understanding of wellbeing goes hand in hand with a theology of redemption' (A. Todd, 2017, p. 33).

A faith-only model of providing business chaplaincy is outlined by Stewart-Darling (Stewart-Darling, 2017). This notes that, by engaging directly with business people, evangelical Christians 'have more freedom than working directly with companies who have a strong ethos in terms of a diversity and inclusion agenda' (Stewart-Darling, 2017, p. 64) and so avoid having to respect the beliefs and cultures of the lifestyles of others (Stewart-Darling, 2017). The role of the team is limited to 'promoting the role and value of wisdom from a faith perspective' (Stewart-Darling, 2017, p. 75) with a broader mission definition of 'helping Christians to live their daily lives as integrated people' (Stewart-Darling, 2017, p. 99). Although highlighting the benefits of diversity, the language used is faith-centric to the extent that faith and belief options are defined as 'religious, spiritual and anti-religious' (Stewart-Darling, 2017, p. 34), or as holding a faith, or not. Belief as an alternative to faith is not recognised 'people of other faiths or no declared faith allegiance' (Stewart-Darling, 2017, p. 42), or else discounted 'those who say that they are not religious' (Stewart-Darling, 2017, p. 65), and 'those of faith and those who say they have no religious conviction' (Stewart-Darling, 2017, p. 74).

Differences between healthcare and other chaplains have been identified. While some workplace chaplains share the view of their healthcare colleagues that proselytising must be avoided, the idea that the role 'must first and foremost to be to win souls for the kingdom of God' (Ryan, 2015, p. 42) was given by a sports chaplain.

Although this view was moderated by the consideration that this should only be done in a reactive rather than pro-active way, there remains the risk of the primary role subconsciously affecting the care provided. A focus not so much as 'what is right for this person', but 'becoming part of the kingdom of God will help this person, how can I help them join?' The opportunity to 'sow seeds' (McClelland, 2014) through chaplaincy is also noted by a university chaplain who describes his role as ''pre-evangelism' or even 'pre-pre-evangelism'' (McClelland, 2014, p. 41). This report also notes falling church numbers, and the potential of chaplaincy to reach those who do not attend (McClelland, 2014).

The use of faith-centric language in theological literature is neither unexpected nor contested, but is in contrast to the inclusive language of healthcare chaplaincy. This discrepancy has already been explored by Savage (2018) and is discussed below. In general, the phrase 'all faiths and none' can frame non-religious beliefs as an absence, while although 'multi-faith' now describes the minority of the British public, is often used to imply broader groupings. NHS chaplaincy facilities, in particular, are often described as multi-faith (Section 3.6.5).

In a guide to PSR care in hospitals that was written before the revised guidelines (Swift, 2015b), McClelland (2014) extends respect to other faiths, while viewing those with beliefs as in need of rescuing:

> 'When someone has a belief in God, there is no need for them to convert to another form of God worship, unless they desire to do so. There are plenty of people in the world that have yet to experience the love and knowledge of God without trying to convert people.' (McClelland, 2014, p. 14).

While the general tone of the book implies a sensitive and caring approach, the language is at times faith-centric (i.e. 'Meaning for the un-churched' (McClelland, 2014, p. 64)). It can be argued that this attitude demonstrates the need for chaplaincy teams to contain non-religious pastoral carers able to support service users who have a similar perspective. Unable to imagine the position of a non-religious young couple following the death of their child, McClelland's natural response is to turn to her faith as a solution for them (McClelland, 2014, p. 64).

3.4 NHS PSR care

The differences between healthcare and other forms of chaplaincy have been noted above. In this section, these differences are explored through training books and academic papers. In particular, the nature of the role, the extent of integration of minority faiths and beliefs and the language used are highlighted.

Hospital chaplaincy focuses on the needs of the patient, with a 'search for health and well-being and the desire to find ways in which people can experience such things even in the midst of illness, disease and disability' (Swinton & Kelly, 2016). This approach allows patients to engage with the broader philosophical, spiritual and religious questions from their perspective. Hospital chaplains meet the need for patients to be heard and understood, to be cared for as they struggle with these questions. For patients experiencing illness, loss, pain and suffering, PSR care helps them 'find themselves and their communities' at this time (Swinton & Kelly, 2016, p. 184).

Hospital chaplains often adopt an approach similar to that of Humanistic therapists, as demonstrated and discussed in books, articles and case studies (Savage, 2018; Baxendale et al., 2015; Bull et al., 2015; Nolan, 2019; Freeth et al., 2017). Chaplaincy who are also trained therapists are able to draw on counselling skills to help staff and patients to enhance their understanding of life and find their own identity (Freeth et al., 2017). As mention in the theoretical section above, there are differences between the roles, but a large amount of cross-over.

In practice, this results in hospital chaplains following rather than leading patients, 'I joined them a few minutes later. Den had not been religious and religion had not been part of my involvement with his family. They did not ask for prayers, and it felt inappropriate to offer any.' (Nolan, 2016). There is a dialogue with patients, and no automatic assumption regarding a desire to discuss faith 'When we first met you asked me about God and what had happened. Is faith something that's been important for you?' (Swift, 2015a, p. 138).

Swift (2014) suggests the need for chaplains to be able to listen respectfully and then respond in a creative way to individual concepts of spirituality. Also pointing to the widening gap between the current Anglican orthodox position from that of sections of Christians in society, Swift notes that it will be chaplains who are affected the most by the resulting tensions (2014). Suggesting that chaplains can no longer rely on the certainty of their historically privileged position, he also questions the need for

so many to be authorised by their organisations following the increased numbers of service users with spiritual needs that are non-religious. His feeling is that this is a growing issue and one which is becoming increasingly harder to defend (2014).

The traditional model of chaplaincy has also been challenged by Nolan (2019) by and Savage (2018), who, writing from a Humanist perspective, covered concerns raised subsequently by the NPSRCH report (2020). Noting how the dominant position of Christian staff within NHS PSR care does not reflect the balance of faiths and beliefs within the British public, Savage highlights the potential difficulty in recognising, respecting and providing care for individual worldviews and beliefs (2018). Examples are also given showing how language, printed literature, symbols and clothing can present a mainly Christian, faith-centric image of a department. Equally, the use of a Humanist logo to cover all forms of non-religious belief and imply full inclusivity is similarly misleading (2018).

In general, the language used within NHS PSR care has evolved to a point where chapels are now described as multi-faith spaces, a term also used for interdenominational teams. In 'A Handbook of Chaplaincy Studies' (Pattison et al., 2015), although the 'continued marginalisation of chaplains from smaller religious traditions, such as Buddhism and Sikhism' is noted (Gilliat-Ray & Arshad, 2016, p. 117), inclusion is limited to those with a faith. Similarly, in a chapter written from the viewpoint of chaplains as business people, PSR spaces are considered strictly in the context of being multi-faith (Hewson & Crompton, 2016), with the debate being about how to integrate the requirements of different faiths only. In highlighting that the term 'secular' is neutral rather than pro or anti-faith, Nolan (2017) confirms that the provision of PSR care should be for all equally, with responsibility for those with non-religious beliefs not provided in a way that would 'privilege religion, nor should it start from a religious perspective or define or constrain spiritual care by religion' (2017, p. 177).

Faith-centric language does occur within healthcare literature. A report on the 2015 guidelines notes concern over 'How equitable is the 'profession' of chaplaincy when viewed from a multi faith perspective? Multi faith and minority Christian denominations are mostly represented by part time chaplains' (McGettrick, n.d., p. 3). Another paper concluded that 'There appears no readily available language/discourse for many staff and patients in the sites visited with which they can talk more widely about faith and health, or faith and healthcare' (L. Todd & Tipton, n.d., p. 5). It will be hard to integrate the PSR needs of the majority of the population if their existence is not recognised.

The broader nature of spirituality is explored by Todd (2015b), although still within the context of multi-faith spaces for the faithful, multi-faith teams and making the argument that because chaplains are deeply rooted in their traditions, they work well with other beliefs and narratives 'their openness grows out of their being religious' (A. Todd, 2015b, p. 83). In a chapter later in the same book (Critical Care), Galashan (2015), notes the challenge to 'avoid replicating the pervasive cultural stigmatisation of certain faith or no-faith groups by the dominant traditions' (Galashan, 2015, p. 109), the dangers of proselytization and the existence of a chaplaincy ruling class. Galashan suggests that, logically, agnostic and atheist chaplains having no ties to faith would provide the most robust protection from spiritual abuse (Galashan, 2015).

An alternative model of PSR care has been developed which ensures that 'diverse and inclusive spiritual care is available to people of all faiths and none' (Marie Curie Organisation, 2018, p. 19). Recognising that it is not possible to meet all PSR needs with a single approach, chaplains were replaced with spiritual care coordinators who can provide PSR care, liaise with different local spiritual and religious communities, recruit appropriate volunteer staff from different belief and faith backgrounds and support staff to 'better understand and meet the spiritual needs of patients' (Marie Curie Organisation, 2018). Similar models may already have been implemented by hospital trusts, the revised title and language however suggest a potentially more equitable approach regarding the integration of minority worldviews.

3.5 Healthcare Chaplains

The literature review search process identified two doctoral theses which were particularly relevant to this study. One included 12 interviews with full-time chaplains who were also priests (Kyriakides-Yeldham, 2017), and another drew on field notes and interview transcripts with majority and minority faith and non-religious staff and volunteers (Bryant, 2018). A paper on Humanist chaplains (Schuhmann et al., 2020) provided similar insights from another perspective. Although only six of the 17 respondents came from the UK, the comments help understand the experiences of non-religious chaplains.

The dual nature of Anglican chaplaincy resulted in participants developing a bias to which role they performed, with some deciding to discard clerical garb (Kyriakides-Yeldham, 2017). Descriptions of the position included a holistic one, providing

'opportunities for people to explore or draw strength from whatever might be the spiritual side' (Kyriakides-Yeldham, 2017, p. 194), and 'helping that person find a sense of identity being, meaning, understanding, belonging, in whatever their community is' (Kyriakides-Yeldham, 2017, p. 200), to being 'no less than the focus of the presence of Christ' (Kyriakides-Yeldham, 2017, p. 194). In general, the patient-led, person-centred approach is described, with one participant adding that 'anything to do with like any rightness by the Church would come way second to that' (Kyriakides-Yeldham, 2017, p. 201). Another chaplain held a more traditional view of his role '[W]e are a missionary frontier of the church... what an opportunity; and the State pays for me to be here and the church doesn't pay a penny... Actually you're a Trojan horse in the NHS and at the forefront of mission' (Kyriakides-Yeldham, 2017, p. 228).

In the transcripts of Anglican NHS chaplains, the language and sentiments are faith-centric, i.e.

> 'In the liminal space of healthcare chaplaincy, the beliefs, practices and texts across the different religions, as well as the wisdom and insights each tradition has to offer ... . Partnerships between the faiths can provide creative and imaginative ministry opportunities especially in situations where people affiliate to more than one faith tradition.' (Kyriakides-Yeldham, 2017, p. 262-3).

Descriptions used by chaplains to describe the faiths and beliefs of others included one example where the non-religious were identified only as 'non-Christians' (Kyriakides-Yeldham, 2017, p. 403). Non-religion is mainly covered through the concept of spirituality as an alternative to religion (Kyriakides-Yeldham, 2017), with one definition being: 'Most of them have not been to a church at all, and out of the ones who say they're spiritual... half of them will be Pagans and half will be Buddhists' (Kyriakides-Yeldham, 2017, p. 407). Showing partial acceptance regarding the idea of Christian chaplains who had not been ordained, the Anglican participants were less enthusiast regarding the employment of minority faith and belief team members (Kyriakides-Yeldham, 2017). When not unaware of their existence, doubts were cast about their professionalism and relevant experience for a senior role, lack of a suitable validating body or just general uneasiness about appointing a non-religious volunteer (Kyriakides-Yeldham, 2017).

Interviews with minority faith chaplaincy team members (Bryant, 2018), include the description of a hospital where all funeral conducted exclusively by Christian

chaplains, irrespective of the parents' faith or belief (Bryant, 2018). An example was also given of chaplains with minority faiths not being given access to computerised patient lists, relying instead on the Catholic chaplain to print outpatients lists for them (Bryant, 2018). The understanding of chaplaincy as a principally Christian role was displayed in a quote from a leading chaplain,

> 'I think we have a rich heritage and I'm afraid we might be throwing some of it away because we are... if I say soft, do you know what I mean? We're not standing up for what we believe to the extent I would like us to. We've allowed others to take our territory. . . ' (Bryant, 2018, p. 127).

In the hospital sites visited, Bryant noted that 'substantive paid roles are less common (if not non-existent) for Buddhist, Jain, and Baha'i representatives.' (Bryant, 2018, p. 129).

Rather than observing progress in multi-faith involvement at all sites, Bryant (2018) noted there had been a regression at two, and generally 'little evidence of career progression for minority faith chaplains, especially for Hindu and Sikh chaplains' (Bryant, 2018, p. 133). While some hospitals included volunteers from minority faiths who worked generically with all patients, others restricted volunteers based on local demographics. According to Bryant, this can be 'one of several gate keeping strategies to ensure the chaplaincy service remained a Christian endeavour' (Bryant, 2018, p. 144). She also comments that 'It is clear that there is a disconnect between the standards set by the religion-specific chaplaincy bodies and 'generic' national level bodies such as the UKBHC, which means that chaplains from particular faith groups are disadvantaged by the regulatory processes of the bodies that claim to be open to all' (Bryant, 2018, p. 228). Overall, Bryant (2018) found significant differences between (and even within) Trust service models, with generally limited autonomy for minority faith chaplains and disagreement over including non-religious pastoral carers in teams.

This last point is reflected in a survey of attendees at a conference of Humanist chaplains, of the 17 respondents (six coming from the UK), 14 had struggled generally or in institutions, encountering discrimination, exclusion, resistance and being perceived as 'angry atheists (Schuhmann et al., 2020). Mixed receptions were experienced, 'Some head chaplains are progressive and welcoming, but many are conservative and put up barriers' (Schuhmann et al., 2020, p. 11) with one respondent noting 'resistance from religious chaplains whose recruitment policies and practices discriminate against non-religious care providers' (Schuhmann et al., 2020, p. 11). There were also

concerns over gaining appropriate education, becoming invisible once accepted by an organisation, and a lack of inclusion 'The chaplaincy team do not include me in meeting and projects' (Schuhmann et al., 2020, p. 11). These challenges to integration are reflected in the recent NRPSN report regarding recruitment:

> 'The evidence shows that PSR service provision has failed to change in our society, and this is having an adverse impact on the way services are provided and on those who may or may not use them. While diversity within PSR teams has increased slightly, the odds on a patient interacting with the PSR services while in hospital are low, particularly if that patient is anything other than Christian. Opportunities for minority faiths and non-religious carers to enter PSR teams as anything other than volunteers (for the most part) are reflective of this problem. There is ongoing resistance to changes in recruitment strategies and a number of barriers need to be addressed, particularly to encourage those from minority faith backgrounds, in order to provide equal opportunities'(O'Donoghue, 2020, p. 43).

Feedback from chaplains, hospitals and hospices also provided insights into the views the British public may have regarding chaplains, a hospice patient stated 'I had to hide under the blanket when the vicar came round. . . I didn't have the strength to tell him *'I am an atheist'*.'(Marie Curie Organisation, 2018, p. 11). Based on her experiences in the Royal Air Force, one patient sorted chaplains into two groups – the kind who helped people, and the 'God-botherer. . . interested in evangelizing people', (Swift, 2015a, p. 135). An unnamed keynote speaker is remembered as suggesting that 'Chaplaincy is the ministry of being able to be told to piss off' (Davies, 2017, p. 190).

3.6 Potential impressions of chaplaincy departments

The 2015 guidelines for National Health Service (NHS) hospitals confirmed that chaplaincy services should be available to all equally, 'whatever their religion or belief' (Swift, 2015b, p. 2). Guidelines can be invaluable when providing clarity regarding minimum standards and best working practice, with compliance then being observable in how they are accepted and put into practice. Responsibility for implementation lies with individual trusts, as the NHS remit in this area is limited to training and

employment (O'Donoghue, 2020). Concerns were also raised regarding the success in making potential users aware of the inclusiveness of the care available, and the equitable nature and use of the rooms, chapels and other spaces (O'Donoghue, 2020). Studying the words and pictures selected or omitted when creating hospital websites may provide insight into the values and culture of chaplaincy departments, both locally, or for a National overview.

The figures below were generated from data which followed the current NHS PSR use of the word 'spiritual' to be inclusive of all. Data presented above in Section 3.1 indicates, however, that a sizeable majority of the non-religious consider themselves as neither spiritual nor religious. As such, headings and wordings that refer to spirituality may not be considered as inclusive, or relevant to many viewers. Future research could establish not only how service users perceive the current provision of service, but also how they would like to see PSR care both provided and presented.

3.6.1 Overview

The critical review of websites focused on five areas, with the heading, picture and wording used to study the image presented by chaplaincy departments, and the descriptions of the facilities and outreach available suggestive of the service provided. These areas were assessed using six bands, ranging from the suggestion of a fully inclusive service to a focus on a single faith or belief. Findings are presented without negatively naming or grading any particular hospitals or trusts, but instead in a collegiate approach to help identify areas for discussion and potential development. Although the nature of search algorithms presents a challenge to replicating this data, it was judged to be an effective way of gaining a nationwide picture regarding the integration of minority beliefs and faiths within NHS PSR departments.

3.6.2 Page heading

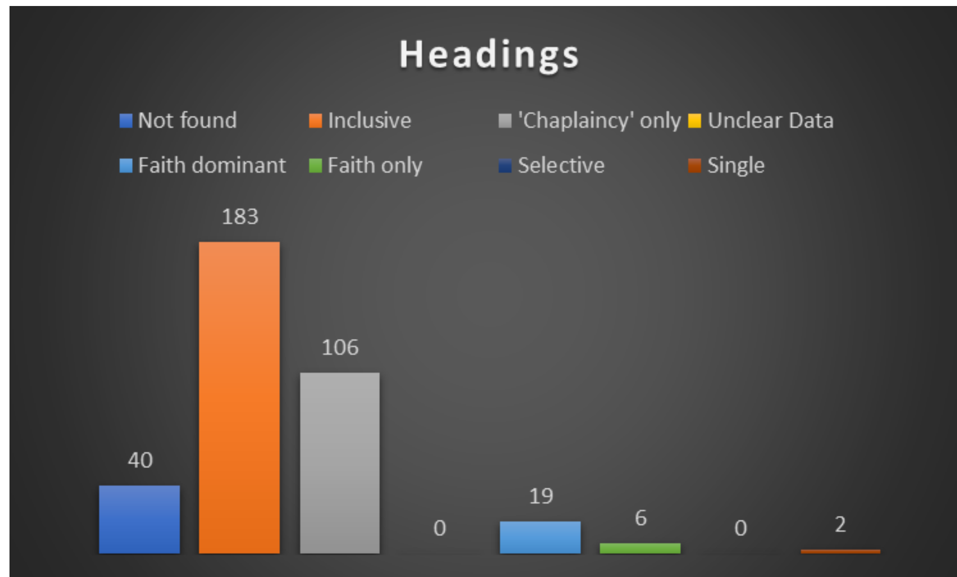


Figure 3.3: Inclusitivity of page headings used in NHS PSR websites

It has been suggested that a headline gains 90% of responses, with probably a couple of seconds – and a maximum of four – to catch and hold a reader's attention (Gorman, 2000). The first words presented to visitors, headings can embrace the updated scope of chaplaincy by including descriptions such as pastoral care or spirituality, or with a brief overview as a subheading. Using the single word 'Chaplaincy' may not make service users aware of the revised, broader role now required from chaplains. If this heading is also matched with a picture that represents only a single faith (nearly 30% of the images available), then those viewing the site could be forgiven for linking the term 'Chaplaincy' with that faith alone.

3.6.3 Inclusivity of pictures used on PSR websites

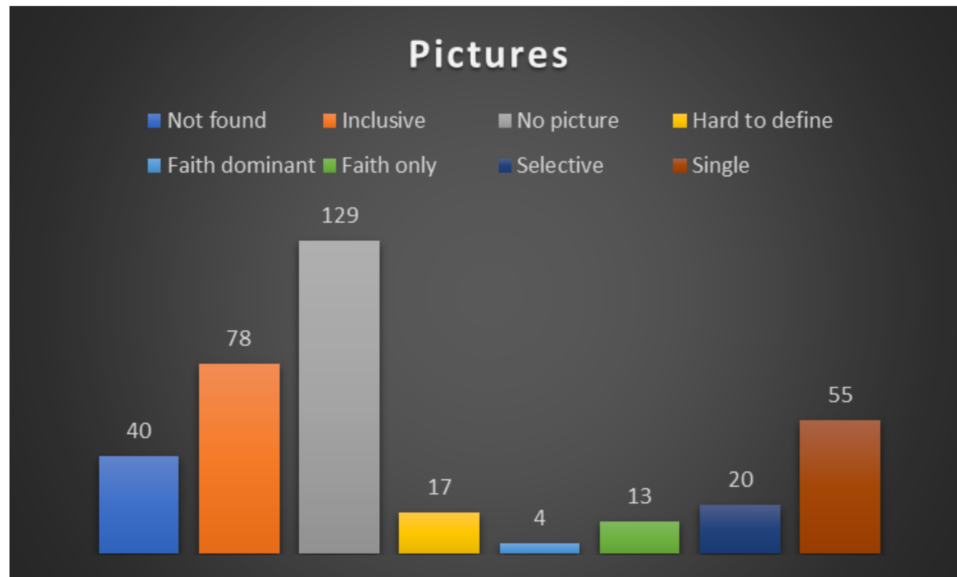


Figure 3.4: Inclusitivity of headline pictures used on NHS PSR websites

A picture can welcome, confirm a preconception or suggest a bias. Multi-faith/belief logos can imply a preference through the selection of those chosen for inclusion and the decision to feature a single faith may suggest the exclusion of all other faiths and beliefs. Pictures of praying hands, religious symbols or rooms devoted to any particular faith can carry a less welcoming message for some than those featuring a handshake, candles or a space that is welcoming to all.

Chaplaincy staff can be shown as representative of a single faith tradition, as an inclusive and representative group without any faith or belief symbols in the background or else sitting with a patient. Pictures can be used that allow the reader to add their interpretation. Over a quarter of hospitals seem to have chosen pictures that are representative for less than half the population (Natcen.ac.uk, 2019), with slightly over a fifth displaying an inclusive image.

3.6.4 Text

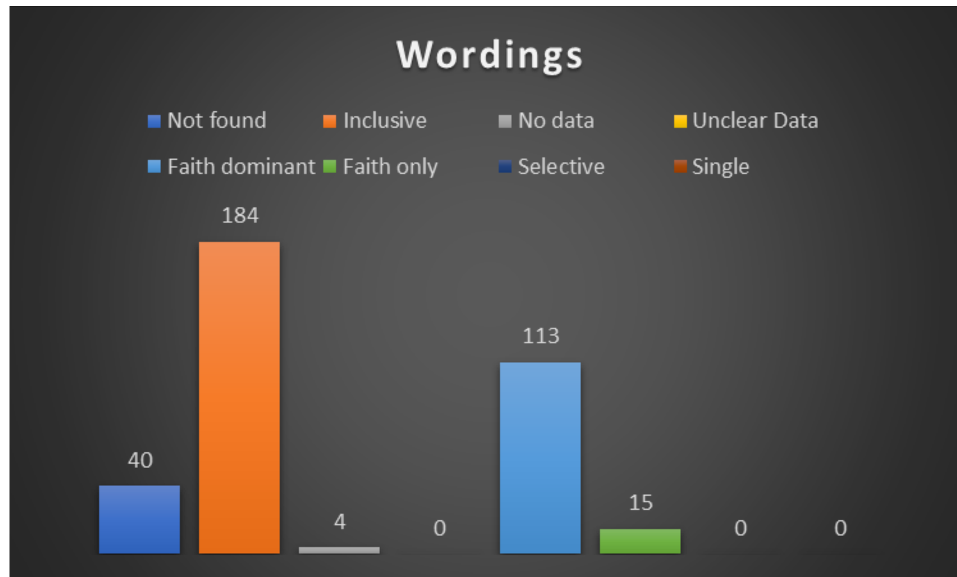


Figure 3.5: Inclusivity of wording used in PSR websites

Building on the initial impact created by the heading and picture chosen, the extent to which different faiths and beliefs are included can be reinforced, contradicted, extended or qualified. The support offered can be restricted by words that imply it is for specific faiths only, all faiths, or with a term such as 'all faiths and none' which frames the alternative to faith as an absence. Over half of the hospitals used the body copy of their web pages to clarify their role, reinforcing a message of inclusion for all. Variations exist where a different terminology is used on separate pages, or between websites and the information given in PDF downloads. Chaplaincy departments may not be aware of all the documentation still publicly available in this way, but misleading impressions of the service currently provided may be formed.

3.6.5 Facilities

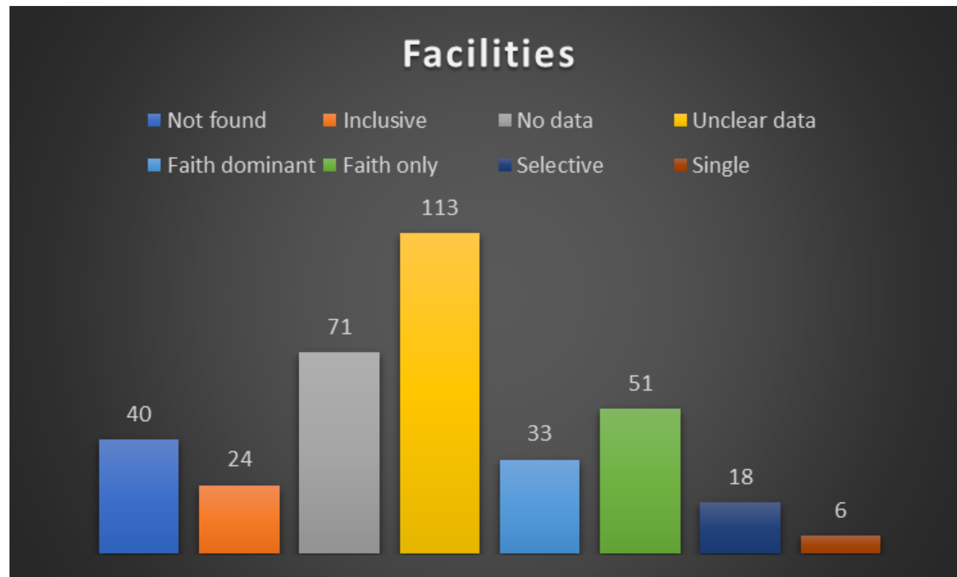


Figure 3.6: The portrayal of facilities on PSR websites

While the first three sections above concern the impression presented through words and pictures, this covers how physical space appears to be allocated. Those visiting or working in a hospital may need a quiet, safe space in which to reflect or come to terms with a physical or emotional challenge. Many chapels are now described as 'multi-faith' rooms or centres while retaining existing religious symbols and sometimes with areas or times of the day reserved for the exclusive use of a particular group.

Without being able to view the facilities, these results can only reflect an impression drawn from the information provided on the website. Rather than make a false assumption, where the details are unclear, this has been recorded. Facilities rated as 'Inclusive' imply that there is a dedicated 'quiet room' or similar space without religious symbols which is available for all, at all times and without public prayers, services or other events taking precedence. Less than a fifteenth of hospital sites describe a room meeting these criteria.

3.6.6 Outreach

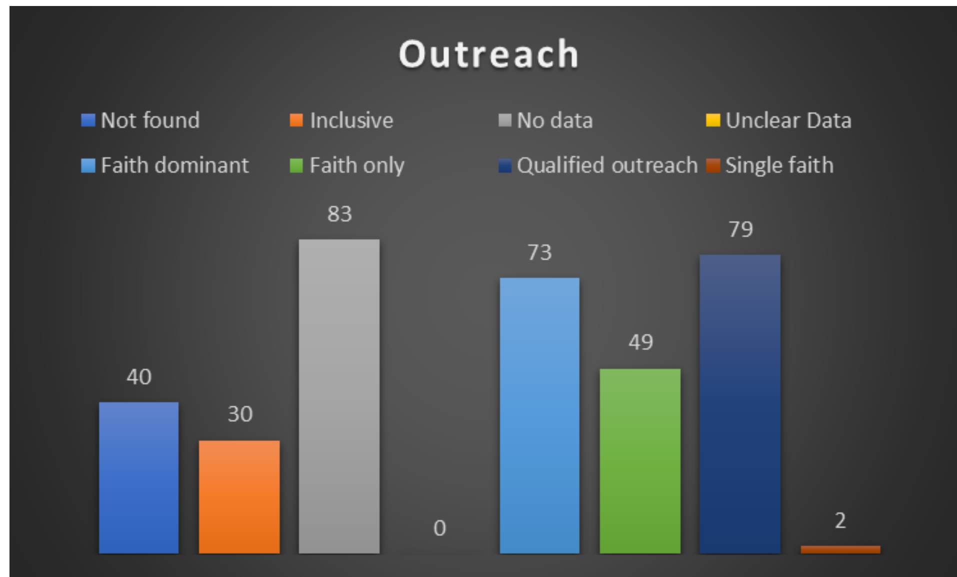


Figure 3.7: Inclusivity of outreach in PSR websites

Chaplaincy departments are now required to provide 'for the care of patients and service users whatever their religion or belief' (Swift, 2015b). While chaplaincy staff may feel confident that they are able to meet the spiritual, pastoral and religious needs of all, those receiving the care may disagree (Humanists UK, 2017) and require pastoral support beyond that available 'in house'. Given the range of formal and personal faiths and beliefs now found in society (Woodhead, 2016) and the potential for spiritual and pastoral support now being available through culture and tradition, chaplaincy teams will probably need to reach out at times to find appropriate care for some patients, relatives and staff. Where no information is given on hospital websites regarding the extent to which chaplaincy departments will reach out for external support (23%), patients and visitors may have concerns regarding the availability of help appropriate to them. When outreach is mentioned online, for 57% of the time it is implicitly or explicitly in terms relating to faith, or qualified by reference to the locality or the nature of the faiths who can/will be approached.

3.6.7 Summary of potential impressions of chaplaincy departments

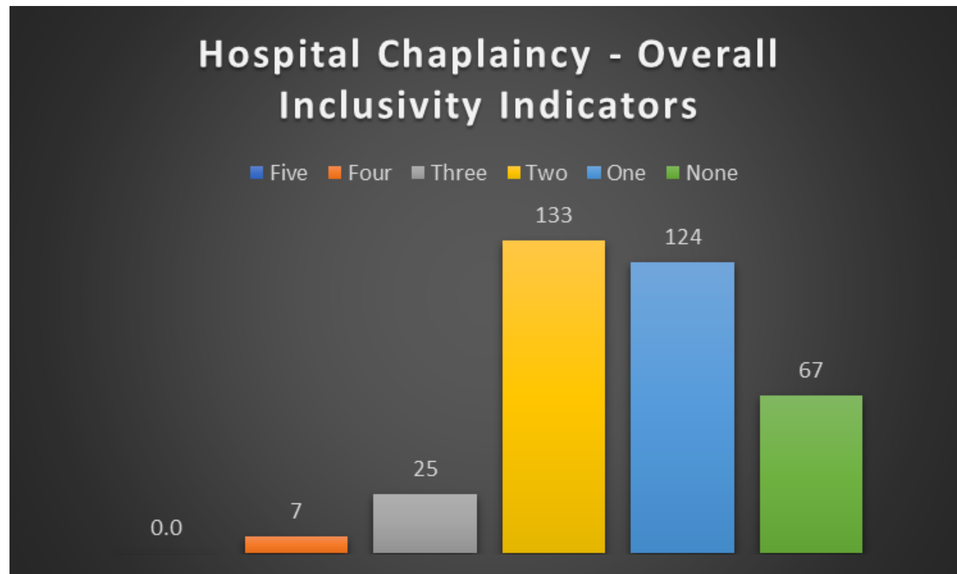


Figure 3.8: Overall inclusivity totals

The image above shows overall percentages of success regarding the five potential ways that hospital chaplaincy departments can demonstrate online their integration of minority beliefs and faiths. Although there were no examples where departments achieved them all, 2% scored four out of five and 7% three out of five. The remaining 91% were considered to have scored two or below.

As noted in the recent NPSRCH retort (O'Donoghue, 2020), it is possible to find excellent examples of inclusive practices. In general, however, the language and images used suggest that chaplaincy department play a role that is disconnected from the majority of the population. Looking online, the majority of patients (if they can find a web site) may well conclude that NHS PSR care remains fixed in the tradition of, and principally for the benefit of one section of the community. Engagement with the public is generally poor, failing to utilise the potential of websites to explain the role of chaplaincy.

3.7 Summary of Findings

This literature review regarding the integration of minority beliefs and faiths within NHS hospital chaplaincy uncovered potential areas of concern regarding inclusion for

those with worldviews other than the traditional:

•Differences were identified in the roles of chaplains within different fields, tensions resulting from complying with NHS codes and guidelines were noted from different sources.

•The term 'spiritual' is often used in chaplaincy and healthcare literature with the assumption of inclusivity, although it is a description rejected by about half of the British population. Other terms in common use, such as 'multi-faith' and 'all faiths and none' can equally exclude or discount those with minority worldviews.

•The structural organisational of staffing and physical spaces within NHS PSR departments largely (but not always) reflect the patterns and perspectives of the past, with a focus on mainstream, primarily Anglican worldviews.

•Opportunities are usually not being taken to quickly and cheaply engage with service users from minority faiths and beliefs, welcoming them with assurances and information regarding the facilities and care available.

CHAPTER 4
Discussion

Successful integration of minority beliefs and faiths within NHS hospital chaplaincy requires the reconciliation of differing worldviews. Traditional chaplaincy can be seen as existing within a framework that provides spiritual support from the perspective of a single faith, relying on established doctrine and rituals and with an assumption of God-given universal concepts of good and evil, right and wrong, saved and sinners. From this perspective, non-religious beliefs may be viewed as failings rather than valid alternatives worthy of respect. The recent stance taken by the Church of England regarding the conduct of those in civil partnerships (Church of England, 2019; Sherwood, 2020; Church of England, 2020) confirms a steadfast commitment to their traditional position. In contrast, modern hospital chaplaincy has its roots more in the Rogerian principles of empathy, congruence and unconditional positive regard.

If a patient is judged as a sinner in need of external guidance, how is it then possible to view them with unconditional positive regard rather than seeing a lost soul in need of rescuing from eternal damnation? A chaplain is required to support to all respectfully, including 'those whose beliefs are not religious in nature' (Swift, 2015b; Munnings, 2016, p. 7), and be aware that 'compassion should always inform chaplaincy and is a key outcome of the patient's experience of the service being provided' (Swift, 2015b, p. 10). This will require referring service users to colleagues where appropriate. If the belief or faith of a patient is not accepted, the only options for a chaplain would appear to be either moving on to the next bed or persuading the patient to adopt the chaplain's worldview. Working from a single, fixed and unquestionable moral position can limit the ability to accept and engage with the worldviews of others when the only tool a carpenter has is a hammer, screws can look like nails.

Differing interpretations of the role of a chaplain can impact the NHS PSR care provided to those with minority worldviews. The language used can distort perceptions of needs, the allocation of physical spaces and the staffing and structure of

hospital chaplaincy departments. While there was previously no need to describe or advertise hospital chaplaincy services, changes to the faiths and beliefs of the British public means that this is no longer the case. As well as the need to update and reform hospital chaplaincy to make it equally available for all, it is necessary to engage with the public to identify their PSR needs, and then publicly confirm that the service has adapted to current needs.

4.1 Differences in the role of chaplaincy regarding the integration of minority beliefs and faiths

The traditional paternalistic role of the Church of England remains that of teacher and shepherd, caring for its flock and assuming overall responsibility of religious instruction and care for the British public and with chaplaincy regarded as part of this mission. In contrast, NHS PSR care is person-centred, driven by the needs and wishes of service of a population who 'hate being preached at and told what to do; they want to think for themselves and make up their own minds' (Woodhead, 2017, p. 256). They also generally 'do not much care for religious leaders, institutions and authorities, but they tolerate them' (Woodhead, 2016, p. 520). This divergence is increasing, as while 'the English people became less religious and dogmatic; their national Church became more so' (Woodhead, 2017, p. 256).

A Chinese proverb says that a man who chases two rabbits catches neither. Anglican chaplains working in hospitals can find themselves torn between following their church or employer, with the growing disconnection from the Church of England by the majority of the population likely to make this dual role increasingly untenable. As recorded above in Section 3.4, while some chaplains go 'native' in embracing the role from a health care perspective, one was happy to use the opportunity to work covertly. Hospital chaplaincy care must now be available to all, at a time those needing care may hold worldviews that embrace concepts such as atheist angels (BBC Radio4, 2018) and the use of tarot cards (BBC News, business, 2018). A truly person-centred approach based on Rogerian principles can provide a service that welcomes those with minority faiths and beliefs, seeking to provide the most appropriate care.

4.2 The impact of language in the integration of minority faiths and beliefs within hospital chaplaincy

The language used within chaplaincy literature generally, and at times within NHS PSR care, retains a faith-centric perspective rooted in its past, which can have a detrimental effect for those with an alternative worldview. The descriptions 'inter-faith' or 'multi-faith' in literature can automatically focus both attention and resources to meet the chaplaincy needs of those who have a religion. An assumption has been made that automatically excludes and disenfranchises those who instead relate to the world through beliefs rather than faith.

The term 'none' can imply an absence, or suggest a void to be filled, especially in those who have been brought up with a 'nebulous do-it-yourself spirituality' (Atherstone, 2016, para. 19) rather than with formal religious education. As demonstrated above in Figure 3.2, when the alternative identity of NSR was available, nearly four times as many respondents chose the latter term. Other descriptions used for those with a non-religious worldview can be faith-centric ('unchurched'), imply hostility ('anti-religious'), may be seen as discounting the sincerity of the speaker ('claim to be') or be experienced as dismissive due to the language used.

While literature concerning NHS PSR care tends to agree on the need to provide spiritual as well as religious care, the term 'spirituality' is open to many different interpretations. It is perhaps most accurately described as 'a Humpty Dumpty word that means whatever the person defining it wants it to mean.' (Slater, 2015, p. 13). As such, its use may not have the same meaning for service users as it does for service providers, particularly when nearly half of the potential service users actively reject being identified as 'spiritual' (Figure 3.2).

The term 'chaplaincy' is not legally restricted or protected. It is also used by those who have goals and working practices that are incompatible with the standards and requirements of hospital chaplaincy. If the Church of England turns to chaplaincy in an attempt to counter falling membership (A. Todd, 2017), there will be an increasing risk that NHS PSR care will be understandably viewed as part of the same process. The current presentations of chaplaincy departments on hospital websites generally do little, if anything, to emphasise the different roles (Figure 3.8).

4.3 Structural and organisational disconnections

Although the NHS has a department responsible for inclusion and diversity, its remit is limited to the training and employment of staff (O'Donoghue, 2020). The autonomous nature of individual trusts has led to a variance in the PSR care provided, with differing levels of integration of minority beliefs and faiths, particularly noticeable with the research on hospital websites (Section 3.6). Access to staff with the same beliefs or faiths as the patient, relative or staff member may or may not be available. Codes and guidelines may be in place regarding the support of minority worldviews; there are inconsistencies in the ways these are put into practice, especially following the revised guidelines (Swift, 2015b).

Chaplaincy staff engage with others at times of their lives when they may be at their most vulnerable, most in need of emotional protection, counsellors and psychotherapists can often find themselves in similar situations. For this reason, all applicants for registration with the British Association for Counselling and Psychotherapy (BACP) are required first to pass a Certificate of Proficiency to show they have the basic skills, abilities and knowledge necessary to provide a competent and professional level of service (BACP, 2018). No such universal basic safety check currently exists within NHS PSR care. Considering the tensions noted between the differing interpretation of the role of chaplain, a similar safeguard for NHS PSR staff would provide hospital trusts with an assurance that compliance with codes and equality legislation has been checked.

The BACP also has a spirituality division for members who are involved in areas such as chaplaincy and pastoral care. Given the skills, training and accredited level of competence regarding diversity, it could be argued that membership of this group is an equal, if not more relevant qualification for employment in NHS PSR than membership of a faith or belief organisation. A group which 'encompasses belief, faith, religion and other ways in which we might experience deeper connection to and appreciation of self, 'Other' and environment' (BACP, 2018, p. 1) is well suited to meeting the PSR needs of those with minority worldviews.

4.4 Engagement with those holding minority beliefs and faiths

NHS PSR departments face the challenge of demonstrating their relevance to a population increasingly rejecting religion. Physical spaces that imply through signage or symbols that they are there for one section of society may equally repel others and could be seen as non-compliant with equality legislation. As well as practical demonstrations of inclusivity at the hospital, chaplaincy teams can provide a wider-ranging message of integration. Websites offer a relatively quick and cheap way to engage with the public; this study suggests there are opportunities for the majority of NHS PSR departments to quickly and significantly improve the way they demonstrate that they respect and welcome those with minority worldviews.

Technology can help in other ways, Swift (2015b) suggested that the internet and telemedicine offer a way to provide chaplaincy support to the community. With the increased range of faiths and beliefs that may be held now, supporting those with minority worldviews will always be a challenge. Using the internet would allow the needs and wishes of minority belief or faith service users to be met where no suitable local representative is available. At the time of writing (April 2020), this is particularly relevant due to the Covid 19 virus. Washable mobiles, tablets and similar devices would allow patients to safely connect with loved ones and others who can provide support.

Traditional chaplaincy had the benefit of starting from a fixed position of established texts and rituals, with few variables, it is the experienced supplier of an established product in a previously protected market. Changes in both social attitudes and demographics have resulted in a population who usually require the information to make their own choices, and who expect to be treated as valued customers. Studies to find out what current PSR needs are (Savage, 2018) would improve the integration of minority faiths and beliefs. '(C)ompassionate care is not about the skills of provision, but more about the skills of response: responding as human beings to need, whatever that need might be, and, if we can't respond, knowing who has the skill to respond.'(Heath, 2017, p. 148).

The Marie Curie model of PSR care (2018) provides a secular structure focused on individual needs able to draw on paid and volunteer staff, local faith groups and communities. Given the NSR rejection of the label 'spirituality' (Figure 3.2), research

to find more appropriate language to use instead in the Marie Curie (2018) framework is likely to increase engagement with those holding minority worldviews. Such a change could provide hospital trusts with a model of PSR care that would not only meet their obligations regarding equality legislation but also be more in tune with the views and needs of service users.

CHAPTER 5

Conclusions

5.1 Reflexive exploration

Although frustrating working within an academic framework at this level, the necessary discipline aided my progress and the benefits are now appreciated. With many potential rabbit holes available, it would have been easy to have become lost along the way. Equally frustrating for a therapist used to using metaphors was the restriction against their use. Many images came to mind, including a picture of sunbeds around a pool... almost all reserved by Anglican towels.

I experienced strong differing emotions in two areas. Studying and writing about Anglican chaplaincy revived echoes of the past, feelings of anger and resentment following attempts to impose a faith on me, with sadness at the resulting rifts. In contrast, I found reading many of the case studies and much of the literature illuminating and inspiring. As with working at the hospital; I am struck not by our differences, but our similarities.

I have aimed to be honest and open in this research, sincerely hope that offence has not been caused to colleagues and that this work will engender dialogue rather than friction. There are areas from this project that I would like to explore in more depth, if not perhaps until after a break! Although not aware of any impact on my encounters with patients as a pastoral carer, undertaking this course has undoubtedly led to new insights and understandings of both the subject and myself, and the development (if grudgingly at times) of new skills.

5.2 Strengths and limitations of the study

While leading to a broader perspective, the benefits of drawing on multiple areas of literature regarding the integration of minority worldviews within hospital chaplaincy have been offset by the reduction in the depth achievable. This was considered to be an acceptable compromise and allowed the opportunity to include the voices of individual chaplains and the potential impressions of service users. It was necessary, however, to exclude research material which could have been utilised in a more focused research question, especially for such a complex and fundamentally defining topic as personal faith and belief. A larger project would have allowed for more individual voices to have been heard, highlighting the practical realities of NHS PSR care. Although research on websites gave a nationwide survey, this only provided an impression of how the public may perceive the chaplaincy services available for those with minority worldviews, rather than a definitive review of the care provided.

The benefits of approaching this subject as an outsider with experience in other areas come with a downside. Bracketing of personal viewpoints can only go so far, especially for a matter in which an emotional investment may colour the researcher's perception. I noticed myself identifying with views expressed by those self-identified as either 'none' or NSR. Flagging up potential conflicts will hopefully enable readers to identify and allow for any distortions.

5.3 Future research

Fruitful areas for future primary research regarding the integration of minority beliefs and faiths within hospital chaplaincy appear to exist.

The role of chaplaincy

Paid and volunteer staff in post before the revised guidelines (Swift, 2015b) may have found that their role has changed in ways that are challenging, or contradictory to their faith or beliefs. Nationally organised research could explore any such impact and resulting tensions. Such a study could identify where support may be needed for staff, and ensure that minority beliefs and faiths are successfully integrated within NHS hospital chaplaincy.

The impact of language

Multiple instances were found of exclusion or discounting by language. Further research could identify the extent to which this shapes public perception of hospital chaplaincy and the nature of the services provided. Additional studies could reveal if negative or discounting language indicates underlying attitudes regarding minority faiths or beliefs that need to be addressed. Discovering the words, phrases and descriptions that service users with minority worldviews feel relevant and appropriate for them could also help with their integration into the NHS PSR care system.

Chaplaincy has a rich heritage of providing care and support from a theological viewpoint, diverging concepts of the role have now evolved though. The extent to which differing perceptions of both the title and role of chaplain may hamper the provision of NHS PSR care could be explored. The questions used by Woodhead in her research (2013a, 2013b) provided very different responses to those used in the 2011 census (Office for National Statistics, 2011b). Further research could identify the most informative questions to use for future census and surveys.

Structural and organisational disconnections

Trial schemes could explore ways to connect service users with trained staff both locally and nationally, using internet technology and developing directories of the individual and organisational resources available. Apart from the benefits regarding infection control and reduced strain on resources such as parking spaces, retired volunteers may face challenges with personal mobility, transport or stamina. Having the ability to online work from home would expand the numbers of those able to provide support, as well as allowing a more representative balance between service providers and users regarding faith or belief.

Engagement with those holding minority beliefs and faiths

Acute hospital chaplaincy teams were created to meet the spiritual needs of the British public at that time, based on the fixed certainties, literature and rituals of the Anglican Church. With that model being expressly rejected by about half of the population, research is needed to establish what non-medical support would be welcomed in hospitals now. Once these are known, reverse-engineering would allow the evaluation of the current use of staff and facilities to identify what changes would be necessary to meet the needs of all patients and staff, including those with minority beliefs and faiths.

References

Atherstone, A. (2016). *Religious 'nones' on the rise, but what's the truth behind the data? An evangelical theologian explains.* Retrieved 02-07-2020, from https://www.thetablet.co.uk/features/2/7829/religious-nones-on-the-rise-but-what-s-the-truth-behind-the-data-an-evangelical-theologian-explains

BACP. (2018). *BACP Register Certificate of Proficiency.* Retrieved 07-19-2019, from https://www.bacp.co.uk/membership/registered-membership/certificate-of-proficiency/

BACP. (2018). *Honouring spirituality, belief and pastoral care in counselling and psychotherapy.* Retrieved 04-11-2020, from https://www.bacp.co.uk/bacp-divisions/bacp-spirituality/

Baxendale, R., Ferguson-Stuart, H., Flatt, S., McCormick, A., Welford, L., Mackinnon, K., ... others (2015). *Critical care: Delivering spiritual care in healthcare contexts* (J. Pye, P. Sedgwick & A. Todd, Eds.). Jessica Kingsley Publishers.

BBC News, business. (2018). *The tarot revival thanks to brexit, trump and dior.* Retrieved 01-20-2020, from https://www.bbc.co.uk/news/business-44471537

BBC Radio4. (2018). *Hashtag Pray, Atheist angels.* Retrieved 06-10-2018, from https://www.bbc.co.uk/radio/play/m0000n94

Brierley, P. W. (2011). *Uk church statistics 2005-2015: Being a fresh complilation of the number of members, churches and ministers in the many denominations in the uk, with summary tables, explanatory articles and other data*. ADBC Publishers.

Brown, A. & Woodhead, L. (2016). *That was the Church, that was. How the Church of England Lost the English People*. Bloomsbury.

Bryant, J. (2018). *The integration of minority faith groups in acute healthcare chaplaincy* (Unpublished doctoral dissertation). Cardiff University.

Bull, A. W., Puchalski, C., Grossoehme, D. H., Piderman, K. M., Gibbons, G., Zollfrank, A., ... others (2015). *Spiritual care in practice: Case studies in healthcare chaplaincy* (G. Fitchett & S. Nolan, Eds.). Jessica Kingsley Publishers.

Bullivant, S. (2017). *Catholic Research Forum Reports 3, the "no religion" population of Britain.* Retrieved 02-22-2019, from https://www.stmarys.ac.uk/research/

centres/benedict-xvi/docs/2017-may-no-religion-report.pdf

Bullivant, S. (2018). *Europe's young adults and religion: Findings from the european social survey (2014-16) to inform the 2018 synod of bishops.* Benedict XVI Centre for Religion and Society.

Cambridge University Hospitals. (2019). *History of chaplaincy.* Retrieved 02-18-2019, from https://www.cuh.nhs.uk/chaplaincy/history-chaplaincy

Caperon, J. (2017). Chaplaincy and traditional church structures. In J. Caperon, A. Todd & J. Walters (Eds.), *A christian theology of chaplaincy* (pp. 119–142). Jessica Kingsley Publishers.

Church of England. (2017). *Renewal and Reform.* Retrieved 03-07-2020, from https://www.churchofengland.org/sites/default/files/2017-11/gs_2038_-_a_vision_for_renewal_and_reform.pdf

Church of England. (2019). *Civil Partnerships – for same sex and opposite sex couples. A pastoral statement from the House of Bishops of the Church of England.* Retrieved 01-31-2020, from https://www.churchofengland.org/sites/default/files/2020-01/Civil%20Partnerships%20-%20Pastoral%20Guidance%202019%20%282%29.pdf

Church of England. (2020). *Statement from Archbishop Justin and Archbishop Sentamu following the College of Bishops Meeting.* Retrieved 02-07-2020, from https://www.churchofengland.org/more/media-centre/news/statement-archbishop-justin-and-archbishop-sentamu-following-college-bishops

Cooper, M. (2016). *Existential therapies.* Sage Publications. Kindle edition.

Critical Appraisal Skills Programme. (2018). *Casp checklist, 10 questionsto help you make sense of a qualitative research.* Retrieved 03-03-2020, from https://casp-uk.net/wp-content/uploads/2018/01/CASP-Qualitative-Checklist-2018.pdf

Davies, J. (2017). A Response. In G. Harrison (Ed.), *Psycho-spiritual care in health care practice* (pp. 188–159). Jessica Kingsley Publishers.

Durairaj, S. (2015). *NHS England Chaplaincy Guidelines 2015: Promoting Excellence in Pastoral, Spiritual and Religious Care Equality Analysis.* Retrieved 01-18-2020, from https://www.england.nhs.uk/wp-content/uploads/2015/03/equality-analysis-nhs-chaplaincy-guidelines-2015.pdf

Equality and Human Rights Commission. (2010). *Equality Act 2010 Employment Statutory Code of Practice.* HMSO.

European Court of Human Rights. (2010). *European Convention on Human Rights.* Retrieved 01-29-2020, from https://www.echr.coe.int/Documents/Convention

_ENG.pdf

Francis, R. (2013). *Report of the Mid Staffordshire NHS foundation trust public inquiry: executive summary,* (Vol. 947).

Freeth, R. (2017). The struggle for meaning. In G. Harrison (Ed.), *Psycho-spiritual care in health care practice* (pp. 115–130). London: Jessica Kingsley Publishers.

Freeth, R., Garman, G., Clarke, I., Nolan, S., Heath, B. & West, W. (2017). *Psycho-spiritual care in health care practice* (G. Harrison, Ed.). Jessica Kingsley Publishers.

Galashan, M. (2015). From atheist to zoroastrians...what are the implications for professional healthcare chaplaincy of the requirement to provide spiritual care to people of all faiths and none? In J. Pye, P. Sedgwick & A. Todd (Eds.), *Critical care, delivering spiritual care in healthcare contexts* (pp. 102–120). Jessica Kingsley Publishers.

Gilliat-Ray, S. & Arshad, M. (2016). Multifaith working. In C. Swift, M. Cobb & A. Todd (Eds.), *A handbook of chaplaincy studies, understanding spiritual care in public places* (pp. 109–122). Routledge.

Gorman, P. (2000). *How to out-sell, out-market, out-promote, out-advertise everyone else you compete against... before they even know what hit them*. Big Sur Publishing.

Heath, B. (2017). Soul and shadows, words, music and the compassionate spirit. In G. Harrison (Ed.), *Psycho-spiritual care in health care practice* (pp. 145–159). Jessica Kingsley Publishers.

Hewson, C. & Crompton, A. (2016). Managing multifaith spaces: the chaplain as entrepreneur. In C. Swift, M. Cobb & A. Todd (Eds.), *A handbook of chaplaincy studies, understanding spiritual care in public places* (pp. 123–136). Routledge.

Humanists UK. (2015). *BHA calls for better statistics on religion in response to first 2021 Census consultation.* Retrieved 02-22-2019, from https://humanism.org.uk/2015/08/28/bha-calls-for-better-statistics-on-religion-in-response-to-first-2021-census-consultation/

Humanists UK. (2017). Humanists uk polling on pastoral care in the uk. *Accessed December*, *22*, 2018.

Humanists UK. (2019). *The art of listening: an interview with humanist pastoral carer Lindsay van Dijk.* Retrieved 12-29-2019, from https://humanism.org.uk/2019/03/19/the-art-of-listening-an-interview-with-humanist-pastoral-carer-lindsay-van-dijk/

Integration. (n.d.). *Cambridge dictionary (online).* Retrieved 04-20-2020, from https://dictionary.cambridge.org/dictionary/english/integrate

Kyriakides-Yeldham, A. P. R. (2017). *Identity and Ministry in Healthcare Chaplaincy: The liminality of the Church of England priest who continues to sing the Lord's song in the strange land of the National Health Service* (Unpublished doctoral dissertation). University of Exeter.

Lancaster University. (2016). *Why 'no religion' is the new religion .* Retrieved 02-23-2020, from https://www.lancaster.ac.uk/news/articles/2016/why-no-religion-is-the-new-religion/

Lee, L. (2015). *Recognizing the non-religious: Reimagining the secular*. O.U.P. Oxford.

Legislation.gov.uks. (2006). *Equality Act 2006.* Retrieved 02-02-2020, from http://www.legislation.gov.uk/ukpga/2006/3/section/44

Legislation.gov.uks. (2019). *Human Rights Act 1998.* Retrieved 01-29-2020, from http://www.legislation.gov.uk/ukpga/1998/42/contents

Marie Curie Organisation. (2018). *Improving access to palliative care forpeople with dementia, learning disabilities and people with different or no religious beliefs.* Retrieved 03-03-2020, from https://www.mariecurie.org.uk/globalassets/media/documents/how-we-can-help/hospice-care/our-hospices/cardiff-and-the-vale/improving-access-project-full-report-english.pdf

McClelland, K. (2014). *Call the Chaplain*. Norwich: Canterbury Press,.

McGettrick, M. (n.d.). *The nhs chaplaincy guidelines 2015 promoting excellence in pastoral, spiritual and religious care* [Report].

Miller, S. D., Duncan, B. L. & Hubble, M. A. (1997). *Escape From Babel: Toward a Unifying Language for Psychotherapy Practice*. New York: W. W. Norton & Company, Inc.

Munnings, K. (2016). *Starting out in health care chaplaincy*. NPSRCH.

Natcen.ac.uk. (2017). *British Social Attitudes: Record number of Brits with no religion.* Retrieved 04-15-2018, from http://www.natcen.ac.uk/news-media/press-releases/2017/september/british-social-attitudes-record-number-of-brits-with-no-religion/

Natcen.ac.uk. (2018). *British Social Attitudes: Losing faith?* Retrieved 12-29-2018, from http://www.bsa.natcen.ac.uk/latest-report/british-social-attitudes-28/religion.aspx

Natcen.ac.uk. (2019). *British Social Attitudes36:Britain's shifting identities and attitudes.* Retrieved 12-29-2018, from http://www.bsa.natcen.ac.uk/latest-report/british-social-attitudes-36/key-findings.aspx

Natcen.ac.uk. (2019). *British Social Attitudes36:Religion:Identity, behaviour and belief over two decades.* Retrieved 01-26-2020, from https://www.bsa.natcen.ac.uk/media/

39293/1_bsa36_religion.pdf
Natcen.ac.uk. (2020). *Social research that works for society.* Retrieved 02-20-2020, from http://natcen.ac.uk/

Nolan, S. (2016). "he needs to talk!": A chaplain's case study of nonreligious spiritual care. *Journal of health care chaplaincy*, *22*(1), 1–16.

Nolan, S. (2017). Psycho-spirituality as discourse for non-religious spiritual care. In G. Harrison (Ed.), *Psycho-spiritual care in health care practice* (pp. 175–185). Jessica Kingsley Publishers.

Nolan, S. (2019). Lifting the lid on chaplaincy: A first look at findings from chaplains' case study research. *Journal of health care chaplaincy*, 1–23.

NRPSN. (2018). *Non Religious Pastoral Support Network Code of Conduct.* Retrieved 07-26-2018, from http://nrpsn.org.uk/wp-content/uploads/2016/02/CodeofConduct.pdf

O'Donoghue, S. (2020). *The State of Inclusion for Acute NHS Chaplaincy Pastoral, Spiritual and Religious Care Services in England.* Retrieved 01-29-2020, from http://dharmicweb.com/network-health.org/documents/NPSPCH_report_print.pdf

Office for National Statistics. (2011a). *QS210EW - Religion (detailed).* Retrieved 01-25-2020, from https://www.nomisweb.co.uk/census/2011/QS210EW/view/2092957699?rows=cell&cols=rural_urban

Office for National Statistics. (2011b). *Religion (detailed), all usual residents.* Retrieved 01-25-2020, from https://www.nomisweb.co.uk/census/2011/qs210ew

Office for National Statistics. (2016). *Marriages in England and Wales 2016.* Retrieved 01-29-2020, from https://www.ons.gov.uk/peoplepopulationandcommunity/birthsdeathsandmarriages/marriagecohabitationandcivilpartnerships/bulletins/marriagesinenglandandwalesprovisional/2016

Office for National Statistics. (2018). *Annual Population Survey and the Labour Force Survey.* Retrieved 01-26-2020, from https://www.ons.gov.uk/employmentandlabourmarket/peopleinwork/labourproductivity

Ozanne Foundation. (2020). *Only a third of english anglicans now believe same sex marriage is wrong.* Retrieved 03-02-2020, from https://ozanne.foundation/same-sex-marriage-research/

Pattison, S., Billings, A., Kevern, P., McSherry, W., Slater, V., Cranmer, F., ... Caperon, J. (2015). *A handbook of chaplaincy studies: Understanding spiritual care in public places* (C. Swift, M. Cobb & A. Todd, Eds.). Ashgate Publishing, Ltd.

Rogers, C. R. (1995). *On becoming a person: A therapist's view of psychotherapy*. Houghton

Mifflin Harcourt.

Ryan, B. (2015). *A Very Modern Ministry*. London: Theos.

Savage, D. (2018). *Non-religious Pastoral Care: A Practical Guide*. Routledge.

Schuhmann, C., Wojtkowiak, J., van Lierop, R. & Pitstra, F. (2020). Humanist chaplaincy according to northwestern european humanist chaplains: towards a framework for understanding chaplaincy in secular societies. *Journal of Health Care Chaplaincy*, 1–15.

Seeley, M., Ryan, B., Whipp, M., Bradley, C. & Williams, R. (2017). *A christian theology of chaplaincy*. Jessica Kingsley Publishers.

Sherwood, H. (2020). *'laughing stock', letter from clergy attacks c of e's guidance on sex.* Retrieved 03-06-2020, from https://www.theguardian.com/uk-news/2020/jan/27/laughing-stock-letter-from-clergy-attacks-c-of-es-guidance-on-sex

Sigal, S. (2019). *Atheists Are Sometimes More Religious Than Christians.* Retrieved 03-23-2019, from https://www.theatlantic.com/international/archive/2018/05/american-atheists-religious-european-christians/560936/

Slater, V. (2015). *Chaplaincy ministry and the mission of the church*. SCM Press.

Stewart-Darling, F. (2017). *Multifaith Chaplaincy in the Workplace*. London: Jessica Kingsley Publishers.

Swift, C. (2014). *Hospital Chaplaincy in the Twenty-first Century*. Ashgate Publishing Limited.

Swift, C. (2015a). I tried to kill myself. will god keep me apart from the person i love in the life-after? In G. Fitchett & S. Nolan (Eds.), *Spiritual care in practice, case studies in healthcare chaplaincy* (pp. 133–153). Jessica Kingsley Publishers.

Swift, C. (2015b). NHS Chaplaincy guidelines 2015: promoting excellence in pastoral, spiritual and religious care. *London: NHS England*.

Swinton, J. & Kelly, E. (2016). Contextual issues: Health and healing. In C. Swift, M. Cobb & A. Todd (Eds.), *A handbppk of chaplaincy studies, understanding spiritual care in public places* (pp. 175–185). Routledge.

Tilney, T. (1998). *Dictionary of transactional analysis*. London: Whurr Publishers.

Todd, A. (2015a). *The value of spiritual care: negotiating spaces and practices for spiritual care in the public domain*. Jessica Kingsley.

Todd, A. (2015b). The value of spiritual care, negotiating spaces and practices for spiritual care in the public domain. In J. Pye, P. Sedgwick & A. Todd (Eds.), *Critical care, delivering spiritual care in healthcare contexts* (pp. 70–86). Jessica Kingsley Publishers.

Todd, A. (2017). A theology of the world. In J. Caperon, A. Todd & J. Walters (Eds.), *A christian theology of chaplaincy* (pp. 21–42). Jessica Kingsley Publishers.

Todd, L. & Tipton, L. (n.d.). *What part does faith play in healthcare.* Retrieved 04-22-2020, from http://network-health.org.uk/documents/HCFBGFullResearchReport.pdf

Tony Kyriakides. (2020). *Hospital chaplaincy.* Retrieved 03-03-2020, from https://www.churchofengland.org/more/clergy-resources/national-clergy-hr/clergy-transitions-service/resources/hospital-chaplaincy

UKBHC. (2014). *Code of Conduct for Healthcare Chaplains.* Cambridge: Author. Retrieved 04-14-2018, from http://www.ukbhc.org.uk/sites/default/files/ukbhc{_}code{_}of{_}conduct{_}2010{_}revised{_}2014{_}0.pdf

van Deurzen, E. (2012). *Existential Counselling & Psychotherapy In Practice* (Third Edition ed.). London: SAGE Publications Ltd.

van Deurzen, E. & Adams, M. (2016). *Skills in Existential Counselling & Psychotherapy* (Second edition ed.). London: SAGE Publications Ltd.

van Deurzen, E. & Kenward, R. (2005). *Dictionary of Existential Psychotherapy and Counselling*. London: SAGE Publications Ltd.

Williams, H. (2020). *Report criticising 'damning inequality' of healthcarechaplaincy is too poor to endorse, says C of E.* Retrieved 03-03-2020, from https://www.churchtimes.co.uk/articles/2020/28-february/news/uk/report-criticising-damning-inequality-of-health-care-chaplaincy-too-poor-to-endorse-says-c-of-e

Woodhead, L. (2016). The rise of no 'religion' in Britain: The emergence of a new cultural majority. *Journal of the British Academy*, *4*(2016), 245–61.

Woodhead, L. (2017). The rise of "no religion": Towards an explanation. *Sociology of Religion*, *78*(3), 247–262.

Yalom, I. D. (2020). *Existential psychotherapy*. Hachette UK.

YouGov / University of Lancaster Survey Results. (2013a). *Fieldwork: 25th-30th January 2013.* Retrieved 02-22-2020, from https://d25d2506sfb94s.cloudfront.net/cumulus_uploads/document/mm7go89rhi/YouGov-University%20of%20Lancaster-Survey-Results-Faith-Matters-130130.pdf

YouGov / University of Lancaster Survey Results. (2013b). *Fieldwork: 5th-13th June 2013.* Retrieved 02-22-2020, from https://d25d2506sfb94s.cloudfront.net/cumulus_uploads/document/4vs1srt1h1/YG-Archive-University-of-Lancaster-Faith-Matters-Debate-full-results-180613-website.pdf