Meeting spiritual needs in mental health care

In this article...

- The role of spirituality in mental health recovery
- How a staff training programme was developed
- Evaluation of training on clinical practice

Abstract


Belief in Recovery is a project introduced into Northumberland, Tyne and Wear Foundation Trust between 2010 and 2012 to develop nursing staff members’ confidence and skills in meeting the spiritual, religious and cultural needs of patients in mental health recovery. This article describes how we assessed and understood their training needs and developed a training programme, and how this led to positive outcomes for staff.

Interest in the role of spirituality in mental health recovery has been increasing, often driven by patients expressing a need to be seen and treated in a person-centred, holistic way. Many people in mental distress turn to spiritual beliefs for comfort, support and hope.

The word spirituality has its origins in the words for “breath”, or that which is essential to life; therefore, if we are to provide holistic care, we should not ignore spirituality. This was recognised by Plato in 300 BC who said:

“The cure of the part should not be attempted without the treatment of the whole. No attempt should be made to cure the body without the soul.”

Despite much talk about patient-centred care and increasing evidence that spiritual assessment and care is both well tolerated (Huguelet et al, 2011) and helpful (Sims, 2009), patients report that health professionals often ignore these needs (Lindridge, 2007). Some service users are also reluctant to express their spiritual needs and religious beliefs because they fear this may lead to increased medication and longer hospital stays (Eagger et al, 2009).

Spirituality and values in nursing

Spirituality is concerned with meaning and purpose, love and harmonious relationships, forgiveness, trust, sources of hope and strength, expressions of personal beliefs and values, and the expression of the concept of God through spiritual practices (McSherry, 2006). Barker (2009) included these aspects in his model of nursing, which demonstrates how each person has different, interconnected levels of functioning that need to be addressed in holistic nursing care.

Spirituality also leads us to consider values such as compassion. Parkes and Gilbert (2011) spoke of the importance of recognising common humanity, which involves taking into account the spiritual and religious dimensions of both caregiver and care recipient.

Bassett and Lloyd (2008) suggested a holistic approach requires an understanding of culture and spiritual beliefs, yet one of the major barriers for health professionals in addressing the spiritual needs of patients is the concern about crossing professional boundaries. This has been highlighted by recent high-profile cases in which nurses and other health professionals have been criticised for imposing their own beliefs on patients. This professional dilemma shows a need for clear guidance to enable health professionals to provide holistic care.

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5 key points

1. Spirituality is a key aspect of patient-centred, holistic care, particularly in mental health care.
2. Although many patients express the importance of spirituality in their recovery, services and staff often neglect this area.
3. Although many staff acknowledge their role in meeting patients’ spiritual needs, they often lack confidence in this area.
4. Training can increase staff confidence in addressing spirituality with patients.
5. Service users for whom spirituality was significant for their recovery can be involved in developing and delivering training.
Innovation

The Belief in Recovery project

The Belief in Recovery project focused specifically on the rehabilitation and recovery division at Northumberland, Tyne and Wear Foundation Trust (NTWFT). The division has 14 wards in various hospital or urban and rural community settings.

An initial audit of patient records found only three patients on the 14 rehabilitation wards had care plans directly related to culture and faith needs. Although a patient experience tool showed spirituality as one of the most important factors to their recovery (Sidgeway and Press, 2004), patients rated it as the least well supported by staff/services. Considering national and local data, we developed a hypothesis that nurses’ responses to patients’ spiritual needs was poor because they lacked confidence in exploring issues of a spiritual nature. We suggested this could be due to their own illiteracy in spiritual language, limited knowledge or unspoken organisational concerns.

The project had two main components and aimed to:

- Develop, implement and evaluate a staff training programme; and
- Employ people with lived experience of mental health recovery (peer support workers), especially if spirituality had played a significant role in it, to support training and to model recovery to both staff and patients.

Assessing training needs

To test our initial hypothesis and inform the content of the training programme, we developed a survey to help us determine staff training needs. When we designed this, we took into account the need to measure change over time, the language used to help staff engage with the survey (considering our initial hypothesis), the learning points we wanted to cover and the methodology needed to encourage nurses to complete and return the survey.

Following refinement through a pilot on two wards, we sent the survey to 14 ward managers who distributed it to the ward team (nurses, support workers, psychiatrists, psychologists and occupational therapists). To maximise the return rate, ward managers encouraged participation from team members, and the survey was kept confidential and could be returned electronically or through internal post.

How the survey informed the training programme

Of 235 surveys distributed, 131 (56%) were returned, of which 22 were completed electronically; 81 (62%) of the respondents were nurses. The highest levels of agreement came from the following statements:

- Meeting patients’ spiritual needs is important for their recovery; and
- It is part of my role to support patients to express spiritual needs.

The areas respondents rated least positively related to:

- Understanding the language used to talk about spirituality;
- Understanding different spiritual needs;
- Locating and following guidance on identifying and supporting spiritual needs; and
- Being confident about assessing spiritual needs and writing a care plan.

These results, which were found to be consistent with later surveys (Parkes and Gilbert, 2011) and the Royal College of Nursing (2011) survey, allowed us to develop a training programme.

Training programme design

The aims of the training programme are outlined in Box 1. The peer support worker, chaplain and nurse worked together to design and deliver the training day on the basis that these three perspectives (patient, clinical and chaplaincy experience) would be helpful in encouraging staff to explore their own spirituality and that of others.

The training itself was designed to maximise team participation, aiming to develop a critical mass (80% of staff) to encourage staff to use it in practice. We developed practice guidance notes and used the FICA spiritual assessment tool (Puchalski, 2006) to guide patient-centred conversations in the clinical setting. The FICA tool covers four key areas for enquiry:

- Faith and belief;
- Importance of this to the patient;
- Their belonging to Community;
- How these needs are Addressed in nursing care.

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### BOX 1. TRAINING AIMS

- To develop understanding of spirituality from staff’s own experience
- To develop understanding of spirituality from a service-user perspective and its importance to recovery
- To make staff aware of how to access resources that support spiritual practices
- To develop staff’s understanding of how they can meet service users’ spiritual needs in practice

### FIG 1. MODEL OF LEVELS OF THE HUMAN BEING

Source: Barker (2009)

### FIG 2. BELIEF IN RECOVERY TRAINING EVALUATION SCORES, 2012 (n=134)

<table>
<thead>
<tr>
<th>Objective Achieved</th>
<th>Range 1 (lowest score) - 6 (highest score)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overall rating</td>
<td>4.6</td>
</tr>
<tr>
<td>Effectiveness of practical activities</td>
<td>5.4</td>
</tr>
<tr>
<td>Logically sequenced</td>
<td>5.3</td>
</tr>
<tr>
<td>Balance of training</td>
<td>5.4</td>
</tr>
<tr>
<td>Enhancing/appreciating own role in meeting needs</td>
<td>5.4</td>
</tr>
<tr>
<td>Extent of skill improvement</td>
<td>5.4</td>
</tr>
<tr>
<td>Extent of understanding improved</td>
<td>5.4</td>
</tr>
<tr>
<td>Personal objective achieved</td>
<td>5.3</td>
</tr>
<tr>
<td>Extent objective achieved</td>
<td>5.4</td>
</tr>
</tbody>
</table>

ScoRES, 2012 (n=134)

FIC...
Exit evaluations
All participants attending the training completed an exit evaluation. The scoring for each question was on a scale of 1-6, with 1 being lowest and 6 the highest. As Fig 2 shows, the programme was rated positively on every aspect, with the overall training receiving a score of 5.33. The comments (Box 2) reflected the ratings.

Impact of Belief in Recovery
The staff survey was repeated in 2012, with results indicating the Belief in Recovery project has had a positive impact. All 18 question areas showed improvement.

Fig 3 highlights the results for the areas used to inform the training module and shows that staff reported that they:

- Felt more confident to assess and write care plans for spiritual needs;
- Had sufficient knowledge about spiritual needs; and
- Knew where to find and how to follow guidance.

However, staff also reported that they continued to have difficulty with the language used to talk about spirituality.

Both surveys revealed meeting patient spiritual needs is important to recovery and staff understood it was part of their role to support those needs. When we surveyed wards again after training, we found a widespread use of the FICA assessment tool and that spiritual needs had been addressed using recovery-care plans.

Conclusion
In her literature review, Cornah (2006) makes a number of recommendations based on evidence. These include asking patients about their spiritual and religious needs when admitted to a service and throughout their care and treatment, as well as asking them to identify the aspects of life that provide them with meaning, hope, value and purpose.

Our own study shows clearly that health professionals recognise the importance of spirituality in the process of recovery. Nurses acknowledge it is within their role but they do not feel competent in addressing those needs.

The findings of the project support our initial hypothesis relating to language, knowledge and organisational concerns. We found language remains an area for continued attention and the project addresses language and knowledge through training, ongoing support and practice guidance. Nurses report they are more aware of what support is available and how they can access it; however, organisational concerns remain relating to competing demands upon time.

The Belief in Recovery project has been shown to have met the needs of staff within the project area and can be adapted to meet the needs of nurses across all areas of mental health care. Swinton (2001) describes spirituality as being like poetry “not to be explained but to be shared and grasped with the heart rather than the head”. We have found that offering guided time (led by a collaboration of nurse, peer worker and chaplain) in a safe space has helped nurses explore the ways and means by which they and others express their spirituality. It has provided them with the confidence and skills they need to promote recovery in its fullest sense. The training gave staff an opportunity to consider the difference and inter-relation between culture, religion and spirituality, and to reflect on their own values and spirituality.

Training has increased confidence and is leading to positive changes in practice. Surveys suggest nurses are including spiritual needs in assessment and care planning, which supports our initial hypothesis that the barriers to spiritual needs assessment and care planning were language and confidence, rather than attitude. It also recognises that: “the provision of spiritual care by NHS staff is not yet another demand on their hard-pressed time but the very essence of their work, which enables and promotes healing in the fullest sense to all parties, both giver and receiver, of such care” [Levison, 2009].

NTWFT has now authorised the practice guidance notes for use in all services and agreed for training to be offered across all care pathways. NT

References