Can the impact of faith and spirituality be measured?

Philip Evans introduces the spirituality and faith outcomes measure he developed

Eighteen months ago, I organised a conference in Northamptonshire, to help local churches respond well to people with mental illness or neurodevelopmental disorders. This was done through the St Andrew's Healthcare Chaplaincy, where I work, and the Peterborough Diocese Healing Ministry Group, of which I am a member. Over 150 people attended, indicating real interest in engaging with these issues, and a definite wish to be able to minister well to those struggling with mental health.

One speaker was a lady sharing bravely from her own experience, telling us that she had been detained under the Mental Health Act for 11 years. She said someone had once told her that she was a '…hopeless case' and would '…never be able to live independently'. But while she was in treatment, she started attending a local church, where she found Christian faith, was baptised, and now, discharged for a few years and living in her own flat, serves in many church roles through the week.

In front of the 150 delegates, she said that two things of equal importance had transformed her life. These were her medication and her faith.

I remember her statement vividly. It goes to the heart of why healthcare chaplaincy is so vital and begs the question of what difference faith and spirituality make to someone's mental health and wellbeing.

I have been a Lead Chaplain at St Andrew's Healthcare for over six years. We are a large mental health charity providing mainly secure hospital accommodation for patients with mental illness, autistic spectrum disorder, learning disability, and neuropsychiatric needs. Our website states, 'We develop innovative ways to help our patients to recover, creating a personalised package of care designed around each individual, which focuses on their physical and spiritual wellbeing as well as mental health.'

It is really positive that spiritual needs are recognised in this explicit way as part of caring for the whole person.

But what is the relationship between spirituality and faith and mental health, and is there a causal connection?

One of the patients I see regularly invited me to his six-monthly review meeting. He was eager to talk about his Christian faith and the way our sessions help him to progress. But there is generally a set structure to such reviews, focusing in order on the range of therapeutic interventions by various professions, and there is no specific section for spirituality. While it was recognised very positively that the patient received a lot of support from the chaplaincy, the purpose of the review was to discuss treatment. The patient was keen to state however that he saw his faith as the most important part of his treatment.

Again, this raises the central question of whether faith and spirituality amount only to a separate piece of human activity or observance, or whether they contribute substantively to someone's health. Equally, there is the related question of whether healthcare chaplaincy exists just to respond to religious or pastoral needs (giving support) or whether it is a clinical service akin to all other healthcare professions and making a similar contribution to health outcomes. In other words, are faith and medication capable in equal measure of transforming a person's life?

In 2018, St Andrew's started to place primary emphasis on a value-based approach to care – focusing on patient health outcomes, rather than on professional inputs. This meant exploring with patients what health outcomes they regarded as important, and seeking to attain these in order to secure value.

I wanted to embrace this wholeheartedly, confident that we could demonstrate the healthcare outcomes of faith, spirituality and chaplaincy provision, at a high value. I saw it as consistent with a truly holistic view of the patient, focusing on what patients said was important for them. And it chimed with a role I had previously had in Whitehall, developing performance measurement for expenditure at the Department of Energy – aiming at and securing value for money.

The chaplaincy, along with all other services, was under pressure to prove its value and worth. It would often be said that the place of faith could not be measured. But I was clear that its impact – and that of the chaplaincy – could be measured, as much as any other provision of patient care.

Developing the outcomes measure

Between April 2019 and March 2020, we went through the process of developing our Spirituality and Faith Outcomes Measure (SAFOM) with 24 patients.

We started with interviews from some 80 patients (some 10% of our patient population at the time), collating statements about what they gained from their faith, spirituality and pastoral care. Some adhered to particular religious faiths, others did not. Our holistic care is based on an ethos that everyone has a spirituality – the expression of that yearning in each of us for personal wholeness that transcends the mere physical or mental parts of our lives.

We then did a rudimentary analysis of the many responses we received, and some broad groups of patient-reported outcomes could be seen:

- **Belonging:** relationship with and connectedness to others, a sense of being part of something
- **Becoming:** a sense of personal identity, of being accepted and valued, and self-worth
- **Believing:** a meaningful and lived-out faith or deepening sense of the spiritual
- **Behaving:** resilience and an ability to cope, and to be robust emotionally and in positive behaviour
- **Blossoming:** an overall sense of progress, recovery and moving on, with hope and confidence for the future.

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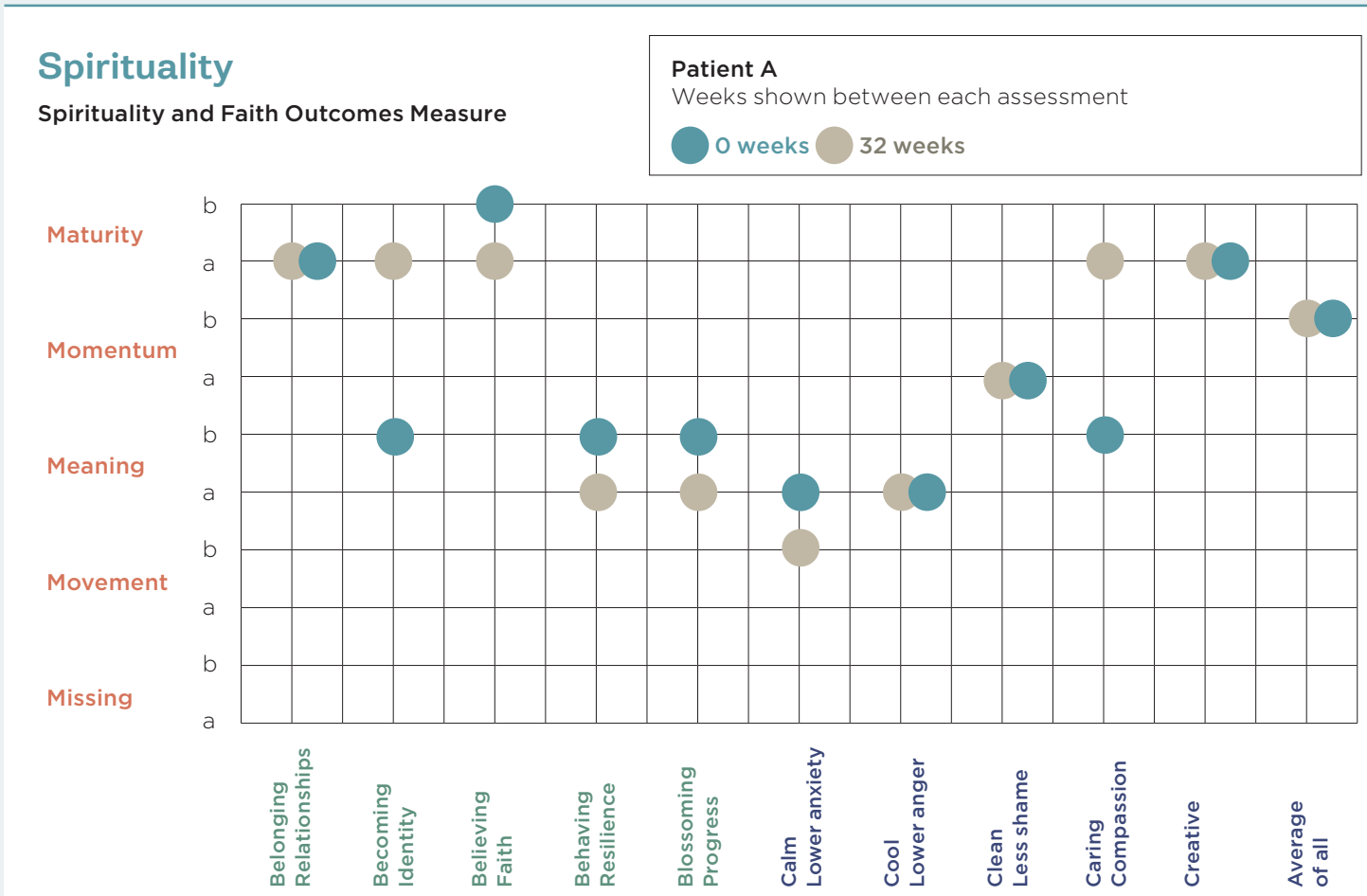
A 10-point non-numerical scale was developed, for patients to 'score' themselves at a particular time, allowing subsequent assessments to show change in health outcomes over a period, and thus the impact of faith and spirituality. The scale comprised five pairs of steps, ranging from where a patient judged an outcome to be **missing** from their health, through stages of **movement**, **meaning**,



momentum, to **maturity**, where the outcome was significantly evident. The 'a' and 'b' in each step represent the lower and the upper ends of that step.

Chaplains conducted the assessment interviews with patients from our autistic spectrum disorder, learning disability and mental health services, with at least two assessments, in some cases three, done in the period. The later assessments were completed 'blind' – with the patient not reminded of previous 'scores' until completing the later exercise. The judgments were very much the patient's own, with interviewing limited to clarification and support.

It emerged that one of the major benefits of this process was giving patients an opportunity to think about their spirituality more deeply, and to explore it in purposeful conversation.

Routine ward rounds and review meetings tend to follow a set structure, based around comments and reports from a series of separate clinical professions. This does not easily give an opportunity to discuss deep and personal matters related to faith, nor to apply them to wellbeing and progress – but we have often seen that this is what patients want.

From these conversations, we identified with the patients additional significant mental health outcome areas related to their faith and spirituality:

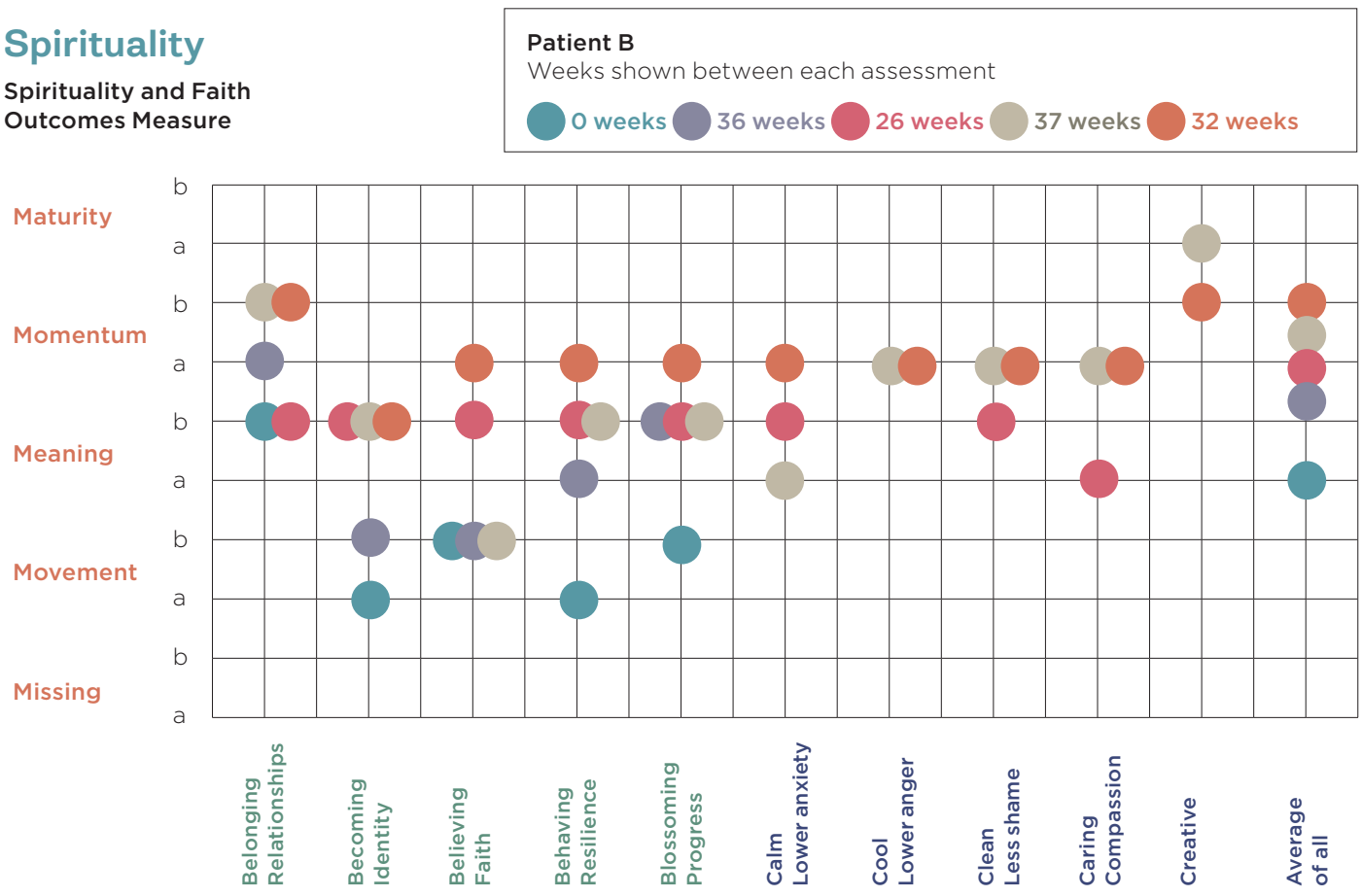
- **Calm:** reduction in anxiety, increase in being calm
- **Cool:** reduction in anger
- **Clean:** reduction in the burden of guilt and shame
- **Caring:** the ability to show compassion towards others
- **Creative:** the ability to be creative.

Most of the 24 patients engaged happily and fully with the assessments, grasping the concepts, and making intelligent and reasoned 'measurements.' They generally found the picture given of their progress through the measurements to be affirming. Increasingly, patients have been asking us to include their SAFOMs in their papers for review and planning meetings. One of our forensic psychologists recently commented that '...having seen one of the outcomes from a patient, there were significant increases in emotional state and quality of life over the years, and this kind of further evidence could be really important when considering discharge pathways'.

So, what of the patient who said his faith was the most important part of his treatment? His SAFOM (Patient A) shows his judgments made about the 10

Spirituality

Spirituality and Faith Outcomes Measure



outcome areas, in September 2020, and then April 2021 (some 32 weeks later).

The striking feature of Patient A's SAFOM is that in two outcomes (Becoming and Compassion) the patient's judgment is that, over the period, he has moved 'backwards'. But his interpretation was that his later judgment was more realistic and less elated, and his faith had helped him to reach a more balanced and grounded view, and he saw this as positive:

'Psychology is helping me think and be more thoughtful. My relationship with Jesus is making me more aware of my problems and what needs to be done to deal with them. This is a more realistic and honest judgment. By relying on the Holy Spirit and allowing him in, we can increase our understanding of who we are – the Holy Spirit gives a mirror into my life.'

Patient A speaks of how his chaplaincy and psychology sessions complement each other, but of greatest importance are the health outcomes gained from the mix of care and therapy:

'Bringing faith and psychotherapy together is like putting on a light switch into the past, which gives you insight, understanding of where we have gone wrong, and healing.'

One of the first patients to complete a SAFOM as we developed the tool was Patient B, who stated he was not religious, but asked for chaplaincy sessions to explore issues of compassion, empathy and guilt. He saw these as spiritual issues as well as psychological ones.

Over the past two-and-a-half years, he has completed his SAFOM five times, and it shows steady movement across all the outcome areas, with significant positive movements between the initial and latest assessments in the areas of Identity, Belief, and Resilience:

'I'm believing in myself much more. And the chaplain and psychologist together have helped me look at the deep things of life. If you don't look deep, you're not going to know yourself. Only when you look deeper and look at yourself, do you know who you are.'

He identified that he was at a stage of beginning to see real momentum in his mental health outcomes, as a result of this process of exploring himself more deeply:

'I've moved to a stage of being ready to use tools in order to really move forward and make progress and take steps towards community living.'

These two examples illustrate that the mental health outcomes from faith, spirituality and chaplaincy provision are substantive, quantifiable and measurable – in a not dissimilar way to outcomes linked with medical and therapeutic intervention. Indeed, spirituality and faith relate to some deep areas of life which are important to patients, but which are not otherwise addressed in their care.

Our results highlight the mental health benefits for patients from things that matter to them, but which do not fit fully into input-based models of care

Following our initial 24-patient pilot, focusing on adult male ASD, LD and mental health patients, we have expanded our use of SAFOMs in the St Andrew's Chaplaincy, now extended to include some 50 patients in all, of different faiths and of no faith – and from a wider range of patient groups, including adult women and even a couple of adolescents.

Time and again, we see patients respond to the opportunity to tell more of their story, embracing issues which are really important to them, where they want to see positive change, and which relate to deep, often unarticulated parts of their lives. The SAFOMs produce data which are of value and encouragement to the patient, which help their multidisciplinary team understand the importance of spirituality and its impact on their mental health journey, and which demonstrate in a clear and substantive way the value for money given by faith and the provision of chaplaincy.

However, it needs to be noted that the data are subjective: it is not possible to measure one patient's outcomes against those of another, nor are the measurements made against some absolute scale. Nevertheless, the measurements are meaningful to and valuable for each individual, affirming their progress and giving positive recognition to the place of spirituality and faith in their lives and mental health journey.

Our results highlight the mental health benefits for patients from things that matter to them, but which do not fit fully into input-based models of care. They therefore challenge our delivery of care to be more truly holistic and raise the question of how spiritual care can be better integrated into overall care planning. Moreover, they raise questions about the resources we devote to chaplaincy, nationally and in all healthcare providers, given the healthcare value which it generates.

Our outcomes work clearly makes the point that faith, like medication, can transform a life.

To find out more, watch a presentation by Philip, and his colleague, Dr Paul Wallang, St Andrew's Associate Medical Director and Outcomes Work Lead, at the Royal College of Psychiatrists Spirituality Specialist Interest Group in December 2020: **www.youtube.com/watch?v=--THhlXVlm0**

St Andrews Chaplaincy would be interested in exploring how to take this work into other settings, including the community. If you would be interested in using the Spirituality and Faith Outcomes Measure in your work, please contact Philip at: **prevans@standrew.co.uk** or on 01604 616375.

Biography

Rev Philip Evans became Lead Chaplain at St Andrew's in 2014. He has served in parish ministry but also as Head of Chaplaincy at St James's University Hospital Leeds. Previously, he worked for the Department of Energy. He trained in Clinical Theology, and obtained the Durham University Certificate in Counselling.