A questionnaire-based study of attitudes to spirituality in mental health practitioners and the relevance of the concept of spiritually competent care.

Abstract

In the light of the increasing recognition of the relevance of spirituality in person-centred, holistic care, this study examines the attitudes of a convenience sample of mental health practitioners, including nurses, to the concepts of spirituality in general and in clinical practice. A series of 5-point Likert-style items were used to assess the two key domains of Spirituality in Everyday life (SEDL) and Spirituality in Practice (SIP). The questionnaire was derived from one previously used with health care educators (including nurses). Each item was scored from 1 point (Strongly Disagree) to 5 points (Strongly Agree). Information was also collected about how far practitioners believed spirituality had been integrated in their education and how they believed that spirituality related to religion. Three further items, not part of the main questionnaire, dealt with respondents' views of spirituality competent practice, in the light of a description provided as part of the questionnaire. Data were collected from 104 respondents. Standard statistical procedures, including reliability analyses, were applied to the data. Respondents who viewed spirituality to be distinct from religion, or a place of worship, were likely to place a higher value on spirituality in everyday life; while respondents who experienced the integration of spirituality within their pre-registration training and/or clinical education were likely to place a higher value on the place of spirituality in practice. The possible reasons for these associations are discussed in the light of the importance of spiritual care as a part of person-centred, holistic practice.

Introduction

Spiritual care is part of an holistic, whole-person approach to health care. Holistic care is part of the underlying philosophy of health care professions, including nursing. It can be defined as:

> a system of comprehensive or total patient care that considers the physical, emotional, social, economic, and *spiritual* needs of the person; his or her response to illness; and the effect of the illness on the ability to meet self-care needs. Holistic nursing is the modern nursing practice that expresses this philosophy of care [our emphasis] (Mosby's Medical Dictionary, 2009).

A briefer definition from the American Holistic Nursing Association emphasises the relationship to the whole-person approach, defining holistic nursing as: "all nursing practice that has healing the whole person as its goal"

The whole-person approach and holistic care are closely related to the *biopsychosocial* model of Engel (1977,1980). This was developed to challenge the *biomedical* model often criticised for its reductionist approach to human nature. The biopsychosocial model has been influential, particularly in the mental health field, liberating the mental health professional from a reductionist approach and being compatible with modern monist philosophical theories of mind (Davies & Roach 2017). Davies and Roach also argued that the holistic approach could be traced back to Hippocrates in ancient Greece. A recent systematic review of the use of the terms whole-person, (w)holistic and biopsychosocial in the English language literature in general practice (Thomas et al. (2018) found these terms were often used interchangeably and all signified a multi-dimensional integrated approach involving biological, psychological and, commonly, spiritual factors. They cited the research of Murray et al. (2003), who suggested that a whole-person approach in primary care needed to consider the spiritual dimension. Sulmasy (2002), writing about end of life care, suggested making the spiritual explicit, to ensure it was not forgotten, by expanding the term to biopsychosocial-spiritual.

The modern philosophical roots of holistic, person-centred care/practice can be found in the work of Martin Buber's *Ich und du*, published in German in 1923 and translated into English several times as *I and Thou* (e.g. Kaufmann, 1996). Buber essentially argued that there were two different ways of

approaching people and things. mode we use the *I-it* when we seek 'scientific' understanding corresponding to the reductionist approach in much medical science. It can be identified with Swinton's (2012) concept of nomothetic knowledge. The *I-thou* mode is the mode of personal *relationship* (aligned with Swinton's idiographic knowledge). Paul Tournier a Swiss general practitioner in the mid- 20th century introduced the idea of medicine of the person (Cox *et al.* 2007) and Carl Rogers the psychologist who introduced client-centred (later person-centred) therapy had a public discussion with Buber in 1957 about the relevance of the *I-thou* mode to his own work (Anderson and Cissna, 1997). For Tournier, spirituality was an integral part of person-centred care and Buber argued that "Extended, the lines of relationship intersect in the eternal you" (Kaufmann, 1996, p 123). Kitwood (1997), again relying explicitly on Buber's concepts, developed person-centred care for people with dementia. He argued that in dementia personhood could be undermined by impersonal care. Kitwood argued strongly for the importance of discourses of 'transcendence' and 'a very powerful sense, held in almost every cultural setting, that being-in-itself is sacred', citing Christianity, Buddhism and other 'non-theistic spiritual paths' even asserting that secular humanism saw 'the ultimate as personal' (Kitwood 1997, p8). Spirituality is now recognised as an important factor which can make a positive contribution to general and mental health (Koenig et al., 2012) as well as to resilience (positive adaptation in adversity) in matters relating to public health and clinical issues (Cook & White, 2018). The importance of spirituality in person-centred, holistic, whole-person or biopsychosocial care seems well established; but how is spiritual care put into practice?

The questionnaire-based study reported here examined health and social care practitioners' attitudes to spirituality in everyday life (SEDL) l andin relation to their work with mental health service users (Spirituality in Practice, SIP). It also explored their views on the usefulness of the concept of spiritually competent practice in this context and their views on the relationship between spirituality and religion and whether they had received any training in this area. A further

component of the study involved free-text answers and qualitative interviews which will be reported separately.

Background

Spirituality and spiritual care are difficult terms to operationalise for research purposes and for this reason some researchers have chosen to use religion or religious practice as an easier-to-define surrogate (Koenig et al., 2012). However, it can be argued that, in modern Western cultures spirituality is a distinct (though overlapping) category from religion (Mohr, 2006; Swinton, 2012; Wattis, Curran and Rogers, 2017). As discussed in the introduction, terms in common use such as person-centred care and holistic care embrace spiritual care.

Despite the importance of this area in holistic health care, curriculum development in undergraduate education is uneven and clinicians in many areas of work report not feeling well prepared to deal with these issues (Royal College of Nursing2011; Puchalski et al., 2012; Ali et al., 2015, Rogers 2016). Part of the problem lies in defining what we mean by spirituality in a secular, multi-cultural society (Bregman 2014; Unruh 2002). The word itself came into the English language at a time when the culture was predominantly Christian (McGrath, 2011) and was thus associated with one particular religion. Its roots go back to the Latin *spiritus* relating to an invisible principle of life (and also used for 'breath' as in inspiration and expiration)I In recent years, in Western cultures, spirituality has come to be used as a term referring to a subjective personal experience, with elements of meaning, purpose, value, hope, relationships and love which exist within and outside traditional religious systems (Swinton, 2012). A fuller discussion of spirituality in Western multicultural societies can be found in Kirshbaum & Rodriguez (2017).

A preliminary study examined how health care educators at one University integrated spirituality in their teaching (Prentis et al., 2014). One of the most interesting findings from this study was that

whilst 90% respondents agreed or agreed strongly that spiritual values were important in their subject area, only 17% agreed that they were integrated into their curricula. Other research within our spirituality special interest group at the University of Huddersfield has explored how occupational therapists approach spirituality in practice (Jones, 2016), how undergraduate nurse education considers spirituality (Ali, 2017), mental health nurses' attitudes to spirituality in practice (Brown, 2017) and Advanced Nurse Practitioners perceptions of spirituality in Primary Care (Rogers, 2016). These studies have led to an emphasis on the concept of Spiritually Competent Practice (SCP, Wattis, Curran & Rogers,2017) – the ability of practitioners of all disciplines to deliver spiritually competent care. This concept is applicable across disciplines and requires not only spiritual care competencies (e.g. Van Leeuwen & Cusveller 2004) but ontological development of practitioners (Ali et al 2018) and a working situation that offers opportunity for the practitioner to deliver spiritually competent care. Spiritual care competencies have been devised for a variety of disciplines. Their value lies in developing competencies for each task undertaken, following functional analysis which can be translated into measurable outcomes. In nursing, for example, van Leeuwen and Cusveller (2004) listed 6 competencies such as addressing the subject of spirituality with people from different cultures in a caring manner, collecting information about spirituality and identifying patient needs and contributing to improving expertise in spiritual care. Competencies-based approaches to spiritual care education and training and their limitations are discussed by Kelly (2012) Our working description of SCP seeks to overcome some of these limitations and accepts that definitions of spirituality vary and is consistent with Swinton and Pattison's (2010, p227) assertion that " a thin, vague and functional understanding of what this word and its cognates might connote and do in the world of health care" might be more useful in practice. SCPproposes engaging with patients *where they* are, as the starting point:

> SCP "involves compassionate engagement with the whole person as a unique human being, in ways which will provide them with a sense of meaning and purpose, where appropriate connecting or reconnecting with a community where they experience a sense of well-being,

> addressing suffering and developing coping strategies to improve their quality of life. This includes the practitioner accepting a person's beliefs and values, whether they are religious in foundation or not and practising with cultural competency." (Wattis, Curran & Rogers, 2017 p3.)

A framework for operationalising spirituality into health and social care practice through "Availability and Vulnerability" (A&V) has also been developed (Rogers & Beres, 2017) and was investigated in the qualitative part of this study, which will be reported separately.

The study reported here sought to ascertain perceptions of the relevance of spirituality in general and in clinical practice of a sample of health and social care practitioners in a Mental Health Care Trust, using a modified version of the questionnaire used in the original study of health care educators (Prentis et al., 2014). The original questionnaire had two parts, one examining attitudes to spirituality in general (and its relationship to religion) and one examining views about the place of spirituality in health care education, The general questions were based, in part, on those used by Mc Sherry and others (RCN, 2010) in their large scale study of nurses in the UK and the education-specific questions were derived by group discussion in the light of existing literature. The study was piloted in a small group of colleagues before being conducted as an email survey in a large University school of health care. Details of the questionnaire, the analysis and statistical techniques used are reported in Prentis et al. (2014). The version of the questionnaire used in the present survey was modified so that the questions asked about the place of spirituality in education were redrafted to apply to spirituality in practice. Participants were provided online with the description of SCP given above.

In addition, the qualitative element of the study sought to develop further understanding of the utility of the concepts of SCP and A&V in developing understanding in this area. The study was passed by the University research ethics panel and approved through the NHS Integrated Research

Application system (IRAS reference 222660), Management approval was also obtained from the relevant NHS Trust,

Methods

The quantitative questionnaire was designed to elicit the perceptions of health care workers regarding spirituality and their views of its place in practice.

Questionnaire design

The questionnaire was a modified version of a questionnaire used in an earlier study exploring perceptions of spirituality in professional education for health care workers (Prentis et al., 2014) The two key domains of *Spirituality in Everyday life* (SEDL) and *Spirituality in Practice* (SIP) were closely aligned with the corresponding domains of *General Perceptions of Spirituality* and *Spirituality in Education* in the earlier study. Items in the questionnaire amenable to quantitative analysis comprised a series of 5-point Likert-style items assessing Each item was scored from 1 point (*Strongly Disagree*) to 5 points (*Strongly Agree*). These domains contained statements as follows:

The SEDL domain was measured using an unweighted sum of responses to the following 6 items:

- *I believe spirituality is associated with values, ethics and morals*
- *I believe spirituality is about finding meaning and purpose*
- *I believe spirituality is about having a sense of hope*
- *I believe spirituality concerns the way we live here and now*
- *I believe spirituality is about liberation and empowerment*
- *I believe spirituality concerns not only individual but wider organisational values*

The SIP domain was measured using an unweighted sum of responses to the following 7 items, with reverse coding applied to starred items:

- *I believe spiritual values are relevant to my clinical practice*

- *I believe spirituality is integral to clinical practice and care*
- *I believe spirituality has nothing to do with the ability to care for patients/clients**
- *I believe an awareness of spirituality is part of the health care process*
- *I believe clinical practice is a spiritual journey*
- *I believe the integration of spirituality in clinical practice should be a transformative experience*
- *I believe my intellect in clinical practice is more important than spirituality**

Hence the ranges of possible scores on these domains were 6-30 on the SEDL measure, and 7-35 on the SIP measure.

The consistency of responses to items comprising each of these domains was assessed using Cronbach's alpha reliability coefficient. Alpha values were calculated for each scale as a whole, and on each scale with each item deleted in turn, to identify any items which had not been answered consistently leading to a detriment in scale reliability.

Further items, scored in the same way, were also included within this series of items, which elicited factual information or personal opinions. The following item was treated as a "stand-alone" predictor ("*Integration in education*"), and did not contribute to either of the above domains:

- *I believe Spirituality was integrated within my pre-registration training and/or clinical education*

Responses from the following two items were summed to form a predictor variable (with reverse coding applied to the starred item) representing perception of spirituality as a distinct concept from religion ("*Distinct"*)

- *I believe spirituality can be distinguished from religion*
- *I believe spirituality is associated with a place of worship**

Three further items, not part of the main questionnaire, dealt with respondents' views of spirituality competent practice (based on the description they were given, see above), considered to be secondary outcomes:

- *Spiritual competencies are an important part of good holistic practice in mental health*
- *Spiritually competent practice is implemented well in clinical practice in my clinical area*
- *Spiritually competent practice is well taught in my discipline*

Respondents were also requested to provide demographic information (age, gender, years worked in clinical practice, areas and roles in clinical practice).

Survey method

Data were collected from April 2018 to May 2018 in a mental health trust in West Yorkshire. The questionnaire was circulated (using the 'Online Surveys' system – formerly Bristol Online Survey) to clinicians working in Mental Health services in a large mental health services provider trust in the North of England. The questionnaire which included a description of Spiritually Competent Practice was open for a 4-week period and cascaded via members of the Trust's R&D department to relevant teams and promoted in the Trust e-newsletter and iHub innovation platform. Participation was entirely voluntary and data were anonymised.

Statistical analysis

The sample was summarised descriptively. The extent of any missing data was noted, with appropriate strategies utilised to deal with missing data

Primary outcome variables were defined as the summed SEDL and SIP scores. Secondary outcomes were scores on each of the individual items corresponding to spiritually competent practice. Demographic variables and the *Integration in education* and *Distinct* variables were considered as potential predictors.

The influence on predictor variables on primary outcome measures was assessed in a series of multiple regression analyses, following univariable screening analyses to dismiss any predictor of no substantive importance. Residual analysis was conducted to verify regression assumptions.

Results

Data were collected from 104 participants: 69 females (66.3% of valid responses); 34 males (33.7% of valid responses); one participant did not disclose their gender. Participants were aged between 22 years and 64 years; with a mean age of 43.5 years (SD 9.98 years). They had worked in clinical practice for between 1 year and 38 years; with a mean period of working of 16.1 years (SD 9.79 years).

The areas of clinical practice reported by respondents were very varied. Areas represented included all branches of mental health nursing (in both acute and community settings), social work, psychotherapy and others. Some of the open answers given by respondents to this question defined their areas by branch (e.g. child and adolescent mental health); others by setting (e.g. community); or with more precise definitions (e.g. *Early intervention in psychosis*); precluding inclusion of these factors in the analysis, due to non-mutually exclusive categories and/or ambiguous categories being reported.

Roles reported by respondents were also varied. Roles represented included: nurse, manager, occupational therapist, health care assistant, psychologist and others. Some respondents were unable to distinguish between area and role. Again, variations in interpretation of the questions precluded inclusion of this variable in analysis.

Responses to all items are summarised in Table 2 below.

Statement	Strongly disagree	Disagree	Uncertain	Agree	Strongly agree	Total valid responses
I believe spirituality is associated with values, ethics and morals	2	8	13	61	20	104
I believe spirituality is about finding meaning and purpose	4	6	8	58	28	104

I believe spirituality is about having a sense of hope	5	4	12	59	23	103
I believe spirituality concerns the way we live here and now	6	7	15	59	17	104
I believe spirituality is about liberation and empowerment	5	12	33	45	9	104
I believe spirituality concerns not only individual but wider organisational values	5	8	24	54	13	104
I believe spiritual values are relevant to my clinical practice	4	9	16	58	17	104
I believe spirituality is integral to clinical practice and care	6	13	24	47	13	103
I believe spirituality has nothing to do with the ability to care for patients/clients	18	46	13	15	12	104
I believe an awareness of spirituality is part of the health care process	1	5	15	64	19	104
I believe clinical practice is a spiritual journey	8	20	35	35	5	103
I believe the integration of spirituality in clinical practice should be a transformative experience	7	11	48	29	9	104
I believe my intellect in clinical practice is more important than spirituality	5	30	31	28	10	104
I believe spirituality can be distinguished from religion	2	4	22	37	39	104
I believe Spirituality was integrated within my pre-registration training and/or clinical education	19	41	18	19	6	103
I believe spirituality is associated with a place of worship	30	49	15	4	5	103

The amount of missing data on both predictor and outcome variables was negligible, and data was not imputed; complete case analysis was utilised throughout. As expected, respondents' ages and years in clinical practice were highly correlated (r=0.719; p<0.001). Hence age was removed from further consideration.

Reliability analysis found both the SEDL and SIP scales to show good internal consistency, with alpha values of 0.864 for the SEDL scale and 0.844 for the SIP scales. Calculations with items deleted showed slight reductions or negligible changes in reliability as expected. Hence the analysis proceeded with no items removed from either scale.

The mean SEDL score reported by respondents was 22.4 (SD 4.50; range 6-30). The mean response of 3.73 points corresponded to a response approaching *Agree* – i.e. a slightly more favourable than

neutral view of the place of spirituality in everyday life. Respondents used the full range of scores in answering each question.

The mean SIP score reported by respondents was 23.7 (SD 5.23; range 8-35). The mean response of 3.39 points corresponded to a response just to the positive side of *neutral* – i.e. a very slightly more favourable than neutral view of the place of spirituality in practice; and slightly less favourable than respondents' view of spirituality in everyday life. Figure 1 indicates that respondents' views of spirituality in everyday life was left-skewed, with a minority of respondents considering that it had little or no place in their lives; but with a majority considering it to be of substantive value. Respondents' views of spirituality in practice was more normally distributed, with most respondents giving generally neutral ratings to this concept. Respondents used almost the full range of scores in answering each question.

(Figure 1 about here)

The outcome measures of SEDL and SIP were mutually correlated (r=0.743; p<0.001). A series of univariable screening analyses revealed that gender, years of practice, and the *Distinct* and *Integration* variables were substantively related to both outcome measures. All variables were carried forward for inclusion in multiple regression analyses. Controlling for other variables, the *Distinct* variable was significantly related to the SEDL outcome (p=0.048) at the 5% significance level; a unit increase in this variable was associated with an increase of 0.564 points on the SEDL scale (95% confidence interval [CI] 0.006 to 1.12). Controlling for other variables, the *Integration* variable was significantly related to the SIP outcome (p=0.029) at the 5% significance level; a unit increase in this variable was associated with an increase of 0.999 points on the SEDL scale (95% CI 0.102 to 1.90). No other variables were significantly associated with either outcome in controlled analyses (Table 1).

(Table 1 about here)

Formal corrections for multiple comparisons were not applied due to the extent of the correlation between outcome measures: however, corrections may be applied informally. A residual analysis revealed that residuals were approximately normally distributed in both models, and plots of standardised residuals against standardised predicted values revealed no evidence for any violation of regression assumptions.

Respondents who viewed spirituality to be distinct from religion, or a place of worship, were likely to place a higher value on spirituality in everyday life, perhaps reflecting the modern trend for spirituality to be viewed as distinct from but overlapping with religion (Wattis, Curran & Rogers,2017 p6). Respondents who experienced the integration of spirituality within their pre-registration training and/or clinical education were likely to place a higher value on the place of spirituality in practice. emphasising the importance of ensuring this area is included in the training and continuing professional development of health care workers. Men and women had similar views of spirituality in both everyday life and in practice; and increasing years in practice (which correlated with age) were not related to any substantive changes in views of spirituality.

Respondents' views of different aspects of spiritually competent practice varied. The mean score reported for the statement *Spiritual competencies are an important part of good holistic practice in mental health* was 3.97 (SD 0.87), with a median response of 4 (agree). This can be interpreted as saying that there was agreement that spiritual competencies are relevant to good holistic practice. The mean score reported for the statement *Spiritually competent practice is implemented well in clinical practice in my clinical area* was 3.13 (SD 1.03), with a median response of 3 (neutral). This signifies that implementation is seen to be weaker than the importance granted to spiritually competent practice in the responses of our sample. The mean score reported for the statement *Spiritually competent practice is well taught in my discipline* was 2.68 (SD 0.99), with a median response of 2 (disagree). This suggests that respondents did not think spiritually competent practice

was well enough taught in their disciplines. Respondents used the full range of scores in answering each question.

Discussion

The questionnaire embraced participants from a diverse group of mental health care practitioners, including nurses and social workers, working in a wide variety of areas. There were negligible missing data and the SEDL and SIP scales showed good internal reliability. Not unexpectedly, there was a positive correlation between the two different scales. Those who were more positive about the statements concerning spirituality in everyday life were also more likely to have more positive views about spirituality in practice. The respondents were a convenience sample of volunteers from a single organisation, so there is a possibility of response bias towards (or against) people with a positive view of spirituality. However, although respondents weakly agreed with statements about the importance of spirituality , they were more neutral about how spiritual care was implemented in practice. Again, whilst they generally agreed that spiritually competent practice was important in their work, they were more neutral about how it was implemented in practice and most thought it was not well taught in their discipline. This reflects findings form the large scale Royal College of Nursing spirituality survey (RCN, 2011) which found that around four fifths of nurses agreed that spirituality and spiritual care were fundamental aspects of nursing care and nearly as many agreed that nurses did not receive sufficient education and training in this area., This also reflects findings in the study amongst health care educators (Prentis et al., 2014)cited earlier where most agreed that spiritual values were important in areas of learning they covered; but a minority said that spirituality was included in their teaching. .

Several possible explanations for the discrepancies between views about the place of spirituality in everyday life, its place in clinical practice and the perceived lack of education in this area can be advanced. Modern secular societies commonly exist in a form which does not seek to exclude religion from the public arena but does not privilege any religion or denomination over any other or

over non-religious beliefs (Stammers & Bulivant, 2017). However, in a multi-cultural society with a variety of religions and many people who not see themselves as "religious" there are concerns, when religion is not distinguished from spirituality, about causing unintended offence. This risk can be minimised if we realise that we must start with the patient and help them find their own sense of meaning and purpose, not impose something from our own position. This is in agreement with Park's (2013) work on the *Meaning Making Model* in health psychology. Park, however, in North American style, tends to confine the term *spirituality* to religion, whereas we (along with Cook, 2004) would argue that spirituality is a fundamental dimension of human experience. Walach (2014, p2) specifically advocates the need to develop a "secular, non-dogmatic spirituality" which he identifies with "the experiential core of any religion, as opposed to its doctrinal-dogmatic teaching". This complex inter-relationship of spirituality and religion can cause problems when we are trying to work in a secular framework with people of many religions or none. However, we would argue that an emphasis on spiritually competent practice avoids disputes about how spirituality is defined. It recognises that supporting the patient's human seeking for meaning in their experiences of illness is an important component of good clinical care. This can also be understood as helping patients to reframe the narrative of their lives in the face of illness or disability (Rogers & Beres , 2017) and is a necessary antidote to the tendency to focus on technical aspects of nursing and medicine at the expense of the vital interpersonal aspects.

In this study, those who believed that spirituality could be distinguished from religion had a more positive view of spirituality in everyday life. Further investigation will be needed to confirm this, and, if confirmed, to establish the reasons for it. One possibility is that those who do not distinguish the two concepts have a less well-developed understanding of the relationship between them, coupled with a relatively negative view of religion; but this needs to be tested. Perhaps one of the most interesting findings was the positive relationship between the belief that spirituality had been integrated in the education of the respondents' discipline, and a raised score on valuing spirituality in practice. This supports previously published work on the need for healthcare professionals to be

educated to help them address this area in practice (Prentis et al., 2014; Ali et al. 2015; Puchaliski et al., 2017, Wigley 2017).

The agreement about the importance of spiritual competencies, the neutral response concerning whether they were implemented in practice and the more negative views about how well they were taught to clinicians supports many calls for for better education and support in this area (RCN 2010, Puchalski et al. 2012, Prentis et al, 2014). This is considerably strengthened by the finding that people who reported more positively about their own learning experience had a more positive view of spirituality in practice. SCP offers one framework for this learning which by-passes endless arguments about the meaning of spirituality (Swinton & Pattison 2010).

The description of SCP was originally developed in a study of occupational therapy practice (Jones, 2016) and was adapted to make it more widely applicable to different disciplines in health care. The concept emphasises that as well as 'spiritual care competencies' (van Leeuwen et al., 2004; Kelly, 2012), the practitioner also needs to develop personal (ontological) qualities, reflecting Wigley's (2017) finding that student nurses saw themselves as carriers of hope and the reflections of Carlin et al. (2012) on professional formation. SCP also emphasises the need to work in an environment which presents opportunities for spiritual care (Wattis, Curran & Rogers. 2017). However, SCP was not reported to be well implemented, and ratings about how well spiritually competent practice was taught in the clinical disciplines were generally negative, reinforcing findings from other studies (Prentis et al., 2014; Rogers 2016, Ali, 2017). This, in turn, reinforces the need to enhance education in this area for nurses and clinicians of all disciplines to complement technical approaches, which tend to reduce patients to a series of problems to be solved, and "industrialise" practices.

This cross-sectional questionnaire was conducted on a relatively small convenience sample. It was multi-disciplinary and focused on Mental Health practice. We plan to expand use of the questionnaire to cover other mental health provider organisations and other areas of practice, including primary care and general hospital care, and to further explore its reliability and validity. We also plan to

continue to use the questionnaire in studies alongside qualitative methodologies before and after educational interventions to examine sensitivity of the questionnaire to change. We would also like to explore have to improve workplace environments to facilitate spiritually competent care

Limitations

This survey was conducted on a relatively small voluntary sample of clinicians in different disciplines working in one large mental health services provider organisation. Voluntary surveys always carry the risk that the self-selected population surveyed is biased in some way but the distribution of responses across the scales was quite wide, implying a level of sample diversity consistent with population characteristics. There is no evidence that ascertainment bias has occurred in the selection of the sample. The involvement of different disciplines and a variety of clinical roles was predicated on the idea that spirituality needs to be approached in a multidisciplinary fashion. However, it would clearly be important to replicate the study in a wider variety of organisations working in this field in a variety of different settings. Relatively small numbers mean that some important trends may not have reached statistical significance. There may also be important distinctions between how clinicians in different disciplines, and nationalities/cultures are prepared to deal with spiritual issues; but this was not a focus of this study.

Conclusion

This study has demonstrated that a group of mental health workers in a variety of roles and settings had attitudes about spirituality in everyday life that were more positive than neutral and that it had a place in clinical practice. Those who reported professional education in this area were more positive than those who did not. They agreed that spiritual competencies had a place in their practice but were neutral about how well SCP was integrated in practice and disagreed that it was well taught in their disciplines. In our discussion we have explored some of the possible reasons for this including the conflation of religion with spirituality and the emphasis on technical rather than interpersonal

knowledge and skills in nursing and medicine. Perhaps the most important lesson is the need for more emphasis in health care professions' education on spiritually competent practice as a vital part of truly person-centred care.

Relevance for clinical practice

The main conclusion is that, for this group of health care workers, spiritually competent practice is relevant to their work but that many feel ill-prepared to work in this area and would appreciate more education to enable them to practice with increased spiritual competency, a finding which was also reflected in the free text responses and qualitative interviews to be reported elsewhere.

Number of words, excluding abstract references and tables currently 5000 approx

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Tables

Table 1: multiple regression parameters SEDL and SIP

Outcome	Predictor	P-value	Parameter estimate	95% confidence interval
SEDL	Gender (reference= male)	0.897	-0.122	(-0.199, 1.75)
	Years in practice	0.122	-0.074	(-0.168, 0.020)
	Religion distinct from spirituality	0.048*	0.564	(0.006, 1.12)
	Integration of spirituality in education	0.080	0.691	(-0.085, 1.47)
SIP	Gender (reference= male)	0.725	0.384	(-1.78, 2.55)
	Years in practice	0.592	-0.030	(-0.139, 0.079)
	Religion distinct from spirituality	0.158	0.463	(-0.183, 1.11)
	Integration of spirituality in education	0.029*	0.999	(0.102, 1.90)

*statistically significant at the 5% level