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Australian perspectives on spiritual care training in healthcare: A Delphi study

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Abstract

Objective. The aim was to to establish core components of spiritual care training for healthcare professionals in Australia.

Methods. This study used the Delphi technique to undertake a consensus exercise with spiritual care experts in the field of healthcare. Participant opinion was sought on (i) the most important components of spiritual care training; (ii) preferred teaching methods; (iii) clinical scenarios to address in spiritual care training; and (iv) current spiritual assessment and referral procedures.

Results. Of the 107 participants who responded in the first round, 67 (62.6%) were female, 55 (51.4%) worked in pastoral care, and 84 (78.5%) selected Christian as their religious affiliation. The most highly ranked components of spiritual care training were "relationship between health and spirituality," followed by "definitions of spirituality and spiritual care." Consensus was not achieved on the item "comparative religions study/alternative spiritual beliefs." Preferred teaching methods include case studies, group discussion, role-plays and/or simulated learning, videos of personal stories, and self-directed learning. The most highly ranked clinical scenario to be addressed in spiritual care training was "screening for spiritual concerns for any patient or resident." When asked who should conduct an initial spiritual review with patients, consensus was achieved regarding all members of the healthcare team, with most nominating a chaplain or "whoever the patient feels comfortable with." It was considered important for spiritual care training to address one's own spirituality and self-care. Consensus was not achieved on which spiritual care assessment tools to incorporate in training.

Significance of results. This Delphi study revealed that spiritual care training for Australian healthcare professionals should emphasize the understanding of the role of spirituality and spiritual care in healthcare, include a range of delivery methods, and focus upon the incorporation of spiritual screening. Further work is required to identify how spiritual care screening should be conducted within an Australian healthcare setting.

Introduction

It is widely agreed that spirituality is an important part of holistic, patient-centered care (World Health Organization, 2007; Puchalski et al., 2014; Timmins and Caldeira, 2019; Best et al., 2020). Studies have shown that spirituality is closely associated with a range of positive health outcomes (Ahmadi et al., 2015; Jim et al., 2015; Jones et al., 2016, 2018) and an aspect of well-being that patients appreciate being asked about (Best et al., 2015). Although spiritual care practitioners (also known as chaplains or pastoral carers) are often available to discuss spiritual needs, any member of the multidisciplinary team might be approached to have an initial discussion with a patient (Hilbers et al., 2010; Best et al., 2016a; Jones et al., 2020c). One study in Australia found that, although over 70% of patients or family members felt it was important for hospital staff to ask about their beliefs, less than 40% indicated they would like to speak to a chaplain (Hilbers et al., 2010). This finding suggests that patients may feel comfortable discussing spirituality with a range of hospital staff, and that a team approach to spiritual care is the best (Balboni et al., 2014). Many healthcare professionals, however, can feel ill-equipped or uncomfortable to enquire about a patient's spiritual needs and would like further training (McSherry and Jamieson, 2011; Best et al., 2016b; Jones et al., 2020b). Internationally, spiritual care training has been developed for healthcare professionals across a range of healthcare contexts and patient groups to address this need (Paal et al., 2015).

Identification with traditional religious affiliations in Australia is in decline. According to national figures (Australian Bureau of Statistics, 2017a, 2017b), in 1991 over 76% of

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Australians identified as religious and 12% as nonreligious. By 2016, just over 60% of Australians identified as religious, and the number of those identifying as nonreligious had increased to 30%. In comparison, in the USA just under 20% did not hold a religious affiliation, and 68% of this group believed in God (Pew Research Center, 2012). At the same time, the diversity of religious faith in Australia is increasing with 2016 figures, reporting that 8.2% of Australians identify with a religion other than Christianity, compared to 2.6% in 1991. The multicultural profile of the country is well illustrated in one study about patient perspectives on spirituality and health, where the birthplace of participants included 35 different nations (Hilbers et al., 2010). Alongside this diversification of cultural and faith backgrounds is a growing recognition of the importance of spirituality to indigenous peoples (Isaacs, 2009; Kingsley et al., 2013).

Kaldor et al. (2010) assert that spirituality is important but is reflected in a growing diversity of approaches to meaning-making that may not incorporate traditional religious views. Definitions adopted by peak spiritual care bodies reflect this broad approach to spirituality and spiritual care (Spiritual Care Australia, 2020). The definition of spirituality we have adopted is that "spirituality is the aspect of humanity that refers to the way individuals seek and express meaning and purpose and the way they experience their connectedness to the moment, to self, to others, to nature, and to the significant or sacred" (Puchalski et al., 2009, p. 887). Spiritual care is described as person-centered care, which "makes no assumptions about personal conviction or life orientation" and "offers a way for people to experience and make meaning of their hopes and fears .... [it] may include presence, conversations, ritual, ceremonies, and the sharing of sacred texts and resources" (Spiritual Care Australia, 2020).

Several spiritual care programs have been developed for healthcare professionals in Australia (Meredith et al., 2012; Bridge and Bennett, 2014; Cooper and Chang, 2016; Jones et al., 2020a). These have been conducted within the contexts of rehabilitation (Jones et al., 2020a, 2020c), palliative care (Meredith et al., 2012; Bridge and Bennett, 2014), and undergraduate nurse education (Cooper and Chang, 2016). Findings from these studies suggest that spiritual care training enabled healthcare professionals to view spirituality as something broader than religion (Cooper and Chang, 2016; Jones et al., 2020c) to understand that they could address patient spiritual needs through listening and compassionate care (Bridge and Bennett, 2014; Cooper and Chang, 2016) and to build levels of confidence, comfort, and competency in spiritual care delivery (Meredith et al., 2012; Bridge and Bennett, 2014; Jones et al., 2020a).

This study aimed to undertake a formal consensus exercise to establish core components of a spiritual care training program for healthcare professionals. The opinions of a range of spiritual care experts working in health, education, and policy were sought. To the best of our knowledge, no studies have explored this question within an Australian healthcare context. Such research is important to ensure that spiritual care training reflects the needs of the local population.

Methods

Participants

Ethical approval was obtained from the University of Notre Dame Australia Human Research Ethics Committee (No. 2020-064S) and St Vincent's Hospital Sydney (No. 2020/ETH00870).

Eligible participants were required to have active research, educational, policy or practical experience in spiritual care, and work in a healthcare field such as palliative care, chronic noncommunicable diseases, aged or dementia care, rehabilitation, or pastoral care. A letter of invitation to participate in the study was sent out to the membership of Spiritual Care Australia, a national professional association of practitioners in chaplaincy, pastoral care, and spiritual care. Members were invited to participate and to forward the survey link to others they knew who worked in healthcare, education, or policy and who could contribute and would meet the eligibility criteria (snowballing) (Neuman and Kreuger, 2003).

Procedure

This study adopted the Delphi technique to survey participants about the topic. The Delphi technique is a multistage survey that aims to achieve consensus among a group of experts on an important issue (Keeney et al., 2011; Trevelyan and Robinson, 2015). Four main characteristics define the Delphi technique: anonymity between participants, iteration with controlled feedback from group participants, statistical aggregation of group responses, and expert input (Trevelyan and Robinson, 2015). There are no formal, universally agreed-upon guidelines for a Delphi study, and a number of modifications have emerged over time (Keeney et al., 2011; Trevelyan and Robinson, 2015). The classical Delphi study involves administering a series of surveys to a panel of experts on a particular topic. Open-ended responses are collected in the first round. The responses are collated, and participants are invited to rank these responses in subsequent rounds, until consensus on a topic is achieved (Keeney et al., 2011).

This study consisted of three rounds, which is considered the optimal number of rounds in a Delphi study (Trevelyan and Robinson, 2015). The first-round survey included study information and provided participants with the opportunity to indicate consent. Once consent was given, participants could proceed with the survey. Demographic details, including field of practice, discipline, years of experience, age, gender, and religious affiliation, were collected for each participant. The first-round survey then invited participants to respond to several open-ended questions. Participant opinions were sought on (i) the most important components to include in spiritual care training; (ii) preferred teaching methods; (iii) which clinical scenarios should be addressed in spiritual care training; and (iv) current spiritual assessment and referral procedures. Responses were analyzed and formed the basis of items, which were ranked in the two subsequent rounds.

Participants were emailed the survey link for each round. Data were collected using the Survey Monkey electronic platform. A period of six to eight weeks was provided for participants to respond to each round. Two follow-up reminder emails were sent during each period.

Data analysis

A qualitative content analysis (Hsieh and Shannon, 2005) was adopted to analyze open-ended responses from the first round. This was conducted by two of the researchers (K.F.J. and M.C.B.). Descriptive statistics were generated for all demographic variables. A descriptive analysis of the demographic data collected in the first round was conducted. The analysis of quantitative data collected in the second and third rounds involved computing the mean, standard deviation, and percentage of agreement for each

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item (IBM SPSS statistics package, version 26). Opinion varies on what level of agreement should be recorded for consensus to be achieved, with figures ranging between 50% and 80% (Hasson et al., 2000). Using the same approach as Attard et al. (2019), consensus for this study was considered to be achieved if over 75% of the sample ranked an item as "desirable" or "essential" on a four-point Likert scale. A three-point Likert scale was used for two items, and for these items, consensus was reached if over 75% of the sample ranked an item as "sometimes" or "always."

Results

The first-round survey was completed by 107 participants (see Table 1). A total of 76 participants completed the second-round survey, and 73 completed the survey for the third round. Most participants were female, which is a typical representation of healthcare professionals in Australia (Australian Institute of Health and Welfare, 2020). Almost 80% were aged over 50, with an average of over 16 years' experience. These figures indicate the significant life and work experience of the sample. Just over half of the participants worked in pastoral care or chaplaincy, with the remainder working as doctors, social workers, researchers, and in other health or education roles. By the third survey, the proportion of the total group working in pastoral care was slightly higher (59.7%). Although approximately one-third of the group strongly agreed they were a religious person, over two-thirds strongly agreed they were a spiritual person. Most of the participants identified as belonging to the Christian faith. Over 80% had received some form of spiritual care training, either through a course or degree, or through their employment (see Table 1).

A wide range of topics were thought to be important to include in a spiritual care training program for healthcare professionals (see Table 2). Of all the identified topics, consensus was achieved on all but one; "comparative religions study/alternative spiritual beliefs," where only 72.4% thought it was essential or desirable. The most highly ranked topic was "relationship between health and spirituality," followed by "definitions of spirituality and spiritual care." Other topics were highly ranked as well, indicating strong consensus.

Of the ranked teaching methods (see Table 3), consensus was achieved on five items, including case studies, group discussion, role-plays and/or simulated learning, videos of personal stories, and self-directed learning. Consensus was not achieved on the items: didactic teaching (podcasts or online teaching), reading (theory or examples in the literature), shadowing a chaplain, or attending a retreat.

The most highly ranked clinical scenario to introduce into spiritual care training was screening for patients' spiritual concerns, closely followed by discussions around end-of-life beliefs (see Table 4). Other highly ranked clinical scenarios to incorporate into training included those relating to existential distress and suffering, and loss of autonomy and independence. Scenarios relating to guilt, or bereavement, and experiences such as dreams and hallucinations did not achieve consensus.

When asked about current assessment and referral practices in the first-round survey, participants shared a range of different spiritual history or assessment tools dependent upon their context and organization. These included the following spiritual history tools: Faith Importance Community Addressing (FICA) (Puchalski and Romer, 2000), Hope Organised religion Personal Effects (HOPE) (Anandarajah and Hight, 2001), the Spiritual Personal Integration Ritualised Implications Terminal events (SPIRIT)

Table 1. Participant demographic details ($N = 107$)

Demographic items	Category	*n* (%)
Gender	Female	67 (62.6)
	Male	39 (36.4)
	No response	1 (0.9)
Age	30–39	8 (7.5)
	40–49	14 (13.1)
	50–59	47 (43.9)
	60–69	38 (35.5)
Health area	Across specialties	52 (48.6)
	Palliative care	29 (27.1)
	Aged care/dementia	9 (8.4)
	General medical	6 (5.6)
	Oncology	3 (2.8)
	Rehabilitation	1 (0.9)
	Other	7 (6.5)
Job description	Pastoral care manager	30 (28.0)
	Pastoral care worker/ chaplain	25 (23.4)
	Medical practitioner/ specialist	15 (14.0)
	Social worker	9 (8.4)
	Researcher	7 (6.5)
	Peak body administrator	3 (2.8)
	Nurse practitioner/manager	2 (1.9)
	Educator	5 (4.7)
	Mission director	2 (1.9)
	Allied health manager	2 (1.9)
	Indigenous health worker	1 (0.9)
	Other[a]	6 (5.6)
Work experience (years): M, SD		16.4, 11.3
Religious affiliation	Christian	84 (78.5)
	Buddhist	3 (2.8)
	Multi-faith	4 (3.7)
	No religious affiliation	16 (15.0)
I am a religious person	Strongly agree	35 (32.7)
	Agree	32 (29.9)
	Neither agree nor disagree	25 (23.4)
	Disagree	10 (9.3)
	Strongly disagree	5 (4.7)
I am a spiritual person	Strongly agree	74 (69.2)
	Agree	26 (24.3)
	Neither agree nor disagree	6 (5.6)
	Disagree	0 (0.0)
	Strongly disagree	1 (0.9)

(*Continued*)

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Table 1. (*Continued.*)

Demographic items	Category	*n* (%)
Spiritual care training (Y/N)	Yes (incl. on the job training)	88 (82.2)
	No (or personal enquiry only)	19 (17.8)
Ethnicity	Australian	84 (78.5)
	Indigenous Australian	3 (2.8)
	European	8 (7.5)
	Asian	5 (4.7)
	Other[b]	7 (6.5)

[a]Other roles: business manager (1), bereavement co-ordinator (2), lifestyle officer (1), quality co-ordinator (1), site manager (1).
[b]Other ethnicity: New Zealand (not Maori) (2), North African (2), North American (1), South African (2).

(Maugans, 1996), and Faith/spiritual beliefs, Application, Influence/importance, Talk/terminal events planning, Help (FAITH) (Neely and Minford, 2009). Also listed were the Spiritual Assessment Matrix (SAM) (Ross and McSherry, 2018), Ars Morendi (Leget, 2007), and Level 1 and 2 assessments outlined by MacKinlay and Burns (2017). When these were ranked in the second round, consensus was not achieved on any of the tools. The highest-ranked tools were HOPE and FICA, with 34 (44.7%) and 33 (43.4%) of the participants indicating that they thought they were desirable or essential to include in spiritual care training, respectively. However, approximately 40% of participants were not familiar with either tool. Other approaches did not achieve greater than 25% consensus on whether they should be included, and over half (56–72%) of the participants were not familiar with the tools.

When invited to consider which member of the multidisciplinary team should conduct the initial review of a patient or client's spirituality and assess for spiritual needs, consensus was reached on all disciplines listed (spiritual care practitioner/chaplain, nurse, social worker, doctor, psychologist, other members of allied health, whoever the patient feels comfortable with). While all participants ($n = 73$, 100%) indicated that a spiritual care practitioner or chaplain should undertake this review "sometimes" or "always," the next closely ranked option was "whoever patient feels comfortable with" ($n = 66$, 86.8%).

When invited to rank which of the clinical scenarios listed in Table 4 should be an indication for referral to a chaplain, consensus was reached on all but one, on the basis of 75% selecting "sometimes" or "always" (see Table 5). Vivid dreams, hallucinations, and agitation were not viewed as an indication for referral to a chaplain. Strong consensus was achieved on the item "religious struggle or crisis of faith" with almost 80% agreeing that this should "always" be an indication for referral to a chaplain.

Four questions were added to the third-round survey after additional comments and responses were received in the second round. These questions invited participants to rank the importance of including one's own spirituality and self-care in spiritual care training, outcomes of spiritual care training, and the preferred duration of a spiritual care training program. Over 97% of participants indicated that addressing both one's own spirituality and self-care was desirable or essential to include in spiritual care training (see Table 6). The highest-ranked outcome for spiritual care training was perception and knowledge, followed by increased levels of confidence and comfort, and improved patient-related outcomes. All outcomes achieved consensus. Participants more frequently indicated that spiritual care training should be between 3 h and 1 week ($n = 28$, 38.4%), or more than 1 week but less than a year ($n = 32$, 43.8%). Only a few participants thought training should be less than 3 h ($n = 3$, 4.1%), or more than one year ($n = 10$, 13.7%).

Discussion

We set out to identify what components should be included in a spiritual care training program for healthcare professionals. The opinions of spiritual care experts working in healthcare were sought. Strong consensus was reached on a range of components, teaching methods, and clinical scenarios to incorporate into training. Participants agreed that it was appropriate for all healthcare professionals to conduct an initial review of a patient's spirituality, with the strongest preference being spiritual care practitioners or "with whoever the patient feels comfortable." Consensus was not achieved on what spiritual care history tools should be introduced into training.

Table 2. What topics should be included in spiritual care training? ($N = 76$)

Topic	Unnecessary	Not so important	Desirable	Essential	M (SD)	Consensus 75%/Rank
1. Relationship between health and spirituality	1 (1.3)	0 (0.0)	14 (18.4)	61 (80.3)	2.78 (0.51)	Y/1
2. Definitions of spirituality and religion and spiritual care	2 (2.6)	0 (0.0)	14 (18.4)	60 (78.9)	2.74 (0.6)	Y/2
3. Understanding suffering	0 (0.0)	3 (3.9)	25 (32.9)	48 (63.2)	2.59 (0.57)	Y/3
4. Learning about the role of chaplaincy and indications for referral	1 (1.3)	7 (9.2)	23 (30.3)	45 (59.2)	2.47 (0.72)	Y/4
5. Advanced communication skills	0 (0.0)	8 (10.5)	27 (35.5)	41 (53.9)	2.43 (0.68)	Y/5
6. Ethics of spiritual care	1 (1.3)	8 (10.5)	24 (31.6)	43 (56.6)	2.43 (0.74)	Y/5
7. Spiritual care approaches	0 (0.0)	12 (15.8)	30 (39.5)	34 (44.7)	2.29 (0.73)	Y/6
8. Barriers to spiritual care	0 (0.0)	9 (11.8)	36 (47.4)	31 (40.8)	2.29 (0.67)	Y/6
9. Training in spiritual assessment	4 (5.3)	12 (15.8)	31 (40.8)	29 (38.2)	2.12 (0.86)	Y/7
10. Comparative religion study/alternative spiritual beliefs	5 (6.6)	16 (21.1)	36 (47.4)	19 (25.0)	1.91 (0.85)	N

0 = "unnecessary," 1 = "not so important," 2 = "desirable," and 3 = "essential."

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Table 3. Which teaching methods are most appropriate for spiritual care training? ($N = 70$)

Teaching method	Unnecessary	Not so important	Desirable	Essential	M (SD)	Consensus 75%/Rank
1. Case studies	2 (2.6)	0 (0.0)	26 (34.2)	42 (55.3)	2.57 (0.55)	Y/1
2. Group discussion	1 (1.3)	5 (6.6)	25 (32.9)	39 (51.3)	2.46 (0.70)	Y/2
3. Role-play/simulated learning	2 (2.6)	9 (11.8)	28 (36.8)	31 (40.8)	2.26 (0.79)	Y/3
4. Video of personal stories	0 (0.0)	7 (9.2)	46 (60.5)	17 (22.4)	2.14 (0.57)	Y/4
5. Encourage self-directed learning	3 (3.9)	8 (10.5)	39 (51.3)	20 (26.3)	2.09 (0.76)	Y/5
6. Didactic teaching — podcasts	2 (2.6)	25 (32.9)	38 (50.0)	5 (6.6)	1.66 (0.66)	N
7. Didactic teaching — online lecture/webinar	2 (2.6)	16 (21.1)	46 (60.5)	6 (7.9)	1.80 (0.63)	N
8. Reading — theory	1 (1.3)	18 (23.7)	35 (46.1)	16 (21.1)	1.94 (0.74)	N
9. Reading — examples in literature	2 (2.6)	21 (27.6)	33 (43.4)	14 (18.4)	1.84 (0.77)	N
10. Shadowing a chaplain	3 (3.9)	15 (19.7)	31 (40.8)	21 (27.6)	2.00 (0.83)	N
11. Attend a retreat	17(22.4)	34 (44.7)	13 (17.1)	6 (7.9)	1.11 (0.88)	N

0 = "unnecessary," 1 = "not so important," 2 = "desirable," and 3 = "essential."

Table 4. Which clinical scenarios should be addressed in spiritual care training? ($N = 70$)

Topic	Unnecessary	Not so important	Desirable	Essential	M (SD)	Consensus 75%/Rank
1. Screening for spiritual concerns for any patient/resident	3 (3.9)	1 (1.3)	19 (25.0)	47 (61.8)	2.57 (0.73)	Y/1
2. Discussion around end-of-life beliefs	0 (0.0)	2 (2.6)	27 (35.5)	41 (53.9)	2.56 (0.56)	Y/2
3. Death anxiety/fear of death	0 (0.0)	3 (3.9)	26(34.2)	41 (53.9)	2.54 (0.58)	Y/3
4. Spiritual or existential distress	0 (0.0)	4 (5.3)	24 (31.6)	42 (55.3)	2.54 (0.61)	Y/3
5. Loss of autonomy/independence/personal agency	0 (0.0)	4 (5.3)	34 (44.7)	32 (42.1)	2.40 (0.60)	Y/4
6. Existential questions/angst	1 (1.3)	9 (11.8)	22 (28.9)	38 (50.0)	2.39 (0.77)	Y/5
7. Loneliness and isolation	0 (0.0)	8 (10.5)	34 (44.7)	28 (36.8)	2.29 (0.66)	Y/6
8. Coping with bad news	1 (1.3)	7 (9.2)	33 (43.4)	29 (38.2)	2.29 (0.71)	Y/6
9. Religious struggle or crisis of faith	1 (1.3)	10 (13.2)	28 (36.8)	31 (40.8)	2.27 (0.76)	Y/7
10. Distress and loss in the emergency context	0 (0.0)	12 (15.8)	31 (40.8)	27 (35.5)	2.21 (0.72)	Y/8
11. Guilt and bereavement, including anticipatory	0 (0.0)	7 (9.2)	32 (42.1)	31 (40.8)	2.34 (0.66)	N
12. Spiritual history taking for any patient/resident	4 (5.3)	10 (13.2)	25 (32.9)	31 (40.8)	2.19 (0.89)	N
13. Unresolved guilt	2 (2.6)	14 (18.4)	41 (53.9)	13 (17.1)	1.93 (0.71)	N
14. Vivid dreams, hallucinations, and agitation	4 (5.3)	23 (30.3)	32 (42.1)	11 (14.5)	1.71 (0.80)	N

0 = "unnecessary," 1 = "not so important," 2 = "desirable," and 3 = "essential."

Many of the components of spiritual care training identified in this study are similar to those identified internationally (Anandarajah et al., 2010; McSherry et al., 2020). In a study with family medicine residents in the USA, Anandarajah et al. (2010) identified a range of spiritual care competencies which included *knowledge* related to understanding spirituality and religion, spirituality and belief in patient care, resources, and literature; *skills* relating to both assessment and therapy, communication and listening, having a compassionate presence, providing spiritual whole-person care, and negotiating differences of belief; and *attitudes* including respect, spiritual self-awareness, spiritual self-care, and spiritual centeredness. In Europe, similar competencies have been identified encompassing intrapersonal spirituality, interpersonal spirituality, spiritual care assessment, and spiritual care interventions (McSherry et al., 2020). More emphasis in this current study appeared to be placed on topics that increased healthcare professionals' understanding of spirituality and spiritual care (and ability to screen for spiritual needs), rather than specific skills in intervention. This is consistent with the preferred model of generalist–specialist spiritual care provision (Balboni et al., 2014). This model of care recognizes that members of a clinical team have different levels of expertise. In the area of spiritual care, therefore, all members of a clinical team are able to "approach the patient as a whole person and to provide relational, dignity-based compassionate care" and can "assess the patient's physical, emotional, social and spiritual well-being and identify distress in these domains" (Balboni et al., 2014, p. 1588). More in-depth interventions, however, are the role of the spiritual care specialist. This may vary according to context and organization. As demonstrated in a study with rehabilitation professionals, a dedicated chaplain is not always available or present on the team (Jones et al., 2020c). In these cases, other members of the

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Table 5. Which clinical scenarios should be an indication for referral to a chaplain? ($N = 70$)

Topic	Never	Sometimes	Always	M (SD)	Consensus 75%/Rank
1. Religious struggle or crisis of faith	0 (0.0)	10 (13.2)	60 (78.9)	2.86 (0.35)	Y/1
2. Existential questions/angst	0 (0.0)	19 (25.0)	51 (67.1)	2.73 (0.45)	Y/2
3. Spiritual or existential distress	0 (0.0)	24 (31.6)	46 (60.5)	2.66 (0.48)	Y/3
4. Death anxiety/fear of death	0 (0.0)	31 (40.8)	39 (51.3)	2.56 (0.50)	Y/4
5. Discussion around end-of-life beliefs	0 (0.0)	31 (40.8)	39 (51.3)	2.56 (0.50)	Y/4
6. Guilt and bereavement, including anticipatory	1 (1.3)	38 (50.0)	31 (40.8)	2.43 (0.53)	Y/5
7. Unresolved guilt	1 (1.3)	40 (52.6)	29 (38.2)	2.40 (0.52)	Y/6
8. Screening for spiritual concerns for any patient/resident	0 (0.0)	50 (65.8)	20 (26.3)	2.29 (0.46)	Y/7
9. Distress and loss in the emergency context	2 (2.6)	48 (63.2)	20 (26.3)	2.26 (0.50)	Y/8
10. Spiritual history taking for any patient/resident	1 (1.3)	53 (69.7)	16 (21.1)	2.21 (0.45)	Y/9
11. Loneliness and isolation	1 (1.3)	53 (69.7)	16 (21.1)	2.21 (0.45)	Y/9
12. Coping with bad news	1 (1.3)	53 (69.7)	16 (21.1)	2.21 (0.45)	Y/9
13. Loss of autonomy/independence/personal agency	2 (2.6)	52 (68.4)	16 (21.1)	2.20 (0.47)	Y/10
14. Vivid dreams, hallucinations, and agitation	13 (17.1)	53 (69.7)	4 (5.3)	1.87 (0.48)	N

0 = "never," 1 = "sometimes," and 2 = "always."

Table 6. How important is it to address one's own spirituality and self-care in spiritual care training? ($N = 73$, survey 3)

How important is it	Unnecessary	Not so important	Desirable	Essential	M (SD)	Consensus 75%/Rank
1. To address one's own spirituality in spiritual care training?	0 (0.0)	2 (2.7)	19 (26.0)	52 (71.2)	2.68 (0.524)	Y
2. To address self-care in spiritual care training?	0 (0.0)	2 (2.7)	14 (19.2)	57 (78.1)	2.75 (0.494)	Y
3. That the following outcomes are achieved by spiritual care training?						
(i) Increased perception or knowledge	0 (0.0)	0 (0.0)	10 (13.7)	63 (86.3)	2.86 (0.35)	Y/1
(ii) Increased confidence and comfort	0 (0.0)	3 (4.1)	32 (43.8)	38 (52.1)	2.48 (0.58)	Y/2
(iii) Improved competency or skills in developing spiritual care	0 (0.0)	4 (5.5)	30 (41.1)	39 (53.4)	2.48 (0.60)	Y/2
(iv) Improved patient-related outcomes	0 (0.0)	3 (4.1)	32 (43.8)	38 (52.1)	2.48 (0.58)	Y/2
(v) Increased awareness of personal spirituality	0 (0.0)	4 (5.5)	32 (43.8)	37 (50.7)	2.45 (0.60)	Y/3
(vi) More referrals to spiritual care specialists	0 (0.0)	14 (19.2)	33 (45.2)	25 (34.3)	2.12 (0.76)	Y/4

0 = "unnecessary," 1 = "not so important," 2 = "desirable," and 3 = "essential."

multidisciplinary team may take on a greater role (Best et al., 2016b).

Responses relating to which clinical scenarios should be incorporated into training also reflected a generalist–specialist model (Puchalski et al., 2009, 2014; Balboni et al., 2014). The most highly ranked clinical scenario to include in training was a screening of spiritual concerns for any patient. Other clinical scenarios to be included were discussion around end-of-life beliefs and fear of death, which may commonly arise for all staff in the field of palliative care. Areas that did not reach consensus were unresolved guilt, guilt and bereavement, and vivid dreams and hallucinations, suggesting that these were either not considered to be associated with spiritual care, or considered to be a specialist area. This was reinforced later in the surveys when almost 80% of participants agreed that religious struggle or crisis of faith should always be an indication for referral to a chaplain.

A topic that did not receive consensus was "comparative religions study/alternative spiritual beliefs." A recent systematic review found that this topic is not often included in spiritual care programs internationally, with only 14/55 studies incorporating such material (Jones et al., in press). Such findings suggest that there is a growing perception that spiritual care training should be person-centered, and that attitudes regarding understanding the person and skills in communication may be more important than learning the details of different faiths (Hilbers et al., 2010; Paal et al., 2015). However, it can also be argued that for some disciplines and contexts, it is helpful for healthcare professionals to learn about different religions and cultures as part of spiritual care education. This was demonstrated in a study with undergraduate nurses (Cooper and Chang, 2016). The students reported benefiting from learning about the potential needs of patients from different religious and cultural backgrounds because of the multicultural nature of Australia. In another study from the UK, participants found it helpful to learn about the practices of different religions in relation to end-of-life care (O'Brien et al., 2019). It has been suggested that it is also a topic that should

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be considered in countries with a high proportion of refugees (Best et al., 2020).

Teaching methods that were most highly ranked in this study were case studies, group discussion, role-plays or simulated learning, and videos of personal stories. A lack of emphasis on didactic teaching reveals the value placed upon interactive learning. The benefits of interactive learning have been known for some time (Knowles, 1990). This knowledge has been already applied to spiritual care training programs. A study with rehabilitation health professionals showed that videos of patient stories were one of the most valued components of the training (Jones et al., 2020c). Likewise, training developed by Meredith et al. (2012) used a mix of case studies and reflection. The high ranking given to these learning approaches suggests that these teaching methods may be particularly appropriate for healthcare professionals who are accustomed to hands-on care. Furthermore, large amounts of theory may not be suitable for training healthcare professionals who are short of time.

An area where participants did not achieve consensus was regarding which spiritual care tool should be incorporated into training. The most likely reason for this is that most participants were not familiar with the list of spiritual tools generated from round one. The FICA spiritual history tool (Puchalski and Romer, 2000) was ranked most highly, yet less than 50% of participants thought that including it in training was desirable or essential. Cultural variations also require consideration. FICA is a tool developed by researchers in the USA, where those reporting to hold a religious affiliation are of a higher proportion than in Australia (Pew Research Center, 2012; Australian Bureau of Statistics, 2017b). The FICA screening tool places a focus on "Faith" and may not be appropriate if patients strongly associate faith with religion. Other factors may also impact upon the willingness of practitioners to incorporate the tool into practice. In Belgium, general practitioners reported that the FICA tool was too structured and prescriptive, preferring to rely on more conversational approaches to spiritual history taking (Vermandere et al., 2012). This has also been identified in a study of palliative care physicians from Australia and New Zealand (Best et al., 2016a).

This study had several limitations. Over half of the sample worked in pastoral care, and almost 80% identified with the Christian faith. A greater range of disciplinary and faith backgrounds may have generated different responses in the first open-ended round. Furthermore, the response rates to the second and third surveys were considerably lower than the first survey.

Our findings suggest that spiritual care training for healthcare professionals should emphasize understanding over specific skills and seek to build strong relationships between generalist and specialist spiritual care providers. This may entail facilitating better partnerships between chaplains and other healthcare workers and enhancing awareness of the chaplaincy role. Furthermore, a range of teaching methods should be deployed. Future studies should focus upon the development and evaluation of spiritual care training to further explore these findings within a practice context.

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