Mind, Body, Heart & Soul

NHS Lanarkshire and Lanarkshire Recovery Network

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Spirituality is not tied to any particular religious belief or tradition. Although culture and beliefs can play a part in spirituality, every person has their own unique experience of what that is; a personal experience for anyone, with or without a religious belief. Spirituality also highlights how connected we are to the world and other people.
(Royal College of Psychiatrists, 2010)

1. Introduction and Background

The Mind, Body, Heart & Soul conference took place on 28 November 2012 providing NHS Lanarkshire (NHSL) and Lanarkshire Recovery Network (LRN) the opportunity to continue the conversation on the role of spirituality within the health agenda. This collaboration sought to gain a deeper understanding of the topic and to explore ways in which it can be integrated and embedded into practice.

Mind, Body, Heart & Soul was not only a response to key Scottish Government policies and drivers[1], published research[2] and resource materials[3], but it is also responds to a growing interest shared by diverse groups including service users and service providers. This conference also helped to address recommendations set out in the Faith in Recovery Report 2012[4] to:

'Encourage NHS staff to challenge stigma and negative approaches to spirituality through training to ensure an individual's spirituality is incorporated into care planning ... from assessment through to discharge.'

Kevin O'Neill, Prof John Swinton, Ann-Marie Newman, Bob Devenny, Martin Stepek, Dr Alastair Cook, Lynne Cruickshank, Dr Tom Brown, Marian McElhinney

Aims of the conference

Gain deeper understanding of the role spirituality has to play in person-centred care
Explore ways to integrate and embed spirituality into psychiatric assessment, recovery based care planning and clinical practice

[1] NHS Lanarkshire Equality Outcomes; Rights, Relationships & Recovery (2006); Mental Health (Care & Treatment) Scotland) Act 2003; Fair to All (2003); Spiritual Care and Chaplaincy in NHS Scotland, CEL 2008 (49)
[2] The Mental Health Foundation: The Impact of Spirituality – A Literature Review(2006)
[3] Spiritual Care Matters: An Introductory Resource for all NHS Scotland Staff; 10 Essential Shared Capabilities; Religion & Belief Matter: An Information Resource for Health Care Staff; Spirituality in Nursing Care (RCN, 2011)
[4] Faith in Recovery: Evaluation & Report (2012)

This report provides LRN partners, NHSL, delegates and other interested parties with an overview and evaluation of the day's event. The report is based on feedback questionnaire returns from 72% of the 108 delegates attending. This figure is based on the number of people recorded at the morning registration and the number of evaluation form returns. Key points or issues that were raised during the morning and afternoon table top discussions are reported as well as feedback from the evaluation returns and results following the option finder sessions at the beginning and end of the day.

2. Key Results

2.1 Advertising the Event

Success of the conference was achieved by engaging doctors, nurses and other mental health and social care workers in the conversation. Promotion of the event was directed to staff working in the field of mental health in the first instance with invitations thereafter being extended to include 'see me' signatories, service users and carers as it was recognised this could provide a diverse perspective and shared experience.

Advertising the event was done through the NHS Lanarkshire mental health promotion and Lanarkshire Recovery Network partners with requests made for dissemination via their appropriate networks to maximise circulation. The conference was also promoted through the Element website, Facebook and Twitter.

2.2 Numbers Attending

One hundred and thirty people registered for the event of which one hundred and eight (83%) attended and registered in the morning. Several apologies were received prior to the conference but tended to be either on the day before the event or on the day itself. Due to demand, a waiting list had been created but because of unconfirmed non-attendance it was too late to inform people of the 22 places available.

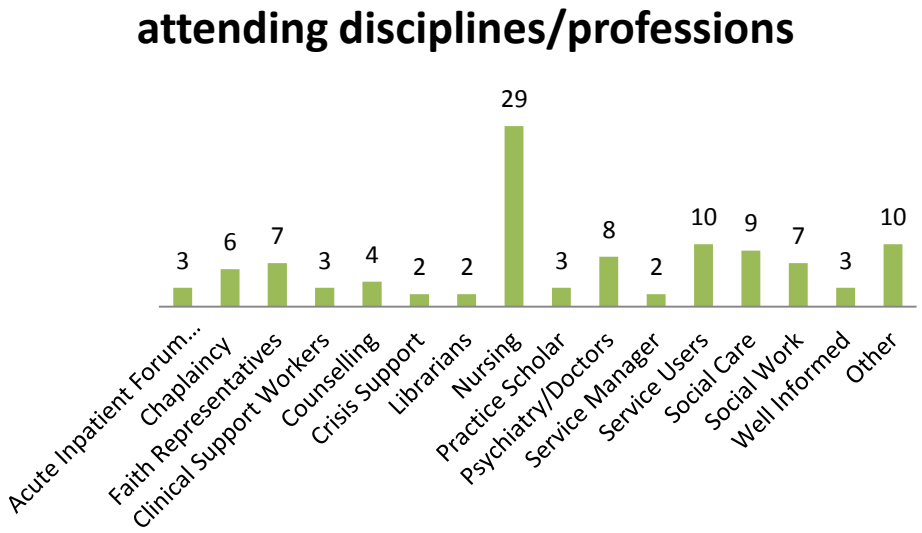


Fig 1

From data collected at the morning registration, nursing was the largest group in attendance along with social care and social work, with a good representation from doctors, chaplaincy, faith representatives and other mental health workers. There were also those whose primary roles do not involve mental health that attended. This, combined with presence of interested service users and carers, contributed hugely to the discussion. Numbers fluctuated throughout the day with some delegates leaving after the morning session, others joining in the afternoon and there was a number that had to leave due to parking restrictions.

2.3 The venue

The conference was held in South Lanarkshire Council's Banqueting Hall in Hamilton. 85% of people returning evaluations thought the venue and catering were of a high standard but identified parking restrictions and environmental factors as problem areas. A number of people thought the room too cold at times and the noise at the back of the hall, while catering staff cleared up, made it difficult to hear speakers at times.

3. Speakers

NHSL and LRN were privileged to welcome Dr Alastair Cook, Associate Medical Director, as Chair, Professor John Swinton, Chair in Divinity and Religious Studies at Aberdeen University and Dr Tom Brown, Retired Psychiatrist and Associate Registrar Royal College of Psychiatrists. A Mindfulness session was delivered by Martin Stepek and delegates were given the opportunity to hear personal perspectives through the use of Digital Stories. All contributed to make the event a worthwhile and enjoyable one.

3.1 Presentations

'Embedding Spirituality in Person Centred Care' - Prof John Swinton
'The Relevance of Spirituality to Clinical Practice and Assessment' - Dr Tom Brown

Feedback reflected a high level of appreciation of the key speakers with most people finding the talks and information presented as excellent or very good. Key speakers' PowerPoint presentations and videos are accessible via the Elament website at:

http://www.elament.org.uk/spirituality/events/mind,-body,-heart-soul.aspx

3.2 Digital Stories

Digital stories are short stories of people's lived experiences. They are meaningful, powerful and empowering. At the conference, three digital stories were shown following three people's experiences of mental health difficulties. The stories were recorded in the person's own words and voice with music and still images to create a three minute mini-movie.

The digital stories were created by Karen Barrie who is currently leading a project entitled *What Matters, What Counts*, hosted by the Health and Social Care Alliance Scotland, which is seeking to establish the importance of enabling people to achieve their 'personal outcomes' or self-identified priorities in life as a critical measure of quality.

The overall opinion was that the digital stories enhanced understanding of people's experiences.
For more information on digital stories, see Appendix 2.

3.3 Mindfulness

Overall, most people participated and enjoyed this brief introduction session to Mindfulness led by Martin Stepek, Director, Mindfulness Scotland. However, one person stated that it challenged their *religious beliefs and understanding* and was therefore *unable to take part*. This provided an opportunity to discuss the ways in which mindfulness and other alternative therapies may conflict with an individual's core beliefs.

3.4 Areas people would like to have seen covered

In most cases people felt satisfied that all areas had been covered although there were some requests for further information that included:

- Spiritual care for people living with dementia and learning disabilities
- More emphasis on resources and services available for service users to engage in developing spirituality
- Exploring ways in which a practitioner's faith/belief has impact on the care they deliver
- How patients or nurses can access appropriate help *(this is addressed by easier access to Spiritual Care Team with the launch of the new referral system and through spirituality section of website)*
- Spending more time on assessing spiritual needs through role play or by delivering a practical session on working with patients
- Presentation by NHSL's Chaplaincy Team

Most people felt they were able to make use of the opportunities given to ask questions particularly during the table top discussions. For others the conference had raised even more questions than they had answers, for example, *'drawing the line between belief and delusion', 'how to increase awareness amongst doctors'* and *'if spiritual care is the responsibility of all, what is the role/value of the spiritual care department'.*
These questions provide further educational opportunities and for raising awareness of the role of the spiritual care team in NHS Lanarkshire.

4. Table top discussions

Following each presentation each of the thirteen tables were guided through facilitated discussions with questions and scenarios provided to encourage as wide a dialogue as possible. This helped groups explore general understanding and opinion, identify training needs and elicit opportunities for future collaborative working.

Written feedback was received from ten of the thirteen groups. It should be noted that not all notes could be deciphered so there are omissions. The following account is based on the key elements of the general discussions.

4.1 Morning Session

Following Prof John Swinton's presentation *'Embedding spirituality in person-centred care'*, questions 1 and 2 formed the basis of discussion.

4.1.1 What might be some of the ways that a focus on the spiritual can help us see the person with a mental illness more clearly and respond more effectively/compassionately?

Prof Swinton described a key element of spiritual care is underpinned by the need for staff working in mental health to feel valued and, in turn, value the people for whom they provide a service. He described staff and client interaction should be underpinned by the value 'It's good that you exist. I'm glad you are here'.

This prompted much discussion with both those working in and using mental health services identifying that priority consideration needs to be given to how we make people feel that 'we are glad they exist and are glad they are here' through how we communicate, how we welcome, how we answer the phone, how we meet people at reception, how we write to them and how we set up our physical environment. One group suggested that the health service could learn from the business industry around good 'customer care'.

> *"It's good that you exist. I'm glad you are here."*

This quote from Prof Swinton resonated with the delegates showing a strong sense of humanity and an appreciation of what it is to be human and in a caring relationship with others. People agreed that spirituality was more than what is seen; the essence of someone displayed through meaning, purpose, love and hope, in their relationships with others and self.

Once delegates had heard Prof Swinton's presentation, many of the audience described that they felt they were already delivering spiritual care but would call it 'person centred care' or 'family centred care' or 'holistic care' or 'recovery focused care'. This highlighted that we need to be mindful of the language we use.

It was felt that spiritual care sits strongest under the 'person centred care' agenda within mental health as this encompasses the key elements of both person centred and spiritual care such as being valued and involved, listened to with individual needs, hopes, strengths and goals identified and met.

> *having the right tools ... capture someone's story ... meaningful engagement*

Person-centred care should always be cognisant of this, respectful of someone's life story. This way our responses can be more effective and compassionate. To elicit meaning and discover someone's story it is essential for staff to be able to communicate in a confident and appropriate way.

Excellent communication skills and the therapeutic relationship were seen to be integral to fostering a sense of connection between service provider and service user. For staff, self-awareness and an understanding of one's own spirituality are essential to making that connection a meaningful one. By being open-minded and mindful of someone's spiritual needs, with or without a religious element, practitioners can work collaboratively to plan care that is compassionate, person-centred and effective.

> *Increasing awareness through better education, not just for professionals, but for our wider communities*

An awareness and understanding of the individual's social and cultural norms was seen to be relevant. Also being able to make the connections to spiritual supports through the Spiritual Care Team and develop knowledge of what is available in the community.

A wider issue was also highlighted. Addressing the general misunderstanding of the true meaning of spirituality and breaking down the barriers that are present are required if we are to truly integrate and embed it in practice. There is also a need to raise awareness of the generic nature of the chaplaincy team along with improved communication between all support networks.

4.1.2 Who delivers spiritual care? What does it look like? What makes it different from other forms of care?

The general consensus was that everyone is responsible for spiritual care, directly and indirectly. Some people initially expressed their confusion over the use of the phrase 'spiritual care', particularly when outwith chaplaincy or faith groups, and suggested that a clearer definition may be required. However, after listening to key speakers and engaging in table top discussions, they now felt that using the term 'person-centred care' instead of spiritual care was more helpful in terms of practice. In doing so, we are able to recognise the number of staff already delivering spiritual care yet not defining it as such.

It was also noted that '*compliance of necessary hospital routines and legislative requirements can dehumanise people'* and a recognition that '*environmental factors [in hospitals] can have an impact on how professionals view patients'*.

More specific issues, such as staff capacity and appropriate time for reflection on practice, were also raised and ought to be addressed.

4.2 Afternoon Session

To assist discussion, two case studies followed Dr Tom Brown's presentation on *'The relevance of spirituality to clinical practice and assessment'*. Below are the two case studies together with set questions prepared by the speakers. Key points raised during discussion have been highlighted.

Case 1

You are seeing a 45 year old divorced man who suffers from depression. He lives alone. His ex wife and children live some distance away and he sees his teenage children only 3-4 times a year. He is not doing well and at his last appointment tells you he feels a bit hopeless and on questioning says he has had some suicidal ideas. You carry out a risk assessment and have no concerns about his immediate safety. You are concerned however to deal with suicidal ideation and hopelessness. You recall that at a previous consultation he mentioned that he needed "to get back in touch with his spiritual side". You did not pursue this at the time but decide to do so now by asking him if he has any religious beliefs. He is very clear that he is not religious and certainly not a believer in any major religion.

4.2.1 How would you further explore his "spiritual side" and how might you use this to instil hope and help him deal with his suicidal ideation?

what spirituality means to you ... what has worked in the past
person-centred planning ... goals and outcomes ... connections ... safety

A range of options for assessment and treatment were discussed amongst the groups with a clear emphasis on the person's safety. Again, the therapeutic relationship was seen to be a key factor to discovery. Establishing reasons for the person's suicidal thoughts and agreeing a safety plan were vital. Discovering the man's life story and gaining insight into what he meant by his '*spiritual side'* was important as was assessing if engaging in spiritual practices had been previously effective and how.

Exploring the possibility of reconnecting with his family and identifying wider support networks also ought to be discussed. Using the correct terminology and focusing on hopes and the future were seen to be crucial to person-centred care planning, in developing goals and identifying support.

Case 2

You work on an inpatient psychiatric unit (as a nurse/doctor/OT/social worker). A 32 year old married woman (with no children) has been admitted with her first episode of acute mania (she had a depressive illness 5 years ago). She is elated, not sleeping and her speech is dominated by religious (Christian) themes. She believes she has a "special" relationship with God and communicates directly with him, sometimes assisted by the Virgin Mary (which is of interest as she isn't a Roman Catholic). She believes she has been chosen to be the wife of Jesus. She is very irritable if challenged about any of this and is refusing to take treatment.

Having previously been only a nominal adherent (and infrequent attendee) of her local church, she attended a Christian evangelistic rally two months ago where she says she had a conversion experience and experienced the Holy Spirit come in to her life. She started attending church regularly (a different church), reading her bible daily and spending time praying. Her behaviour was in other ways unaltered though her husband noticed had had stopped swearing. She continued to do her job (as a district nurse) perfectly well and her day to day functioning was normal. Her husband, who describes himself as an atheist was disconcerted by her new found religiosity but reports they continued to have a good relationship, including a satisfactory sexual relationship. He became more concerned a week ago when he noticed she was talking incessantly and he couldn't always follow what she was saying. She was hardly sleeping, her religious ideas have become more prominent and in his views more extreme (for example she had declined to have sex with him on the grounds she was now married to Jesus). She was also very elated but at other times irritable. He said she hadn't gone to work for a week as she "had to do God's work".

4.2.2 What issues does this case raise for you?

- This will probably vary to some extent depending on your own beliefs/world views-give all of these an airing!
- Does this confront you with any prejudices you may have? If so how might you deal with these?
- Apart from providing the usual care and treatment for acute mania what other steps would you take to optimise this lady's care?

Throughout discussion it was evident that groups recognised and understood that, for some, religion may be integral to their recovery but that spiritual care is not always necessarily linked to religious belief and practice.

For the purpose of this case study, it was agreed that an assessment of the patient would be needed to establish normal spiritual practice and the possibility of psychosis. Clarifying the woman's usual personal spiritual framework (PSF) is an important factor as is establishing whether she is well enough to continue to participate in religious practice at this time. Involving her husband and family in the care planning process and gaining insight into her faith community's response to mental illness would certainly be valuable as this could have a significant impact on her recovery.

In much of the feedback, it was also noted that insight into one's own beliefs, the ability to identify potential conflicts that might prejudice one's approach and how to overcome them, based on the best interests of the patient, were seen to be crucial. Again, usage of the term person-centred may be more useful.

5. Results of Option Finder Sessions

Set questions were presented to delegates at the beginning of the day and at the end of the day. This session was facilitated by South Lanarkshire Council who also produced the results which were forwarded in Microsoft PowerPoint format. For the purpose of this report these results were transferred to Excel and are found in Figs 2 – 10.

5.1 Rationale

The original intention was to obtain a baseline measurement and compare it to results after speakers' presentations and table top discussions to signify any changes in attitudes and opinion. Unfortunately, because the numbers fluctuated during the day, a direct comparison on a like for like basis between the morning and afternoon results is unable to be made.

However, we are still able to gauge levels of interest, a general understanding of the topic and identify areas or gaps that need to be improved upon. The two sessions have therefore been analysed as two separate sample groups.

5.2 Overview of results

It should be noted that whilst the following results are encouraging, if we are to consider the probability that the majority of people attending the conference have a particular interest in this topic and therefore may have a greater understanding it is difficult to say whether or not these results are representative of a wider group. Further investigation is required to a wider audience. Where it is noted that the question was not applicable, this refers to the number of service users and/or carers present.

5.2.1 I would best describe my current responsibilities and circumstances as?

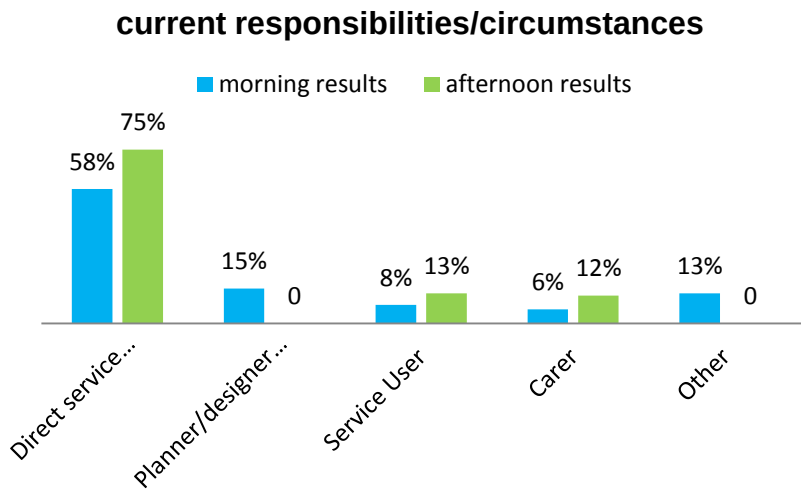


Fig 2

Note: these figures should not be compared on a like for like basis due to constituent changes.

The composition of responsibilities and circumstances changed throughout the day. In the morning 58% of people voting declared themselves as direct service providers and 75% in the afternoon. 15% of people in the morning said they were planners/designers of services and in the afternoon there was no-one who fitted this category. Of the 108 people who registered in the morning, 8% said they were service users with 13% attending in the afternoon.

5.2.2 Who is mostly responsible for spiritual care?

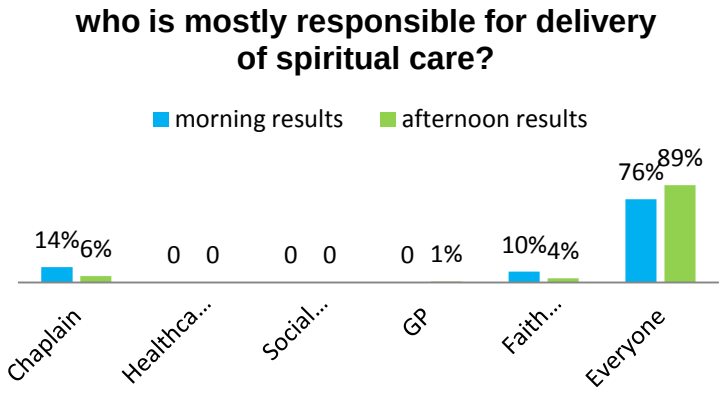


Fig 3

Note : these figures should not be compared on a like for like basis.

The morning results show 76% of people stating they believed that spiritual care was everyone's responsibility and 89% in the afternoon. It is difficult to conclude if this was a shift in attitude given the fluctuation in numbers between those who voted in morning and afternoon sessions. To ascertain if this is a shift in attitude or representative of a wider cohort, further work would need to be done.

5.2.3 There is a difference between religious and spiritual care

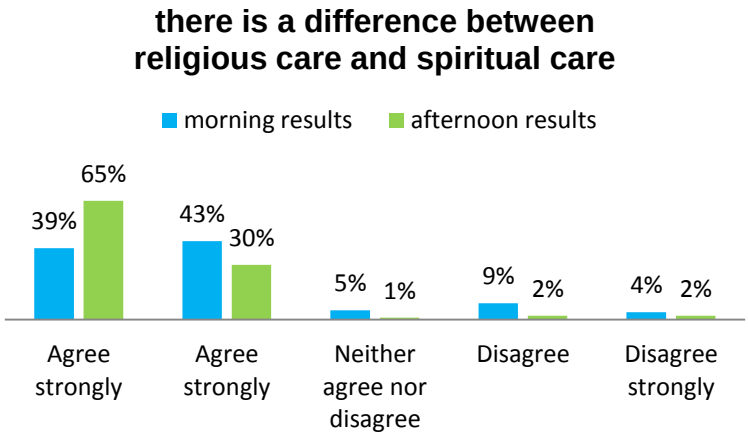


Fig 4

Note: *these figures should not be compared on a like for like basis.*

The morning and afternoon results both showed that the majority of people either agreed strongly or agreed that there is a difference between religious and spiritual care, noting that a distinction can be made between the two. It could be said that this result may have been expected given the interest of those attending and therefore it would be worthwhile researching a wider sample.

5.2.4 I would feel confident asking about spiritual care needs as part of assessment and care planning

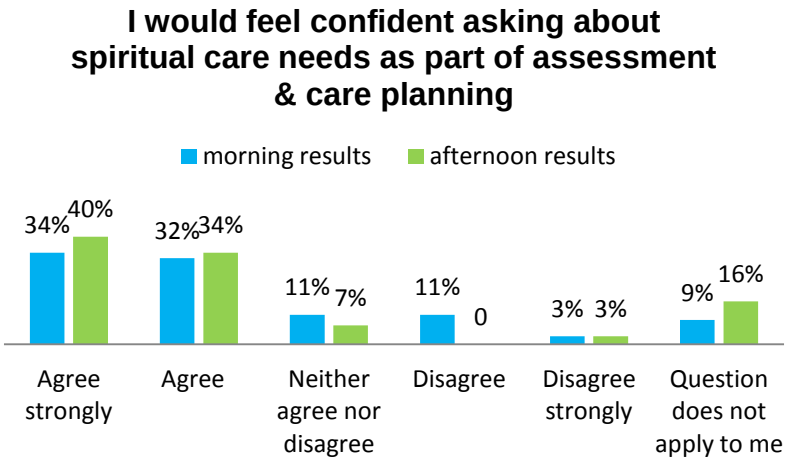


Fig 5

Note : these figures should not be compared on a like for like basis.

The majority of people voting both in morning (66%) and afternoon sessions (75%) either strongly agreed/agreed that they felt confident to include spiritual care as part of the assessment and care planning process. 11% of people said they were uncertain in both morning and afternoon and there was a small percentage (3%) who disagreed strongly. This question was not applicable to 9% of delegates in the morning and 16% in the afternoon.

5.2.5 I have enough knowledge and information to include spiritual care in assessment and care planning

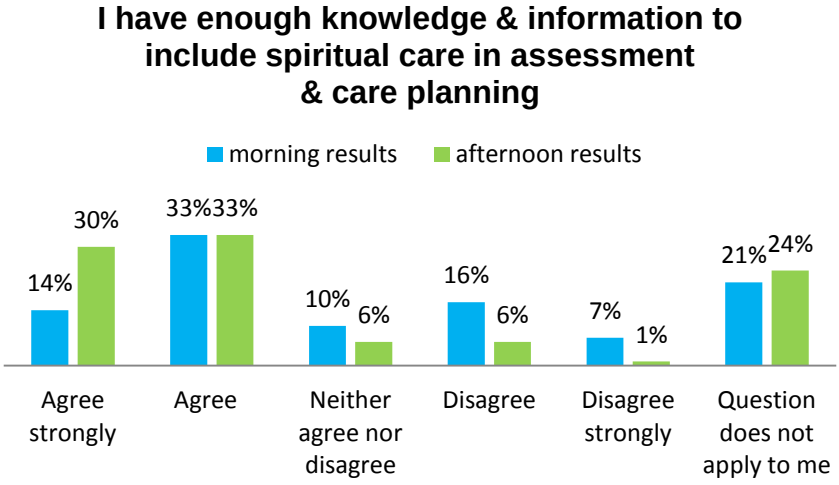


Fig 6

Note : these figures should not be compared on a like for like basis.

Morning results showed that 47% of people either strongly agreed/agreed that they had enough knowledge with 26% neither agreeing nor disagreeing. In the afternoon 63% said they strongly agreed/agreed compared with 12% who neither agreed nor disagreed. This result is supported by earlier feedback from people suggesting they now felt that they were more informed and had enough knowledge that would allow them to include spirituality as part of assessment and care planning. This question was not applicable to 21% of people in the morning and 24% in the afternoon.

5.2.6 I am encouraged and supported by my employer to include spirituality in my day to day practice

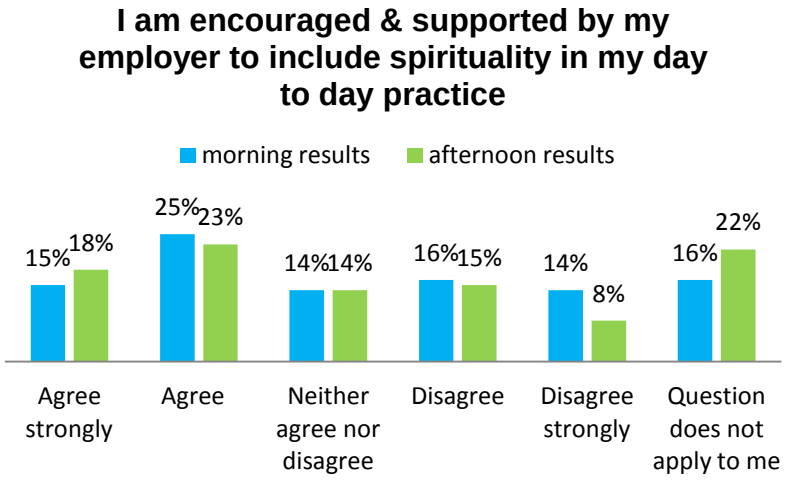


Fig 7

Note : these figures should not be compared on a like for like basis.

Both morning and afternoon results show that encoura spirituality in day to day practice could be improved upon. In the morning 40% of people said they were encouraged and supported compared with 30% who disagreed/disagreed strongly.
In the afternoon, 41% agreed and 23% disagreed with 14% neither agreeing nor disagreeing in the morning and afternoon. This question was not applicable to 16% of people in the morning and 22% in the afternoon.

5.2.7 I have a good understanding of what supports are available to help meet people's spiritual needs

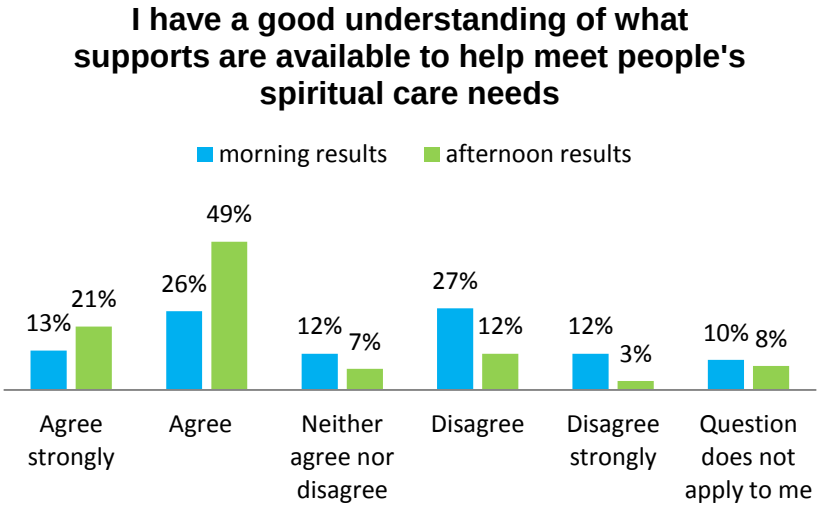


Fig 8

Note : these figures should not be compared on a like for like basis.

Whilst the majority of people stated they felt confident including spiritual care as part of the assessment and planning process, the morning results showed that only 39% of respondents agreed and said they had an understanding of what supports are available compared with 34% of those who disagreed. In the afternoon 70% either agreed strongly/agreed compared with 15% who disagreed.

Given that there will be a number (unknown) of people voting in both morning and afternoon, this may imply that following the speakers and table top discussions there was an increased level of understanding of what spiritual care supports are available or they now knew where to look. This question was not applicable to 10% of those voting in the morning and 8% in the afternoon.

5.2.8 Lanarkshire Mental Health Services (LMHS) help to meet people's spiritual care needs most of the time

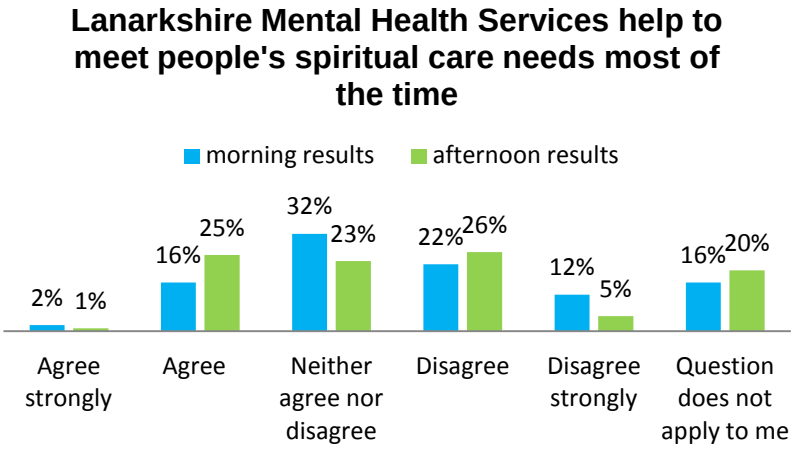


Fig 9

Note : these figures should not be compared on a like for like basis.

18% of respondents in the morning agreed strongly/agreed that LMHS met people's spiritual care needs most of the time compared with 34% who disagreed and 32% unable to make up their minds. In the afternoon 26% agreed strongly/agreed whilst 31% disagreed and 23% neither agreed nor disagreed. These results may in part be due to lack of evidence and perception. 16% of people attending in the morning did not apply to this question.

5.2.9 I am a service user and/or carer and I believe LMHS help to meet people's spiritual care needs most of the time

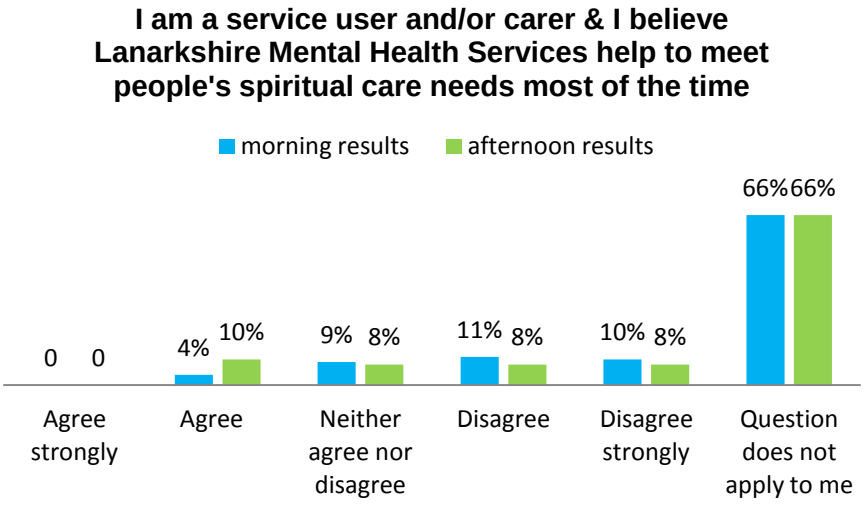


Fig 10

Note : these figures should not be compared on a like for like basis.

In the morning only 4% of service users and/or carers agreed that LMHS met the spiritual care needs with 21% either disagreeing/disagreeing strongly and 9% of people neither agreed nor disagreed. The afternoon provided similar results with 10% agreeing and 16% disagreeing strongly/disagreeing. 8% neither agreed nor disagreed. This feedback from service users and carers is disappointing. There is a clear relation to service providers' feedback stated in 7.2.8. This provides an opportunity for further investigation to gauge how representative this dissatisfaction is amongst service users and carers and reinforces the need for inclusion of spiritual care into assessment and care planning.

6. Working together

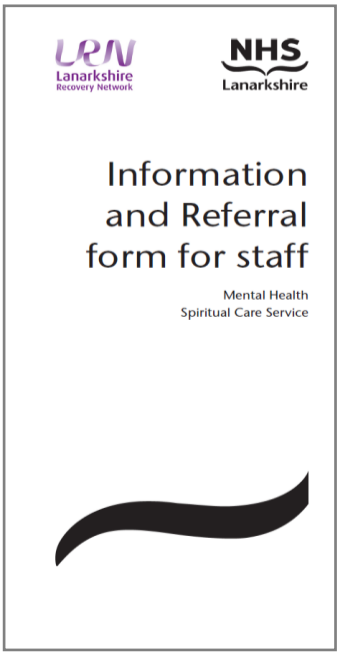
6.1 Lanarkshire Recovery Network

Registering with Lanarkshire Recovery Network means access to regular email updates about what is happening in Lanarkshire along with news of events and training opportunities. Of those who completed evaluation forms, 49% said they would like to be registered as new members, 41% did not respond or said no and 10% were members already.

6.2 Launch of New Resources

This conference also provided the opportunity to launch a section on the Elament website that is designated to 'spirituality'. This provides general information on spirituality along with a range of resources and research. There is also information on a range of faith and belief groups, inspiring stories, events and the Spiritual Care Team.

The new leaflet, *'Information and Referral form for staff: Mental Health Spiritual Care Service',* was also launched. This provides staff with a referral pathway for spiritual care to NHSL Spiritual Care Team along with contact details.



6.3 Pledge Cards

Delegates were encouraged to look at ways they could contribute to this ongoing work on an individual and personal basis. Forty six delegates wrote a personal commitment on a postcard which was then placed inside an envelope and addressed to them. Envelopes were gathered and will be posted out to them by LRN at the end of February 2013 as a reminder of their pledge.

7. Debrief

The steering group met following the conference to review and discuss the day and identify its strengths, any issues arising, development opportunities and further actions.

7.1 Strengths

Mind, Body, Heart & Soul responded to a number of Scottish policies and drivers as well as recommendations set out in the Faith in Recovery report. This conference provided the opportunity for a *'rich and diverse group discussion'* to take place and, in particular, psychiatric involvement was well received by everyone who attended. Quality speakers, the use of digital stories, session on mindfulness and the opportunity to discuss in small groups contributed to people feeling valued and motivated. The conference was seen to be the perfect platform on which to launch and raise awareness of the new Spirituality section on Element and also the Information and Referral form for staff. Monitoring referrals through the use of this form will be monitored by the Spiritual Care Team and number of visits to the website will be tracked by LRN. These figures will be looked at quarterly.

7.2 Weaknesses

- Parking was the main challenge resulting in people having to leave the venue throughout the day to top up parking meters and some left the event early
- More than one facilitator or a facilitator and scribe at each table would have been preferred and, given the nature of the case studies, more preparation or discussion time prior to the event would have resulted in facilitators feeling better equipped to respond to issues that arose
- A definition of 'spirituality' would have been helpful for some people at the beginning of the day to provide context to the day
- A contribution from the chaplaincy team could have proved helpful and valuable in raising the team's profile and remit
- It was noted that some faith group representatives had little knowledge or understanding of broader mental health problems or how to respond to them and therefore training opportunities for faith groups may be required

7.3 Opportunities

The conference provides many opportunities to:

- Build on engagement and learn from feedback
- Invite others to contribute to the ongoing plans and take recommendations forward
- Develop a training agenda that includes further work around assessment and practical workshops on useful ways to include spiritual care into a conversation
- Consider ways to open up discussion around religious experiences, differences between beliefs and delusions, conversations around demonic possession and deliverance
- Some faith groups may benefit from a training programme specific to their context and community

7.4 Action

Home for this work sits closely with compassionate, person-centred and recovery focused care. Outcomes for the steering group will mean looking at training for non mental health staff, following up on assessment training including and assessment workshop session. It was also suggested that a research, reading or focus group may be an idea to look at existing spiritual care assessment tools and how these can be used or adapted for use in Lanarkshire and integrated with assessment and care planning. For the future it will benefit the ongoing programme to maintain contact with those people who have declared an interest and to involve faith representatives and psychiatry in future conversations. This will include continuing with multi-faith meetings in 2013 to help progress.

8. Conclusion

Mind, Body, Heart & Soul set out to gain a deeper understanding of the role spirituality has to play in person-centred care and explore ways to integrate and embed it into psychiatric assessment, recovery based care planning and clinical practice. The demand for places and the attendance of doctors, nurses, social work, social care and other mental health workers, as well as a small number of interested representatives from faith communities, service users and carers, contributed to its success. 92% of people said they had found the event worthwhile and 91% of those attending would attend future events about spirituality, mental health and recovery.

This conference not only responded to key Scottish Government policies and drivers but also continued the conversation that began with Faith in Recovery in 2012. It provided a learning opportunity that allowed people to explore the meaning of spirituality in its broadest sense, discuss the relevance of spiritual care and who was responsible for it, and dispelled some of the myths surrounding it.

Key speakers, Prof John Swinton and Dr Tom Brown, presented around the key themes of the relevance of spirituality in practice and how to embed it. Questions were set by the speakers to be examined by thirteen facilitated groups and these resulted in a high level of discussion around the tables with valuable feedback collated and opportunities for future development identified.

> *"It's good that you exist; I'm glad you are here."*

Through listening, learning, sharing and conversation a deeper understanding of the role of spirituality was achieved and, as a consequence, a renewed and fresh expression of person centred care discovered.

Cognisance of someone's life story was seen to be essential to person-centred care, facilitated by a relationship that is therapeutic, reciprocal and trusting. There was also an understanding of the real impact that consuming paperwork and procedures, hospital routines, legislative requirements and environmental factors can have on an individual's humanity and that it was crucial this was not eroded but that identify, meaning and purpose were preserved. However, there was also recognition that connecting to people and fostering a therapeutic relationship can take time which, for some, raised issues around staff capacity and appropriate time for reflection.

9. Recommendations

The recommendations set out below have been identified from evaluation forms, table top discussion feedback and morning and afternoon option finder sessions.

1. Embed the spiritual care strategic agenda within the person centred care agenda

2. More educational and practical opportunities on assessing spiritual needs through role play or by delivering a practical session on working with patients

3. Improved focus on traditional customer care to ensure that people feel services 'are glad they exist and glad they are here'

4. Discuss ways in which alternative therapies may conflict with core beliefs of those involved in receiving, planning and delivering care

5. Specific spiritual care training and resources for people living with dementia and learning disabilities

6. Identify current spiritual care assessment tools and their appropriateness for inclusion as part of assessment and care planning in Lanarkshire

7. Investigate and collate a list resources and services available for service users

8. Explore ways in which a practitioner's faith/belief has impact on care they deliver

9. Raise awareness of the generic role of the Chaplaincy Team

10. Training on assessing the difference between spirituality and psychosis, belief and delusion

11. Continue to increase awareness through better education, not just for professionals, but for the wider communities to ensure that spiritual care and religious care are understood

12. Staff capacity and appropriate time for reflection

13. Specific training opportunities for faith groups through collaboration with mental health staff

14. Promote the spirituality section on eLament and encourage its growth through contribution and track number of visits

15. Ensure all mental health staff are aware of the Information and Referral Form and encourage referrals through this route and monitor number of referrals made through the use of the Information and Referral Form

16. Ensure facilitators are given enough preparation time prior to events to explore potential challenges and how to overcome them

17. Further research required to gauge levels of understanding of the role of spirituality in person-centred care amongst staff in mental health services

18. Continue to explore creative ways to integrate and embed spirituality into psychiatric assessment, recovery based care planning and clinical practice

Attending Disciplines/Professions

Acute Inpatient Forum Workers	3
AHP Director	1
Chaplaincy	6
Faith Representatives	7
Clinical Support Workers	3
ClubNet	1
Counselling	4
Crisis Support	2
Engineer	1
Equality & Diversity	1
Lecturer (MH)	1
Librarians	2
MH Practitioner	1
Nursing	29
Occupational Therapy	1
Practice Development	1
Practice Scholar	3
Psychiatry/Doctors	8
Psychology	1
Service Manager	2
Service Users	10
Social Care	9
Social Work	7
Teaching	1
Well Informed	3

DIGITAL STORYTELLING
Mind, body, heart & soul:
Embedding spirituality in person centred care

You are invited to take part in making a 'digital story'. To help you decide whether or not this is something you would like to do, this information sheet explains why you are being asked to help and what you can expect if you do take part.

What are 'digital stories'?

Digital stories are short stories, usually around three minutes long. They are recorded in the teller's own words and voice. Music and still images are then added to create a 'mini-movie'.

Why is my digital story being created?

NHS Lanarkshire and the Lanarkshire Recovery Network have teamed up to run the mind, body, heart and soul conference, which will be held on 28th November 2012. [Please see the event flyer]. The conference will continue the conversation about spiritual care in the health agenda. We hope to create a safe space for discussions that are grounded in lived experience. With your agreement, your digital story would be screened at the event. This would allow those attending to listen to and quietly reflect upon your personal experience of recovery and the importance that you attach to spiritual care.

Would I have to do anything beforehand?

You wouldn't ***have*** to do anything before we meet, but it would help us to make good use of the time available if you'd given some thought to your story ideas. It would also be helpful if you were able to look out some photographs or objects that hold particular meaning for you to help you to tell your story.

What would making a 'digital story' involve?

We would meet somewhere convenient and comfortable for you. After spending a bit of time finding out more about each other, we'd talk through your ideas as to how you might share your experiences. If necessary, we would support you to develop your experiences into a short story. This could mean building upon a basic idea, or trying to focus on one aspect of a complex story in order to keep to the 'three minute' guide. You'd have total control over what to say and what to leave out – it's your story.

We'd then discuss the sort of images that you might want to use to illustrate your story, such as personal photos or stock images. We would be able to take new photos on the day or scan any old photos that you'd looked out, providing that you

were happy for us to do so. We would then record you telling your story in your own words and at your own pace.

How long would it take to capture my story?
The time it takes to capture a story varies hugely. Most take a couple of hours, but we'd be guided by your availability and readiness, and if necessary would organise a follow-up meeting. If you wanted to stop at any time, you could do so without giving any reason at all.

What would happen afterwards?
Afterwards I'd put together your digital story using your voice recording, music and image choices, or we could arrange to do this together if you prefer. Once finished, you'd be shown the completed story privately and I'd make any changes that you required. You would only be asked to agree to your story being shown at the mind, body, heart and soul event if and when you are fully satisfied with it.

You would also be given a copy of your story on DVD for your own personal use.

How else could my digital story be used?
Upon completion of your story, you'd be asked to sign a form called '*Further use of my digital story*'. This form records any limits that you wish to place on the future use of your story, including time limits.

With your consent, your story could be shown at future mental health or spiritual care conferences. Copies could also be made available on DVD to health / social care organisations for local use, such as within staff training and awareness raising programmes, or to inform the redesign of mental health services.

If you decide that you do not want your story to be used at all, you would still be offered your own DVD copy of your story to keep. All other copies would be destroyed.

Who should I contact for further information?
We hope that this information sheet has told you what you need to know before deciding whether or not to take part. If you have any further questions, or wish to chat through your initial story ideas at any point, please don't hesitate to get in touch.

Marian Mcelhinney:
01355 584669

Many thanks for reading th

Karen Barrie: 07756778271

Many thanks for reading this information sheet and for considering this request.