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Evaluation of the Interprofessional Spiritual Care Education Curriculum in Australia: Online

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Abstract

Objective. Spiritual care is a component of quality palliative care, but healthcare providers have reported lack of training as a barrier to its provision. This paper describes the evaluation of the Interprofessional Spiritual Care Educational Curriculum (ISPEC)© which is a six-module evidence-based curriculum developed for teaching interprofessional spiritual care based on a generalist-specialist model of spiritual care.

Method. The course was run online in 2020 and attended by 20 healthcare workers who were invited to join the evaluation. Questionnaires were completed by participants before the training program (baseline), immediately after the training (post), and 3 months following the end of the program (follow-up). After the follow-up questionnaires, participants were invited to join a Focus Group to expand on their responses. Descriptive and exploratory statistical analysis was performed on quantitative data, and qualitative data was subjected to Thematic Analysis.

Results. Exploratory data analysis showed that self-reported competence, confidence, and comfort in providing spiritual care significantly improved following training ($p = 0.002$) and were maintained over time ($p = 0.034$). In qualitative analysis, the main themes were: (1) overwhelmed by content; (2) the importance of practical training; (3) spiritual care is for everyone; (4) spiritual care should come from the heart; (5) training needs to be inclusive; and (6) spirituality is culturally specific.

Significance of results. This article describes an evaluation of the ISPEC© spiritual care training course administered to an Australian healthcare cohort using an online format. These preliminary findings suggest that the ISPEC© program is effective in improving the ability of healthcare professionals to provide spiritual care. More work is needed to improve the cultural relevance of the program in Australia.

Introduction

Spiritual care has always been a key domain of quality palliative care and spiritual needs are known to increase at the end of life (World Health Organization, 2002; Best et al., 2015c). Strong associations between spirituality and positive health benefits, such as improved palliative care outcomes and quality of life, have been widely documented (Koenig, 2012; Best et al., 2015a). Furthermore, hospital patients and their family members have indicated that they would like to discuss spirituality with their healthcare professionals (Best et al., 2015b). Palliative care outpatients and their families are more likely to discuss spirituality if the physician asks them about their concerns (Best et al., 2019). However, staff have reported that they do not feel equipped to address the spiritual needs of patients and would like further training in the provision of spiritual care (Best et al., 2016a, 2016b; Jones et al., 2020b). A recent review of spiritual care training found that it can improve healthcare professionals' competence across a range of healthcare settings (Jones et al., 2021a).

To address the spiritual care training needs of healthcare professionals, the George Washington Institute for Spirituality and Health at George Washington University in Washington, USA, developed the Interprofessional Spiritual Care Educational Curriculum (ISPEC©) (Puchalski et al., 2019). ISPEC© is an empirically grounded curriculum developed for teaching interprofessional spiritual care to healthcare professionals. ISPEC© is based on a generalist-specialist model of interprofessional spiritual care, in which all clinicians provide generalist spiritual care and collaborate with trained chaplains who provide specialist spiritual care. This work has developed from the spiritual care consensus conference held in the USA in 2009 (Puchalski et al., 2009). It is comprised of six modules and uses case-based learning, slide presentations, videos, and self-directed reading material to build knowledge and expertise.

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Australia is a secular country with diverse views on religion and spirituality (Australian Bureau of Statistics, 2016). Figures obtained from national census data reveal that Australians are moving away from traditional religious affiliations, with 30% identifying as non-religious in 2016 and 8.2% identifying with a religion other than Christianity. These figures have changed markedly since 1991, when only 12% identified as non-religious and 2.6% with a religion other than Christianity (Australian Bureau of Statistics, 2017). Concurrent with these changes is a growing awareness of the cultural and spiritual beliefs of indigenous Australians. Indigenous Australian concepts, such as "dadirri" (deep listening) (Ungunmerr, 1988) and "liyan" (the sense of connection and well-being) (Yap and Yu, 2016), are making rich contributions to a broader understanding of spirituality and spiritual wellbeing within Australia.

As a result of these changes, spiritual care has been conceptualized broadly within Australian services. Spiritual Care Australia, a national body of spiritual care providers in Australia, provides accreditation for trained spiritual care practitioners, such as chaplains and pastoral care practitioners, and has developed standards for the delivery of spiritual care within a variety of settings (Spiritual Care Australia, 2013). They affirm that "all people, regardless of religious faith or cultural background, have spiritual and pastoral needs that require a sensitive, respectful response from skilled practitioners" and define spiritual care as encompassing "all the ways in which attention is paid to the spiritual dimension of life … is person-centred and makes no assumptions about personal conviction or life orientation. It offers a way for people to experience and make meaning of their hopes and fears … Spiritual care may include presence, conversations, ritual, ceremonies and sharing of sacred texts and resources" (Spiritual Care Australia, 2013) (pp. 5–6). National guidelines for spiritual care have also been introduced into aged care (Meaningful Ageing Australia, 2016), revealing a growing acknowledgment at policy level of the important role spirituality may play across different contexts.

While little work has been done on the role of cultural diversity in the integration of spiritual care into healthcare (Liefbroer et al., 2019), it is known that culture influences how healthcare and illness are experienced, especially at the end of life (Gysels et al., 2012). According to Long (2011), culture defines "who an individual is within the context of society and life itself" (S96) and can refer to a system of shared ideas, values, concepts, rules, and meaning about life. It is therefore important to locally assess spiritual care education programs which are developed within a different cultural context to ensure that they meet the needs of clinicians and their patients. As ISPEC© was developed in the USA, a more religious society than Australia, we could not assume that it would translate for Australian audiences. This project aimed to evaluate the effectiveness of the ISPEC© with pastoral care practitioners (PCPs) (also known as chaplains or spiritual care providers) and other healthcare professionals in Australia by measuring participant levels of competency, confidence, and comfort in providing spiritual care, and to assess the relevance of the program for an Australian audience.

Methods

This evaluation used a longitudinal mixed-methods design, with three surveys followed by a qualitative focus group. Data were collected from participants of the ISPEC© training program held in October and September 2020 in Sydney, Australia.

Healthcare staff of a large Sydney hospital were invited to attend the training via an emailed advertisement sent by the Pastoral Care Manager. Training was free of charge for participants, with course fee costs paid by the researchers. The original ISPEC© format was designed to include six face-to-face sessions along with self-directed learning modules, but due to the COVID-19 pandemic, this was amended to an interactive online format. Each interactive module is 90 min in duration and was conducted during staff training time. These sessions were led by J.S. and M.C.B., who had attended an ISPEC© Train-the-Trainer Program in the previous year (Puchalski et al., 2019). Most participants completed the accompanying six self-directed online learning modules in their own time. The course fee includes the 1-year access to the online learning modules.

Online interactive sessions were run using Microsoft Teams, with use of the Rooms function to allow breakout groups for exercises and discussion among participants. Time was also taken during the presentations for personal reflection. Professional actors were employed to assist with role-playing scenarios in one of the online modules.

All course participants were invited to join the evaluation. Those interested in participating were provided with information about the study and the opportunity to ask questions. All agreed to participate, and consent was given by completion of an online form.

Participants completed online questionnaires before the training program (baseline), immediately after the training (post), and 3 months following the end of the program (follow-up). After the follow-up questionnaires, participants were invited to join a Focus Group to explain the reasons for their responses, to enrich the quantitative results.

Measures

The following information was collected at baseline only.

Demographics

It includ age category, gender, years of work experience, previous spiritual care training, self-rated spirituality and religiosity, religious affiliation.

The following information was collected at all three time points:

Self-rated spiritual care competency, confidence, and comfort

The Spiritual Care Competency Scale (SCCS) (van Leeuwen et al., 2009) is a validated 27-item measure designed to assess nurses' competencies in providing spiritual care. It collects self-reported ratings of competency in relation to six domains: assessment and implementation of spiritual care; professionalization and improving the quality of spiritual care; personal support and patient counseling; referral to professionals; attitude toward the patient's spirituality; and communication. Responses are given by five-point Likert scales. from "completely disagree" to "completely agree," with total possible scores ranging from 27 to 135. Confidence and comfort levels regarding spiritual care were rated according to the six SCCS domains, on a scale from 0 to 10. Higher scores indicated higher levels of confidence or comfort. As the SCCS was originally designed for nursing staff, minor adjustments were made to the wording to ensure suitability for other clinical staff. The SCCS has been successfully administered in a previous Australian study (Jones et al., 2020b).

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Spiritual well-being

The World Health Organization's Quality of Life instrument (WHO-QOL BREF) (Skevington et al., 2013) is a 12-item measure of spiritual well-being that has been validated cross-culturally. Responses are given by five-point Likert scales.

The following information was collected after the course.

Participant satisfaction survey

This was a study-developed 14-item measure of participant satisfaction regarding the usefulness of the course content, course structure, and cultural relevance of the program, scored using a five-point Likert scale. Participants were asked to give free-text feedback regarding what they enjoyed about the course, how it could be improved, and intentions to change practice as a result of the training.

The following information was collected at follow-up only.

Change in practice

This was a study-designed question inviting participants to indicate the most significant change they had made as a result of participating in the program, as a free-text response.

Focus group

All participants were invited to join a focus group to explore questionnaire responses. The discussion was held face-to-face and led by a trained researcher (K.J.). Questions were asked about the participants' experience during the program and their views on the content.

Analysis

Quantitative and qualitative data were collected and analyzed separately then integrated using a matrix to synthesize the results (Bazeley, 2009).

Quantitative

An exploratory statistical analysis was conducted using IBM SPSS Statistics Version 26. Descriptive statistics were employed to analyze the demographic data and questionnaire responses. Data were inspected for normality, and as the majority of variables achieved normality (Kolmogrov–Shmirnof test), the paired sample *t*-test was used to measure differences relating to competency, confidence, and comfort at each time point. Preliminary correlational analyses (Pearson's product-moment) were conducted to explore whether there were relationships between the spiritual well-being of the participants and the other variables.

Qualitative

The focus group was audio-recorded, transcribed verbatim, and anonymized. Text responses from the quantitative surveys were added to the focus group transcript for qualitative analysis. The transcripts were independently coded by three researchers (M.C.B., K.J., and J.W.) using Thematic Analysis (Braun and Clarke, 2006), and results compared to determine over-arching themes. Relevant quotes to illustrate the identified themes were extracted. Differences in researcher opinion were resolved through discussion, with the multidisciplinary nature of the team (medicine, social work, pastoral care) minimizing researcher bias regarding the meaning of the results (Berger, 2015). The study was approved by the St Vincent's Human Research Ethics Committee (No. 2020/ETH00191).

Table 1. Demographics ($n = 20$)

Age group (years)	21–29	1 (5.0)
	30–39	3 (15.0)
	40–49	3 (15.0)
	50–59	5 (25.0)
	60 or above	8 (40.0)
Sex	Female	14 (70.0)
	Male	6 (30.0)
Ethnicity	Australian	11 (55.0)
	Asian	5 (25.0)
	New Zealander	1 (5.0)
	North American	1 (5.0)
	Middle Eastern/North	1 (5.0)
	African	1 (5.0)
I am a religious person	Strongly disagree	1 (5.0)
	Disagree	2 (10.0)
	Neither agree nor	8 (40.0)
	Disagree	7 (35.0)
	Agree	2 (10.0)
	Strongly agree	0 (0.0)
I am a spiritual person	Strongly disagree	1 (5.0)
	Disagree	0 (0.0)
	Neither agree nor	0 (0.0)
	Disagree	4 (20.0)
	Agree	15 (75.0)
	Strongly agree	0 (0.0)
Religious affiliation	Buddhist	1 (5.0)
	Christian	10 (50.0)
	Hindu	1 (5.0)
	Jewish	1 (5.0)
	Muslim	1 (5.0)
	Omnist	2 (10.0)
	None	3 (15.0)
Previous formal spiritual care training		12 (60.0)
Discipline	Pastoral care/ clergy	10 (50.0)
	Nurse	6 (30.0)
	Allied Health	4 (20.0)
Years work experience	–	Median 6 years (IQR 9.0) Range 1–32 years

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Table 2. Changes to spiritual care competency, confidence, comfort, and spiritual well-being over time

	Pre-program, M (SD)	Post-program, M (SD)	*t*	*p*
Competency	107.5 (16.5)	118.5 (8.7)	−3.7	0.002
Confidence	44.9 (11.3)	52.6 (5.5)	−3.4	0.004
Comfort	45.1 (10.9)	53.8 (5.1)	−4.3	0.001
SWB	32.5 (3.9)	33.6 (3.9)	−2.5	0.023
	Pre, M (SD)	Follow-up, M (SD)	*t*	*p*
Competency	107.6 (17.1)	116.0 (14.1)	−2.4	0.034
Confidence	44.6 (12.0)	51.0 (7.4)	−2.6	0.022
Comfort	45.2 (11.0)	51.6 (7.7)	−2.6	0.023
SWB	31.8 (5.0)	32.2 (5.3)	−0.5	0.650
	Post M, (SD)	Follow-up, M (SD)	*t*	*p*
Competency	119.4 (8.86)	117.9 (13.3)	0.68	0.510
Confidence	52.8 (5.8)	51.9 (6.5)	1.0	0.358
Comfort	54.3 (5.4)	52.9 (6.5)	1.9	0.083
SWB	34.6 (4.3)	33.5 (4.8)	1.4	0.182

Results

Twenty participants enrolled in the evaluation. The sample had a predominance of females (70%) with the majority of participants aged over 50 years. They were a moderately religious and highly spiritual cohort. Participants represented disciplines including PCP (50%), nursing (30%), and allied health (15%) (see Table 1). Overall, the questionnaire response rate was 70.0–95.0% over three time points. Five participants joined the focus group as a convenience sample.

Quantitative data

Exploratory analysis using paired sample *t*-tests showed total scores of competency, confidence, and comfort improved following training, and the improvement was partially maintained over time to follow-up. Spiritual well-being scores significantly increased after training; however, the increase was not maintained over time (see Table 2). Correlational analyses showed that there was a significant association between spiritual well-being (WHOQOL-BREF total) and levels of competency ($r = 0.61$, $p = 0.005$), confidence ($r = 0.60$, $p = 0.007$), and comfort ($r = 0.60$, $p = 0.006$) at pre-program measurement. However, there was no association between spiritual well-being and any other outcome measures at post or follow-up time points.

In the post-course survey, no participants scored the program as "Not at all useful." The course scored more highly for increasing knowledge and comfort levels compared to skills and confidence. The majority of responses ranged from moderately to extremely useful for each area. See Table 3.

Most participants were moderately to very satisfied in all areas assessed, including time allocated for each module, balance between theoretical and practical content, program content, exercises, level of interaction, use of relevant language and case examples, overall ISPEC© program, and the online self-study modules. The time allocated to each interactive module and the balance between theoretical and practical content had the lowest satisfaction ratings. See Table 4.

Participants were asked to assess how culturally relevant the ISPEC© program is for an Australian audience. Quantitatively, all respondents thought it was either somewhat ($n = 7$, 38.8%) or very relevant ($n = 11$, 61.1%). However, while the content was valued, it was criticized in the qualitative data for using American-specific examples of chaplaincy practice, race, images, and presentation. Insufficient inclusion of non-Christian faiths was criticized. Details are given below.

Table 3. Usefulness of the ISPEC program ($N = 18$)

	Not at all useful *n* (%)	Slightly useful *n* (%)	Moderately useful *n* (%)	Very useful *n* (%)	Extremely useful *n* (%)
Increasing my knowledge of spirituality and spiritual care	0 (0.0)	2 (11.1)	6 (33.3)	5 (27.8)	5 (27.8)
Increasing my confidence in delivering spiritual care	0 (0.0)	3 (16.7)	4 (22.2)	9 (50.0)	2 (11.1)
Increasing my comfort levels in delivering spiritual care	0 (0.0)	3 (16.7)	4 (22.2)	6 (33.3)	5 (27.8)
Increasing my skills in delivering spiritual care	(0.0)	4 (22.2)	3 (16.7)	7 (38.9)	4 (22.2)

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Table 4. Satisfaction with the ISPEC program ($N = 18$)

	Very unsatisfied, *n* (%)	Unsatisfied *n* (%)	Moderately satisfied, *n* (%)	Very satisfied, *n* (%)	Extremely satisfied, *n* (%)
Time allocated to cover each module	1 (5.6)	2 (11.1)	10 (55.6)	4 (22.2)	1 (5.6)
Balance between theoretical and practical content	0 (0.0)	3 (16.7)	9 (50.0)	5 (27.8)	1 (5.6)
Program content	0 (0.0)		6 (33.3)	8 (44.4)	4 (22.2)
Exercises	0 (0.0)	3 (16.7)	7 (38.9)	6 (33.3)	2 (11.1)
Level of interaction encouraged	0 (0.0)	1 (5.6)	4 (22.2)	10 (55.6)	3 (16.7)
Use of relevant language and case examples	0 (0.0)	2 (11.1)	1 (5.6)	12 (66.7)	3 (16.7)
Overall ISPEC program	0 (0.0)	1 (5.6)	7 (38.9)	6 (33.3)	4 (22.2)
Online self-study modules	0 (0.0)	3 (16.7)	5 (27.8)	6 (33.3)	4 (22.2)

Qualitative data

The main themes identified were: (1) overwhelmed by content; (2) the importance of practical training; (3) spiritual care is for everyone; (4) spiritual care should come from the heart; (5) training needs to be inclusive; and (6) spirituality is culturally specific. Tensions were expressed regarding each of these themes. Illustrative quotes are shown in Table 5.

Overwhelmed by content

Participants were greatly appreciative of the information they were given during the course. In particular, many participants enjoyed learning about the empirical evidence which supports spiritual care, as well as the place of spiritual care within the holistic care of the patient. However, most found the sheer bulk of material presented during the group sessions challenging to cover in the time provided, with some participants describing their experience as "overwhelming."

Views varied on whether the content should be reduced, or more time allocated to the interactive sessions to allow it to all be covered comprehensively. General consensus was that a shorter version would be needed for use by multidisciplinary staff team members, who were considered to be time poor and not in need of the depth of information provided in the program. However, several of the PCP attending the course appreciated the extent of the content and regretted that they would not have permanent access to the group meeting slides or the online course (once the 1-year access window had ended).

With regard to the self-learning modules, participants varied in whether they accessed them during work time or in their own time, but all struggled to get through the full curriculum. Knowing that they had access to the modules for 12 months meant some participants were planning to cover it slowly over the year, but others were disappointed they were unable to cover each unit between the (related content) interactive sessions. Many participants found the self-directed modules burdensome and difficult to engage with on account of the didactic presentation, and some did not complete this element of the training.

The importance of practical training

Participants' feedback showed that the most-appreciated aspects of the course were the opportunities to role-play spiritual care assessment with professional actors, and to interact with fellow students to learn from each other. It was understood that these elements were reduced for this course due to the need to move the interactive components online, but the importance of balancing the theory with more practical applications was emphasized.

Participants also stressed the benefits of learning the vocabulary of spiritual care. This was seen as important as it was thought that the easier and more comfortable the conversation is for the staff member, the easier it would be for the patient to respond.

Opportunities to practice taking a spiritual history using the FICA© tool were a highlight of the course for some. However, other participants found even the FICA© spiritual history tool to be too detailed for use in general patient care, particularly for nursing staff. The need to focus on utility for busy clinical staff was stressed.

Qualitative feedback showed that many participants observed changes in their spiritual care practice as a result of attending ISPEC© training. This included motivating other healthcare colleagues to give more attention to spiritual care, and engaging more with patients' spiritual concerns themselves. Participants also reported using the FICA© spiritual care assessment tool, and incorporating skills of compassionate presence and silence more in their work. This led them to feeling they could identify and better address the spiritual needs of patients.

Requests were made for the inclusion of more case studies and more time during the course to practise spiritual care skills. A wider range of spiritual assessment tools was also requested. The course was criticized by one healthcare professional for not being sufficiently solution-focused, being concerned that spiritual problems might be identified without the clinician knowing how to respond. In relation to this, one PCP wished that more specific referral information for the local context had been provided.

Spiritual care is for everyone

The course was designed for use in palliative care, but some participants would have preferred a broader focus, in order to develop skills that could be used across all healthcare settings. However, other participants found the material presented was widely applicable to patient care, due to the linking of spiritual care with existential crises. Respondents reported that the raising of existential questions was a frequent occurrence in the patient population, and that the idea of approaching spiritual care as

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Table 5. Qualitative quotes

Theme	Quotes
1. Overwhelmed by content	"It's almost a training the trainer program." (114, PCP) "[Ideally the course would be] tailored for the multidisciplinary team to be run as a really shortened version and really specific in what the objectives are, versus someone like pastoral care – I really love the material, to be able to stew over it and it could potentially be a lot longer." (111, PCP) "People may need [the content] at a future point and there's not the accessibility then to go back …" (111, PCP) "Use of more interaction, stories and videos would have made [the self-directed modules] easier to engage with". (119, HP)
2. The Importance of practical training	"One of the things that I found about ISPEC© was that it didn't seem that we heard a lot from everyone in the group. I know when we did the little breakout rooms, it was good to be in the smaller group and hear a bit more from people from the other disciplines and how they were experiencing it." (113, PCP) "I think that's one of the beauties of the course, it provided a lot of language. And a lot of words to talk about spirituality and spiritual care." (113, PCP) "I think if you're easy with that [spirituality] conversation, the patient responds a whole lot better, because there's no awkwardness around it … It's not everyday conversation, but it's in that level in terms of the easy flow between the interchange and interaction." (103, PCP) "For me, I think the FICA© model and patient dignity question were the main things that I got out of the ISPEC© training … It has to be practical … And I think particularly for our nurses, if it's not practical, it's not really useful … " (114, PCP) "I've tried the FICA© with our nurses for them to use it as a spiritual assessment tool, but a couple of the feedbacks I got is even that, in itself, is just too much [content]. Can we have one question to ask?" (113, PCP)
3. Spiritual care is for everyone	"It was pretty much focused in the palliative care area. And spiritual care needs to happen everywhere." (104, PCP) "What really spoke to me was that [the course] identified existential crisis with spirituality. And that's something we all have to deal with every day … To be honest, I think [the course] is directed not so much people who are young and, - - - really not trusting authority … So to them, the whole spiritual idea doesn"t make sense. You know, why would you do that or follow it? So if I start with the idea of existential crisis, then I've got a bridge." (107, HP)
4. Spiritual care should come from the heart	"I think when you're talking to the person in terms of their mortality, there's a sacredness that happens with the dialogue that's happening. And I felt that that aspect of it was missing a little … because ultimately, we're working from the person's agenda, not ours. When we're having these dialogues, we're actually learning as well. And we're, I would like to think, increasing our own repertoire and broadening that on how we engage people, irrespective of their faith background … I think I had expected it to be somewhat like a model of reflective learning, but this was very much more prescriptive, quite scientific based, so it was much more cerebral sort of thinking … Less contemplative, less reflective. So it was about spiritual care, but it was very, much more head-based, heavy. You know? Than the heart thing." (114, PCP) "I think what alleviated that tension, for me, was the delivery from the facilitators. And so, as they interacted and presented the material, that was a really good collaboration and – and in some ways, a balance, you know? It gave me a balanced experience of it." (103, PCP) " … allowing people to share their own experiences. I think sharing stories is a powerful way of not only yourself reflecting, but also inviting others to reflect on themselves." (114, PCP)
5. Training needs to be inclusive	"I felt that it was very Christian-based and it didn't include enough diversity in terms of Judaism, Islam, Buddhist, Hindu, Sikh. Bearing in mind that we're in different areas and the demographics of that area changes, so the demands of us will change." (103, PCP) "We don't say much about Aboriginal spirituality, which is [associated with] sacred listening, yeah, deep – deep listening." (107, HP)
6. Spirituality is culturally specific	"To me, it feels like there's a bit of an assumption that people are religious." (113, PCP) "Australians are more spiritual [than religious]: 'There is something greater than myself. Even if I don't know that, even if I can't put a name to it, there is definitely something greater'." (103, PCP) "The first couple of modules, when they talk about the skills, like the listening skills and [FICA©] questions that we went through – what I found valuable was some of [the facilitators] questions that were more contextual to our situation. I found that more practical than some of the prescriptive stuff." (111, PCP). "We deal with a lot of suffering and we need to be mindful that people have this need. That you might be able to say something in a moment where you make a person feel better or accept what's going on. And I think it's a good thing." (107, HP)

HP, healthcare professional; PCP, pastoral care practitioner.

an existential concern was particularly helpful in relating to younger patients who may not follow organized or traditional spiritual paths.

Spiritual care should come from the heart

Participants were aware of the irony of learning about spirituality through didactic teaching. The interactive component was run by a pastoral care worker (J.S.) and a physician (M.C.B.). Respondents appreciated the different but complementary approaches to teaching spiritual care, reflective and empirical, respectively, and the creation of a safe space in which to learn. Some felt that a theoretical approach to spiritual care was inappropriate, and that a more contemplative approach would be preferable.

The different backgrounds of the facilitators were seen to blend the two aspects of the training, and were helpful in applying the training to a local context. Participants would have appreciated more opportunity to discuss the content within the group to gather further perspectives, and to encourage reflection through the sharing of personal stories.

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Training needs to be inclusive

Australia is a very multicultural society and participants were surprised by the lack of diversity in the material presented. This led to some participants expressing a sense of finishing the course without being fully equipped to engage with the full range of patients that would be encountered in the workplace. The absence of indigenous spirituality was also noticed, and regretted, partly because it seemed particularly helpful in this context, given its emphasis on deep listening.

Spirituality is culturally specific

It was suggested that the context of the content was clearly specific to America, and that much of it was not relevant for Australian healthcare workers, for example, details about standards for professional chaplains in North America. Many images and scenarios were also culturally unfamiliar to this Australian cohort due to differences in population demographics and structure of the healthcare system.

Participants also felt that Australians tended to be more "spiritual" than "religious," and that this created some tension with the tools introduced in the course which were thought to imply religiosity, for example, the FICA© tool questions.

The use of a local facilitator was stressed as an important requirement to maximize the cultural relevance of the curriculum for a local audience. However, the universality of spiritual needs was a factor that made the course valuable to participants despite the cultural differences in presentation.

Discussion

This study was a mixed-methods evaluation of the ISPEC© training course in spiritual care. Although the sample size was small and analysis preliminary, we found significant increases in self-reported competence, confidence, and comfort in providing spiritual care to patients as a result of undergoing training, which were maintained at 2-month follow-up. This has been found elsewhere (Jones et al., 2020a). This is interesting, given that nearly half of the cohort were employed as PCPs and had received previous training in spiritual care. This characteristic of our cohort could also explain why baseline levels on the SCCS were higher for our study than that of another Australian healthcare cohort attending spiritual care training (Jones et al., 2020a), where no PCPs were involved. However, the improvement in scores for both groups underlines the effectiveness of spiritual care training in increasing self-rated competency, confidence, and comfort for all staff, regardless of baseline levels of skill.

Qualitative feedback showed that the PCPs particularly benefited from the theoretical content, especially that relating to end of life care. However, regardless of discipline, all participants reported benefits from this course. The value participants consistently place on role play and group discussion in similar programs (Bristowe et al., 2014) suggests that this should be maintained as part of the training, although the cost of professional actors to facilitate this aspect of the course is a consideration regarding its ongoing feasibility. The need to allow time to practice newly learnt skills was also stressed by our cohort, as is the case with other groups involved in communication skills training (Clayton et al., 2012). While some participants found the FICA© spiritual history tool too long, it was developed for doctors and nurses to use as part of the complete assessment and formation of treatment plans (Borneman et al., 2010). As formal spiritual history taking is still unusual in Australia, it is possible that some participants were mistakenly trying to use it as a screening tool. We observe that the PCPs participating in ISPEC© did not object to the extent of content or history-taking tools and would have liked to spend more time absorbing the material. This is understandable, given that they have expertise in spiritual care, and may reflect the need for differences in curricula for the two groups. Much work has been done in recent years to identify the core spiritual care training needed for healthcare professionals (Anandarajah et al., 2010; Attard et al., 2019; Jones et al., 2021b).

Participants also expressed appreciation for the skills and sensitivity of the facilitators, the safe learning environment, and the opportunity for interprofessional learning. These findings are similar to those found in other training courses for communication with patients at the end of life, which also report self-reported improvements in participants' abilities (Brighton et al., 2018). While the amount of content was considered overwhelming by some participants, we note that in response to this type of feedback, the ISPEC© content has since been reduced.

A recent review of spiritual care training courses for healthcare professionals (Jones et al., 2021a) found that, while even short courses reported a positive impact on the confidence and comfort levels of staff to deliver spiritual care, there have been few formal longitudinal evaluations of spiritual care training courses to assess the impact of short courses over time. It is, therefore, encouraging that our cohort still reported increased competence, confidence, and comfort in providing spiritual care to patients at 2-month follow-up. Further research is required to determine what training requirements are needed to maintain staff skills over time.

This cohort of Australian participants wanted spiritual care training that was inclusive of the broad range of spiritual expression found within the community. Australia is a multi-faith country, with many of the population not affiliating with formal religion. The response from some participants was that ISPEC© training was not as culturally inclusive as it could be. For example, while the FICA©tool is designed to be applicable to all cultures and specifically is not focused on religion alone, it was perceived as such by some participants. Assumptions about the religiosity of patients may be more appropriate in a country such as the USA. Cultural differences between the USA and more secular nations in relation to spiritual care training have been observed elsewhere (Paal et al., 2017). Such differences need to be taken into consideration when training is adapted within another context.

The findings of this study highlight the importance of working toward cultural competence among healthcare professionals who provide spiritual care. Medical staff have previously expressed discomfort providing spiritual care to patients who ascribe to a different belief system to their own (Best et al., 2016a). As patients from different cultural backgrounds have been found to vary in their spiritual needs, this has been identified as an area requiring specialist training (Astrow et al., 2018), but it is an area that has received little attention to date (Liefbroer et al., 2019). Training which enables healthcare professionals to be aware of cultural differences among those they are caring for, without stereotyping, is called for (Galanti, 2000). The Purnell Model for Cultural Competence is a possible basis for developing a culturally sensitive approach to spiritual needs (Purnell, 2000). As Long (2011) suggests, spirituality is one component of culture often overlooked yet a key domain in the Purnell Model. Including spiritual care training, such as ISPEC©, as part of a broader focus on cultural competence (alongside other domains such as healthcare

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practices, nutrition, and communication) will lead to a greater emphasis on person-centered and person-directed care which recognizes that values, beliefs, and practices may vary between patients and provides support accordingly (Long, 2011). Furthermore, attention to cultural variations between palliative care patients will be important to avoid offense and support them in their end-of-life care.

Limitations of this study include the small study sample, and the fact that the course was not conducted in person as originally intended at the time of development. The cohort was over-represented for women and older participants and contained a significant proportion of PCPs compared to other healthcare professionals. Future evaluations should aim to recruit larger and more heterogeneous samples, using objective measures of practitioner competence and patient outcomes. More work is also needed to discover what spiritual care training is required to maintain competency levels.

Conclusion

The ISPEC© was trialed in an online format with a small group of healthcare and PCP in Sydney, Australia. Our preliminary evaluation found that all participants significantly improved in self-reported competence, confidence, and comfort in practising spiritual care. This favorable finding encourages the continued development of the course alongside rigorous evaluation. Based on our initial findings, more work is required to adapt the content to a non-North American context.

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