J Relig Health (2013) 52:46–65
DOI 10.1007/s10943-012-9622-9

ORIGINAL PAPER

Chaplaincy and Mental Health Care in Aotearoa New Zealand: An Exploratory Study

Lindsay B. Carey · Laura Del Medico

Published online: 12 June 2012

Abstract This paper summarizes an initial exploratory study undertaken to consider the ministry of New Zealand chaplaincy personnel working within the mental health care context. This qualitative research (a first among New Zealand mental health care chaplains) was not concerned with specific health care institutions per se, but solely about the perspectives of chaplains concerning their professional contribution and issues they experienced when trying to provide pastoral care to patients, families, and clinical staff involved in mental health care. Data from a single focus group indicated that chaplains were fulfilling various WHO-ICD-10AM pastoral interventions as a part of a multidisciplinary and holistic approach to mental health care; however, given a number of frustrations identified by participants, which either impeded or thwarted their professional role as chaplains, a number of improvements were subsequently identified in order to develop the efficiency and effectiveness of chaplaincy and thus maximize the benefits of pastoral care to patients, families, and clinical staff. Some implications of this exploratory study relating to mental health care chaplaincy, ecclesiastical organizations, health care institutions, and government responsibilities and the need for further research are noted.

Keywords Chaplains · Pastoral care · Spiritual care · Mental health care · Aotearoa New Zealand

Introduction

Over recent decades, renewed attention and enthusiasm has been given to studying the contribution of religion and spirituality to mental health care (e.g., Mela et al. 2008; Swinton 2006). Much of the literature over the years has acknowledged religion and spirituality as potentially significant mechanisms that can affect the well-being of service users in mental health care facilities (e.g., Macmin and Foskett 2004; Fallot 2001; Koenig et al. 2012, 2001, 1998; Harrison et al. 2001; Pargament 1997; Neeleman and Lewis 1994).

L. B. Carey (✉) · L. D. Medico
Palliative Care Unit, School of Public Health, La Trobe University, Melbourne, VIC 3000, Australia
e-mail: lindsay.carey@latrobe.edu.au

Within New Zealand, religious and spiritual factors have been extensive in terms of shaping its culture (e.g., Mol 1982) and of considerable importance to mental health care users across New Zealand (e.g., Mitchell and Romans 2003).

It can also be argued that clerics and chaplains, through the provision of their pastoral care, have been influential in the development of various forms of health care since the time of Constantine (Ferngren 2009). Despite some debate concerning global secularization and the relevance of religion (e.g., Casanova 2006), there is evidence that the clergy have been and are still sought out by those facing personal crises and that the clergy can be influential with regard to health care issues within the community (e.g., Miller and Rubin 2011). Likewise, there is also increasing literature concerning the pastoral interventions of chaplains within health care contexts—including within New Zealand—that indicates their active role in assisting patients, their families, and clinical staff with regard to behavioral issues and bioethical decision making (e.g., Lowery 2012; Carey 2012a, b).

Swinton (2006) in his text "*Spirituality and mental health care: Rediscovering a forgotten dimension*" argued that chaplains in mental health care "…have a vital role to play… and are in a perfect position to make a major contribution to the process of care and assessment" (p. 154). Yet, over the years, while there has been some limited acknowledgment of the various roles and tasks of chaplains in mental health care noted by a number of authors (refer examples in Table 1), there has been very little actual empirical research regarding the interventions or the issues that chaplains experience as a result of their pastoral contribution. Further, while some previous research conducted in New Zealand considered clinical pastoral education among chaplains (Carey and Newell 2002) and the attitudes or thoughts of chaplains with regard to bioethical issues (Carey 2012a, b), such research did not specifically focus upon chaplains in mental health care.

Aims and Research Background

To help address the lack of chaplaincy research in mental health care, and particularly in New Zealand, the aim of this research was to undertake an initial qualitative exploration of the role, contribution, and issues faced by New Zealand health care chaplains working within mental health care facilities.

The central liaison church–government authority for employing and appointing chaplains in NZ public hospitals has been, for over three decades, the "Interchurch Council for Hospital Chaplaincy, Aotearoa New Zealand Trust Board" (hereafter ICHC)—an ecumenical and well-organized para-church council and charitable trust, authorized to represent nine Christian denominations (i.e., Anglican, ACTS Pentecostal churches, Baptist, Catholic, Christian Churches of Christ New Zealand, Congregational, Methodist, Presbyterian, and Salvation Army)—that predominantly have European ("Pakeha") origins. Unfortunately, while Aotearoa New Zealand is a multicultural multiethnic society, only chaplains from Christian denominations were involved in this study—simply because at the time of the research, there were no chaplains from non-Christian religious faiths employed within mental health facilities. Nevertheless, while the ICHC was not mandated to represent non-Christian religious faiths (Islamic, Buddhist, etc.), all ICHC chaplains were permitted to actively engage in "interfaith spiritual care" by providing person-centered holistic care to those of any religious/spiritual faiths in mental health care (NZMH 2006).

All ICHC appointed health care chaplains specializing in mental health, in both North and South Islands of New Zealand, were asked by the principal researcher (first author) to volunteer information about their perspective concerning their pastoral interventions with

Table 1 Examples of literature identifying chaplaincy roles within mental health care

Morrow and Matthews (1966)	• Provision of Standard or Core Ministerial activities (e.g., provide religious, spiritual, pastoral counseling, and lead ritual/worship activities) • Involvement in Clinical activities (e.g., diagnostic, treatment, and therapy activities)
Perske (1966, 2003)	• Establishing pastoral relationships • Leader of the worship of God • Provider of religious education programs • Member of the inter-professional clinical team • Theologian about the mentally retarded
Slaughter (1978)	• Generalist: Assist staff–patient treatment, share in administration tasks, and participate in committee work • Specialist: Assist patients, co-therapist with staff, resource staff, consultant to staff, provide in-service training
Stephens (1994)	• Supportive friend to patients and staff, • Resource person, • Liaison with faith communities, • Availability—"being there," • Provision of religious/seasonal services, and • advocate
Ratray (2002)	• Chaplains provide religious/spiritual expert for both patients and staff • Chaplaincy provision ensures holistic teamwork that reflects a care for the whole person/patient/client • Chaplaincy involvement in discussions and debates about physical, spiritual, and mental health issues provides an example of a healthy team relationship genuinely trying to care for patients
Macritchie (2004)	• Praxis theologian—developing theological praxis in mental health utilizing psychological and theological/religious paradigms • Suffering interventionist—developing an understanding of mental suffering and appropriate interventions that might require a pastoral and prophetic/advocate role to support patients and/or call into question certain institutional circumstances • Religious/Spiritual Interventionist/Therapist—Recognizing/critiquing negative and positive religious experience and using these as a potential avenue for healing and wholeness, forgiveness and absolution, love and acceptance
Swinton (2006)	• Chaplains provide religious and spiritual knowledge/expertise • Chaplains provide extended pastoral counseling time to engage/understand an individual's spiritual state • Chaplains provide accurate discernment of individual spiritual experiences • Provision of assessment/information for multidisciplinary teamwork • Provide vital conduit into individual's religious/spiritual communities • Access to and understanding of religious community belief structures and potentially problematic cultish belief systems

patients, their families, and clinical staff utilizing (as a systematic and structured frame of reference) the WHO "Pastoral Intervention Codings," namely (1) pastoral assessments, (2) pastoral ministry support, (3) pastoral counseling, (4) pastoral education, plus (5) pastoral ritual and worship activities (WHO 2002: Table 2). Participants were also encouraged to consider any key pastoral care or administration issues that arose within their respective mental health care contexts.

Table 2 World Health Organization ICD-10-AM "Pastoral Intervention Codings" (WHO 2002)

Description of Pastoral Intervention Codings
PASTORAL ASSESSMENT (ICD code 96186-00) [Major Heading: 1824]
Description : An appraisal of the spiritual well-being, needs, issues, and resources of a person within the context of a pastoral encounter
PASTORAL MINISTRY/SUPPORT (ICD code 96187-00) [Major Heading: 1915]
Description: The provision of the primary expression of the service, which may include establishing of relationship/engagement with another, hearing the story, and the enabling of pastoral conversation in which spiritual well-being and healing may be nurtured, and companioning persons confronted with profound human issues of death and dying, loss, meaning, and aloneness. Predominantly, a "ministry of presence and support" that may include advocacy or other supportive facilitation
PASTORAL COUNSELLING or EDUCATION (ICD code 96087-00) [Major Heading 1869]
Description: An expression of Pastoral Care that includes personal or familial counsel, ethical consultation, a facilitative review of one's spiritual journey, and support in matters of religious belief or practice
The intervention expresses a level of service that may include counseling and catechesis, for example, and the following elements may be identified : "emotional/spiritual counsel," "ethical consultation," "religious counsel/catechesis," "spiritual review," "death and dying," "bereavement care/counsel," and "crisis care/debriefing."
Note: The interventions "bereavement care/counsel" and "crisis care/debriefing", for example, are not profession-specific to Pastoral Care and are therefore given generic code numbers in ICD-10. When making annotations in the Patient/Resident record, therefore, these latter terms may be used by Pastoral Care personnel, but coders will record such activity within the relevant generic codes
PASTORAL RITUAL/WORSHIP (ICD code 96109-01) [Major Heading 1873]
Description: This intervention contains the pastoral expressions of informal prayer and ritual for individuals or small groups and the public and more formal expressions of worship, including Eucharist and other services, for faith communities and others. Elements of this intervention may include
(a) "private prayer and devotion," bedside "Communion" and "Anointing" services, "Blessing and Naming" services for the stillborn and miscarried, and other "sacrament" and ritual expressions
(b) "public ministry"—"Eucharist/Ministry of the Word", funerals, memorials, seasonal, and occasional services

Method

This exploratory research utilized a qualitative grounded theory methodology (Glasser and Strauss 1967) and engaged a single-stage focus group method (Bryman 2011). A focus group was considered ideal to gain a cross-sectional insight into the professional and personal experiences and interpretations of chaplains "through their own eyes" and "in their own words," plus it provided the advantage of participants presenting their perspective for consideration by other members of the group (Bryman 2011). This allowed issues to surface, to be collectively considered and discussed or commented upon and subsequently enhance the credibility of the data. Given the limitations of time, distance, and finance, the focus group was also seen as the most efficient and effective strategy to maximize concurrent data collection from a number of chaplains from across different regions of New Zealand.

Chaplaincy Respondents and Informants

At the time of the research, New Zealand had only a relatively small workforce of hospital chaplains appointed to mental health care facilities. Like all hospital chaplains in NZ, to be accredited as a chaplain in mental health care, an individual must have completed ordination or religious order training approved by a statutory recognized faith system, preferably have at least completed one unit of clinical pastoral education (CPE), be in good

Table 3 Chaplaincy focus group participants ($n = 8$)

Column 1	Column 2
Hospital chaplains	$n = 8$
Chaplain assistants	$n = 0$
General psychiatric	$n = 2$
Forensic psychiatric	$n = 6$
North Island	$n = 7$
South Island	$n = 1$
Part time	$n = 6$
Full time	$n = 2$
Male	$n = 6$
Female	$n = 2$
Protestant	$n = 8$
Catholic	$n = 0$
Ringatu/Ratana	$n = 0$

NB 1: participant response, $n = 8/9 = 88.8$ %

NB 2: the only Catholic Chaplain was unable to attend

standing with their particular faith organization, and be formally approved and contracted by the ICHC to work within public hospitals.

Due to strict confidentiality legislation within New Zealand, the ICHC forwarded an invitation to participate in a focus group and a participant information consent form (explaining the research) directly to all chaplains ($N = 9$) who were contracted within mental health care facilities (i.e., full-time, $n = 2$ and part-time, $n = 7$). From the total number of employed HCs in mental health care, eight attended the focus group session ($n = 8$), thus achieving 88 % involvement ($n = 8/9$: 88 %). One female Catholic HC from the South Island was *unable* to attend. The majority of focus group participants were from the North Island ($n = 7/8$:87.5 %), were males ($n = 6/8$:75 %), worked part time ($n = 6/8$:75 %), and were Protestants ($n = 8/8$:100 %). Two chaplains ($n = 2$) served within general psychiatric positions, and six chaplains ($n = 6$) served within forensic psychiatric facilities but also provided some general psychiatric duties. At the time of the research, there were no Maori chaplains from the indigenous Ratana and Ringatu churches or other chaplains from non-Christian faith traditions contracted by the ICHC to minister in mental health care facilitates (refer Table 3).

The focus group was conducted and audio-recorded by the principal researcher at the ICHC head office in Wellington (NZ) and lasted approximately 2 h. The focus group data were transcribed by a research assistant (second author). Thematic compilation and analysis was undertaken utilizing the NVivo qualitative technique (QSR 2011), and reliability agreed upon by consultation and agreement between both researchers and subsequent comments from participants who received a copy of the research findings.

Results

It is not possible, given the limited space of this article, to relay all the qualitative results of this exploratory research but to present an overview of the research findings. To maximize the presentation of participants' perspectives and minimize interpretive bias, at least one example of raw focus group data (in the participants' own words) is presented for each major thematic coding regarding both pastoral interventions and the key issues that arose for chaplains given those interventions. Key themes will be subsequently considered further within the discussion.

Pastoral Interventions

Pastoral Assessment

In overall terms, participants noted that within both *general* mental health and *forensic* mental health areas, chaplains were often involved in providing spiritual/religious or pastoral assessments about a patient's well-being. Chaplains attended inter-disciplinary staff meetings (e.g., every 4, 6, or 8 weeks), where different professionals (including chaplains) "*expressed their professional perspectives concerning a patient's well-being*" and (if obtainable) relevant factors concerning family issues. Sometimes, chaplains were required to "*write up in our slots about [a patient's] spirituality*" [I-1].

However, the most common assessment method utilized by chaplains could be termed "*informal*" or "*exploratory*" assessment that involved a pastoral visit and subsequent verbal report. These were affirmed as being invaluable given limited time and the flexibility to explore individual uniqueness and circumstances. As indicated by one chaplain, a pastoral assessment could be helpful in understanding a patient's peculiar religious idioms but it could also be informative about the physicians involved:

> I sometimes think that [when] a [pastoral] assessment occurs…[it can be]…very informative….I was asked a couple of weeks ago to see a patient because they [doctors] thought she might be religious… Like scrambled eggs, her thoughts were all over the place…I sat down and listened to this lady and for twenty minutes she spoke to me in Beatle's lyrics…[*Group Laughs*]…and [at first] I was lost. But actually when you put all [her] Beatle's lyrics together, there was a message and it made sense. And you know, it actually was the start of being able to say [to the doctors], "Well actually if you listen to the lyrics…you would [learn] the truth". I realized…that what she was saying wasn't really a spiritual thing because I recognized the lyrics. [For me] it was a sign that a lot of the time the doctors just actually don't recognize the lyrics, or rather the truth [of what is happening]…they miss it totally because they don't recognize…you know [whether] the person is speaking in Bible scriptures verses Beatles lyrics. She asked me to pray for her, so I prayed; I prayed that "Mother Mary would come to her…" [a Beatles lyric; McCartney and Lennon 1969] [I-4].

Several chaplains expressed a frustration with the concept of utilizing formal spiritual and religious assessments (e.g., "Spiritual Well-Being Scale," Paloutzian and Ellison 1982). One chaplain argued that formal assessments were very different from the "usual style" of chaplaincy pastoral care, because formal assessments were based on asking questions which tended to control the conversation and undervalued the natural reciprocity of pastoral care dialogue and "the way pastoral care should be offered" [I-4]. Another chaplain indicated that while comfortable with asking standardized questions to undertake a spiritual assessment, the formally stipulated questions seemed inappropriate and resonated more with "*the sort of questions that a psychologist would put or psychiatrist would query*" [I-6] rather than the non-directive approach of a pastoral care practitioner.

In a similar vein, another participant argued that while he/she would love to do formal spiritual or religious assessments (because such instruments "*try and represent the interests of patients*" [I-7]), nevertheless, due to the large numbers of patients and reduced chaplaincy availability, there "*was simply not sufficient time*" for chaplains to undertake formal assessments. The chaplain was also concerned that formal assessments may be

indicative of mental health care becoming "*a process*" and "*a reflection of a system that has actually become uncompassionate*" about individual needs [I-7].

Pastoral Ministry Support

Two pastoral support roles could be clearly identifiable from participant's responses. The first was in terms of chaplains "*being there*" with patients (sometimes described as a "ministry of presence") and providing a non-medical support by their presence. The second, and perhaps more contentious role, yet considered important, was an advocacy role. One chaplain indicated her role of providing "comfort and support" and being a communication facilitator to assist a patient to fully understand a committee's determination:

> …Where I've been involved…[is when] patients…are having a care planning meeting or discharge planning meeting…where they [the assessors] like to know, for instance, if this [patient's religious belief] is within a normal range of spiritual understanding and belief or is there something 'whacky' going on here…so I can be asked to offer insight on that…but mainly, when I'm invited along to things like that, it is to be a comfort and support to the person who is afraid to go into that meeting because of what might happen there or what she/he is going to be told there…so it, it's about me sitting there listening very carefully to what's being reported especially…when the person is going to be kept on their compulsory treatment order for instance…often they're [the patient] you know, is drugged and anxious and upset and whatever and they don't remember what has been said and sometimes there's a compliance issue because of undeveloped communication …. So, I'm involved like that…[I-3].

An often repeated pastoral support role noted by chaplains was that of advocacy. Several chaplains were concerned that at times the system breached basic social and bioethical principles such as autonomy, beneficence, non-maleficence, and particularly, justice and that it was necessary for chaplains to intervene.

> I had a case where a woman who had previously had cancer…she had a pretty reasonable understanding of the various drugs that would affect her and she said…'This one [drug] that they're giving me has a chance of re-igniting my cancer'. So I looked it up and it appeared to be the case and I said, 'Well, okay', and she wanted me to look at her records, and so I looked at her records and then I went to the chief psychiatrist and I said, 'This is why [the patient] is so anxious and concerned about her particular medication'. And they put her onto something else but then a new doctor comes along and they put her back on to the original [drug] because I think it was a standard [drug], and [I said], 'You're frightening [the patient] to death; that you're going to give her cancer'. So he went and looked at the records, talked to the staff and he came back ten minutes later and he said, 'Okay, there'll be a change' and [the patient's] behavior improved and she was discharged in seven days. She had been there for four months fighting - well she was going to die, she thought, and became stressed. So, yeah, sometimes it's not just the mental illness it's the way that people are treated…they seem crazy, but they're not crazy in a mental health way, you know, they're crazy in a frustrated and emotional way [I-6].

Pastoral Counseling and Education

The roles of counseling and education undertaken by chaplaincy personnel seemed substantial and often thematically inseparable from one another. As summarized by one chaplain, this role predominantly seemed to involve dealing with prejudices and antagonistic attitudes held by both patients and staff toward one another, which chaplains indicated required some diplomatic intervention:

> 'We have a compulsory treatment order [NZMH 1992] and if they're [patients] are required by their doctor to take something and they refuse, then ultimately they will be held down by four really big guys and they'll [patients] be injected, and of course they [patients] don't like that…So what I say is [to patients], 'You're going to take the medication, you're going to take it by tablet or you'll…take an injection…they'll force you to stay still and they'll jab you, it's your choice!'. Now, whether the medicine is right or wrong, and that can be an issue too, but at that moment they have to learn to submit or they will just continue to be injected and they [the clinical staff] won't listen to their [patient] concerns…Then once they [patients] start taking it [their medication] then they can say [to the clinical staff], 'Well you know this is my concern about this thing'. So my role - well that's both counselling and its education. And it's also a role I do with the staff because I usually go and talk with the staff…and you know it's amazing how quickly people can change their attitude but it has to…come from the staff, [they] have to know that there's been at least an awareness and a willingness [by the patient], you know, to try to get along. But it's both sides - because sometimes those antagonisms, it's not just the patients that are antagonistic, sometimes the staff can become very hardened and antagonistic–but with a little pastoral education and counseling things can improve…[I-5].

Pastoral Ritual and Worship

Pastoral ritual and worship interventions predominantly involved European ("Pakeha") traditional religious applications; however, there was some evidence of chaplains also undertaking rituals that were specifically relevant and encouraged by the Maori culture. It is important to note, however, that similar to previous chaplaincy research (Carey 2012a, b; Carey et al. 2006), a chaplain's ritual and worship role may be considered secondary to other pastoral interventions, but uniquely within mental health care, the ritual and worship activities tended to be of greater utility and importance in assisting patient well-being. Collectively, a number of participants identified a variety of ritual and worship activities which they fulfilled:

> There is 'corporate worship' which they are all invited to, and many will come, particularly from the acute unit…we will also do…one-on-one [rituals] when people do ask [for these]'[I-8] [*Group Agrees*], plus funerals, memorials, weddings [I-8]…We are celebrating at the moment a season of Matariki … the constellation that comes on the horizon in winter [I-7]…[also] Maori New Year [I-6]…Christmas plays; they love being part of Christmas plays' [I-10]…'Easter plays as well' [I-5] [*Group Laughs*]…One of the other things we do is… that staff often call us into units to bless the units…the whole unit…[I-1]…couple of baptisms…[I-11][*Group Agrees*]…I've had to anoint patients with Holy oils…that's always very appreciated [I-7]…I think I've had the first marriage in the forensic unit that's come through, and the first funeral of a baby in the forensic unit…[I-1] …You can't underestimate

handshakes and remembering names. There are lots of rituals that we do instinctively'[I-8][*Group Agrees*]

Ritual and worship activities, however, were not only provided to support patients to cope with their circumstances. Such activities were also supportive of staff given the stressors of their work:

I had a man who had murdered his wife and he was on a suicide watch …for a long, long, time because as soon as he was medicated he'd realize what he'd done and then he felt he needed to pay for it [by self-harm]. …he [eventually] killed himself…they called me up [as chaplain] immediately… it was one of those fluke things with a towel and in 2 min, you know, that's all it took, [he was dead]. And… the whole staff decided - that we needed to do something. So we had a memorial service in the courtyard for all the patients, for the staff, for everyone involved. And everyone came and they devised what they wanted to do and at the end of it - we had some balloons - we let the balloons with the helium go and we stood in the courtyard watching the balloons head towards the east coast of New Zealand[1-I]

Issues and Frustrations

A second exploration for this research concerned the types of issues that chaplains in mental health care experienced while seeking to provide pastoral interventions. Invariably, the data revealed a number of frustrations. These included limited patient access and poor staff communication, restricted reciprocity with families, cultural and spiritual dilemmas, and difficulties with both their national privacy and compulsory treatment acts.

Limited Access and Communication

Participants noted that while some "in-house" differences existed between mental health care facilities (e.g., acute vs forensic mental health facilities), nevertheless, irrespective of the institution, there was unanimous agreement that chaplaincy involvement with patients and their families was often limited and their interaction with staff varied. One difficulty for chaplains was that of limited patient access and communication protocols with families and staff.

My experience, um…well the clinical and nursing staff usually don't spend time speaking with the chaplain [about patients] unless they know that the chaplain is seeing a particular client….when it comes down to it…interacting about a particular 'service-user' - as they're [patients] are called - very little happens in that way unless I make that approach because I have some concerns. When it comes down to families often the families *haven't* been offered *any* chaplaincy support. Often that [chaplaincy support] has come about…as families have approached me…because they saw my photo on a wall …And, they don't realize that the support is there until they see that [photo]. I do have access to all the clients, so, you know, I mean I can freely come and go but the other side of that is because [clients] are often medicated and in bed I need to ask the staff to see the [client], so staff go off to the [clients] room, so, I mean…that interaction is actually in the hands of that particular [staff] person…at the end of the day it can make it difficult because some [clients] don't actually get to see me, they see the staff members asking, 'Do you want to see the chaplain?'…. I think that there is a communication side of it which is difficult [I-3].

Restricted Familial Reciprocity

All participants unanimously agreed that, in their opinion, there were a number of restrictions that prevented basic reciprocity between chaplains and families—these included institutional issues (such as the foreboding environment of mental health care facilities, poor communication, and time constraints) and familial issues (such as spiritual shame, intolerance, and alienation). Several participants became quite engaged regarding this issue:

> [Families] are alienated from the system – and us as chaplains - and sometimes they [the staff] ostracize the patient from the family as well. Ah, and a lot of occasions the member has become so acutely unwell and has done things like criminal actions, that the family just cannot accept or tolerate it - and so be it – but they become alienated from one another…[I-2]. …I think they [the family] would like to spend more time with the chaplain but we - because we're in the forensic set-up…you might as well say…that it is very foreboding for them, it's scary…[I-2]. *(R: So if they do [visit] why do you think the family might want to spend more time with the chaplain?].* There is a lot of shame accompanying Pacific and Maori mental illness …[*Group agrees*]…and the things associated with mental illness… it is thought to be, that they should just get better and they've done something wrong and they should simply recover [I-6]. I think…they would want to spend more time with us because we know the fact that many of them come from a paradigm which is a Pacific or Maori paradigm. And the Pacific or Maori paradigm, to put it in simple terms, is that we are first created by 'Io Matua Kore',[1] by God, our spirit is created by God and we seem to have a human experience, and then, when that's completed, we return to our creator, to 'Io Matua Kore' and… in the human experience we are bound…but the Chaplain is very much the contact person with God [I-2]. *[R: So you, as a chaplain form a spiritual 'link', in other words, for the family?].* Yes, yes [I-2].

Cultural and Spiritual Issues

Given New Zealand's dominant Maori culture as well as the increasing multiculturalism as a result of migration, chaplains indicated that cultural and religious issues within the mental health context were considerable, yet sometimes overlooked, and therefore, chaplains argued that there was a lack of understanding and thus sub-standard holistic care that directly affected the health and well-being of patients.

> *[R: Do cultural issues impact upon your chaplaincy work?]* 'Yes, huge amount' [I-1] [*Group Agrees*]. *[R: In what way, how so?].* Well, I'll give an example…because we have…a number of Samoan patients…this Samoan patient had been isolated from the 'aiga'…from the family…you know his extended family for a long time. Now, he's continued to deteriorate and…I think that's got a lot to do with the isolation from 'aiga', I really, really, do…when they no longer visit…I went in there one day just recently…and he…comes over…speaks to me in Samoan and gives me a big hug and he says to me, "[Chaplain] I've got nobody left", crying his eyes out…that I think has added to his un-wellness…[*Group Agrees*]…that loss of contact from the aiga' [I-7]. 'And for the Maoris, it's no longer being a part of the

[1] "Io Matua Kore" : Māori for "Io the Parentless who was always existent without beginning or end"—the supreme God.

> 'Marae'…you come across all these sorts of things across cultures [I-1]. *[So, it's the same for Samoans and the Maoris, also the Tongans…?]* [*Group Agrees*]…Maori [however] are [always] well catered for - looking at their background and where they come from, etcetera. [However]…a number of Somalis and other people that were in the [mental health facility] which was, culturally, very white…ah…they [as refugees] were saying that nobody asks, 'What their religion is?', nobody asks, 'What their culture is?", nobody asks those things. But if they are Maori, we will [ask] all of it…But how can the doctors and the others…get any understanding of a person if they don't ask those questions? [I-2].

Chaplains also emphasized the importance of spirituality and its place within the mental health care system for all personnel but noted there can be a lack of appreciation for one another's spirituality—including those from traditional European traditions ("Pakeha"). As argued by several chaplains:

> [As chaplains] I think we're trying to address the origin of spirituality, which is often not "individualistic" but "community-based" [*Group Agrees*] and I would like to acknowledge that I think a lot of the ground that chaplains have gained within the health system is because of the "resurrection" or heightened awareness in New Zealand of "spirituality". That when they've [clinical staff] have come along to forensic meetings, they come with a spirituality and the cultural worker will also have a dimension of spirituality, alongside my dimension of spirituality, [and] that person [patient] will be going to their formal meetings with a spirituality…they may even start with worship and [perhaps] share privately [with their] minister, and…so it's more developing an awareness and feeling about others spirituality…[I-7]. 'Well for Pakeha too – but spirituality virtually no longer exists with the DHB…'[I-4]. 'As if there's not even a Pakeha culture!'[I-6]. 'We in [mental health facilities] have all official functions given to the Maori to do, any blessings go that Maori way. It's a real point of tension… at the moment and the vast chunk of the hospital population staff are saying, "Well, when did spirituality and Maori become synonymous?" And that's a problem we're going to have in the political system I reckon [I-4].

Privacy Act

Perhaps one of the most dominating frustrations noted by all participants was that of the New Zealand Privacy Act (NZPA 1993) and its utilization within mental health care which, according to participants, was a main cause of poor patient and staff communication plus restricted basic familial communication and family care, which in turn led to considerable suspicion of the mental health care system by families and the wider community. Chaplains were collectively quite vocal and critical about this issue:

> There is also a lot of stories of the…mistrust of the whole system, the psychiatric system [I-4]…Oh yeah! [I-6] [*Group agrees*]…And those stories do the rounds [I-7]. *[R: So is that another reason why the families would like to talk to a chaplain?]*…Well they [families] come to know that we sit in a very different position and sometimes [families] feel that we may well be the ones that they can…get some sense out of it all and certainly trust [I-8]…And the…Privacy Act is…often used too - as a way of keeping the families not very well informed about what's happening with their family member, which is very frustrating [I-6]. Yes. Well the case with the two families over two years that have sought my help and support, um - they have an

adult loved one in mental health care - and they couldn't get any information, they didn't know what was happening, they didn't understand what was happening because they had never had any contact [with] mental health services before…and the Privacy Act was quite hard when they tried to get information [I-3]. *[R: So one could skeptically ask then, 'who does the Privacy Act actually protect?'] [*Group laughs*]. I thought the NZ Privacy Act was there to protect the client but it sounds as if it's more protecting the institution than actually the client]. [*Group laughs*].* Well I mean [the Privacy Act] it's been criticized - some staff have been criticized as being…using the Act to avoid actually having to make explanations or be…forthcoming with help and time, you know, 'Oh, I can't tell you anything. Goodbye.' Yeah, that might be a wee bit cynical but certainly [the Privacy Act] it is overused in many cases [I-6].

Compulsory Treatment Act

Similar to other chaplaincy research (Carey and Cohen 2008, 2009), the majority of participants in this study were clearly adamant about being involved in patient health care treatment decisions and consulting with medical staff about patient treatment. Several participants noted their involvement in encouraging patient compliance with required treatment:

'Absolutely [we're involved] yeah'[I-3]. 'We've talked [with patients] about medication and quite often when they get it, we explain, "There's nothing in that medication that God hasn't made". That makes a difference for some patients' [I-1] [*Group Agrees*]. 'Particularly for those who might discontinue treatment – I'm talking particularly about those going to [theologically conservative] churches [who say], "They pray" and therefore they, "don't need medication anymore" and [yet end up] coming back to hospital. It's all about, you know, explaining, "Well you wouldn't do without it [medication] for epilepsy would you?" [I-4]. *[R: So how do you react though when some people would say, "Well no, it's not the chaplain's job to be involved in health care treatment issues"?].* 'It's not our job to actually tell people what medications. That's not our job…to actually diagnose or prescribe medications, but I think it's our job to encourage patients to be wise with the medications and with their health, [I-2].

Nevertheless, despite such involvement, all participants identified that in addition to the Privacy Act (noted earlier), another policy issue negatively impacting upon chaplaincy work was that of New Zealand's "Mental Health Assessment and Compulsory Treatment Act" (NZMH 1992). Chaplains generally agreed that in some cases, questionable enforcement of the Act not only unnecessarily detained patients but was inappropriate and uncompassionate.

'Ah, the "Compulsory Treatment Act" *[R: Can you elaborate on that?].* Well that's what I mentioned before [refer pastoral counseling and education], that if you've been prescribed by your psychiatrist that you'll take these medications – "you will!" There is no informed consent, and this policy is different in [some other countries] I'm reliably informed…that people…can refuse, but in New Zealand if you're under the Act, you're on a compulsory treatment order, you have no right to refuse. Well, you may have the right but it doesn't matter if you refuse…they're going to inject you in the end'[I-5]. *[So whereas in some countries patients have the right to refuse*

treatment…] 'No, not here' [I-6]…'Sometimes we are pretty certain in our minds that [some clients] are very safe to be returned to the community but "forgiveness" isn't built into legislation. And "mercy", the system doesn't know what that word means. So when you question about politics and policy [these have] a huge impact on the people in the mental health system [I-7]…'Yes some are having to stay there until they're deemed fit to be discharged aren't they [*Group Agrees*]. And that's why some people hate going in [to mental health care], because they've seen all the movies and they think, "Once I'm in here I'm never getting out!"…It feels to some like being a bird in a cage who is never getting out of the cage' [I-6][*Group Agrees*].

Cost Value

Another two areas of frustration noted by chaplains related to being undervalued in terms of efficiency and effectiveness. The first could be described as "ordinal value," in that chaplains provided a service which they knew was relatively inexpensive to district health boards and thus government health expenditure, and considerably cost-efficient in comparison with other services. The second area of being undervalued could be described as "cardinal value." Participants argued that their pastoral interventions helped to improve patient "through-put" by assisting patients to effectively accept responsibility for their behavior, being respectful of the medical advice given and to modify their behavior, which expedited their discharge and thus, again, saved hospital costs:

I can honestly say, that I can get people out of [hospital] a lot quicker than if I *hadn't* been there, because I help them [patients] to work out how, you know, what spiritual, religious or other anxiety that's keeping them there, because a lot of times as I've said before, they're doing something that can easily be changed and a lot of times they're just over-wrought by whatever is going on in their lives. You help them to understand what's going on, and then they can leave. And so people get out of there much quicker….It saves the hospital heaps of money. Or actually what happens is that they treat more people in the same amount of time which is efficiency [I-6]. [Yet there is] …very little appreciation of what chaplains actually do and what the outcomes are that we achieve' [I-7] [*Group Agrees*].

Discussion

Limitations

There are numerous issues arising from the findings of this exploratory research that require further investigation particularly given the inherent limitations of a qualitative study with regard to "transferability," "confirmability," "dependability," and "credibility" (Bryman 2011). While the majority of New Zealand mental health care chaplains participated in this study, nevertheless, the small sample limits the transferability of results to other chaplaincy contexts. Also, while utilizing a focus group method assisted the confirmability of data by having multiple participants collectively considering the same issues at the same point in time, there were, however, no Catholic, Ratana, Ringatu, or other faith groups represented; Christian Protestant perspectives dominate the data collected. In addition, the data collected were purely from a chaplaincy perspective, and

additional research would need to be undertaken to consider the views of patients, families, and staff about the role and interventions of chaplains. Nevertheless, dependable data were gained from a majority of experienced participants, which are auditable and repeatable plus research credibility was maintained by ensuring the accurate recording, transcription, thematic compilation, and presentation of data that participants were subsequently able to consider and challenge—individually or collectively.

Pastoral Interventions

In overall terms, it is clear that the mental health care chaplains in this study were fulfilling WHO-recognized pastoral interventions. Several issues, however, were noted by participants regarding these interventions. Perhaps the most obvious was that while all participants were accepting of doing *informal* assessments, some objected to *formal* assessments as they were wary of the language utilized in such assessments and that they were impersonal, uncompassionate, and time-consuming—something which was considered problematic given the demand upon chaplains and their limited chaplaincy numbers.

Nevertheless, formal religious and spiritual assessments have been utilized and reviewed for well over three decades leading to a range of assessments to better understand patient spirituality to assist psychiatric and mental health care treatment (Griffith 2012). These have provided a systematic and validated empirical method for gauging religious/spiritual well-being that chaplains can implement as professional experts in this field. Obviously, however, such rationale does not overcome the fundamental problem of limited time constraints upon chaplains to effectively implement such protocols—additional chaplaincy time would clearly need to be allocated by District Health Boards and/or the Ministry of Health for such advanced assessments to be completed.

Pastoral ministry support was perhaps one of the most emphasized chaplaincy roles—that of being present and available or as colloquially stated "being there." As an adjunct to "being there," the role of "advocacy" was also considered instrumentally important for the well-being of patients given the overwhelming experience of institutionalization, the loss of autonomy, and, at times, the injustice of excessive medicalization and incarceration. As a balance to this intervention, however, "pastoral counseling and education" was another role undertaken by participants, not just with regard to religious and spiritual issues, but also, more pragmatically, in terms of encouraging among patients the importance of conforming to institutional and/clinical requirements and educating patients with regard to understanding appropriate behavior that was expected to aid their treatment.

While religious and spiritual adherence may be perceived as declining among the general population in New Zealand—due to increasing secularization—nevertheless, pastoral ritual and worship activities in mental health care facilities (both public and private) were also noted by participants to be a very important and popular intervention for patients within mental health care—irrespective of religious or non-religious affiliation. Similar to the findings of previous research, participants in this study noted that patients who sought-out such an intervention did so to cope with their circumstances of segregation and/or incarceration, to seek comfort, consolation and forgiveness, plus obtain pastoral support and spiritual guidance (Macmin and Foskett 2004). Participants noted that staff also appreciated this form of intervention, not only for the benefit of patients, but also for the staff themselves to help them cope with the demands of their work and even (sometimes) to endure the undesirable outcomes (e.g., patient suicide) of being involved in mental health care.

However, whether deliberate or unintentional, restrictions of access, and thus limited direct communication with patients, meant that chaplains could be prevented from implementing appropriate pastoral interventions, thus disabling any potential benefits for patients through regular pastoral assessments (formal or informal), support or advocacy, counseling, or private ritual and worship activities. Further, limited familial reciprocity for mental health care chaplains meant that, while chaplains and clergy in other specialties could gain ready access to families to provide spiritual and psycho-social support, the situation for mental health care chaplains was very different due to government policy and inhibiting institutional protocols.

Yet ironically, given the social, communal, and spiritual isolation that families experienced by being segregated from their loved ones, any reciprocity between families and chaplains should be regarded as considerably *more* important in mental health care facilities—*not less* important. Indeed, it can be argued that encouraging chaplaincy–familial communication would seem to be advantageous for all concerned, as it would demonstrate a more caring institution concerned for families and their associated communities. Greater chaplaincy–familial reciprocity would provide families with direct emotional, religious, and/or spiritual support, plus enables chaplains to provide a non-diagnostic communication link between families and patients, which would actually encourage a more apposite attitude about the mental health care service being provided—rather than a negative attitude. Developing chaplain–familial reciprocity can also directly benefit the patient as "…assisting psychiatric patients to develop connections with congregations and clergy can provide continuing religious support after discharge," which may well break the cycle of re-institutionalization (Fitchett et al. 1997, p. 325).

Another issue concerned the exploitation of New Zealand's Privacy Act. Chaplains unanimously agreed that quite frequently the Act, far from protecting patients, would be utilized by some clinical staff to restrict or limit information and communication that would, in turn, actually confound holistic care, limit beneficent outcomes, and thus affect the well-being of patients and augment the potential of harm. Predominantly, participants held the view that by facilitating open communication between patient, family, and clinical staff, not only was an important ethical pastoral care task being undertaken by chaplains, namely "love and justice" (Dunn 1994), but an important form of treatment was being encouraged, namely honesty!

Pastoral Administration and Pastoral Care

A number of pastoral care and pastoral administration issues were also discernable from this research. Perhaps the most obvious was that participants identified an important role they undertook in relation to protecting patient's cultural and spiritual beliefs, not only for those of the dominant spirituality, namely Maori and the traditional 'Pakeha' Christian denominations (e.g., Catholic, Anglican, Presbyterian, and Methodist,) but for other cultures and religions as well (e.g., Moslem, Hindu, Bahai, and Sikh). Nevertheless, as New Zealand has clearly become a multifaith nation, there is a need for chaplaincy to consider a formal model, paradigm, or strategy to affirm the relevance and implementation of pastoral care and chaplaincy given increasing multifaith demands (e.g., Mol's 'Sacralization of identity' multifaith paradigm'; Carey et al. 2009; Mol 1982, 1976).

Similar to other research, chaplains clearly affirmed the importance of their involvement in patient treatment issues and consulting medical staff (Galek et al. 2007; Carey and Cohen 2008, 2009). However, the Compulsory Treatment Act was unquestionably a bone-of-contention for participants, as enforced medication seemed somewhat adverse to

pastoral care principles and a breach of basic rights under common law that would normally allow a person (who is competent) to refuse any type of medical treatment, or if treatment was forcibly implemented, then a charge of medical trespass could be permissible. Of even greater concern to some participants was that some patients, under the Act, were being unnecessarily detained from returning to the community and that this was creating unjustifiable suffering for the patient and their family, plus suspicion within the community about the legitimacy of mental health care facilities.

With regard to economic efficiency, participants confidently asserted that chaplaincy within mental health care was unquestionably cost-efficient given that their pastoral care department costs were very low (in comparison with other services) and that chaplains helped to improve patient care, compliance, and/or patient throughput—which they argued helped to reduce costs—plus they additionally provided support to families and clinical staff at no additional charge. However, the cost benefits of chaplaincy were not a unique phenomenon to this research, as other chaplaincy evaluations have also noted the cost efficiency of chaplaincy (Carey 2012; Newell and Carey 2000). Nevertheless, if such efficiency is verifiable, it would clearly benefit mental health care facilities to actually give greater support to chaplaincy services to help improve their effectiveness, particularly as the total number of clients within mental health care facilities has increased over recent years, but there has been no proportional increase in financial support for chaplaincy from the respective District Health Boards or the Ministry of Health. It can also be argued that increasing economic and human resource support to chaplaincy would not only proactively engage greater pastoral care for patients, their families, and staff but also, from a political perspective, improve community liaison and support for the government.

A final issue regarding both economic efficiency and community liaison, which was briefly alluded to within the focus group discussion, but (due to insufficient space) not presented within the results, was the lack of contractual or resourced provision for pastoral care to be undertaken by mental health care chaplains when a patient is initially discharged from mental health care facilities back into the community. Thus, while a chaplain may have the opportunity to assess, support, counsel, and educate a patient on their spiritual journey while within a mental health care facility, there is unfortunately no provision for chaplaincy follow-up to assist or support patient re-engagement when patients initially return to the community; yet, according to participants, chaplaincy support and advocacy for patients within the community could prove to be an important role for chaplains to help patients re-integrate into their communities (Morgan 2010; Carey 2011). Chaplains indicated that the current lack of re-integration support undoubtedly contributes to the "revolving door syndrome" whereby patients soon return, sometimes repeatedly, to the very institution from which they have supposedly recovered. Increased chaplaincy involvement as a link between institution and community would not only assist patients and the community to properly re-adjust (and thus provide a cardinal benefit) but also achieve an ordinal economic benefit by helping to break the cycle of costly re-institutionalization.

Future Directions

Utilizing the WHO pastoral intervention codings allowed the systematic identification of the current utility of New Zealand chaplains within mental health care facilities and the various issues that need to be attended to by the NZ Ministry of Health, district health boards and supporting faith organizations so as to increase the effectiveness and efficiency

Table 4 Mental health care chaplaincy roles, utility, and issues for improvement

Chaplaincy role	Utility	Issues for improvement
Pastoral assessment	Informal assessments undertaken appraising patient spiritual/religious state and over-all well-being	Chaplain–patient direct access sometimes limited by staff—restricting assessments Chaplains limited by insufficient time, resourcing, and training to conduct formal patient assessments
Pastoral ministry/ support	Being with patients, establishing patient rapport, undertaking pastoral conversations, and engaging in patient narratives to help alleviate frustration, anxiety, and anger Being communication facilitator to assist patients/families to interpret/understand treatment issues Being an advocate to ensure fundamental bioethical principles are endorsed/not beached	Chaplains restricted by Privacy Act limiting communication reciprocity and support to patient's family Chaplains restricted by Compulsory Treatment Act limiting advocacy support for patients. Chaplains time-limited restricting adequate support/visitation of patients Chaplains time-limited restricting adequate support/visitation of patient's family
Pastoral counseling/ education	Exploration/review of patient's personal or familial religious/spiritual beliefs and practice Review and guidance with patients in relation to their behavioral response/ acceptance to treatment Review/education of staff attitudes towards patients	Chaplains time-limited restricting adequate counseling/education of patients/families Chaplains time-limited restricting adequate counseling/education of staff
Pastoral ritual and worship	Conduct of private rituals/worship for patients Conduct of public rituals/worship for patients Conduct of public rituals for staff, families/ community	Chaplaincy time-limited restricting the implementation of some creative ritual and worship activities Chaplaincy limited by dominant cultural issues
Pastoral administration	Administration/liaison with institution Administration/liaison with clinical staff Administration/liaison with patients/clients Administration/liaison with families Administration/liaison with community Administration/liaison with diverse religious/spiritual organizations	Chaplaincy under-staffed/under-resourced/administrative support needed Chaplaincy family–community liaison not resourced Chaplaincy effectiveness/efficiency under-valued Chaplaincy evaluation/research/research training required

of chaplaincy and pastoral care services within mental health care facilities. Other literature has noted that the utility of chaplains can be quite extensive (Carey 2012a, b), and thus, a number of suggestions have been recommended in Table 4 to improve New Zealand chaplaincy within mental health care services (refer "Issues for improvement," Table 4).

Beyond the more obvious issues for improvement, it can be argued that given the experience and tacit knowledge of chaplains engaged in mental health care, district health boards and related health care institutions could fundamentally help to ensure policies which affirm that chaplains are equally and fully valued as allied health professionals who are mandated to make certain that cultural, ethical, and spiritual aspects are being respected within the mental health arena for the betterment of patients, families, and clinical staff.

Such acknowledgement will undoubtedly assist chaplaincy–physician consultancy and mutual inter-professional respect (Carey and Cohen 2009).

Further, given the long-standing and culturally important contribution that chaplaincy personnel have made and can make to the public health arena within New Zealand (and mental health care in particular), it is understandable that government and district health boards would want, and should seek, to increase (both in principle and fiscally) mental health care chaplaincy training and employment so as to ensure adequate ongoing pastoral support for patients, families, and clinical staff. Such increase in employment and training should also be inclusive of chaplains from non-Christian faiths. Religious and public institutions could also re-evaluate their contribution to chaplaincy training and offer tertiary subjects at post-graduate level that would prepare future chaplains for the complexity and demand of ministering to an increasing number of clientele with mental health care issues.

In addition, it might also be ideal that, wherever possible, chaplains involved in mental health could increase their "chaplaincy health care communication role" (Carey 2011) by utilizing mental health care forums, seminars, and conferences to present, educate, and reiterate within the clinical and wider community, about the value of religious/spiritual support and the role of chaplaincy personnel in mental health care.

Additional Research

This exploratory research involved a single focus group. As recommended in other research concerning health care chaplains in New Zealand (Carey 2012), and mental health care in particular (Merchant and Wilson 2010), at the very least, it would seem wise that additional research exploring chaplaincy and mental health care should be supported so as to improve the quantity and quality of evidence-based material with the aim of achieving more generalizable findings. Such additional research would help improve the *'appreciation of what chaplains actually do and what the outcomes are that [they] achieve'* [I-7]. Without doubt, however, this would mean that health care chaplaincy in New Zealand would need to become a more research-informed profession (Fitchett and Grossoehme 2012) and particularly literate in spirituality and health research (Koenig, 2011). Such developments will not only benefit the professional practice of chaplaincy, plus the nature and content of a chaplain's role in mental health care, but also assist other chaplaincy specialties as well (e.g., acute care, palliative and aged care, prison, and military chaplaincy).

Similarly given the indication that chaplaincy involvement in mental health care could help to reduce the time taken for patients, families, and staff to address complex mental health issues, it could also be argued that health care institutions, government authorities, and district health boards would benefit substantially from supporting chaplaincy research—particularly that which explores, not only cost saving to health care facilities and hence the Government's health-budget, but such research could also provide some direction for improving chaplaincy services in order to achieve better outcomes for the well-being of patients, families, and staff.

Acknowledgments While no funds were directly granted to conduct this research, some administrative and research support were provided by the Palliative Care Unit, School of Public Health, La Trobe University (Victoria, Australia), The Healthcare Chaplaincy Council of Victoria (Melbourne, Victoria), and the Interchurch Hospital Chaplaincy Council (Aotearoa New Zealand). Acknowledgment is also given to the mental health care chaplains who willingly gave of their time to participate in this research.

References

Bryman, A. (2011). *Social research methods* (4th ed.). Oxford: Oxford University Press.

Carey, L. B. (2011). Chaplains and health care communication: An Australian perspective. In A. N. Miller & D. L. Rubin (Eds.), *Health communication and faith based communities* (pp. 263–278). Cresshill, New Jersey: Hampton Press.

Carey, L. B. (2012a). The utility and commissioning of spiritual carers. In M. Cobb, C. Puchalski, & B. Rumbold (Eds.), *The Oxford handbook of spirituality and health*. Oxford: Oxford University Press.

Carey, L. B. (2012). Bioethical issues and health care chaplaincy in Aotearoa New Zealand. *Journal of Religion and Health*, 51 (in press).

Carey, L. B., & Cohen, J. (2008). Religion, spirituality and health care treatment decisions: The role of chaplains in the Australian clinical context. *Journal of Health Care Chaplaincy, 15*, 25–39.

Carey, L. B., & Cohen, J. (2009). Chaplain-physician consultancy: When chaplains and doctors meet in the clinical context. *Journal of Religion and Health, 48*, 353–367.

Carey, L. B., Davoren, R., & Cohen, H. (2009). The sacralization of identity: An interfaith spiritual care paradigm for chaplaincy in a multi-faith context. In D. Schippani & L. Beaukhert (Eds.), *Interfaith spiritual care: Understandings and practices* (pp. 1–24). Onatario: Pandora Press.

Carey, L. B., & Newell, C. N. (2002). Clinical pastoral education and the value of empirical research: Examples from Australian and New Zealand Datum. In L. VandeCreek (Ed.), *Professional chaplaincy and clinical pastoral education* (pp. 53–64). New York: Haworth Press.

Carey, L. B., Rumbold, B., Newell, C. J., & Aroni, R. (2006). Bioethical issues and health care chaplaincy in Australia. *Scottish Journal of Healthcare Chaplaincy, 9*(1), 23–30.

Casanova, J. (2006). Rethinking secularization. *Hedgehog Review*, Spring & Summer 7–22.

Dunn, H. P. (1994). *Ethics for doctors, nurses and patients*. New York: Alba House.

Fallott, R. (2001). Spirituality and religion in psychiatric rehabilitation and recovery from mental illness. *International Review of Psychiatry, 13*, 110–116.

Ferngren, G. B. (2009). *Medicine and health in early Christianity*. Baltimore: John Hopkins University Press.

Fitchett, G., Burton, L. A., & Sivan, A. B. (1997). The religious needs and resources of psychiatric inpatients. *The Journal of Nervous and Mental Disease, 185*(6), 320–326.

Fitchett, G., & Grossoehme, D. (2012). Health care chaplaincy as a research-informed profession. In S. B. Roberts (Ed.), *Professional spiritual and pastoral care: A practical clergy and chaplains handbook* (pp. 387–406). Vermont: SkyLightpaths publishing.

Galek, K., Flannelly, K. L., Koenig, H., & Fogg, S. L. (2007). Referrals to chaplains: The role of religion and spirituality in health care settings. *Mental Health, Religion and Culture, 10*(4), 367–377.

Glasser, B. G., & Strauss, A. (1967). *Discovery of grounded theory: Strategies for qualitative research*. Chicago: Aldine Publishing Co.

Griffith, J. L. (2012). Spirituality in psychiatric and mental health care treatment. In M. Cobb, C. Puchalski, & B. Rumbold (Eds.), *The Oxford handbook of spirituality and health*. Oxford: Oxford University Press.

Harrison, M., Koenig, H., Hays, J., Eme-Akwari, A., & Pargament, K. (2001). The epidemiology of religious coping: A review of the literature. *International Review of Psychiatry, 2*, 86–93.

ICHC (2006). *Code of practice for hospital chaplaincy*, New Zealand Ministry of Health Service Schedules, Pt 3.F: Service Specification Standard Contract with Interchurch Council for Hospital Chaplaincy 244806/325268/00, Wellington, The Interchurch Council for Hospital Chaplaincy Aotearoa New Zealand: Te Kaunihera Whakawhanaunga o nga Minita Hohipera, Hauora, pp. 41–53.

Koenig, H. G. (2011). *Spirituality & health research: Methods, measurement statistics and resources*. Conshohocken: Templeton Press.

Koenig, H. G., King, D. E., & Carson, V. B. (2012). *Handbook of religion and health* (2nd ed.). New York: Oxford University Press.

Koenig, H., Larson, D., & Weaver, A. (1998). Research on religion and serious mental illness. In R. Fallott (Ed.), *Spirituality and religion in psychiatric rehabilitation* (pp. 81–95). San Francisco: Jossey-Bass.

Koenig, H. G., McCullough, M. E., & Larson, D. (2001). *Handbook of religion and health* (1st ed.). New York: Oxford University Press.

Lowery, M. J. G. (2012). Behavioral health. In S. B. Roberts (Ed.), *Professional spiritual and pastoral care: A practical clergy and chaplains handbook* (pp. 267–281). Vermont: SkyLightpaths publishing.

Macmin, L., & Foskett, J. (2004). "Don't be afraid to tell": The spiritual and religious experience of mental health service users in Somerset. *Mental Health, Religion & Culture, 7*(1), 23–40.

Macritchie, I. (2004). Worlds apart? A comparison of acute and mental healthcare chaplaincy. *Scottish Journal of Healthcare Chaplaincy, 7*(2), 23–27.

McCartney, P., & Lennon, J. (1969). *Let it be, apple records*. London: EMI Studios.
Mela, M. A., Marcoux, E., Baetz, M., Griffin, R., Angelski, C., & Deqiang, G. (2008). The effect of religiosity and spirituality on psychological well-being among forensic psychiatric patients in Canada. *Mental Health, Religion and Culture, 11*(5), 517–532.
Merchant, R., & Wilson, A. (2010). Mental health chaplaincy in the NHS: current challenges and future practice mental health. *Religion & Culture, 13*(6), 595–604.
Miller, A. N., & Rubin, D. L. (2011). *Health communication and faith based communities*. Cresshill, NJ: Hampton Press.
Mitchell, L., & Romans, S. (2003). Spiritual beliefs in bipolar affective disorder: Their relevance for illness management. *Journal of Affective Disorders, 75*, 247–257.
Mol, H. (1976). *Identity and the sacred: A new social-scientific theory of religion*. Oxford: Blackwell.
Mol, H. (1982). *The fixed and the fickle: Religion and identity in New Zealand*. Gerrards Cross: Wilfred Laurier University Press.
Morgan, G. (2010). Independent advocacy and the ''rise of spirituality'': Views from advocates, service users and chaplains. *Mental Health, Religion & Culture, 13*(6), 625–636.
Morrow, W. R., & Matthews, A. T. (1966). Role-definitions of mental hospital chaplains. *Journal for the Scientific Study of Religion, 5*(3), 421–434.
Neeleman, J., & Lewis, G. (1994). Religious identity and comfort beliefs in three groups of psychiatric patients & a group of medical controls. *International Journal of Social Psychiatry, 2*, 124–134.
Newell, C., & Carey, L. B. (2000). Economic rationalism and the cost efficiency of hospital chaplaincy. *Journal of Health Care Chaplaincy, New York, 10*(1), 37–52.
NZMH (1992). *New Zealand Mental Health Compulsory Assessment and Treatment Act (1992)*, No. 46 Public Act, November, Wellington, New Zealand Government.
NZMH (2006). *New Zealand Ministry of Health Service Schedules*, Pt 3.F: Service Specification Standard Contract with Interchurch Council for Hospital Chaplaincy 244806/325268/00, New Zealand Government, Wellington, pp. 38–40.
NZPA (1993). *New Zealand Government Legislation Privacy Act, Public Act No 28*, New Zealand Government, Wellington, 17 May.
Paloutzian, R. F., & Ellison, C. W. (1982). Loneliness, spiritual-well-being and the quality of life. In L. A. Peplau & D. Perlman (Eds.), *Loneliness: A sourcebook of current theory, research and therapy* (pp. 224–234). New York: Wiley.
Pargament, K. (1997). *The psychology of religion and coping: Theory, research, practice*. New York: Guilford Press.
Perske, R. (1966). Chaplains role in an institution for the mentally retarded, *McCormick Quarterly*, vol. XIX. March, pp. 1–17.
Perske, R. (2003). Chaplains role in an institution for the mentally retarded. *Journal of Religion, Disability & Health 7*(1–2), 13–28.
QSR (2011). *NVivo 9,* Qualitative Software Research International (QSR), Melbourne, Victoria.
Ratray, L. H. (2002). Significance of the chaplain within the mental health care team. *Psychiatric Bulletin, 26*, 190–191.
Slaughter, J. T. (1978). The roles of chaplains in community mental health: In an inpatient setting. *Hospital & community psychiatry*, *29*(12) S797.
Stephens, J. (1994). A personal view of the role of the chaplain at the reaside clinic. *Psychiatric Bulletin, 18*, 677–679.
Swinton, J. (2006). *Spirituality and mental health care: Rediscovering a 'forgotten' dimension*. London: Jessica Kingsley Publishers.
WHO (2002). Tabular List of Procedures ICD-10-AM: Australian Classification of Health Interventions, vol. 3 of *The international statistical classification of diseases and related health problems*, 10th revision, 'Pastoral Intervention Codings'. World Health Organization and the National Centre for Classification in Health, University of Sydney: Sydney.