RESOURCE

Chaplaincy with Children and Young People as Community Work

Susy Insley

MCYM Reflection

Email: cccyp@stjohns-nottm.ac.uk

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Susy Insley, Midlands CYM student

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In his book, 'Analysing Community work', Popple writes that 'definitions of community are elusive, imprecise, contradictory and controversial' (2000:3). The historical view of community is one of idealized local neighbourhoods where there is warmth, security, social cohesion and togetherness (Popple 2000:2), but this interpretation is no longer adequate. Buchroth and Parkin write that the difficulty in determining a definition stems from the multiplicity of uses for the term community (2010:28), however, there are four common themes which they consider helpful when thinking about what constitutes community. These are;

- geographical area or locality
- common interest or characteristics e.g. 'gay community', 'black community' or even 'stamp collecting community'
- sense of belonging
- relational network – families (Buchroth and Parkin 2010:30)

My role as Chaplaincy youthworker is within an NHS hospital in the UK. Although the hospital community is based around a fixed location, it is not a geographical community in its truest sense, as the people within the community; patients, visitors and staff, hale from all over the region and the hospital is not their home. The nature of the hospital and the area it serves means that it encompasses people from all backgrounds and ethnicities, and so it is also a community of diversity with all the differing needs that this presents.

The hospital is also a community that has a common interest or purpose. Everyone within it, be that doctor, physiotherapist, cleaner or volunteer, is working towards the therapeutic care of the hospital service users. The patients and visitors also have this as a common interest. In this it matches the assertion of the churches working party, that a hospital community is a specialized functioning community which shares a common purpose and has interdependence between its members (1991:200). Gilchrist also identifies a community as a group of people with a common interest or purpose, but writes that this then raises an expectation of loyalty, support and affirmation (2011:3). While this is a reasonable expectation for the staff at the hospital, it does not necessarily hold as true for the patients and visitors, who, while a significant part of the community, are transitory. Their community participation is forced upon them through illness or accident, whereas staff choose to be part of it and so are more committed to it.

As Chaplaincy youthworker I work alongside other multi-disciplinary teams to create a community that works towards the wellness of its members and delivers patient centred care. NHS England states that the role of healthcare chaplaincy is to provide 'highly skilled and compassionate pastoral, spiritual or religious

support for patients, carers and staff facing situations which are at times harrowing and stressful' (england.nhs.uk). This statement precisely describes my community practice within the hospital.

In many ways, the community of the hospital is a microcosm of the wider communities which make up our towns and cities. Each bed space represents a household. If a child or young person is in hospital they are usually accompanied by their parents who often sleep in the hospital with their child. They are visited by their friends and families and for the period of their hospitalisation they live their life with their bed space as their home. This is evidenced by the way in which long term patients personalise it with pictures, cards, toys and even photographs. The hospital also has the social structures associated with a geographical community; a hospital school, shops, a library, a restaurant, a garden, a youth room and play spaces. It also has a multi faith centre with a synagogue, a Chapel, Muslim, Sikh and Hindu prayer rooms, all for the use and benefit of the community. The needs of the community have been considered and provided for. However, for these facilities to be readily available to everyone they have to have the ability to go to those who cannot go to them. Staff and families can access the shops and restaurant etc., but patients who are restricted to their bed space or ward need the facilities to come to them. The hospital school therefore works with young people at the bedside, the library visits each ward and a shop trolley regularly goes around the hospital. In the same way I, as a member of the 'worship location' in the hospital, go to the community and serve them and support them where they are, be this at the bedside, in outpatients or supporting a member of staff over a coffee in the restaurant. This familiarity with my community enables me to work out what the issues are and how I, as a community worker, can respond to them (Buchroth and Parkin 2010:36). The nature of the hospital means that my work is both entrepreneurial and responsive (Slater 2015:67), knowing that I need to go to young people where they are enables me to plan my work accordingly and visit each ward, making myself available to the young people and their families. Jesus's ministry is a model for this, he ministered to his community, revealing the sacred in the midst of their everyday experiences (Slater 2015:67) and taking God's active mission to where people are.

Slater writes that chaplaincy is a 'guest' in a secular context and needs to understand and respect the plurality of spiritualities in contemporary culture to be able to respond to people's needs appropriately (2015:15). As Chaplaincy youthworker I am sensitive to the culture and community that I work within and try to respond to it appropriately. Ward writes that foundational to the Christian faith is the belief that God became human in Jesus and revealed himself to us within human history and human culture (1997:90). In the same way, we too must develop a ministry which identifies with and responds to the culture we are in (Griffiths 2013:36). The hospital is a community of great diversity and so, as I work with people of all faiths and none, my youth work practice has to respect this. Smith writes that tolerance, reciprocity and trust are hallmarks of communal life (2001:13). A tolerance and understanding of world views other than my own is essential in my role and this then builds trust. To be welcomed on wards as an active part of the community, staff need to be able to trust that I will not proselytize or impose my world view on others. I

make no assumptions about the personal conviction or life orientation of the young people I work with (NHS Scotland in www.ukbhcc.org). In this both the youth work principle of equality and my own faith inform my youth work practice. Knowing that we are all made in God's image and are loved by him teaches me to treat all who I meet with equality and respect. One young person I worked with over a long period was Muslim. When making a spiritual care bracelet with her she identified that she drew strength from her faith and so chose a green bead to represent God as this is the favourite colour of the prophet Mohammed. Although her faith tradition is different to mine, my work with her enabled her to gain an awareness of self and the transcendent. This confirms Slater's assertion that chaplaincy, and therefore my own community practice, reflects God's concern and love for each one of us as it is available for everyone in the community, whatever their faith tradition or background (2015:46).

At the hospital my community practice is to support the healing community. My work with young people is usually one to one, and is person centred. It aids recovery by recognising and responding to the spiritual needs of the young people who are facing all the challenges that hospitalization can bring. I do this through creating a safe space in which they can try and understand their present situation, express their thoughts, feelings and fears and make meaning of it. When visiting one young person who had been an inpatient for several weeks I intended to do a craft activity with her to relieve her boredom. She was very distressed when I arrived and it became apparent that her most pressing need was for someone to listen to her. She had been told that, as she had been in hospital for many weeks, she would now have to re-sit her year at school. This meant separation from friends and taking her GSCEs a year late. Her anxiety about this was exacerbating her medical condition and so I spent time talking to her about her fears, her illness and her treatment. Although I wasn't able to change her situation, I was able to provide her with a forum where her concerns were heard and given validity. I also spoke to the hospital school and they promised to contact her school and see if a resolution could be found. Another example of where my youth work practice has contributed to the common purpose of the hospital and has demonstrated my role within the multi-disciplinary hospital community is with a young man who was admitted to hospital after a suicide attempt. He was exploring his gender identity and had a gay pride flag by his bed. I was asked to talk to him as he had just heard about the shootings in a gay club in Orlando and was visibly distressed. As I listened to him it was clear that this event was causing him spiritual pain and was adding to his cycle of negative thoughts. We talked about ways in which he could process this and lessen his spiritual distress and together we came up with the idea of him painting a canvas to commemorate the people who had died. He told me that this had helped him to process the event and so it was successful in easing his spiritual distress. Through these interventions I am contributing to the purpose of the hospital community by improving patient well-being and promoting healing.

Recognising that one of the primary assets of the hospital community is the staff who work in it, I am also available to give them support, encouragement or help. While my primary responsibility is for young

people, when I am on wards I do ask staff how they are and listen to them as they tell me about the pressures of their day. After the death of a young man on a ward I made sure that I visited it the next day to offer staff support. The churches working party wrote that a healthy community is one in which people interact with each other, listen and share, therefore supporting staff is beneficial. Community is life in action, in order to be healthy, we must carry each other's burdens (Sobell 1991:205-6). God has given us an example of a caring, supportive community in the Trinity. McGrath writes that while all parts of the community of the trinity are distinct, yet they work together in a mutually loving, interacting and sustaining society (2012:132). The greatness of the Trinitarian communion is this distinction of persons within it, who each give themselves totally to the other and uphold each other (Boff and Burns:2005:150-1). Nouwen writes that community is a quality of heart, 'it is the fruit of our capacity to make the interests of others more important than our own' (henrinouwen.org). Proactive care of hospital staff enhances the community of the hospital and increases its social capital. By promoting a caring environment for staff and patients alike, I hope that good will, fellowship and sympathy can be built, which in turn develops a shared trust and mutuality that benefits both individuals and the community as a whole (Gilchrist 2009:9).

While NHS England recognises that chaplaincy has 'an immediate and enduring benefit' and states in its guidelines that delivering spiritual, religious and pastoral care is integral to the care that patients should receive (england.nhs.uk), this is not always recognised by all within the hospital where my role as chaplaincy youthworker is not always understood. Girali writes that within a community there may be subgroups that interpret the values of the wider community slightly differently to fit their perceived needs (2001:286). In some situations there is the lack of understanding about what spiritual care involves and how it can contribute to the recovery of patients and the social capital of the hospital as a whole, this can lead to a lack of referrals.

Another point of resistance is the changing view of faith. There has been a paradigm shift in worldviews and people have moved away from traditional moral institutions and codes of thought. The process of modernisation has led to individualisation, pluralism and rationalisation, all of which challenge people's capacity to engage with the Christian faith (Collins-Mayo et al 2010:12). Also, the multi-cultural nature of Britain has led to exposure to many different faith traditions and for many there are no longer any absolutes. My experience is that some staff have a hostility towards religion and think that chaplaincy has nothing to contribute to the care of young people. Therefore, unless a young person specifically expresses a Christian faith, they do not think to, or want to, involve me in their care.

Whether it is through prejudice against faith based work or through a lack of understanding of what spiritual care can offer, I sometimes experience powerlessness. It also prevents young people accessing the breadth of care that they may need. And yet, in 2 Corinthians 12:9 Paul reminds us that it is in our

weakness that God's power can work through us and this is in this that I put my confidence. In view of this I feel that there is a clear opportunity to expand my community practice. My objective is to raise the profile of my role as chaplaincy youthworker and educate staff and patients so that they are aware of my availability as a resource and also understand what my skills are and what I can contribute. My aim is to gain a recognition within the hospital for spiritual care practitioners as part of the multi-disciplinary team. Using Lovell's definition of community development as helping people to work together to improve their environment (1992:38) meeting my objectives will give members of the community access to an asset that many are presently unaware of, this will improve their present locale. I would hope that by identifying this opportunity for development and working towards it I will see ward staff referring young people directly to me and including me in their planning of patient care.

Smith writes that the three vital aspects of community development are informal education, collective action and organisational development (2013:13). When I visit each ward I use informal education as I talk to staff and highlight the work I do with young people. One nurse was surprised that I had used pompom making to engage with a young person that they had found uncommunicative and when I next visited her ward, she readily referred young people to me. However, I am now also using formal education to develop my role. With my line manager I have led a teaching session for a particular team on spiritual care. The feedback received was positive and a doctor commented that it had changed his view that chaplaincy only offered religious care. When asked, those present said that following the training they would be more likely to consider the spiritual needs of their patients. We have more training sessions planned with other multi-disciplinary teams. I have also attended the regular ward managers meeting where I was given the opportunity to talk about my role and what it could contribute to patient well-being and staff care. As a result of this I have had patient referrals from ward managers and have also been asked by them to meet members of staff to give pastoral support. Educating and informing ward managers led to collective action, they apprised their nursing staff about my role within the hospital and encouraged them to see me as a resource in patient care.

In order to look at how the role of chaplaincy youthworker can be extended and developed in the future there was a meeting with the Director of Nursing. Although she manages the hospital, she too was unaware of how my role contributed to its healing environment. She quickly identified how the work I am doing fits in with the overall objectives of the hospital and so, following on from this meeting we have been asked to give a presentation at a strategy meeting in December and produce a poster about spiritual care to be displayed in the hospital. This links chaplaincy in with the organisational development of the hospital community.

Community is a crucial dimension to all of our lives. We all have a connectedness with the people around us through our communities and take on its norms and shared expectations (Smith 2001:12). The Trinity demonstrates to us that living in communion and reciprocity brings fellowship, equality of opportunity and generosity (Boff and Burns 2001:151) and so, if chaplaincy is to provide a distinctive Christian voice at the heart of community (Slater2015:44), it must reflect this. Community development is not just quantative, it is also qualitative. If a community's culture is defined by its attitudes, beliefs and values, then any development which improves relationships and encourages communion between its members is positive (Lovell 1992:31). While I hope to use numbers of referrals as a way of measuring my success at promoting an awareness for the need to care for the spiritual dimension in each one of us, I also hope that my professional practice will encourage an attitude of care in the community of the hospital and promote a culture of trust and interconnectivity between its diverse but interdependent teams.

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