Out of Hours
Primary care chaplaincy:
a valid talking therapy?

The end of the Quality and Outcomes Framework (QOF) in Scotland from April 2017, I believe, heralds new opportunities for both clinician and patient alike. With the many benefits of QOF have come the negatives of the inverse care law,[1] the prevention paradox,[2] and target centredness. It is exciting to envisage new initiatives of person-centred care that can be organised around our patients as we form local practice clusters.

As a practice we have run one such service for several years — chaplaincy. This has been delivered, irrespective of faith or non-faith background, by our part-time chaplain, in line with Scottish Executive guidelines.[3] Our service is a synthesis of Prof. Hanlon's 'modern maladies' approach and Karis Medical Centre's 'deepest human needs' approach.[4] Prof. Hanlon has helpfully described modern maladies such as loss of wellbeing, obesity, addictive behaviours, and depression.[5] We use these presentations as cues that there may be an unmet deeper inner need such as significance or security that leads to a chaplaincy referral. Addressing these issues unsurprisingly involves time, hospitality in the form of listening and compassion, practical advice, and spiritual direction in the search for meaning in the midst of loss.

HELPING WITH THE SYMPTOMS OF DEPRESSION AND LOSS OF WELLBEING

It is well described that patients are living longer with increasing numbers of long-term conditions. One definition of health[6] encourages the concept of adapting and self-managing, which seems particularly relevant for patients with multimorbidity. Patients can be enabled to reach these health goals by receiving the holistic care described by Freeman, which was specifically inclusive of spirituality.[7] Having practised medicine for over 20 years I recognise that, although some patients may state a reductionist worldview, there are few patients who do not function as dualist interactionists and accept the concept of body–mind fusion. We have therefore found that patients are typically open to being referred to the practice chaplain.

The advantages of such in-house referral are numerous: close working relationship, ease of referral, and flexibility to operate without a waiting list. This is in stark contrast with other NHS 'talking therapies'. The government is keen to increase the availability and access to such talking therapies, and certainly primary care chaplaincy achieves this for our patients.

As with any service, evidence of effectiveness is important. In this case we chose to compare our chaplaincy service with antidepressants, which are seen by many patients as the solution to their symptoms of depression and loss of wellbeing.

We used the Warwick–Edinburgh Mental Wellbeing Scale (WEMWBS)[8] (a well-validated scoring tool where a mean improvement of 7 or more is clinically significant) to assess pre- and post-intervention wellbeing scores. Initially, there were 80 patients with complete datasets on antidepressants and 86 with complete datasets in the chaplaincy group. However, when those co-prescribed antidepressants were removed from the chaplaincy group the number fell to 45. Data were expressed as based on 86 where the mean improvement in WEMWBS was 7.3. The treatment effect was maintained in the 45 pure chaplaincy group with the mean rise in WEMWBS being 7.53. The final WEMWBS score was 80 days in both groups.

Baseline characteristics including sex, ethnicity, and age showed no statistically significant difference between the two groups. The mean baseline WEMWBS score was lower in the antidepressant group. We also found that patients with lower baseline scores had larger improvements in WEMWBS.

A REASONABLE ALTERNATIVE TO MEDICATION

The mean improvement in WEMWBS in the chaplaincy intervention group was 7.53 (95% CI = 4.86 to 10.21, $P<0.0001$), and in the antidepressant group 8.81 (95% CI = 6.79 to 10.83, $P<.0001$). The difference between these outcomes was not statistically significant.

It is recognised that this is a simple service evaluation with all the attendant biases of a retrospective observational study. However, it is interesting to note that primary care chaplaincy showed equivalent improvements in wellbeing to antidepressants.

In conclusion, the evaluation and our experience suggest that primary care chaplaincy is a valid talking therapy and could be considered as a reasonable alternative to medication. Perhaps as we enter this new post-QOF era we may be able to deliver such a service within our clusters. Perhaps we will be ticking new boxes such as wellbeing, enablement, and reduced prescribing with a consequent reduced burden of treatment, and perhaps patients will be helped to coexist with their dis-ease.

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ADDRESS FOR CORRESPONDENCE

Gordon Macdonald
Regent Gardens Medical Centre, 18 Union St, Kirkintilloch, Glasgow, G66 1DH, UK.
E-mail: Gordon.macdonald@nhs.net

Gordon Macdonald,
GP, Regent Gardens Medical Centre, Kirkintilloch, Glasgow.

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