UTS UNIVERSITY OF TECHNOLOGY SYDNEY

# Exploring the role and value of chaplains in Australian ambulance services: A mixed methods study

**by Katie Tunks Leach**

Thesis submitted in fulfilment of the requirements for
the degree of

**Doctor of Philosophy (Health)**

under the supervision of:
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January 2024

## Certificate of original authorship

I, Katie Tunks Leach, declare that this thesis is submitted in fulfilment of the requirements for the award of Doctor of Philosophy (Health), in the Faculty of Health at the University of Technology Sydney.

This thesis is wholly my own work unless otherwise referenced or acknowledged. In addition, I certify that all information sources and literature used are indicated in the thesis.

This document has not been submitted for qualifications at any other academic institution.

This research was supported by the Australian Government Research Training Program.

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Katie Tunks Leach

3 October 2023

## Acknowledgements

You would think that four and a half years is enough time to think this through and get it right, but I fear I may have forgotten someone. Please forgive me if I have. I would like to thank the following people, without whom this research would not be what it is today:

To my incredible supervisors Tracy, Jo and Paul. Thank you for your support, encouragement and patience. I am a better researcher because of your example and there aren't enough words to express my gratitude. Thank you to the University of Technology Sydney for providing an outstanding Doctoral studies program, and to Dr Campbell Aitken for his professional editing services performed in accordance with the Institute of Professional Editors' *Guidelines for editing research theses*. This research was supported by an Australian Government Research Training Program Scholarship.

Thank you to the paramedics, past and present, of NSW Ambulance. Your honesty, courage and vulnerability pointed me toward the need for this study. My sincere hope is that it results in a program that makes your life a little better. My thanks also to the chaplains who offered their insights. A special thanks to Kate, Heather and Biz who encouraged or challenged me when required and listened when I needed to think out loud or just plain vent.

And to the tribe of friends and family who stuck with me and got me through the last four and a half years, I am the luckiest person in the world to have you sharing the ride with me. A special thank you to my dear friend Clare – your unwavering support, patience and belief in me means more than you know. To my Mum and Dad for supporting me and showing me what hard work really looks like, I love you guys. To my Nan and Poppa, I still miss you every day and am so sad you didn't get to see me finish, but when you told me how proud you were of me, that meant everything. And to my darlings Wayne, Amélie and Claudia, you mean the world to me. Thank you for being my biggest cheer squad and the craziest, funniest humans I know. I wouldn't change a thing. Love you from the skies of heaven to the bottom of the universe.

# Statement of thesis format

This thesis is a thesis by compilation. It is a single manuscript comprising of chapters and publications arising from this research.

# Publications, presentations and collaborations

## Publications resulting from this research

**Tunks Leach, K**., Simpson, P., Lewis, J., & Levett-Jones, T. (2022). The role and value of chaplains in an Australian ambulance service: A comparative study of chaplain and paramedic perspectives. *Journal of Religion and Health*. https://doi.org/10.1007/s10943-022-01685-4

**Tunks Leach, K**., Simpson, P., Lewis, J., & Levett-Jones, T. (2022). The role and value of chaplains in the ambulance service: Paramedic perspectives. *Journal of Religion and Health 61*(2), 929–947. https://doi.org/10.1007/s10943-021-01446-9

**Tunks Leach, K**., Lewis, J., & Levett-Jones, T. (2020). Staff perceptions on the role and value of chaplains in first responder and military settings: A scoping review. *Journal of High Threat and Austere Medicine, 2*(1). https://doi.org/10.33553/jhtam.v2i1.25 (This journal is being migrated to the Cambridge Media platform, and the doi shown here no longer works. The article can be found at: https://journals.cambridgemedia.com.au/application/files/1616/8352/3487/Tunks.pdf)

## Other publications during candidature

Barker, M.-E., **Tunks Leach, K.**, & Levett-Jones, T. (2023). Patient's views of empathic and compassionate healthcare interactions: A scoping review. *Nurse Education Today, 131*, 105957. https://doi.org/10.1016/j.nedt.2023.105957.

Layson, M. D., **Tunks Leach, K.**, Carey, L. B., & Best, M. C. (2022). Factors influencing military personnel utilizing chaplains: a literature scoping review. *Journal of Religion & Health, 61*(2), 1155-1182. https://doi.org/10.1007/s10943-021-01477-2.

## Conference presentations resulting from this research

*Peer-reviewed conference presentations*

**Tunks Leach, K.**, Lewis, J., Simpson, P. & Levett-Jones, T., "I'm not religious, but thank god you're here": A mixed methods study exploring chaplains in Australian ambulance services (oral presentation). Australasian College of Paramedicine International Conference (peer-reviewed abstract accepted), Melbourne, September 2023.

**Tunks Leach, K.** & Levett-Jones, T., Soul care: Supporting clinicians to provide person-centred pastoral and spiritual care (oral presentation). 9th International Clinical Skills Conference, Together: Diversity and inclusion (peer-reviewed abstract accepted), Monash University, Prato Italy, 2023.

**Tunks Leach, K.**, Simpson, P., Lewis, J. & Levett-Jones, T., Caring for the carers: Qualitative findings from an exploratory study on the role and value of chaplains in an Australian ambulance service (oral presentation). 4th International Nordic College of Caring Science and European Academy of Caring Science Conference, Caring in a changing world (peer-reviewed abstract accepted), Mälardalen University, Sweden, 2022.

**Tunks Leach, K.**, Lewis, J., Simpson, P. & Levett-Jones, T., Ambulance chaplaincy: A mixed methods project to improve paramedic spiritual support (oral presentation). Australian and New Zealand Mental Health Association, 2022 Frontline Mental Health Conference (peer-reviewed abstract accepted), Gold Coast Australia, March 2022.

**Tunks Leach, K.**, Lewis, J., Simpson, P. & Levett-Jones, T., Exploring the role and value of chaplains in the ambulance service: Paramedic perspectives (oral presentation). Annual International Paramedicine Research Conference 2021: Global Developments in Paramedic Research (peer-reviewed abstract accepted), Online, 1 December 2021.

**Tunks Leach, K.**, Lewis, J., Simpson, P. & Levett-Jones, T., Exploring the role and value of chaplains in the ambulance service: Paramedic perspectives (oral presentation). Australasian College of Paramedicine International Conference (peer-reviewed abstract accepted), Online, November 2021.

**Tunks Leach, K.**, Lewis, J. & Levett-Jones, T., Staff perceptions on the role and value of chaplains in first responder and military settings: A scoping review (oral presentation). Paramedicine Research Symposium (peer-reviewed abstract accepted), Frankston, Victoria, November 2019.

*Invited presentations*

**Tunks Leach, K.**, What is the role of spiritual care in frontline services? Institute for Ethics and Society Researchers in Spirituality (Online), University of Notre Dame, Sydney, October 2022.

**Tunks Leach, K.**, Chaplaincy: past, present and future. Chaplaincy Australian – NSW/ACT annual conference, Terrigal, March 2022.

**Tunks Leach, K.**, Reconnecting with yourself and others. Wellbeing Australia, First Responder Wellbeing Summit (online), February 2022

**Tunks Leach, K.**, Exploring the role and value of chaplains in the ambulance service: Preliminary results from the paramedic perspective. New South Wales Ambulance Chaplains annual conference, Stanmore House, Sydney, May 2021.

**Tunks Leach, K.**, Staff perceptions on the role and value of chaplains in first responder and military settings: An exploration of the literature and early research insights. Navy Chaplains annual conference, HMAS Penguin, Sydney, March 2021.

**Tunks Leach, K.**, Does chaplaincy have a role in secular Australia? Anglican Deaconess Ministries, online conference, January 2021.

**Tunks Leach, K.**, Ambulance Chaplaincy: The Bushfires and Beyond. Anglican Deaconess Ministries, Engage Evening, February 2020.

**Tunks Leach, K.**, Exploring the role and value of chaplains in the ambulance services: A proposed PhD project. New South Wales Ambulance Chaplains annual conference. Stanmore House, Sydney, November 2019.

**Tunks Leach, K.**, Exploring the role and value of chaplains in the ambulance services: A PhD project. Centre of Interprofessional Collaboration within Emergency Care (CICE) Conference, Vaxjo, Sweden, October 2019.

## Collaborations resulting from this research

Mats Holmburg (November 2022) Sörmland Ambulance, Sweden – Development of a staff wellbeing video

Collaborative paper with the Australian Defence Force Anglican Chaplaincy research team: Layson, M. D., **Tunks Leach, K.**, Carey, L. B., & Best, M. C. (2022). Factors influencing military personnel utilizing chaplains: A literature scoping review. *Journal of Religion and Health, 61*(2), 1155-1182. https://doi.org/10.1007/s10943-021-01477-2

Russell Meyers and Louise Reynolds (February 2022): *Providing relational support to paramedics after a bad call* (editorial), Minnesota, United States of America. https://www.ems1.com/ems-products/fitness-mental-health-wellness/articles/providing-relational-support-to-paramedics-after-a-bad-call-QQiYplWCbMBsJZwD/

Carina Elmquvist, Mats Holmburg, Anders Svensson (October 2019) *Preparing for the job, building resilience* (video), Växjö University, Sweden.

## Statement of contribution of authors

Conception and design of each publication, data collection, data analysis and interpretation of data was conducted by Katie Tunks Leach under the supervision of Distinguished Professor Tracy Levett-Jones, Associate Professor Joanne Lewis and Associate Professor Paul Simpson. Katie Tunks Leach drafted all publications, with guidance and edits by Distinguished Professor Tracy Levett-Jones, Associate Professor Joanne Lewis and Associate Professor Paul Simpson. All authors approved the final versions of manuscripts prior to submission.

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## Fellowships, awards and funding granted as part of this thesis

2023 Vice Chancellor’s Post Graduate Research Students Conference Fund – $3,000

2022 Funding from UTS for open access publication – $4,000

2021 Three Minute Thesis Award – Faculty of Health Runner Up

2021 Funding from UTS for open access publication – $4,000

2021 Australian Government Research Training Stipend – $28,597

2020 Higher Degree Research Student Development Award – $3,000

2020 Anglican Deaconess Ministries Senior Research Fellowship – $48,000

2019 Research Development Program ‘Shark Tank’ Award – $1,750

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## Abstract

### *Introduction*

This thesis by compilation explores the provision of chaplaincy and spiritual care in Australian ambulance organisations. Contemporary research has demonstrated that occupational and organisational pressures have resulted in paramedics experiencing higher rates of bio-psycho-social ill-health than the average population, resulting in ambulance organisations implementing staff wellbeing teams. A growing body of evidence demonstrates strong connections between people's spiritual/religious beliefs and health outcomes, but to date, few studies have examined the role of spiritual care in ambulance services or its impact on paramedic wellbeing, and none in Australia. Therefore, the aim of this study was to explore the role and value of chaplains in Australian ambulance services.

### *Methods*

This exploratory sequential mixed methods study was guided by four research questions: (1) Who uses ambulance chaplaincy? (2) What is the role of chaplains in Australian ambulance services? (3) How do chaplains add value to Australian ambulance services? and (4) What factors impact a chaplain's effectiveness? To answer these research questions, the study began with semi-structured interviews with paramedics and chaplains in one jurisdictional ambulance service (Phase 1). The findings from Phase 1 informed the development of a survey (Phase 2), which was distributed to registered paramedics across Australia to test whether the findings identified in Phase 1 were consistent with the views of the wider paramedic population (Phase 3).

### *Results*

Qualitative findings from interviews with 17 paramedics and 13 chaplains were integrated with the 150 quantitative/survey responses to answer the research questions. While personal beliefs were important in determining whether paramedics would seek chaplain support, pre-existing relationships were also influential. The ambulance chaplain's role included providing relational care to paramedics in their workspaces, and to bystanders at significant jobs. Incorporating not only spiritual care but emotional, psychological and social care, this

proactive frontline role involved skills including listening, assessment and supportive conversations. Chaplain care was perceived to promote emotional, psychological and spiritual wellbeing, reduce barriers to help-seeking, and facilitate specialist referrals. How ambulance organisations implemented chaplaincy programs, including employing the right chaplains and providing clear role descriptions, influenced the effectiveness of chaplaincy programs.

### *Conclusion*

Findings from this study show that ambulance chaplains have a valued and valuable role. With the right skillset and in the presence of professional caring relationships, chaplains can promote paramedic wellbeing in their workplaces, regardless of personal beliefs. However, the perceived religiousness of chaplains and poor organisational implementation of the role deters some paramedics from seeking chaplain support. To enhance ambulance chaplaincy programs, organisations should ensure minimum education levels for chaplains, that role descriptions and frameworks for practice align with contemporary evidence-based spiritual care, and that chaplaincy care is paramedic-centred.

## List of definitions

**Atheist**: A personal identity that incorporates ethics, cultural practices and affective states through a "without God" worldview (Newheiser, 2022).

**Chaplain or spiritual care practitioner**: "Someone appointed and recognised as a specialist in the provision of spiritual care. The practitioner may be paid or unpaid, providing spiritual care to individuals through person-centred, relational, supportive and holistic care, seeking out and responding to expressed spiritual needs. This may include managing requests from an individual for a faith representative of their choice" (Spiritual Care Australia, 2023, p. 42).

**Critical incident or significant job**: "Any situation faced by emergency workers that causes them to experience unusually strong emotional reactions which have the potential to interfere with their ability to function either at the scene or later" (Australian Institute for Disaster Resilience, n.d.).

**Non-religion**: No consensus definitions were identified for this term. For the purposes of this thesis, non-religion refers to people who do not identify with organised religion, but may **choose** to self-identify as spiritual.

**Religion**: "Religion involves beliefs and practices related to the transcendent", relying on rules to guide behaviour and doctrines on what happens after death (Koenig, 2015, p.19).

**Spiritual care**: Spiritual care "encompasses all the ways in which attention is paid to the spiritual dimension of life. It is most commonly offered in a one-to-one relationship, is person-centred and makes no assumptions about personal conviction or life orientation. It offers a way for people to make meaning of their lived experience. Spiritual care is provided by practitioners to appropriately meet the individual's spiritual and emotional needs. Spiritual care may include presence, conversations, ritual, ceremonies and sharing of sacred texts and resources. Spiritual care is not proselytising and does not impose the practitioner's beliefs or values" (Spiritual Care Australia, 2023, p. 42).

**Spirituality**: "Spirituality is a dynamic and intrinsic aspect of humanity through which persons seek ultimate meaning, purpose, and transcendence, and experience relationship to

self, family, others, community, society, nature, and the significant or sacred. Spirituality is expressed through beliefs, values, traditions, and practices" (Puchalski et al., 2014, p. 646).

**Wellbeing**: "Wellbeing is a state of positive feelings and meeting full potential in the world. It can be measured subjectively and objectively using a salutogenic approach" (Simons & Baldwin, 2021, p. 984).

# List of abbreviations

| | |
|---|---|
| COVID-19 | coronavirus disease 2019 |
| CPR | cardiopulmonary resuscitation |
| CVI | content validity index |
| EMS | emergency medical services |
| FA | framework analysis |
| FWCI | field-weighted citation impact |
| HREC | Human Research Ethics Committee |
| NHMRC | National Health and Medical Research Council |
| NSWA | New South Wales Ambulance |
| PTG | post-traumatic growth |
| PTSD | post-traumatic stress disorder |
| UTS | University of Technology Sydney |
| WHO | World Health Organization |

*Things happen in your life, terrible things, great obliterating events, where the need for spiritual consolation can be immense, and your sense of what is rational is less coherent and can suddenly find itself on very shaky ground. We are supposed to put our faith in the rational world, yet when the world stops making sense, perhaps your need for some greater meaning can override reason.*

Nick Cave (2022) *Faith, Hope and Carnage*

# Chapter 1 – Introduction

*What we do is not a normal job, we are there to help those Australians who are having the worst or last days of their life, and we do it because we care.*
(Pat Jones, Commonwealth of Australia, 2019, p. xi)

## 1.1 Introduction

Paramedics provide out-of-hospital care to the Australian population 24 hours a day, seven days a week, frequently in settings that involve trauma or danger. The intense emotions generated by these experiences, along with other operational challenges such as perceived lack of organisational support, can have a profound impact on paramedics' health and wellbeing (Bevan et al., 2022; Lawn et al., 2020). Rates of anxiety, depression and post-traumatic stress disorder (PTSD) among paramedics are higher than in the general population (Hoell et al., 2023; Petrie et al., 2018), and there have been calls for urgent action to address the underlying causes (Lawn et al., 2019; Phelps, 2018; Varker et al., 2018). The provision of staff support, such as chaplaincy, by paramedic services is considered a key method of ameliorating psychological distress (Beyond Blue Ltd, 2018; Petrie et al., 2018; Phelps, 2018), but chaplaincy and most other interventions have not been evaluated (Claringbold et al., 2022; McCreary, 2019). Indeed, little is known about what ambulance chaplains do in their role, what paramedics think of it, or if they perceive benefit from it.

In the study presented in this thesis, I explored the role and value of chaplains in Australian ambulance services, prioritising the perspectives of paramedics through seeking their voices in interviews and a survey. Using an exploratory sequential mixed methods design, I sought to understand the role ambulance chaplains play in staff wellbeing programs, and how ambulance chaplaincy can improve paramedic wellbeing.

## 1.2 Paramedicine in Australia

### *1.2.1 Who are paramedics and what do they do?*

People that provide out-of-hospital emergency care are known by different names depending on the country in which they practice. For example, in the United States they are sometimes called emergency medical technicians, or in Sweden, ambulance nurses. In Australia, the people who provide this care are known as paramedics, but are sometimes also referred to as first responders. Paramedicine is "a domain of practice and health profession that specialises across a range of settings including, but not limited to, emergency and primary care" (Williams et al., 2021, p. 3568). From 2018, the required entry-to-practice qualification for paramedics was a university degree from a Paramedicine Board of Australia-approved university program (Paramedicine Board, 2022b). Along with the theoretical and practical knowledge and skills required to undertake the role, these programs offer content aimed at promoting paramedic wellbeing from the outset of their careers.

The Australian paramedic's scope of practice is vast, spanning major and acute critical illness through to minor presentations (e.g., soft tissue injuries) and interfacility transfers. In one shift a paramedic may preform cardiopulmonary resuscitation (CPR), treat asthma, transport a child with a broken limb, provide care to people experiencing drug or alcohol-related problems, or help an elderly patient return to their usual residence. Additionally, paramedic practice will vary according to location (Australia includes sprawling cities housing millions and extremely remote and sparsely populated areas), and by their qualifications and specialisation (e.g., intensive care paramedic, extended care paramedic, retrieval paramedic and/or community care paramedic) (Johnston & Acker, 2016; Ross et al., 2022; Wilkinson-Stokes, 2021). These factors, along with COVID-19, high patient acuity, large workloads and extended working hours with few or no breaks, have been shown to affect paramedic wellbeing (Lawn et al., 2020; Lipman et al., 2021).

### *1.2.2 Paramedic health and wellbeing*

The decade to 2023 saw a considerable increase in research into paramedic health and wellbeing, producing much evidence on the impacts of paramedic work and working conditions (Lawn et al., 2020; Lipman et al., 2021; Meadley et al., 2020). Paramedic health

and wellbeing is influenced by factors in their environment, as well as their individual characteristics. Environmental factors include repeated exposure to trauma, physical and verbal violence, perceived lack of support and/or belonging in the workplace, and exposure to strong emotions that result in identification with patients, compassion fatigue, stigma, guilt and shame (Hutchinson et al., 2021; Jonsson & Segesten, 2004; Lawn et al., 2020; Phoenix Australia, 2016; Renkiewicz & Hubble, 2021). Individual characteristics contributing to health outcomes include disruption to core beliefs, individual coping mechanisms and vulnerability to mental health conditions (Halpern et al., 2012; Koenig, 2012; Lawn et al., 2020; Surgenor et al., 2020).

Holistic approaches to health and wellbeing consider emotional, physical, psychological, social and spiritual factors (New South Wales Health, 2022; Spiritual Health Association, 2021). While these factors are inextricably linked, I consider the research on each separately herein. Emotional wellbeing focuses on a broad scope of feelings, including positive emotions, relative absence of negative emotions, life satisfaction, and satisfaction with work and relationships (Feller et al., 2018; Park et al., 2022). Studies in paramedicine have identified connections between individual coping strategies and positive/negative health outcomes (Avraham et al., 2014; Kirby et al., 2011). Additionally, workplace experiences and exposure to major life events – especially those invoking strong emotions, such as the death of children, or occupational violence – can reduce wellbeing (Boland et al., 2018; Shakespeare-Finch & Daley, 2017).

Paramedic work has been shown to decrease physical wellbeing. Musculoskeletal injuries, including back and upper limb injuries, result in high rates of workers' compensation claims, while fatigue and alterations to sleep patterns erode physical and mental ill-health (Lawn et al., 2019; Maguire et al., 2014). Some studies have highlighted the need for further research on the effect of elevated cortisol levels and inflammatory markers bought on by sleep deprivation and fatigue on health concerns such as cardiovascular disease and obesity (Hegg-Deloye et al., 2014; Wolkow et al., 2015).

Social factors at work and at home can reduce paramedic health and wellbeing. For example, physical and mental fatigue resulting from high workload, lack of support, poor communication, shift work, tension with colleagues, and the unpredictable nature of the

paramedic's work, including being on call, can prevent paramedics from connecting with their social circles (Beyond Blue Ltd, 2018; Halpern et al., 2009; Lawn et al., 2019). Outside of the workplace, fatigue, work–home conflict and self-stigma can result in social withdrawal (Beyond Blue Ltd, 2018; Commonwealth of Australia, 2019; Lawn et al., 2019). Studies have identified social support as a protective buffer against some physical and psychological health problems (Aasa et al., 2005; Shakespeare-Finch & Daley, 2017).

Adverse mental health outcomes are a significant concern for paramedic organisations and are perceived to be the primary target of most wellbeing programs (Phung et al., 2022). The pressures and experiences identified above can result in moral injury, PTSD, depression, anxiety and suicidal thoughts (Commonwealth of Australia, 2019; Davis et al., 2019; Lawn et al., 2020; Rosen et al., 2022; Varker et al., 2018) . Hoell et al. (2023) estimated that up to 20% of ambulance staff experience PTSD, compared with an estimated rate of 4% in the general Australian adult population. Furthermore, Beyond Blue Ltd (2018) identified that 6.5% of ambulance employees had suicidal thoughts and 2% reported a suicide plan (compared with 0.6% of the general population).

The role of moral injury in first responders is receiving increasing focus. Moral injury is defined as the "psychological, biological, behavioural, social and spiritual sequelae arising from exposure to potentially morally injurious events […] which entail perpetrating, failing to prevent, bearing witness to or learning about acts that transgress deeply held moral beliefs and expectations" (Litz et al., 2009, p. 700). Recent studies have shown that first responder exposure to potentially morally injurious events result in psychological and spiritual ill-health and functional impairment, with contemporary studies on moral injury increasingly focusing on treatment that includes both psychological and spiritual approaches (Ritchie et al., 2023; Tappenden et al., 2023).

Spiritual health and wellbeing in paramedics is an area in which there is very little research, with most work on spiritual care having taken place in the palliative care setting (Best et al., 2023). According to one cross-cultural and multilingual validated tool (for those living with cancer), spiritual wellbeing includes relationship with self, relationship with others, relationship with someone or something greater, and existential elements (Vivat et al., 2017). A search of the literature since 2013 identified no peer-reviewed studies on the connection

between paramedic spirituality and their wellbeing outcomes. One book chapter discusses paramedicine and spirituality more broadly, but the authors also identify the absence of research literature on the topic (Lazarsfeld-Jensen & O'Meara, 2018). While some other first responder literature has explored concepts like relationships, meaning, purpose, guilt, shame, helplessness, vulnerability and intense compassion experienced by paramedics from a psychological perspective (Halpern et al., 2009; Hamling, 2018; Jonsson & Segesten, 2004), there is no published literature on these issues in the context of spiritual wellbeing or spirituality in paramedicine.

### *1.2.3 Services to support paramedic wellbeing*

In 2016, an Australian mental health agency commenced a study designed to improve understanding of the mental health and wellbeing support needs of first responders (Beyond Blue, 2020). Of the paramedic cohort, 42% of respondents indicated a need for staff support (Beyond Blue Ltd, 2018). A recent Australian Senate inquiry into the mental health of first responders also highlighted the need for action to implement support strategies to protect first responder mental health. Recommendation 12 is that "early intervention mental health support services be made available to all employees of first responder organisations with the aim of preventing or reducing the severity of mental health conditions" (Commonwealth of Australia, 2019, p. viii).

First responders in the Beyond Blue Ltd (2018) research identified using a range of wellbeing resources, both internal and external to their organisations. Internal support options provided by Australian ambulance services included physiotherapy, nutrition and dietetics, peer support, domestic violence support, family support, legacy support (for retired staff) psychologists and chaplaincy programs (Ambulance Victoria, 2016; Beyond Blue Ltd, 2018; New South Wales Ambulance, 2020).

Outside of ambulance organisations, general and targeted physical, mental and social support services exist to support paramedic wellbeing (Fortem Australia, 2022; Phoenix Australia, 2022). For example, paramedics can access general medical practitioners, community psychologists and first responder support groups. Additionally, Employee Assistance Programs, health and wellbeing programs paid for by ambulance organisations but provided

by external providers to provide psychological, spiritual and social support, are standard in Australia.

Despite the progress made in the provision of staff support programs for paramedics, evidence of their effectiveness with regard to their impact on paramedic health and wellbeing remains scarce (Claringbold et al., 2022; McCreary, 2019). This is equally true of paramedic chaplaincy and spiritual care.

## 1.3 Spiritual care and its impact on wellbeing

### *1.3.1 What is spiritual care and why does it matter?*

According to the World Health Organization (WHO), "health is a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity" (World Health Organization, 1946). The recognition, inclusion and exclusion of spirituality in this definition has a complicated history, but in recent decades the WHO has acknowledged the need to revisit the connection between religion, spirituality and health due to the identification of a connection between people's beliefs and their health choices, and religious leaders' roles in health education (Peng-Keller et al., 2022). For example, in light of the COVID-19 pandemic, individual beliefs, religion and religious activities were identified as playing a significant role in super-spreader events, but also the sharing of health promotion information and reducing the spread of misinformation (Peng-Keller et al., 2022). There is increasing recognition that "secularism remains the exception rather than the rule in global health", and of the need to incorporate spirituality as the fourth dimension of public health, resulting in a combined bio-psycho-social-spiritual approach to health and wellbeing (Dhar et al., 2013; Peng-Keller et al., 2022, p. 228).

There are many definitions of spirituality. For this study, I chose to use a Puchalski et al. (2014) consensus definition derived from a large group of ethnically diverse people from faith and non-faith backgrounds alike:

> "Spirituality is a dynamic and intrinsic aspect of humanity through which persons seek ultimate meaning, purpose, and transcendence, and experience relationship to

self, family, others, community, society, nature, and the significant or sacred. Spirituality is expressed through beliefs, values, traditions, and practices." (p.646)

This definition allows for and embraces people of all beliefs and none, acknowledging the inherent need for humans to connect with themselves and others with regard to meaning, purpose and transcendence (the ability to see beyond the limitations of the current situation and/or suffering) (Weathers et al., 2016). Under the broad umbrella of spirituality, we find subthemes including religion, atheism, agnosticism and spiritual-but-not-religious, among others.

Numerous researchers have explored the connections between spirituality and mental, physical, emotional and social health outcomes. In a systematic review of over 3300 quantitative studies, Koenig (2012, 2015) concluded that spirituality had a significant impact on mental health, health behaviours and physical health. With regards to mental health, the review identified positive associations between people who are spiritual/religious and the ability to cope with adversity, wellbeing and happiness, and meaning and purpose. Furthermore, inverse relationships were noted between rates of depression, anxiety, suicide and substance abuse, and spiritual/religious belief (Koenig, 2012, 2015). When examining health behaviours and physical health, those who were more spiritual/religious were found to smoke less, exercise more, and demonstrate less risky sexual behaviours, but were more likely to be overweight (Koenig, 2012). People who were more spiritual/religious were also found to have lower rates of coronary heart disease and hypertension, and better immune function (Koenig, 2012, 2015).

Other studies have identified that spirituality/religiosity or a personal moral compass can promote healthy behaviours, serve as a coping resource and social support system, facilitate meaning-making, influence decision-making, and promote resilience and post-traumatic growth (PTG) (Bray, 2013; Fletcher & Sarkar, 2013; Grych et al., 2015; Iacoviello & Charney, 2014; Sharma et al., 2017; Tsai et al., 2015). PTG encompasses the "positive psychological changes experienced as a result of the struggle with traumatic or highly challenging life circumstances" and is best understood when biomedical models are combined with other models of health, including existential and spiritual/philosophical models (Tedeschi et al., 2018, p. 3). Participation in spiritual or religious activities may

predispose people to PTG by helping them create meaning around critical events and their place in the world (Tedeschi et al. (2018).

Lazarsfeld-Jensen and O'Meara (2018) suggested that empathy and resilience are the result of spiritual exercises designed to nurture the human spirit, and are essential tools for paramedic coping. They added that sickness is not inevitable, and employers and educators have a responsibility to educate paramedics on empathy and resilience, therefore equipping staff with skills to self-heal, and reduce the potential for cynicism, burnout, compassion fatigue and traumatic stress injuries (Lazarsfeld-Jensen & O'Meara, 2018).

### *1.3.2 Provision of spiritual care in the Australian context*

Since European colonisation, spiritual care in Australia has traditionally been provided by people who identify as chaplains. Stemming from the 4th century CE, chaplaincy's origins go back to St Martin de Tours, a Roman centurion who split his cape (*cappa*) in half to share with a poor beggar (Carey et al., 2016). The cape was subsequently preserved in a special tent and later chapel, where it was cared for by chaplains appointed by the king (The Editors of Encyclopaedia Britannica, 2023). The role and responsibilities of chaplains increased to include both religious and secular service to monarchs (The Editors of Encyclopaedia Britannica, 2023). In Western countries, for hundreds of years, ministers of religion (predominantly Christian) educated at theological schools to lead congregations, with no specific training in chaplaincy, were considered sufficiently equipped to be chaplains (Cadge et al., 2020). However, in recent years, as the role of spiritual care in person-centred holistic approaches has been increasingly acknowledged, there has been a move away from exclusively religious care to a more professional, spiritually diverse and evidence-based approach, including the use of new and more inclusive terms like "spiritual care practitioner" (Holmes, 2021).

Basic requirements in terms of education and standards of practice as chaplains or spiritual care practitioners in Australia are applied inconsistently across organisations and faith/belief communities. Two professional spiritual care organisations have developed professional standards and frameworks (Spiritual Care Australia, 2020, 2023; Spiritual Health Association, 2022), but their use is optional. Furthermore, there are no mandated minimum

education levels that must be reached in order to practise as a spiritual care practitioner. Practitioners receive theological or religious training from (or with the endorsement of) their faith/belief communities, but the skills included in these programs are variable. While there are undoubtedly some exceptionally qualified and experienced chaplains, many do not recognise person-centred and research-informed approaches to the provision of spiritual care (Hall et al., 2016; Nolan, 2021). At the time of writing, Clinical Pastoral Education was the only religiously unaffiliated program in Australia that met the needs of people wishing to practise as chaplains by giving equal recognition to the value of spiritual/religious education, adherence to educational pedagogy, and the behavioural sciences (Australia and New Zealand Association for Clinical Pastoral Education, 2022).

The changing landscape of Australian religious and spiritual orientation requires explanation. The most recent Australian census identified that the proportion of citizens identifying as Christian continued to decline, while the proportions of those identifying as having "no religion" or belonging to religions other than Christian increased (Australian Bureau of Statistics, 2022a). This shift has resulted in some calling for the removal of chaplains from public institutions altogether, and others to call for increased diversity in spiritual care practitioners to accommodate changing spiritual needs. However, contemporary spiritual care researchers have identified problems with this false dichotomy of "religious-or-not-religious". For example, recent studies show younger Australians are defining spirituality in more diverse ways beyond basic "religious" and "not religious" labels, instead believing that spirituality is an individual experience while religion is more about communal expressions of belief, and people can be spiritual but not religious (Ebejer, 2018; McCrindle & Spiritual Health Association, 2021). Further research into these perspectives is required.

## 1.4 Spiritual care in paramedicine

Having identified the unique challenges paramedics experience in the course of their work (see 1.2.2 Paramedic health and wellbeing), the importance of ambulance organisations taking a multi-pronged approach to staff health, and the impact of spirituality and religion on a person's health and wellbeing, I sought to understand the role of chaplains in ambulance services. In Australia, ambulance chaplains operate in five states and two territories, some paid but most as volunteers. At the time of writing, there were an estimated to be a little over

100 chaplains in Australia: 50 in New South Wales (one paid), 29 in Victoria (seven paid part- or full-time), 27 in Queensland, three in the Australian Capital Territory (providing care to all first responder agencies), and one in the Northern Territory and Western Australia (New South Wales Ambulance, n.d.-a; Queensland Ambulance Service, 2018; St John Ambulance Australia Ltd, 2021). Ambulance chaplains are described as:

> … part of a multidisciplinary support team that provides non-judgmental support to Ambulance staff and their families as well as support to bystanders at traumatic incidents. [They] assist with the provision of 24/7 post-incident support and pastoral care. This may occur at the scene of an incident, a workplace, a home or a hospital. Chaplains also provide spiritual guidance or help to access other faith-based care or welfare services and may be requested for a baptism, wedding, funeral or other ceremony. (New South Wales Ambulance, n.d.-b).

Chaplains may be approached directly by paramedics, or contacted by managers or control centres to visit people or ambulance stations and provide support.

Criteria for the recruitment and selection of ambulance chaplains were not available for all states and territories. In two publicly available descriptions, chaplain-specific requirements were summarised in a broad statement on accreditation for ministry or ordination from "a denomination having official status with the National Council of Churches and/or the [State-based] Ecumenical Council", a certificate or experience in pastoral care or chaplaincy, and successful completion of a Clinical Pastoral Education module or similar (Ethical Jobs, 2022; New South Wales Government, 2023). Neither of these descriptions specifically identifies a role for non-faith practitioners, but in one, "experience in delivering and providing high quality pastoral care and chaplaincy services" was an alternative selection criterion to accreditation from within a faith community (Ethical Jobs, 2022).

Literature on ambulance chaplaincy is limited to the perspectives of chaplains themselves. For example, Myers (2019, 2021), in his editorials on emergency medical services (EMS) chaplaincy, provided examples of the types of jobs ambulance or EMS chaplains may be required to attend, as well as the activities that a chaplain might undertake. Another author stated that ambulance chaplains support staff prior to, during and after significant events,

building trust and rapport through visiting stations, going “on-road” in ambulances with crews, and attending critical incidents to provide immediate practical and emotional support and post-incident support if required (Power, 2018). I could identify no historical or contemporary research-based literature on the role of ambulance chaplains.

## 1.5 Problem statement

The literature on chaplaincy and spirituality contains much about the associated health outcomes. Chaplains’ activities and their roles in organisations, including in the military and healthcare sectors, have received particular attention, especially in the United States and European contexts (Cadge & Rambo, 2022). Additionally, a large body of high-quality literature has demonstrated the connections between people’s spiritual and religious beliefs and their health outcomes (Koenig, 2012, 2015). However, no previous researchers have studied the role of chaplains within ambulance services, or the activities they undertake as part of this role. Furthermore, no studies have explored what paramedics themselves believe works (or not) to maintain or improve their health and wellbeing. Including person-centred perspectives – or in this study, paramedic-centred perspectives – is essential to create a better understanding of this phenomenon and more effective interventions for the recipients of chaplaincy and spiritual care (Lawton & Cadge, 2023).

## 1.6 Aim of study

The overarching aim of this study was to explore the role and value of chaplains in Australian ambulance services.

## 1.7 Research questions

The overarching research question was: What is the role and value of chaplains in Australian ambulance services? The following sub-questions were used to guide the study:

1. Who uses ambulance chaplain support?
2. What is the chaplain’s role in Australian ambulance services?
3. How do chaplains add value to Australian ambulance services?
4. What factors impact a chaplain’s effectiveness?

## 1.8 Researcher's motivation and position

My motivation for researching this topic arose from my roles as a senior emergency and trauma nurse, and in more recent years as a volunteer chaplain for New South Wales Ambulance (NSWA), Australia's largest ambulance service. For over 25 years I have stood alongside my paramedic peers and shared significant and often tragic experiences. I have trained for major incidents alongside them, cried and laughed with them, often hiding and internalising intense feelings like guilt and shame along with them. We trained and practised in an era when you were told to "harden up or get out". When I started to lose my nursing and paramedic peers to mental illness and suicide, I knew that something had to change, but at the time I had no idea what.

By 2018, I was working as a nurse academic at a university. My interest in health, wellbeing and spiritual care was growing rapidly, and I began to work as a volunteer chaplain in NSWA. Without any chaplain-specific training, I asked for resources to guide my practice. Instead of research papers and multifaith resources, I was given two books written by Christian chaplains on their experiences, neither of which were about ambulance chaplaincy. This concerned me, not only because of the lack of resources to guide me as a practitioner, but because there appeared to be no clear evidence on what paramedics themselves wanted or needed from spiritual care. I decided to undertake this PhD as a chaplain-researcher, and play my part in ensuring paramedics received evidence-based and research-informed spiritual care that was tailored to their context.

In light of contemporary discussion on chaplaincy as being process- or outcomes-based, I feel it is important to declare my position early in this thesis. I am passionate about adopting person-centred approaches that meet the needs of spiritual, religious and non-religious people alike, and appreciate these journeys are frequently not linear or simple. As a chaplain, I seek to make time and space to be with people and allow them to drive the interaction. However, I have worked in the public health system long enough to know that two things – money and evidence – dominate, and that they are inextricably linked. Without evidence that something works for patients, it will not be funded and may in fact be removed altogether. I therefore

adhere to the school of thought that chaplaincy is both process- and outcomes-based, with these being two sides of the same coin (Damen, Schuhmann, Leget, et al., 2020). In undertaking research and generating evidence, the quality and process of spiritual care provision can be improved, and the legitimacy of spiritual care can be demonstrated to the wider healthcare community (den Toom et al., 2022).

## 1.9 Significance of study

Most chaplaincy research papers do not originate from Australia, and the small number that do focus on healthcare chaplaincy (Advocat et al., 2023; Holmes, 2021). While the types of chaplaincy covered in these papers share some similarities with ambulance chaplaincy, there are notable differences. For example, there is a need for paramedics' perspectives on the impact of chaplain care, essential and desirable requirements of chaplains in the ambulance context, objective measures of the effect of chaplain care on paramedic wellbeing, chaplain care of staff, bystanders and other first responders, how to strengthen the profile of ambulance chaplaincy, and ambulance chaplain education and certification (Cadge & Rambo, 2022; Damen et al., 2018; Damen, Schuhmann, Lensvelt-Mulders, et al., 2020; Fitchett, 2017).

While my study prioritised paramedics' perspectives on the role of ambulance chaplaincy, it included chaplains' perspectives in order to obtain a more complete picture of the work of ambulance chaplains in caring for staff. It also provided paramedics' perspectives on the perceived impact of chaplaincy on their wellbeing, as well as identifying who uses chaplains, and whether chaplains are regarded as only for spiritual or religious paramedics. My findings about these issues can be used to:

- Develop training programs targeted to meet the specific needs of ambulance chaplains, equipping them to better meet the spiritual wellbeing needs of paramedics;
- Generate role descriptions to facilitate recruitment of the most appropriate candidates as ambulance chaplains;
- Provide evidence-based recommendations and representation to Australian ambulance organisations on how to incorporate paid and professional spiritual care within staff

wellbeing programs, as well as develop and implement policies and frameworks for ambulance chaplain practice;

- Provide evidence-based recommendations to other first responder wellbeing researchers, and support organisations other than ambulance services to provide effective and inclusive spiritual care for members; and
- Contribute an ambulance perspective to the ongoing professionalisation of spiritual care in Australia that aims to better meet the needs of people of all faiths and spiritualities.

## 1.10 Impact of COVID-19 on this study

My research began before the COVID-19 pandemic; I had drafted this chapter and the scoping review, designed the study, and submitted an ethics application for the qualitative interviews. While I was waiting for ethics approval, the COVID-19 virus arrived in Australia. In the state where I lived, a full lockdown was initiated, meaning most people were required to work and study from home, prohibited from going more than five kilometres from home, and allowed to leave home for only one hour each day. The main impact on my research was lack of time and space to think uninterrupted, due to working from the kitchen bench with three other people in the house, two of whom required supervision for their schooling due to attention deficit hyperactivity disorder. Additionally, research into COVID-19-related matters took precedence, and ethics approval for my work was delayed for nearly six months.

When I received ethics approval in May 2020, I began conducting interviews. Because I was employed within the ambulance service, I received permission to conduct interviews under a set of conditions including passing mandatory temperature checks, cleaning rooms before and after interviews, and social distancing (mask wearing had not yet begun). If I was not an employee of NSWA this permission would not have been given, and I am very grateful for the support of NSWA. As COVID-19 had not infected many people in Australia when interviews commenced, there was little discussion of it by paramedics and I was able to proceed with my original research plan. Some paramedics elected to participate in the interviews over the phone instead of in person, but I had planned to do this prior to the pandemic so as to capture the perspectives of those who lived in in regional and remote areas whom I would not otherwise have been able to interview.

## 1.11 Structure of thesis

This thesis by compilation has seven chapters (*Figure 1*). The first three chapters set the scene for my research.

In this chapter (Chapter 1), I establish the context for the study, outline the challenges and threats to paramedic wellbeing identified in the literature, describe the steps currently being taken to combat these problems, note the lack of evidence supporting spiritual care in the paramedicine context, and summarise research about the impact of peoples' spiritual and religious beliefs on their health and wellbeing. I conclude chapter one by identifying the gap in the literature I aimed to fill, presenting the aim and research questions underpinning the study, and outlining its significance for ambulance services and paramedic wellbeing.

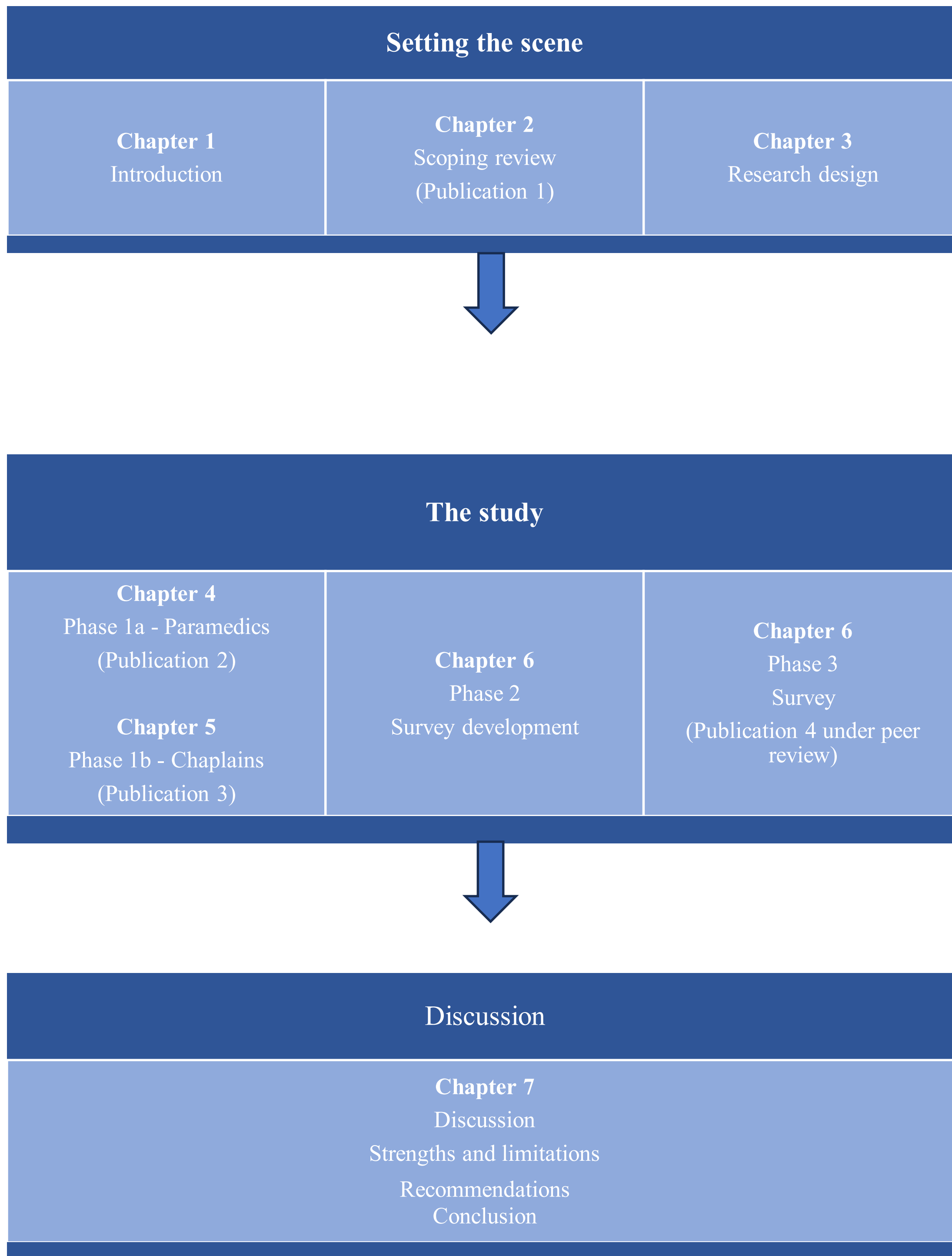
In Chapter 2, I present a scoping review of staff perceptions of the role and value of chaplains in first responder and military settings. This chapter was published as a peer-reviewed journal article in 2020.

In Chapter 3, I present the methodology and research design underpinning my exploratory sequential mixed methods study.

In Chapters 4, 5 and 6, I present my results as part of papers published in (4 and 5) or submitted to (6) Quartile 1 journals. In Chapter 4, I present results from Phase 1a of my exploratory sequential process – semi-structured interviews with paramedics to identify themes relating to the chaplain's role and perceived value, as understood by those who had used chaplaincy. In Chapter 5, I present results from Phase 1b of the study – semi-structured interviews with chaplains to gain a deeper and more rounded understanding of their role and its perceived value. The significant themes identified in these qualitative phases were used to develop a survey that I distributed to paramedics across Australia to determine if the findings from Phase 1 resonated with the wider paramedic population; the results are presented in Chapter 6.

In Chapter 7, I present a discussion of the study. I show how I answered my research questions, discuss the strengths and weaknesses of the study, offer recommendations for future work, and provide a concluding statement.

*Figure 1. Structure of thesis*



## 1.12 Conclusion

In this chapter, I established the rationale for this thesis by compilation: namely, that if we are to consider paramedic wellbeing from a truly holistic perspective, it is vital that we include a spiritual care perspective. However, there is no research literature on chaplaincy in the ambulance context, especially from a paramedic- or person-centred perspective; research is required to establish an evidence base for its inclusion. In Chapter 2, I present a scoping review of the literature on staff perspectives on chaplaincy programs in first responder and military settings.

# Chapter 2 – Staff perceptions on the role and value of chaplains in first responder and military settings: A scoping review

## 2.1 Introduction

Chapter 1 outlines the background to and rationale for this doctoral study of ambulance chaplaincy. It identifies the impact of paramedic work on their health and wellbeing, and highlights contemporary literature on the role of spiritual care. In Chapter 1, I also note the lack of research on ambulance chaplains and their role in contributing to paramedic wellbeing, and emphasise the need for more paramedic-centred evidence (Carey & Cohen, 2015; Carey & Rumbold, 2015; Cunningham et al., 2017). Against this background, Chapter 2 presents a published scoping review of staff perspectives on the role and value of chaplains in first responder and military organisations.

The aim of this scoping review was to map the available literature on staff perceptions of the role and value of chaplains in first responder and military settings. First responder services include police, fire, paramedics, emergency medical technicians, EMS and other rescue organisations, while the military cohort includes Air Force, Army and Navy personnel. I reviewed literature about this diverse group of emergency responders due to the paucity of research related to chaplains in ambulance services or EMS, and in the first responder community more broadly. Like first responders, military personnel encounter injury and death not only on the battlefield or in the line of duty, but in motor vehicle accidents, suicides, training accidents, disaster responses (Prazak & Herbel, 2020; Seddon et al., 2011). In addition, there is a long-established history of using chaplains to support staff in the military. Knowledge gained from this scoping review was used to develop interview questions for Phase 1 of the study (outlined in Chapters 4 and 5).

## 2.2 What does the review add to existing knowledge?

My scoping review mapped the literature on chaplains' activities, attitudes and attributes, and first responders and military personnel's perceptions of their value. It provided insights into the provision of emotional, spiritual and pastoral care, in the field and in the day-to-day work of first responder and military personnel. It also identified the attributes that research subjects

perceived made a chaplain desirable or undesirable. Lastly, the scoping review identified knowledge gaps and opportunities for further research relating to ambulance chaplaincy, particularly with regard to the perspectives of paramedics.

## 2.3 Impact of this review

The paper presented in this chapter was submitted to the *Journal of High Threat and Austere Medicine* because its target audience includes military and paramedicine leaders and researchers from Australia and abroad. After its acceptance and publication, I was invited to join a research team connected to the Australian Defence Force to explore care provided by military chaplains. This study resulted in two publications that are not included in this thesis, one published (Layson et al., 2022) and another under review.

At the time of submitting this thesis, the *Journal of High Threat and Austere Medicine* was being migrated to the Cambridge Media platform and the article was only available as a PDF. Prior to this process, the paper had been accessed over 1,400 times and cited three times in peer-reviewed publications.

Citation:

Tunks Leach, K., Lewis, J., & Levett-Jones, T. (2020). Staff perceptions on the role and value of chaplains in first responder and military settings: A scoping review. *Journal of High Threat & Austere Medicine, 2*(1). https://journals.cambridgemedia.com.au/application/files/1616/8352/3487/Tunks.pdf

Benjamin Mackie (Editor, Journal of High Threat and Austere Medicine, Cambridge Media, 3 July 2023) granted permission for “Staff perceptions on the role and value of chaplains in first responder and military settings: A scoping review” to be included within this thesis.

## 2.4 Published paper

Journal of High Threat & Austere Medicine

Official Journal of the Australian Tactical Medical Association

# Staff Perceptions on the Role and Value of Chaplains in First Responder and Military Settings: A Scoping Review

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## Abstract

### Background

Chaplains in first responder and military services support staff prior to, during, and after critical incidents. Some studies have explored the role of chaplains in these settings predominantly in the military, and from chaplains' perspectives. However, few studies have explored the perspective of staff. This scoping review aims to map the literature on staff perceptions of the role and value of chaplains in first responder and military settings.

### Method

A scoping review using the Arksey & O'Malley (2003) and Joanna Briggs Institute Scoping Review Methodology was conducted. English language, peer-reviewed, and grey literature in CINAHL, PubMed, PsychINFO, ProQuest and Google Scholar from 2004-2019 was reviewed for inclusion. Records were included if they provided staff perspectives on the role and value of chaplains in first responder and military settings. The initial search identified 491 records after removal of duplicates. All titles and abstracts were then screened for relevance to the research question and 84 were selected for full-text review. Seven records were included in final review; five dissertations and two peer-reviewed articles. Five of these were from the military and two from the police. Data was extracted and thematically analysed to identify staff perceptions of the role, skills and attributes, and value of chaplains in first responder and military settings.

### Results

Staff understood the role of chaplain to include the provision of spiritual and pastoral care, guidance, and in the case of police, providing scene support. Staff from all of the services identified requisite skills and attributes for chaplains such as being available, approachable and engaged; counselling; maintaining confidentiality and trust; being organisationally aware; and possessing distinct personality traits and knowledge of specialty content areas. The value chaplains brought to their services emerged from chaplains being trusted as a result of being proactively available for staff, families and bystanders for formal and informal conversation; organisational belonging and awareness resulting in enhanced staff satisfaction and retention; and promoting staff physical, mental, social and spiritual wellbeing.

### Conclusions

Although military and police staff identified spiritual, psychological and social benefits to chaplains maintaining an active and visible role in their services, the small number of papers identified make generalization of these findings to other first responder services problematic. Further research is therefore required to understand the impact of the chaplain's role as part of the care team in first responder services.

**Key words:** chaplain, pastoral care, spiritual care, military, emergency responder, paramedic, allied health personnel.

## 1. Background

The term 'chaplain' originates from the Latin word 'cappa' which means hooded cloak or cape (Carey et al., 2016). The first historical reference to chaplains emerged from France in approximately 316-397 AD when St Martin de Tours, a Roman centurion, split his own cloak in half and shared it with a beggar (Carey et al., 2016; Paget & McCormack, 2006). Chaplains have continued to provide practical ministry and a ministry of presence – being present to support and care for those experiencing hardship or illness, and ensuring people are not alone – ever since (Paget & McCormack, 2006).

Embedded across a range of sectors including military, hospitals, and prisons for hundreds of years, chaplains have more recently become a part of first responder services to support staff prior to, during, and after critical incidents (Cisney & Ellers, 2009). They may work with staff to promote wellbeing and resilience in their everyday work and life; provide on-scene support to staff, patients, and bystanders exposed to trauma and distress; and in the aftermath of critical incidents provide psychological first aid, pastoral care, and support (Cisney & Ellers, 2009; McFarlane, 2019; Robinson, 2011). Chaplains work independently and as part of wellbeing teams which may also include psychologists and peer support officers.

The focus of this scoping review was to explore what is known about staff perceptions on the role of chaplains, and the value they add to first responder and military services. These diverse organizations were included in the review due to lack of available research on chaplains, specifically in the ambulance service, and more broadly in first responder services in general. First responder services incorporate police, fire,

paramedics, emergency medical technicians (EMT) and other rescue organizations. Like first responders, military personnel work in evolving and potentially volatile situations, and encounter trauma and death, not only on the battlefield, but also in civilian settings such as a motor vehicle accidents, suicides, or death in the line of duty. (Seddon, Jones, & Greenberg, 2011). In addition, there is an established history of using chaplains to support military staff.

Established chaplain researchers have emphasized the need for more research in this space and the importance of incorporating spiritual care as part of an holistic model of health care (Carey & Cohen, 2015; Carey et al., 2016; Stallinga, 2013; World Health Organisation, 1946). Furthermore, there is greater need to understand how chaplains work individually and as part of a team (Carey & Rumbold, 2015; Carey, Willis, Krikheli, & O'Brien, 2015; Cunningham, Panda, Lambert, Daniel, & Demars, 2017). The aim of this scoping review was to map the available literature on staff perceptions of the role and value of chaplains in first responder and military settings.

## 2. Methods

A scoping review of the literature was conducted to map literature and to identify key concepts, sources, and knowledge gaps (Arksey & O'Malley, 2005; Peters, 2017; Tricco et al., 2018). This review was conducted with reference to the Arksey and O'Malley (2005) methodological framework, and the Preferred Reporting Items for Systematic reviews and Meta-Analyses extension for Scoping Reviews (PRISMA-ScR) (Tricco et al., 2018), and is appropriate for use where limited research

has been undertaken, or where evidence is emerging (Arksey & O'Malley, 2005; Levac, Colquhoun, & O'Brien, 2010). The Arksey and O'Malley (2005) framework consists of the following stages: 1) identify the research question, 2) identify relevant studies, 3) selection of appropriate studies, 4) charting the data, and 5) collating, summarising and reporting of results. An optional sixth stage of consultation with stakeholders may also be included (Arksey & O'Malley, 2005; Joanna Briggs Institute, 2015). As evidence arises from a range of sources, formal assessment of the quality of studies is frequently not performed (Joanna Briggs Institute, 2015).

### 2.1 Stage 1: Identification of Research Question

The purpose of stipulating the research question in stage one is to "provide a roadmap for subsequent stages" (Levac et al., 2010, p. 3). Levac et al. (2010) further state research questions should be broad enough to summarize the available evidence yet clear enough to provide scope for the enquiry. Consequently, the guiding question for this scoping review was "What is known about staff perceptions on the role and value of chaplains in first responder and military settings?"

### 2.2 Stage 2: Study Selection

A systematic search of electronic databases (CINAHL, PubMed, PsychINFO, and ProQuest), and the first 50 results in Google Scholar, were searched to identify peer-reviewed and grey literature. Hand searching of reference lists and selected texts was also conducted. A specialist librarian was consulted to determine the most suitable databases, and to construct a comprehensive search strategy based on the research question. Papers were limited to English language and published between 1 January 2004-2019. This timeframe correlates with the observed increased volume and quality of chaplaincy research (Delaney & Fitchett, 2018; Fitchett, 2017; Weaver, Flannelly, & Liu, 2008). Search terms were informed by two domains, which included keyword and MeSH terms.

#### 2.2.1 First Responder Populations

Terms included ambulance, paramedic, first responder, emergency medical technician, emergency medical service, police, law enforcement, firefighter, military, defence forces, air force personnel, armed forces personnel, army personnel, navy personnel, United States Marine Corps and military personnel.

#### 2.2.2 Chaplains

Terms included chaplain, clergy, pastoral care, spiritual care, and spiritual wellbeing.

The initial search produced 491 articles after removal of duplicates.

### 2.3 Stage 3: Selection of Appropriate Studies

Reviewers met at the beginning of the review process to discuss inclusion and exclusion criteria, alignment with research question and consistency. Two reviewers independently assessed each article for eligibility and extracted data before comparing results. The lead author (KTL) screened all papers with remaining authors independently conducting the second screening. In line with the iterative nature of the scoping review, consultation between reviewers was ongoing (Joanna Briggs Institute, 2015). Discrepancies were resolved during meetings between reviewers or via personal communication between meetings.

#### 2.3.1 Inclusion Criteria

Inclusion criteria were formulated using the Population, Concept, Context (PCC)

format (Arksey & O'Malley, 2005; Joanna Briggs Institute, 2015). Therefore, any record that included staff perspectives of the role of chaplains and the value they add to first responder or military services was eligible for inclusion. For the purpose of this review, first responder services include Police, Fire, Ambulance or Emergency Medical Services (EMS). Military services included Air Force, Army and Navy.

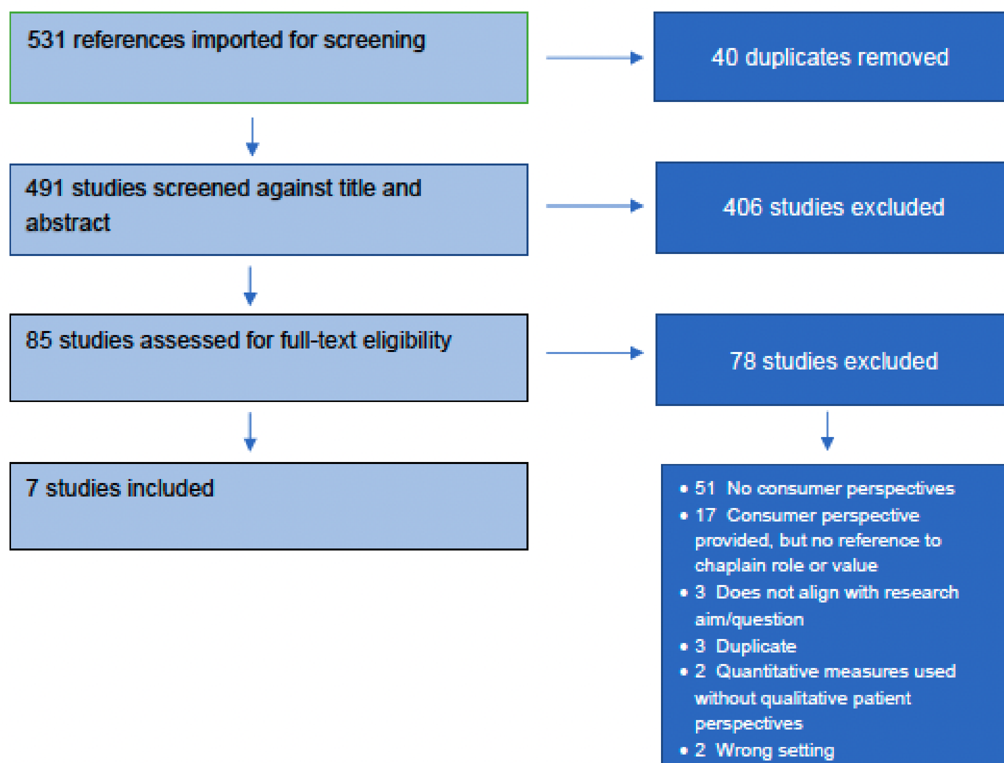
#### 2.3.2 Exclusion Criteria

Studies involving chaplains outside of the nominated services were excluded (eg. hospital chaplains).

Articles identified as appropriate for review were imported and stored in Covidence. This also allowed reviewers to document rationale for decisions.

All titles and abstracts were screened for relevance to the research question and 84 were selected for full-text review. The 84 results were independently reviewed against the inclusion/exclusion criteria by two authors. Seven articles were included in the final review, as summarised in the modified PRISMA flowchart (see Figure 1).

**Figure 1:** PRISMA Flowchart




### 2.4 Stage 4: Charting the Data

This data extraction process provides the reader with a descriptive summary of results, and should align with the aim of the scoping review (Joanna Briggs Institute, 2015). A charting form was developed as a

result of collaborative discussions between reviewers *a priori*, and used to extract data from selected studies with the purpose of addressing the research question (Arksey & O'Malley, 2005; Levac et al., 2010). This became an iterative process as unanticipated themes emerged. Extracted data included first author, date, title, aims/objectives, participants, data sources/methodology, and key findings (Arksey & O'Malley, 2005; Joanna Briggs Institute, 2015) (see Table 1).

### 2.5 Stage 5: Collating, Summarizing and Reporting of Results

While a scoping review is designed to present a narrative account of the identified literature rather than 'synthesize' evidence, specific steps are taken to enhance rigour (Arksey & O'Malley, 2005). Levac et al. (2010, p. 6) propose three steps: analyse the data (collating and summarising), report the results, and apply meaning to the results. Data analysis occurred through iterative discussions between reviewers, and results of the review included a descriptive numerical summary, as well as a 'thematic construction' (Bindley, Lewis, Travaglia, & DiGiacomo, 2019; Levac et al., 2010). Unanticipated findings that emerged from the scoping review were staff opinions on the requisite skills and attributes of chaplains. Consequently, the major categories identified were (1) the chaplain's role, (2) the chaplain's skills and attributes, and (3) the chaplain's value to the organisation. These results were analysed in line with the aim of the scoping review and research question.

### 2.6 Stage 6: Consultation

Rigour in scoping reviews can be enhanced through consultation with practitioners and consumers (Arksey & O'Malley, 2005; Levac et al., 2010). These additional perspectives can enhance meaning and applicability to the scoping review (Levac et al., 2010). Consultation with a limited number of stakeholders within ambulance services took place regarding additional sources of data for inclusion.

**Table 1: Tabulated data from review**

| Author (year) | Title of the study | Aims/objectives | Participants | Data sources/Methodology | Key findings |
|---|---|---|---|---|---|
| Bowlus (2018) | The relationship between religious coping and resilience among senior army leaders in the United States Army War College | To determine the relationship between resilience and religious coping among senior Army officers. | 21 Army War College students | **Methodology:** Descriptive correlational<br><br>**Data source:** Dissertation - mixed methods survey and interviews. | 1) Chaplain's role included provision of spiritual leadership, prayer, religious services fellowship opportunities, encouraging religious involvement, teaching religious practices, and inquiring about spiritual life.<br>2) Skills or attributes essential for this role included being proactively available, visible, approachable, checking on the leaders, being an advisor, helping with personal issues, following-up on leaders' needs, and being organisationally aware.<br>3) Value was recognised in promoting connection, shared experiences, understanding the organization and therefore demands on leaders, providing friendship, being present at right time and place.<br>4) Suggestions for improvements or perceived barriers to chaplains were lack of maturity and experience, rank (similar |

| | | | | | |
|---|---|---|---|---|---|
| | | | | | rank preferred), and lack of Catholic chaplains. |
| Cafferky et. al. (2017) | Air Force Chaplains' perceived effectiveness on service member's resilience and satisfaction | To examine male United States Air Force (USAF) service members' (SM) perceptions of chaplains' effectiveness related to the importance SMs placed on spirituality, resilience, family coping, relationship satisfaction, satisfaction with the Air Force (AF), and how rank and location of family residence moderated these associations. | 3777 USAF male active duty SMs who completed the 2011 USAF Community Assessment Survey | **Methodology:** Quantitative survey<br><br>**Data sources:** USAF Community Assessment Survey. | 1) No data identifying staff perceptions on role of chaplain.<br>2) Value was recognised through the significant positive contribution to resilience, family coping, relational satisfaction and satisfaction with the AF.<br>3) Quantitative data only available. |
| Chang, et.al. (2012) | Spiritual needs and spiritual care for veterans at end of life and their families. | To explore the perspectives of Veterans receiving Veterans Affairs (VA) palliative care and their families. | 17 male Caucasian Veterans and 9 family members | **Methodology:** Grounded theory<br><br>**Data source:** Semi-structured individual interviews. | 1) Chaplain's role included providing spiritual care, religious ritual, and pastoral care.<br>2) Skills or attributes essential for this role included knowledge of combat/trauma and counselling skills to help veterans process guilt, and awareness of link |
| | | | | | between Veterans' service and their spirituality.<br>3) Value was recognised in a 'ministry of presence', personal and family support.<br>4) Suggestions for improvements or perceived barriers were lack of chaplain availability. |
| Gouse (2017) | Ministry of Presence: An investigation of communication between police chaplains and local civilians in crisis. | To examine the nature of the ministry of presence of chaplains particularly in terms of their listening behaviour when engaged with local civilians in crisis under an expanded police chaplaincy model. | 28 chaplains, 11 law enforcement officers, 13 civilians | **Methodology:** Ethnographic<br><br>**Data source:** Dissertation - qualitative interviews | 1) Chaplain's role focussed on scene support.<br>2) Skills or attributes essential for this role included the ability to effectively communicate, empathise, listen, comfort, and demonstrate compassion.<br>3) Value was recognised in their ministry of presence, particularly through the ability to bring a sense of calm to staff and civilians, to act as a 'buffer or bridge' between police and the community in crisis situations, and to allow police to more efficiently do their job. Chaplain care of civilians had a stress-reducing effect on police. |
| Hale (2013) | Professional Naval Chaplaincy: The Ministry of the Navy Chaplain in a US Navy Bureau of | To determine the attitudes of professional hospital staff and ancillary staff regarding the | 250 Navy staff aboard one ship | **Methodology:** phenomenological and ethnographic | 1) Chaplain's role included traditional ministry roles (e.g. minister or priest); and providing moral, spiritual, and pastoral care. |

| | | | | | |
|---|---|---|---|---|---|
| | Medicine and Surgery Hospital. | role and value of the US Navy chaplain in a US Naval hospital. | | **Data source:** Dissertation - cross-sectional online questionnaire. | 2) Skills or attributes essential for this role included empathy, communication, comfort, trust and maintaining confidentiality.<br>3) Value was recognised in the chaplain's ability to maintain a ministry of presence, to work as part of a multidisciplinary team, and to provide spiritual and moral care to patients. |
| Moosbrugger (2006) | The Leadership of a Law Enforcement Chaplain – influence, effectiveness and benefit to the agency and community: a case study of the Arlington Police Department, Arlington, Texas. | The purpose of this study was to provide information from law enforcement officers' on how chaplains benefits their professional pursuits and personal life. | 29 police officers from Arlington, Texas | **Methodology:** Phenomenological<br><br>**Data source:** Qualitative case study | 1) Chaplain's role included attending scenes to support police, including delivering death notices. Also, in traditional duties including providing pastoral care, and conducting weddings and funerals.<br>2) Skills or attributes essential for this role included being available, approachable, non-judgemental, self-aware, acting as a positive role model, being supportive of multifaith staff and confidential.<br>3) Value was recognised in 'bridging the gap' between police and community and reducing stress by working alongside police officers in the field and in the station. Promotion of wellbeing through |
| | | | | | work/life balance, family support, spiritual leadership, sound decision making (personal and professional) and building morale was also valued. Chaplains successful in these skills were seen as a valid first point of contact when seeking help.<br>4) Chaplains value to the organisation was acknowledged through comprehension of police and civilian experiences, enhancing staff retention, and humanising the public for officers. |
| Roberts (2016) | A Comprehensive plan for providing chaplaincy support for wounded female soldiers: A Delphi study | The purpose of this study was to build consensus on a comprehensive plan and model for creating a system by which male chaplains could provide effective support to wounded female soldiers. | 10 female soldiers, 11 female chaplains | **Methodology:** Feminist Systems Theory<br><br>**Data source:** Modified qualitative Delphi study. | 1) Chaplain's role included provision of religious, pastoral and spiritual care.<br>2) Skills or attributes essential for this role included 'caregiving traits', experience with trauma, trustworthiness, experience of women after sexual assault.<br>3) Value was recognised in visiting staff and being actively engaged, neutrality (i.e. not in chain of command), assisting staff to seek further help, assisting staff to find forgiveness, and reducing stress. |
| | | | | | 4) Suggestions for improvements or perceived barriers were lack of life experience, visibility and established relationships.<br>5) Trust of chaplain regardless of gender was possible with most women if longer term relationships had been developed. |

## 3. Results

### 3.1 Characteristics of Included Studies

Of the seven records included in this review, five were dissertations and two original research articles. Five were from military settings and two from first responder (police) services. All articles were from the United States of America (USA), and the majority of participants were male, with the exception of one study that focused on female soldiers.

A significant gap in research from first responder services was observed. Only two papers from police services were found, both of which were dissertations. No information was available from ambulance, fire, or other emergency services.

### 3.2 Key Themes

#### 3.2.1 The Chaplain's Role

Six records specifically focused on chaplain roles, which included providing (1) spiritual support or guidance, (2) pastoral care, and (3) scene support. Five of the studies from military and police described chaplains' roles as providing spiritual support or guidance (Bowlus, 2018; Chang et al., 2012; Hale, 2013; Moosbrugger, 2006; Roberts, 2016). This included the performance of rituals and services such as weddings and funerals (Bowlus, 2018; Chang et al., 2012; Hale, 2013; Moosbrugger, 2006). In addition, advising on spiritual life and practices, encouraging religious involvement, providing opportunities for fellowship, encouraging prayer and reflection, and assisting staff to find forgiveness were considered key roles unique to chaplains in the military (Bowlus, 2018; Chang et al., 2012; Hale, 2013; Roberts, 2016). Evidence from police studies on the other hand, saw chaplains in a less traditional way, with staff reporting that the example and actions of chaplains reminded them of how they aspired to "live a more spiritual life" (Moosbrugger, 2006, p. 73).

Pastoral support was another emergent theme from the review. This can be defined as "shepherding of an individual or community in terms of guiding, healing, sustaining, reconciling and nurturing their religious faith and well-being within an ecological context" (Carey & Rumbold, 2015, p. 1418). One paper used the specific term '*pastoral care*' (Hale, 2013), while four others used terms that implied pastoral care, such as guiding and supporting (Bowlus, 2018; Chang et al., 2012; Moosbrugger, 2006; Roberts, 2016).

In describing the role of police chaplains, staff identified that chaplains attend incidents or scenes to support staff and community members (Gouse, 2017; Moosbrugger, 2006). Scene support was not included in the military papers, however chaplain's presence at hospitals to visit wounded or ill soldiers or veterans was considered important (Chang et al., 2012; Hale, 2013; Roberts, 2016).

#### 3.2.2 The Chaplain's Skills and Attributes

The outcomes of the scoping review highlighted that to be effective, chaplains should possess particular skills or attributes. Across both the first responder and military records the requisite skills and attributes of chaplains included (1) being proactively available, approachable and engaged; (2) counselling; (3) maintaining confidentiality and trust; (4) being organisationally aware; and (5) possessing

distinctive personality traits and knowledge of specialty content areas.

Being proactively available, approachable and engaged with staff and veterans were identified as important attributes across military and police papers (Bowlus, 2018; Chang et al., 2012; Gouse, 2017; Hale, 2013; Moosbrugger, 2006; Roberts, 2016). Sitting with patients in the hospital setting, and working with a multidisciplinary team to support staff and patients was important in one Navy study (Hale, 2013). Understanding the unique demands on leaders and having a chaplain 'check-in' on them was important to Army leaders in another study (Bowlus, 2018; Moosbrugger, 2006). One police study identified the importance of having chaplains present on-scene, and also available for conversations in downtime (Moosbrugger, 2006). Lack of engagement or availability was considered a negative aspect of chaplain care (Chang et al., 2012), leaving staff in one paper feeling isolated and not trusting the chaplain (Roberts, 2016).

Furthermore, providing a '*ministry of presence*' was identified as an important aspect of this attribute. The exact phrase '*ministry of presence*' appeared in three papers (Chang et al., 2012; Gouse, 2017; Hale, 2013) while three other papers described actions or behaviours constituting a ministry of presence including being present at the right time and place (Bowlus, 2018; Moosbrugger, 2006; Roberts, 2016). Chaplains who possessed these attributes were trusted and perceived as caring (Bowlus, 2018; Roberts, 2016).

Counselling or possessing specific caregiving skills were viewed as important in all settings. Integral to these skills were the ability to communicate, empathize, listen and comfort (Gouse, 2017; Hale, 2013; Moosbrugger, 2006; Roberts, 2016). A study on female soldiers further outlined the importance of chaplains knowing how to make staff feel comfortable and being able to ask the right questions to encourage soldiers to tell their stories (Roberts, 2016).

The ability to maintain confidentiality and trust were identified in three papers. In one study, 85% of staff agreed or strongly agreed that chaplain confidentiality was important (Hale, 2013). Consequently, it was important for chaplains to not be part of the chain of command as this was perceived to make them less approachable or unlikely/less likely to maintain confidentiality (Moosbrugger, 2006; Roberts, 2016).

Organizational awareness and shared experiences were viewed as important in four papers; this included an understanding of organizational pressures, procedures, and experiences (Bowlus, 2018; Moosbrugger, 2006; Roberts, 2016). One study specifically referred to knowledge of military culture and pressures as essential to meeting the particular needs of military leaders (Bowlus, 2018). Military veterans also believed that chaplain's comprehension of the military culture and battle experiences, and the way these contribute to spirituality, was important (Chang et al., 2012). Similarly, one police study described how chaplains with organizational awareness helped staff to cope with the demands on the job, and work-life balance away from the job (Moosbrugger, 2006).

Chaplains having an in-depth knowledge of job-related trauma was viewed as essential to staff in military and police services

(Chang et al., 2012; Gouse, 2017; Moosbrugger, 2006; Roberts, 2016), and in a study of female soldiers, the need for chaplains to be familiar with the needs of those who had experienced sexual assault was considered important (Roberts, 2016).

In the military and first responder services, being non-judgemental and self-aware were viewed as essential attributes. (Moosbrugger, 2006; Roberts, 2016). Chaplains maintaining role awareness and understanding their limitations was also valued by female soldiers (Roberts, 2016). The ability to embrace diversity and other faiths was considered to be critical, irrespective of the organisational context (Moosbrugger, 2006; Roberts, 2016).

#### 3.2.3 The Chaplain's Value to the Organization

The value chaplains added to services emerged from chaplains (1) being proactively available for staff, families and bystanders for formal and informal conversation, (2) organizational awareness and belonging, and (3) promoting and modelling wellbeing.

Chaplains who were proactively available for staff, families and bystanders for formal and informal conversations were valued in first responder and military papers. They helped staff feel comfortable to initiate conversations and seek guidance about personal and professional matters (Hale, 2013; Moosbrugger, 2006). A Navy study found having chaplains available to provide moral and spiritual care to service people as part of a multidisciplinary team was considered "mission essential" by more than 90% of staff (Hale, 2013, p. 35). Similarly, when chaplains initiated conversations with Army leaders, the leaders were left "feeling better afterwards" (Bowlus, 2018, p. 87). For military veterans in palliative care, the presence of chaplains facilitated supportive conversations with patients and their family members, and feedback indicated both groups wanted more frequent visits and time with chaplains (Chang et al., 2012).

For police, having a chaplain present on-scene held value as a means of 'buffering' from, or building bridges between the police and community (Gouse, 2017; Moosbrugger, 2006). One study found having a chaplain on traumatic scenes alleviated stress and reduced their burden of being the bearer of bad news (Moosbrugger, 2006). It also released the officer to better perform their job, leaving them reassured that members of the public were being supported and comforted by the chaplain (Gouse, 2017; Moosbrugger, 2006). Another study found police believed chaplains bought a sense of calm and comfort to scenes thereby diffusing and deescalating tensions between police and the community. They also promoted enhanced communication, and cooperation, between civilians and police (Gouse, 2017).

Chaplains who were available, approachable and maintained confidentiality were valued when seeking support (Moosbrugger, 2006; Roberts, 2016). One police officer stated staff felt more comfortable talking to a chaplain than they did a supervisor, psychologist or Employee Assistance Program (EAP) due to fears that the conversation may be relayed to others in the organisation (Moosbrugger, 2006). Similarly, female soldiers felt talking to chaplains was safer due to fears of reprisals from managers (Roberts, 2016).

Organizational awareness and belonging served to promote staff satisfaction and

retention. Shared experiences or an in-depth understanding of soldier/police challenges and cultures gave chaplains knowledge and credibility when supporting staff, and in two papers resulted in increased staff retention (Moosbrugger, 2006; Roberts, 2016). One police interviewee identified that chaplains were able to work with staff in ways that managers could not by helping officers cope with the job, and boosting morale and productivity resulting in significant financial benefits (Moosbrugger, 2006). Two military papers found chaplains who had deployment experience were more likely to be trusted (Bowlus, 2018; Roberts, 2016).

The chaplain as a person responsible for and capable of promoting wellbeing was valued across the literature. Value lay in supporting staff at work prior to, during or after challenging incidents, and promoting work-life balance (Bowlus, 2018; Gouse, 2017; Moosbrugger, 2006; Roberts, 2016). One Air Force study found chaplains provision of spiritual care promoted resilience, family relationships and organizational satisfaction (Cafferky, Norton, & Travis, 2017). Similarly, an Army study identified that chaplains promoted wellbeing through helping military leaders to reprioritize faith and family before their job, and teaching them effective coping strategies (Bowlus, 2018). Veterans receiving palliative care saw value in chaplains making space to help them work through spiritual issues (Chang et al., 2012). Female soldiers in one study stated that chaplains who were trusted were able to reduce stress through providing support and reassuring soldiers they were not alone, therefore reducing anxiety, depression and overcoming PTSD (Roberts, 2016). One police paper recognized the importance of chaplains in reducing stress and burnout, promoting work-life balance, and reducing the impact of work on families and relationships (Moosbrugger, 2006). Two military studies found that chaplains helped soldiers and veterans overcome guilt and find forgiveness for perceived transgressions (Chang et al., 2012; Roberts, 2016).

## 4. Discussion

This review sought to map the literature on first responder and military staff perceptions on the role and value of chaplains. Three clear domains were identified around roles, skills, and attributes, and value to the individual and organization were identified. Of note were the different expectations of the chaplain's role between military and police services. Chaplains in the military were expected to take more of a 'ministry' role and conduct religious rituals (e.g. weddings and funerals) and services for staff, whereas those in police services played more of a supportive role within the organization, allowing staff to pursue their own spiritual or religious activities outside of work.

The findings demonstrated that first responder and military staff perceive the chaplain to be of value when they possess skills and attributes that meet the needs of staff prior to, during (in the case of police), and after both everyday experiences and significant incidents. The results suggested that by having chaplains present to build relationships outside of critical incidents, both staff and the organization benefit. Staff also found value in having someone confidential and supportive to initiate conversations with and to seek guidance from. Additionally, one study participant suggested there may be financial benefits to the organization in having chaplains in the service (Moosbrugger, 2006).

While first responders may attend similar jobs, their different standing in the public eye may impact staff views on and needs of their chaplains. For example, papers on police identified public hostility at times, however ambulance staff are often considered a 'trusted profession', potentially impacting how chaplains in each service can best support staff and bystanders. Chaplains are embedded in these services globally yet evidence supporting their role and value from the perspective of their staff is missing.

### Limitations

Despite a methodical review of four databases and searches of grey literature, only data that is publicly available was included. Private data held by first responder or military agencies could not be accessed. This may have limited findings of this research.

Insufficient data was available from diverse staff groups, including from countries outside the USA, women, and people from differing ethnic backgrounds. While some military papers contained information regarding soldiers' previous religious or spiritual beliefs, this data was inconsistent or missing from police papers. This information would be valuable to determine if all staff gain benefit from chaplains, regardless of spiritual or religious beliefs. The absence of primary research was notable in this emerging area of research.

The lack of studies highlighting staff voices also limits the strength of the findings as well as the representativeness of the research.

## 5. Conclusion

The findings from this review suggest that chaplains provide a positive contribution in military and first responder services, especially relating to supporting staff during times of stress, and promoting wellbeing and retention. However, the small number of studies and the dearth of information about perspectives limits the strengths of the overall results. Further, without evidence of the value of chaplains to first responder services their work and impact may be underutilised and/or under resourced. Lastly, one commentator noted that "the absence of research contributes to the isolation of chaplains from existing care teams in which they could play a crucial role" (Stallinga, 2013, p. 27). Thus, further research is needed to identify how chaplains' presence prior to and at significant events may promote resilience, reduce outcomes associated with scene/organisational stress, and act as a first point of contact or referral agent for psychology and EAP.

### Acknowledgements

Thank you to Rev Paul McFarlane at NSW Ambulance for his feedback in the consultation stage and early versions of the manuscript. Thank you also to Helen Chan at the University of Technology Sydney library for her assistance developing the search strategy for this scoping review.

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# Chapter 3 – Research design

## 3.1 Introduction

Chapter 2 presents my published scoping review of staff perceptions of the role and value of chaplains in first responder and military settings, and identified the evidence gap with respect to paramedic chaplaincy. While it is likely that commonalities exist between the views of paramedics and those of the participants in the research included in the scoping review, Australian ambulance services have their own unique culture, thus necessitating targeted research. My identification of this knowledge gap informed the development of a mixed methods study designed to examine the role and value of ambulance chaplains, with particular emphasis on the perspectives of paramedics.

This chapter outlines the research design for my exploratory sequential mixed methods study, including the methodology, methods, and justification for methodological decisions. Ethical considerations are also discussed.

## 3.2 Research design and methodology

### *3.2.1 Philosophical foundations*

A paradigm or worldview is a term used to describe underlying assumptions or sets of beliefs that guide a research design or inquiry, taking into consideration philosophical considerations like ontology, epistemology and axiology (Creswell & Plano Clark, 2018). A paradigm refers to how the researcher sees the world and how this view aligns with the understandings of a particular community of scholars (Schneider et al., 2016; Shannon-Baker, 2015). When it comes to spiritual care research, I believe in holding all worldviews as equal and valuable. I also believe in strengths-based approaches and looking beyond what makes us unwell to what promotes wellbeing. On this basis, my research aligns with pragmatist and salutogenic worldviews.

### *3.2.2 Pragmatism*

I used pragmatism, a philosophical paradigm that is widely recognised as appropriate for mixed methods designs, to frame my study (Halcomb & Hickman, 2015; Maarouf, 2019).

Pragmatism emphasises the need to design research that aligns with the research question/s and embraces a commitment to using multiple methods of appropriate data collection for answering them (Biesta, 2010; Creswell & Plano Clark, 2018; Maarouf, 2019). While debate continues on whether paradigms are necessary, relevant or helpful (Mertens & Hesse-Biber, 2012; Schneider et al., 2016; Shannon-Baker, 2015), and even on the validity of pragmatism as a philosophy (Biddle & Schafft, 2015; Hall, 2013), proponents of pragmatism as a philosophical approach argue in favour of its ontological, epistemological and axiological elements.

Creswell and Plano Clark (2018) stated that reality in pragmatism may contain both singular and multiple "truths", with Maarouf (2019) adding that there are multiple perceptions of these truths. For example, in a single study, researchers can both test a theory or hypothesis, and provide multiple participant perspectives (Creswell & Plano Clark, 2018). Epistemologically, rather than adopting a set position, like remaining close to or maintaining distance from what is being researched, pragmatism creates space for subjective and objective knowledge to be used according to "what works best" in line with the research questions (Creswell & Plano Clark, 2018). Axiologically, Maarouf (2019) argued that no research can be truly bias-free, and in fact "previous knowledge or perceptions should only enrich the qualitative research by helping the researcher to add more insights and discover more sides of this shared reality" (p.9). By including both "biased" and "unbiased" approaches, pragmatism can help researchers achieve their research objectives (Creswell & Plano Clark, 2018; Maarouf, 2019). This paradigm empowered me to be aware of and use my experience as a chaplain–researcher to enrich the study, and to adopt practices like bracketing and reflexivity (discussed later in this chapter) to be mindful of and attentive to the potential for bias.

In line with the idea that people hold multiple "truths" or viewpoints about religion, non-religion and spirituality, the pluralist approach inherent in pragmatism allowed me to work collaboratively with participants to examine their perspectives in the context of their organisations and recognise them as equally truthful and valid (De-Cuir & Schutz, 2017). The "functional pragmatism" approach taken in this study was essential to enable the research to move beyond a theory to provide practical benefits for paramedics in their workplaces (Goldkuhl, 2012; Maarouf, 2019).

### *3.2.3 Salutogenesis*

In Chapter 1 I discussed the WHO's definition of health, and its focus not only on the absence of illness but the presence of health. To better understand if and how chaplaincy and spiritual care can contribute to paramedic wellbeing, I considered my research results from a salutogenic theoretical perspective. Antonovsky (Antonovsky, 1979) developed salutogenesis to increase focus on factors that contribute to health, as opposed to disease.

Ontology is a branch of philosophy exploring "being" or reality (Whitehead et al., 2020); salutogenesis includes two important ontological ideas. The first is about "man in interaction with his environment", focusing on the individual as they exist in a particular context (Haugan & Eriksson, 2021, p. 9). The second reality holds that chaos and change are normal states of life, and individuals are challenged to "manage the chaos and find strategies and resources available for coping with the changes in everyday life" (Haugan & Eriksson, 2021, p. 9). Both of these perspectives are relevant to the paramedic experience.

Antonovsky did not specify an epistemological underpinning for salutogenesis, but this theory aligns with a constructivist approach which, like pragmatism, allows for multiple truths or realities (Whitehead et al., 2020). Antonovsky focussed on salutogenesis as a constant learning process in which a person develops a sense of cohesion, "viewing life as structured, manageable, and meaningful… It is a personal way of thinking, being and acting, with an inner trust, which leads people to identify, benefit, use, and re-use the resources at their disposal" (Haugan & Eriksson, 2021, p. 11).

Salutogenesis was also deemed suitable for this study because it aligns with the health promotion principles outlined in the Ottawa Charter: (1) advocate for health equity, (2) enable people to achieve health equity, and (3) mediate for collaboration between health sectors, based on the principles of empowering, participatory, holistic, equity, sustainable and multi-strategy approaches (Haugan & Eriksson, 2021; World Health Organization, 2021). Empowering paramedics to take ownership of their health, to promote their own wellbeing, to prevent illness, and to have access to resources should they become unwell, must be a foundational goal of staff health programs in ambulance services.

## 3.3 Methodological approach

A mixed methods exploratory sequential design was used to structure this study (Creswell & Plano Clark, 2018). Mixed methods studies allow researchers to obtain a more complete understanding of complex issues through integrating qualitative and quantitative approaches, which are then used to comprehensively answer research questions (Creswell & Plano Clark, 2018; Halcomb & Hickman, 2015). Mixed methods approaches have also been identified in the chaplaincy literature as being important to "respect the integrity of the profession" (Damen, Schuhmann, Leget, et al., 2020, p. 131).

An exploratory sequential design was employed due to so little being known about ambulance chaplaincy(Creswell & Plano Clark, 2018). Exploratory sequential studies contain three phases:

1. Phase 1 – design and implement a qualitative strand;
2. Phase 2 – identify and use strategies that build on the qualitative findings to design a quantitative strand, grounded in the perspective of participants; and
3. Phase 3 – implement the quantitative strand. (Creswell & Plano Clark, 2018)

An exploratory sequential design allowed me to develop an in-depth understanding of the perspectives and experiences of paramedics and chaplains, before integrating these findings into a survey grounded in the culture and perspectives of ambulance staff (Coffey et al., 2017; Halcomb & Hickman, 2015).

Data integration is a deliberate and purposeful way of linking qualitative and quantitative findings to draw inferences and meta-inferences (Bazeley, 2018; Younas & Durante, 2023). To ensure this was truly a mixed methods study, rather than two separate studies involving qualitative and quantitative methods, data were integrated at two separate points. The first point of data integration involved combining findings from paramedic and chaplain interviews to create the survey, and the second involved linking qualitative and quantitative results to answer the research questions. The integration of findings is described in detail in Chapter 7.

Employing a mixed methods approach allowed for and embraced diverse paramedic and chaplain perspectives. Paramedics and chaplains include people of differing life stages, gender identities, levels of work experience, and spiritual or religious orientations. Understanding these different worldviews and the cultural, spiritual and political contexts of paramedic work helped me to develop a deeper understanding of the chaplain's role, identify factors that are helpful or unhelpful in a chaplain's role, personality or skillset, and recognise the perceived value of chaplains in ambulance organisations that are at the same time secular and plural (Halcomb & Hickman, 2015; Swinton & Mowat, 2016).

## 3.4 Methods

This section outlines in more detail the phases of the exploratory sequential mixed methods research design used in this study (Figure 2).

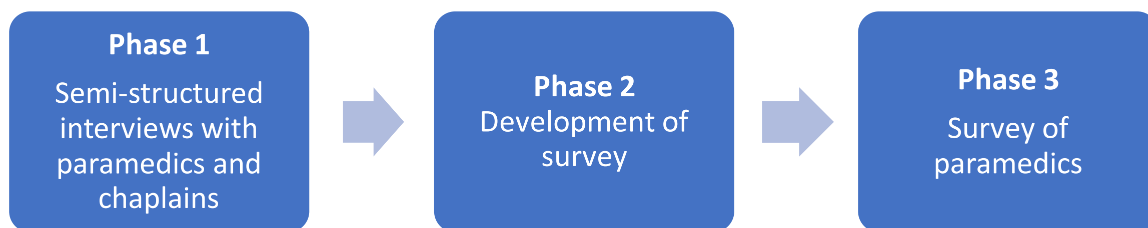


*Figure 2. Phases of the exploratory sequential mixed methods study*

### *3.4.1 Phase 1 – Qualitative data collection and analysis*

#### *Aim*

The aim of Phase 1 was to explore the perceived role and value of Australian ambulance chaplains using qualitative responses from paramedics and chaplains. It was designed to explore all four research questions.

#### *Ethics*

Prior to participant recruitment, ethics approval was sought from South-Eastern Sydney Local Health District (2019/ETH13593), NSWA and the University of Technology Sydney (UTS) Human Research Ethics Committee (HREC) (ETH19-3820) (Appendix 1).

### *Participants and context*

In Phase 1, paramedics (Phase 1a) and chaplains (Phase 1b) were recruited in order to construct a comprehensive understanding of the chaplain's role and value. Any AHPRA-registered paramedic employed by NSWA was eligible to participate in the interviews. In line with a pragmatist approach, all perspectives on the role and value of the chaplain were considered important, regardless of previous experience with a chaplain (Biesta, 2010; Shannon-Baker, 2015). Additionally, a lack of experience with or understanding of chaplains may deter staff from seeking chaplaincy services, so eliciting this information was considered important.

### *Sample*

In Phase 1, 17 paramedics and 13 chaplains were interviewed. Participants included paramedic interns, qualified paramedics, managers, educators, those working in control rooms, and those in peer support roles. Chaplains included practitioners and managers. This sample size was determined by data saturation being reached, or the point at which no additional information was generated (Coffey et al., 2017; Minichiello, 2004). Literature gives very varied opinions about necessary sample sizes; the sample size for this phase was determined based on previous mixed methods studies and guidelines (Creswell & Plano Clark, 2018; Hennink & Kaiser, 2022; Schneider et al., 2016).

### *Participant recruitment*

Recruitment for this project commenced on 16 June 2020, with the NSWA research unit distributing an email inviting participation in my research to the Deputy Directors of Clinical Operations in each ambulance sector (a geographical grouping of ambulance stations), and to the Senior Chaplain; they forwarded the email to managers and staff under their command. Additional information about the study and contact details were made available through flyers posted at ambulance stations across NSW, the NSWA intranet and word of mouth between paramedics and chaplains. I initially intended to interview only paramedics, but decided that incorporating the perspectives of chaplains would broaden and deepen my understanding of the role and the value they bring to ambulance service (Coffey et al., 2017; Creswell & Plano Clark, 2018). Combining the perspectives of staff and chaplains allowed

me to identify areas of consensus and disagreement, draw meaningful conclusions and refine survey questions. Paramedics and chaplains wishing to participate contacted me directly by email. To maintain ethical practice, I did not approach any NSWA staff members directly.

To ensure the most appropriate participants were recruited to achieve my aim, I employed purposive and snowball sampling (Creswell & Plano Clark, 2018; Minichiello, 2004; Schneider et al., 2016). Purposive sampling involves the researcher deciding who is best placed to provide the necessary information, and selecting participants accordingly (Creswell & Plano Clark, 2018; Minichiello, 2004); snowball sampling occurs when invitee or participants pass on details of the study to other potentially interested colleagues (Schneider et al., 2016). Participants volunteering in this phase coincidentally had diverse gender identities, included spiritual believers and non-believers, included metropolitan and rural practitioners, and had a range of years of experience (Creswell & Plano Clark, 2018; Schneider et al., 2016).

Participants were screened in person or by telephone to confirm their eligibility for inclusion in the study. They were again made explicitly aware of my role as a chaplain prior to consent being obtained, then sent the participant information sheet (Appendix 2) and consent form (Appendix 3), along with the questions to be asked during the interview (Appendix 4), to ensure complete transparency and give them time to consider their responses before consenting to participate.

### *Data collection*

Phase 1 involved qualitative open-ended semi-structured interviews with paramedics and chaplains. Semi-structured interviews with predetermined questions were designed to ensure that research aims were met and questions answered, but this approach was flexible enough to allow for emerging themes to be explored (Schneider et al., 2016). I based interview questions on my aims and research questions, the scoping review, and previous surveys of perspectives of chaplains' role and value in sectors such as hospitals and the military (Carey & Rumbold, 2015). I developed an interview protocol based on the questions provided to participants (Appendix 4).

Individual face-to-face or phone interviews took place at a mutually agreed time and place: in a private meeting room at NSWA headquarters, at the paramedic's or chaplain's station, or at the Sydney city campus of UTS. In line with my university requirements, I considered my safety when arranging these meetings: I ensured I would not be isolated, and had a means of seeking assistance or removing myself safely from a dangerous situation if needed. In addition, in preliminary discussion and at the interview itself, I advised the participant that if they felt privacy was not being maintained, the interview could be paused and moved to an alternative meeting place or terminated, according to their preference. Interviews took 30–60 minutes, and were audio recorded and transcribed verbatim.

Rigour in Phase 1 was established through trustworthiness, using the criteria credibility, dependability, confirmability and transferability (Forero et al., 2018). Credibility refers to whether the results are credible and true from the participants' perspectives, and was established through member-checking of the transcripts, and prolonged engagement with paramedics and chaplains during and after the interviews (including by inviting them to read a draft of the study findings)(Coffey et al., 2017; Forero et al., 2018). Dependability was established through the development of study protocols and the maintenance of clear audit trails, ensuring findings of this study could be repeated if applied to the same participant cohort (Forero et al., 2018). Confirmability ensured my findings were supported by the data, and was achieved through my use of practising reflexive journaling, regular meetings with my supervisors and the integration or triangulation of my qualitative and (later in this study) quantitative results (Brink et al., 2012; Coffey et al., 2017; Creswell & Plano Clark, 2018). Transferability, seeking to ensure results can be transferred or generalised to other settings, was established through purposive sampling and determining that data saturation was achieved when no new significant themes were identified when analysing the data (Coffey et al., 2017; Forero et al., 2018).

### *Data analysis*

Data analysis began after the completion of all qualitative interviews. Verbatim transcripts of the audio-recorded data were created, checked for accuracy, deidentified, and formatted for analysis (Creswell & Plano Clark, 2018; Schneider et al., 2016). With the guidance of my supervisors, I analysed interview data using framework analysis (FA). FA is a problem-

focused form of thematic data analysis designed to "draw descriptive and/or explanatory conclusions clustered around themes", and aligns with the pragmatist worldview previously outlined (Biesta, 2010; Gale et al., 2013, p. 2; Ward et al., 2013). Goldsmith (2021, p. 2061) stated that "the objective of framework analysis is to identify, describe and interpret key patterns within and across cases of and themes within the phenomenon of interest".

Recommendations for the number of FA stages vary (Gale et al., 2013). I took the following steps in analysing my data:

1. Transcription – verbatim as previously outlined;
2. Familiarisation with interviews – I revisited each interview to familiarise myself with it and record any preliminary thoughts;
3. Coding – open coding allowed me to code anything I felt was relevant to the study questions, rather than being restricted by predefined codes. This was conducted on the first three to five interviews of the chaplain cohort and the paramedic cohort;
4. Developing an analytical framework – codes were grouped together into clearly defined categories which became the working analytical framework. This stage was iterative;
5. Applying the analytical framework – at this stage all transcripts were once again analysed by applying the framework codes and categories;
6. Entering the data into a framework matrix – categories from each transcript were then charted into a Microsoft Excel spreadsheet; and
7. Interpreting the data – I identified themes, similarities/differences and connections between categories to explore relationships during this stage.

Using this approach, I generated rich data about paramedics' and chaplain's perspectives on chaplains' role. Findings moved beyond being simply descriptive to explanatory, thereby providing deeper insight into the chaplains' role, their skills and attributes, and the perceived value they added to ambulance services (Gale et al., 2013; Ward et al., 2013). FA allowed examination of similarities and differences, as well as relationships between different parts of the data (Gale et al., 2013), notably the paramedics' and chaplain's perspectives, which provided greater depth than analysing paramedics' perspectives alone. Phase 1 is described in more detail in Chapters 4 and 5.

### *3.4.2 Phase 2 – Quantitative instrument development*

#### *Aim*

The aim of Phase 2 was to develop a quantitative survey that was "grounded in the culture and perspectives of the participants" (Schneider et al., 2016, p. 87) – in this case, Australian paramedics. The questions generated from qualitative findings were formulated to align with all four research questions.

#### *Survey development*

Key themes generated from Phase 1a and 1b were combined in a joint display, and subsequently used to generate a pool of potential survey questions (Appendix 5) (Creswell & Plano Clark, 2018). Items that were assessed as being most likely to help me answer the research questions were then used to develop a survey intended to be distributed to Australian paramedics. 5-point Likert scales were used throughout the survey to indicate level of agreement or disagreement, or importance or unimportance. Free text responses were also collected. More information on survey questions is provided in Chapter 6.

The rigour of a quantitative study is determined by assessment of validity and reliability. Validity examines whether an instrument measures what it is supposed to; in Phase 2, face, construct and content validity were ascertained using expert panel consultation (Almanasreh et al., 2019; Andrew & Halcomb, 2009). Face validity refers to the level of agreement between the researcher and participants about the researcher's interpretations and conclusions, while content validity is established through expert consensus on the survey questions (Andrew & Halcomb, 2009; Brink et al., 2012). Construct validity mandates that the researcher account for their personal constructs and the origin of these (Andrew & Halcomb, 2009; Brink et al., 2012). Creswell and Plano Clark (2018, p. 251) stated that validity in mixed methods research is about using strategies that minimise potential internal and external threats to draw "correct inferences and accurate assessments from the integrated data". They outlined three threats to validity in exploratory sequential designs: the final instrument is not derived from the qualitative results, quantitative features do not contain enough rigour, and the use of the same individuals for both qualitative and quantitative research (Creswell & Plano Clark, 2018). Several steps were taken to account for these

threats and enhance the validity of this survey. Firstly, key themes identified from the qualitative phase were presented alongside proposed questions for the quantitative phase via a joint display, to ensure questions remained true to the qualitative findings. Once I had developed a tentative list of questions using instrument design principles, I sent it to an expert panel (described below) to assess for content validity (Creswell & Plano Clark, 2018; Dillman et al., 2009; Whitehead et al., 2020).

I assembled a panel of seven Australian experts in paramedicine, chaplaincy and spiritual care research, and statistics/epidemiology, ensuring diverse academic and practitioner perspectives. I asked the panel to assess each potential survey question for relevance and clarity using the content validity index (CVI), a 4-point ordinal scale (1 = not relevant to 4 = highly relevant), and invited them to give written feedback (Gilbert & Prion, 2016; Polit & Beck, 2006). Polit and Beck (2006) stated that when an expert panel includes more than six people, the individual CVI threshold for including a question in a survey is 0.78. Individual content validity scores were 0.85–1.0 for all questions on relevance, but four questions rated 0.71 on clarity (Appendix 6). Because the panel rated the relevance of those questions highly, I used the written feedback (which predominantly mentioned repetition) to rewrite those questions for the final survey.

Reliability in quantitative studies relates to the consistency and repeatability of participants' accounts and the researcher's ability to accurately collect information (Brink et al., 2012; Coffey et al., 2017). Test-retest was not an option due to the difficulty in getting the sample group to repeat the survey, along with this survey being designed to be integrated with qualitative findings from Phase 1 rather than be repeated, so reliability was not determined (Whitehead et al., 2020).

Finally, parallel sampling, or studying different people within the same population, was used for the qualitative and quantitative streams as a means of enhancing validity in developing the survey (Coffey et al., 2017). Once I had developed the final survey and received approval from the UTS HREC, the instrument was piloted with a small sample group of paramedics who had not participated in the qualitative interviews or evaluated the survey's validity (i.e., were not members of my expert panel). Once these steps were taken, I commenced Phase 3 (Brink et al., 2012). Further information about the survey can be found in Chapter 6.

### *3.4.3 Phase 3 – Quantitative data collection and analysis*

#### *Aim*

The aim of Phase 3 was to explore the role and value of ambulance chaplains through analysis of quantitative responses from Australian paramedics, in line with all four research questions.

#### *Ethics*

Prior to participant recruitment for this phase, ethics approval was sought and received from the UTS Human Research Ethics Committee (ETH22-7416) (Appendix 7).

#### *Participants and context*

Phase 3 of this study was open to jurisdictional and private ambulance organisations across Australia. AHPRA-registered paramedics, currently or previously employed by a state-based or private paramedicine organisation, were eligible for inclusion in the survey. As in Phase 1, participants were eligible to participate even if they had no previous experience with an ambulance chaplain. I expressly sought these views because I wanted to identify the factors that impact chaplain effectiveness, and in order to do this I needed to understand the barriers to paramedics accessing chaplaincy.

#### *Sample*

In Phase 3, I aimed to recruit 378 participants. While there were approximately 22,500 registered paramedics in Australia at the time of the study (Paramedicine Board, 2022a), the prevalence of use of chaplain services in this population was unknown, which complicated power calculations. Therefore, the sample size was determined using a sample size calculator, based on the population size and a 95% confidence interval (Australian Bureau of Statistics, 2022b).

### *Participant recruitment*

I employed convenience sampling, recruiting participants through email and social media. Beginning on 3 November 2022, I shared the survey URL on my own social media pages. In addition, the Australasian College of Paramedicine agreed to promote the study in its weekly publications, on its website and through Twitter and Facebook, between 3 November and 15 December 2022. However, for reasons unknown, the survey URL was only shared once on the College's social media platforms at the commencement of the study, and not published on its website or in weekly publications. Despite weekly emails from me, and a separate one from my paramedic supervisor, this situation did not get resolved until the day before the study closed when it was again shared via email to its members. I consequently kept the study open for one additional week. Nonetheless, the online survey received 202 responses over the seven weeks it was active.

### *Data collection*

Data were collected and managed through the UTS REDCap platform (National Health and Medical Research Council, 2018; University of Technology Sydney, 2018). To encourage participation, the survey was designed to be completed in 5 –15 minutes. Prior to commencing the survey, participants were shown a participant information sheet (Appendix 8). Consent was taken to be implied by the submission of a completed survey (participants were informed of this). No identifying data (e.g., IP addresses) were collected, and all identifying data were removed prior to publication.

### *Data analysis*

Quantitative data analysis commenced with data being converted from raw into useable data (e.g., incomplete responses removed) and analysed using IBM SPSS Statistics Version 29 (Andrew & Halcomb, 2009; Creswell & Plano Clark, 2018). In conjunction with supervisors and specialist staff, I used descriptive and inferential statistics to draw conclusions from the data (Brink et al., 2012; Schneider et al., 2016). I conducted chi-square analyses and used Cramer's V to determine the strength of these associations (Kirkwood & Sterne, 2003). Free-text quotes were analysed using inductive thematic analysis (Braun & Clarke, 2013).

*Integration of data*

In mixed methods research, data from qualitative and quantitative streams require independent analysis prior to the results being merged and interpreted (Andrew & Halcomb, 2009; Creswell & Plano Clark, 2018). The results from Phase 1 and Phase 3 were thematically integrated and presented in a joint display (see Chapter 7). Inferences were then made in line with the research questions to identify paramedics' perspectives on the role and value of chaplains (Brink et al., 2012; Creswell & Plano Clark, 2018).

## 3.5 My position as the researcher

To ensure transparency in this project, I acknowledged my position at all stages of the study (See section 1.8). All my affiliations and relationships were explicitly stated verbally and/or in print as part of the consent process prior to recruiting participants for interviews or the survey.

## 3.6 Ethical considerations

Informed consent was obtained from participants as outlined in the *National Statement on Ethical Conduct in Human Research* (National Health and Medical Research Council, 2018). In accordance with these guidelines, participants were given a participant information statement that described:

- how privacy and confidentiality will be preserved,
- how research will be conducted and monitored,
- how to seek assistance should they feel affected by the research questions,
- contact details of those conducting the research and a person to receive complaints,
- their right to withdraw at any stage for any reason without having to provide justification,
- any funding or financial benefits associated with researchers,
- how research results will be disseminated, and
- any expected benefits. (National Health and Medical Research Council, 2018)

Ensuring the physical and psychological safety of research participants is a crucial aspect of any research project. Consideration of the participant's moral values (e.g., autonomy, privacy, dignity and integrity) and protection from physical, psychological, social or spiritual distress must be factored into the research process (National Health and Medical Research Council, 2018; Schneider et al., 2016). National Health and Medical Research Council (2018) outlined seven elements common to research:

1. Research Scope, Aims, Themes, Questions and Methods
2. Recruitment
3. Consent
4. Collection and management of data and information
5. Communication of research findings or results to participants
6. Dissemination of research outputs and outcomes
7. After the project – how the data will be managed or disposed of. (National Health and Medical Research Council, 2018, p. 23)

In the following sections, I discuss participant risk versus benefit; privacy, anonymity and confidentiality; and dissemination of research outputs and outcomes.

### *3.6.1 Participant risk versus benefit*

Ensuring that the risks involved in conducting research are justified by the benefits is another key element of the *National Statement on Ethical Conduct in Human Research* (National Health and Medical Research Council, 2018). Because this study involved asking ambulance staff to reflect on interactions with chaplains, which can occur as a result of or in association with extremely distressing events, potential existed for participants to experience strong emotions while completing the interviews or survey. In Phase 1, participants were verbally informed of this possibility prior to attending the face-to-face interview, and I sent the questions to be asked in advance of the interview to ensure full disclosure and informed consent. In Phases 1 and 3, this information was provided in written format on the participant information sheet, alongside information about available support services including Employee Assistance Programs, Beyond Blue and Lifeline. As an additional precaution, I

requested that the NSWA Chief Psychologist allow her direct mobile number to be provided to qualitative interview participants should they require it, which she approved.

As outlined in Chapter 1, my study aimed to explore what ambulance chaplains do, the skills and attributes they should possess, and the perceived value they add to individual paramedics or their organisations. Consequently, the intended benefit of this study is a spiritual support program that meets paramedics' needs, and promotes their wellbeing, more effectively than the present arrangements.

### *3.6.2 Privacy, anonymity and confidentiality*

Ensuring research participants' privacy involves protecting their confidentiality and anonymity (Brink et al., 2012). According to Element 4, Chapter 3.1 of the NHMRC guidelines, all data and information collected were deidentified, and each participant was allocated a pseudonym (eg. Paramedic 1, Chaplain 5) (National Health and Medical Research Council, 2018). Participants in Phase 1 had minimal personal data collected; any identifying data were removed from the transcripts, and numbers were used instead of names (National Health and Medical Research Council, 2018). In Phase 3, surveys were anonymous and included no identifying marks or symbols. No participants were identifiable in publications, reports or presentations related to the research described in this thesis.

### *3.6.3 Participant withdrawal*

Participants were informed that participation in this study was voluntary. They were advised that if they decided to withdraw or not participate, it would not affect their employment or future access to/communications with a chaplain, or any other support services.

In Phase 1, participants were informed that if they wished to withdraw from the study once it started, they could do so at any time without having to give a reason. In Phase 3, participants were informed that they could withdraw from the survey at any time by not clicking on the "submit" button. However, it would have been impossible to withdraw data once identifying details were removed (Phase 1) or the submit button had been clicked (Phase 3).

## 3.7 Bracketing and reflexivity

In Chapter 1, I discussed my role as an ambulance chaplain. As previously outlined by Maarouf (2019), this "bias" could have worked both for and against me, because I had experience and insight into the subject I studied. These assets could have helped me design more relevant research, but it was essential that I did not allow any preconceived ideas or thoughts to affect the research findings. It was therefore essential, before commencing this study, to document or "bracket" my assumptions and how I intended to practice reflexivity. Bracketing can be described as the researcher documenting their assumptions, thoughts, hypotheses and beliefs about the phenomenon to be studied (Tufford & Newman, 2010).

The following points are assumptions and/or hypotheses I held prior to undertaking the research:

- Relationships are important – staff want to know their chaplain, and are unlikely to trust an unknown person, especially ones with religious symbols on their uniform. Additionally, no one is going to reach out to someone they don't know, personally or for support at the significant jobs;
- The chaplain and their personal characteristics are important – people will not talk to chaplains who are not trustworthy or approachable;
- Chaplains are "neutral" and not considered a threat to paramedic careers – they are not management, but they know enough about the organisation and culture to be trusted as a confidant;
- Chaplains go in when the paramedics want to go out – if a paramedic calls a chaplain to the scene of a significant job, it's because they are uncomfortable with the emotional elements and would like someone to take over so they can do their job and leave; and
- A chaplain having a paramedicine/nursing background is helpful – content knowledge means paramedics can talk about more than their emotions, freely mixing clinical discussion with emotional content. This may result in more holistic care.

Reflexivity is the process of the researcher engaging in critical reflection practices (Peddle, 2022). Considering beliefs and assumptions throughout the research process can enhance the

credibility and dependability, and hence the overall quality, of quantitative research (Peddle, 2022). During this study I was careful to journal and keep analytical memos, documenting not just thoughts about the data but to challenge my assumptions and whether they were grounded in the research or personal experience. I kept a note next to my computer with the question "Would my supervisors come to this conclusion too?" to remind me to be mindful of how I was interpreting the data. Furthermore, I met regularly with supervisors to discuss my thoughts, and to maintain rigour in my findings.

Finally, I was aware that I would be exposed to multiple stories involving significant trauma, therefore increasing my exposure to vicarious trauma. Consequently, I arranged supervision with a clinical psychologist whilst undertaking the qualitative interviews.

## 3.8 Data management

In keeping with the obligation to protect participants' privacy, a data management plan was incorporated with this research proposal (National Health and Medical Research Council, 2018). Data for this project was managed in accordance with UTS data management policy (University of Technology Sydney Library, 2019) and the NHMRC's *National Statement on Ethical Conduct in Human Research* (National Health and Medical Research Council, 2018). Under this policy, identifiable data remains confidential, and can be disclosed only with the participant's permission or if required by law (National Health and Medical Research Council, 2018). Other than me, only my supervisors had access to data, but if participants requested data be restricted to my eyes only, they were not disclosed to them.

A Research Data Management Plan was created in UTS Stash, and data were stored in a password-protected University of Technology OneDrive account, to be transferred in a password-protected University of Technology eResearch Store account for five years on completion of this degree, then archived or disposed of in accordance with UTS data management policies (University of Technology Sydney Library, 2019). UTS has vetted these programs for security, legal jurisdiction and legislative compliance (University of Technology Sydney, 2019). Data kept on external hard drives was encrypted, and all laptops and external hard drives were password protected and kept in a secure location (University of Technology Sydney Library, 2019).

## 3.9 Conclusion

In this chapter, I presented a rationale for an exploratory sequential mixed methods study from a pragmatic and salutogenic perspective, and described how I conducted it, including undertaking semi-structured interviews, developing a survey and distributing the survey to Australian paramedics. Additionally, I demonstrated how my study met strict nationally recognised ethical standards to ensure the safety of participants. The next chapter contains a published article that outlines Phase 1 of the study.

# Chapter 4 – The role and value of chaplains in the ambulance service: paramedic perspectives

## 4.1 Introduction

In Chapter 1 of this thesis, I set the scene for my study by outlining the challenges to paramedic wellbeing, the role of spiritual care in health, and the absence of literature on the provision of spiritual care in Australian ambulance organisations. In Chapter 2, I presented a scoping review that confirmed the lack of knowledge about chaplains in ambulance or EMS, especially with regard to the views and perspectives of paramedics, and provided the rationale for my study. In Chapter 3, I provided an overview of the design of this study and how it would be completed in line with Australian standards.

Chapter 4 presents key findings from the first qualitative phase (Phase 1a), in which I explored the role and value of chaplains in ambulance organisations from the perspectives of paramedics working in NSWA, an Australian jurisdictional service. It does so in the form of a publication titled "The role and value of chaplains in the ambulance service: Paramedic perspectives".

## 4.2 What does the paper add to existing knowledge?

The major findings presented in this paper are that the chaplain's role encompassed both proactive and reactive elements of providing care in both ordinary or day-to-day aspects of paramedic work and during emergency responses in which chaplains supported paramedics and bystanders. The findings also demonstrate how organisational decisions relating to the chaplain's role, such as lack of clarity around role descriptions, can determine its success or failure. Finally, the study participants described how chaplains improved their wellbeing by reducing barriers to accessing additional support and promoting help-seeking behaviour.

## 4.3 Impact of this paper

This paper was published in a Quartile 1 journal. At the time of writing, this paper had seven citations and a field-weighted citation impact (FWCI) of 9.38 in SciVal*.

*A score of greater than 1.0 indicates the article is cited more often than the average for similar publications (University of Technology Sydney, n.d.).

Citation

Tunks Leach, K., Simpson, P., Lewis, J., & Levett-Jones, T. (2022). The role and value of chaplains in the ambulance service: Paramedic perspectives. *Journal of Religion and Health 61*(2), 929–947. https://doi.org/10.1007/s10943-021-01446-9

Assoc. Prof. Lindsay Carey (Editor-in-Chief, JORH, Springer Science, 3 July 2023) granted permission for replication of the publication "The role and value of chaplains in the ambulance service: Paramedic perspectives" in this thesis.

## 4.4 Published paper

Journal of Religion and Health
https://doi.org/10.1007/s10943-021-01446-9

ORIGINAL PAPER

# The Role and Value of Chaplains in the Ambulance Service: Paramedic Perspectives

**Katie Tunks Leach**[1,2] · **Paul Simpson**[3] · **Joanne Lewis**[4] · **Tracy Levett-Jones**[1]

Accepted: 15 October 2021
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**Abstract**
Chaplains are employed by ambulance services in many states across Australia as one element in a suite of initiatives to support the health and wellness of paramedics. The aim of this paper is to present key findings from a study that explored paramedic perspectives on the role and value of chaplains in the ambulance service. Seventeen paramedics participated in semi-structured interviews. Data were analysed using framework analysis. Two themes were identified: scope of the chaplain's role and organisational factors influencing the chaplain's role. Paramedics highly valued what they believed to be proactive and reactive support provided by ambulance chaplains, regardless of paramedics' personal spiritual or religious beliefs.

**Keywords** Paramedic · Emergency medical services · Well-being · Chaplaincy · Spiritual care

## Introduction

Chaplains have long been established in ambulance services around the globe as one aspect of staff health and wellbeing programs. Modern-day chaplaincy teams are made up of multi- or interfaith spiritual care practitioners experienced in supporting staff, regardless of personal beliefs and religious affiliation, through assessment, support, counselling, education, and spiritual or religious care (Carey, 2012; Carey & Cohen, 2015; WHO, 2017). Among the issues

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Published online: 25 October 2021 Springer

which chaplains help staff explore, are values, beliefs, purpose, meaning, hope, forgiveness and personal philosophies (Cunningham et al., 2017; Timmins et al., 2018).

Ambulance chaplains work independently and collaboratively in staff support teams that may also include psychologists, fitness support and peer support officers among others (Ambulance Victoria, 2016; NSW Ambulance Service, n.d.; Queensland Ambulance Service, 2018; St John Northern Territory, 2020). These teams have been implemented by the majority of Australian ambulance services in response to emerging evidence indicating less than optimal psychological, physical, emotional, and spiritual health among paramedics caused by the nature of the work and organisational culture, contributing to paramedics experiencing higher rates of depression, anxiety, post-traumatic stress disorder (PTSD) and suicidal ideation than the average population (Beyond Blue Ltd, 2018; Davis et al., 2019; Lawn et al., 2020; Senate Education Employment References Committee, 2019). These holistic support programs aim to provide a positive response for supporting the needs of staff; however, a dearth of research evaluating their effectiveness is evident (McCreary, 2019).

While chaplains would appear to be a valuable addition to paramedic wellness strategies to address social, emotional and spiritual needs, debate continues in Western cultures on their relevance by those who see the role as solely religious (Best et al., 2021). These views highlight common misconceptions about spirituality, religion and the role of chaplains. A consensus definition developed by Puchalski et al., (2014, p. 646) holds that spirituality is:

> "…a dynamic and intrinsic aspect of humanity through which persons seek ultimate meaning, purpose, and transcendence, and experience relationship to self, family, others, community, society, nature, and the significant or sacred. Spirituality is expressed through beliefs, values, traditions, and practices."

This definition separates religion from spirituality, while still accommodating those holding religious views. It also underpins the work of chaplains in delivering person-centred care for all. Additionally, considerable evidence supports the connection between religion, spirituality and positive health outcomes including enhanced levels of wellbeing, optimism and hope, and reduced rates of depression, anxiety and suicide, along with other positive physical, psychological and social outcomes (Koenig, 2012, 2015). Considering these potential health benefits, maintaining chaplains in the ambulance service may in fact promote positive health outcomes for paramedics (Best et al., 2021; Puchalski et al., 2014). Finally, spirituality is important not only for the paramedic's personal life but also in their professional practice, through the use of skills including empathy, compassion and resilience which add depth to their role and move it beyond merely technical (Lazarsfeld-Jensen & O'Meara, 2018).

To understand more about how paramedics view chaplains, a systematic scoping review conducted by the first researcher (KTL), on staff perceptions of chaplains in first responder and military settings explored chaplain roles and the

perceived value of chaplains; however, the paramedic perspective was noticeably absent from the review (Tunks Leach et al., 2020). The aim of this paper is to present key findings from a study that explored paramedic perspectives on the role and value of chaplains in the ambulance service.

## Methods

### Study Design and Setting

This study was carried out in New South Wales Ambulance (NSWA), Australia in 2020. NSWA employs over 5971 staff (NSW Ambulance, 2020a) and has the largest multifaith ambulance chaplaincy program in Australia. This program employs one paid and 55 volunteer chaplains (23 female and 22 male), including 1 Muslim, 1 Jewish and 53 Christian chaplains. It aims to provide 24 h/7-day support to staff, their families and bystanders, regardless of their spiritual or religious views (NSW Ambulance, 2020b).

This study represents the first phase of an exploratory sequential mixed-methods approach. Underpinned by a pragmatic philosophical framework, this approach allows for multiple 'truths' or viewpoints in line with the definition of spiritual care underpinning this study. Pragmatism is driven by the research questions and a commitment to using multiple forms of data to find answers (Biesta, 2010; Creswell & Plano Clark, 2018). This phase consisted of semi-structured interviews with paramedics and will be the basis for developing a survey designed to examine the views of a broader cross section of paramedics in phases 2 and 3 (Creswell & Plano Clark, 2018; Schneider et al., 2016).

As the first researcher is a practicing ambulance chaplain in NSWA, bracketing occurred prior to undertaking any research to document thoughts, assumptions and hypotheses, as well as throughout the research process via reflexive journaling and analytical memos (Tufford & Newman, 2010). To maintain a degree of objectivity, the first researcher also discussed the findings at regular meetings of the broader research team.

### Sample and Recruitment

Following ethics approval, participants were recruited via emails distributed by NSWA's research unit. Purposive sampling and maximal variation approaches were employed to ensure diverse perspectives were obtained, including people of diverse gender identities, ages, professional experience, city or regional experience and personal spiritual beliefs (Creswell & Plano Clark, 2018; Schneider et al., 2016). Follow-up was by email or telephone to ensure participants met inclusion criteria and understood the interviewer's role as a chaplain/researcher. Interviews were ceased when no new data were emerging (Coffey et al., 2017; Collins, 2010).

### Ethical Considerations

Ethics approval was obtained from South East Sydney Local Health District Human Research Ethics Committee [2019/ETH13593]. This was then ratified by the University of Technology Sydney Human Research Ethics Committee [ETH19-3820]. Participant information sheets were provided to all participants prior to obtaining written informed consent, and staff were informed that their responses would be deidentified to ensure privacy and confidentiality. Furthermore, they were informed that data would be used in peer-reviewed publications and conference presentations.

### Data Collection

Paramedics were interviewed between July and October 2020. All interviews were conducted by the first researcher in a mutually convenient location and lasted between 30 and 60 min. Eight participants had previously met or worked with the interviewer while nine had not, and all were informed of the first researher's reasons for conducting the research. Interview questions were generated and refined following a scoping review and pilot interviews (Appendix 1). They were provided to participants in advance and used to guide the conversation. The semi-structured interviews allowed the researcher to clarify and pursue themes as appropriate. Each interview was audio recorded and transcribed verbatim.

While some face-to-face interviews were undertaken, the majority took place via telephone due to the research being conducted during the early stages of the COVID-19 pandemic, and the associated restrictions in place. At this stage of the pandemic in NSW, there were very few cases of COVID-19 circulating in the community, with the majority contained to hotel quarantine. Consequently, some chaplains remained in their workplaces while others were removed according to localised restrictions. Therefore, the impact of COVID-19 on chaplain support was not assessed as part of these interviews.

### Data Analysis

Data were analysed using framework analysis, a thematic data analysis method originally developed by Richie and Spencer (1994). This 'problem focussed' approach generates thematic groupings, allowing analysis to move beyond the descriptive to the explanatory (Gale et al., 2013; Ward et al., 2013). Transcripts were coded and analysed according to the seven steps outlined by Gale et al. (2013). Regular meetings were held between the research team during the data analysis.

## Results

The sample consisted of 17 permanently employed paramedics; nine identifying as male and eight as female with a mean age of 42 years, and duration of service ranging from two years to 43 years (mean 15.1 years) (Table 1). Nine participants were

**Table 1** Participant demographic characteristics

| Paramedic pseudonym | Gender | Age range | Duration of service | Religion |
|---|---|---|---|---|
| Paramedic 1 | Male | 30–39 | 5–10 years | Not spiritual or religious |
| Paramedic 2 | Male | 50+ | 20 + years | Not spiritual or religious |
| Paramedic 3 | Male | 40–49 | 20 + years | Spiritual not religious |
| Paramedic 4 | Female | 50+ | 20 + years | Not spiritual or religious |
| Paramedic 5 | Female | 50+ | 20 + years | Spiritual not religious |
| Paramedic 6 | Male | 40–49 | 5–10 years | Not spiritual or religious |
| Paramedic 7 | Male | 20–29 | 5–10 years | Spiritual not religious |
| Paramedic 8 | Male | 30–39 | 11–20 years | Not spiritual or religious |
| Paramedic 9 | Male | 40–49 | 11–20 years | Not spiritual or religious |
| Paramedic 10 | Female | 40–49 | 5–10 years | Not spiritual or religious |
| Paramedic 11 | Female | 50 + | 20 + years | Spiritual not religious |
| Paramedic 12 | Female | 20–29 | < 5 years | Religious |
| Paramedic 13 | Male | 50 + | 5–10 years | Religious |
| Paramedic 14 | Female | 20–29 | < 5 years | Not spiritual or religious |
| Paramedic 15 | Female | 20–29 | 5–10 years | Not spiritual or religious |
| Paramedic 16 | Male | 50 + | 11–20 years | Religious |
| Paramedic 17 | Female | 30–39 | 5–10 years | Not spiritual or religious |

from Metropolitan Sydney and eight from regional New South Wales. All were qualified paramedics and four had additional specialist qualifications. Four had experience in management roles, two in education roles, two in control centres, and two as Peer Support Officers. Three paramedics were classified by the first researcher as religious (believing in a higher power and attend religious gatherings), four as spiritual but not religious (believing that there might be a higher power but do not regularly attend religious gatherings) and ten as not spiritual or religious (atheist/agnostic/do not believe there is anything out there). Steps were taken to ensure confidentiality, including assigning pseudonyms and removing identifying features of quotes.

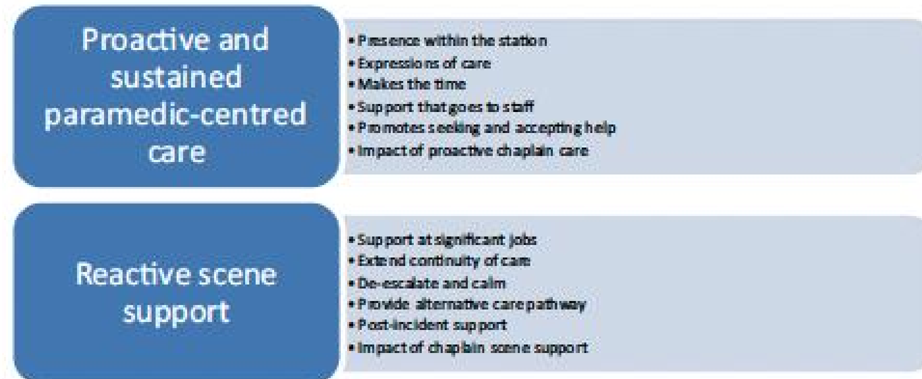
Findings were categorised into two overarching themes: (1) Scope of the chaplain's role; and (2) Organisational factors impacting the chaplain's role (Fig. 1).

## Scope of the Chaplain's Role

### Proactive and Sustained Paramedic-centred Care

Participants observed that chaplains were proactive, making the time and effort to regularly attend stations and build trust with staff and management. Their activities included hosting barbeques, providing food, or any activity that was perceived to "help create…community" (Paramedic 12). Additionally, paramedics spoke of the value of having someone voluntarily give up their time at any time of the day or night to support them and the powerful message this sends:

**Scope of chaplain's role**




**Factors influencing the chaplain's role**

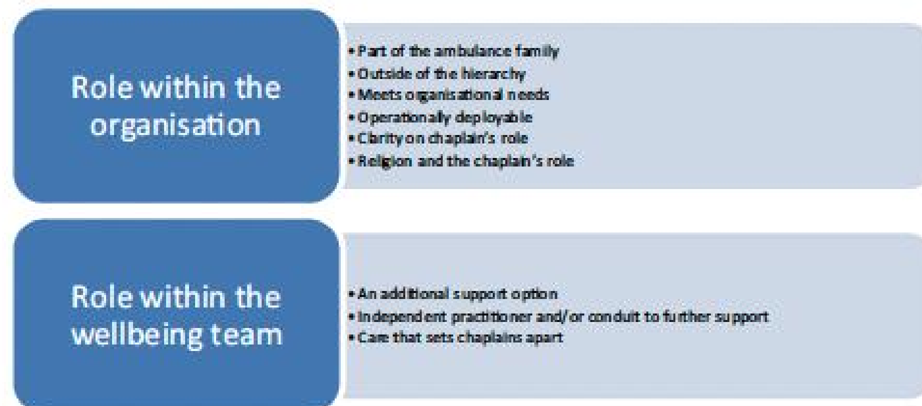



**Fig. 1** Results Summary

> "The fact that we've got this group of people who say we value what you do every day enough that we will contribute our own time and resources to just come and help you out, is incredibly valued and impactful for those staff. I think it opens up a heap of conversations that would otherwise not be accessible if someone had just come along and plonked a big program of staff wellness on top of us" (Paramedic 1).
> "If everyone had access to one, or just in passing. It doesn't need to be when your house almost burns down in a bushfire. If I'd met [the chaplain] before, I might have been more willing to reach out sooner if I needed something. I might have been able to say to [my manager], look, I don't think I need a psychiatrist, I'm actually having a chat with [the chaplain], over this string of bad jobs, if I'd have known what they were like" (Paramedic 15).

Some participants expressed a desire for more chaplains with greater availability and station presence, however recognised the limitations due to their voluntary role:

> "We have to be able to get hold of them. More often than not it goes through the message bank and that is understandable given what they do. They have primary roles and we're secondary, which is fair enough. Unlike the New South Wales police who use chaplains as a full-time, that's their job. They are on-call all over the place, they get flown to locations if necessary" (Paramedic 3).

Chaplain support was seen to be mobile, going to paramedics in their workspaces rather than relying on them to make an appointment or attend a specified location. Support included taking staff off-road for coffee, standing with them at significant jobs, meeting them at hospitals, and riding in ambulances with crews to talk in between jobs:

> "It would be over a coffee or over a sandwich. We were moving around. It wasn't like they sat us down in the office and then had a talk. Like you might just have a day with [the chaplain] and you'd go and treat on jobs, and you'd do all this and that, but in between is when you talk about that horrific job you did, or I've got some shit going on at home, or whatever. It's in between the jobs, driving to jobs" (Paramedic 15).

These pre-existing relationships and activities undertaken by chaplains were seen to promote conversation and help-seeking, and normalise supportive conversations. Furthermore, participants felt safer divulging personal information to a chaplain they knew and were familiar with:

> "When I was in a bit of a rough patch myself. It was just hard to think through the process of who I needed to contact to get some help. When you're in that sort of frame of mind where everything's really difficult…reaching out to someone that you don't know is alienating. It's terrifying. It's not something that you're going to do. Having someone that you're familiar with and has been on-station that you're comfortable with, that you can just – you know you'll call, and something will happen. The help you need will be started" (Paramedic 14).

Some participants reflected on incidents where they perceived that chaplain intervention prevented or minimised staff leaving on workers' compensation or sick leave, and two instances where chaplain potentially prevented staff from dying by suicide:

> "I think personally from having used [a chaplain] in a situation whereby we had serious concerns for the physical and mental wellbeing of one of our staff - I think five years ago that person could have easily killed themself. Easy because they were just so, so over the edge. I don't think you could put a value on that. Absolutely extraordinary. Even if their mental and physical health improved somewhat, they wouldn't have lasted in the job without having that support from the chaplain" (Paramedic 8).

Particular reference was made to the additional value chaplains with clinical experience bring, such as paramedicine or nursing. This experience was perceived to promote faster connections, and a more holistic understanding of the paramedic in their role and life:

> "You've got the chaplains that are obviously clinically minded as well, so they're even more in tune with what's going on. I think that's really important. I'm not saying the best chaplains are nurses or paramedics, but I do think that's important because they have a good understanding of what we're doing medically as well… they can talk about the whole thing, not just about their emotions" (Paramedic 11).

### Reactive Scene Support

Paramedics also spoke of support provided by chaplains called out to significant jobs or 'on-scene'. These include major incidents, patients known to paramedics, high profile jobs reported in the media, and jobs eliciting strong emotions or with personal impact (e.g. paediatric cardiac arrests and death by suicide):

> "We've got all these staff psychologists and it's another tool to add to the belt for staff welfare, but they're only available Monday to Friday between those hours…I know that if it's two in the morning and shit goes down, I can call the number and I can get a chaplain in ambulance uniform on the scene within whatever timeframe. I think that is just absolutely invaluable" (Paramedic 8).

Chaplains were also seen to bridge a perceived gap in care between paramedics and bystanders, extending the ambulance continuity of care beyond the clinical. Paramedics spoke of the value in chaplains who de-escalated bystanders or brought a sense of calm, supported people who witnessed the trauma, answered questions, provided grief support, and connected bystanders to external support services. In some instances, chaplains provided an alternative pathway of care for patients who could not be left alone but did not necessarily need hospitalisation. Paramedics said it gave bystanders someone to connect with and enabled them to maintain focus on the patient:

> "A young guy came home to find his dad dead. There was nothing for us to do as ambulance paramedics because it was already done, and the chaplain came and sat with this family. They had no-one but themselves and the chaplain there, and it was just beautiful… It's bridging that gap of care. And it's not clinical care, it's compassionate care and love and warmth, and making them feel that they've got something and someone to talk to" (Paramedic 11).

Post-incident support was also identified as part of the chaplain's role. Paramedics spoke of the value in knowing chaplains would check in on them after "calamitous sad stuff" (Paramedic 1) in person and via phone. Support could be formal, such as at post-incident clinical debriefs, or through informal conversation. It was noteworthy that paramedics did not necessarily want to talk about the job at the debriefing:

"We went to the train station where unfortunately the bloke died. We got a coffee afterwards. The chaplain had taken us offline for a short period and it was only 20 minutes or so but I don't think we talked about anything about the job, but I really took comfort in that. That was brilliant. A couple of days later, I might not be feeling as good potentially. It's always nice just to have a [follow up] phone call" (Paramedic 7).

Interviewees frequently attached an element of emotion or impact to their reflections. Words like 'worry' or 'guilt' were associated with needing to focus on the patient and forgo bystander support or needing to leave bystanders with no support after someone has died. Others reflected on the personal impact of constant exposure to a trauma. Having chaplains attend to take over patient/bystander care or turning up with a tray of coffees was perceived to make a positive impact, with participants using phrases like 'you can get closure', 'you can let go', and 'they are our pressure release valve':

"It's like when we walk out in past years, we just shut a door and we go, sorry we had to meet you under those circumstances. But having someone there to hold their hand at the end of the day. It's like we leave them we say, hey, we're tapping out, you're tapping in. There's a sense of, you're just not walking away and leaving them by themselves. It tugs at your heart, but now you go, actually there's a person I can leave to take that over for me so I can go back out and do my job" (Paramedic 11).

Some paramedics reflected on the value of talking to chaplains in the aftermath of significant trauma (e.g. paediatric death, suicide) and engaging in "no-holds-barred conversation". They reflected on the value of having someone available to listen and let them get things off their chest 'without agenda' or 'feeling they were being diagnosed', and how this validated their experiences: "It's about feedback. Our feelings are quite normal in extreme situations, and they're happy to talk to explain, and there's no ridicule" (Paramedic 2). The listening element was especially valued by most participants in these conversations:

"I didn't feel like I needed to see a psychiatrist. Sometimes you just need to talk. Sometimes you don't need anyone to say anything to you about it, but just go, that's terrible. You've been through hell, seeing that. How do you feel? Then you talk about it. I don't need any answers. I don't need help" (Paramedic 15).

Additionally, these conversations were valued because participants felt they could talk about confronting content or topics that otherwise could not be discussed with family or friends outside of work. However, some participants were concerned about the impact of these conversations on chaplains:

"We are offloading onto the chaplains the worst of the worst, worst shit that we go to and see or have to deal with. We're not just giving them the little fluffy shit to deal with. It's the worst. That's what I worry about, that they are going to lose it or go crazy" (Paramedic 8).

## Organisational Factors Influencing the Chaplain's Role

### Role Within the Organisation

Embedding chaplains within the organisation was overwhelmingly viewed as positive if they met paramedic needs. Participants spoke of a protective culture suspicious of outsiders, and how having someone 'on the inside', in uniform and easily recognisable to paramedics, promoted the idea that chaplains are part of the ambulance family:

> "I think we're incredibly resistive to outsiders. Massively. Even other emergency services. We hate everyone, but to have someone turn up in an ambulance uniform with the roundel on their shoulders knowing that you've come in and you've seen the same shit that we have, you've been in the trenches with us, I think there's a respect gained there" (Paramedic 8).
> "When we speak to each other, we speak to each other. We speak our own language. In Emergency Services we live and breathe a life that nobody else sees…A chaplain in the organisation is - it's someone else to talk to" (Paramedic 13).

Paramedics expressed the importance of chaplains being outside the hierarchy, reflecting on the value of having support that was not management or clinical, rather someone whose sole focus was paramedic welfare:

> "They're completely outside the chain of command, which makes them fully independent. That's why the chaplains coming in, they do not represent management. The people can actually have a bitch about processes to be empathetically listened to without being judged, or 'toughen up, young lad, that's life'. You can't put a price on that" (Paramedic 2).

Having a workforce that met organisational needs and was operationally deployable promoted the idea that chaplains could support staff and bystanders 'on the front line'. Paramedics appreciated being able to call for chaplains to be deployed on-scene. They also valued having diverse genders of chaplains, a chaplain team that could mobilise rapidly to meet demand, and the desire for more of them:

> "Often on the way to a job if they think it's complicated or complex enough, some of them will ask, is there any chance we can get a chaplain? Give a chaplain a heads-up now and we'll let you know if we need them. I've done that before too" (Paramedic 3).

There was a lack of clarity around the chaplain's role throughout most interviews. Many participants could not explain what chaplains do, and in some instances did not know chaplains existed until they met them on their station or on-scene. Other participants stated the chaplain's role included emotional support, staff welfare, to meet spiritual needs and educate staff on topics including grief:

> "It comes down to paramedic wellbeing is the main function. I also sort of thought that if someone is a person of faith and they witness a horrific scene

> and they have trouble reconciling that, I think the chaplains can be a bit of a stepping stone. I don't have faith. I see a bad thing, I think that's just a bad thing" (Paramedic 10).

For a considerable number of participants, there was a lack of clarity around the role religion plays in the chaplain's activities. Several paramedics stated that prior to knowing a chaplain they were concerned about having religion pushed on them, about negative public sentiment towards the church, and how the religious symbolism on the chaplain's uniform was off-putting. After meeting the chaplain, others were confident that there was 'no denominational component' to chaplain activities unless requested. Those who identified as religious appreciated opportunities to discuss their job and faith:

> "Given that we are dealers in life and death, and professionally we spend our time fighting God over our patients, it's important to have some sort of spiritual guide there, I think. Someone that's involved" (Paramedic 16).

### Role within the Wellbeing Team

Paramedics saw value in having a greater range of choices should they decide to reach out for help, acknowledging that no single service was going to meet everyone's needs. Despite acknowledging the organisation is promoting psychology as a confidential treatment option, suspicion remained for some due to negative historical experiences:

> "I trust the chaplains. I trust the chaplaincy service more than I trust the psychological service. I know they're trying to break down those barriers, and I understand that. I just don't know if I want to risk it. So, without the chaplaincy there, I would be in a pickle. … It's just comforting to know it's there if I need it, and that I can trust him" (Paramedic 5).

Paramedics spoke of chaplains who could function independently, and as a conduit to further care (e.g. psychology, management) if needed:

> "[Chaplains] are keen to listen and – but then also willing to take action. Like I will listen to you, but I can put this in place or get you in contact with someone else. Whatever you need, I'll get started…I think having that understanding of the way we work and then being linked into the other support structures that exist and then the operational structures, so that you can talk to our managers and that sort of thing is absolutely pivotal" (Paramedic 14).

When reflecting on what differentiates chaplains from other support options, paramedics spoke of chaplains "providing a more human level of engagement than [other services] can sometimes provide" (Paramedic 9), a role that is "about paramedic support first and foremost" (Paramedic 7), and knowing that someone is there "that's got my back" (Paramedic 5). Paramedics reflected on the value of chaplains who 'get it' or understood the language and pressures because of shared knowledge

and experiences. Consequently, staff felt it made it easier to accept support and the chaplain's input as valid:

> "I've actually had a psychologist who said, 'yes, I know what you mean'. No, you don't. Or, 'I know how you feel'. You haven't got a clue how I feel. This [chaplain], they know exactly how I feel. They can be at a job standing next to you and if they said, 'I get what you mean', they actually did get what you meant" (Paramedic 4).

The final question in each interview asked if participants thought chaplains add value to the ambulance service?" Sixteen of the seventeen participants expressed in the affirmative. The remaining participant had previous experiences with chaplains engaged in unprofessional behaviour and believed chaplains did not meet their needs. Their response to this question was "I think it comes down to the chaplain… they didn't meet my need and I wouldn't consider them" (Paramedic 17).

## Discussion

This study explored paramedic perspectives on the role and value of chaplains in the ambulance service. Data analysis identified that paramedics valued what they perceived to be proactive and reactive support provided by ambulance chaplains, regardless of their personal spiritual beliefs. Several findings in this study were new owing to the lack of peer-reviewed research specific to ambulance chaplaincy, while others were supported by research in similar settings such as first responder, military and hospital emergency/critical care environments. Additionally, findings aligned with the World Health Organisation's (WHO) Spiritual Intervention Codings of religious/pastoral/spiritual assessment, support, counselling/guidance, education and ritual (Carey & Cohen, 2015; WHO, 2017).

Results relating to the role of ambulance chaplains were clustered around two significant themes: relationships and professional capability. Relationships were built through proactive activities undertaken by the chaplain within ambulance stations, at hospitals or more broadly in their assigned areas, and occurred outside of operational work. Chaplains physically and emotionally present within ambulance stations provided social, psychological, emotional and spiritual support, and provided spontaneous opportunities for paramedics to engage in conversation, therapeutic or otherwise. This care was valued because it was not geographically removed from paramedics, rather it was situated in their workplace and humanised staff support for paramedics, consistent with narratives and reports from other first responder services (Calams, 2017, August 22; Cunningham et al., 2017; Myers, 2019, March 6; Phoenix Australia, 2016).

Relational support (as opposed to managerial, operational or clinical) was important to paramedics. They valued having someone available who was not there to diagnose, critique clinical performance or fix, but to listen, offer words of reassurance and to connect them to further support if required, which in turn promoted rapport and trust. Like similar studies, paramedics perceived this to reduce barriers to accessing support, normalise help-seeking conversations and make it easier to

disclose personal information (Beyond Blue Ltd, 2018; McCormick & Hildebrand, 2015; Moosbrugger, 2006). Some paramedics suggested that pre-existing relationships meant that chaplains knew staff well enough to recognise when something was amiss and to proactively ask them if they were ok.

Professional capability of chaplains was established through a combination of organisational and individual factors. Recruiting a diverse group of volunteer chaplains who sought to be available around-the-clock, providing them with uniforms and building capacity to dispatch them alongside staff to 'the front line' promoted the perception that the chaplain's role was to support staff from within the organisation and mitigated against paramedic self-described suspicion of outsiders. As an organisation built on rank and hierarchy, situating chaplains outside the chain of command was perceived as important and promoted the idea that chaplains were not management and therefore more trustworthy.

Training chaplains to provide on-scene support to paramedics and bystanders was identified as another element of the capable chaplain. This was seen to 'bridge a gap' in the ambulance model of care by taking over bystander support, physically and emotionally freeing paramedics to focus on patient care. This was similar to hospital chaplains who cared for and supported patients, their families and organisational staff (Cunningham et al., 2017; Timmins & Pujol, 2018). Some paramedics noted the 'relief from guilt' and 'worry' chaplains provided in these instances. Further exploration of how these relate to factors preventing or treating burnout, moral distress and injury, compassion fatigue or PTSD and promote post-traumatic growth is warranted (Carey & Hodgson, 2018; Carey et al., 2018; Hylton Rushton, 2018; Tedeschi et al., 2018). Chaplain involvement in post-incident clinical debriefs and follow-ups was also important for paramedics. Giving staff the opportunity to discuss normal emotions in these abnormal events, or simply giving paramedics the opportunity to 'grab a coffee' and engage in informal conversation, even if the incident was not directly discussed, was valued. These activities hold similarities to models of psychological first aid, suggesting this may be another element to the chaplain's role (Australian Red Cross, 2020). Relationship with chaplains was also important in this space, as paramedics on-scene found it easier to work alongside chaplains they already knew and trusted, and saw as professionally capable.

This relational and capability-building approach to the ambulance chaplain model of care promoted the idea that chaplains genuinely understood the pressures participants faced. Because they supported paramedics in all areas of their practice, including on the frontline or in the ambulance trucks in between jobs, chaplains were seen to genuinely 'get it' when some other support options were not. While some of these findings represent new evidence, there are similarities with police and military chaplain research (Davie, 2015; Gouse, 2017).

A noteworthy theme underpinning several interviews was the value in chaplains with clinical experience, such as paramedicine or nursing. These chaplains were valued for their ability to engage with staff beyond the spiritual and emotional to incorporate a more holistic view of the clinician, including understanding of common terminology and humour. Literature from hospital critical care settings examining the role of clinically trained chaplains shows promising correlations with these findings (Cunningham et al., 2017; Timmins & Pujol, 2018). Exploration of a clinical

chaplain or 'expert companion' model of care may provide benefits in areas such as promoting moral resilience and post-traumatic growth through having chaplains in ambulance vehicles working alongside and supporting staff at, and in the immediate aftermath of, clinical care (Hylton Rushton, 2018; Tedeschi et al., 2018). Additionally, promising results from military literature have shown chaplains act as first-line providers of care and facilitate staff connecting to further mental health support (Besterman-Dahan et al., 2012).

As part of a staff health team, chaplains were valued as an additional support option. Paramedics stated that no single staff support service would meet everyone's needs, and having chaplains available gave them more choice. Chaplains' ability to care for paramedics individually and confidentially, yet also act as a conduit to help staff access additional support, was valued. Some paramedic stories explored the chaplain's role in supporting staff returning from worker's compensation/leave, or preventing suicide or significant harm, with some staff powerfully moved when recounting the impact of these interventions. For some paramedics, historic stigma associated with accessing other formal support such as psychology remained, and chaplains remained their preferred way to access help, which was consistent with other findings (Phoenix Australia, 2016; Senate Education Employment References Committee, 2019).

While no one staff support role is truly independent of others, findings from this study suggest paramedics see chaplains as offering a unique skillset. The participants indicated that ambulance chaplains established relationships, maintained close proximity to staff, were clinically capable and frequently available around-the-clock. Furthermore, participants saw chaplains as a support option who, through shared experiences, genuinely understood paramedic life. They were trusted to support emotional, spiritual and welfare needs when staff did not feel comfortable discussing these with other support services, yet also able to triage and guide staff towards additional support if required. However, it is important to note these are preliminary findings and further research on the views of both chaplains and a wider paramedic cohort will be valuable to consolidating these findings.

Two recurring themes were identified across interviews that limited or inhibited chaplains in their role. On one hand, the voluntary nature of chaplains in this service 'sent a powerful message' to paramedics about how much chaplains valued their welfare, yet many simultaneously made statements wishing there were more chaplains with greater availability. For many paramedics this limited their access to chaplains because they feared disturbing chaplains in their paid roles outside of NSWA, or the chaplain was not available when they wanted them. This was a new finding not seen in military or other first responder data and warrants further investigation as it suggests a negative impact on capacity building of chaplains for the current and future ambulance service.

Another significant inhibitor of staff accessing a chaplain was not understanding the chaplain's role, and the role religion plays in their activities. Paramedics held concerns about chaplains evangelising, and the wearing of religious symbols on their epaulettes further contributed to these concerns suggesting consideration should be given to the use of religious symbols on uniforms. While relationships appeared to overcome some of these reservations, these visual cues and the lack of

clarity from the outset on the chaplain's professional role and responsibilities within the ambulance service generated reservations. These findings hold similarities to police, military and healthcare chaplaincy literature (Best et al., 2021; Moosbrugger, 2006; Roberts, 2016; Snowden, 2021). To address this, ambulance chaplains should also consider taking steps to establish minimum education requirements, standards of practice and affiliation with professional health and chaplaincy organisations, and organisations should develop and promote clear role descriptions in line with their specialised chaplain workforce (Association of Professional Chaplains, 2021; Best et al., 2021; Spiritual Care Australia, 2020; Timmins et al., 2018).

Despite expectations that participants in this study may primarily be spiritual or religious paramedics, it was noteworthy that ten of the seventeen were not spiritual or religious yet still valued chaplaincy. This suggests that personal spiritual beliefs may not be a barrier to accessing chaplain support. Evidence describing those who utilise chaplains and the personal spiritual beliefs they hold more broadly is scarce, however these findings are similar to findings from military and hospital literature (Hale, 2013; Ormsby et al., 2017). One recent study suggested people positively evaluated chaplain encounters even in the absence of faith concordance, with key factors like relationship building and a move from 'religious' motivations to more spiritual or existential approaches contributing to this perspective (Liefbroer, et al., 2021).

## Limitations

While the ambulance service in this study was selected for the large size of its chaplaincy team, confining the interview cohort to a single ambulance service impacts its generalisability. Phase three of this exploratory sequential study will be important to test these findings more widely to determine if they are generalisable to the wider paramedic population. Additionally, the perspectives of chaplains themselves were absent from this paper, and there was a lack of representation from people of faiths beyond the Judeo-Christian population.

In addition to addressing the limitations outlined above, opportunities for further research may include establishing and evaluating education programs for frontline chaplaincy, exploring novel approaches to the provision of chaplaincy care including incorporating clinically trained chaplains, and exploring chaplain collaboration with other mental health professionals in prevention and treatment of psychospiritual and emotional aspects of conditions including moral distress and injury, and PTSD—an area showing promise and favourable results in the military setting (Carey & Hodgson, 2018; Starnino et al., 2019).

## Conclusion

The chaplaincy program examined in this study appeared to be a proactive and reactive support option available to staff in their workspaces. Built on a foundation of relationships, trust and a 'reaching in' approach, chaplains provided opportunities

for formal and informal conversation, the provision of psychological first aid, and facilitation of access to further support when required—a 'first responder' to the first responders. Additionally, by situating trained and equipped chaplains within the ambulance service to respond alongside paramedics enabled chaplains to provide on-scene support and extend the ambulance continuity of care for staff and bystanders. Through their presence they potentially protect staff from strong emotions generated by morally and emotionally challenging encounters, and enhance the paramedic's capacity to focus on patient care. While work remains to be done educating staff on the chaplain's role and the evidence underpinning spiritual care, as well as clarifying the place of religion in chaplain activities, and on testing these findings on a larger and more diverse cohort, these results suggest chaplaincy is a valued spiritual, emotional and social support option for staff in ambulance services.

## Appendix 1: Interview Questions

The following questions were used to guide the semi-structured interviews. They may or may not have been asked in the order listed, depending on the flow of the conversation:

1. Can you tell me about your experience or experiences with a chaplain?
2. What do you understand the chaplain's role to be?
3. What skills and attributes should chaplains possess to be effective?
4. Do you think the chaplain is valuable to the organisation? Why or why not?
5. Do you think the chaplain is valuable to you personally? Why or why not?
6. Do you think your interactions with a chaplain have impacted your wellbeing? If so, how?
7. Is there anything else you would like to tell me more about in relation to chaplains, or anything else we have discussed today?

**Acknowledgements** Thank you to New South Wales Ambulance for your support of this project and assistance in sourcing participants. Thank you also to Anglican Deaconess Ministries for supporting KTL with a fellowship allowing her to take time away from work to focus on her research during 2020.

**Author Contributions** All authors contributed to the study conception and design. Material preparation, data collection and analysis were performed by KTL as part of her dissertation. The first draft of the manuscript was written by KTL under the supervision of her co-supervisors TLJ, JL and PS, and all authors commented on previous versions of the manuscript. All authors read and approved the final manuscript.

**Funding** Open access funding provided by the University of Technology Sydney. KTL is the recipient of an Australian Government Research Training Stipend.

**Availability of Data and Materials** Requests for access to the framework matrices can be made to KTL after submission of her thesis.

### Declarations

**Conflict of interest** KTL currently works as a chaplain with New South Wales Ambulance.

**Consent to participate** Informed consent was obtained from all individual participants included in the study, including consent for the findings to be published.

**Ethical approval** The questions and methodology for this study was approved by the South East Sydney Local Health District Human Research Ethics Committee (HREC) [2019/ETH13593] and was ratified by the University of Technology Sydney HREC [ETH19-3820].

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# Chapter 5 – The role and value of chaplains in an Australian ambulance service: A comparative study of chaplain and paramedic perspectives

## 5.1 Introduction

The insights from the research described in Chapter 4 were that the chaplain's role is broad in scope, and encompasses provision of care across all aspects of the workplace. Additionally, the participating paramedics perceived that in the presence of relationships, chaplain care was valued and valuable in supporting their wellbeing. While paramedics discussed many elements of chaplaincy care, they did not offer deep insights about chaplains' practices. For this reason, studying chaplains' perspectives was essential to obtain a more complete understanding of their role. Chapter 5 presents Phase 1b, a qualitative study of the role and value of chaplains in ambulance organisations, based on the perspectives of chaplains working within NSWA. It does so in the form of a publication titled "The role and value of chaplains in an Australian ambulance service: A comparative study of paramedic and chaplain perspectives".

## 5.2 What does this paper add to existing knowledge?

The article presented in Chapter 5 provides meaningful insights into the role of ambulance chaplains and the perceived impact of their work. Paramedics participating in Phase 1a noted that chaplains provide support at the scene of significant jobs, but did not detail the activities chaplains perform in that capacity. Chaplains participating in Phase 1b added depth to my understanding by outlining their activities, both on station and at significant jobs. While no chaplains used the term "psychological first aid" in interviews, their activities at significant events aligned closely to its components (Australian Red Cross, 2020). And again, whilst no chaplains used the term "primary health care", their activities on station were aligned with its key elements – promoting health and wellbeing, and facilitating paramedic access to additional specialised support when they experienced distress.

Comparing paramedics' and chaplains' perspectives revealed similarities, but also notable differences. For example, paramedics did not believe spiritual care constituted a large part of

the chaplain's role, whereas chaplains spoke about paramedics' desire to discuss issues like meaning, purpose, and life and death – all spiritual care themes. Furthermore, paramedics discussed the religious symbols on chaplains' uniforms and how these had deterred them from seeking chaplains' support in the past, but few chaplains identified this issue. Areas of consensus between the two groups included the value of establishing relationships in the provision of chaplaincy care, and how this helped to build trust and facilitated supportive conversations.

## 5.3 Impact of this paper

This paper was published in a Quartile 1 journal. At the time of writing, this paper had 3 citations and an FWCI of 7.91 in Scopus*.

*A score of greater than 1.0 indicates the article is cited more often than the average for similar publications (University of Technology Sydney, n.d.).

| Citation<br><br>Tunks Leach, K., Simpson, P., Lewis, J., & Levett-Jones, T. (2023) The role and value of chaplains in an Australian ambulance service: A comparative study of paramedic and chaplain perspectives. *Journal of Religion and Health*. https://doi.org/10.1007/s10943-021-01446-9 |
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Assoc. Prof. Lindsay Carey (Editor-in-Chief, JORH, Springer Science, 3 July 2023) granted permission for replication of the publication "The role and value of chaplains in the ambulance service: a comparative study of paramedic and chaplain perspectives" in this thesis.

## 5.4 Published paper

Journal of Religion and Health (2023) 62:98–116
https://doi.org/10.1007/s10943-022-01685-4

ORIGINAL PAPER

# The Role and Value of Chaplains in an Australian Ambulance Service: A Comparative Study of Chaplain and Paramedic Perspectives

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Accepted: 18 October 2022 / Published online: 19 November 2022
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**Abstract**
Chaplains are embedded in several ambulance services across Australia, however as Australia's religiosity is currently in decline and questions are being asked about retaining chaplains, little is actually known about their role and value within Ambulance services. The aim of this paper is to present the key findings from interviews with chaplains about their role and value of being ambulance chaplains. These findings are then compared with those of paramedics derived from an earlier phase of this study. Thirteen chaplains participated in semi-structured interviews, and data were analysed using framework analysis. The results indicated that ambulance chaplains provided paramedic-centred emotional and spiritual care through proactively and reactively supporting paramedics in their work. Chaplains saw value in their relational approach which facilitated trust and access, did not seek to 'fix' or diagnose but instead offered physical and emotional presence, and promoted supportive conversations. Chaplains and paramedics valued operationally trained and equipped ambulance chaplains who provided a relational, around the clock, 'frontline' staff support presence in paramedic workplaces, regardless of the paramedic's personal religious/spiritual beliefs.

**Keywords** Paramedic · Emergency medical services · Wellbeing · Chaplaincy · Spiritual care

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## Introduction

Multifaith chaplains are embedded in health and wellbeing teams in many ambulance services across Australia to support the pastoral, spiritual and emotional needs of their staff. It is a role that exists alongside other wellbeing roles including peer support officers and psychologists, as well as exercise and nutrition specialists (Magele, 2020; Mammone & Grant, personal communication, 21 March 2022; NSW Ambulance, 2020b). However, calls for the removal of religious chaplains from some organisations are increasing, especially in Australia where religiosity has been in decline (Kanowski, 2022; Australian Bureau of Statistics, 2022; Caro, 2022; Price, 2022). Subsequent public discourse from those on each end of the for/against spectrum continues, yet notably absent from these discussions are the voices of the people who choose to access chaplain care. As Swinton (2014, p. 172) noted:

> "The point that is being made here relates to the importance of recognising and valuing 'the spiritual'…irrespective of what one thinks its origins might be".

Studies exploring consumer perspectives of chaplaincy or spiritual care programmes in a range of settings have demonstrated numerous benefits, and in many instances these remain even when the consumer does not share the same personal or religious beliefs as the spiritual care provider (Callis et al., 2021; Department of Education & Training, 2018; Liefbroer & Nagel, 2021). Furthermore, the body of evidence examining the connection between one's spirituality and health outcomes is significant. For example, positive health benefits for those who are moderately spiritual or religious include reduced burnout and increased longevity and resilience, with these health outcomes reducing and in fact becoming negative for those who are highly spiritual or religious (Birkett, 2015; Frankl, 1985; Koenig, 2012, 2015; Tak et al., 2017). Additionally, research by Tedeschi et al. (2017) demonstrates the essential role of spiritual change and core beliefs in posttraumatic growth (PTG). Another study exploring the role of core beliefs in paramedic Posttraumatic Stress Disorder (PTSD) and PTG further stressed the importance of organisations providing workplace interventions in support of bettering these outcomes (Surgenor et al., 2020). Consequently, more healthcare groups are acknowledging the importance of offering and providing high-quality spiritual care to consumers as part of an holistic approach to enhancing health outcomes (Royal Australian & New Zealand College of Psychiatrists, 2018; World Health Organization, 2021; World Psychiatric Association, 2019).

Despite this evidence, there are limited studies exploring first responder perceptions of chaplains in their services. In a scoping review on this topic, only seven papers were identified across first responder and military settings (Tunks Leach et al., 2020), and since that review, only one additional paper was found that explored consumer perceptions (Flores, 2021). Consequently, in a previous paper, we explored paramedic perspectives on the role and value of chaplains in the ambulance service (Tunks Leach et al., 2022). In the current paper, we

present the findings from a subsequent study of chaplains' views of their role and we compare this with the paramedics' perspectives, with the aim of creating a comprehensive understanding of the role and value of chaplains in the ambulance service.

## Methods

### Study Design and Setting

Set in New South Wales Ambulance (NSWA) in Australia, this study took place between June and August 2020. NSWA is a state-based ambulance service that employs over 5,900 staff spanning metropolitan, regional and remote areas (NSW Ambulance, 2020a). The chaplaincy service is one of a suite of internal staff support initiatives that include a peer support programme, psychology service, exercise and nutritional support. An external Employee Assistance Program (EAP) is also available (NSW Ambulance, 2020b).

The chaplaincy programme, at the time of this study, employed one paid and 55 volunteer chaplains (McFarlane, personal communication, July 2019). Twenty-three of these chaplains were female and 22 male, with one from the Muslim faith, one from the Jewish faith and 53 from the Christian faith. The ambulance chaplaincy service endeavours to provide 24 h/7-day care to staff, their families, and bystanders, regardless of their spiritual or religious beliefs (NSW Ambulance, 2020b). Chaplains may be activated by a manager or directly by the paramedics for support.

This paper presents the second arm in phase one of an exploratory sequential mixed-methods study, exploring the role of ambulance chaplains and their impact on paramedic wellbeing. It is underpinned by a pragmatic philosophical framework. Driven by the research questions and a commitment to using multiple types of data to answer these questions, a pragmatic framework is a pluralist approach which posits that people will bring multiple viewpoints to the study and are held as being equally true (Biesta, 2010; Creswell & Plano Clark, 2018). This study sought to investigate pastoral, spiritual and emotional care activities undertaken by chaplains and their impact on paramedic wellbeing. This phase of the study comprised semi-structured interviews with NSWA chaplains and, along with the data obtained from the paramedic interviews, the findings will be used to develop a survey that will explore the views of a broader cross-section of paramedics in phases two and three of the study.

In this study, trustworthiness was demonstrated through bracketing, reflexivity and member checking. The first researcher currently practices as a chaplain in NSWA, so bracketing was used prior to undertaking the research so as to document existing beliefs, assumptions and hypotheses (Tufford & Newman, 2010). Reflexive journaling and analytical memos on thoughts relating to participants' comments, or the author's own views and observations, were kept throughout the research process (Saldana, 2016). Furthermore, the first researcher also met to discuss findings with the research team at regular meetings. Finally, a summary of the major themes from the qualitative data analysis phase were member checked by sending these themes

to the participants for feedback, with nine participants responding to confirm their agreement with the findings (Whitehead et al., 2020).

### Ethical Considerations

South East Sydney Local Health District Human Research Ethics Committee provided primary ethics approval [2019/ETH13593] which was subsequently ratified by the University of Technology Sydney Human Research Ethics Committee [ETH19-3820]. All participants received participant information sheets prior to providing written informed consent, and they were made aware that their responses would be de-identified for privacy and confidentiality, and subsequently used in peer-reviewed publications and presentations.

### Sample and Recruitment

Following ethics approval, participants were recruited via an email sent by NSWA's research unit and the Senior Chaplain. A purposive sampling approach was used to ensure participants had the required knowledge and experience to answer the research questions, and represented views from different genders and geographical areas (e.g. metropolitan and regional). Follow-up via telephone and email was used to check that participants met the inclusion criteria and were comfortable with the interviewer's position as a fellow chaplain and researcher (Whitehead et al., 2020). When no new significant themes were emerging, recruitment was discontinued at 13 participants (Coffey et al., 2017; Creswell & Plano Clark, 2018).

### Data Collection

Chaplain interviews took place between June and August 2020. They lasted between 30 and 60 min and were conducted by the first researcher at a mutually agreed location. Interviews were undertaken in-person and over the phone. As they took place in the early stages of the COVID-19 pandemic, decisions regarding how and where interviews were conducted were determined by organisational policies, geographic restrictions (many of the participants resided in regional NSW) and/or participant preferences.

Prior to commencing the interviews, participants were reminded that the researcher's motivation for conducting the study was to better understand the role of chaplains in the ambulance service and what impact their actions have on paramedic wellbeing. Questions used to guide the semi-structured interviews were generated from a scoping review (Tunks Leach et al., 2020), refined following pilot interviews, and provided to the participants in advance of the meetings (Appendix 1) (Peters et al., 2020). Semi-structured interviews were used to allow the researcher to pursue emerging themes as directed by the participants (Arksey

& O'Malley, 2005; Peters et al., 2020). Interviews were audio recorded and transcribed verbatim.

### Data Analysis

Data were analysed using the framework analysis method. Initially developed by Richie and Spencer (1994), this 'problem focussed' thematic data analysis approach requires the development of frameworks and matrices, and enables analysis to move beyond purely descriptive to explanatory (Gale et al., 2013; Ward et al., 2013). Transcripts were thematically coded and analysed using the seven steps proposed by Gale et al. (2013), and meetings between researchers occurred at regular intervals throughout this phase to review findings, clarify any issues arising and ensure accuracy of the qualitative methodology. The framework for analysing the chaplain interviews used the same overarching themes as those used to analyse data from the paramedic interviews previously conducted (Tunks Leach et al., 2022); however, the subthemes were specific to the chaplain interviews.

## Results

The final sample consisted of 13 chaplains. Ten participants identified as male and three as female with a mean age of 52 years and duration of service of 5.5 years. Eight chaplains were from Metropolitan Sydney and five from regional NSW. All chaplains were from the Christian faith, self-identifying as either from Evangelical, Pentecostal or Anglican traditions. Three participants had Masters level education, two Bachelors level and four vocational level, with five participants not disclosing their education. This education was not necessarily specific to chaplaincy, rather it included theological, healthcare and management studies. Six chaplains were recognised or ordained by their faith tradition, while seven were employed as chaplains because of other training and/or experience. Four chaplains had previous experience as a paramedic or ambulance officer. Each chaplain was assigned a pseudonym and any identifying features regarding demographics or quotes with personal information were removed to protect confidentiality. In NSW when the interviews were conducted, COVID-19 was not widely circulating in the community. Consequently, most interviews did not explore the impact of COVID-19 on chaplaincy practice.

Findings were grouped into two overarching domains in line with the framework developed for the paramedic interviews: (1) The chaplain's role and (2) Organisational factors impacting the chaplain's role (Fig. 1).

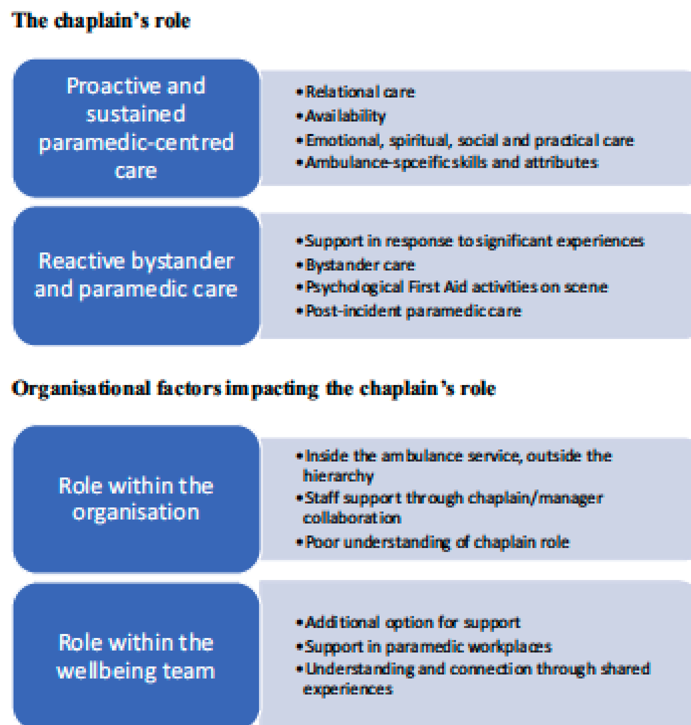


**Fig. 1** Chaplain results—summary of themes

## Scope of the Chaplain's Role

### Proactive and Sustained Paramedic-Centred Care

Ten of the 13 participants discussed the essential nature of relationships to the chaplain's role, and they felt that the long-term nature of their role helped to facilitate these relationships and trust. Terms such 'a friend who cares' were used to describe the relational element of their role, and how "…it's very different from a psychological paradigm in that you walk with people and…they become your friends, they become family" (Chaplain 9). The participants identified that established relationships underpinned whether paramedics accessed them for support:

> "If you haven't established that relationship, when the big job does come, or the big crisis, or the big family situation, they're not going to call you. If you haven't taken the time to go and sit with them on their station and get to know them, you're not going to be a thought" (Chaplain 6).

Twelve chaplains reflected on the importance of being committed and available, and its impact on building relationships. Maintaining a physical and emotional presence at their ambulance station/s, in and outside business hours, was

described as a significant contributor to relationships by ten of the chaplains. Chaplains at "superstations" (stations with more than 100 paramedics) said the volume and turnover of staff was a barrier to building relationships "…because it's a bit of a revolving door there…" (Chaplain 5).

Most chaplains believed their role primarily involved providing pastoral, emotional and spiritual care. This could be related to the job, for example, individual or cumulative job stress and organisational challenges, but also personal support related to relationships, domestic violence, children and general life struggles. This support required chaplains to use active listening skills, and to provide opportunities for the paramedics to reflect and explore their feelings. Chaplains with paramedic experience reflected on the challenges of providing pastoral and emotional care to their colleagues:

> "…being a paramedic myself, I know how they work. I know how they internalise things. Sometimes that's what we have to do to try and understand what's just happened…We can be very hard on ourselves as paramedics when stuff goes wrong. It's a very fine road to tread with my fellow officers. [It is] complex" (Chaplain 8).

In addition to emotional care, 11 chaplains spoke about the spiritual support provided in their role. They reflected on conversations involving meaning, purpose, existential explorations, and the 'big questions' like life and death:

> "The chaplain [addresses] the questions about life and death…about reality, about meaning, fear and hope, stress, loss. Chaplains can explore these issues confidentially, honestly, openly and in that caring loving manner…The goal is to give people meaning and purpose and connection wherever they're at" (Chaplain 3).

Seven chaplains said their role included providing care to meet physical and social needs both to paramedics and their families. Physical care included ensuring paramedics had food, water and shelter, and supporting them with activities like cleaning or restocking ambulances. Social care included exploring and promoting ways for paramedics to connect with recreational and essential services both within and outside of the organisation:

> "I think, we're strongly networked with our community care as well…[a paramedic] said 'you guys don't realise how connected you are with so many support services, the rest of us don't even know about them. Whether its people needing a meal or a roof over their head or something for family violence or whatever, you guys know who to talk to and how to find someone discreetly to help them out, and it's never a problem'" (Chaplain 1).

When asked about their thoughts on the value of proactive care, chaplains considered: how their relational model of care promoted trust, the value of being a staff support resource that is available around the clock, their ability to provide holistic care that extends beyond the spiritual, and the capacity to care for all staff and not just paramedics.

## Reactive Support

The second theme identified by chaplains as part of their role was the provision of reactive support. Reactive care took place at or immediately after significant experiences such as a major trauma, natural disaster, terrorist incidents, death by suicide, or death of a baby/child. Reactive care was also provided during and after jobs that held personal significance to a paramedic because of sights, sounds or smells, the cumulative nature of their experiences, or the death of a colleague.

Once on the scene of significant jobs, most chaplains identified that caring for paramedics primarily involved assuming care of bystanders such as family members, witnesses and other first responders including police. Chaplain 12 stated "I supported four policemen, the mother and father of the deceased and the extended family as they filtered in". Another chaplain stated:

> "…sometimes the paramedics call us out because their heart goes out to the family. So, it's not essentially about them, but I guess their compassion extends to the family and they want to make sure that they're okay." (Chaplain 13).

Care provided by chaplains varied according to the nature of the job. Twelve participants spoke of 'walking alongside' paramedics and/or bystanders in the immediate minutes and hours following an incident. This care could be autonomous or manager-directed, but always under the direction of the ambulance commander-in-charge. It included meeting immediate needs (mostly for bystanders but occasionally for paramedics) such as food, shelter and safety. A small number of chaplains spoke of being used as "an extra set of hands" when requested by paramedics. Care also involved explaining police and coronial processes to family members in the aftermath of unexpected deaths, and supporting family members to break bad news to others. After immediate physical and emotional needs were met, chaplain's reactive care also included providing hope and connecting bystanders to support:

> "…it's just gently listening, then moving them to think of their own network, is there anyone that they feel they need to talk to or speak to. Sometimes arranging connections with funeral directors…Especially when the contractors come to take away their beloved. I think just stepping them through that process, but also guiding them emotionally, psychologically and spiritually as well through all of that" (Chaplain 13).

Chaplains providing on-scene support focused their activities on minimising paramedic exposure to strong emotions:

> "I've found that the paramedics very much know what they're doing clinically but when there's emotional issues, they will get me involved…I think the paramedics can see where their limitations are but they're also resourced to know that their limitations are someone else's strengths" (Chaplain 12).

Eleven chaplains said observation of paramedics on-scene and immediately after significant jobs was important. Some identified their role was to monitor a scene for threats or areas of need which were possibly not immediately identified by

paramedics, while others focused on observing paramedics during clinical debriefs for any who maybe showing signs that "all was not ok". This was especially true for chaplains with paramedic experience who felt there was additional value in being able to talk about the clinical alongside the emotional:

> "…There was one guy in the background who was really quite silent and was avoiding me. He's somebody I've worked with. I spoke to him afterwards and found out that he'd been to three or four paediatric [cardiac] arrests in a couple of weeks…I think it's something that chaplains look for" (Chaplain 7).

In the hours, days and weeks following significant jobs, most chaplains said they were asked to attend post-incident clinical debriefs and then follow-up with paramedics. A small number of chaplains noted their follow-up care was declined by paramedics on the day of the event, however this was often better received in the days following the job:

> "…after a job, paramedics are not real keen to just sit there and have a chat… They just want to get the job done, they want to go and clean-up, they want to go and eat something before someone annoys them with something else. I think being able to recognise when you're needed, and when you're not, is a big thing" (Chaplain 6).

## Organisational Factors Influencing the Chaplain's Role

### Role Within the Organisation

Nine chaplains stated that being employed within the ambulance organisation (as opposed to being an external provider of chaplain care) had a significant impact on their role. They spoke about the importance of wearing a uniform, undergoing ambulance training and being part of the culture to fully appreciate the pressures on paramedics:

> "You need an understanding of emergency services culture…you've got to understand, the shift work, that they're a closed bunch, they're tough. They're exposed to a lot of trauma that the normal population doesn't see. You've got to have an understanding of the incident control systems, and how they actually function in a job" (Chaplain 3).

While having chaplains retained in the organisation was seen as important, it was equally important to the chaplains that they were outside of the hierarchy:

> "A lot of [paramedics] won't go to their [peer support officers], because the PSOs are now getting in positions of being inspectors and people won't go to somebody higher than them in the hierarchy" (Chaplain 7).

Being situated outside the hierarchy was perceived to promote trust and confidentiality:

"We're not their partners, we're not their bosses, we have no rank which I think is quite valuable. We sit just outside and offer that human connection and listening ear for everyone, from the seniority down to the guys on the road" (Chaplain 10).

At the same time, the relationship between chaplain and manager was perceived to be important. Some chaplains described their role as being a mediator between management and staff, while others felt their roles were sometimes misunderstood by managers. At times, chaplains were approached by managers for advice and support or to discreetly support paramedics:

"We're also very good at dealing with the problem child. The thorn in the side of the [Duty Operations Manager (DOM)] that they just can't deal with because that person's a pain in their arse. Get the chaplain onto them. All of those things that are not noticed" (Chaplain 6).

Organisationally, chaplains frequently perceived their role to be poorly understood. Six chaplains said people expected them to provide ritual support (e.g. weddings, funerals, baptisms) and moral or ethical advice to the organisation. Eight chaplains believed there was significant misunderstanding about their role more broadly, especially from groups such as the LGBTQI community, having experienced discrimination from some religious organisations. Overwhelmingly, misconceptions related to religion and the role of chaplains:

"When I started as a chaplain, a lot of paramedics were very hesitant…there was kind of an uncertainty of what chaplains do…I think throughout the years people actually see that week-to-week reality of what chaplains do and it's not just a religious thing, we are definitely there to support them and support community members, family members" (Chaplain 13).

Most chaplains were not able to communicate a clear role description, however they could clearly identify key elements of their work. They spoke of conducting informal assessments to determine how they could best support, and also make referrals when an issue was outside their scope of care:

"People come to me and go, can I have a talk to you over a coffee? This is happening, I don't know what to do, what do you think? It's kind of at that level and we shouldn't underestimate the power of listening, but we've also got enough experience and professionalism to know when we need to refer onwards and how to refer people onwards too" (Chaplain 1).

Additionally, chaplains said they provided support to paramedics after exams, at court appearances, at graduations and during mass recruitments of staff at the beginning of the COVID-19 pandemic. Skills used by chaplains in the course of their work included basic counselling, knowledge of first aid, grief and loss education and support, marriage preparation, psychological first aid, and knowledge of internal and external referral pathways.

A noteworthy theme resulted from chaplains reflecting on how providing support impacted their own personal wellbeing. They took satisfaction from their

"ability to stand in that place where most people don't want to be, because it's so emotionally uncomfortable" (Chaplain 1), yet also spoke about how exposure to other people's emotions meant "sometimes you don't cope" (Chaplain 7). The impact of these experiences appeared to be short-term with chaplains discussing their self-care strategies, including the use of pastoral supervision, drawing on their personal belief systems and handing over management of jobs to other chaplains. Most reflected on how they also experienced great happiness from their work. Chaplains said they often used these shared experiences as a mechanism for providing better support to paramedics:

> "[Paramedics] don't want to unburden something on someone who's not prepared. You're going to hear some horrible things...when you've won their confidence and they know they're in a safe place, it's an open door for them" (Chaplain 8).

When considering the value of chaplaincy to the organisation, chaplains focussed on their ability to be flexible and dynamic. They reflected on their willingness to personalise the support they provided and their ability to fill gaps according to organisational needs:

> "Chaplains are now filling the gaps. We're stepping into spaces that we never had before. [Supporting] 180 paramedic recruits…doing fire deployments, sitting in meetings as a support person…[or getting] a group of chaplains to go to the airport to support the medical staff that are around-the-clock COVID testing. All of these spaces where they don't know how to fill…we [chaplains] are filling the voids" (Chaplain 6).

While chaplains felt they added value to the organisation, a number stated they did not feel valued. They spoke of the tension between NSWA saying they valued holistic approaches to paramedic health, yet not providing resources or funding to the chaplaincy programme:

> "The ambulance as a whole, they verbally support chaplains. I'm not sure how far that would go to helping practically…there was an inspector whose impression was that [ambulance] wants chaplains, but we need to give them more resources in order to help them be effective in their roles" (Chaplain 10).

### Role Within the Wellbeing Team

Chaplains in NSWA are part of the wider staff health team. Eleven chaplains said their role was to provide another option for staff who needed support, acknowledging that no one service can meet everyone's needs:

> "…organisationally it's good that they have a number of different things, because not everybody is going to go to a chaplain, not everybody is going to go to a psychologist. People resisted going to psychologists and for years people resisted going to chaplains" (Chaplain 7).

Twelve chaplains spoke about supporting paramedics wherever they worked and not remotely from an office. This work took place at ambulance stations, at hospitals while staff were waiting to offload their patients, or in the ambulances so paramedics or managers could discuss issues in between jobs. For regional chaplains, this was perceived to be even more important due to the lack of staff support roles in regional areas:

> "…my local peer support officer is three hours away…the DOM might be a couple of hours away…for regional areas, the chaplain provides face-to-face contact in an area where you may not see anybody... When the chaplain comes in they sit and have a coffee or a chat, or take you up the street for a coffee so you can get out of the station and just talk to somebody that cares about you" (Chaplain 6).

Most chaplains believed they added value as part of the wellbeing team, especially through "pastoral" care. They spoke of the value in being perceived as neutral and not seeking to make a diagnosis, fix things or critique clinical performance. They saw their role as listening and being present with paramedics through their experiences. Eight chaplains used the words 'journey' and 'alongside' to explain the value of their work in connection with the previous themes of relationship, geographical location of chaplain work and shared experiences with paramedics. They believed it not only helped them tailor their care, but also gave them credibility with paramedics for their willingness to be "in the trenches" at any time of the day or night:

> "He said 'You're not just an outsourced support network like an EAP psychologist who doesn't understand our context, but you actually are with us and you look like us. More than that, you ride along with us. You actually do the hard yards with us. It's not just about big jobs, you're doing life with us'" (Chaplain 13; relaying feedback from a paramedic).

While chaplains spoke of their role in addressing the "big questions", more than half spoke about how "having a holistic approach to [paramedic] wellbeing, including their spiritual wellbeing, actually makes them better at what they do on the frontline (Chaplain 1)".

However, some chaplains felt that because they were volunteers, their worth was less than that of paid support staff:

> "I know they [staff health] keep saying that we [chaplains] are an integral part of it, and we work together, but I think they see themselves as a separate entity and we're just around to fill in the holes" (Chaplain 5).

## Discussion

The aim of collecting data from the chaplains in addition to paramedics was to obtain a '360 degree' perspective of the chaplain role, and to see if any new data could be obtained that would address the research aims. Where paramedic interviews gave a broad perspective on the chaplain's role and its value, the addition of the chaplain interviews added depth and more detailed explanations of chaplain activities.

In this study the activities outlined by chaplains painted a picture of a proactive and reactive frontline role, providing holistic care to paramedics and psychological first aid to bystanders. Chaplains undertaking these activities used skills including assessment, support, counselling, education and ritual in line with the spiritual interventions outlined by the World Health Organization (Carey & Cohen, 2015; WHO, 2017). These findings were common to both paramedics and chaplains, along with a broader understanding that chaplains provided emotional support, social connection and practical or pastoral support. These findings also align with broader research regarding chaplaincy utility and their pastoral/spiritual care activities (Carey, 2012; Carey & Rumbold, 2015; Fitchett, 2017; Liberman et al., 2020).

A major theme discussed by the chaplains was the provision of spiritual care, supporting paramedics with existential, religious and 'big life questions'. However, this was only a minor theme in paramedic interviews. Reasons for this are not clear, but factors may include a lack of shared understanding of what constitutes spiritual care (i.e. activities paramedics do not see as spiritual, yet chaplains do), chaplains over-reporting or paramedics under-reporting spiritual care encounters, stigma surrounding help-seeking behaviours, or spiritual conversations being deeply personal and paramedics were therefore reluctant to discuss them with the researchers (Morgan et al., 2016; Zullig et al., 2014).

Chaplains providing holistic care, which incorporates not only spiritual but also bio-psycho-social-emotional approaches, align with findings from Spiritual Health Australia on what constitutes high-quality spiritual care (Spiritual Health Association, 2020). Connections between these elements of holistic person-centred care and common health phenomena experienced by paramedics, require further exploration in the light of this study. For example, the provision of emotional and social support promotes PTG, a far more common outcome from exposure to traumatic events than PTSD (Tedeschi et al., 2017). The management of moral injury (MI), a condition recognised as being experienced by paramedics exposed to morally injurious events, is increasingly involving chaplains as part of an holistic healthcare approach. (Koenig & Al Zaben, 2021; Murray, 2019). In fact, emerging research in the military MI space is demonstrating the value of chaplain-lead and chaplain-psychology collaborative models of care in promoting recovery from MI (Ames et al., 2021; Carey & Hodgson, 2018; Hodgson et al., 2021; Koenig & Al Zaben, 2021).

From the chaplains' perspective, their role centred around and was valued because of its relational model of care. Because chaplains endeavoured to be available 24 h/7 days to share experiences alongside paramedics in their 'down times' and 'on the job', chaplains felt this facilitated familiarity and trust with the people they

supported. This correlated with the paramedics' perspectives and other healthcare chaplaincy literature (Aiken, 2022; Cunningham et al., 2017). However some paramedics stated that chaplains were mostly only volunteers, which acted as a barrier when they were considering using chaplains as a support resource (Tunks Leach et al., 2022). Yet, when chaplaincy is considered through a healthcare lens, the work of chaplains sits under a primary health care banner (World Health Organization, 2022) and should be more available to paramedics simply because chaplains provide person-centred care in the workplace. This can empower paramedics to take control of their wellbeing and faciliate their access to further treatment when required.

Challenges however clearly remain for ambulance chaplains. Chaplain and paramedic interviews confirmed that ambiguity remains in relation to chaplain activities. A number of paramedics stated they were not clear on exactly what chaplains do, and voiced concerns about the religious association with the 'chaplain' title/symbolism. However most said this was overcome through the development of relationships. This finding regard the 'chaplain' title however was not mirrored in the chaplain interviews. While some chaplains identified wider societal concerns regarding the chaplain's role and religion, the majority did not specifically discuss the use of the word chaplain or the associated symbolism on their uniforms, only stating they would not discuss religion unless specifically requested. Confusion surrounding the chaplain's role is not new in the literature and suggests a problem with role clarity more globally (Best et al., 2021; Layson et al., 2022; Pater et al., 2021). Further studies are required to determine if this in fact prevents paramedics from accessing chaplains as a support option.

Exploration of the chaplain role on a national and global level provides more clarity on why these challenges may exist at the local ambulance level. Lack of consistent and standardised education pathways are impacting on professionalisation of spiritual care practitioners in Australia. Furthermore, only two professional organisations have developed standards of practice for spiritual care practitioners, and there is currently no mandate for membership to either of these organisations (Spiritual Care Australia, 2020; Spiritual Health Association, 2022). Clinical Pastoral Education, seen as a mainstay of chaplain credentialling in many countries around the globe, is also not mandatory for chaplaincy practice in Australia. Consideration should be made whether chaplains would benefit from working towards recognition with the Australian Health Practitioner Regulation Agency (AHPRA) which would serve to professionalise spiritual care practitioners, provide clarity to other health care workers on the role of spiritual care, and provide protection to the consumers of chaplaincy care (Australian Health Practitioner Regulation Agency, 2022). These challenges with chaplaincy education and professional identity are actively being examined by researchers both in Australia and abroad (Cadge et al., 2019, 2020; Holmes, 2021; Swinton, 2013).

## Limitations

This study into ambulance chaplains contained several limitations. The most significant was the lack of diversity, with most chaplains in this study representing white Christian male perspectives. The lack of diverse faith group representation may be

because the chaplaincy service in this study only employs one Muslim and one Jewish chaplain, and electing to participate in this study makes anonymity challenging. Furthermore, there were only participants from one ambulance service in Australia. Exploration of chaplaincy in other ambulance organisations is important to see if this lack of diversity or other findings can be generalised to ambulance chaplaincy programmes more widely.

## Conclusion

While some contemporary discourse may argue for the removal of chaplaincy, phase one of this study has highlighted the critical importance of not confusing 'popular opinion' with evidence, and instead adopting a person-centred approach that seeks the opinions of chaplaincy providers and consumers. Participants in this study believed uniformed and operationally capable ambulance chaplains can provide paramedic-centred pastoral, emotional and spiritual support through proactively and reactively working alongside paramedics and sharing their experiences in all the places where they operate. Chaplains and paramedics valued this care because of its relational approach which: (1) facilitated trust, (2) did not seek to fix or diagnose but instead offer physical and emotional presence, (3) sought to be available at any hour of the day or night, (4) reduced barriers to help-seeking and (5) promoted engagement in supportive conversations that facilitated referrals to additional support when required. Overlaying paramedic perspectives on these findings, suggests these views exist regardless of the paramedic's personal spiritual beliefs. Further work is required to identify if these findings are generalisable to the wider Australian paramedicine context. Additonal research is also needed to explore the connection between the provision of chaplaincy care and health experiences, such as posttraumatic growth and moral injury, and the need to further professionalise the chaplain's role in Australia.

## Appendix 1: Interview Questions

The following questions were used to guide the semi-structured interviews. They may or may not have been asked in the order listed, depending on the flow of the conversation:

1. What do you understand the chaplain's role to be?
2. What skills and attributes should chaplains possess to be effective?
3. Do you think chaplains are valuable to the organisation? If so, how?
4. Do you think chaplains are valuable to staff individually? If so, how?
5. Do you think interactions with chaplains impact staff wellbeing? If so, how?
6. Is there anything else you would like to tell me more about in relation to chaplains, or anything else we have discussed today? This may include a story or an observation, or anything you wish to add.

**Acknowledgements** Thank you to NSW Ambulance for your support of this project and assistance in sourcing participants. Thank you also to the paramedics and chaplains who took the time to contribute to this project. Katie is the recipient of an Australian Government Research Training Stipend. Thank you also to Assoc. Prof. Lindsay B. Carey (La Trobe University, Melbourne & University of Notre Dame, Sydney) for his assistance with helping to edit this research.

**Author Contributions** All authors contributed to the study conception and design. Material preparation, data collection and analysis were performed by KTL as part of her dissertation. The first draft of the manuscript was written by KTL under the supervision of her co-supervisors TLJ, JL and PS, and all authors commented on previous versions of the manuscript. All authors read and approved the final manuscript.

**Funding** Open Access funding enabled and organized by CAUL and its Member Institutions.

**Availability of Data** Requests for access to the framework matrices can be made to the first author.

**Code Availability** Not applicable.

## Declarations

**Conflict of Interest** Katie Tunks Leach currently works as a volunteer chaplain with NSW Ambulance.

**Ethical Approval** The questions and methodology for this study were approved by the South East Sydney Local Health District (SESLHD) Human Research Ethics Committee (HREC) [2019/ETH13593] and were ratified by the University of Technology Sydney (UTS) HREC [ETH19-3820].

**Consent to Participate** Informed consent was obtained from all individual participants included in the study, including consent for the findings to be published.

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# Chapter 6 – Chaplaincy and spiritual care in Australian Ambulance Services: A cross-sectional Study

## 6.1 Introduction

Chapters 4 and 5 describe Phases 1a and 1b of this study. I obtained the perspectives of both paramedics and chaplains to build a broad and rich understanding of the work ambulance chaplains do, how they do it, how chaplains were valued, how chaplaincy was perceived to affect paramedic wellbeing, and the factors that influenced chaplains' effectiveness. However, Phase 1 was limited to paramedics and chaplains in NSWA.

In this chapter, I outline how data from Phase 1 was used to inform the development of a quantitative survey to collect data about Australian paramedics' perspectives on chaplaincy (Phase 2); paramedics in all states and territories were invited to complete the survey, and the resulting data were analysed (Phase 3). The aim of this quantitative study was to reveal Australian paramedics' perspectives on the role and value of ambulance chaplains.

## 6.2 What does the paper add to existing knowledge?

The sample size of this cross-sectional study was too small to generalise findings to the wider paramedic population, but were helpful understanding if the findings were with consistent with those identified in Phase 1. I identified that the surveyed Australian paramedics (who indicated that they would use ambulance chaplaincy) perceived that the most important elements of chaplains' role were not those performed at significant jobs; rather, it was seen as more important that chaplains invest time and effort in ongoing relationships. In fact, the data indicate that the existence of these relationships is a stronger determinant of chaplain use than paramedics' personal spiritual or religious preferences. In addition, emotional, psychological and social care was perceived to be more important to paramedics than spiritual care, but large majorities of paramedics rated care relating to meaning, purpose and other spiritual concepts as important or very important. The value of ambulance chaplains was strongly grounded in both relationships and shared experiences in the workplace, which served to promote help-seeking conversations and help paramedics access other staff support when required.

For those paramedics who expressed the view that they would not consult a chaplain, the most significant barriers centred on preconceived ideas of chaplains and the perceived association between chaplains and religion.

## 6.3 Manuscript under review

The manuscript below was accepted for publication (with amendments) by the *Journal of Health Care Chaplaincy*, a Quartile 1 journal, on 12 December 2023.

## 6.4 Submitted manuscript

### Chaplaincy and spiritual care in Australian ambulance services: A cross-sectional Study

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**Abstract**

Ambulance staff wellbeing programs aim to support the bio-psycho-social and sometimes spiritual needs of paramedics. While evidence demonstrates strong connections between spirituality and/or religion to wellbeing outcomes, little is known about spiritual care in ambulance services or its impact. The aim of this study was to investigate paramedics' perspectives on the role and value of Australian ambulance chaplains. A cross-sectional online study of registered paramedics in Australia was conducted between November and December 2022. Analysis of the 150 responses identified that paramedics viewed the chaplain's role as one built on professional caring relationships that provided proactive and reactive care in paramedic workplaces. Chaplains were perceived to promote wellbeing by incorporating emotional, psychological, social and spiritual care, and assisting paramedics to access additional support. Perceived religiousness of chaplains and organisational factors were barriers to paramedics accessing chaplains, while pre-existing relationships and shared experiences positively influenced paramedics decision to seek chaplain support.

Keywords: Paramedicine, Ambulance, Emergency Medical Services, Chaplaincy, Spiritual Care

## Introduction

Paramedics experience occupational stress resulting in compassion fatigue, burnout, moral distress/injury, depression and anxiety at higher rates than the general population (Copel et al., 2023; Ghahramani et al., 2021; Rosen et al., 2022; Xu et al., 2020). Evidence from research and government enquiries on these impacts have led to enhanced staff support for healthcare workers across Australia, including in Australian ambulance services, with models of care designed to meet the physical, psychological, social, emotional and sometimes spiritual needs of staff (Beyond Blue, 2020; Claringbold et al., 2022; Education Employment References Committee, 2019). However, the inclusion of spiritual care in Australian ambulance services is inconsistent and contentious, with the terms 'chaplaincy' and 'spiritual care' invoking strong and complex responses in individuals.

Contemporary spiritual care has evolved to include practitioners of all spiritual and religious traditions, including practitioners who identify as neither spiritual nor religious. It aims to support all people (regardless of their beliefs) and promote wellbeing by helping people to find meaning, purpose and connection with themselves, others and/or a higher power (Puchalski et al., 2014). Preconceived ideas about the role of chaplains continue to impact the use and perceived value of chaplaincy, including concerns about the chaplain and religion, the desire for non-religious support, and concerns about chaplains caring for minority communities (Cunningham et al., 2017; Layson et al., 2022; Pater et al., 2021; Roberts et al., 2018). However, contemporary research has also identified positive outcomes resulting from chaplain care, including the promotion of spiritual wellbeing, improved coping and sense of hope, improved quality of life and lower rates of burnout, anxiety and depression (Damen et al., 2020; De Diego-Cordero et al., 2022; Koenig, 2015; Wachholtz & Rogoff, 2013). Additionally, chaplains have been shown to provide care to diverse groups, including staff, patients and bystanders in the community (Aiken, 2022; Gouse, 2017; Grimell, 2020; Torke

et al., 2022). Consequently, offering spiritual care is considered an important element in the provision of holistic person-centred care and the promotion of wellbeing by the World Health Organization and other peak health bodies (Peng-Keller et al., 2022; World Psychiatric Association, 2019).

Previous studies in first responder settings, albeit limited, have identified perceived value of chaplains through the provision of proactive and reactive relational care, often with staff who did not identify with the same spiritual or religious beliefs as the chaplain (Gouse, 2016; Moosbrugger, 2006; Tunks Leach et al., 2022, 2023). However, generalising these findings to the broader ambulance community is problematic as the ambulance context is considerably different, therefore limiting the conclusions that can be drawn (Claringbold et al., 2022). Therefore, the aim of this study was to examine paramedics' perspectives on the role and value of ambulance chaplains across multiple Australian jurisdictions using a quantitative instrument derived from the findings of earlier qualitative studies (Tunks Leach et al., 2020; Tunks Leach et al., 2022, 2023).

## Methods

### *Study design, theoretical framework and reporting*

This cross-sectional online survey used convenience sampling to recruit Australian paramedics. The research questions that framed the survey sought to identify: (1) Who uses ambulance chaplains? (2) What is the role of chaplains in Australian ambulance services? (3) What factors impact a chaplain's effectiveness? and (4) How do chaplains add value to Australian ambulance services?

A pragmatic worldview underpinned this study. This ontological stance suggests that participants bring multiple realities and diverse perspectives to the study, and that it is important to hold all worldviews as equal (Creswell & Plano Clark, 2018; Halcomb & Hickman, 2015). Epistemologically, and in line with the pragmatic approach, we selected the research design most appropriate to answering the research questions (Creswell & Plano Clark, 2018; Halcomb & Hickman, 2015). Additionally, a salutogenic theoretical perspective was used to interpret findings, in order to better understand how chaplains promote health, wellbeing and coping, along with how they support ill-health (Antonovsky, 1979; Haugan & Eriksson, 2021). The STROBE cross-sectional checklist informed the writing of this paper (von Elm et al., 2007).

***Setting***

This study took place in jurisdictional and private paramedic organisations across all eight Australian states and Territories. Australian paramedics provide emergency and primary care in ambulance services, clinics and hospitals, as well as in non-clinical areas like education, research and public health (Paramedicine Board, 2022; Williams et al., 2021). Paramedics in Australia are tertiary-qualified practitioners who are registered with the Australian Health Practitioner Regulation Agency (AHPRA). They have diverse skills allowing them to practice independently or under medical direction to provide healthcare to patients, frequently in unpredictable and dynamic settings (Ross et al., 2022; Williams et al., 2021).

At the time of this publication, chaplains were included as part of staff support teams in five out of eight Australian States and Territories, with New South Wales employing the highest number of chaplains, followed by Victoria, Queensland, the Australian Capital Territory and Northern Territory, overall consistent with population sizes. No chaplains were employed in

Tasmania, and no information was available as to whether chaplains were employed in South Australia or Western Australia. While two Australian professional spiritual care organisations have produced frameworks or standards for practice for their members (Spiritual Care Australia, 2023; Spiritual Health Association, 2022), there are no mandatory requirements for chaplain education or licensure in Australia, so the current workforce includes practitioners with Masters Degree qualifications and Clinical Pastoral Education, through to volunteers with no formal chaplain-specific education.

***Recruitment***

Following ethics approval, social media was used to recruit participants via convenience and snowball sampling over a period of six weeks between November and December 2022. The Australasian College of Paramedicine also promoted the study to their members via email and social media.

***Participants***

Eligible participants were AHPRA-registered paramedics, currently or previously employed by Australian jurisdictional or private companies. Informed consent was sought and implied from all participants.

***Instrumentation***

This survey represents Phase 3 of an exploratory sequential mixed methods study. This approach is recommended when little is known about a topic, as is the case with ambulance chaplaincy, and where no previous peer-reviewed studies on the topic have been undertaken (Halcomb & Hickman, 2015). A joint display was used to map qualitative findings from phase 1 to the design of quantitative questions developed in phase 2, resulting in a survey

"grounded in the culture and perspectives of the participants" (Creswell & Plano Clark, 2018; Schneider et al., 2016, p. 87). To ensure face, content and construct validity, the resulting survey was reviewed by an expert panel of seven academics and practitioners representing the fields of paramedicine, spiritual care and epidemiology. The expert panel was asked to provide feedback on the clarity, relevance and structure. Feedback resulted in minor modifications to the survey, before final testing, ethics approval and implementation (Brink et al., 2012).

While the focus of the overall study was to learn about the role and value of chaplains from the perspective of those who had experience with or would use ambulance chaplains, we felt it was important to also include the perspectives of those who would not use chaplains to gain a deeper understanding of the issues and better answer the research questions. Consequently, at the beginning of the survey participants were stratified into two groups based on their responses to the question: "Would you ever seek support from an ambulance chaplain?" Participants who responded "no" were presented with three questions, while participants who responded "yes" were presented with twenty-four questions (Appendix 1). Questions about demographic characteristics were included at the end of the survey as was the question "Is there anything further you wish to tell us about chaplains in ambulance organisations?" to which participants could provide free-text responses.

***Ethics approval***

UTS Health and Medical Research Ethics Committee approved this research project (ETH22-7416).

### *Data collection*

Data were collected and managed using REDCap electronic data capture tools (Harris et al., 2019) hosted at the University of Technology Sydney (UTS) in Australia. Prior to commencing the study participants were presented with a Participant Information Form and consent was implied on submission of a completed survey. No data from incomplete surveys were included in this study. Privacy and continentality were assured through no identifying data being collected (eg. IP address), and any potentially identifying data were removed during data cleaning and prior to publication.

### *Sample size*

A sample size of 378 was calculated using an Australian Government sample size calculator, based on the Australian paramedic population size of 22,500 and a confidence interval of 95% (Australian Bureau of Statistics, 2022).

### *Data analysis*

Data were downloaded, cleaned and analysed in IBM SPSS Statistics (Version 29). Chi-square analyses were conducted on past and future use of chaplain support with age, years of service and spiritual and religious identity. Cramer's V was used to determine the strength of associations (Kirkwood & Sterne, 2003) and interpreted as weak if the effect size (ES) was ≤2, moderate if ES was 0.2-0.8, and strong if ES was >0.8 (Ferguson, 2016). Statistical significance for descriptive data were established when p = < .05 (Kirkwood & Sterne, 2003). Descriptive analysis was conducted on remaining data. Where a 5-point Likert scale was used in the survey, explicit categories were reported by combining 'strongly agree' and 'agree' ('explicit agreement'), 'very important' and 'important ('explicit importance'), 'strongly disagree' and 'disagree' ('explicit disagreement'), and 'not at all important' and 'unimportant

('explicit unimportance') (Joshi et al., 2015). Free-text quotes were reviewed and thematically analysed to identify recurring themes (Braun & Clarke, 2013, p. 178). These findings were then mapped back to the survey questions to illustrate salient points.

## Results

### *Demographic characteristics*

A total of 202 paramedics commenced the survey. Of these, 52 responses contained incomplete data and were removed leaving 150 participants (see Table 1). Most respondents were male (59.3%), aged 50+ (32.7%), employed for between 5-9 years (22.0%), employed in a jurisdictional ambulance service ($n = 137$) and worked in New South Wales (NSW) ($n = 72$). The biggest spiritual or religious identity was 'Atheist' ($n = 57$), followed by 'Agnostic' ($n = 43$) and 'Open to spiritual matters' ($n = 40$), however as more than one response could be selected, some identified as 'agnostic' but 'open to spiritual matters'.

Table 1 – Participant demographics ($N$=150)

When asked if chaplains were available in their ambulance service, most participants indicated that they did not know (77.4%, $n = 127$). A small number (9.1%, $n = 15$) indicated that they did have access to chaplains, and 13.4% ($n = 22$) indicated that they did not.

### *Chaplaincy use*

Most participants indicated they had not previously sought chaplain support (62.7%, $n = 94$). Approximately half of the participants indicated they would not seek chaplain support in future (51.3%, $n = 77$) and the other half indicated they would (48.7%, $n = 73$). A little over half of all male participants (55.1%, $n = 49$) and less than half of female participants (41.5%,

$n = 22$) indicated they would seek chaplain support. Of the eight participants who identified as non-binary, preferred to self-describe or preferred not to disclose their gender identity, 75.0% ($n = 6$) stated that they would not seek support from a chaplain. The 56 participants who had previously accessed chaplain support represented all spiritual or religious beliefs or non-belief, and most indicated they would seek chaplain support again in future (n = 50, 89.3%).

The relationship between previous use of a chaplain and duration of ambulance service was not significant ($\chi^2$ (5, $N = 150$) = 6.656, $p = .248$, $V = .211$). Similarly, there was no relationship between previous use of a chaplain and age of participants ($\chi^2$ (3, $N = 150$) = 6.011, $p = .111$, $V = .200$). Conversely, the relationship between future use of a chaplain and duration of paramedic service was significant, with moderate effect ($\chi^2$ (5, $N = 150$) = 17.148, $p = .004$, $V = .338$). The relationship between future use of a chaplain and age was also significant, with moderate effect ($\chi^2$ (3, $N = 150$) = 11.692, $p = .009$, $V = .279$). These results indicate that older paramedics and those with more years of service were more likely to seek chaplain support in future.

A significant relationship with moderate effect was noted between those who had not used chaplains and those who identified as atheist ($\chi^2$ (1, $N$=150) =18.239, $p$=<.001, $V$=.349), indicating those who identified as atheist were unlikely to have accessed a chaplain. Similarly, the relationship between those who had previously accessed chaplaincy care and those who identified as monotheistic was significant, with moderate effect ($\chi^2$ (1, $N = 150$) = 10.578, $p = .001$, $V = .266$), as was the relationship between those who had previously accessed chaplaincy care and those who identified as belonging to a religious community ($\chi^2$

(1, $N = 150$) = 10.487, $p = .001$, $V = .264$), with these groups more likely to have accessed chaplaincy support.

A significant relationship with moderate effect was noted between future use of a chaplain and those who identified as atheist ($\chi^2$ (1, $N = 150$) = 39.778, $p = <.001$, $V = .515$), indicating that those who identified as atheist were unlikely to seek future chaplain support. Similarly, the relationship between future use of a chaplain and being an active participant in spiritual activities ($\chi^2$ (1, $N = 150$) = 7.363, $p = .007$, $V = .222$), belonging to a religious community ($\chi^2$ (1, $N = 150$) = 14.665, $p = <.001$, $V = .313$), monotheistic ($\chi^2$ (1, $N = 150$) = 16.270, $p = <.001$, $V = .329$) and open to spiritual matters ($\chi^2$ (1, $N = 150$) = 24.993, $p = <.001$, $V = .408$) were all significant with moderate effect, indicating those who identify with these groups would likely seek chaplain support in future. No significant relationships were identified between those who would use a chaplain in future and those who identified as agnostic ($\chi^2$ (1, $N = 150$) = 1.233, $p = <.267$, $V = .091$). Due to inadequate responses from those who identified as polytheistic, assumptions were violated resulting in insufficient data to report (Kirkwood & Sterne, 2003).

A significant relationship with moderate effect was noted between previous use of a chaplain and future use of a chaplain ($\chi^2$ (1, $N = 150$) = 59.017, $p = <.001$, $V = .627$), indicating that those who had previously used chaplaincy were likely to seek chaplain support in future, regardless of spiritual or religious beliefs.

***What is the role of an ambulance chaplain in Australia?***

Questions relating to this research question sought to understand what paramedics understood the role of an ambulance chaplain to be with reference to proactive care (care provided

outside of significant jobs) and reactive care (care during and immediately after significant jobs), in line with themes identified in previous studies (Tunks Leach et al., 2022, 2023).

*Proactive care*

Paramedics who indicated they would use chaplaincy were asked to consider the importance of ambulance chaplains conducting assessments of their needs (Table 2). The majority of participants considered chaplains to play an important role in assessing their emotional, mental and social health needs, and approximately half considered assessment of their pastoral, spiritual or physical health needs to be within the remit of chaplains.

Table 2 – Assessments conducted by ambulance chaplains

Paramedics were then asked what types of supportive conversations they wanted chaplains to be able to engage in. More than 90% of participants indicated they felt it was important or very important for chaplains to be able to engage in supportive conversations relating to work stress, personal stress and paramedic experiences.

Beyond supportive conversations, the majority of participants reported that it was very important or important for chaplains to engage in counselling, education and guidance relating to normal and abnormal reactions to significant jobs, accessing support beyond chaplain care, life purpose and meaning making, and personal wellbeing. Less than half of the participants felt that spiritual or religious support was important (Table 3).

Table 3 – Counselling, education and guidance activities desired from ambulance chaplains

An additional question exploring participant expectations of the role of spiritual and religious care in chaplaincy were diverse. While approximately half (50.7%, $n = 37$) of participants saw corporate expressions of spirituality or religion (e.g. weddings, funerals) as important, just over a third felt that individual expressions or religious beliefs (e.g. prayer) were important (38.4%, $n = 28$).

When it came to a broader understanding of chaplains' roles in ambulance organisations, most participants (83.6%, $n = 61$) felt their role was to listen, empathise and validate, not diagnose or 'fix', and 78.1% ($n = 57$) thought chaplain should be adaptable to meet organisational requirements.

*Reactive care*

Participants who indicated they would use chaplains were asked about the provision of support at significant jobs. Most indicated they would request chaplain support for jobs with actual or potential emotional impact such as paediatric death or death by suicide (91.8%, $n = 67$), cumulative trauma arising from paramedic work (86.3%, $n = 63$), and major disasters (75.3%, $n = 55$). A very small number indicated they would not request chaplain support for significant jobs (5.5%, $n = 4$).

Participants were also asked how they wanted chaplains to provide support on the scene of significant jobs (Table 4). Scene support primarily focussed on supporting family, bystanders and other first responders through the provision of emotional, practical and spiritual or religious support. Direct care of paramedics was more important in the aftermath of these jobs.

Table 4 - Desired ambulance chaplain activities at significant jobs*

When asked if ambulance chaplains should be operationally trained, uniformed and capable, the majority of participants (90.5%, $n = 66$) strongly agreed or agreed. A further 91.8% ($n = 67$) indicated they wanted chaplains to be available for individual paramedic post-incident support (separate to group clinical debriefs).

Participants who indicated they would not use chaplains were also asked how they would want chaplains to support them should they ever choose to access this service. Participants indicated a preference for emotional (22.1%, $n = 17$), social (13.0%, $n = 10$), and mental health support (10.4%, $n = 8$). When asked how they would want chaplains to support bystanders should they choose to use them, 45.5% ($n = 35$), indicated they would access chaplains to provide bystanders with emotional support and 33.8% ($n = 26$) to provide spiritual or religious support.

***Paramedic perceptions on the value and impact of chaplain-provided support***

Paramedics who indicated they would access chaplains for support were asked about the value and impact of care provided by chaplains. Most participants strongly agreed/agreed that chaplains better understand paramedic experiences because they are situated within their workplace (79.5%, $n = 58$), and 85.0 % ($n = 62$) indicated that having chaplains in their workplace promoted trust and rapport.

Paramedics who had engaged with chaplains believed that this had positively impacted their wellbeing. A large majority of 90.5% ($n = 66$) responded that knowing a chaplain makes it easier to reach out if they need help, and 89.0% ($n = 65$) agreed/strongly agreed with the

statement "situating chaplains in my workspaces means I can engage in supportive conversations when it suits me". Additionally, 64.4% ($n = 47$) felt that chaplains could proactively check in on their wellbeing, and 80.8% ($n = 59$) agreed or strongly agreed that knowing a chaplain had taken over care of bystanders at significant jobs made them feel better.

Paramedics who indicated they would access chaplains for support believed chaplaincy should be included in staff support teams, with 91.8% ($n = 67$) agreeing with this statement. Free text comments again added to our understanding of this theme:

> Reaching out to a chaplain has been of enormous benefit to me…I would not have reached out had I not known the chaplain I was reaching out to. There is a great sense of comfort I feel knowing our local chaplain and knowing I can reach out and have that support (Female, 30-39 years, jurisdictional service).

***Factors that impact a chaplain's effectiveness***

Paramedics who indicated they would access chaplains for support were asked about the importance of chaplain attitudes and attributes (Table 5). All respondents identified it was important for chaplains to be approachable, confidential, non-judgemental and supportive, with strong importance also placed on being a good listener, trustworthy, empathic, discrete, available and a relationship-builder.

Table 5 – Ambulance chaplain attitudes and attributes

Participants were asked if ambulance chaplains should have tertiary qualifications in chaplaincy or pastoral care. Most were undecided (38.4%, $n = 28$), while 32.9% ($n = 24$)

strongly agreed/agreed and 28.7% ($n = 21$) disagreed /strongly disagreed. When participants were asked if they thought ambulance chaplains with additional healthcare qualifications could better support them, only 38.4% ($n = 28$) strongly agreed/agreed. However, several free text comments revealed that participants valued clinically experienced chaplains who could provide a deeper level of support to paramedics:

> I'm in a service where the ambulance chaplains are…also operational staff. I love this model as the chaplains completely understand the operational and organisational issues we encounter and make them FAR more relatable to us. (Female, 30-39 years, jurisdictional service).

To better understand the factors impacting chaplain effectiveness and potential barriers to their use, the perspectives of the participants who indicated they would not use chaplains (51.3%, $n = 77$) were sought. Their responses indicated that they would rather talk to a secular or non-religious counsellor (74.0%, $n = 57$) or seek help from another staff support team member (64.9%, $n = 50$). The majority (63.6%, $n = 49$) didn't want to talk to a religious person, were not convinced chaplains could provide the type of support they needed (57.1%, $n = 44$); and would rather seek help outside their organisation (42.9%, $n = 33$). It is noteworthy that 37 of the 78 free-text responses made reference to the association between chaplains and religion. For example:

> I strongly feel that support roles should be appropriately trained professionals with NO religious agenda. (Female, 50+ years, jurisdictional service)

> I have seen a large regional city station refuse to work with the 'local Chaplain' because they were judgmental (strong religious beliefs), and lacked clinical skills/experience… (Male, 30-39 years, jurisdictional service)

> As a survivor of faith-based abuse, I would absolutely never use any faith-based support, regardless of any claimed neutrality. (Gender withheld, 30-39 years, jurisdictional service)

**Discussion**

The aim of this study was to examine paramedics' perspectives on the role and value of ambulance chaplains across multiple Australian jurisdictions using a quantitative instrument derived from the findings of earlier qualitative studies.

The results identified that paramedics who are more open to spirituality and religion were more likely to use chaplaincy that those who identified as atheists. Additionally, the majority of those who identified as women, non-binary or who preferred to self-describe their gender, stated that they would not use a chaplain, possibly for reasons relating to historical discrimination of women and members of the LGBTQIA+ community by some conservative religious organisations (Ezzy et al., 2022; Whitaker, 2019). It is noteworthy however, that participants who had previously used chaplains, irrespective of religious affiliation, stated that they would use chaplains again in the future. This suggests that meaningful prior relationships between chaplains and paramedics may be more important than religious backgrounds. Previous studies examining faith concordance between chaplains and clients have found that faith-disconcordant encounters can be received just as positively as faith-concordant encounters (Cunningham et al., 2017; Liefbroer & Nagel, 2021; Liefbroer et al., 2017). While it's not possible to determine if this is the case from this study, further research

is required to determine whether the presence of caring relationships can be more influential than, or as powerful as, spiritual beliefs in determining chaplain use.

For the participants who indicated they would use chaplains, the role was seen to be both proactive and reactive. Participant responses suggested that chaplaincy is a 'frontline' wellbeing role grounded in relationships and situated in paramedic workplaces. It addressed more than just spiritual and religious needs, and incorporated a holistic perspective which included emotional, psychological and social wellbeing. These findings indicate that ambulance chaplains have the potential to promote and support health, wellbeing and flourishing in order to pre-empt and prevent ill-health.

The focus on psychological elements of care identified in this study is a novel finding in the ambulance setting although similar themes have been identified in other chaplaincy contexts (Nieuwsma et al., 2013; Prazak & Herbel, 2020). Nieuwsma et al. (2014) reported that seeing a pastoral counsellor was associated with an increased likelihood of seeing a mental health professional. This finding suggests a need for a review of ambulance chaplains' skillsets to ensure they are equipped to undertake basic mental health assessment and to refer paramedics to psychological specialists when appropriate. Additionally, opportunities for collaboration between chaplains and psychologists to identify those struggling with mental ill-health earlier and connect them to specialised support needs to be explored.

Ambulance chaplains also provided care beyond just the workplace. Supporting paramedics with both professional and personal issues, along with bystanders and other first responders was seen to be part of the role. Similar findings have been identified in settings including the military and hospitals (Aiken, 2022; Cadge & Rambo, 2022; Carey & Rumbold, 2015;

Liberman et al., 2020; Nolan & Damen, 2021). Additionally, chaplains caring for paramedics and bystanders as outlined in this study, align with World Health Organization's International Statistical Classification of Diseases (ICD) and Related Health Problems which describe interventions that can be undertaken by spiritual care practitioners (Carey & Cohen, 2015; World Health Organization, 2002).

The value of chaplains identified by paramedics in this study arose through the relational care chaplains provided to paramedics in the course of their everyday work, which resulted in reduced barriers to help-seeking and reduced emotional burdens on paramedics as they perform their role. Situating chaplains in paramedic workplaces, sharing experiences, establishing trusted professional caring relationships, assuming care of bystanders and developing a deeper comprehension of the realities of being a paramedic, appeared to contribute to paramedics' sense of wellbeing, along with recognising ill-health and helping people connect to further support services. These activities align with a salutogenic perspective of wellbeing, which focuses on factors that contribute to health and not just those that contribute to disease (Haugan & Eriksson, 2021). While other studies conducted in chaplaincy settings have identified similar findings with rapport and relationships being central to chaplain effectiveness (Hodgson et al., 2021; McCormick & Hildebrand, 2015; Prazak & Herbel, 2020), this is an original finding in the paramedic wellbeing literature. These self-reported findings by paramedics were not measured using established tools, however they offer promising insights and highlight further the need for research to formally measure the outcomes of chaplain care.

Factors impacting chaplains' effectiveness included the need for clarity of the chaplain's role and frameworks for practice, and how ambulance organisations implement chaplaincy

programs. Participants identified the importance of chaplains being trained in ambulance culture and procedures, and equipped (eg. uniforms) to undertake their role safely and effectively. Similar findings have been found in military chaplaincy literature where chaplains/padres train and serve in the field alongside their staff (Behlin, 2021; Besterman-Dahan et al., 2012; Grimell, 2020). However, one of the biggest factors detracting from chaplain effectiveness was the lack of understanding about the chaplain's role. Widespread discussion exists in spiritual care literature regarding the problematic nature of poorly defined chaplaincy roles and standards for practice (Best et al., 2021; Carey & Rumbold, 2015; Holmes, 2021; McCormick & Hildebrand, 2015; Tunks Leach et al., 2022) and the results from this study support these views.

As previously discussed, spiritual wellbeing can include religion, but it also extends beyond religion to help all people regardless of beliefs to make meaning, find purpose, foster connection and provide hope (Puchalski et al., 2014). Many elements of ambulance chaplain wellbeing work identified in this study fall into this category and align with the wider spiritual care literature (McCormick & Hildebrand, 2015; Pater et al., 2021; Taylor, 2021). Despite participants indicating spiritual care was not important, many elements of chaplain practice identified in this study that were rated as very important, suggesting that there may be a lack of shared language and understanding about what constitutes spiritual care. This is one potential factor creating a barrier to accessing chaplaincy. Additionally, to ensure chaplain success in their role and greater accessibility for staff, chaplaincy programs should ensure diverse representation of all belief systems, clearly communicated frameworks for practice, and minimum standards of training for chaplains in line with recommendations from peak bodies (Spiritual Care Australia, 2023; Spiritual Health Association, 2020).

### Limitations

While this survey was open to all AHPRA-registered paramedics in Australia, the low response rate mean that the results are not necessarily representative of the Australian paramedic population due to factors including sampling and non-response bias (Sedgwick, 2014; Wang & Cheng, 2020). Additionally, while this study used a cross-sectional observational design that examined correlations and relationships, causation could not be determined. Finally, self-report outcome measures have limitations, such as differing interpretations of scale values and social desirability bias (Cook et al., 2021). The results from this study should therefore be interpreted as exploratory and hypothesis-generating, and viewed in that context. Despite these limitations, the findings from this study have the potential to inform future studies investigating chaplaincy in ambulance services.

### Conclusion

Findings from this study identified that ambulance chaplains provide care to paramedics in the places where they work, extending beyond the provision of spiritual care to incorporate holistic approaches to promote and support paramedic wellbeing. It appeared that in the presence of professional caring relationships and shared experiences, this care could support people of all spiritual and religious beliefs or none. However, in the absence of relationships and clear communication around the role of chaplains in pluralist organisations like ambulance services, barriers remain for a significant number of staff to access their care. Ambulance organisations should provide clear communication of chaplains' frameworks for practice, establish minimum standards for education, and ensure chaplaincy programs represent diverse belief systems to maximise opportunities to provide spiritual care to all who choose to access it.

**Acknowledgements**

The authors would like to thank the Australasian College of Paramedicine for their assistance in promoting this study.

**Funding**

KTL is the recipient of an Australian Government Research Training Stipend.

**Declaration of interest**

KTL works as a Volunteer Ambulance Chaplain.

**Data availability statement**

Data that support the findings of this study may be made available from the corresponding author following consideration of what use and application is proposed. However, restrictions apply and data are not publicly available.

**Author contribution statement**

KTL, TLJ, JL and PS contributed to the study conception and design. Material preparation, and data collection were performed by KTL as part of her doctoral studies. All authors contributed to data analysis. The first draft of the manuscript was written by KTL under the supervision of her co-supervisors TLJ, JL and PS, and DD. All authors commented on previous versions of the manuscript and approved the final manuscript.

**Ethics approval**

UTS Health and Medical Research Ethics Committee approved this research project (ETH22-7416).

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**Appendix 1 – Survey Questions**

1. Have you ever sought support from an ambulance chaplain?
    - Yes
    - No

2. Would you ever seek support from an ambulance chaplain?
    - Yes
    - No

*(At this point the survey breaks into two streams, depending on the response to question 2)*

*Yes stream*

In this survey, we ask you to consider ambulance chaplains across four domains: (1) the skills and attributes of an ambulance chaplain, (2) the role and value of chaplains in your day-to-day work, (3) the role and value of chaplains at significant jobs, and (4) the role and value of chaplains within the wider ambulance organisation.

*Skills and attributes of an ambulance chaplain*

Please reflect on the qualities, skills and attributes of ambulance chaplains and answer the following questions using the following scale: (1) not at all important, (2) unimportant, (3) neither important or unimportant, (4) important and (5) very important.

3. How important is it that you have an established working relationship with an ambulance chaplain?

   1 2 3 4 5

4. How important to you are the following attitudes and attributes in establishing a working relationship with an ambulance chaplain? Please answer the following questions according to the following scale: (1) not at all important, (2) unimportant, (3) neither important or unimportant, (4) important and (5) very important.

| | | | | | |
|---|---|---|---|---|---|
| a. Adaptable | 1 | 2 | 3 | 4 | 5 |
| b. Approachable | 1 | 2 | 3 | 4 | 5 |
| c. Available | 1 | 2 | 3 | 4 | 5 |
| d. Committed | 1 | 2 | 3 | 4 | 5 |
| e. Community minded | 1 | 2 | 3 | 4 | 5 |
| f. Confidential | 1 | 2 | 3 | 4 | 5 |
| g. Discrete | 1 | 2 | 3 | 4 | 5 |
| h. Does not express religious views without express invitation | 1 | 2 | 3 | 4 | 5 |
| i. Empathic | 1 | 2 | 3 | 4 | 5 |
| j. Good listener | 1 | 2 | 3 | 4 | 5 |
| k. Leadership | 1 | 2 | 3 | 4 | 5 |
| l. Multifaith approach to spirituality/religion | 1 | 2 | 3 | 4 | 5 |
| m. Non-judgemental | 1 | 2 | 3 | 4 | 5 |
| n. Proactively builds relationships with people | 1 | 2 | 3 | 4 | 5 |
| o. Supportive | 1 | 2 | 3 | 4 | 5 |
| p. Team player | 1 | 2 | 3 | 4 | 5 |

q. Trustworthy 1 2 3 4 5

r. Other (please specify)

5. How important are the following ambulance chaplain skills and activities to you? Please answer the following questions according to the following scale: (1) not at all important, (2) unimportant, (3) neither important or unimportant, (4) important and (5) very important.

a. Assessment of:

| | | | | | |
|---|---|---|---|---|---|
| Pastoral and spiritual wellbeing needs | 1 | 2 | 3 | 4 | 5 |
| Emotional wellbeing needs | 1 | 2 | 3 | 4 | 5 |
| Mental health wellbeing needs | 1 | 2 | 3 | 4 | 5 |
| Physical wellbeing needs | 1 | 2 | 3 | 4 | 5 |
| Social wellbeing needs | 1 | 2 | 3 | 4 | 5 |

b. Supportive conversations relating to:

| | | | | | |
|---|---|---|---|---|---|
| Work-related stress | 1 | 2 | 3 | 4 | 5 |
| Personal stress | 1 | 2 | 3 | 4 | 5 |
| Holding space to listen to paramedic experiences or narratives | 1 | 2 | 3 | 4 | 5 |

c. Counselling, guidance and education relating to:

| | | | | | |
|---|---|---|---|---|---|
| Accessing further support beyond chaplain care | 1 | 2 | 3 | 4 | 5 |
| Spiritual or religious support | 1 | 2 | 3 | 4 | 5 |

Moral and/or ethical support 1 2 3 4 5

Personal wellbeing 1 2 3 4 5

Life purpose or making meaning of events 1 2 3 4 5

Normal or abnormal reactions to significant jobs

1 2 3 4 5

d. Spiritual or religious ritual relating to:

Private prayer or worship 1 2 3 4 5

Paramedic weddings, funerals, baptisms or other service

1 2 3 4 5

e. Other (please specify)

Please respond to the following statements by selecting the most appropriate response: (1) strongly disagree, (2) disagree, (3) undecided, (4) agree and (5) strongly agree.

6. Ambulance chaplains should have a tertiary qualification in chaplaincy or pastoral care.

   1 2 3 4 5

7. Ambulance chaplains with healthcare qualifications* are better able to support me than ones without.

   1 2 3 4 5

*The role and value of chaplains in paramedic day-to-day work*

Please consider the role and value of chaplains in your everyday work (i.e. not at significant jobs) and respond to the following statements by selecting the most appropriate response: (1) strongly disagree, (2) disagree, (3) undecided, (4) agree and (5) strongly agree.

8. Situating chaplains in paramedic workspaces promotes rapport and trust with paramedics.

   1 2 3 4 5

9. Situating ambulance chaplains in my various workspaces means I can engage in supportive conversations when it suits me including during my shift or in between jobs.

   1 2 3 4 5

10. Ambulance chaplains better understand paramedic experiences because they are situated in our workspaces.

    1 2 3 4 5

11. Ambulance chaplains promote wellbeing in my workplace by acting as advocates between management and staff.

    1 2 3 4 5

12. Knowing an ambulance chaplain makes/would make it easier to reach out when I need help.

    1 2 3 4 5

13. Ambulance chaplains proactively check in on my wellbeing.

1 2 3 4 5

*The role and value of chaplains at significant jobs*

For this section, please consider the role and value of chaplains when they are called to attend significant jobs.

14. What types of clinical jobs would you consider requesting chaplain support for? (Choose all that apply)
    a. Jobs that are significant due to magnitude (eg. major disaster)
    b. Jobs that are significant due to actual or potential emotional impact (eg. suicide, paediatric death)
    c. Jobs that are significant due to my or my colleague's personal reaction (eg. cumulative trauma, trigger from sight/sound/smell)
    d. I would not use chaplains for clinical jobs
    e. Other (please specify)

15. If an ambulance chaplain attends clinical jobs, I want them to: (choose all that apply)
    a. Support paramedic needs, which may include practical support such as retrieving equipment from the ambulance vehicle or paramedic wellbeing needs.
    b. De-escalate or calm family members or bystanders.
    c. Create a sense of safety for family members or bystanders.
    d. Act as a liaison between paramedics and family members or bystanders.
    e. Provide physical care to family members or bystanders (eg. providing shelter, food/water, physical safety).

f. Provide emotional support for family members or bystanders (eg. grief support).

g. Provide spiritual or religious support for family members or bystanders.

h. Help family members or bystanders connect to support.

i. Support other first responders.

j. Participate in the post-incident clinical debrief.

k. I do not use chaplains for clinical jobs

Please respond to the following statements by selecting the most appropriate response: (1) strongly disagree, (2) disagree, (3) undecided, (4) agree and (5) strongly agree.

16. It is important to me to have a trained, uniformed chaplain who is safe and capable in a clinical setting.

    1 2 3 4 5

17. It makes me feel better about leaving a significant job when I know I have an ambulance chaplain to provide support to family members/bystanders.

    1 2 3 4 5

18. I want ambulance chaplains to be available for post-incident support if I choose.

    1 2 3 4 5

<u>The role and value of chaplains within ambulance organisations</u>

Please consider chaplain activities and their impact within ambulance organisations more broadly and please answer the following questions according to the following scale:

(1) strongly disagree, (2) disagree, (3) undecided, (4) agree and (5) strongly agree.

19. Chaplaincy should be included in ambulance staff support teams

1 2 3 4 5

20. I would talk to an ambulance chaplain because they are outside the ambulance hierarchy.

1 2 3 4 5

21. The chaplain's role is to listen, validate and empathise, not diagnose or fix.

1 2 3 4 5

22. The chaplain's role should be adaptable to meet organisational requirements.

1 2 3 4 5

*No stream*

3. Why wouldn't you seek support from an ambulance chaplain? (Choose all that apply)
   a. Because I have not needed one
   b. There have been no chaplains available
   c. I'm uncertain about what chaplains do
   d. They are for patient or bystander support, not paramedic support
   e. I do not trust them to maintain confidentiality
   f. I am not convinced Chaplains can provide the type of support I need
   g. I don't want to talk to a religious person

h. I would rather talk to a secular/non-religious counsellor

i. I would rather seek help from another staff support team member (eg. Peer support, psychology)

j. I would rather seek help outside of my organisation

k. Other (please specify)

4. If you were to choose to access a chaplain, how would you want them to support **<u>you</u>**? (Choose all that apply)

   a. Provision of emotional support

   b. Provide physical support

   c. Provide spiritual or religious support

   d. Provide social support

   e. Provide mental health

   f. I would never use a chaplain for support.

   g. Other (please specify)

5. If you were to choose to access a chaplain, how would you want them to support **<u>bystanders, family or community members</u>**? (Choose all that apply)

   a. Provision of emotional support

   b. Provide physical support

   c. Provide spiritual or religious support

   d. Provide social support

   e. Provide mental health support

   f. I would never use a chaplain for support.

g. Other (please specify)

*Final question*

Is there anything further you wish to tell us about chaplains in ambulance organisations?

(Free text)

Demographic information

Gender: (check box that applies to you)

Female

Male

Non-Binary

Prefer to self-describe/other (please specify):

Prefer not to say

Age: (check box that applies to you)

20-29 years old

30-39 years old

40-49 years old

50+ years old

Ethnic identity: (Insert)

Do you identify as: (check box that applies to you)

Aboriginal

Torres Strait Islander

Both

Neither

Please describe your own spiritual or religious worldview: (check as many that apply)

Atheist – there is no god

Agnostic - unsure

Polytheistic – believe in many gods

Monotheistic – believe in one God

Active participant in spiritual activities

Belong to a religious community

Open to spiritual matters

State/Territory of employment: (check as many that apply)

ACT

NSW

Vic

Tas

NT

WA

Qld

SA

Which service are you employed by? (check as many that apply)

State service

Private company

Both

Do you have access to a chaplain through your ambulance service? (check box that applies to you)

Yes

No

I don't know

How many years have you worked as a paramedic (including intern year)? (check box that applies to you)

<5 years

5-9 years

10-14 years

15-19 years

20-24 years

>25 years

Table 1 – Participant demographics (*N*=150)

| Demographic characteristics | n | % |
|---|---|---|
| Gender identity | | |
| Male | 89 | 59.3% |
| Female | 53 | 35.3% |
| Non-binary | 3 | 2% |
| Prefer not to say | 3 | 2% |
| Prefer to self-describe | 2 | 1.4% |
| TOTAL | 150 | |
| Age | | |
| 20-29 | 20 | 13.3% |
| 30-39 | 47 | 31.3% |
| 40-49 | 34 | 22.7% |
| 50+ | 49 | 32.7% |
| TOTAL | 150 | |
| State of employment* | | |
| New South Wales | 72 | 48.0% |
| Victoria | 34 | 22.7% |
| Queensland | 31 | 20.7% |
| Tasmania | 8 | 5.3% |
| South Australia | 7 | 4.7% |
| Western Australia | 5 | 3.3% |
| Northern Territory | 4 | 2.7% |
| Australian Capital Territory | 3 | 2.0% |

| | | |
|---|---|---|
| TOTAL | 164 | |
| Employed in state service or private sector* | | 91.3% |
| Jurisdictional service | 137 | 13.3% |
| Private sector | 20 | |
| TOTAL | 157 | |
| Years of service | | |
| <5 | 28 | 18.7% |
| 5-9 | 33 | 22.0% |
| 10-14 | 21 | 14.0% |
| 15-19 | 24 | 16.0% |
| 20-24 | 21 | 14.0% |
| >25 | 23 | 15.3% |
| TOTAL | 150 | |
| Spiritual or religious identity* | | |
| Atheist | 57 | 38.0% |
| Agnostic | 43 | 28.7% |
| Open to spiritual matters | 40 | 26.7% |
| Monotheistic | 26 | 17.3% |
| Belong to religious community | 22 | 14.7% |
| Active participant in spiritual activities | 13 | 8.7% |
| Polytheistic | 4 | 2.7% |
| TOTAL | 205 | |

* Option to select more than one

Table 2 – Assessments conducted by ambulance chaplain

| Needs | Explicit importance | Neither important nor unimportant | Explicit unimportance |
|---|---|---|---|
| Emotional health needs | 93.2% ($n = 68$) | 4.1% ($n = 3$) | 2.7% ($n = 2$) |
| Mental health needs | 85.0% ($n = 62$) | 12.3% ($n = 9$) | 2.7% ($n = 2$) |
| Social health needs | 83.6% ($n = 61$) | 15.1% ($n = 11$) | 1.3% ($n = 1$) |
| Pastoral and spiritual health needs | 53.4% ($n = 39$) | 32.9% ($n = 24$) | 13.7% ($n = 10$) |
| Physical health needs | 52.0% ($n = 38$) | 41.1% ($n = 30$) | 6.9% ($n = 5$) |

Table 3 – Counselling, education and guidance activities desired from ambulance chaplains

| Needs | Explicit importance | Neither important nor unimportant | Explicit unimportance |
|---|---|---|---|
| Normal or abnormal reactions to significant jobs | 91.8% (n = 67) | 5.5% (n = 4) | 2.7% (n = 2) |
| Accessing further support beyond chaplain care | 89.0% (n = 65) | 4.1% (n = 3) | 6.9% (n = 5) |
| Life purpose or meaning making | 85.0% (n = 62) | 8.1% (n = 6) | 6.9% (n = 5) |
| Personal wellbeing | 85.0% (n = 62) | 10.9% (n = 8) | 4.1% (n = 3) |
| Moral and/or ethical support | 80.8% (n = 59) | 9.6% (n = 7) | 9.6% (n = 7) |
| Spiritual or religious support | 48.0% (n=35) | 31.5% (n=23) | 20.5% (n=15) |

Table 4 - Desired ambulance chaplain activities at significant jobs*

| Chaplain activity | Yes |
|---|---|
| Provide emotional support for family members or bystanders (eg. grief support). | 86.3% ($n = 63$) |
| Help family members or bystanders connect to support. | 83.6% ($n = 61$) |
| Participate in the post-incident clinical debrief. | 80.8% ($n = 59$) |
| Support other first responders. | 72.6% ($n = 53$) |
| De-escalate or calm family members or bystanders. | 68.5% ($n = 50$) |
| Provide spiritual or religious support for family members or bystanders. | 68.5% ($n = 50$) |
| Act as a liaison between paramedics and family members or bystanders. | 54.8% ($n = 40$) |
| Provide safety for family members or bystanders. | 50.7% ($n = 37$) |
| Provide physical care to family members or bystanders (eg. providing shelter, food/water, physical safety). | 43.8% ($n = 32$) |
| Support paramedic needs, which may include practical support such as retrieving equipment from the ambulance vehicle or paramedic wellbeing needs. | 34.2% ($n = 25$) |
| I do not use chaplains for clinical jobs | 5.5% ($n = 4$) |

* Option to select more than one

Table 5 – Ambulance chaplain attitudes and attributes

| | Explicit importance | Neither important nor unimportant | Explicit unimportance |
|---|---|---|---|
| Confidential | 100% ($n = 73$) | ./. | ./. |
| Approachable | 100% ($n = 73$) | ./. | ./. |
| Non-judgemental | 100% ($n = 73$) | ./. | ./. |
| Supportive | 100% ($n = 73$) | ./. | ./. |
| Good listener | 98.6% ($n = 72$) | 1.4% ($n = 1$) | ./. |
| Trustworthy | 98.6% ($n = 72$) | ./. | 1.4% ($n = 1$) |
| Discrete | 95.9% ($n = 70$) | 4.1% ($n = 3$) | ./. |
| Empathic | 95.9% ($n = 70$) | 4.1% ($n = 3$) | ./. |
| Available | 94.5% ($n = 69$) | 5.5% ($n = 4$) | ./. |
| Proactively builds relationships | 94.5% ($n = 69$) | 5.5% ($n = 4$) | ./. |
| Adaptable | 93.1% ($n = 68$) | 5.5% ($n = 4$) | 1.4% ($n = 1$) |
| Team player | 85.0% ($n = 62$) | 10.9% ($n = 8$) | 4.1% ($n = 3$) |
| Does not express religious views without express invitation | 75.3% ($n = 55$) | 19.2% ($n = 14$) | 5.5% ($n = 4$) |
| Connected to the wider community | 60.3% ($n = 44$) | 30.1% ($n = 22$) | 9.6% ($n = 7$) |
| Leadership | 54.8% ($n = 40$) | 35.6% ($n = 26$) | 9.6% ($n = 7$) |
| Multifaith approach | 52.0% (n = 38) | 37.1% (n = 27) | 10.9% (n = 8) |

# Chapter 7 – Discussion and conclusion

> *When I was in a bit of a rough patch myself, it was hard to think through the process of who I needed to contact to get some help. When you're in that frame of mind where everything's really difficult … reaching out to someone you don't know is alienating. It's terrifying. It's not something you are going to do. Having a chaplain that you're familiar with and has been on-station that you're comfortable with, that you can just – you know, you'll call and something will happen. The help you need will be started.*
> (Paramedic 14)

## 7.1 Introduction

This is the first study of the work of chaplains in an Australian ambulance service context. The papers in the preceding chapters of this thesis outline a three-phase study that sought to fill this research gap, with a focus on the role and value of chaplains in ambulance organisations. This chapter integrates the qualitative and quantitative results to answer the research questions that framed this study.

Beginning with a summary of each chapter included in this thesis, I present a joint display showing how the results from the three stages were integrated in line with a mixed methods approach (*Table 1*). A discussion of the meta-themes follows, along with recommendations for future chaplaincy practice, policy and research. Then, I present the strengths and limitations of the study. This chapter concludes with a personal reflection, and with a statement about the importance of the provision of spiritual care for ambulance staff of differing spiritual and religious worldviews.

## 7.2 Background

The aim of this thesis by compilation of publications was to understand the role of chaplains in Australian ambulance organisations, and paramedics' perceptions of the value of their work. In **Chapter 1**, I established a rationale for including spiritual care as part of a holistic approach to paramedic wellbeing, and examined the rapidly expanding body of knowledge on the role of spiritual health more generally. The absence of research on chaplaincy and spiritual care in the paramedic context was noteworthy, especially considering the large body

of research demonstrating connections between a person's spiritual or religious beliefs and their health outcomes (Koenig, 2012; Ransome, 2020). This absence of knowledge was the impetus for the research questions that guided each phase of this study.

**Chapter 2** describes my review of the literature on chaplains in first responder and military settings, undertaken to learn what was already known about the role and value of chaplains in these contexts. The scoping review presented in this chapter prioritised the perspectives of those receiving chaplain care. While I identified some literature on the role of chaplains and the barriers to and facilitators of chaplaincy care, as well as the value of chaplains in military and police settings, no data were available on chaplains in the paramedicine context.

In **Chapter 3**, I outlined the methods and methodology underpinning this study. By integrating and analysing qualitative and quantitative data, guided by my research questions, I gained a deeper and more complete understanding of ambulance chaplaincy (Creswell & Plano Clark, 2018). Underpinning the study with a pragmatic worldview ensured the study enabled multiple ways of seeing or making sense of the world, and for these perspectives to be equally represented and held as valid, an essential element when considering one's highly personal spiritual and/or religious beliefs (Creswell & Plano Clark, 2018; Greene, 2007).

**Chapters 4 and 5** describe Phase 1, the qualitative arm of this study. The aims of this phase were to reveal both paramedics' and chaplains' perspectives on the role and value of chaplains, identify the key factors or themes that would help me answer my research questions, and provide a comprehensive understanding of the role. In this phase, I identified that paramedics who accessed chaplains were not necessarily religious, and that the chaplain's role was enacted primarily in paramedic workplaces and included both proactive and reactive elements. Whilst there were some differences between the views of chaplains and paramedics, both identified the importance of meaningful relationships to effective chaplaincy. They also believed that the "right" chaplain was valuable because of their physical and emotional proximity to paramedics, and that shared experiences and relationships promoted help-seeking conversations and broke down barriers to accessing care. I also discovered some factors that deterred paramedics from using a chaplain, including poor communication about the role of chaplains in ambulance services, and the perception that chaplains provided a religious service for religious people.

**Chapter 6** presents a paper that describes Phases 2 and 3 of this study. The aim of Phase 2 was to develop a survey, using the findings from Phase 1 to generate questions that aligned with the research questions (see Chapter 6, Appendix 1). The survey was reviewed by an expert panel comprised of researchers and practitioners from the fields of paramedicine, spiritual care and statistics to ensure content, face and construct validity, and that language of the survey items was representative of paramedic culture and chaplaincy practice (Creswell & Plano Clark, 2018). This review process resulted in only minor modifications to the survey.

Phase 3 consisted of a quantitative survey of registered paramedics across Australia. The aim was to determine whether findings from Phase 1 were consistent with the perspectives of the wider paramedic population. One hundred and fifty paramedics responded to the survey. The proactive and reactive elements of a chaplain's role were confirmed as themes, and my analysis of the survey data deepened our understanding of the types of activities ambulance chaplains undertake. Like the qualitative responses in Phase 1, paramedics who would use chaplains valued them for the type of care they provided through relationships in paramedic workplaces. This was perceived to promote help-seeking conversations and facilitate paramedics accessing support beyond chaplaincy when required. The results also revealed that paramedics believed chaplains' attitudes and attributes, along with how chaplains' roles were implemented and perceived, influenced their perceived effectiveness.

## 7.3 Joint display of results

The overarching aim of this sequential mixed methods study was to obtain a more complete understanding of ambulance chaplaincy through data integration. This "purposeful interdependence between different sources, methods and approaches" drew on the strengths of both approaches, ensured the study was completed as a coherent whole, and enabled me to more completely answer the research questions and generate the inferences discussed in this chapter (Bazeley, 2018, p. 7; Creswell & Plano Clark, 2018; Guetterman et al., 2015). The first point of integration took place when paramedic perspectives and chaplain perspectives were obtained, analysed independently, then integrated (Chapters 4 and 5) to build a survey grounded in paramedic culture (Chapter 6) (Younas & Durante, 2023). The second point of

integration was the development of a tabular joint display to represent the qualitative and quantitative findings, explain their interpretation and draw inferences (see *Table 1*).

*Table 1. Joint display representing linked results*

| Who uses chaplaincy support services? | | | | |
|---|---|---|---|---|
| Theme | Chapter 4<br><br>Qualitative subtheme – paramedics | Chapter 5<br><br>Qualitative subtheme – chaplains | Chapter 6<br><br>Quantitative results | Mixed inferences and meta-inferences |
| Spiritual/religious identity and chaplain use | Paramedics thought chaplains were for religious people – unless they knew one, and then they thought chaplains could support non-religious people too. | Chaplains perceived a reluctance from some paramedics to accept their support because of their spiritual or religious beliefs, but for many, this was overcome in the course of their work and they subsequently supported people of faith and no faith. | Those who identified as atheist were significantly less likely to seek chaplain support in future than people who did not identify as atheist ($p < .001$).<br><br>Those who identified as:<br>An active participant in spiritual activities ($p < 007$), belonging to a religious community ($p < .001$), monotheistic ($p < .001$), and | While personal beliefs were important in determining if a paramedic had or would seek chaplaincy support, those who had previously used chaplains, including those identifying as atheist, were very likely to do so again in future. |

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| | | | open to spiritual matters (p <.001), significantly more likely to seek chaplain support in future than people who identified as atheist.<br><br>Those who had previously used a chaplain were more likely do so again in future than those who had not, regardless of spiritual or religious beliefs (p <.001). | |

| What is the role of ambulance chaplains in Australian ambulance services? | | | | |
|---|---|---|---|---|
| Theme | Chapter 4<br><br>Qualitative subtheme – paramedics | Chapter 5<br><br>Qualitative subtheme – chaplains | Chapter 6<br><br>Quantitative results | Mixed inferences and meta-inferences |
| Relationships | Paramedics reported that it was important for ambulance chaplains to establish relationships based on familiarity, rapport and trust in order to perform their role effectively. | Chaplains reported that their role was to build relationships and trust, which allowed them to journey alongside paramedics throughout their careers, rather than having one-off interactions. | Paramedics reported that relationships (94.5%) and trust (98.6%) were important. | Relationships were seen as foundational to the chaplain's role, and were important to paramedics because they promoted trust. |
| Proactive care | **In paramedic workplaces:** paramedics reported that chaplaincy involved undertaking proactive care in ambulance workplaces, such as on stations, in hospitals or | Chaplains reported that their work primarily took place on stations and in other spaces where paramedics work. They believed proactive care involved checking in with | Situating chaplains in paramedic workplaces meant they could engage in supportive conversations about work and personal life (>90%) | Proactive chaplain care took place in the spaces where paramedics worked, and involved undertaking a range of activities to promote individual and station/community wellbeing. |

| | | | | |
|---|---|---|---|---|
| | in ambulance vehicles. They said it was here chaplains engaged in conversations when it was convenient to them/in between jobs, promoted community, and proactively checked in on paramedics if they noticed something amiss. | paramedics if they noticed something was wrong, providing an emotional and physical presence, promoting a sense of community on stations, undertaking ceremonies like weddings and funerals, and providing support around work life, personal life, stressful milestones such as exams, coroner's court and during COVID-19. | at times that suited them (89%). | |
| | **Care beyond the spiritual and religious:** Paramedics reported that the chaplain's role included supporting their emotional, social, psychological and (to a lesser extent) spiritual wellbeing. | Chaplains reported providing emotional, social, practical/pastoral and spiritual care, relating to both work and personal life. | Most paramedics identified that it was important to them for chaplains to assess their emotional (93.2%), psychological (85.0%) and social needs (83.6%), while only half indicated it was important for chaplains to | While chaplains placed greater focus on spiritual care, and paramedics on emotional and psychological care, both groups agreed chaplain care was holistic in its approach. A lack of shared understanding on what constitutes spiritual care was evident. |

| | | | | |
|---|---|---|---|---|
| | | | assess their pastoral and spiritual needs. | |
| Reactive care | **Significant jobs:** Paramedics reported that chaplaincy involves undertaking reactive care during and after significant jobs – jobs that included major trauma, emotionally confronting jobs, and jobs paramedics felt were emotionally significant for individual reasons. | Chaplains reported that reactive care occurred around significant events, including major trauma, natural disaster, death by suicide, death of a child or jobs that held personal significance for paramedics' personal reasons. | Paramedics indicated they would request chaplain support for jobs with actual or potential emotional impact, including paediatric deaths or death by suicide (91.8%), jobs that were significant for personal reasons (86.3%) and jobs of significant magnitude, such as major disaster (75.3%). | Paramedics were likely to request chaplain assistance at the scene of significant jobs. Significant jobs mostly related to emotionally challenging calls including paediatric death and suicide, or jobs that affected paramedics personally for their own self-defined reasons. |
| | **Role in significant jobs:** Paramedics said chaplains were seen to "go to the frontline" with paramedics. This care involved supporting bystanders through providing additional compassionate care when | Chaplains reported that reactive care primarily involved supporting paramedics by minimising their exposure to unnecessary bystander emotions, and by assuming responsibility for the emotional and practical | Paramedics said they wanted chaplains to:<br>• provide emotional support for family members and bystanders at the scene of significant jobs (86.3%), | The focus of chaplain support at significant jobs shifted from direct care of the paramedic to caring for the paramedic by assuming care of those who were not patients (i.e., family and bystanders). Paramedics preferred direct chaplain support for their needs after the job through |

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|---|---|---|---|---|
| | paramedics had completed clinical care and needed to depart with their patient. They also expressed a desire for post-incident support. | care of bystanders. They also believed their role was to be available for post-incident clinical debriefs and for paramedic support in the days and weeks afterward. | • support family or bystanders to connect to support (83.6%),<br>• participate in post-incident clinical debriefs (80.8%),<br>• support other first responders (72.6%),<br>• de-escalate or calm bystanders (68.5%), and<br>• provide spiritual or religious support for bystanders (68.5%). | support at clinical debriefs, or for post-incident follow-up in the days afterward. |
| Chaplain activities | **Type of chaplain activities:** Paramedics reported that chaplain care took place through assessing paramedic needs then deciding whether the chaplain alone could provide support through supportive conversations, or if the chaplain should help | Chaplains believed their strength was in assessing paramedic needs to determine if a supportive listening role or pastoral counselling was all that was needed, or if they needed to educate and/or support the paramedic to access additional care beyond | Aside from assessing their needs, paramedics wanted chaplains to:<br>• engage in supportive conversations (>90%),<br>• engage in counselling, education and guidance, especially in the areas of: | The chaplain's role consisted of activities that promoted wellbeing and responded to paramedic needs through assessing needs, engaging in listening and supportive conversations, educating paramedics on wellbeing, pastoral counselling and guidance, and facilitating |

| | | | | |
|---|---|---|---|---|
| | connect the paramedic to additional support. | chaplaincy. They also said they provided spiritual/religious care and moral/ethical advice. | ○ normal and abnormal reactions to significant jobs (91.8%),<br>○ accessing support beyond chaplaincy (89.0%),<br>○ discussing life's purpose and meaning (85.0%),<br>○ personal wellbeing (85.0%) and<br>○ moral or ethical support (80.8%).<br>• Approximately half of participants identified spiritual or religious support as important (48.0%). | referrals to other healthcare providers when necessary. |
| | **Not to fix:** The ambulance chaplain's role was not designed to critique or fix, rather to listen and offer words of support. | Chaplains said their role was more like "a friend who cares". It included listening and presence. | Most paramedics believed a chaplain's role was to listen, empathise and validate, not diagnose or fix (83.6%). | Ambulance chaplains were not about fixing or diagnosing, rather they were there to genuinely listen and empathise with paramedics. |

| What is the value and impact of chaplaincy in Australian ambulance services? | | | | |
|---|---|---|---|---|
| Theme | Chapter 4<br><br>Qualitative subtheme – paramedics | Chapter 5<br><br>Qualitative subtheme – chaplains | Chapter 6<br><br>Quantitative results | Mixed inferences and meta-inferences |
| Shared experiences and cultural understanding | Paramedics reported that having chaplains inside the organisation, who possessed shared language and comprehension of paramedic experiences, meant paramedics saw chaplains' input as more valid and meaningful. | Chaplains believed sharing experiences with paramedics promoted credibility and enabled them to provide care better that aligned with paramedic experiences. They also believed that being inside the organisation yet outside the hierarchy promoted trust and confidentiality. | Most paramedics agreed/strongly agreed that chaplains understand their experiences because they are situated in paramedic workspaces (79.5%).<br><br>Most paramedics agreed/strongly agreed that they would use chaplains because they are outside the ambulance hierarchy (72.6%). | Shared experiences, organisational awareness and rank outside of ambulance hierarchy promoted chaplains' trust and credibility, and made their input more valid. |

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|---|---|---|---|---|
| Reduced barriers to help-seeking conversations | Paramedics identified that having chaplains in their workplaces reduced barriers to accessing support, enabled them to engage in supportive conversations at times convenient to the paramedic, and normalised help-seeking conversations. | Chaplains believed their presence in paramedic workspaces and their ability to discuss paramedic wellbeing from a holistic perspective promoted help-seeking conversations. | A significant majority of paramedics indicated that knowing a chaplain makes/would make it easier to reach out for help if needed (90.5%). | Chaplain accessibility and familiarity promoted opportunities for help-seeking conversations. |
| Chaplains give paramedics choices | Paramedics valued having chaplains on the staff health team because it gave them extra support options. | Chaplains reported that not everyone would use chaplains, but some paramedics value having options. | Paramedics in the “yes to using chaplains” stream strongly believed chaplains should be included in staff health teams (91.8%). | Those who would seek chaplain support in future indicated they wanted a chaplain as part of the wider staff health team. |
| Assuming bystander care | Paramedics reported that having chaplains take over care of bystanders relieved some of the guilt or worry they felt when leaving distressed bystanders behind. | Chaplains believed they enhanced paramedics’ wellbeing through assuming emotional and practical care of bystanders, and minimising paramedics; exposure to strong emotions. | Paramedics reported that knowing a chaplain was caring for family or bystanders in the wake of a significant job made them feel better (80.8%). | Chaplains’ support at significant clinical jobs was perceived to improve paramedic wellbeing by reducing guilt and worry related to the people paramedics were not there to support. |

| What factors impact a chaplain's effectiveness? | | | | |
|---|---|---|---|---|
| Theme | Chapter 4<br><br>Qualitative subtheme – paramedics | Chapter 5<br><br>Qualitative subtheme – chaplains | Chapter 6<br><br>Quantitative results | Mixed inferences and meta-inferences |
| Organisational factors | Paramedics reported that the chaplain's role was most effective when they were incorporated in the organisation through appropriate training and being equipped with uniforms. | Chaplains felt it was important that they were employed inside the ambulance organisation, wore the same uniform as paramedics and trained similarly because it gave them a better understanding of the paramedic experience and therefore enabled bespoke care. | A large majority of paramedics said it was important for chaplains to be operationally trained, uniformed and capable (90.5%). | Employing, training and equipping chaplains to effectively undertake their role inside ambulance organisations can enhance a chaplain's effectiveness. |

| Availability | Paramedics reported that availability was important for chaplains to be successful in their role. They wanted chaplains to be available at any hour of the day or night, and were frustrated that this wasn't always possible due to the volunteer nature of the chaplain's role. | Chaplains said they endeavoured to be available around the clock, including after hours and weekends, but because of the volunteer nature of their role this wasn't always achievable. | A large majority of paramedics who would use a chaplain said it was important/very important for chaplains to be available (94.5%).<br><br>Most respondents in the survey did not know if chaplains were available in their service (77.4%). | Availability was an important factor for chaplain effectiveness, but lack of clarity around chaplain availability may reduce their use. |
|---|---|---|---|---|
| Lack of role clarity | Paramedics reported that chaplaincy has a problem with role clarity. Before they got to know a chaplain, they may not have used one due to the religious symbols on their uniform, and/or the perceived association between chaplains and religion. | Chaplains reported feeling their role was poorly understood, especially among minority groups (e.g., LGBTQI+ communities). Most were unable to communicate a clear role description. | Of those who would not use a chaplain, reasons included:<br>• preferring a secular or non-religious counsellor (74%), and<br>• not being convinced chaplains could provide the type of support they needed (57.1%). | Preconceived ideas about chaplaincy and lack of clear communication on the chaplain's role deters access to chaplain care. |

| | | | | |
|---|---|---|---|---|
| Attitudes and attributes | Paramedics said it was important that the right person was in the role of chaplain, someone who can listen and cope with no-holds-barred conversation. | Chaplains said attitudes and attributes matter, and the right chaplain should be a good listener, fully present and able to cope with significant trauma. | All paramedics who would use a chaplain said it was important/very important for chaplains to be approachable, non-judgemental, supportive and to maintain confidentiality. More than 90% of paramedics said it was important/very important for chaplains to be a good listener, trustworthy, discrete, empathic, available, adaptable and proactively build relationships. | Chaplains should be trustworthy, good listeners, non-judgemental and able to cope with significant trauma to be effective in their role. |

## 7.4 New and confirmatory findings from this study

### *7.4.1 Research question 1 – Who uses ambulance chaplain support?*

In the introduction to this thesis (Chapter 1), I discussed the changing demographic of religious diversity in Australia, and the push to remove chaplaincy from public institutions based on a commonly held belief that chaplains only provide religious care for religious people (Best et al., 2021; Lawton et al., 2023). In fact, paramedics participating in both phases of this study who identified as religious represented only a small proportion of participants; unsurprisingly, most of them indicated they would use chaplain support. Conversely, most survey participants who did not identify as religious indicated they were reluctant to use a chaplain due to concerns about their religion or religious affiliation. Both of these perspectives feed into the traditional narrative of chaplaincy only being religious care for religious people. Lack of awareness of chaplaincy and spiritual care is a new finding in the ambulance context, but is a common finding in the global chaplaincy literature (Liefbroer & Nagel, 2021; Timmins et al., 2018).

In contrast to the narrative outlined above, my study showed that chaplaincy and spiritual care can be a service for all people. A large majority of paramedics who had previously used a chaplain indicated they would use chaplaincy again in future, regardless of their spiritual or religious belief or non-belief. Interviews with paramedics added to my understanding of why their perspective changed after meeting a chaplain. Most paramedics reported that their concerns about someone pushing religion were unfounded when they met and became familiar with a chaplain, suggesting that the religious affiliation of the chaplain was not in fact a barrier once professional caring relationships were established. While previous studies into faith concordance between chaplains and care recipients have identified that shared faith is important to some people and faith traditions, other studies have identified that faith concordance is not essential for effective provision of spiritual care, and that solid relationships can negate religious differences (Hodge & Lietz, 2014; Liefbroer & Nagel, 2021; van Nieuw Amerongen-Meeuse et al., 2018); my findings align with this perspective.

Aside from chaplains providing direct care to paramedics, interview and survey results identified that chaplains were called upon to provide support to people encountered at significant jobs – bystanders, patients' families, and other first responders. This appears to be

a novel finding in ambulance chaplaincy, but aligns with findings from the police chaplaincy literature (Gouse, 2016; Moosbrugger, 2006).

### *7.4.2 Research question 2 – What is the chaplain's role in Australian ambulance services AND Research question 3 – How do chaplains add value to Australian ambulance services?*

Through relational care, the role of ambulance chaplains in this study was identified as providing proactive and reactive, holistic and paramedic-centred care alongside paramedics in the places where they work. In line with the WHO definition of health and the salutogenic framework discussed previously (see 3.2.3 Salutogenesis), I considered the chaplaincy role from a health-promoting perspective as well as an "ill-health supporting" perspective (Antonovsky, 1979; White, 2015; World Health Organization, 1946). Ambulance chaplains worked to promote health and prevent illness through their day-to-day activities, and undertook secondary prevention through early detection and intervention.

At the outset of this study, I wanted to know what chaplains did in their role and why it was valued by paramedics. I believed these warranted two separate research questions, however as the study progressed I came to believe that they were inextricably linked. Therefore, Questions 2 and 3 are answered together.

#### *Relational care*

Connection is a core element of spirituality and spiritual care (Puchalski et al., 2014), so it is noteworthy that one of the most significant findings from both paramedics and chaplains across all phases of this study was that relationships are crucial. Paramedics (Chapters 4 and 6) identified the importance of knowing, becoming familiar with and trusting chaplains, along with care that was not transactional but established over time. In his study of hospital chaplains, Aiken (2022, p. 959) identified a similar finding, stating "if there is a key word or practice that is foundational to staff experiencing chaplaincy support, it is relational", and that this resulted in staff believing that chaplains "were available to and for them". Other chaplaincy researchers have reported similar findings (Cadge & Rambo, 2022; Jeuland et al., 2017; Massey et al., 2015).

The existence of relationships was also a factor in paramedics choosing to call chaplains to attend significant jobs, and therefore extending the role of a chaplain to include reactive care. Paramedic interviews added depth to my understanding of why relational care was important in this reactive capacity, engendering frequent comments about paramedics having enough to worry about when responding to significant jobs, so being able to call on a familiar chaplain for help was important.

Paramedics valued the relationships they developed with chaplains because the focus was not on fixing or diagnosing problems, but simply listening, empathising, validating and guiding. One chaplain described these relationships as being like "a friend who cares". Several paramedic participants spoke of the desire to have someone to whom they could talk and "offload", and differentiated this care from more formal psychological support. These findings recall the expert companions described in the PTG literature. According to Tedeschi et al. (2018, p. 141), expert companions are rarely trained clinicians, but people who understand and can explain "common physiological and psychological responses to traumatic events … willing to listen … patient … and able to encourage disclosure and discussion of things that can be very uncomfortable". To date, no studies of the role of spiritual or religious care in Australian ambulance organisations and PTG have been undertaken, despite Tedeschi and others showing that those with positive spiritual and existential coping mechanisms experienced higher rates of PTG (Tedeschi et al., 2017; Tedeschi et al., 2018). The mix of attitudes, attributes and training identified by paramedics and chaplains in my qualitative and quantitative findings (also discussed later in this chapter) equip chaplains to carry out this role and improve promoting paramedic wellbeing.

### *Paramedic-centred care*

The chaplain's role was perceived to be paramedic- or person-centred in its approach. Literature on person-centred care from other healthcare specialties describes the importance of the environment in which care takes place, genuine clinician–patient relationships, and clear and open communication supported by skilled and competent practitioners (Kitson et al., 2013; McCance et al., 2021; Wiechula et al., 2016). In addition to the relational care elements discussed above, paramedic interviewees spoke of the value of chaplains "coming into their world", learning their culture, wearing their uniform, being willing to share in all

their experiences, and seeking to be available day or night (including outside of traditional office hours) – activities that were considered to be paramedic-centred. This finding shares similarities with Laird et al. (2015) who found patient-centred care is more than just moments, but instead it is a system or program that makes it truly person-centred. Additionally, the paramedics valued being able to engage in opportunistic conversations while at work and not needing to make appointments to seek support on their days off. Other first responder researchers have identified the need to go outside of the organisation or to access care on days off as a barrier to help-seeking (Jones et al., 2020).

One consistent theme throughout the qualitative and quantitative phases of this study was the role and value of chaplains who had additional clinical (e.g., paramedic or nursing) experience. Participants perceived the care chaplains could provide in this instance was even more paramedic-centred, because they could talk about the nuts and bolts of the job in conjunction with their wellbeing. There is very little literature on chaplains with qualifications in the field in which they are practising; further research is required to determine how this affects paramedic wellbeing.

As noted earlier, paramedic-centred care at significant jobs involved assuming care of family members, bystanders and other first responders. Paramedics said this care freed them up to focus on their patients, buffered them from distressing bystander emotions, and relieved them of worry and guilt about leaving distressed people without support. Satchell et al. (2023) confirmed family and bystanders experience strong emotional responses during medical episodes and often seek communication and support from paramedics, which can add pressure when paramedics are trying to focus on their patients. While no other paramedicine literature on the role and impact of ambulance chaplains supporting bystanders was identified, previous studies into police chaplaincy identified similar findings (Gouse, 2017; Moosbrugger, 2006).

### *Holistic care that incorporates spiritual and religious care*

Some paramedics, in both the qualitative and quantitative phases of this study, opined that spiritual or religious care was an important part of chaplains' role. These paramedics identified the desire for their spiritual or religious needs to be met within their organisation,

and to be able to talk through the impact of their work with someone who understands the demands of the job and shares their beliefs. However, most participants believed that the chaplain's role went beyond the spiritual and religious, stating that it was most important for chaplains to provide emotional, psychological and social support with respect to both work and personal life. This is the first study to identify the need for this holistic approach in paramedicine, although studies in other fields of chaplaincy have noted that chaplains can and do adopt holistic approaches to care. A recent consensus statement from Handzo et al. (2023) on the role of healthcare chaplains noted the role of spiritual care specialists in helping those they care for with not only spiritual and existential needs, but emotional and cultural needs. Furthermore, Handzo et al. (2023) discussed healthcare chaplains as psycho-social generalists, whose role is to collaborate with "other mental-health [sic] experts to provide unified psychosocial-spiritual care" (Handzo et al., 2023, p. 748). Other studies on the roles of chaplains within healthcare teams have found that chaplains were able to identify and support patients with psycho-social-spiritual needs, as well as provide emotional support to staff in the wake of distressing encounters such as the death of a patient or delivering bad news to a family member (Hemming et al., 2016; Pater et al., 2021; Ruth-Sahd et al., 2018).

That paramedics identified ambulance chaplain care as extending beyond the spiritual or religious was a valuable finding. However, spiritual care was still a significant theme in this study. As previously stated, chaplains seek to support people spiritually by using their skills (discussed in the following section) to help people connect with themselves, others, and with what gives them meaning and purpose (Puchalski et al., 2014; Spiritual Health Association, 2020b). In the interviews and the survey, paramedics did not explicitly acknowledge spiritual care as important, yet there was implicit acknowledgement of the value of spiritual care, expressed as the desire for chaplains to support them with respect to their sense of meaning and purpose, with moral and ethical decisions, and with their personal wellbeing. This suggests a lack of shared language and understanding between paramedics and chaplains about spiritual care and the role of chaplains, and as stated in other spiritual care literature, represents an area in which more work is needed to establish a better understanding of contemporary spiritual care (Best et al., 2021; Handzo et al., 2023).

This is the first study in the ambulance context to demonstrate that chaplains can fulfil more than spiritual or religious needs in their role. Adopting a holistic approach to paramedics'

wellbeing positions chaplains to identify their broader wellbeing needs and ensure the most appropriate support is provided.

### *Ambulance chaplain skillset*

In the qualitative and quantitative phases of this study, chaplains and paramedics agreed that chaplains' activities include conducting assessments, engaging in supportive conversations, providing guidance, counselling and education, and undertaking religious or other ritual provision when appropriate. While these align with those previously identified by Aiken (2022); Carey and Cohen (2015) and the WHO (World Health Organization, 2017), these studies primarily focused on activities taking place during the provision of spiritual and religious care. Findings from this study demonstrate that the activities outlined above extend beyond just the spiritual and religious for ambulance chaplains, to also encompass psychological, social and emotional elements (as discussed in the previous section).

As paramedics and chaplains identified in the interviews, ambulance chaplains are part of a culture exposed to considerable trauma, well above the levels that most other members of the population ever face. Both paramedics and chaplains agreed that chaplains were a useful first point of care for paramedics wishing to discuss topics like normal and abnormal reactions to traumatic events, and the need to access support beyond chaplain care. The military chaplaincy literature suggests that chaplains are frequently the first point of contact for personnel experiencing poor mental health, and recognised the need for stronger integration between chaplains and mental health professionals (Nieuwsma et al., 2014; Nieuwsma et al., 2013).

These findings relating to ambulance chaplain skills suggest that a standard (non-ambulance) chaplain skillset is inadequate for the role. Accordingly, those wishing to practice as ambulance chaplains should receive additional skills and training, which should include topics such as trauma-informed care, basic mental health assessment, and psychological first aid. Additionally, implementing formal pathways that enable chaplains to connect paramedics to other support, and enhancing communication and collaboration between chaplains and mental health professionals, is vital. These skills and connections could enable chaplains to

recognise and respond to paramedic ill-health sooner, resulting in more timely and effective support.

### *The chaplain's role in ambulance wellbeing teams*

As previously stated, the WHO defines health as not merely the absence of disease, but complete wellbeing (World Health Organization, 1946). It also states that health care providers should aim to promote and support people's health and wellbeing needs before they become ill (health promotion) in addition to treating them once they become ill, ideally through initiatives located in their everyday environments (World Health Organization, 2022). My analysis of the data collected in this study indicates that chaplains in Australian ambulance wellbeing teams contribute mostly to promoting and supporting wellbeing, rather than treating ill-health.

"Flourishing" is a term from the health promotion and positive psychology literature with strong links to the salutogenic framework underpinning this thesis. It is used "to describe high levels of subjective wellbeing" (Hone et al., 2014, p. 62), or "a state where people experience positive emotions, positive psychological functioning and positive social functioning, most of the time" (Jankowski et al., 2020, p. 79) and includes themes like positive relationships, engagement, meaning and purpose (McCance et al., 2021). In addition to themes discussed already, including relationships and ongoing engagement in paramedic workplaces, chaplains and paramedics spoke about chaplains promoting social connections on stations through sharing meals or coffee, "riding along" with paramedics in ambulances during shifts, and educating, supporting and guiding paramedics on topics like normal and abnormal reactions to paramedic work, meaning and purpose, personal wellbeing, morals and ethics – all activities that enhance flourishing. Flourishing has been demonstrated to buffer against stress and trauma and result in improved holistic wellbeing encompassing bio-psycho-social and spiritual outcomes (Bolier et al., 2013; Frankl, 1985; Hamling, 2018; Koenig, 2012; Sin & Lyubomirsky, 2009).

Another way chaplains contribute to ambulance wellbeing teams is by breaking down barriers to help-seeking. Barriers to help-seeking are complex and multifactorial. They may include stigma, confidentiality concerns, lack of knowledge about mental health, not wanting to

burden family or friends with job-associated trauma, resistance to “outsiders”, and the inability to take time off work (Jones et al., 2020; Rikkers & Lawrence, 2022). Early help-seeking is seen to be essential in preventing and reducing adverse outcomes for first responders (Hamling, 2018; Rikkers & Lawrence, 2021). Again, in the qualitative and quantitative phases of this study, paramedics identified several chaplain activities or traits that contribute to reducing barriers to help-seeking. For example, familiarity with paramedics enabled chaplains to notice changes in behaviour or mood and proactively check on paramedics' welfare. Most paramedics said that established relationships meant they felt more comfortable reaching out to chaplains when they wanted to engage in a help-seeking conversation. Additionally, they valued having someone who could start the process of connecting with them with additional support, and who shared the burden of help-seeking.

Chaplains sharing in the negative experiences of paramedics’ work was also seen to reduce barriers to help-seeking. In their interviews, paramedics and chaplains expressed the view that sharing the sights, sounds, smells and pressures of paramedic work meant chaplains could handle the sometimes-challenging content of open conversations. Paramedics said this encouraged them to talk to chaplains about their work when they could not or did not want to do so with family or friends. However, paramedics did express concerns about the impact of consistent exposure to significant trauma on chaplains. Similar findings have been reported in other chaplaincy contexts (Bonner et al., 2013; Kim et al., 2016), but this is the first study to prioritise paramedics’ perspectives on the characteristics of chaplains that influence help-seeking behaviour.

At present, there are no consensus definitions of ambulance or first responder wellbeing. While wellbeing may include elements like relationships (personal and professional), work-life balance, self-esteem, and meaning and purpose (Jarden et al., 2018), Hamling (2018) argued a wellbeing definition should be contextual to the emergency service it is being used in, and supported by programs that include health promotion, prevention and treatment. Contemporary literature shows that paramedic wellbeing programs tend to take a deficit perspective, prioritising mental health and trauma prevention over positive perspectives and other elements of holistic wellbeing (Claringbold et al., 2022; Hamling, 2018; Phung et al., 2022). Including chaplaincy and these positive workplace-based strategies in ambulance

organisations may support wellbeing and prevent ill-health (Haugan & Eriksson, 2021), but requires further research to determine their specific impact on paramedic wellbeing.

### *7.4.3 Research question 4 – What factors impact a chaplain's effectiveness?*

The way ambulance organisations implement chaplaincy programs has a powerful influence on their effectiveness. My analysis of the qualitative data revealed that factors such as availability, role clarity and individual chaplain attitudes and attributes impact the effectiveness of chaplaincy programs, and these findings were confirmed in the quantitative phase of the study. Some of these factors are linked to challenges in the wider spiritual care space in Australia and globally, such as lack of consensus on minimum standards of education and frameworks for practice (Cadge et al., 2019; Holmes, 2021).

#### *Implementation of chaplaincy programs in ambulance services*

Embedding chaplains in ambulance organisations was found to enhance their credibility as a support option in both qualitative and quantitative phases due to factors previously discussed, including relationships and shared experiences. The qualitative phase added to this knowledge by identifying that paramedics valued having chaplains inside their organisation, in uniform yet outside the hierarchical structure, and cognisant of ambulance culture, language and protocols. Essentially, incorporating chaplains as "one of us" resulted in paramedics being more inclined to use them. Similar findings were identified in studies of hospital and military chaplains (Aiken, 2022; Prazak & Herbel, 2020), suggesting that chaplains who are part of the organisation have a greater positive impact on staff wellbeing than external or contract chaplaincy support. It was noteworthy that almost all participants in the qualitative phase said they believed chaplains added value to the organisation, over 90% of participants in the quantitative phase who would use chaplaincy believed chaplaincy should be included in staff support teams, and a similar percentage indicated that they would use chaplaincy again. While these are not satisfaction scores, they reflect the findings of other studies that those who use chaplaincy services rate their satisfaction with care highly (Lawton & Cadge, 2023; Rikkers & Lawrence, 2021).

In the survey, paramedics identified the attitudes and attributes they believed were important for chaplains to possess, and in interviews most paramedics and chaplains agreed that

employing a chaplain with these characteristics was key in determining their success or failure. All surveyed paramedics who would use chaplaincy agreed that being non-judgemental, confidential, approachable and supportive was vital, with being trustworthy, discrete, empathic, a good listener and willing to proactively build relationships also scoring very highly. These new findings add to the ambulance chaplaincy literature and align with contemporary literature in other fields (Advocat et al., 2021; Aiken, 2022; Carey & Rumbold, 2015; Layson et al., 2022). Additionally, these findings are consistent with Adams (2019) operational definition of chaplain presence. Paramedics and chaplains stated that chaplains without these qualities were unable to build relationships, and that paramedics would not only not use such chaplains, but actively avoid them.

Availability and access were significant themes identified as impacting chaplains' effectiveness. Paramedics in Phase 1 said that chaplains who support them communicated a powerful message about the chaplain's commitment to providing support, but many paramedics were unsure about which chaplain was available for support and when, and sometimes experienced guilt when calling chaplains away from their paid jobs or contacting them after hours. It should be noted that chaplains who participated in the qualitative phase of this study were mainly volunteers, unlike many other chaplains in Australian ambulance services; further research is required to understand if or how volunteer status affects chaplains' use. An interesting finding from the survey was the number of paramedics unaware of chaplaincy services in their organisation. All participants were asked if they had access to chaplains through their service; most did not know. Additionally, many answered this question incorrectly: some employed in NSW incorrectly indicated that their service lacked chaplains, and some employed in Tasmania incorrectly indicated the reverse.

### *Role clarity within ambulance organisations*

Role clarity was a theme throughout this study, with both paramedics and chaplains identifying it as a significant barrier to paramedics accessing chaplains. The inclusion of paramedics who had not previously used chaplains in the survey was essential to obtaining a better understanding of the barriers to accessing chaplaincy, and their data was essential to generating the theme of not wanting to use chaplains due to the perceived association between chaplains and religion. Paramedics stated that prior to meeting a chaplain they were

worried about having religion “pushed” on them and were “put off” by the religious symbols on their uniforms (not all Australian ambulance chaplaincy programs require chaplains to wear religious symbols on their uniforms, but most chaplains do). Paramedics in the survey who had not and would not use chaplains, expressed the same concerns.

My discovery of a perceived an association between chaplains and religion is consistent with the wider chaplaincy literature, especially because chaplains continue to be confused with faith/religious leaders, a belief that is perpetuated by the inclusion of religious symbols on chaplains’ uniforms (Best et al., 2021; Hemming et al., 2016; Lawton et al., 2023; Snowden, 2021). Furthermore, in the absence of clear role descriptions, there is potential for chaplaincy practice to vary greatly according to individual beliefs. For example, in interviews, most chaplains told me that proselytising was unacceptable in their role, but a small minority of participants explained practices that in fact constituted proselytising. This is the first study in the Australian ambulance context to identify and explore the association between chaplains and religion as a reason for not accessing chaplains. This is an important area for ambulance organisations to consider should they desire to improve the uptake and impact of chaplaincy programs.

### *Australian and global perspectives on chaplaincy and spiritual care impacting ambulance chaplaincy*

The lack of clarity about chaplains’ roles likely extends beyond ambulance services to the field of spiritual care more widely, which is moving away from traditional clergy-based models of care towards professional spiritual care practitioners. Within Australia, peak bodies such as Spiritual Care Australia and the Spiritual Health Association have developed standards and frameworks for practice, and are endeavouring to establish minimum competencies and education levels for chaplains and spiritual care workers (Spiritual Care Australia, 2020, 2023; Spiritual Health Association, 2020a, 2022). However, these standards are not currently mandated for chaplains, including those in the ambulance setting.

In Australia, health professionals including nurses, psychologists, doctors, physiotherapists and paramedics (among others) are mandated to maintain registration with the Australian Health Practitioner Regulation Agency. This organisation is responsible for ensuring

healthcare providers practice according to their designated standards, ensuring the community can access safe healthcare (Australian Health Practitioner Regulation Agency, 2022, October). Most other ambulance and staff health practitioners are registered with this organisation, and the absence of minimum competencies, standards or frameworks for practice makes communicating chaplains' scope of practice to paramedics and wellbeing co-workers difficult.

The need for increased professionalisation to ensure the provision of clear and consistent chaplain care extends beyond the ambulance context. Chaplaincy has evolved towards professionalisation in recent decades as chaplains increasingly operate in healthcare and other settings that rely on evidence, so there is a need to demonstrate outcomes and develop evidence-based standards for practice (den Toom et al., 2022; Vandenhoeck et al., 2019). For example, it was only recently that a consensus statement on "the role and qualifications of health care chaplains for research and quality" was published (Handzo et al., 2023, p. e745). As one researcher has noted, no-one is going to pay chaplains for just "being present"; further research is needed to clearly communicate the role of chaplaincy and spiritual care to other healthcare professionals and consolidate its place in holistic, multidisciplinary approaches to person-centred care (Handzo et al., 2023; Vandenhoeck et al., 2019). This will enable ambulance chaplaincy to demonstrate the value of chaplains in promoting paramedic wellbeing.

## 7.5 Strengths and limitations

This chapter so far has described the new knowledge generated by this study; in this section, I discuss my study's strengths and limitations, beginning with the latter.

In the survey, I sought the perspectives of those who had not and would not use chaplaincy to gain a deeper understanding of the factors affecting chaplain effectiveness. In hindsight, I believe my understanding of the data could have been strengthened by presenting participants with a definition of spirituality and spiritual care, then asking if they would use chaplaincy if they believed it aligned with this definition. My qualitative interviews concentrated on chaplains in one ambulance service, and the experiences I documented from one model of care may not represent those of chaplains in other chaplaincy programs across Australia.

There was a lack of diversity in survey respondents relative to the Australian paramedic population, with too little representation from Australian First Nations paramedics, women, the LGBTQI+ population, and faith groups other than Christian. Additionally, the sample size for the survey was considerably smaller than desired, limiting generalisability to the wider paramedic population. Finally, paramedics' data were entirely self-reported and potentially influenced by social desirability and selection bias.

My study had several strengths, the first being its unique contribution to knowledge about chaplaincy in Australian ambulance services. While books, editorials and opinion pieces have provided chaplains' perspectives on their role in ambulance services and other EMS, mine was the first study to take a person-centred approach and prioritise paramedics' perspectives on chaplaincy. Furthermore, my aim was not just to generate new knowledge, but to determine whether paramedics and chaplains perceived that chaplaincy and spiritual care could promote better health and wellbeing outcomes for paramedics, and I achieved this goal.

Another strength of this study was its rigorous mixed methods approach. Through using multiple approaches and perspectives to answer the research questions, and integrating qualitative and quantitative approaches, I gained a deeper comprehension of the themes being explored. The rigour of this study was a particular strength. The challenges of establishing rigour in mixed methods studies are well documented (Brown et al., 2015; Creswell & Plano Clark, 2018), and knowing these at the outset allowed me to plan and implement practices to overcome them. For example, as a chaplain–researcher, there was significant potential for my personal beliefs to influence interpretation of the findings, so I used bracketing and reflexivity throughout this study (see 3.7 Bracketing and reflexivity). Pausing to reflect on my observations and analysis allowed me to ask whether my interpretations were based on the data or my experiences, and if my supervisors would come to the same conclusions based on the data in front of them. Additionally, using various methods to maximise credibility, trustworthiness and validity, and using joint displays, increased the rigour of this study.

Finally, as a chaplain–researcher, I believe my experience and understanding of ambulance culture allowed me to identify cues and terminology used by paramedics and chaplains during the interviews that may have been missed by someone without the same positioning. I am confident that the resulting survey was an accurate reflection of the paramedic culture it

was designed to explore, and I believe the overwhelmingly positive feedback from the expert panel reflected this.

## 7.6 Recommendations

The findings generated from this study have implications for chaplaincy in the areas of education and practice, standards and frameworks for practice, and future research.

### *7.6.1 For chaplaincy education and practice*

A key finding of this study was the need for ambulance chaplains to have skills beyond a foundational chaplaincy skillset. Therefore, I recommend:

- Mandating minimum standards of education for ambulance chaplains. Theological training alone may be insufficient to equip faith leaders for this role, and may in fact add to role confusion. In addition to a grounding in a faith tradition, foundational ambulance chaplaincy training should include skills like active listening and basic counselling that are not grounded in religious or denominational perspectives (Cadge & Rambo, 2022)
- Developing a consensus ambulance-specific skillset for chaplains, including generalist psychological skills, designed to ensure that chaplains can identify and connect paramedics to additional support early and effectively. Extending the foundational chaplaincy curricula to include targeted skillsets that meet ambulance service needs would equip chaplains to support their organisations more effectively (Cadge & Rambo, 2022)
- Until all ambulance chaplains are paid professionals employed by ambulance organisations, developing and implementing two chaplaincy roles that reflect different levels of spiritual care education: (1) spiritual care specialists, whose training would include both a chaplaincy component and a theological component in their faith tradition, that equips them to provide specialist spiritual care to those seeking a higher level of existential care or specific religious care, and (2) spiritual care generalists (eg. paramedics, nurses, healthcare workers, lay workers), whose training might not include a theological component, but at a minimum would equip them to provide

paramedics with broad spiritual care supporting exploration of meaning and purpose, and the capability to refer paramedics to specialist chaplains if required

- Ensuring ambulance chaplains are equipped to undertake their work according to best practice through: (1) receiving appropriate support for the ongoing exposure to trauma they experience, (2) mandating the inclusion of reflective practice and engagement with contemporary research through participation in continuing professional development, and (3) mandating pastoral supervision from a suitably qualified pastoral supervisor
- Enhancing workforce diversity by employing chaplains from a range of spiritual/religious traditions to meet the needs of paramedics more effectively
- Creating opportunities for paramedics to provide regular feedback on chaplaincy in ambulance organisations, to ensure that it remains person- or paramedic-centred
- Ambulance chaplains with these skills and training should be paid to ensure the provision of high-quality spiritual care for paramedics.

### *7.6.2 For standards and frameworks for practice*

A key finding from this study was the lack of role clarity and the confusion of chaplaincy with traditional religious care practice. Therefore, I recommend:

- Aligning ambulance chaplains' practice of spiritual care with the guidelines set by Australia's national body governing healthcare providers, the Australia Health Practitioner Regulation Agency, to ensure professional recognition, clear national standards for practice, and protection for the recipients of chaplain care
- Encouraging ambulance chaplains to become members of accredited professional organisations that provide standards and frameworks for practice, such as Spiritual Care Australia or the Spiritual Health Association, organisations that represent and support spiritual care practitioners of all faith traditions and none
- Developing and implementing ambulance-specific versions of existing standards and frameworks for practice to ensure the nature of ambulance chaplaincy is clear to paramedics and other healthcare professionals within the healthcare sector.

### *7.6.3 For future research*

This thesis describes an exploratory study of chaplaincy in ambulance organisations; further research is required to better understand the role of ambulance chaplains and the impact they have on paramedic wellbeing. I recommend that future ambulance chaplain researchers:

- Undertake quantitative studies to objectively measure the impact of spiritual care on paramedic wellbeing. In line with studies in similar fields such as the hospital sector and the military, researchers should determine the impact of chaplaincy on paramedics' PTG, burnout and moral injury
- Undertake qualitative, quantitative and mixed methods studies of the care provided by chaplains from different backgrounds, including training (e.g., spiritual care specialists and spiritual care generalists) and beliefs (e.g., religious and non-religious chaplains), to identify any differences in care, especially as perceived by paramedics
- Explore how to educate and train paramedics on the topic of spiritual care, in both their personal lives and when caring for patients and their loved ones.

## 7.7 Personal reflection on the PhD journey

This journey for me really began when I started working as a volunteer chaplain. I was very new to the role and had little chaplaincy training, but extensive experience as an emergency and trauma nurse. One day, I arrived at a job involving a young person who had died; the media and the person's school friends were swarming, as were the general public going about their day. I set about supporting the family of the deceased, providing guidance to the paramedics on their interactions with the family, keeping the media away from the family and paramedics, ensuring the school's administration had engaged a counsellor to help the students to cope with the tragedy, and (because it was an exceptionally hot day) supplying the paramedics with refreshments. At the end of the day, when the situation had subsided, one paramedic (whom I had not met before) shook my hand and said "I'm not religious, but thank god you're here!" I realised that I had worked very hard at multiple tasks that day, and I wondered if this was normal. Should I have done anything else, or refrained from any of my actions? Why was someone who was not religious grateful to see me? Why did any of it matter?

The nurse in me went looking for answers to these questions, and I was shocked by the lack of evidence about chaplaincy in ambulance services. At that time I was employed as a nurse academic, and over a coffee with my work supervisor I mentioned my surprise at the paucity of knowledge in the area. Before I knew it, I was enrolling in a PhD. My supervisor believed so strongly in this study that she volunteered to become my primary supervisor; another colleague didn't even read my proposal before signing on to co-supervise. And, right at the point when I decided I needed a paramedic's perspective as part of my supervision, a conversation at the Sydney Gay and Lesbian Mardi Gras resulted in a senior paramedicine academic at another university offering his time to co-supervise me. To say I was blown away by this support was an understatement.

Having supervisors who were not only knowledgeable but gracious in their feedback and empathic in their responses was a major reason this project was successful. I began the PhD process oblivious to where to start, how things worked, and frankly overwhelmed by what lay in front of me. But my supervisors' experience gave me a solid foundation, helping me bracket my thoughts and assumptions before I began. They taught me about reflexivity, which turned out to be critical in making sure that my decisions at every stage were based on the data (so much so that I kept a note on my computer to remind me to consider if Tracy, Jo or Paul could come to the same conclusion). Being a chaplain–researcher was also invaluable in helping me know where to start, and identify small cues or perspectives that I would not have noticed if I wasn't part of the ambulance service.

The PhD journey itself has been full of great highs, professionally and personally, with moments of excitement and anticipation. I signed up to as many courses as I could, through my university and other institutions, to learn as much as possible. I loved meeting other researchers, going to conferences, getting lost in hours of reading. Those "ah-ha!" moments when after days or weeks of pondering you suddenly understand what the data are telling you, or the feedback given to you by your supervisors helps you find clarity and move out of the spiral of being stuck, were exhilarating. And the highs weren't just limited to the study: having the opportunity to take what I was learning and put it into practice was invaluable. Moreover, paramedics wanting to talk to me about what I was doing and what I had published, and encouraging me to keep going meant so much.

The PhD process has been both rewarding and challenging, and I am profoundly grateful for the privilege. As the first in my family to undertake a PhD, I have enjoyed the encouragement of my grandparents, parents, husband and children. At school I did so badly that I was told to "never give up my job at McDonalds, because study is not for you". Completing this program has helped me learn so much more about myself to not only challenge that narrative, but look forward to taking what I've learnt back into the academic setting and making sure my teaching practices are more inclusive. Many personal challenges arose during the 4.5 years of this study, including COVID-19, an interstate move, and unexpected major medical diagnoses, but the hardest part was losing both grandparents, to whom I was very close, and them not seeing me graduate. However, they always told me how loved I was, and my beloved Nan's final words about how proud she was meant everything.

Professional lows arose when I felt overwhelmed and questioned what I was doing. The biggest challenges were battled in my head: negative self-talk, vulnerability, dread about my work ending with feelings of shame and inadequacy, and fear that I would make mistakes and the whole study would be invalid. These weren't helped by people telling me via email or social media that my research was a waste of public funds and that spiritual care is stupid and irrelevant in this day and age (some with language not fit for repeating here), organisations not sharing and promoting my study as promised, and one journal not responding to emails. More than once I have presented my research at conferences and saw large numbers of people stand up and leave when I showed my introductory slide (one official apologised to me because they felt embarrassed by this). My own chaplaincy team and ambulance organisation have voiced strong opinions about or shown disinterest in my research. Practicing in a chaplaincy role that does not align with my personal ideas of best practice has been morally and ethically challenging. As a nurse academic my research experiences have and continue to be respectful and collegial, but as a spiritual care researcher in the current Australian climate, this has not proved to be the case.

Despite some disappointments, I am proud of this PhD and how hard I worked to complete it. It is certainly not perfect, and there were many times when I wanted to walk away, but that's when I reminded myself of why I wanted to do this research. When it's 2am and I am sitting alongside my paramedic colleagues after a job so heinous in nature that it will stay with us all for the rest of our lives, and we are laughing, crying and connecting over black humour and

endless cups of tea or coffee, I know that this study has changed my practice, and hopefully the practice of other ambulance chaplains, to make the lives of paramedics a little better. And that makes it totally worth it.

## 7.8 Conclusion

Findings generated from this study identified a valued and valuable role for ambulance chaplains, regardless of personal spiritual or religious beliefs. The right ambulance chaplain invests in paramedic wellbeing through non-judgemental and empathic care, establishing caring relationships, and is present in paramedic workplaces to share their experiences. The right chaplain listens when paramedics want to talk, and helps them find meaning, purpose and connection in their work and personal lives. As part of ambulance wellbeing teams, the chaplain's role is well suited to health promotion and health-supporting activities, such as equipping and empowering paramedics to make choices that promote their wellbeing, and support them to access help if required. However, in the absence of relationships, poor communication on chaplain and spiritual care roles, inconsistent frameworks and standards for practice, and traditional and preconceived ideas of chaplains remain barriers that deter many paramedics from seeking chaplain support.

My research produced new knowledge from the Australian ambulance context on what paramedics want from spiritual care programs. I demonstrated that chaplains are perceived to make a positive contribution to paramedic wellbeing, and that including spiritual care as part of a holistic approach to wellbeing is likely to contribute to better outcomes for paramedics. The findings from this study contribute to an expanding body of knowledge and highlight the need for further research on how high-quality, evidence-based spiritual care can ameliorate contemporary health concerns for paramedics such as moral injury, burnout and suicide, and promote PTG. Ambulance services are urged to consider using the knowledge generated from this study to develop spiritual support programs that more effectively meet paramedics' needs, and promotes their wellbeing.

*Given that we are dealers in life and death, and professionally we spend our time fighting God over our patients, it's important to have some sort of spiritual guide here, I think. Someone that's involved. (Paramedic 16).*

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# Appendix 1 – Ethics approvals for Phase 1

*South East Sydney Local Health District*

**Monday, May 25, 2020 at 10:52:03 Australian Eastern Standard Time**

**Subject:** 2019/ETH13593: Application HREA - Approved
**Date:** Friday, 22 May 2020 at 5:39:04 pm Australian Eastern Standard Time
**From:** no_reply@regis.health.nsw.gov.au
**To:** Katie Tunks Leach
**CC:** Katie Tunks Leach

Date of Decision Notification: **22 May 2020**
Dear Katie Tunks Leach,

Thank you for submitting the following Human Research Ethics Application (HREA) for HREC review;

2019/ETH13593: Exploring the role and value of chaplains in the ambulance service

This project was considered by the **South Eastern Sydney Local Health District HREC** at its meeting held on 24 April 2020 and was determined to meet the requirements of the National Statement on Ethical Conduct in Human Research (2007).

This project has been Approved to be conducted at the following sites:

- NSW Ambulance (excludes Aeromedical)

The following documentation was reviewed and is included in this approval:

- Protocol_v3.1 12 Mar 2020
- Consent-Withdrawal-v.3.1-12-Mar-2020
- Interview protocols-v.3.1-12-Mar-2020
- Participant information sheet-v.3.1-12-Mar-2020
- Promotional material-v.3.1-12-Mar-2020
- Promotional material-v.3.1-12-Mar-2020
- Recruitment email-v.3.1-12-Mar-2020
- Stash data management plan-v.3.1-12-Mar-2020

Application Documents - **(Please note : Due to security reasons, this link will only be active for 14 days.)**

The Human Research Ethics Application reviewed by the HREC was:
Version: 1.02
Date: 12 Mar 2020

It is noted that the South Eastern Sydney Local Health District HREC is constituted in accordance with the National Statement on Human Conduct in Research, 2007 (NHMRC). The approval is for a period of **5 years from the date of this e-mail (22 May 2020)** , on condition of the submission of Annual Reports.

We wish you all the best with the project and remind you that any changes to the application and safety reports will need to be submitted and reviewed by the approving HREC prior to implementation.

**This email constitutes ethical and scientific approval only.**

This project cannot proceed at any site until separate research governance authorisation has been obtained from the institution under whose auspices the research will be conducted at that site.

**This HREC is constituted and operates in accordance with the National Statement on Ethical Conduct in Human Research (2007). The processes used by this HREC to review multi-centre research proposals have been certified by the National Health and Medical Research Council.**

Please contact us if you would like to discuss any aspects of this process further, as per the contact details below. We look forward to managing this application with you throughout the project lifecycle.

**Page 1 of 2**

Kind Regards,

**Andrew Bohlken**

Research Ethics & Governance Manager I **SESLHD Research Office**
G71 East Wing Edmund Blacket Building, Prince of Wales Hospital, Randwick NSW 2031
Tel (02) 9382 3386 I Tel (02) 9113 2481 I Andrew.Bohlken1@health.nsw.gov.au
https://seslhd.health.nsw.gov.au/services-clinics/directory/research

*New South Wales Ambulance*



**Subject:** 2019/STE17865: SSA - Authorised (TRIM 20/225; D20/10623)
**Date:** Tuesday, 26 May 2020 at 5:52:03 pm Australian Eastern Standard Time
**From:** no_reply@regis.health.nsw.gov.au
**To:** katie.tunksleach@uts.edu.au
**CC:** Rosemary Carney (NSW Ambulance)

Date of Decision Notification: 26 May 2020

TRIM 20/225; D20/10623

Dear Katie Tunks Leach

Thank you for submitting the following Site Specific Assessment (SSA) for governance review;

2019/STE17865: Exploring the role and value of chaplains in the ambulance service

The Application has been reviewed by the Chief Executive/Delegate who has determined the application can now be authorised at this site:
NSW Ambulance (excludes Aeromedical)

The following documentation is included in this authorisation:

- Protocol_v3.1 12 Mar 2020
- Consent-Withdrawal-v.3.1-12-Mar-2020
- Interview protocols-v.3.1-12-Mar-2020
- Participant information sheet-v.3.1-12-Mar-2020
- Promotional material-v.3.1-12-Mar-2020
- Promotional material-v.3.1-12-Mar-2020
- Recruitment email-v.3.1-12-Mar-2020
- Stash data management plan-v.3.1-12-Mar-2020

Application Documents (Please note : Due to security reasons, this link will only be active for 14 days. The approved documents are also available to download from forms section of this project in REGIS)

The Site Specific Assessment reviewed/authorised is:
Version: 1.00
Date: 25 Feb 2020

It is noted that the South Eastern Sydney Local Health District Human Research Ethics Committee approved the Human Research Ethics Application (HREA) associated with the SSA on 22 May 2020. Site authorisation with cease on the date of HREA expiry 22 May 2025.

The following conditions apply to this research study. These are additional to those conditions imposed by the human research ethics committee (HREC) that granted ethical approval:

- The appropriate documentation must be submitted to me for authorisation before any external researcher is authorised to conduct research procedures at this site.
- Proposed amendments to the research protocol or conduct of the research which are submitted to the lead HREC for review, must be copied to me.
- Proposed amendments to the research protocol or conduct of the research, which may affect the ongoing site acceptability of the study, must be submitted to me.
- Progress and final reports submitted to the HREC must be copied to me together with the HREC's acknowledgement of these.
- Any proposed conference presentations or publications in peer reviewed journals will be submitted to me for information before publication.

Please ensure that conflict of interest is well-managed in the conduct of this research.

We wish you all the best with the study and remind you that any changes to the application and safety reports will need to be submitted via REGIS and authorised by the approving HREC prior to implementation.
Please contact us if you would like to discuss any aspects of this process further, as per the contact details below.

Yours Sincerely,

**Rosemary CARNEY**
Research Governance Manager I **Clinical Systems Integration**
Locked Bag 105, Rozelle NSW 2039
p: (02) 9779 3851 I m: [redacted] I rosemary.carney@health.nsw.gov.au
www.ambulance.nsw.gov.au

From: Research.Ethics@uts.edu.au
Subject: HREC Approval Granted - ETH19-3820
Date: 10 June 2020 at 3:37 pm
To: Research.Ethics@uts.edu.au, Tracy.Levett-Jones@uts.edu.au, Katie.TunksLeach@uts.edu.au

Dear Applicant

**Re: ETH19-3820 -**
**"Exploring the role and value of chaplains in the ambulance service"**

[External Ratification: South Eastern Sydney LHD Human Research and Ethics Committee, HREC approval 2019/ETH13593 - 5 years]

The UTS Human Research Ethics Expedited Review Committee has reviewed your application and agreed that the application meets the requirements of the NHMRC National Statement on Ethical Conduct In Human Research (2007). I am pleased to inform you that your external ethics approval has been ratified.

This ratification is subject to the standard conditions outlined in your original letter of approval.

You are reminded that this letter constitutes ethics approval only. This research project must also be undertaken in accordance with all UTS policies and guidelines including the Research Management Policy.

Your approval number is UTS HREC REF NO. ETH19-3820.

Approval will be for the period specified above and subject to the provision of annual reports and evidence of continued support from the above-named Committee.

Please note that the ethical conduct of research is an on-going process. The National Statement on Ethical Conduct in Research Involving Humans requires us to obtain a report about the progress of the research, and in particular about any changes to the research which may have ethical implications. This report form must be completed at least annually, and at the end of the project (if it takes more than a year). The Ethics Secretariat will contact you when it is time to complete your first report.

This research must be undertaken in compliance with the Australian Code for the Responsible Conduct of Research and National Statement on Ethical Conduct in Human Research.

You should consider this your official letter of approval. If you require a hardcopy please contact the Ethics Secretariat.

## Appendix 2 – Phase 1 participant information sheet

**PARTICIPANT INFORMATION SHEET AND CONSENT FORM**

CLINICAL RESEARCH

EXPLORING THE ROLE AND VALUE OF CHAPLAINS IN THE AMBULANCE SERVICE

Invitation

You are invited to participate in a research study into perceptions on the role and value of chaplains in the ambulance service.

The study is being conducted by Katie Tunks Leach. Katie is:

- a PhD (Health) candidate at the University of Technology Sydney (UTS);
- a Lecturer in the Faculty of Health at UTS: and
- a Volunteer Chaplain with the New South Wales Ambulance (NSWA).

Before you decide whether or not you wish to participate in this study, it is important for you to understand why the research is being done and what it will involve. Please take the time to read the following information carefully and discuss it with others if you wish.

1. What is the purpose of this study?

The purpose is to investigate paramedic and chaplain perceptions on the role, skills and attributes, and value of chaplains in the ambulance service.

2. Why have I been invited to participate in this study?

You are eligible to participate in this study because you have expressed an interest in participating and have met the criteria for inclusion which is:

- Paramedics - you are an AHPRA-registered paramedic employed by NSWAS.
- Chaplains - employed by NSWAS with at least one year of experience.

3. What if I don't want to take part in this study, or if I want to withdraw later?

Participation in this study is voluntary. It is completely up to you whether or not you participate. If you decide not to participate, it will not affect future access to or communications with a chaplain, or your relationship with NSW Ambulance.

If you wish to withdraw from the study once it has started, you can do so at any time without having to give a reason. However, it may not be possible to withdraw your data from the study results if these have already had your identifying details removed.

4. What does this study involve?

If you agree to participate in this study, you will be asked to sign the Participant Consent Form and complete an interview with Katie. The interview will involve answering questions about your experiences with a chaplain (paramedics) or your experience as a chaplain (chaplains). These questions focus on your understanding of the chaplain's role, their skills and attributes, and if you perceive there to be individual or organisational value from chaplains. A set of guiding questions will be provided to you in advance and on the day, however the interview may be flexible to accommodate the flow of discussion.

The interview will take place at a location mutually agreed upon, including but not limited to a private location (eg. NSWA Headquarters, UTS or your preferred ambulance station).

It may also take place over the phone. Questions will be forwarded to you in advance to ensure you are comfortable with participating.

This overall study will be conducted over three years as part of Katie's PhD studies, however your participation will only be for approximately 60 minutes.

5. How is this study being paid for?

The study is being paid for by the researcher.

6. Are there risks to me in taking part in this study?

As this study will ask you to consider interactions between staff and chaplains in in the ambulance service, potential exists for you to experience unanticipated strong emotions while completing the interviews. In addition, there may be risks associated with this study that are presently unknown or unforeseeable.

Should you experience distress as a result of this interview, you may seek assistance through the following means:

NSW Ambulance Employee Assistance and Psychological Services (EAPS) Program 1300 360 364

NSW Ambulance Chief Psychologist (deleted in thesis for privacy)

Lifeline 13 11 14

Beyond Blue 1300 22 46 36

7. Will I benefit from the study?

This study aims to develop knowledge around what chaplains do, the skills and attributes you perceive chaplains should possess, and the value they may add to an individual or the organisation. As a result of participating in this study education, training, and role descriptions of chaplains may be altered to better meet paramedic needs, however it may not directly benefit you.

8. Will taking part in this study cost me anything, and will I be paid?

Participation in this study will not cost you anything, however you will not be paid for this interview and you will be required to complete it outside of work hours in your own time.

9. How will my confidentiality be protected?

Only Katie will know whether or not you are participating in this study. Any identifiable information that is collected about you in connection with this study will remain confidential and will be disclosed only with your permission, or except as required by law. Only Katie's supervisors at UTS (Professor Tracy Levett-Jones and Dr Joanne Lewis) will have access to your details.

Results will be held securely on the password-protected University of Technology OneDrive server and an encrypted and password-protected external hard drive that can **only** be accessed by the researcher and her supervisors. All identifying information removed after data is entered into the secure database, and any data being disposed of will occur in line with UTS data management policies.

10. What happens with the results?

If you give Katie your permission by signing the consent document, she plans to discuss/publish the results in her thesis by compilation; a thesis made up of traditionally written chapters and also articles submitted for publication in peer-reviewed journals. It may also be disseminated at conferences or other professional forums.

In any publication or presentation, information will be provided in such a way that you cannot be identified. Results of the study will be provided to you if you wish.

11. What should I do if I want to discuss this study further before I decide?

When you have read this information, the researcher (*Katie*) will discuss it with you and any queries you may have. If you would like to know more at any stage, please do not hesitate to contact her on (deleted from thesis for privacy).

12. Who should I contact if I have concerns about the conduct of this study?

This study has been approved by the South Eastern Sydney Local Health District Human Research Ethics Committee. Any person with concerns or complaints about the conduct of this study should contact the Research Support Office which is nominated to receive complaints from research participants. You should contact them on 02 9382 3587, or email SESLHD-RSO@health.nsw.gov.au and quote **2019/ETH13593**.

The conduct of this study at NSW Ambulance has been authorised by the Research Governance Manager Rosemary Carney. Any person with concerns or complaints about the conduct of this study may also contact her on 02 9779 3851.

Yours sincerely,

Katie

Katie Tunks Leach

@student.uts.edu.au

Thank you for taking the time to consider this study.

If you wish to take part in it, please sign the attached consent form.

This information sheet is for you to keep.

## Appendix 3 – Phase 1 participant consent form

CONSENT FORM

"Exploring the role and value of chaplains in the ambulance service."

1. I,...........................................................................................................

of...........................................................................................................

agree to participate in the study described in the participant information statement attached to this form.

2. I acknowledge that I have read the participant information statement, which explains why I have been selected, the aims of the study and the nature and the possible risks of the investigation, and the statement has been explained to me to my satisfaction.

3. Before signing this consent form, I have been given the opportunity of asking any questions relating to any possible physical and mental harm I might suffer as a result of my participation and I have received satisfactory answers.

4. I understand that I can withdraw from the study at any time without prejudice to my relationship with New South Wales Ambulance Service, the chaplaincy service or any other support services.

5. I agree that research data gathered from the results of the study may be published, provided that I cannot be identified.

6. I understand that if I have any questions relating to my participation in this research, I may contact Katie Tunks Leach on telephone xxxx, who will be happy to answer them.

7. I acknowledge receipt of a copy of this Consent Form and the Participant Information Statement.

Complaints may be directed to the Research Ethics Secretariat, South Eastern Sydney Local Health District, Prince of Wales Hospital, Randwick NSW 2031 Australia (phone 02-9382 3587, fax 02-9382 2813, email SESLHD-RSO@health.nsw.gov.au .

Signature of participant | Please PRINT name | Date

______________________ _________________________ ______________

Signature of investigator | Please PRINT name | Date

______________________ _________________________ ______________

"Exploring the role and value of chaplains in the ambulance service."

WITHDRAWAL OF CONSENT

I hereby wish to **WITHDRAW** my consent to participate in the study described above and understand that such withdrawal **WILL NOT** jeopardise my relationship with the University of Technology Sydney, or the NSW Ambulance Service.

Signature of participant Please PRINT name Date

__________________________ __________________________ ________________

The section for Revocation of Consent should be forwarded to Katie Tunks Leach at @student.uts.edu.au.

## Appendix 4 – Phase 1 Interview protocols and questions

### *Chaplain interview questions*

The following questions were used to guide the semi-structured interviews. They may or may not have been asked in the order listed, depending on the flow of the conversation:

1. What skills and attributes should chaplains possess to be effective?
2. Do you think chaplains are valuable to the organisation? If so, how?
3. Do you think chaplains are valuable to staff individually? If so, how?
4. Do you think interactions with chaplains impact staff wellbeing? If so, how?
5. Is there anything else you would like to tell me more about in relation to chaplains, or anything else we have discussed today? This may include a story or an observation, or anything you wish to add.

### *Paramedic Interview questions*

The following questions were used to guide the semi-structured interviews. They may or may not have been asked in the order listed, depending on the flow of the conversation:

1. Can you tell me about your experience or experiences with a chaplain?
2. What do you understand the chaplain's role to be?
3. What skills and attributes should chaplains possess to be effective?
4. Do you think the chaplain is valuable to the organisation? Why or why not?
5. Do you think the chaplain is valuable to you personally? Why or why not?
6. Do you think your interactions with a chaplain have impacted your wellbeing? If so, how?
7. Is there anything else you would like to tell me more about in relation to chaplains, or anything else we have discussed today?

## Appendix 5 – Joint display linking qualitative findings to potential survey questions

Instrument formation/Joint display - item pool based on participant language from qual.

1. Have you sought support, or would you seek support from an ambulance chaplain?
    - Yes
    - No

(At this point, survey divides into 2 streams)

Yes stream

The role of the chaplain includes providing proactive and sustained paramedic-centred care

| Qualitative theme | Qualitative subtheme | Quantitative question | Relevance | Clarity |
| --- | --- | --- | --- | --- |
| Relationships | The importance of relationship was the biggest theme in the qualitative interviews.<br><br>Question<br><br>Is relationship important? | 2. Knowing the chaplain and having rapport with them is important to me. (Likert 5 – agree/disagree) | 1 2 3 4 | 1 2 3 4 |
| | The attributes of a chaplain impact the ability to build and maintain a relationship.<br><br>Question<br><br>How important are the listed chaplain attributes? | 3. When I think about chaplain/s I have worked with, the following characteristics were important to me: (Likert scale for each one)<br><br>Approachable<br><br>b. Friendly<br><br>c. Engaging<br><br>d. Outgoing | 1 2 3 4 | 1 2 3 4 |

| | | | | |
|---|---|---|---|---|
| | | e. Caring<br>f. Self-motivated<br>g. Available<br>h. Trustworthy<br>i. Non-judgemental<br>j. Discrete<br>k. Confidential<br>l. Familiar<br>m. Does not express religious views or opinions<br>n. Good listener<br>o. Supportive responses to my concerns<br>p. Other | | |
| | The training and experience of a chaplain can impact the relationship between paramedic | 4. Chaplains with healthcare experience (eg. paramedic, nurse) can provide more holistic care that includes wellbeing and clinical care. (Likert 5 – agree/disagree) | 1 2 3 4 | 1 2 3 4 |

| | | | | |
|---|---|---|---|---|
| | and chaplain. For example, chaplains with healthcare experience were perceived to be able to provide care that incorporates wellbeing expertise with clinician expertise. However most paramedics were not clear on the chaplain's training but they had thoughts on what a chaplain's training should include.<br><br>Question<br><br>How does the chaplain's training and experience impact the chaplain paramedic relationship? | 5. It is important that chaplains have a tertiary education. (Likert 5 – agree/disagree) | 1 2 3 4 | 1 2 3 4 |
| | | 6. I think ambulance chaplains should have education in the following areas: (Likert scale for each one)<br>a. Counselling<br>b. Mental health assessment<br>c. Mental health first aid<br>d. Spiritual care<br>e. Religious care<br>f. Trauma informed care<br>g. Primary health promotion and care<br>h. Paramedic health and wellbeing issues from an holistic perspective (ie. physical, mental, emotional, social and spiritual)<br>i. Other | 1 2 3 4 | 1 2 3 4 |
| Chaplain activities and interventions | Paramedics spoke of specific activities chaplains undertake in their role. | 7. I want chaplains to be skilled in the following activities when providing care. (Choose all that apply)<br>a. Assess my needs | 1 2 3 4 | 1 2 3 4 |

| | | | | |
|---|---|---|---|---|
| | Question<br><br>What activities do chaplains undertake as part of their role? | b. Refer me to services inside or outside the ambulance organisation<br>c. Share short term supportive conversations<br>d. Listen without diagnosing or trying to fixing my problems<br>e. Provide ongoing relationships<br>f. Provide counselling<br>g. Provide spiritual and/or religious support<br>h. Provide moral and/or ethical support<br>i. Educate me on health and wellbeing issues<br>j. Other | | |
| Value of proactive chaplain care | The value or impact of proactive chaplain care centred around reducing barriers to seeking and accessing support. | 8. Knowing the chaplain outside of significant jobs promotes credibility and trust. (Likert 5 – agree/disagree) | 1 2 3 4 | 1 2 3 4 |
| | | 9. Knowing the chaplain makes it easier to reach out for help. (Likert 5 – agree/disagree) | 1 2 3 4 | 1 2 3 4 |
| | Question<br><br>What is the value or impact of proactive chaplain care? | 10. Having a chaplain who knows me means I don't always have to reach out for help. Because they know me, they | 1 2 3 4 | 1 2 3 4 |

| | | can reach in and check on my wellbeing. (Likert 5 – agree/disagree) | | |
|---|---|---|---|---|

The role of the chaplain includes providing reactive chaplain care

| Qualitative theme | Qualitative subtheme | Quantitative question | Relevance | Clarity |
|---|---|---|---|---|
| Nature of significant job | Significant jobs ranged from those large in magnitude (eg. major disaster) to those small in magnitude but significant for the paramedic/s.<br><br>Question<br><br>What types of jobs to paramedics call chaplains for? | 11. I have/would request a chaplain for the following types of jobs (choose all that apply):<br>a. Jobs that are significant due to magnitude (eg. major disaster)<br>b. Jobs that are significant due to emotional impact (eg. suicide, paediatric death)<br>c. Jobs that are significant due to my or my colleague's personal reaction (eg. cumulative trauma, trigger from sight/sound/smell)<br>d. Other | 1 2 3 4 | 1 2 3 4 |
| Who is support for at significant jobs? | Paramedics and chaplains suggest the best way to care for paramedics | 12. I use chaplains at the scene of a significant jobs to support: (Choose all that apply)<br>a. Paramedics<br>b. Family or friends of patient | 1 2 3 4 | 1 2 3 4 |

| | | | | |
|---|---|---|---|---|
| | is in fact to take over care of bystanders.<br><br>Question<br><br>Who do paramedics want chaplains to support on the scene of a significant job? | c. Bystanders<br>d. Other first responders | | |
| Chaplain activities at significant jobs | Paramedic observations of chaplain activities at significant jobs revolved around assuming care for bystanders and were seen to 'bridge a gap in care' or 'extend ambulance continuity of care".<br><br>Question | 13. When chaplains support staff at significant incidents, their role includes (choose all that apply):<br>a. Supporting paramedic needs, which may include practical support such as retrieving equipment from the ambulance vehicle or paramedic wellbeing needs.<br>b. Deescalating or calming bystanders.<br>c. Acting as a liaison between paramedics and bystanders.<br>d. Assuming physical care of bystanders (eg. providing shelter, food/water, safety).<br>e. Helping bystanders connect to support. | 1 2 3 4 | 1 2 3 4 |

|  |  |  |  |  |
|---|---|---|---|---|
|  | What activities do chaplains undertake when on the scene of a significant job? | f. Participate in the post-incident clinical debrief.<br>g. Following up with me in the days following the incident. |  |  |
| Post-incident support | Post-incident support was valued by most paramedics, but not all.<br><br>Question<br><br>Do paramedics want or value post incident support? | 14. It is important for chaplains to provide post-incident support. (Likert 5 – agree/disagree) | 1 2 3 4 | 1 2 3 4 |
| Value of support around significant jobs | Value or impact of chaplain support at or after significant jobs focussed on the emotional impact.<br><br>Question | 15. I feel better leaving bystanders in the aftermath of a significant job if I know a chaplain in caring for them. (Likert 5 – agree/disagree) | 1 2 3 4 | 1 2 3 4 |

| | Does chaplain support at or after significant jobs make paramedics 'feel better'? | | | |
|---|---|---|---|---|

Chaplain care situated within a person-centred holistic framework

| Qualitative theme | Qualitative subtheme | Quantitative question | Relevance | Clarity |
|---|---|---|---|---|
| Elements of holistic care provided by chaplains | Paramedics and chaplains spoke of chaplain care that incorporated all elements of holistic care - a bio/psycho/social/emotional/spiritual model of care. Emotional and social care was a significant theme amongst both groups, however chaplains spoke more about spiritual care while paramedics spoke more | 16. When I think back to chaplain care provided at both significant jobs and outside of significant jobs, I think chaplains: (Likert scale for each one)<br>a. Provide emotional support (eg. discuss personal or professional issues, grief or loss support).<br>b. Provide physical support (eg. provide food, water or shelter.<br>c. Provide spiritual or religious support (eg. meet my religious requirements, providing space to discuss questions relating to meaning and | 1 2 3 4 | 1 2 3 4 |

| | | | | |
|---|---|---|---|---|
| | about the practical care provided by chaplains.<br><br>Question<br><br>How do paramedics view chaplain care through an holistic care framework? | purpose, provide religious support to bystanders).<br>d. Provide social support (eg. create opportunities for social connection on station or outside of work, connect bystanders to community support).<br>e. Provide mental health support (eg. assess my needs and refer me to appropriate support services, educate on normal responses to abnormal events).<br>f. I don’t really know or understand what chaplains do. | | |

The chaplain's role within the organisation

| Qualitative theme | Qualitative subtheme | Quantitative question | Relevance | Clarity |
|---|---|---|---|---|
| Multiple support options to choose from | Staff frequently expressed the desire for a range of support options to choose from according to their personal preference.<br><br>Question<br><br>Is it important to have a range of support options to choose from? Why? | 17. Chaplaincy should be included in the staff support team because I want options to choose from. (Likert 5 – agree/disagree) | 1 2 3 4 | 1 2 3 4 |
| | | 18. I worry about chaplains pushing religion on me. (Likert 5 – agree/disagree) | 1 2 3 4 | 1 2 3 4 |
| | | 19. I prefer to access chaplains for support because I worry other staff support options may report back to the organisation. (Likert 5 – agree/disagree) | 1 2 3 4 | 1 2 3 4 |
| | | 20. Chaplains need a clearer role description so I can understand what they do and don't do. (Likert 5 – agree/disagree) | 1 2 3 4 | 1 2 3 4 |
| Differentiated from other staff support options | Paramedics and chaplains spoke of chaplaincy as differentiated from other roles through its proximity to | 21. Thinking about what distinguishes chaplains from other support options, please rate the following statements: (Likert scale for each one) | 1 2 3 4 | 1 2 3 4 |

|  |  |  |  |  |
|---|---|---|---|---|
|  | the paramedic and its perception as 'paramedic focussed'.<br><br>Question<br><br>How is chaplaincy different to other staff support roles? | a. The chaplain promotes staff support in the workplace because they work alongside me and not offsite in an office.<br>b. Because the chaplain is based on my station, it's easier to talk when it suits me (eg. in between jobs).<br>c. Because chaplains work alongside me on station and at significant jobs, they have a better understanding of my lived experience.<br>d. The chaplain's role is to listen and empathise, not diagnose or fix.<br>e. I trust the chaplain to help me connect to additional support, either inside the organisation or outside the ambulance service.<br>f. Because the chaplain is in uniform, trained and equipped they can support me in all the environments where I work (eg. at the station, at a job).<br>g. I feel more comfortable talking to the chaplain because they are outside the hierarchy. |  |  |

|  |  |  |  |  |
|---|---|---|---|---|
|  |  | h. The chaplain's role is dynamic and can adapt to meet organisational requirements.<br>i. The chaplain promotes staff support in the workplace because they can be a conduit between management and staff.<br>j. Other |  |  |

No Stream

1. Have you sought support, or would you seek support from an ambulance chaplain? (No)

| Qualitative theme | Qualitative subtheme | Quantitative question | Relevance | Clarity |
|---|---|---|---|---|
| Barriers to accessing a chaplain | This question is to attempt to capture data on why people would not use a chaplain.<br><br>Question<br><br>Why wouldn't you consider using a chaplain? | 2. Why wouldn't you access a chaplain for support? (Choose all that apply)<br>a. Because I have not needed one<br>b. They are for patient or bystander support, not paramedic support<br>c. I'm uncertain about what chaplains do<br>d. Considerations of trust and confidentiality<br>e. I am not convinced Chaplains can help much<br>f. I don't want to talk to a religious person<br>g. There have been no chaplains available<br>h. I would rather talk to a secular counsellor<br>i. I would rather seek help from another staff support team member (eg. Peer support, psychology)<br>j. I would rather seek help outside of my organisation | 1 2 3 4 | 1 2 3 4 |

| | | | | |
|---|---|---|---|---|
| | | k. Other | | |
| | What would people want from a chaplain should they choose to use one?<br><br>Question<br><br>Is there an instance where you would consider using a chaplain? | 3. If you were to choose to access a chaplain, how would you want them to support you? (Choose all that apply)<br>a. Provide emotional support (eg. discuss personal or professional issues, grief or loss support).<br>b. Provide physical support (eg. provide food, water or shelter).<br>c. Provide spiritual or religious support (eg. spiritual or religious support for paramedics or bystanders, provide space to discuss questions relating to meaning and purpose).<br>d. Provide social support (eg. create opportunities for social connection on station or outside of work, connect bystanders to community support).<br>e. Provide mental health support (eg. assess my needs and refer me to appropriate support services, educate on normal responses to abnormal events).<br>f. I would not use a chaplain for support.<br>g. Other | 1 2 3 4 | 1 2 3 4 |

Demographic data

1. Gender

Female

Male

Transgender

Non-binary/non-conforming

Other

Prefer not to respond

2. Age

20-29

30-39

40-49

50-59

>60

3. Marital status

Single

Married/Partnered

Divorced

Prefer not to say

Other

4. What is your country of birth?

(Free text)

5. Primary language spoken at home?

English

Other

6. Ethnicity - Do you identify as:

Aboriginal and/or Torres Strait Islander

Neither

Other

7. Do you identify as belonging to a minority group? (Choose all that apply)

LGBTQIA+

Living with a disability

Neurodiverse

Other

8. State of employment

ACT

NSW

Vic

Tas

NT

WA

Qld

SA

9. Do you have access to a chaplain in your ambulance service?

Yes

No

10. How many years have you worked as a paramedic?

>5 years

5-9 years

10-14 years

15-19 years

>20 years

11. Religious affiliation?

Atheist

Agnostic

Christian – protestant

Christian – Catholic

Buddhist

Hindu

Jewish

Muslim

Sikh

Spiritual but not religious

Other (Please specify)

N/A

# Appendix 6 – Expert panel feedback on survey

**Survey cover letter for expert panel**

This survey is being conducted by Katie Tunks Leach, a PhD (Health) Candidate at the University of Technology Sydney, under the supervision of Distinguished Professor Tracy Levett-Jones, Associate Professor Joanne Lewis and Associate Professor Paul Simpson.

The aim of this research project is to understand paramedic views on the role and value of chaplains in the ambulance service. It asks paramedics to consider ambulance chaplains across four domains; (1) In the day-to-day life of paramedics, (2) At significant jobs (the paramedic determines what is 'significant' for them, for example trauma, paediatric deaths or the cumulation of high impact jobs), (3) Their role within the ambulance organisation more broadly, and (4) Ambulance chaplain education and experience.

This survey represents the final phases in my exploratory sequential mixed methods study conducted as part of my PhD (Health) through the University of Technology Sydney. Questions in this survey were generated following thematic analysis of paramedic and chaplain interviews, in conjunction with my supervisors.

This survey is designed to elicit your views on the relevance and clarity of the items in the 'The role and value of chaplains in the ambulance service: Paramedic perspectives survey'. There are two arms to this survey: 1) For those who have or would seek support from a chaplain, and 2) those who have not or would not seek support from a chaplain. Please assess each item for:

- Relevance – is this item relevant to a survey designed to elicit paramedic perceptions on the role and value of chaplains in the ambulance service? Please rate each item from **1** = not relevant to **4** = highly relevant.
- Clarity – is this item clear? Is there any uncertainty or ambiguity? Please rate each item from **1** = not clear to **4** = totally clear.

I have included space on each question for you to provide feedback should you wish, for example if you find a question repetitive or redundant. Any feedback will be strictly confidential.

Your feedback will be pooled with that provided by others then used to modify the survey enhance its validity prior to being distributed for data collection.

Thank you once again for taking the time to review this survey.

Warm regards,

Katie

The role and value of chaplains in the ambulance service: Paramedic perspectives survey

| Question in expert panel survey | Question in final survey | Question sent to expert panel | Relevance mean score | Clarity mean score | Feedback |
|---|---|---|---|---|---|
| 1 | 1 | Have you sought support from an ambulance chaplain?<br>○ Yes<br>○ No | 4.0 | 3.8 | Participant 1 suggested it was a double-barrelled question. Subsequently split into 2 questions for all other surveys. This has impacted the scores for this question as participant one's response has been removed.<br><br>Should include timeframe (eg. ever) |

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| 2 | 2 | Would you seek support from an ambulance chaplain?<br>○ Yes<br>○ No | 4.0 | 3.67 | This question should have something along the lines of 'in any situation' as you are more specific at a later point. |

(At this point, survey divides into 2 streams according to the answer to Q.2)

Yes stream

Chaplains in the day-to-day life of the paramedic

| Question in expert panel survey | Question in final survey | Question sent to expert panel | Relevance mean score | Clarity mean score | Feedback |
|---|---|---|---|---|---|
| 3 | 3 | How important to you is having a working relationship with the ambulance chaplain? (5-point Likert scale – very important/not important) | 4.0 | 3.71 | Working, relationship/professional relationship. |
| 4 | 4 | How important to you are the following characteristics in establishing a working relationships with ambulance chaplains? (5-point Likert scale for each one - very important/not important)<br><br>a. Approachable | 3.71 | 3.14 | Two terms in particular were singled out for review in people that gave a score of 2 – self-motivated, outgoing and familiar. These terms were reviewed in light of the interviews |

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| | | b. Friendly<br>c. Engaging<br>d. Outgoing<br>e. Caring<br>f. Self-motivated<br>g. Available<br>h. Trustworthy<br>i. Non-judgemental<br>j. Discrete<br>k. Confidential<br>l. Familiar<br>m. Does not express religious views or opinions<br>n. Good listener<br>o. Supportive<br>p. Comments…. | | | and chaplaincy literature and removed or changed. Reviewed with supervisors.<br><br>-<br><br>Some overlap suggested from some participants.<br><br>-<br><br>Chaplain participants suggested mapping these to existing literature to help with wording. |

Please respond to the following statements:

| Question in expert panel survey | Question in final survey | Question sent to expert panel | Relevance mean score | Clarity mean score | Feedback |
|---|---|---|---|---|---|
| 5 | 8 | Incorporating the ambulance chaplain in my day-to-day work promotes rapport and trust. (5-point Likert scale – agree/disagree) | 3.14 | 2.86 | Considerable feedback emerged from this question and it required significant review with regards to clarity.<br><br>-<br><br>I think this sentence needs clarity of the subject – promotes rapport and trust with whom?<br><br>-<br><br>You don't know if they actually incorporate the chaplain in their day-to-day work… I would delete this part as it otherwise builds two questions to which they may have two separate answers. |

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| 6 | 12 | Knowing the ambulance chaplain makes/would make it easier to reach out when I need help. (5-point Likert scale – agree/disagree) | 4.0 | 3.57 | Include tense words to clarify.<br><br>Knowing personally or know of?<br><br>Really liked wording – addresses what is being asked in Q5 |
| 7 | 9 | Situating ambulance chaplains in my various workspaces (e.g. on station, at hospitals) means I can engage in supportive conversations when it suits me including during my shift or in between jobs. (5-point Likert scale – agree/disagree) | 4.0 | 4.0 | |
| 8 | 10 | Ambulance chaplains better understand my lived experiences because they work alongside me on station and in the clinical setting. (5-point Likert scale – agree/disagree) | 3.71 | 3.57 | Clarify lived experiences – working life experiences instead?<br><br>-<br><br>Similar to Q5 above, there are two questions in here, one about |

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| | | | | | understanding lived experiences and one about working alongside. Depending on the individual situation, they may not perceive them to be working 'alongside them' |
| 9 | 13 | Ambulance chaplains proactively check in on my wellbeing. (5-point Likert scale – agree/disagree) | 4.0 | 3.86 | |
| 10 | 4(c) | Ambulance chaplains can help me access additional support when required (e.g. peer support, psychology). (5-point Likert scale – agree/disagree) | 4.0 | 3.86 | Consider advocate as better word. |
| 11 | 11 | Ambulance chaplains can act as a conduit between management and staff to promote support in my workplace. (5-point Likert scale – agree/disagree) | 3.57 | 3.71 | I'm unsure about this one. There's a lot to unpack with what you mean by conduit and promoting support? Are you asking if paramedics think that chaplains can act as advocates for their wellbeing? |

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| | | | | | Also, this asks if they can do something and not how important this is to the staff member. These can have different answers. |

Chaplains and significant jobs

| Question in expert panel survey | Question in final survey | Question sent to expert panel | Relevance mean score | Clarity mean score | Feedback |
|---|---|---|---|---|---|
| 12 | 14 | What types of clinical jobs would you consider requesting chaplain support for? (Choose all that apply)<br><br>a. Jobs that are significant due to magnitude (eg. major disaster)<br><br>b. Jobs that are significant due to emotional impact (eg. suicide, paediatric death) | 4.0<br><br>4.0<br><br>4.0 | 4.0<br><br>4.0<br><br>4.0 | Consider including the word 'potential' (eg. potential emotional impact) |

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| | | c. Jobs that are significant due to my or my colleague's personal reaction (eg. cumulative trauma, trigger from sight/sound/smell)<br><br>d. I would not use chaplains for clinical jobs<br><br>e. Other (please specify) | 3.86<br><br>4.0<br><br>4.0 | 4.0<br><br>4.0<br><br>4.0 | |
| 13 | 15 | If an ambulance chaplain attends clinical jobs, I want them to: (choose all that apply)<br><br>a. Support paramedic needs, which may include practical support such as retrieving equipment | 4.0<br><br>4.0 | 3.86<br><br>3.57 | Perhaps consider adding "family members"/bystanders. They're totally separate beings in my head. |

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| | | from the ambulance vehicle or paramedic wellbeing needs. | | | |
| | | b. De-escalate or calm bystanders. | | | |
| | | c. Act as a liaison between paramedics and bystanders. | 3.86 | 3.71 | |
| | | d. Assume physical care of bystanders (eg. providing shelter, food/water, physical or psychological safety). | 4.0 | 3.71 | |
| | | e. Help bystanders connect to support. | 4.0 | 3.71 | |
| | | f. Support other first responders. | | | |

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| | | g. Participate in the post-incident clinical debrief. | 4.0 | 3.71 | |
| | | h. I do not use chaplains for clinical jobs | 4.0 | 4.0 | |
| | | | 4.0 | 4.0 | |
| | | | 4.0 | 4.0 | |

Please respond to the following statements:

| Question in expert panel survey | Question in final survey | Question sent to expert panel | Relevance mean score | Clarity mean score | Feedback |
| --- | --- | --- | --- | --- | --- |
| 14 | 16 | Having chaplains in uniform, who are trained and equipped to be safe and capable in the clinical setting, is important to me. (5-point Likert scale – agree/disagree) | 4.0 | 3.14 | Needs clarifying<br><br>It's important to me to have a trained, uniformed chaplain who is safe and capable in a clinical setting |
| 15 | 17 | Having ambulance chaplains caring for bystanders in the aftermath of significant jobs can make me feel better about leaving because I know they are getting support. (5-point Likert scale – agree/disagree) | 3.86 | 3.14 | Needs clarifying<br><br>It makes me feel better about leaving a significant job knowing that having ambulance chaplains for bystanders in accessing support |

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| | | | | | Remove word ‘can’ |
| 16 | 18 | I want ambulance chaplains to be available for post-incident support if I choose. (5-point Likert scale – agree/disagree) | 4.0 | 3.86 | |

Chaplains and their role within the organisation

| Question in expert panel survey | Question in final survey | Question sent to expert panel | Relevance mean score | Clarity mean score | Feedback |
|---|---|---|---|---|---|
| 17 | 5(a) | How important is it for chaplains to provide you with the following support? (5-point Likert scale for each one – very/not at all)<br><br>g. Provision of emotional support (this may include but is not limited to discussions on personal or professional issues, grief support for paramedics and/or bystanders). | 4.0<br><br>4.0 | 3.43<br><br>3.29 | Feedback was around repetition, and 2 people suggested removing the bystander element and just including paramedic. Could be split into 2 questions.<br><br>One respondent found the questions too detailed. This is the error of the author – |

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| | | h. Provision of physical support (this may include but is not limited to providing food/meals, water or shelter). | 4.0 | 3.43 | extra detail to be included in optional drop-down box. |
| | | i. Provision of spiritual and/or religious support (this may include but is not limited to supporting religious requirements for paramedics or bystanders, providing space to discuss questions relating to meaning and purpose). | 4.0 | 3.43 | All low clarity scores related to confusion between bystander v paramedic. Wanted question to be specific to paramedics. |
| | | j. Provision of social support (this may include but is not limited to creating opportunities for social connection on station or outside of work, connecting bystanders to support). | 4.0 | 3.43 | |

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| | | k. Provision of mental health support (this may include but is not limited to assessing my needs and referring me to appropriate support services, educating on strategies to promote mental health).<br><br>l. I don't know or understand what chaplains do. | 4.0<br><br>4.0 | 3.43<br><br>3.71 | |
| 18 | 4 and 5 (all) | How important are the following ambulance chaplain skills or activities to you? (5-point Likert scale for each one – very/not at all)<br><br>a. Undertake health and wellbeing assessment | 4.0<br><br>3.57 | 3.71<br><br>3.71 | Respondents with lower relevant scores commented on the inclusion of the word 'health'. Felt this was not relevant for chaplains.<br><br>Chaplain research reviewers suggested mapping these to WHO |

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| | | b. Capable of referring to additional support services inside or outside the ambulance organisation | 4.0 | 3.86 | SPICs and rewording the question to align with other chaplain research. |
| | | c. Ability to maintain professional relationships with paramedics | 4.0 | 3.86 | Some repetition with q.26 |
| | | d. Conversational skills | 4.0 | 3.86 | |
| | | e. Listening skills | 4.0 | 3.86 | |
| | | f. Counselling skills. | 4.0 | 3.86 | |

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| | | g. Capable of providing spiritual and/or religious support | 4.0 | 3.86 | |
| | | | 4.0 | 3.86 | |
| | | h. Capable of providing moral and/or ethical support | | | |
| | | | 3.57 | 3.71 | |
| | | i. Ability to educate or train staff on health and wellbeing issues | | | |
| | | | 4.0 | 3.86 | |
| | | j. Ability to educate staff on all available options for wellbeing support | | | |
| | | | 3.57 | 3.86 | |
| | | k. None of these are important to me | | | |
| | | | 4.0 | 3.86 | |

| | | l. Other | | | |
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Please indicate your level of agreement with the following statements:

| Question in expert panel survey | Question in final survey | Question sent to expert panel | Relevance mean score | Clarity mean score | Feedback |
|---|---|---|---|---|---|
| 19 | 19 | Chaplaincy should be included in the staff support team because paramedics should have many options to choose from. (5-point Likert scale – agree/disagree) | 3.57 | 3.0 | Remove 'included in staff support team' was reason for low clarity. |
| 20 | 4 | I would access chaplains for support because I worry some other staff support options may report back to the organisation. (5-point Likert scale – agree/disagree) | 4.0 | 3.86 | Multiple suggestions for rewording here. |
| 21 | 3 | I would access a chaplain because I know they won't push religion on me. (5-point Likert scale – agree/disagree) | 4.0 | 3.86 | This is one-sided again taking away the answer. This is OKAY if there is a similarly phrased question stating |

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| | | | | | something along opposite lines (this is how it is done in psychology to ensure there is no bias in the question itself). |
| 22 | 20 | I would talk to an ambulance chaplain because they are outside the ambulance hierarchy. (5-point Likert scale – agree/disagree) | 4.0 | 4.0 | |
| 23 | 21 | The chaplain's role is to listen and empathise, not diagnose or fix. (5-point Likert scale – agree/disagree) | 3.71 | 4.0 | |
| 24 | 22 | The chaplain's role should be adaptable to meet organisational requirements. (5-point Likert scale – agree/disagree) | 4.0 | 3.85 | |

Ambulance chaplain education and experience

| Question in expert panel survey | Question in final survey | Question sent to expert panel | Relevance mean score | Clarity mean score | Feedback |
|---|---|---|---|---|---|
| 25 | 6 | How important is it to you that ambulance chaplains have a tertiary qualification in chaplaincy or pastoral care? (5-point Likert scale – agree/disagree) | 3.57 | 4.0 | Some repetition -multiple suggestions for rewording to make more relevant. |
| 26 | 4 and 5 | What training and education do you think an ambulance chaplain should have? (Choose all that apply)<br><br>j. Counselling | 4.0<br><br>4.0 | 4.0<br><br>3.86 | Recommendations to separate skills from 'approaches'.<br><br>Training and education recognised as important but ?clearer wording/integration of questions. |

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| | | k. Mental health assessment | 4.0 | 4.0 | I really like this section. It made me consider an aspect of chaplaincy that I have never given much thought too. |
| | | l. Mental health first aid | 4.0 | 4.0 | |
| | | m. Spiritual care | 4.0 | 4.0 | |
| | | n. Recognition by a religious organisation (eg. Muslim chaplains be Imams, Christian chaplains be priests or pastors) | 3.71 | 3.86 | |
| | | o. Trauma informed care | 4.0 | 4.0 | |
| | | p. Primary health promotion and care | 4.0 | 3.86 | |

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| | | q. Paramedic health and wellbeing issues from a holistic perspective (ie. physical, mental, emotional, social and spiritual)<br><br>r. Other | 3.71 | 3.71 | |
| 27 | 7 | Ambulance chaplains with health care qualifications (information tab – ‘For example, paramedicine, nursing) are better able to support me than ones without.? (5-point Likert scale – agree/disagree) | 4.0 | 4.0 | |

The role and value of chaplains in the ambulance service: Paramedic perspectives survey

No stream (Questions in this stream align with the same numbers as the final survey)

| Question sent to expert panel | Relevance mean score | Clarity mean score | Feedback |
|---|---|---|---|
| 1. Have you sought support from an ambulance chaplain?<br>○ Yes<br>○ No | 4.0 | 4.0 | |
| 2. Would you seek support from an ambulance chaplain?<br>○ Yes<br>○ No | 4.0 | 3.86 | |

| Question sent to expert panel | Relevance mean score | Clarity mean score | Feedback |
|---|---|---|---|
| 3. Why wouldn't you access a chaplain for support? (Choose all that apply)<br><br>l. Because I have not needed one<br><br>m. They are for patient or bystander support, not paramedic support<br><br>n. I'm uncertain about what chaplains do<br><br>o. I do not trust them to maintain confidentiality | 4.0<br><br>4.0<br><br>4.0<br><br>4.0 | 3.86<br><br>4.0<br><br>4.0<br><br>4.0 | Maybe rephrase this to match the wording above; "Why wouldn't you seek support from…"<br><br>The terms "Access" and "seek support" have different meanings to me.<br><br>-<br><br>Mixed timeline. |

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| | 4.0 | 4.0 | |
| p. I am not convinced Chaplains can provide the type of support I need | 4.0 | 4.0 | |
| q. I don’t want to talk to a religious person | 4.0 | 4.0 | |
| r. There have been no chaplains available | 4.0 | 4.0 | |
| s. I would rather talk to a secular counsellor | 3.71 | 4.0 | |
| t. I would rather seek help from another staff support team member (eg. Peer support, psychology) | 4.0 | 4.0 | |

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| u. I would rather seek help outside of my organisation<br><br>v. Other | <br><br>4.0 | <br><br>4.0 | |
| 4. If you were to choose to access a chaplain, how would you want them to support you? (Choose all that apply)<br><br>h. Provision of emotional support (eg. discuss personal or professional issues, grief or loss support).<br><br>i. Provide physical support (eg. provide food, water or shelter). | 4.0<br><br>4.0<br><br>4.0<br><br>4.0 | 3.86<br><br>3.57<br><br>3.57<br><br>3.71 | Again, map to WHO SPICs and previous questions.<br><br>Clarify paramedic v bystander elements.<br><br>Consider adding 'personality clash' to options? |

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| j. Provide spiritual or religious support (eg. spiritual or religious support for paramedics or bystanders, provide space to discuss questions relating to meaning and purpose). | 4.0 | 3.86 | |
| k. Provide social support (eg. create opportunities for social connection on station or outside of work, connect bystanders to community support). | | | |
| l. Provide mental health support (eg. assess my needs and refer me to appropriate support services, educate on normal responses to abnormal events). | 4.0 | 3.71 | |
| m. I would not use a chaplain for support. | 3.86 | 3.86 | |
| n. Other | | | |

|  | 4.0 | 4.0 |  |
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Demographic information

| Question sent to expert panel | Relevance | Clarity | Feedback |
|---|---|---|---|
| Gender<br><br>Female<br><br>Male<br><br>Transgender<br><br>Non-binary/non-conforming<br><br>Other<br><br>Prefer not to respond | | | Wording of this question to be substituted for UTS approved terms. |
| Age (insert age) | | | Multiple suggestions to use age range. |

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| Marital status<br><br>Single<br><br>Married/Partnered<br><br>Divorced<br><br>Prefer not to say<br><br>Other | | | Multiple suggestions to remove as not relevant. |
| What is your country of birth?<br><br>(Free text) | | | Consider use of ethnic identity instead? |
| Primary language spoken at home?<br><br>English | | | |

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| Other | | | |
| Do you identify as:<br><br>Aboriginal<br><br>Torres Strait Islander<br><br>Both<br><br>Neither | | | |
| Religious identity?<br><br>Atheist<br><br>Agnostic<br><br>Christian – protestant | | | Chaplain researcher provided a list used by their student – will adopt |

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| Christian – Catholic<br><br>Buddhist<br><br>Hindu<br><br>Jewish<br><br>Isamic<br><br>Sikh<br><br>Spiritual but not religious<br><br>Other (Please specify)<br><br>N/A | | | |
| State of employment<br><br>ACT<br><br>NSW | | | Please include state service or private service. |

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| Vic<br><br>Tas<br><br>NT<br><br>WA<br><br>Qld<br><br>SA | | | |
| Do you have access to a chaplain in your ambulance service?<br><br>Yes<br><br>No | | | Include ‘not sure’ as option |
| How many years have you worked as a paramedic? (insert) | | | Range |

Expert panel content validity scores

Yes and no streams

| Item number | Expert 1 | Expert 2 | Expert 3 | Expert 4 | Expert 5 | Expert 6 | Expert 7 | Number in agreement | Item CVI |
|---|---|---|---|---|---|---|---|---|---|
| 1 | 4,4 | 4,4 | 4,4 | 4,1 | 4,4 | 4,3 | 4,4 | 7,6 | 1.0 0.85 |
| 2 | 4,4 | 4,4 | 4,4 | 4,4 | 4,3 | 4,3 | 4,4 | 7,7 | 1.0 1.0 |

Yes stream

| Item number | Expert 1 | Expert 2 | Expert 3 | Expert 4 | Expert 5 | Expert 6 | Expert 7 | Number in agreement | Item CVI |
|---|---|---|---|---|---|---|---|---|---|
| 3 | 4,4 | 4,4 | 4,3 | 4,4 | 4,3 | 4,4 | 4,4 | 7,7 | 1.0 1.0 |
| 4 | 4,4 | 2,2 | 4,4 | 4,2 | 4,3 | 4,3 | 4,3 | 6,5 | 0.85 0.71 |
| 5 | 3,3 | 4,1 | 3,3 | 4,2 | 3,3 | 1,4 | 4,4 | 6,5 | 0.85 0.71 |

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|---|---|---|---|---|---|---|---|---|---|
| 6 | 4,4 | 4,1 | 4,4 | 4,4 | 4,4 | 4,4 | 4,4 | 7,6 | 1.0 0.85 |
| 7 | 4,4 | 4,4 | 4,4 | 4,4 | 4,4 | 4,4 | 4,4 | 7,7 | 1.0 1.0 |
| 8 | 4,4 | 4,4 | 4,4 | 4,3 | 4,3 | 4,3 | 4,4 | 7,7 | 1.0 1.0 |
| 9 | 4,4 | 4,4 | 4,4 | 4,3 | 4,4 | 4,4 | 4,4 | 7,7 | 1.0 1.0 |
| 10 | 4,4 | 4,4 | 3,4 | 4,3 | 4,3 | 4,4 | 4,4 | 7,7 | 1.0 1.0 |
| 11 | 4,4 | 4,4 | 3,4 | 4,3 | 4,3 | 2,4 | 4,4 | 7,7 | 1.0 1.0 |
| 12 | | | | | | | | | |
| A | 4,4 | 4,4 | 4,4 | 4,4 | 4,4 | 4,4 | 4,4 | 7,7 | 1.0 1.0 |
| B | 4,4 | 4,4 | 4,4 | 4,4 | 4,4 | 4,4 | 4,4 | 7,7 | 1.0 1.0 |
| C | 4,4 | 4,4 | 3,4 | 4,4 | 4,4 | 4,4 | 4,4 | 7,7 | 1.0 1.0 |
| D | 4,4 | 4,4 | 4,4 | 4,4 | 4,1 | 4,4 | 4,4 | 7,6 | 1.0 0.85 |
| E | 4,4 | 4,4 | 4,4 | 4,4 | 4,4 | 4,4 | 4,4 | 7,7 | 1.0 1.0 |

| 13 | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| A | 3,2 | 4,4 | 4,4 | 4,3 | 4,4 | 4,4 | 4,4 | 6,7 | 0.85 1.0 |
| B | 4,4 | 4,4 | 4,4 | 4,3 | 4,4 | 4,3 | 4,4 | 7,7 | 1.0 1.0 |
| C | 4,4 | 4,4 | 4,4 | 4,3 | 4,4 | 4,3 | 4,4 | 7,7 | 1.0 1.0 |
| D | 4,4 | 4,4 | 4,4 | 4,3 | 4,4 | 4,3 | 4,4 | 7,7 | 1.0 1.0 |
| E | 4,4 | 4,4 | 4,4 | 4,3 | 4,4 | 4,3 | 4,4 | 7,7 | 1.0 1.0 |
| F | 4,4 | 4,4 | 4,4 | 4,3 | 4,4 | 4,4 | 4,4 | 7,7 | 1.0 1.0 |
| G | 4,4 | 4,4 | 4,4 | 4,3 | 4,4 | 4,4 | 4,4 | 7,7 | 1.0 1.0 |
| H | 4,4 | 4,4 | 4,4 | 4,3 | 4,1 | 4,4 | 4,4 | 7,7 | 1.0 1.0 |
| 14 | 4,4 | 4,1 | 3,4 | 4,3 | 4,2 | 4,4 | 4,4 | 7,5 | 1.0 0.71 |
| 15 | 4,4 | 4,1 | 4,4 | 4,3 | 4,3 | 4,3 | 4,4 | 7,6 | 1.0 0.85 |
| 16 | 4,4 | 4,4 | 4,4 | 4,3 | 4,4 | 4,4 | 4,4 | 7,7 | 1.0 1.0 |

| 17 | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| A | 4,4 | 4,4 | 4,4 | 4,4 | *,2 | 4,2 | 4,4 | 6#,5 | 1.0 0.71 |
| B | 4,4 | 4,4 | 4,3 | 4,4 | *,2 | 4,2 | 4,4 | 6#,5 | 1.0 0.71 |
| C | 4,4 | 4,4 | 4,3 | 4,4 | *,2 | 4,2 | 4,4 | 6#,5 | 1.0 0.71 |
| D | 4,4 | 4,4 | 4,4 | 4,4 | *,2 | 4,2 | 4,4 | 6#,5 | 1.0 0.71 |
| E | 4,4 | 4,4 | 4,4 | 4,4 | *,2 | 4,2 | 4,4 | 6#,5 | 1.0 0.71 |
| F | 4,4 | 4,4 | 4,4 | 4,4 | *,2 | 4,2 | 4,4 | 6#,5 | 1.0 0.71 |
| 18 | | | | | | | | | |
| A | 4,4 | 1,4 | 4,4 | 4,3 | 4,3 | 4,4 | 4,3 | 6,7 | 0.85 1.0 |
| B | 4,4 | 4,4 | 4,4 | 4,3 | 4,4 | 4,4 | 4,3 | 7,7 | 1.0 1.0 |
| C | 4,4 | 4,4 | 4,4 | 4,3 | 4,4 | 4,4 | 4,4 | 7,7 | 1.0 1.0 |
| D | 4,4 | 4,4 | 4,4 | 4,3 | 4,4 | 4,4 | 4,4 | 7,7 | 1.0 1.0 |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| E | 4,4 | 4,4 | 4,4 | 4,3 | 4,4 | 4,4 | 4,4 | 7,7 | 1.0 1.0 |
| F | 4,4 | 4,4 | 4,4 | 4,3 | 4,4 | 4,4 | 4,4 | 7,7 | 1.0 1.0 |
| G | 4,4 | 4,4 | 4,4 | 4,3 | 4,4 | 4,4 | 4,4 | 7,7 | 1.0 1.0 |
| H | 4,4 | 4,4 | 4,4 | 4,3 | 4,3 | 4,4 | 4,4 | 7,7 | 1.0 1.0 |
| I | 4,4 | 1,4 | 4,4 | 4,3 | 4,3 | 4,4 | 4,4 | 6,7 | 0.85 1.0 |
| J | 4,4 | 4,4 | 4,4 | 4,3 | 4,4 | 4,4 | 4,3 | 7,7 | 1.0 1.0 |
| K | 4,4 | 4,4 | 4,4 | 4,3 | 1,3 | 4,4 | 4,4 | 6,7 | 0.85 1.0 |
| 19 | 4,4 | 4,1 | 3,4 | 4,4 | 4,3 | 2,1 | 4,4 | 6,6 | 0.85 0.85 |
| 20 | 4,4 | 4,4 | 4,4 | 4,4 | 4,3 | 4,2 | 4,3 | 7,6 | 1.0 0.85 |
| 21 | 4,4 | 4,4 | 4,4 | 4,4 | 4,3 | 4,4 | 4,4 | 7,7 | 1.0 1.0 |
| 22 | 4,4 | 4,4 | 4,4 | 4,4 | 4,4 | 4,4 | 4,4 | 7,7 | 1.0 1.0 |
| 23 | 4,4 | 4,4 | 2,4 | 4,4 | 4,4 | 4,4 | 4,4 | 6,7 | 0.85 1.0 |

| | | | | | | | | | |
|---|---|---|---|---|---|---|---|---|---|
| 24 | 4,4 | 4,4 | 4,4 | 4,3 | 4,4 | 4,4 | 4,4 | 7,7 | 1.0 1.0 |
| 25 | 4,4 | 4,4 | 3,4 | 4,4 | 2,4 | 4,4 | 4,4 | 6,7 | 0.85 1.0 |
| 26 | | | | | | | | | |
| A | 4,4 | 4,4 | 4,4 | 4,4 | 4,3 | 4,4 | 4,4 | 7,7 | 1.0 1.0 |
| B | 4,4 | 4,4 | 4,4 | 4,4 | 4,4 | 4,4 | 4,4 | 7,7 | 1.0 1.0 |
| C | 4,4 | 4,4 | 4,4 | 4,4 | 4,4 | 4,4 | 4,4 | 7,7 | 1.0 1.0 |
| D | 4,4 | 4,4 | 4,4 | 4,4 | 4,4 | 4,4 | 4,4 | 7,7 | 1.0 1.0 |
| E | 4,4 | 4,4 | 4,4 | 4,4 | 2,3 | 4,4 | 4,4 | 6,7 | 0.85 1.0 |
| F | 4,4 | 4,4 | 4,4 | 4,4 | 4,4 | 4,4 | 4,4 | 7,7 | 1.0 1.0 |
| G | 4,4 | 4,4 | 4,4 | 4,4 | 4,3 | 4,4 | 4,4 | 7,7 | 1.0 1.0 |
| H | 4,4 | 4,4 | 4,4 | 4,4 | 2,2 | 4,4 | 4,4 | 6,6 | 0.85 0.85 |
| 27 | 4,4 | 4,4 | 4,4 | 4,4 | 4,4 | 4,4 | 4,4 | 7,7 | 1.0 1.0 |

No stream

| Item number | Expert 1 | Expert 2 | Expert 3 | Expert 4 | Expert 5 | Expert 6 | Expert 7 | Number in agreement | Item CVI |
|---|---|---|---|---|---|---|---|---|---|
| 3 | | | | | | | | | |
| A | 4,4 | 4,4 | 4,4 | 4,4 | 4,4 | 4,4 | 4,4 | 7,7 | 1.0 1.0 |
| B | 4,4 | 4,4 | 4,4 | 4,4 | 4,4 | 4,4 | 4,4 | 7,7 | 1.0 1.0 |
| C | 4,4 | 4,4 | 4,4 | 4,4 | 4,4 | 4,4 | 4,4 | 7,7 | 1.0 1.0 |
| D | 4,4 | 4,4 | 4,4 | 4,4 | 4,4 | 4,4 | 4,4 | 7,7 | 1.0 1.0 |
| E | 4,4 | 4,4 | 4,4 | 4,4 | 4,4 | 4,4 | 4,4 | 7,7 | 1.0 1.0 |
| F | 4,4 | 4,4 | 4,4 | 4,4 | 4,4 | 4,4 | 4,4 | 7,7 | 1.0 1.0 |
| G | 4,4 | 4,4 | 4,4 | 4,4 | 4,4 | 4,4 | 4,4 | 7,7 | 1.0 1.0 |
| H | 4,2 | 4,2 | 4,4 | 4,4 | 4,4 | 4,4 | 4,4 | 7,6 | 1.0 0.85 |
| I | 4,4 | 4,4 | 4,4 | 4,4 | 4,4 | 4,4 | 4,4 | 7,7 | 1.0 1.0 |

| J | 4,4 | 4,4 | 4,4 | 4,4 | 4,4 | 4,4 | 4,4 | 7,7 | 1.0 1.0 |
|---|---|---|---|---|---|---|---|---|---|
| 4 | | | | | | | | | |
| A | 4,4 | 4,4 | 4,3 | 4,3 | 4,4 | 4,4 | 4,4 | 7,7 | 1.0 1.0 |
| B | 4,4 | 4,4 | 4,3 | 4,3 | 4,3 | 4,4 | 4,4 | 7,7 | 1.0 1.0 |
| C | 4,4 | 4,4 | 4,4 | 4,3 | 4,3 | 4,4 | 4,4 | 7,7 | 1.0 1.0 |
| D | 4,4 | 4,4 | 4,4 | 4,3 | 4,3 | 4,4 | 4,4 | 7,7 | 1.0 1.0 |
| E | 4,4 | 4,4 | 4,4 | 4,3 | 4,4 | 4,4 | 4,4 | 7,7 | 1.0 1.0 |
| F | 4,4 | 4,4 | 4,4 | 4,3 | 1,1 | 4,4 | 4,4 | 6,6 | 0.85 0.85 |

* Relevance not ranked

# Calculations for question 17 relevance were rated out of 6 instead of 7

## Appendix 7 – Phase 3 ethics approval

**From:** Research.Ethics@uts.edu.au <Research.Ethics@uts.edu.au>
**Sent:** Monday, October 24, 2022 2:02:38 PM
**To:** Research Ethics <research.ethics@uts.edu.au>; Katie Tunks Leach <Katie.J.Leach@student.uts.edu.au>; Tracy Levett-Jones <Tracy.Levett-Jones@uts.edu.au>; Joanne Lewis <Joanne.Lewis@uts.edu.au>
**Subject:** UTS HREC Approval - ETH22-7416

Dear Applicant

**Re: ETH22-7416 - "Exploring the role and value of chaplains in the ambulance service: Phase 3 (Quantitative phase)"**

The assigned UTS Human Research Ethics Committee has reviewed your application and agreed that this application meets the requirements of the *National Statement on Ethical Conduct in Human Research* (2007) and has been approved on that basis. You are therefore authorised to commence activities as outlined in your application.

You are reminded that this letter constitutes ethics approval only. This research project must also be undertaken in accordance with all UTS policies and guidelines including the Research Management Policy.

Your approval number is UTS HREC REF NO. ETH22-7416.

Approval will be for a period of five (5) years from the date of this correspondence subject to the submission of annual progress reports.

The following standard conditions apply to your approval:

- Your approval number must be included in all participant material and advertisements. Any advertisements on Staff Connect without an approval number will be removed.
- The Principal Investigator will immediately report anything that might warrant review of ethical approval of the project to the Ethics Secretariat.
- The Principal Investigator will notify the Committee of any event that requires a modification to the protocol or other project documents, and submit any required amendments prior to implementation. Instructions on how to submit an amendment application can be found here.
- The Principal Investigator will promptly report adverse events to the Ethics Secretariat. An adverse event is any event (anticipated or otherwise) that has a negative impact on participants, researchers or the reputation of the University. Adverse events can also include privacy breaches, loss of data and damage to property.
- The Principal Investigator will report to the UTS HREC or UTS MREC annually and notify the Committee when the project is completed at all sites. The Principal Investigator will notify the Committee of any plan to extend the duration of the project past the approval period listed above.
- The Principal Investigator will obtain any additional approvals or authorisations as required (e.g. from other ethics committees, collaborating institutions, supporting organisations).
- The Principal Investigator will notify the Committee of his or her inability to continue as Principal Investigator including the name of and contact information for a replacement.

This research must be undertaken in compliance with the Australian Code for the Responsible Conduct of Research and National Statement on Ethical Conduct in Human Research.

You should consider this your official letter of approval. If you require a hardcopy please contact the Ethics Secretariat.

If you have any queries about your ethics approval, or require any amendments to your research in the future, please don't hesitate to contact the Ethics Secretariat and quote the ethics application number (e.g. ETH20-xxxx) in all correspondence.

Yours sincerely,
The Research Ethics Secretariat

on behalf of the UTS Human Research Ethics Committees
**C/- Research Office**
University of Technology Sydney
Research.Ethics@uts.edu.au | Website
PO Box 123 Broadway NSW 2007

*Ref: E13-4*

## Appendix 8 – Phase 3 participant information sheet

# PARTICIPANT INFORMATION SHEET

CLINICAL RESEARCH

EXPLORING THE ROLE AND VALUE OF CHAPLAINS IN THE AMBULANCE SERVICE

Invitation

You are invited to participate in a research study into paramedic perceptions on the role and value of chaplains in the ambulance service.

The study is being conducted by Katie Tunks Leach. Katie is:

- a PhD (Health) candidate at the University of Technology Sydney (UTS);
- a Sessional Academic at UTS;
- a Volunteer Chaplain with the New South Wales Ambulance (NSWA): and
- supervised by Distinguished Professor Tracy Levett-Jones, Associate Professor Joanne Lewis and Associate Professor Paul Simpson.

Before you decide whether or not you wish to participate in this study, it is important for you to understand why the research is being done and what it will involve. Please take the time to read the following information carefully.

13. What is the purpose of this study?

The purpose of this study is to investigate paramedic perceptions on the role, skills and attributes, and value of chaplains in the ambulance service. Barriers and facilitators to accessing chaplain support are also investigated, as well as understanding who uses chaplain

support, and if this support is exclusively to paramedics with religious backgrounds or religious in nature.

14. Who is being invited to participate in this study?

You have been invited to participate in this study because you are an AHPRA-registered paramedic, currently or previously employed by a state based or private paramedicine organisation.

15. What if I don’t want to take part in this study, or if I want to withdraw later?

Participation in this study is voluntary and completely anonymous. If you decide not to participate, it will not affect future access to or communications with a chaplain, or your relationship with your employer.

If you wish to withdraw from the study once it has started, you can do so at any time without having to give a reason by closing the browser or not clicking on the “submit” button. However, it will not be possible to withdraw your data from the study results once you have submitted your survey as identifying data (e.g. personal details, IP address) will not be collected.

16. What does this study involve?

If you agree to participate in this study, you will be asked to complete an online questionnaire that takes between 5-15 minutes to complete.

17. How is this study being paid for?

The study is being paid for by the researcher.

18. Are there risks to me in taking part in this study?

As this study asks you to consider your experiences with chaplains in your ambulance service, potential exists for you to experience unanticipated strong emotions while completing the survey. In addition, there may be risks associated with this study that are presently unknown or unforeseeable.

Should you experience distress as a result of this survey, you may seek assistance through the following means:

| | |
|---|---|
| Lifeline | 13 11 14 |
| Beyond Blue | 1300 22 46 36 |

Employee Assistance Program within your organisation

19. Will I benefit from the study?

This study aims to provide significant evidence into what ambulance chaplains do, the skills and attributes paramedics think ambulance chaplains should possess, and what makes them valued or not valued by an individual or the organisation. Consequently, outcomes from this study may drive organisational change through improving education and training of ambulance chaplains, and position descriptions for ambulance chaplains may be altered to better meet paramedic needs. However, it is not possible to say if this will directly benefit you.

20. Will taking part in this study cost me anything, and will I be paid?

Participation in this study will not cost you anything, and you will not be paid.

21. How will my confidentiality be protected?

As no identifying data are collected, no one will know you are participating in this study. Any potentially identifiable information will be removed, and only disclosed as required by law.

Results will be collected through the REDCap platform hosted by UTS and held securely on the password-protected University of Technology OneDrive server. Data will be stored on encrypted and password-protected computers or an external hard drive that can **only** be accessed by the researcher and her supervisors. Any data being disposed of will occur in line with UTS data management policies.

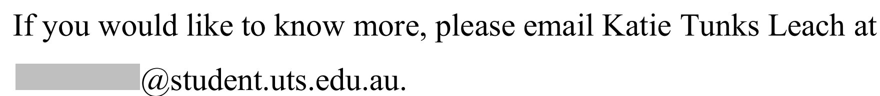
22. What happens with the results?

By signing the consent document, you give the researcher permission to discuss/publish the results in her thesis and in peer-reviewed journals. The results may also be disseminated at conferences or other professional forums.

In any publication or presentation, information will be provided in such a way that you cannot be identified. Results of the study will be provided to you if you wish.

23. What should I do if I want to discuss this study further before I decide?

If you would like to know more, please email Katie Tunks Leach at



@student.uts.edu.au.

24. Who should I contact if I have concerns about the conduct of this study?

This study has been approved by the University of Technology Human Research Ethics Committee (approval number ETH22-7416). Any person with concerns or complaints about the conduct of this study should contact the Research Support Office which is nominated to receive complaints from research participants. You should contact them on (removed from thesis for privacy), or email Research.ethics@uts.edu.au and quote the approval number.

Yours sincerely,

Katie