RAAF Pastoral Care and Hospitable Spaces:

Designs that nourish restoration and rehabilitation

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Contents

PREFACE

This report is an initial exploratory scoping review prepared for CHAP (SQNLDR) Christine Senini, Chaplaincy Branch of the Royal Australian Air Force (RAAF), Australian Defence Force (ADF). Support for this report was provided by La Trobe University, Department of Public Health Participatory Field Placement Internship program (PHE3PFP).

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ABSTRACT

Introduction: This scoping review explores both national and international literature databases to identify any published literature in relation to the military and hospitable sacred-spaces. This report also explores how these hospitable sacred-spaces best contribute towards defence members and their family's sense of welcome and hospitality that encourages restoration and rehabilitation **Aims/purpose:** The aim of this report was to detail, based on the accessible literature, the benefits of hospitable sacred-spaces and the influence that hospitable sacred-spaces have for military members and their families. Additionally, this report aimed to provide an overview of factors that influence hospitable sacred-spaces and the benefits provided to those needing rehabilitation. Furthermore, a comparison between civilian and ADF hospitable sacred-spaces is undertaken to consider possible recommendations for change. **Method:** To conduct this scoping review, a modified framework from Arksey and O'Malley (2005) was utilised, namely: (i) identifying the research question, (ii) developing inclusion and exclusion criterion, (iii) identifying relevant studies for study selection, (iv) charting the data, and (v) collating, summarising and reporting the results. **Results:** Six key themes were identified throughout the sourced literature; (i) empathetic communication, (ii) harmony and peace, (iii) spirituality, (iv) room design, (v) client satisfaction and (vi) insufficient ADF health care staff. **Discussion:** There is insufficient literature relating to the facilities that the ADF currently possess with regard to hospitable sacred-spaces. However, there is a range of non-ADF hospitable sacred-spaces literature that describes the key factors that create an environment which promote restoration and rehabilitation for clients/patients. The literature indicates that there are a number of strategies that the ADF could adopt to implement hospitable sacred-spaces in an attempt to create a welcoming centre for all defence members and their families. **Conclusion:** This scoping review indicates several key elements which the ADF could adopt to improve their facilities in order to enhance the rehabilitative care being provided to ADF personnel and their families. Additionally this report will be best utilised as a resource for the ADF to conduct further study into the topic of hospitable sacred-spaces to nourish restoration and rehabilitation.

Key words: Royal Australian Defence Force, Australian Defence Force, Military, Hospitable space, Rehabilitation, Therapy, Multifaith spaces, Sacred spaces

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INTRODUCTION

A hospitable sacred-space for the purposes of this report will be defined as a specific area set aside to enable individuals to feel welcomed and comfortable allowing a "connectedness to the moment, to self, to others, to nature, and the significant or sacred" (Puchalski et al., 2014). Hospitable sacred-spaces within an organisation such as the Australian Defence Force (ADF), include, but are not limited to areas such as chaplaincy centres, chaplaincy centre waiting areas, chapels, multifaith prayer/meditation spaces and counselling offices (Senini, 2020).

This project focuses on the exploration of both national and international literature databases, to identify any resources in relation to the military and hospitable sacred-spaces. In order to achieve this, consideration will be given to hospitable sacred-space room design and other factors that influence user/client perceptions of wellbeing experiences in terms of the physical, emotional, psychological, and spiritual dynamics. This report also focuses on how best to contribute towards a defence member and/or their family's sense of welcome and hospitality that encourages restoration and rehabilitation while present in these spaces.

ADF

The Australian Defence Force (ADF) is the military organisation accountable for the defence of Australia and its national interests. The ADF consists of the Royal Australian Navy, Australian Army, Royal Australian Air Force, and several "tri-service" units. The ADF is a major employer of Australian citizens which means the health of ADF personnel is of utmost importance (Department of Defence, 2020). The health of personnel is dependent upon the physical, psychological/emotional, social and spiritual wellbeing of its members.

Currently, ADF policy and procedures specify that ADF personnel require a certain level of fitness and maintain a level of resilience with regard to their physical, psychological/emotional, social and spiritual activities in order to serve and work throughout the ADF. Without this level of fitness and resilience, ADF personnel cannot participate to their maximum capacity within the ADF. However, while the ADF is very clear about physical fitness requirements and the amenities needed to maintain physical fitness, the current policies seem ambiguous regarding the provision of hospitable sacred-spaces that nourish psychological/emotional, social and spiritual wellbeing. (Department of Defence, 2020).

Hospitable sacred-spaces

Hospitable sacred-spaces may include venues such as retail, food and beverage, sports, individual homes, parks and recreation centres, leisure centres, meditation/multifaith religious centres, health and medical centres. Hospitable sacred-spaces are dependent on many factors including service, products, design, lighting, colour, shape, room size, furnishing, signage, privacy, cleanliness and imagery.

This scoping review will be focusing on meditation/multifaith religious centres and health care centres that are available for ADF personnel. A comparison of these hospitable sacred-spaces and those available to the general public will be conducted in order to recognise any reoccurring themes.

Rehabilitation

According to the World Health Organisation (2019), rehabilitation is a set of interventions needed when a person is experiencing or is likely to experience limitations in their everyday functioning due to ageing or a health condition, including chronic diseases or disorders, injuries or traumas. The ADF offers multiple hospitable sacred-spaces for personnel to participate in their rehabilitation programs and activities. These spaces are used for spiritual, physical and mental health rehabilitation of ADF personnel and their immediate families (Senini, 2020).

PURPOSE / AIMS

This report aims to detail the benefits of hospitable sacred-spaces and the influence which hospitable sacred-spaces have for military members and their families. This report also provides a review of existing factors that influence hospitable-sacred spaces for the benefit or detriment of the general public undergoing rehabilitation, compared with the hospitable sacred-spaces provided for military members and their families.

Identifying factors that influence hospitable sacred-spaces have been noted to contribute to a more meaningful experience for rehabilitation clients; factors such as colour, the size of the room, furnishings, privacy, décor and military or religious imagery. Additionally, this report aims to identify how these factors contribute to a person's sense of welcome and hospitality whilst undergoing rehabilitation.

The precise aims for this scoping review are:

(i) To consider factors that contribute to the rehabilitation of clients and how these factors aid in their recovery.

(ii) To consider how hospitable sacred-spaces influence military members and their families.

(iii) To compare the literature with respect to civilian hospitable sacred-spaces and ADF hospitable sacred-spaces and produce recommendations for change.

METHOD

A scoping review framework modified from Arksey and O'Malley (2005) was utilised to map the research area utilising a predetermined process of: (i) identifying the research question, (ii) developing inclusion and exclusion criterion, (iii) identifying relevant studies for study selection, (iv) charting the data, and (v) collating, summarising and reporting the results (p. 22).

(i) Identifying the research question

The research questions were developed using the PICO (Population, Intervention, Comparison, Outcome) technique (Fineout-Overholt & Johnston, 2005) (refer to Table 1). The key questions for this research report are: (a)What factors help to make/influence hospitable sacred-spaces? (b) What factors help to make/influence hospitable sacred-spaces within the military context?

Table 1

PICO research question development

Population	Intervention/ Exposure	Comparison	Outcome
• Military members/spouses/families • ADF members/spouses/families • People connected to religion/faith/counselling services • Users/customers/clients of counselling offices, chaplaincy centre waiting areas, multifaith prayer/meditation spaces	• Designing interior spaces benefiting users/clients	• Whether or not spaces contribute towards a sense of welcome and hospitality for users/clients	• Review of literature seeking a record of ***all*** outcomes

(ii) Inclusion and exclusion criterion for study selection

This scoping review will only include articles and resources that have been published in English language and articles that have been published between the years of 1990 – 2020. Only articles that were deemed relevant to the research topic will be included and only those articles which contain within the title, abstract, article content, the term/s of one or more of the following: (1) hospitable sacred-space, (2) hospitable sacred-space in the military context, and/or cross-referenced with the key terms (a) chaplain, (b) sacred-space, (c) hospitable and (d) military. Please refer to Table 2 for additional cross-referenced search terms.

These search terms were created to ensure that articles and other resources were excluded from the scoping review if these did not specifically cite any reference to any of the designated keywords or synonyms. Articles and other resources were also excluded if they were not published in English and were written outside of the years ranging between 1990-2020.

(iii) Identifying relevant studies

The PICO strategy (Fineout-Overholt & Johnston, 2005) was utilised to identify specific search elements, synonyms and key database search terms to identify relevant literature (refer to Table 2). Databases used for this search included Medline, CINAHL, La Trobe University Research Online Library and Google Scholar.

Table 2

PICO element, related synonyms and database search terms

PICO Element	Synonyms	Database Search Terms
Military	• Defence • Service • Armed Forces • Combat	Defen* OR Defen?e + Service* OR Military*
Hospitable Spaces	• Sacred Spaces • Hospitable Spaces • Multifaith Spaces	Sacred space* OR Hospitable space*
Rehabilitation	• Rehabilitate • Rehabilitation • Therapy • Therapist • Recovering • Recovery time	Rehab* OR Treatment* OR Therap*

(iv) Charting the data

All articles were then screened for duplicates and relevancy to the PICO topics of 'hospitable sacred-spaces' within civilian contexts and 'hospitable sacred-spaces' within military contexts (refer Appendix A). Seven articles were initially found to be relevant to the topic. Additional articles were identified as a result of a manual search through the La Trobe University databases (refer to Appendix B). Further hand searching was conducted of article references and subsequently additional key words to ensure that all aspects of the topic were investigated thoroughly which resulted in an additional eight articles. Details and abstracts of final articles deemed valid for thematic analysis were combined at Appendix C. Relevant themes based on the findings of each article were determined by agreement between authors. Each theme is identified and numerically coded in Appendix C and described within the results section.

RESULTS

(v) Collating, summarising and reporting the results

Key themes

The common themes identified across the literature were: (1) empathetic communication, (2) harmony and peace, (3) spirituality, (4) room design, (5) client satisfaction and (6) insufficient ADF health care staff [refer to Figure 1].

Figure 1. Key themes

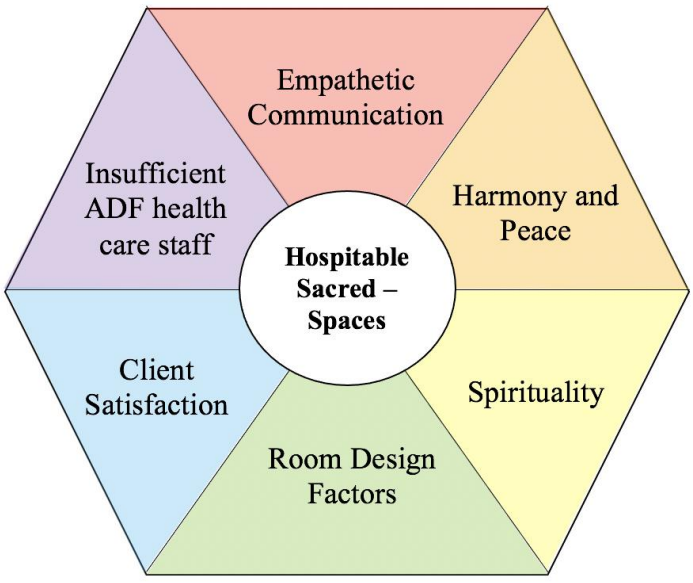

Table 3 lists the research authors and the associated themes with their work. More specific detail for each of the articles within Table 3 are noted at Appendix C – Literature and Thematic Coding.

Table 3

Literature and Thematic codes

Author/s (Year)	**1**	**2**	**3**	**4**	**5**	**6**
Anon. (2017)	✓	✓	✓			✓
Butcher and Carey (2018)	✓	✓	✓	✓	✓	
Byrne and Levey (2018)	✓	✓	✓	✓	✓	
Foster (2006)	✓	✓	✓	✓		
Geva and Mukherji (2007)		✓	✓	✓		
Gowers (2017)	✓	✓				✓
Leibrich (2016)	✓	✓	✓	✓	✓	
Lupone (1999)		✓		✓		
O'Callaghan and Edwards (2018)	✓	✓	✓		✓	✓
Perriam (2014)	✓	✓	✓			
Quinn (1992)	✓	✓		✓	✓	
Salmon (2001)	✓	✓	✓		✓	
Stuckey and Brown (2018)	✓		✓			
Suess and Mody (2017)	✓			✓	✓	
Westphalen (2017)	✓					✓
Total:	13	12	10	8	7	4

Note 1: Themes are: (1) empathetic communication, (2) harmony and peace, (3) spirituality, (4) room design, (5) client satisfaction and (6) insufficient ADF health care staff. ***Note 2:*** Abstracts for each article are provided in Appendix C.

Summary of themes

Empathetic Communication

The largest amount of published literature found for this topic related to empathetic communication. Communication is important in any setting but communication in the military context has proven essential with regard to preserving life. Communication between health care staff and their clients is also an important factor within the health care system in general. Positive outcomes have been evidenced within various international literature regarding health care staff who reflectively listen to a client's perspective before the staff make a diagnosis. This technique also encourages an empathetic reaction from the staff towards the client and helps to bring down the "wall" that health care staff often create in order to professionally distance themselves from their client's and their own feelings. Such techniques have been used in Quinn (1992), "Holding sacred space: The nurse as healing environment".

In particular, a paper exploring places of spiritual significance and their relationship to healing in the 'uncertain' quest for alleviation or cure, written by Perrium (2014), states that, "To understand the relationship between place, spirituality and healing, unhelpful binaries of wellness/illness, inner and outer lives, body and mind, need to give way to more nuanced interpretations of human experiences of suffering and pain" (p. 20). Perrium indicates therefore, that communication between health care staff and their clients with respect to their client's spirituality and spiritual experiences, are of utmost importance for their client recovery. Perrium focuses on compassion-focused exercises which mostly involve communication.

Harmony and Peace

The second most common themes found within the literature were harmony and peace. When considering patients undergoing rehabilitation, having a tranquil environment can nourish their restoration.

Byrne and Levey (2018) claim that art generates a language that links the "brokenness of the body with the wholeness of the spirit" (p. 139) thus replacing any empty/ meaningless

feelings with “vitality and healing”. This feeling of the body being fulfilled and at peace with their spirit enables patients to experience and appreciate spiritual care in all stages of illness and health. Additionally, in ancient times, human suffering was acknowledged as more than a biological malfunction, it was seen as disconnection of the body with the mind and spirit (Foster, 2006). This disconnection creates an imbalance in the body and cannot function in isolation. Freedom of the mind and spirit enables the exploration of imagination, art, music and creativity (Leibrich, 2016).

Being open minded about a person’s spirit and how it can bring harmony and peace may ultimately assist in the restoration of a patient’s rehabilitation. In relation to the ADF and hospitable spaces, having different qualities present in those spaces, such as art and music can activate a sense of open-mindedness and freeing of the individual’s spirit, allowing them to unwind in a tranquil and calming environment.

Spirituality

Another common theme found across the literature was that of spirituality. Based upon the definition of Puchalski et al. p.887 (2009), spirituality has been defined by the ADF as “the way individuals seek and express meaning and purpose and the way they experience their connectedness to the moment, to self, to others, to nature, and the significant or sacred”.

Spiritual spaces can be often found within physical infrastructures such as chapels and designated religious prayer rooms (Butcher & Carey, 2018). The push however, from traditional sacred spaces filled with religious symbols towards neutral spaces filled with art and nature, emphasises the notion that patients embrace space in different ways with respect to their culture/religion and beliefs (Butcher & Carey, 2018). Another factor, according to Perriam (2014), is that it is ***not*** the religious symbols and meanings per say that constitute a building as a sacred-space, rather it is the significance of the site with respect to the individual’s beliefs that determine whether or not a location is spiritually meaningful — hence, the importance of ceremoniously declaring a site as being spiritually significant.

Additional research conducted on adult cancer patients indicated that music also improves coping abilities, spiritual wellbeing and their overall mood, suggesting that spiritual care can be achieved in different forms rather than purely through religious imagery and symbols (O’Callaghan & Edwards, 2018). In relation to the ADF, members are from different

religious and ethnic groups; factors other than religious imagery and symbols may be implemented into hospitable sacred-spaces such as music and art, to ensure that every member has a chance to engage spiritually in ways they see fit. Perhaps in the future, it may even be possible through the use of technology, to visually alternate the appearance of any designated sacred space (e.g. Christian religious art electronically changing to Islamic art) allowing users to have a more personalised religious/spiritual experience that is appropriately meaningful.

Room Design

The design of a room can impact the recovery process of an individual – positively or negatively. (Lupone, 1999). Many room factors need to be taken into consideration when determining what would ultimately nourish restoration and recovery for ADF members and their families undergoing rehabilitation.

Room factors can ultimately depend on the patient's preference. In a study conducted by Quinn (1992), patients preferred environments that contained no noise and allowed them to have private and quiet rooms. In contrast, some patients prefer to have music playing in their rooms; music that reminds them of a happier time in their lives (Salmon, 2001). Based on the individual's preference, there are a range of options that need to be considered when creating a space for a patient to rest and recover. In recent times, institutions have been considering shifts towards improved physical design, environment and overall ambience to accommodate patients (Suess & Mody, 2017). With the advancement of technology, the internet and digital media, a wider range of issues can be addressed to determine what factors may or may not influence a patient's rehabilitation. By ensuring a well-designed physical space for patients, satisfactory experiences are then created, thus increasing the patient's positive experience of rehabilitation.

Client Satisfaction

Client communication about their experiences is also important to ensure that the clients utilising hospitable sacred-spaces are receiving the support or service that they require. Satisfaction is important due to an organisation wanting to create a positive rapport with their

clients. This, in turn, will encourage clients to return, so as to gain adequate health care that nourishes and restores their rehabilitation.

Suess and Mody's (2018) report focuses on client satisfaction and the influence of hospitable spaces and their personal experiences. This quantitative research was conducted to determine how hospitable space design was influencing the clients overall experience within the health care system. Outcomes of the surveys showed that clients with a positive hospitable design experience were more inclined to return to that hospitable space to continue their treatment.

Quinn (1992) focuses on how nurses working together with clients better promote a comfortable healing environment. Questions that have arisen through this article comprised: '"What can the nurse do to create an environment that is more healing for the client?" "What changes could be made in this environment?" "What could be deleted and what could be added?"' (p. 26 – 27). These answers were created by asking nurses and clients about their experiences within the hospitable spaces to which they have access. This article then focuses on the use of these experiences to better influence the hospitable space design and therefore, helping the nurse-client relationship.

Insufficient ADF health care staff

The least amount of literature regarding this topic, but by no means insignificant, considers the insufficient number of ADF health care staff in hospitable spaces such as health care centres. Health professionals play a major role within hospitable spaces for both civilian and military personnel. An adequate number of health staff employed within civilian and/or military settings is fundamental for helping to create/develop and maintain hospitable spaces.

To maintain hospitable spaces however, that are suitable for patients/clients, the health care staff, who are employed/contracted by military organisations need to be aware and understand the roles that each patient/client has within an organisation. Westphlan (2017) notes that health care staff take a minimum of 12 months to completely understand their military client's role within the ADF. This is an unacceptable amount of time due to an insufficient number of health care staff employed by the ADF, and possibly other military organisations. A summary of Commander Neil Westphlan's article within the ADF Journal, concludes that delivery of a more mature health care model would take at least 10-15 years to

implement, given the inadequate state of the ADF's occupational and environmental health services (Westphlan, 2017). An article written by Anon (2017), of the Australian Army, suggested that biggest barrier to their effective implementation of changes to cultural training and capability is the current limitation in manpower and time available within the ADF. This lack of manpower also affects the development and maintenance of hospitable sacred-spaces that would encourage the efficiency and effectiveness of client/patient rehabilitation.

DISCUSSION

This scoping review found a number of articles that related to how the design of hospitable sacred-spaces influence client satisfaction and client perceptions as they encounter the healthcare system and related support services. With regard to a military context, however, there was minimal specific literature that had direct relevance to military hospitable sacred-spaces; it is obvious that there needs to be additional research undertaken, and subsequent literature, to acquire a greater understanding about hospitable sacred-spaces within the military.

The minimal amount of military literature that was accessible related to the importance of cultural training (e.g., for military personnel to be respectful of other's beliefs and values; Anon 2017) and the recognition that, due to current insufficient ADF health care staff, it would take over a decade to implement improvements or achieve significant change (Westphelan, 2017; Anon, 2017). Most of the literature related to the civilian context centred around the importance of ensuring: (1) empathetic communication, (2) harmony and peace, (3) spirituality, (4) room design and (5) client satisfaction. Overall, this report regarding 'RAAF Pastoral Care and Hospitable Spaces: Designs that nourish restoration and rehabilitation', indicates that the RAAF/ADF is substantially behind the rest of Australia with regard to their hospitable sacred-spaces.

Rehabilitation outside of the ADF

For the general public, rehabilitation is something that many people experience every day. One of the key aspects of rehabilitation centres is the substantial amount of empathetic communication and interest in client satisfaction to satisfy their users/clients. By listening to their clients, staff members allow their clients to express their feelings regarding recovery and rehabilitation (Foster, 2006). Additionally, by allowing clients to speak their mind, staff members are able to discover more information about their clients, which facilitates the rehabilitation process.

Client satisfaction is something that increases a patient's inclination to return to the care that they have received previously. For example, in the Royal Children's Hospital Melbourne (RCHM), a neutral environment was created to provide therapeutic relaxation for parents and families who complained of experiencing high levels of stress due to the calamitous situation in which they found themselves (Butcher & Carey, 2018). A two-story-high cylindrical aquarium was developed to present a tranquil and colourful scene for those in the waiting area of the emergency department (Butcher & Carey, 2018). Taking the feelings of the patient and their families into consideration has allowed for the RCHM to appeal to the satisfaction of the clients by providing them with something to reduce their anxiety.

The facilities outside of the ADF have more intentionally focused upon the client's needs and what can be done to assist them and their families whilst undergoing rehabilitation. This urge to appeal to the clients has created an environment where people can feel at ease during a difficult time.

Current ADF facilities

This scoping review has shown that for the ADF to have quality hospitable sacred-spaces, a sufficient number of ADF health care staff need to be employed to provide care for the military members and their families. The health care staff that are being employed also need to have sufficient training to ensure that they understand the job requirements based on each client that they may encounter. Due to the limited amount of literature available for the topic of ADF hospitable sacred-spaces room design, further research is needed, thus the current ADF hospitable sacred-spaces cannot be discussed in further detail within this report. Hospitable sacred-spaces play an important role for ADF members and their families. These chaplaincy centres provide an environment for members to engage in something sacred where they believe will help them find peace. The lack of information currently available for ADF hospitable sacred-space facilities has made the comparison to civilian hospitable sacred-spaces unfeasible.

Considerations

There are a number of considerations that should be taken into account by potential stakeholders to ensure that the care provided by the ADF for military members and their families is of a high standard. These considerations are summarised below (refer Table 4). In

order to provide adequate care for clients undergoing rehabilitation, the findings within the literature should be engaged. A consideration for future hospitable sacred-spaces within the ADF is to make them easily accessible to all members of the defence force and their family members, this, therefore, can create a better rapport within the ADF community. Considerations that are predominantly based on client satisfaction will also help clients to reconnect with designated ADF hospitable sacred-spaces rather than seeking refuge elsewhere.

Table 4

Room factors/décor considerations

Room Factors/Décor	Summary
Cleanliness	It can be noted that the key idea for health care facilities is to have cleanliness, quality and accessibility for all its users/clients. Cleanliness and hygiene can impact cognitive and affective consumer satisfaction thus creating a more welcoming environment (Suess & Mody, 2018).
Colour	Integrating colour and art into a setting that many people associate fear with can promote the life, health and positivity. It provides the setting with a brighter and more cheerful surrounding to promote health healing (Bryne & Levey, 2018).
Décor/Imagery	Imagery, visualisation music therapy and relaxation may all be used to alter the feeling that clients may be feeling when recovering through rehabilitation. Being in a room that feels a lot like a hospital room will not promote a healthy and quick recovery as it may bring upon more stress for the client (Quinn, 1992).
Environment	Atmospheric environments can play a large role in the rate of recovery for a patient. The calming ambience of being able to relax with soft noise, music or temperature can really impact a patient's sense of comfortability (Suess & Mody, 2018).
Furnishings	Being in a hospital or rehabilitation clinic may be an unsettling experience for patients. Having welcoming furnishing where people are able to feel comfortable may help with their attitudes towards being in a place where they may feel uneasy (Butcher & Carey, 2018).
Lighting	The impact lighting can have in a sacred space is that it can influence the user/client's feelings towards rehabilitation and ultimately create a sense of relaxation for users/clients allowing them to focus on sacred traditions such as prayer (Geva and Mukherji, 2007).
Room Size	Considering the size of the room a client is staying in can be a crucial point when determining what may benefit a client's recovery. Being situated in a room with no one around you can be daunting to most people, having a large enough room to share with a patient undergoing the same procedure may assist them with their loneliness and ultimately assist with their recovery (Leibrich, 2006).
Toys for children	Simplicity plays a large role in feeling comfortable in a foreign setting. A small gesture of a stuffed toy may make all the difference in a child's road to recovery as they can be seen as a tangible symbol of love and care (Butcher & Carey, 2018).

CONCLUSIONS AND RECOMMENDATIONS

Key Recommendations

i) Further research is needed in order to gain a better understanding of the facilities (or the lack of adequate facilities) that the ADF currently has/does not have, and the changes that should be implemented to ensure that ADF members and their families are receiving quality care.

ii) It is recommended that the ADF implement a number of non-ADF hospitable space strategies to ensure that ADF facilities achieve a high-quality standard.

iii) More funding and investments should be implemented into the health and rehabilitation sector within the ADF – particularly with regard to pastoral care rehabilitation facilities, as the years of neglect have no doubt restricted services which inevitably limits professional practice and ultimately has a negative toll on the recovery of ADF members and their families.

Conclusion

In conclusion, while there is minimal literature regarding hospitable sacred-spaces within the military context, there is sufficient literature to indicate that the ADF health care system is not up to equal standard with non-ADF health care systems with respect to hospitable sacred-spaces. This statement can be supported by articles written and published by the ADF themselves in the ADF Journal, including, Westphalen (2017), Anon (2017) and Gowers, (2017). Considerations such as client satisfaction surveys should be implemented within the ADF to ensure that they are improving their hospitable sacred-spaces to client's wants and needs.

Further research needs to be conducted to ensure the ADF can implement sufficient changes within their hospitable sacred-spaces and their overall health care system. These changes need to be addressed to ensure that ADF members and their families have access to facilities to nourish their restoration and rehabilitation. Key recommendations for this are to actively investigate the hospitable sacred-spaces of civilians to compare and make appropriate changes within the ADF.

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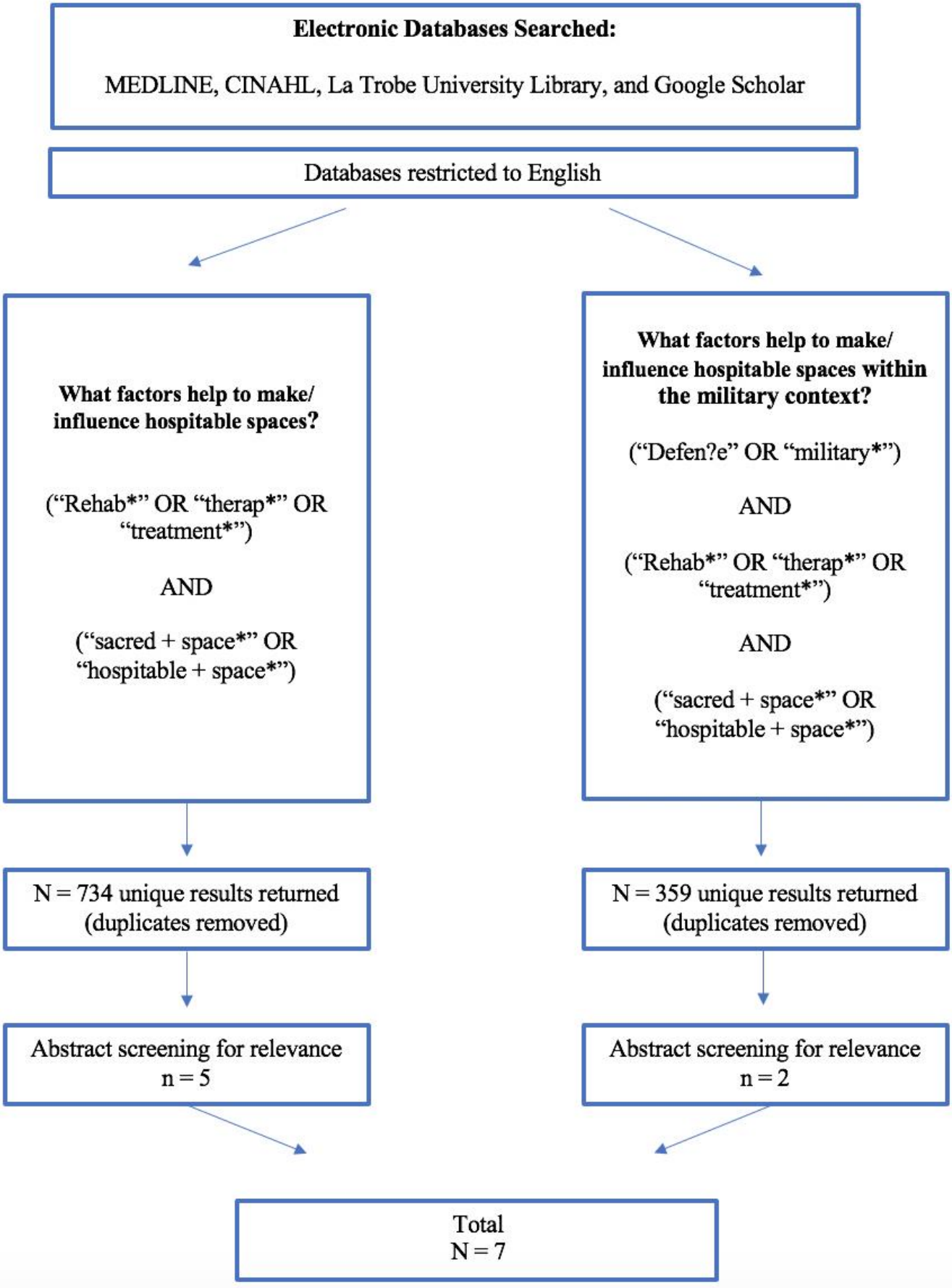
APPENDIX A



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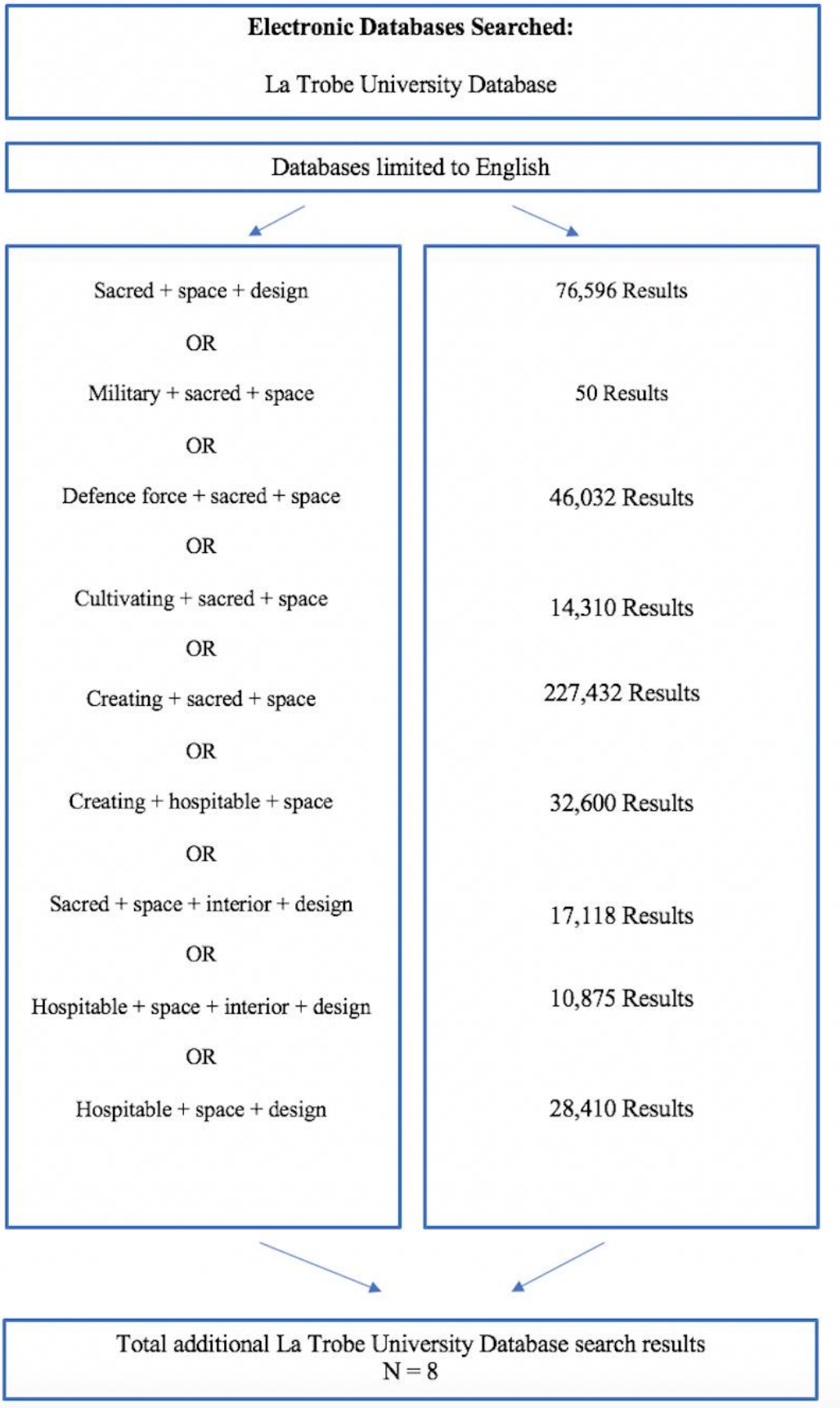
APPENDIX B

Additional Search Terms Method



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APPENDIX C

Literature and Thematic Coding

No.	Author/Year	Title	Abstract	Thematic Coding
1	Anon. (2017).	Cultural competence and linguistic capability in ADF human-intelligence source operations	Changes to both cultural training and linguist capability are small and relatively cheap by comparison to the cost of other intelligence-collection capabilities. These would, however, be significant in enabling an increase in the quality of human-intelligence reporting in the crucial early period of an ADF operation. The biggest barrier to their effective implementation is the current limitation in manpower and training time available within the ADF's human-intelligence capability. It would be necessary, therefore, to balance the importance of understanding (both literally and figuratively) the human terrain and the importance of other training that the ADF's human-intelligence resources are currently committed to.	1,2,3,6
2	Butcher, W., & Carey, L. B. (2018).	Paediatric Spirituality, Space and Environment	Despite the secular influence of the twentieth century, it would be fair to say that spiritual and religious influences plus the importance of identity, culture and rituals are slowly regaining traction in the twenty-first century as being integral to providing fully holistic care. Creating and developing sacred space, both internally and externally, is an important element for encouraging a positive and creative environment for children that, amidst the increasing pace and stress of technological society, provides a sanctuary for peace of mind, body and spirit – which benefits not only children but also parents, staff and, ultimately, the wider community. Chaplains/spiritual carers are integral to this sacred space creativity.	1,2,3,4,5
3	Byrne, L., & Levey, L. (2018).	Art therapy and spiritual care	In both of the case examples we have presented we have seen that the immanence of art materials and the presence of the work of art in public health facilities can draw the attention of patients and families into the present moment, enabling time and space for the spirituality of action and contemplation to expand. An Open Studio is a place that dissolves cultural boundaries, allowing the essence of what was shared in human spirituality—a place to be seen, heard, felt and lived. It is imbued with something akin to the Dadirri experience ("inner, deep listening and quiet, still awareness") and the union with reality that is the art of contemplative practice. It is a place that offers an opportunity to be awakened to the possibility of transcendence and interconnectedness within our embodied human experience. The presence of an Open Studio in a public health facility signified the provision of a supportive and stabilizing environment in an ever changing and chaotic world. It is a liminal space in which our secular understanding of the human condition can be transformed into an experience of spirituality that is embodied, heard and seen within the life of a community. It is evident from these case studies that making, being with and seeing art enables people to discover an embodied experience of spirituality that embraces both illness and health as aspects of immanence and transcendence in human life. Embodied spirituality integrates the social, physical and psychological aspects of being human, drawing them together into the active presence of a living	1,2,3,4,5

			being who is becoming. Integrating the arts into the provision of healthcare enables the transformation of an environment that provokes fear into a place where life and health can flourish. The provision of Open Studios within public health facilities enables the compassionate integration of spirituality into health services, the community, and particularly into the lives of those who are challenged by serious illness, death and dying. Such commitment also indicates that contemporary society is able to reconcile in a creative way the historical division between mind, body and spirit.	
4	Foster, E. (2006).	The spiritual encounter within a complementary therapy treatment.	Interest in both spirituality and complementary therapies is growing, with their inclusion in both daily life and in health care. The concept of spirituality and the delivery of a therapy have a certain synergy as they both espouse a view of the world that recognises the importance of the whole person. Increasingly, clients want their values and beliefs attended to, perhaps choosing a therapy as a pathway to nourish their sense of the spiritual. Consequently, working in a holistic way, the complementary therapist needs to acknowledge the spiritual dimension of the client. Integral to this is how the therapeutic encounter facilitates this engagement and how important it is that the therapist develops and explores their own spirituality and life values. This article is an exploration of how spirituality and complementary therapies can legitimately work together, creating a sacred space for both therapist and client.	1,2,3,4
5	Geva, A., & Mukherji, A. (2007).	A Study of Light/Darkness in Sacred Settings: Digital Simulations	Studying light/darkness and sacred architecture reveals that the "holy" light dramatizes the spiritual state and affects the mood of the user in the sacred space. Furthermore, it shows that faith dictates the treatment of light/darkness in the sacred setting as means to enhance the spiritual experience. These two premises were investigated by conducting digital daylight simulations on the Brihadeshvara Hindu Temple (1010 AD) of Tanjore, Tamilnadu, India. This sacred monument, listed as one of UNESCO's World Heritage Sites, is an intriguing case study since the treatment of the 'holy light' in the temple is actually the treatment of the 'holy darkness'. The simulated values were compared to the Illuminating Engineering Society (IES) standards. The results demonstrate that digitized simulations can illustrate the significance of light/darkness in sacred settings as a spiritual experience. Moreover, this quantitative investigation can augment the qualitative studies in the field of historic sacred architecture. The work presented here unites and extends some previously published work.	2,3,4
6	Gowers, P. R. (2017).	Primary health care in the Gambia.	With ADF personnel arguably exposed to the most diverse range of occupational and environmental hazards of any Australian workforce, high rates of preventable workplace illness and injury indicate the need to improve the management of occupational and environmental health hazards, with better emphasis on prevention rather than treatment. This suggests that the ADF's health services should be premised on an occupational and environmental health paradigm, with revised fundamental inputs to capability that would lead to a genuinely holistic and sustainable work- force-based ADF health service delivery model by 2030. Although general practitioners would still maintain an essential primary health care role within such a paradigm, they lack the skills and expertise to provide the full range of clinical and other occupational and environmental health services required for a young, fit, geographically mobile and predominantly male (although this is changing) ADF workforce. However, occupational and environmental physicians have the skills and expertise to provide primary health care for	1,2,6

			workplace-related musculoskeletal and mental health injuries, as well as managing workplace-based rehabilitation, and assessing medical suitability for employment and deployment. Such a delivery model would entail recruiting and training more service and civilian medical officers who are interested in an occupational and environmental physician career.	
7	Leibrich, J. (2016).	An Introduction to Sanctuary: The Discovery of Wonder	This article is a personal reflection of the author's life and spiritual journey using a number of personal stories. It addresses multiple themes including the concept of sanctuary – what kind of experiences illuminate what sanctuary is, and how we can protect our own inner sense of sanctuary. It also discusses the relationship between mystery meaning and miracle, which can lead to experiences of sanctuary. A former Mental Health Commissioner with the New Zealand Government the author was one of the keynote reflective addresses at the national Spiritual Care Australia Conference held in Melbourne in May 2016. An earlier version of this essay was presented as a paper at the conference.	1,2,3,4,5
8	Lupone, L. (1999).	Feng Shui: therapy for the new millennium.	Feng Shui the ancient, 5,000-year-old Chinese Art of Placement, also known as the art and science of healing spaces, has captured the imagination of the western world. Based on lessons and the wisdom of an ancient Chinese text, the I Ching or Book of Changes, one's proper placement within the cosmological forces can support one's health, balance, sense of harmony, prosperity and thereby affect one's destiny. The therapeutic benefit of working with feng shui principles begins with a personal conversation, an evaluation, of how one is doing with respect to the energies expressed in the I Ching and its 64 hexagrams. The fundamental energies are Water (Career), Mountain (Wisdom), Thunder (Elders/Health), Wind (Prosperity), Reputation (Fire), Relationships (Earth), Creativity/Children (Lake), Benefactors/Travel (Metal) and the tai chi, the complementary opposite forces of yin and yang in perfect balance. The goal is to create a sacred space of home where chi, the cosmic breath or life force, can flow smoothly and nourish the inhabitants. Changes in one's physical space, particularly placement of bed, desk, and stove, can have remarkable and profound effects on one's feelings about one's sense of harmony. When changes are made with intention and clarity, a metaphor has been created for the home to be 'a place for experiencing and fulfilling the meaning of existence through the fullest development of our natures.'	2,4
9	O'Callaghan, C., & Edwards, J. (2018).	Music therapy and spiritual care	Music therapy refers to the use of music-based methods in a professional relationship to improve biopsychosocial and spiritual wellbeing. In music therapy, patients and families tend to choose or play music that elicits feelings, thoughts, images, memories, spiritual states, and people with which/whom they want to be connected. When caring for people affected by life-threatening conditions, music therapists' aims are similar to those of pastoral care workers/chaplains. This chapter presents research findings and case studies to illustrate how music therapists offer generalist spiritual care to support patients and their families. Case studies will focus on the care of those affected by life-threatening conditions. Five spiritual need areas, described in the Standards for Hospice & Palliative Care Chaplaincy (AHPC 2006) provide the framework for illustrating how music therapy methods are offered, including live familiar music, song writing, improvisation, and music-supported counselling. The case studies also illustrate how music therapy can potentially improve the spiritual wellbeing of patients, and those	1,2,3,5,6

			significant to them, by connecting them with what and who matters in their lives, and enabling validation of self-worth, relief, and/or pleasure.	
10	Perriam, G. (2014).	Sacred Spaces, Healing Places: Therapeutic Landscapes of Spiritual Significance	Understandings of the relationship between space, culture and belief are formative in the experience of seeking healing. This paper examines the relationship between place, healing and spirituality in the context of interdisciplinary perspectives (particularly those of the medical humanities) on healing and well-being. The paper examines places of spiritual significance and their relationship to healing in the 'uncertain' quest for alleviation or cure, exploring these thematics in the context of the work on the geographies of 'therapeutic landscapes.' Through a discussion of fieldwork at two sites in Perthshire, Scotland, a frame- work is proposed for the investigation of therapeutic sites of spiritual significance, detailing features such as connection, renewal, reproduction, participation, alleviation and expectation. A deeper examination of sites of healing with spiritual significance, it is proposed, has the potential to develop greater understandings of the ways in which people experience illness and well-being.	1,2,3
11	Quinn, J. F. (1992).	Holding sacred space: the nurse as healing environment.	Inherent in the basic premise of this article is a challenge and a call to the nurse who aspires to practice out of a holistic, unitary framework. If we accept the basic premises of holism, of an interconnected universe, and of the fundamental inseparability of individuals one from the other, then we are called to look anew at how we knowingly participate in that universe. We can no longer view the environment solely as being "out there", amenable to our knowing participation in repatterning it yet somehow fundamentally other than self. We are the environment, for our patients, our colleagues, our communities, and out world. Dillbeck reports on a series of studies on the effects of the number of people participating transcendental meditation (TM) in various cities and the corresponding crime rates. The data demonstrate decreases in crime rate when more than 1% of the community meditate regularly. This effect has been termed the "Maharishi effect," since it was predicted by the Maharishi Mahesh Yogi, the founder of TM. What would be the effect in a single hospital if 1% of the nurses began to practice healing modalities using expanded consciousness? The view put forth in this article would seem to demand much of us as nurses. Yet it is clear that in the process of expanding our own consciousness, of becoming healing environments, sacred spaces, we ourselves are healed. What could be more deserving of our intent and effort?	1,2,4,5
12	Salmon, D. (2001).	Music therapy as psychospiritual process in palliative care.	This paper proposes a theoretical framework for understanding how music therapy elicits and supports depth experiences in palliative care. The author explores music therapy as a containing or sacred space in which ventures into the realm of psychospiritual awareness may safely occur. The ultimate goal is to facilitate the process of connecting to that which is psychologically and spiritually significant for the patient, thereby transforming experiences of suffering into those of meaning.	1,2,3,5
13	Stuckey, R. Brown, J. W. (2018).	Occupational Ergonomics and	This chapter, from an occupational ergonomics perspective, explores the relationship between meaningful work and health, wellbeing and job performance, and how spirituality in its varied expressions may be used to enrich the experience of contemporary workplaces. It addresses the questions of, "What is spirituality in the	1,3

		Spiritual Care in the Workplace	workplace?"; Why is consideration of spirituality important to workplace design and culture?"; and "How can ergonomists integrate spirituality into contemporary workplace practices?" There has been little research into the role and benefits of ergonomic interventions in the area of spirituality and their effect on meaning and wellbeing for workers and workplaces. We propose a model that draws on workplace consultation and engagement and acknowledges the many cultural influences on meaningful work and wellbeing. Ergonomic interventions in collectivist cultures may include adopting more spiritually oriented values to guide work and productivity, in a climate where employees are encouraged to experience and practice their spirituality within their work. Interventions in individualistic workplace cultures and those with secular/humanistic values can include strategies to enhance core job characteristics and improve organizational culture and leadership through a process of comprehensive and constructive worker involvement. The role of occupational ergonomics practitioners is to enhance efficiency, safety, comfort, and production through improved design of work, workplaces, and workplace cultures. The relationship between meaningful work and health, wellbeing, job performance, and spirituality underpins the significant contribution ergonomists can bring to the integration of spirituality into contemporary workplace practices.	
14	Suess, C., Mody, M. (2017).	The influence of hospitable design and service on patient responses	A study of 216 respondents examined a medical centre environment's influence on patient responses. A stimulus– organism–response (S-O-R) model was adapted to the theory that more hospitable healthcare servicescape elements will affect patients' overall satisfaction with healthcare experience, loyalty intentions, and willingness to pay out-of-pocket expenses for healthcare services. Servicescape elements included atmospherics of the healthcare environment, service delivery by healthcare staff, physical design of the healthcare environment, and wayfinding. Results of structural equation modelling confirmed that the four servicescape elements – had a significant impact on patients' overall satisfaction with the healthcare experience. Furthermore, overall satisfaction with the healthcare experience predicted patients' loyalty intentions and willingness to pay out-of-pocket expenses for healthcare services. The study makes a significant contribution to the empirical modelling of patients' behavioural responses to hospitable healthcare environments.	1,4,5
15	Westphalen, N. (2017).	Occupational and environmental health in the ADF	ADF personnel are arguably exposed to the most diverse range of occupational and environmental hazards of any Australian workforce. Controlling these hazards is complicated by the number, size and complexity of the ADF's workplaces, and its workforce demographics. Workplace hazards significantly affect the physical and mental health of ADF personnel. High rates of preventable workplace illness and injury suggest the need to better manage the occupational and environmental hazards associated with all deployed and non-deployed ADF workplaces, with increased emphasis on prevention rather than treatment. It therefore seems reasonable that the ADF's health services should reflect a paradigm premised on the Australasian Faculty of Occupational and Environmental Medicine's definitions of occupational and environmental medicine. Among its other attributes, the resulting health care delivery model would include military and civilian occupational and environmental physicians, who not only can perform occupational and environmental health policy and other roles but also provide workforce rehabilitation and other clinical primary health care services alongside general practitioners, in both the garrison and operational settings. However, the current state of the ADF's occupational and environmental health services,	1,6

	and the small number of civilian specialist practitioners within the Australasian Faculty of Occupational and Environmental Medicine, suggests that a mature health delivery model would take 10-15 years' sustained effort with respect to occupational and environmental physicians alone. This suggests an urgent need to reassess the fundamental inputs to capability for Joint Health Command and the Defence Work Health and Safety Branch. The reassessment should facilitate inputs to capability that reflect an occupational and environmental health paradigm, leading to a genuinely holistic and sustainable workforce based ADF health service delivery model by 2030.