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1 INTRODUCTION

There is growing recognition that religion and belief are not a peripheral idiosyncrasy which can be ignored, but for much of the world's population are an intrinsic aspect of what it means to be human (Baker, Crisp, & Dinham, 2018). The need to effectively respond to religious diversity has been proposed as a strategy for managing tensions between individuals and groups who have different beliefs (Ezzy, 2013; Hovdelian, 2015), particularly in contexts of migration and globalisation, producing greater plurality. This not only includes the decreasing numbers of citizens who have an appreciation of, if not active involvement in, the activities of established religious groups (Boisvert, 2015), but also the growing numbers who identify with other belief systems (Ezzy, 2013) including those who claim to identify with no religion (Singleton, 2018). For example, a 2003 EU directive on refugees included the following definition:

> The concept of religion shall in particular include the holding of theistic, non-theistic and atheistic beliefs, the participation in, or abstention from, formal worship in private or public, either alone or in community with others, other religious acts or expressions of view, or forms of personal or communal conduct based on or mandated by any religious belief. (in Doe, 2009, p. 148)

Although it has been suggested that social policy scholarship has paid little attention to the role of religion (Jawad, 2012), for health and social care professionals in the UK, there has been a growing sense that they should be able to engage with the religion and belief of the individuals and communities with whom they work (Furness & Gilligan, 2010). However, many report feeling inadequately prepared to discuss religion and belief with service users (Horwath & Lees, 2010), or even knowing how to refer to religious celebrations in ways which will avoid offending people of other religions (Bradstock, 2015). There may be important impacts on their ability to engage with the nuances associated especially with the impact of religion or belief on issues such as sexuality, marriage, parenting and care of the elderly (Tan & Zhang, 2014) or matters associated with food or parts of the body (Boisvert, 2015).

For many 21st century health and social care professionals, another substantial change from the professional world of their 20th century colleagues is increased requirements to adhere to regulatory standards. Indeed, it has been proposed that the development of standards of practice have not only been integral to the modernisation of health and social care in the UK over the last two decades (Humphrey, 2003) but are a tangible expression of social policy in the public sphere. Growing mistrust in the capacity of professions to self-regulate (Moran, 2001) has contributed to several professions moving from informal self-regulation by peers (Jha & Robinson, 2016) to becoming subject to statutory regulatory bodies, some of which have responsibility for several professions (Speed & Gabe, 2013). The rationale often given is “that regulation can and should improve the quality of service that is provided, and this in turn can serve the public interest” (Roberts, 2005. p. 510) by protecting both service users and service providers. This is particularly so for

professionals whose work with vulnerable people tends to take place in private spaces (Roberts, 2005).

Standards change over time and signal what the community can currently expect of a profession (Crisp, 2011). Hence, a growing acceptance that a professional's "ethnicity, gender, spiritual values, sexuality, culture, religion, upbringing, education and age have the capacity to influence his or her ethical sensitivity to moral issues" (Schluter, Winch, Holzhauser & Henderson, 2008, p. 306) may well be reflected in the ongoing development of professional standards concerning the obligation to provide services to people of diverse religions and beliefs. While it is readily accepted by most health and social care professionals that they should not explicitly impose their own religious beliefs onto service users there is little recognition of the "implicit imposition of religious beliefs [which] occurs when workers assume stereotypical knowledge of religions to be universally accepted and uncontested" (Crisp et al., 2018, p. 105). Indeed, individuals who do not have the tools to critically analyse their beliefs about religion may inadvertently convey opinions on religious matters which are in stark contrast to their stated position (Whitlock, 2018). It has been proposed that such difficulties are due to a lack of religious literacy, which is not just an issue for health and social care professionals, but is a widespread issue within British society which at the same time is increasingly secular and needing to engage in debates about the role of religion in public life (Baker et al., 2018). In particular, it has been argued that

> British people are losing their knowledge of religion (that is, of vocabulary, concept and narrative) just when they need this most, given the requirement, on an increasingly regular basis, to pass

> judgement on the rights and obligations of the very varied religious actors (individual and corporate) that currently cohabit this country. (Davie, 2015, pp. ix-x)

This is certainly the case for health and social care professionals of whom it has been argued need sufficient religious literacy in order to handle the complexities of religious beliefs and practices within their fields of practice (Dinham & Francis, 2015). This requires the capacity to both recognise the importance that religion and belief may be playing in a particular situation and then having the skills to engage with service users to ascertain the role of religion and belief, as well as an understanding that these may differ from stereotypes of them, tradition's own claims about them, and substantially from one's own worldview (Castelli, 2018). Furthermore, this may require a fundamental change of viewpoint in rejecting prevailing ideas that religion is simply a problem to be managed and recognising that religion and belief are among the many pervasive aspects of identity which health and social care professionals should engage with (Dinham & Francis, 2015).

By examining the regulatory standards which govern their work, this paper explores the current obligations of UK health and social care workers to understand and engage with matters of religion in their professional practice. In doing so, we have utilized the framework developed by Dinham (Dinham & Jones, 2012; Dinham & Francis, 2015; Dinham & Shaw, 2015) which identifies four dimensions of religious literacy which are concerned with i) how religion is understood; ii) attitudes and beliefs about religion; iii) knowledge about religions; and iv) skills to engage with matters involving religion in the professional arena. As such, it offers two additional dimensions to explore than the framework for analysing religious literacy outlined by

Castelli (2018, p. 151) which proposed the need for “religious literacy” which for Castelli is concerned with knowledge and understanding of religions and “religious oracy” which is the capacity to discuss relevant matters of religion. Castelli’s framework does not however consider how religion is understood or the beliefs and attitudes which individuals often unconsciously bring to their encounters with religious ideas. To some extent Moore (2006) acknowledged this latter issue in the two dimensions of religious literacy: an understanding of the role of religion in society and knowledge of major religions. However, Moore does not identify skills as a separate component of religious literacy.

In addition to offering a greater number of dimensions by which to explore religious literacy, the framework developed by Dinham and colleagues has been used in a number of UK studies which have considered the need for religious literacy in a range of settings including higher education (Dinham and Francis, 2015), teacher education curriculum (Dinham and Shaw, 2015) and also underpins a recent study about religious literacy among hospice care workers (Pentaris, 2019).

The first element in Dinham’s framework is “categorisation”. This element asks what do we mean by religion and how can we think about it. It observes the dominance of the idea of secularity in sociology as the primary lens through which religion is understood as simply in decline – probably to a vanishing point - and how this has translated in to its social dominance more broadly. It proposes that understanding the real religious landscape, and the contested idea of the secular which frames it, is just as important as understanding the religion, belief and non-belief within it. To do religion justice, religious literacy proposes a stretchy understanding of religion to include religious traditions; informal, non-traditional religion, to do with nature,

goddesses, angels and afterlife; non-religion, like secularism, atheism and humanism; and non-religious beliefs, like environmentalism. At the same time it demands an understanding that European societies continue to be varyingly secular but also Christian and plural, and that all of these things are happening at once.

The second aspect is disposition which asks what are the emotional and atavistic assumptions which are brought to the conversation and what are the effects of people's own emotional positions in relation to religion or belief. It addresses whether feelings about religion or belief may be part of why the conversation is often ill-informed and ill-tempered, preoccupied with the ways in which religion, belief and non-belief clash, or oppress people. It explores the connections to controversies which result. This dimension proposes that moving from untested assumptions and emotions which underpin so much experience to the expressly understood will be important if professions are to engage well with the religion, belief and non-belief they encounter.

The third dimension is knowledge and here the starting point is that comprehensive knowledge is neither possible nor desirable. The religious literacy framework talks about a degree of general knowledge about at least some religious traditions and beliefs and the confidence to find out about others (Dinham & Jones, 2012). The knowledge that is needed is about the shape of religion, belief and non-belief where you find yourself. This is referred to as "the real religious landscape" (Dinham & Shaw, 2015), and it varies from place to place and time to time. So an engagement with religion, belief and non-belief as identity, rather than tradition, is proposed, which releases us from the notion that we can and ought to learn some sort of

comprehensive A-Z of a *tradition*, as though this is always the same, everywhere, in every person.

This leads to the fourth dimension which is skills. This is rooted in understanding the challenges and needs presented by religion, belief and non-belief in any given professional spaces. The task which follows is to translate those findings in to training for practice which skills professionals for encounter with the real religious landscape. In this stage, stakeholders will co-produce the shape and purposes of new training, and this will lead in to the co-production of training materials and resources which will follow, and their piloting and evaluation.

2 METHOD

2.1 Approach

We use this framework here to analyse the regulatory standards as they relate to religion and belief. Whereas interviewing key stakeholders is likely to result in individual opinions as to what is necessary or important (Ervin, Carter & Robinson, 2013), analysis of regulatory documents in terms of their content regarding religion and beliefs has the advantage of enabling the scope of domains in which religion and belief are considered as requiring attention of professions. Published guidelines also provide members of the public with information as to what they should be able to expect from service providers (Moran, 2001). Furthermore, comparing current guidelines across professions and places enables what is already considered possible to be revealed.

2.2 Data collection

Regulatory standards for professional practice involving direct service provision, but excluding regulations for laboratory based scientists, were obtained from the websites of the regulatory bodies for health and social care in the United Kingdom. These organisations were:

- General Dental Council [GDC], responsible for the regulation of dental staff across the UK including dentists, dental nurses, dental hygienists, dental therapists, orthodontic therapists, dental technicians and clinical dental technicians;
- General Medical Council [GMC], responsible for the regulation of medical practitioners across the UK;
- General Optical Council [GOC], responsible for the regulation of optometrists and dispensing opticians across the UK;
- General Pharmaceutical Council [GPC], responsible for the regulation of Pharmacists and pharmacy technicians in Great Britain;
- Health and Professions Care Council [HCPC], which is the UK regulator for art therapists, chiropodists/podiatrists, dietitians, hearing aid dispensers, occupational therapists, orthoptists, paramedics, physiotherapists, practitioner psychologists, prosthetists/ orthotists, radiographers, and speech and

language therapists. At the time of data collection, it was also the regulatory authority for social workers in England.

- Nursing and Midwifery Council [NMC], responsible for the regulation of nurses and midwives across the UK;
- Northern Ireland Social Care Council [NISCC], responsible for the regulation of social care workers and social worker in Northern Ireland;
- Scottish Social Services Council [SSSC] is responsible for the regulation of social workers, social care workers and other social service workers working with children and young people; and
- Social Care Wales [SWC] regulates domiciliary care workers, residential child care workers, social care workers, social care managers, and social workers.

A full list of the standards documents analysed is provided at the end of this article. As both the current standards (NMC, 2015) and the new standards to be implemented in 2019 (NMC, 2018) were available for registered nurses, both documents were included.

2.3 Data analysis

Each document was searched electronically using the following keywords and related terms using truncations as noted in brackets:

- Beliefs (belie*)

- Religion (relig*)
- Spirituality (spirit*)

All documents were also read in entirety to locate additional material which the keyword searching was unable to identify. Relevant text was entered onto an Excel spreadsheet, along with details of the professional group for which the standard was a requirement, country, title and year of the source document, information as to where this was located within the document, and relative location to any other data extracted from the same document. Each author then separately rated each text fragment as either 'Yes', 'No' or 'Maybe' in respect of each of the four dimensions of the framework for religious literacy. Where there was initial disagreement, these items were discussed and the data presented here represents the subsequent agreed position.

3 Results

One or more statements associated with religion and belief was found in the standards for all occupational groups except for those whose work is regulated by the SSSC in Scotland (SSSC, 2016). The standards in each place in respect of occupational groups and geographical coverage for the four dimensions of the framework are summarized in Table 1.

INSERT TABLE 1 ABOUT HERE

While there were some standards which were designed for specific professions or subsets of a professional group, many of the standards were generic and the same across multiple professional groupings. This was particularly so for the standards produced by the HCPC, for whom the only mention of religion or belief for art therapists, chiropodists and podiatrists, dieticians, hearing aid dispensers, orthoptists, paramedics, physiotherapists, radiographers, and speech and language therapists was to "be aware of the characteristics and consequences of verbal and non-verbal communication and how this can be affected by factors such as age, culture, ethnicity, gender, socio-economic status and spiritual or religious beliefs". The same wording was also to be found in standards for occupational therapists and practitioner psychologists in addition to more profession-specific specifications.

3.1 Categorisation

None of the documents included any definition as to what is meant by terms such as 'religion' or 'belief'. Instead, religion and belief tend to be mentioned as part of long lists of factors which contribute to diversity within communities. For example, it is an expectation that medical graduates will "respect all patients, colleagues and others regardless of their age, colour, culture, disability, ethnic or national origin, gender, lifestyle, marital or parental status, race, religion or beliefs, sex, sexual orientation, or social or economic status" (GMC, 2015a, p. 8). The NISCC standards for social care workers (NISCC, 2015a, p. 32) and social workers (NISCC, 2015b, p. 38) take this further with a "Glossary" which defines "Equality" as "Treating everyone fairly and ensuring they have access to the same opportunities irrespective of their race,

gender, disability, age, sexual orientation, religion or belief". This reflects the list of protected characteristics in the *Equality Act 2010* in England.

3.2 Disposition

Only three of the regulatory bodies included guidance in respect of awareness of their stance or disposition in relation to religion and belief. Pharmacy professionals in Great Britain should "recognise their own values and beliefs but do not impose them on other people [and] take responsibility for ensuring that person-centred care is not compromised because of personal values and beliefs" (GPC, 2017, p. 8). However, this is not required of pharmacists in Northern Ireland (PSNI, 2016). Only for optometrists and dispensing opticians was the possibility raised that this might involve referring a service user to a colleague when told that they need to "ensure that your own religious, moral, political or personal beliefs and values do not prejudice patients' care. If these prevent you from providing a service, ensure that you refer patients to other appropriate providers" (GOC, 2016, p. 21).

The consequences of imposing personal views on service users was more strongly emphasized by Social Care Wales who discussed disposition in a section on "Professional Boundaries" in each of its standards documents. While the wording differed slightly, the message to all workers was the same, i.e. "Some things clearly breach acceptable boundaries. Whilst not a complete list, unacceptable things include … using your personal beliefs, for example, political, religious or moral, in a way which exploits or causes distress" (SWC, 2018, pp. 9-10). The need to avoid distress was also a requirement for dental workers who are instructed that "You must

not express your personal beliefs (including political, religious or moral beliefs) to patients in any way that exploits their vulnerability or could cause them distress" (GDC, 2013, p. 15).

The most extensive guidance in respect of disposition was found in the regulations of the Nursing and Midwifery Council for registered nurses, which expire at the end of 2018. It is expected that of all nurses that

> They must be aware of their own values and beliefs and the impact this may have on their communication with others. They must take account of the many different ways in which people communicate and how these may be influenced by ill health, disability and other factors, and be able to recognise and respond effectively when a person finds it hard to communicate. (NMC, 2015b, p. 9)

For mental health nurses, this also includes the expectation that that they will use supervision to explore the impact of their own beliefs on their professional practice:

> have and value an awareness of their own mental health and wellbeing. They must also engage in reflection and supervision to explore the emotional impact on self of working in mental health; how personal values, beliefs and emotions impact on practice, and how their own practice aligns with mental health legislation, policy and values-based frameworks. (NMC, 2015b, p. 17)

In the field of mental health nursing, this need to reflect on one's own beliefs is not only for those involved in direct service provision, but also an imperative on the managers of clinical staff who should "actively promote and participate in clinical

supervision and reflection, within a values-based mental health framework, to explore how their values, beliefs and emotions affect their leadership, management and practice" (NMC, 2015b, p. 19).

The explicit requirement for nurses to reflect on their own beliefs was removed by NMC in its revised standards coming into effect in 2019. While there is an expectation that nurses can reflect on the circumstances of particular patients, arguably this reflection on beliefs is more appropriately categorized as required knowledge rather than disposition when "At the point of registration the registered nurse will be able to … provide and promote non-discriminatory, person centred and sensitive care at all times, reflecting on people's values and beliefs, diverse backgrounds, cultural characteristics, language requirements, needs and preferences, taking account of any need for adjustments" (NMC, 2015b, pp. 8-9).

3.3 Knowledge

As noted previously, the common standard for all professions regulated by the HCPC, except social work in England, was a need for knowledge of "religious and spiritual beliefs". Indeed, for many professions, this was the only regulation relating to religion and beliefs. Interestingly, in the standards for English social workers, the most recent standards published by the HCPC, the words "and spiritual" have been deleted (HCPC, 2017, p. 9). In respect of practitioner psychologists, the HCPC published two additional standards. The first, pertaining to all psychologists called for the need to "understand the impact of differences such as gender, sexuality, ethnicity, culture, religion and age on psychological wellbeing or behaviour" (HCPC,

2015, p. 8), whereas a requirement to "understand the spiritual and cultural traditions relevant" (HCPC, 2015, p. 15) was only a requirement for counseling psychologists.

For medical practitioners and midwives, this knowledge was not just for understanding but expected to be applied in practice. Hence, medical practitioners should be able to "interpret findings from the history, physical examination and mental-state examination, appreciating the importance of clinical, psychological, spiritual, religious, social and cultural factors" (GMC, 2015a, p. 5), whereas midwives are expected to "act on their understanding of psychological, social, emotional and spiritual factors that may positively or adversely influence normal physiology, and be competent in applying this in practice" (NMC, 2015a, p. 4). Subsequent more detailed guidance for midwives notes a requirement that they "Practise in a way which respects, promotes and supports individuals' rights, interests, offering culturally sensitive family planning advice; ensuring that women's labour is consistent with their religious and cultural beliefs and preferences; and the different roles and relationships in families, and reflecting different religious and cultural beliefs, preferences and experience (NMC, 2015a, p. 10)

Knowledge of effective practice which takes account of the beliefs of service users was also discussed in the regulations for domiciliary care workers published by Social Care Wales:

> Individuals expect you to respect their life choices, culture and beliefs. They expect you to try and understand their world from their point of view. You need to have a good understanding of the individual's background and which approaches will work. This is particularly

important where the individual is living with a condition such as dementia. (SWC, 2018, p. 11)

A few documents noted the need for knowledge of relevant legislation. For registered nurses, the requirements in force until the end of 2018 included knowledge as to “how their own practice aligns with mental health legislation, policy and values-based frameworks” (NMC, 2015b, p. 17). Standards documents from Social Care Wales for residential childcare workers, social care managers and social workers included the same statement relating to a specific piece of legislation, “The Equality Act 2010 [which] covers the following groups – age, disability, gender reassignment, race, religion or belief, sex, sexual orientation, marriage and civil partnership, and pregnancy and maternity” (SCW, 2017a, p. 14; 2017c, p. 13; 2017d. p. 13).

3.4 Skills

Although some mentions of knowledge were coupled with skills, standards which stated required skills did not necessarily include any statement as to the knowledge required, and vice versa. Implicit statements around knowledge underpin standards that call for “respect” such as the requirements for pharmacists from Northern Ireland to “respect diversity in the cultural differences, beliefs and value-systems of others and always act with sensitivity and understanding” (PSNI, 2016, p. 8) and for their peers elsewhere in Great Britain to “recognise and value diversity, and respect cultural differences – making sure that every person is treated fairly whatever their values and beliefs” (GPC, 2017, p. 8). Similarly, medical graduates are expected to “respect patients’ right to hold religious or other beliefs, and take these into account

when relevant to treatment options" (GMC, 2015a, p. 8). However, medical trainees are cautioned that these are not always relevant when it comes to treatment decisions. As such, they are required to "demonstrate that they are sensitive and respond to the needs and expectations of patients, taking into account, only where relevant, the patient's age, colour, culture, disability, ethnic or national origin, gender, lifestyle, marital or parental status, race, religion or beliefs, sex, sexual orientation, or social or economic status" (GMC, 2015b, p. 5).

The imperative is stronger for dental staff who are not called to passively respect differences but actively ensure they "must not discriminate against patients on the grounds of: age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief, sex, sexual orientation" (GDC, 2013, p. 14). Optometrists and dispensing opticians are also encouraged to "Promote equality, value diversity and be inclusive in all your dealings and do not discriminate on the grounds of gender, sexual orientation, age, disability, gender reassignment, marriage and civil partnership, pregnancy and maternity, race, religion or belief" (GOC, 2016, p. 21).

For both medical graduates and medical trainees, the need for respect does not just pertain to service users but also to colleagues and members of the wider community. For example, medical trainees are expected to "demonstrate respect for everyone they work with (including colleagues in medicine and other healthcare professions, allied health and social care workers and non-health professionals) whatever their professional qualifications, age, colour, culture, disability, ethnic or national origin, gender, lifestyle, marital or parental status, race, religion or beliefs, sex, sexual orientation, or social or economic status" (GMC, 2015b, p. 6).

Whereas medical practitioners are encouraged to be collegial, the new standards for nurses urge them to “provide leadership in the delivery of care for people of all ages and from different backgrounds, cultures and beliefs” (NMC, 2018, p. 3). This is a change from the earlier standards where a leadership role was identified only in respect of learning disability nurses who must be able to “take the lead in ensuring that people with learning disabilities receive support that creatively addresses their physical, social, economic, psychological, spiritual and other needs, when assessing, planning and delivering care” (NMC, 2015b, p. 16).

Not only should nurses be able to recognize ‘spiritual needs’ but also to prioritize these over other needs when required:

> Registered nurses prioritise the needs of people when assessing and reviewing their mental, physical, cognitive, behavioural, social and spiritual needs. They use information obtained during assessments to identify the priorities and requirements for person-centred and evidence-based nursing interventions and support. They work in partnership with people to develop person-centred care plans that take into account their circumstances, characteristics and preferences. (NMC, 2018, p. 13)

Yet only for occupational therapists is it made explicit that they need to “be able, through interview and personal discussion, to understand the values, beliefs and interests of service users, their families and carers” (HCPC, 2013d, p. 10). In addition to assessing needs and providing services to individuals, only standards published by Social Care Wales referred to the need to “promote equality of opportunity and inclusion” (SWC, 2017c, p. 13; 2017d, p. 13) for people of different

religions or beliefs and to "where appropriate, promoting and upholding the rights, values, beliefs, views and wishes of both individuals and carers" (SWC, 2017b, p. 9).

4 Implications for Practice

This study has found that there are widespread requirements that UK health and social care workers need to engage with religion and belief, with all regulators except the SSSC making some reference to them. Yet, while the existence of standards can lead to the view that issues have been addressed (O'Rourke, 2006), concerns about low levels of religious literacy are unlikely to be allayed by these findings, with many professions only required to meet standards in one of the four dimensions of Dinham's framework and only in the vaguest of terms. There are four specific issues which suggest this. First, the language relating to religion appears to be interchangeable and undefined, incorporating varying combinations of "religion", "belief", "spiritual", "values" and "worldviews" with no critical engagement with the meanings of each of these terms and where they differ. Second, there are no stated rationale for why and where these terms are used and on what basis they should differ between professions and settings. Third, knowledge is not specified, so there are calls for knowledge of "beliefs" (which ones?), "practices" (whose?), and "differences" (between what?). The requirement for knowledge of "effective practices" and "legislation" are more concrete but mostly still fail to point to which practices and laws in particular. Fourth, how knowledge should translate in to skills is left almost entirely unstated with references only to "respect" and "leadership",

though standards for occupational therapists provide a method, rooted in interviews and personal discussion with service users.

The presence of standards arguably says more about the images which professions and regulators are seeking to promote (O'Rourke, 2006) and therefore references to religion and belief do not necessarily amount to a commitment to developing religious literacy. This is particularly so when standards place the onus on individual workers to act in a prescribed manner without any requirement on funders or employers to ensure that they have the capacity to do so (Cook et al., 2017).

Standards supposedly provide measures against which regulatory bodies can assess whether a professional has breached their obligations and should be sanctioned (Jayaratne, Croxton and Mattison, 1997). However, the capacity of regulators to enforce standards is often limited by resources (Moran, 2001). Moreover, many of the standards in respect of religion and beliefs are characterised by a lack of clarity and specificity (Leka, Jain, Widerszal-Bazyl, Zołnierczyk-Zreda & Zwetsloot, 2011) and open to interpretation by individual practitioners:

> If the standards are vague and overbroad, professionals are left vulnerable to grievance claims. Practitioners may believe they are conforming to appropriate practice standards when in fact they are not, and judges or licensing boards may render judgments in the absence of specific standards, which is unfair to practitioners. Those who judge practitioners may be forced to impose de facto standards … to the detriment of the profession (Jayaratne et al., 1997, p. 188)

Regulatory standards tend to be developed in contexts in which there are multiple and often conflicting requirements of different stakeholders (Black, 2008). However,

it is unknown the extent to which the different standards for UK health and social care workers in respect of religious literacy reflect the views of an influential, but not necessarily representative, view as to what is required or if the standards are a compromise between differing viewpoints. Either way, the standards documents pose some interesting questions. For example, why is it that only mental health nurses are expected to be aware of the impact of their own beliefs on their practice, when arguably all nurses need to be able to do this? The same document also only requires learning disability nurses to take account of the spiritual needs of individual service users but does not have this requirement more generally for nurses (NMC, 2015b). Comparison across the standards published by the HCPC similarly poses questions about why it is that only occupational therapists need the capacity to discuss religion and beliefs with service users (HCPC, 2013d) or counselling psychologists who should be able to understand relevant spiritual traditions (HCPC, 2015).

For regulatory bodies, employers and service users, each of whom might deal with several professionals, having shared expectations makes sense. Furthermore, it can also assist in the process of gaining legitimacy for standards (Leka et al., 2011). However, the tendency to genericism in the HCPC standards also leads to some important omissions, such as no recognition of religious issues in respect of diet, food and drink. These can be highly significant issues for patients and service users and at the very least one might expect that there might be a standard for dieticians, and possibly some other professions.

It has recently been proposed that it is not just religious literacy but religious 'expertise' which is required in civil society (Lewis, 2018, p. 97). However, to date,

although most of the regulatory standards for UK health and social care workers include cursory mentions of religion and belief, on the whole they fall significantly short of religious literacy as it is understood in the framework. Alternate ways of analysing standards would likely have produced a similar conclusion about the overall level of religious literacy. As noted earlier, Castelli (2018) has proposed the need for “religious literacy” and “religious oracy” but many of the standards reviewed in this research would fail to meet even these two criteria. Similarly, while several of the standards would make some contribution towards one of Moore’s (2006) two dimensions of religious literacy, i.e. knowledge of major religions, none of these addresses her other dimension concerned with an understanding of the role of religion in society.

It would appear that the regulatory standards are beginning to recognise that some degree of religious literacy is required for a diverse range of UK health and social care professionals. But they remain too vague and inconsistent to have real traction in practice. They are silent on the question of what counts as religion or belief or how to think about them. Likewise there is very little requirement to develop a reflective, self-critical awareness of one’s own stance, though there are a number of requirements to avoid imposing one’s own religion or belief on service users. The knowledge and skills required are implicit rather than being specific. Consequently, adherence by professionals of various regulations is likely to be highly dependent on the interpretations of individual workers and their managers as to what is required of them (Furness and Gilligan, 2010). Lack of specificity also results in it being difficult for regulatory authorities to enforce requirements and consequently limits the extent to which any regulations mentioning religion can be protective of service users.

Including references to religion and belief in standards is likely to be insufficient on its own to create a religiously literate workforce. However, it is an important step in signalling to health and social care workers that engaging with religious beliefs and practices may be essential for effective practice with service users. Research is needed to explore the understandings of British health and social care professionals as to the regulations which pertain to religion and the tensions experienced by practitioners as they seek to be religiously literate practitioners. For example, professional values may appear to be in conflict with some religious viewpoints, e.g. around gender roles, sanctity of marriage or acceptance of violence and abuse as normative (Crisp et al., 2018).

Recognition by regulators that health and social care professionals require some religious literacy is only in the realm of aspiration if practitioners are not provided the tools for training and practice which the standards presume they possess. Regulatory bodies and providers of professional education need to work together to ensure that future graduates are able to meet the regulatory standards. Furthermore, given that current practitioners may have had little or no opportunity to develop religious literacy during their professional training or subsequently (Whiting, 2008), consideration is required as to what continuing professional education modules might be made available around religious literacy for health and social care practice.

5 Standards documents

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Table 1. Regulatory standards by occupation and place: Stated requirements for religious literacy by category

Occupation	Place	Categorisation	Disposition	Knowledge	Skills
Arts therapists	UK	No	No	Yes	No
Chiropodists and podiatrists	UK	No	No	Yes	No
Dental workers	UK	No	Yes	No	Yes
Dieticians	UK	No	No	Yes	No
Domiciliary care workers	Wales	No	Yes	Yes	Yes
Hearing aid dispensers	UK	No	No	Yes	No
Medical graduates	UK	No	No	Yes	Yes
Medical trainees	UK	No	No	No	Yes
Midwives	UK	No	No	Yes	Yes
Registered nurses (until end 2018)	UK	No	Yes	Yes	Yes
Registered nurses (from 2019)	UK	No	No	Yes	Yes
Occupational therapists	UK	No	No	Yes	Yes
Optometrists and dispensing opticians	UK	No	Yes	No	Yes

Orthoptists	UK	No	No	Yes	No
Paramedics	UK	No	No	Yes	No
Pharmacy professionals	England, Scotland and Wales	No	Yes	No	Yes
Pharmacists	Northern Ireland	No	No	No	Yes
Physiotherapists	UK	No	No	Yes	Yes
Practitioner psychologists	UK	No	No	Yes	No
Prosthetists/Orthotists	UK	No	No	Yes	Yes
Radiographers	UK	No	No	Yes	Yes
Residential childcare workers	Wales	No	Yes	Yes	Yes
Social care worker	Wales	No	No	No	Yes
Social care worker	Northern Ireland	No	No	No	Yes
Social care manager	Wales	No	Yes	Yes	Yes
Social worker	England	No	No	Yes	No
Social worker	Northern Ireland	No	No	No	Yes
Social Worker	Scotland	No	No	No	No

Social Worker	Wales	No	Yes	Yes	Yes
Speech and language therapists	UK	No	No	Yes	No