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Frames for the Future: Developing Continuing Education & Professional Development Programs for Spiritual Care Practitioners: A Perspective from Victoria, Australia

Shinen Wong
Spiritual Health Victoria, Australia

Heather Tan
Spiritual Health Victoria, Australia

Abstract
This article examines the educational issues in ongoing professional education for spiritual care practitioners. A meta-evaluation of registration and evaluation data over four years (between 2013 and 2016) of one such monthly program conducted by Spiritual Health Victoria (Australia) will be examined. Recommendations are made to support healthcare managers and spiritual care educators in designing and developing continuing education programs for spiritual care practitioners in a variety of other professional health and care contexts.

Keywords
Spiritual care, Australia, professional development, continuing education, professionalization, pastoral care

Introduction

Spiritual Health Victoria (SHV) is a registered, not-for-profit peak body funded by the Victorian government Department of Health and Human Services working in the state of Victoria, Australia, to enable and to maintain high quality, compassionate and person-centered spiritual care in hospital, health service and welfare contexts. SHV has worked in collaboration with our faith community members, spiritual care practitioners and health services in Victoria for over 40 years.[1]

One of SHV's key deliverables is a monthly professional development program for Spiritual Care Practitioners (PDP). The PDP is managed by the primary author of this article, who is supervised by the secondary author; this program is conducted by SHV in association with the Victorian chapter of Spiritual Care Australia (SCA Vic)[2] and the Association for Supervised and Clinical Pastoral Education in Victoria (ASACPEV).[3] Unless otherwise stated, in the PDP, as in this article, we use the term 'spiritual care practitioner' as an umbrella term which includes pastoral care workers, hospital chaplains, faith-specific community representatives, and other affiliated care specialists who provide spiritual care within hospitals and the broader health care system.

Various iterations of the PDP have been run in Victoria by SHV (which includes our organizational predecessors, prior to constitutional and/or organizational name changes, etc.) since the 1970s. This article will discuss the educational and managerial issues of running the PDP from the authors' perspectives as professionals who have inherited the management of the program since 2014. In addition, data collated from registration forms and evaluation between the years of 2013 to 2016 will be reflected alongside discussion of educational issues. At the end, we provide recommendations for improving ongoing design of continuing education professional development programs

Corresponding author:
Shinen Wong, Spiritual Health Victoria, PO Box 396 Abbotsford, Victoria 3067, Australia.
Email: educationofficer@spiritualhealthvictoria.org.au

for spiritual care practitioners, which may be of relevance for healthcare and educational professionals, managers and spiritual care practitioners in a wider range of contexts than just our own.

Contexts, Contexts

Professional Development and Continuing Education in Spiritual Care

There is a wide range of literature covering spiritual care training for broader community and health professionals (Daaleman, 2012), including nursing (Bradshaw, 1997; Attard, Baldacchino & Camilleri, 2014; Carron & Cumbie, 2011), aged care (Wilkes, Cioffi, Fleming & LeMiere, 2011), palliative care (Otis-Green et al., 2012; Puchalski et al., 2009), and mental health (Goncalves, Lucchetti, Menezes & Vallada, 2015).

While much has been written about the importance and relevance of spiritual care per se (Puchalski, Vitillo, Hull & Reller, 2014), including the need for trained spiritual care specialists in healthcare settings, there has been comparatively little written about what continuing education for practicing professional spiritual care practitioners can look like. Two notable exceptions include those which focus on the practical and ethical issues of how spiritual care practitioners are to document in medical records (Handzo, 2011; Glenister, 2011), and a 2009 survey of USA-based chaplains, pastoral counselors and clinical pastoral educators which included questions on continuing education (Montonye et al., 2010).

In the latter survey, which had 2030 respondents, practitioners overwhelmingly and conclusively ranked continuing education as among the most important activities that spiritual care practitioners should be engaged in, with 91% of respondents reporting that their cognate groups would be strengthened with in-person continuing education events (Montonye et al., 2010, p.3). However, little else has been written on what this could look like programmatically, and the survey gives little indication as to what examples of education the respondents are already getting, either on ad hoc or ongoing bases. This article attempts to bridge the gap in the literature by reflecting on our professional development program for spiritual care practitioners as a case example of an ongoing program in this field, as part of the process of professionalization.

In the Australian context, Spiritual Care Australia (SCA), the peak national membership body for spiritual care practitioners, endorses that spiritual care practitioners must undergo a minimum of 25 hours a year of ongoing professional development for full time employees and 12 hours a year for part time employees, to maintain their professional qualification and to continue practice. They also must attend up to 10 hours of supervision depending on their pro rata working hours (Spiritual Care Australia, 2013).

In his piece "Are Health Care Chaplains Professionals?" Woodward (2001) writes "pastoral care has increasingly assumed the form of a modern profession, with the emergence of national professional societies, the promulgation of standards, the accreditation of training programmes and certification of pastoral care givers" (p.91).

In turn, one of the operating assumptions of the PDP is to support spiritual care practitioners in negotiating the tensions

> between the expectations of the more secular professional groups within the health care organisation on one side, and the expectations of more theologically orientated religious communities on the other [which presupposes that] pastoral care is [in significant part] a religious activity and therefore its special body of knowledge, to a significant degree, is religious knowledge . . . [where, in] terms of standards, religion does not qualify as public truth but only as private belief. (Woodward, 2001, p.91)

As part of the PDP, we understand professionalization to be a way for spiritual care practitioners to increase their skills in negotiating the above tensions, while meeting the minimum standards set by our national membership body. The PDP supports professionals in maintaining their accreditation, and creates opportunities to develop skills, explore issues, share perspectives relevant to their care practice, and network with extended colleagues from across the state of Victoria.

Victorian Demographics

The most recent demographic data on the Australian population that we have have been sourced from the Australian Bureau of Statistics (2017) Census of Population and Housing between 2006 and 2016.

These data indicate that Christianity remains the most commonly reported religion in Australia (at 52.1% in 2016), though the proportion of Christians has been significantly decreasing (down from 61.6% in 2011). The two largest non-Christian religions reported in Australia are Islam (2.6% of all Australians, and 3.3% of all Victorians) and Buddhism (2.4% of all Australians, and 3.1% of all Victorians). From this, we can also see that both Islam and Buddhism are disproportionately represented in the state of Victoria compared to the rest of the country. Hinduism, at just 1.9% of the total Australian population, has nonetheless seen the fastest rate of increase of all religious groups since 2006. On the other hand, the fastest rate and total population increase overall is of people who identify with "No religion" (18.7% of Victorians in 2006 to 32.0% in 2016).

We can contrast this with the reported religious demographics of participants in our PDP, who are predominantly Christian, with small but increasing numbers of attendees

from non-Christian backgrounds. The current demography of Victorian practitioners who attend the PDP reflects the history of spiritual care as it has historically been rooted in Christian-based pastoral care and chaplaincy, alongside the evolving strategic direction of the PDP's managing organization Spiritual Health Victoria, as we move increasingly toward inclusion and pluralism.

Structure of the Professional Development Program

For Spiritual Care Practitioners

The PDP runs on an annual basis starting in March each year and comprises eight or nine sessions held on the second full Wednesday of each month. The program is held at a different hospital or care facility each month. Between 30 and 50 spiritual care practitioners from health and care contexts (e.g. hospitals, aged care, palliative care, etc.) come from across Victoria to participate in the PDP at these host sites. The program includes two parts, divided into morning and afternoon sessions.

A typical month's program structure looks like this:

MORNING SESSIONS (EDUCATION)

9.30am	Arrivals and Morning Tea
10am	Contemplation, prayer, meditation, ritual and reflections *This session is led by the particular host site's pastoral/spiritual care team*
10.30am	Announcements from SHV and SCA Vic
10.45am	Guest Presentation Presenters are either particular invited guest educator or a panel of speakers
12noon	Q&A
12.15pm	Lunch

AFTERNOON SESSIONS (CLINICAL SUPERVISION)

The afternoon sessions are reserved for peer groups and clinical supervision, led by appointees of ASACPEV. Since 2016, we have included a casual facilitated reflection group, for people who may not have enrolled for clinical supervision but who may nonetheless wish to discuss and reflect on the morning education session with colleagues.

1pm	Clinical Supervision Groups *(and facilitated reflection group since start of 2016)*
2pm	Breathing Space
2.15pm	Pastoral Groups
3.15pm	Supervisors' Group

Registrations

There are two kinds of registrations: Individual and Institutional.

Individual registrations. Individual registrants are further broken down into two possible categories: Annual Registrants and Casual Registrants (since 2015).

a. Annual registrants. In this option, individual registrants for the PDP may choose to attend *either*:

i. The whole day program (morning education + afternoon clinical supervision), *or*
ii. The morning education sessions only.

Afternoon sessions are *clinical supervision sessions*, coordinated by ASACPEV, held in small groups and include peer reflection on pastoral ministry reports, with supervision by accredited supervisors appointed by ASACPEV. These sessions include sharing matters of spiritual concern and pastoral ministry with the group, according to terms set within a Clinical Pastoral Education (CPE) model. Annual individual registrants who choose the whole day option are assigned a particular supervision group, with whom they will remain as a single cohort for the whole year.

b. Casual registrants. In this option, individual registrants for the PDP apply on a month-by-month basis.

Prior to 2015, registrants for the PDP were de facto annual registrants. Since 2015, the option for month-by-month casual registrations has been formally introduced and included as an option.

This option is useful for individuals and organizations who have resource- or time-based constraints; resources can thus be allocated to professional development for particular practitioners who are interested in the specific content of a particular months' morning education session. These casual registrants are not eligible for afternoon clinical supervision groups. Instead, they are invited to attend a *facilitated reflection group* in the afternoon, along with other casual attendees, and with institutional registrants.

Institutional registrations. Eligible organizations can apply for this option. These may include spiritual/pastoral care departments, faith community organizations, and other affiliated

health and care organizations who have spiritual care practitioners requiring professional development. Appointed members of staff from the registering institution will be eligible to attend the morning education sessions for a total of eight attendances in the year. Different staff from the registering institution may be allocated to different months.

Since 2015, institutional attendees have also been invited to attend the afternoon facilitated reflection group at no additional cost. This group is intended for institutional attendees and other casual individual registrants to discuss the morning education session, and any implications for work practice.

Attending the afternoon facilitated reflection group is optional, both for individual casual registrants and for institutional attendees. Additionally, while we absolutely stress the importance of clinical supervision as an integral aspect of the professional development of spiritual care practitioners, for the purposes of this article, we will be focusing our analysis on a review of the morning education sessions only.

Management of the PDP

Our most recent organizational predecessor was the Healthcare Chaplaincy Council of Victoria (HCCVI). In 2014, we changed our name to Spiritual Health Victoria (SHV). This name change reflects our strategic decision to expand upon our constitutional mandate, historically rooted in ecumenical Christian approaches, to work more inclusively in the evolving professional field of spiritual care, particularly with peak faith community councils in Victoria, attending to demographic change.

The authors of this article inherited management of the PDP in 2014. At the time, program decisions for the PDP were determined by a small group of about six program participant-representatives, along with the then HCCVI appointed staff member. This group of participant representatives would make decisions on the program during the lunch break of each month's program.

Since 2015, the PDP has undergone an intentional and significant change management process. This was in response to the relative lack of transparency around decisions on program curriculum and choice of guest presenters and the relative lack of clarity on the roles and responsibilities of our associated organizations (SCA Vic and ASACPEV). This ongoing change management process consolidates SHV's strategic intention to shift from Christian-based pastoral care education for practitioners, to more multi-perspectival professional education that would be accessible to practitioners from a more diverse range of backgrounds, regardless of their cultural or faith affiliation(s).

Currently, primary responsibility for the management of the PDP remains with the appointed representative(s) of SHV, the authors of this article. At the same time, decision-making is now held by a steering committee, comprising people who fill ten different strategic positions.

These representative positions are from:

a. SHV × 2 (the authors of this article)
b. SCA (Vic) × 2
c. ASACPEV × 2
d. Ordinary participants from the PDP × 2
   [Ordinary participant representatives are democratically elected for a two-year term on the steering committee by broader PDP participants. The first election took place at the end of 2015, for the first PDP steering committee formed in 2016.]
e. Under-represented (non-Christian) groups × 2
   These two current representatives have been nominated through SHV's Council members, who include peak faith community councils in Victoria. For this initial 2-year term of the new steering committee, SHV proposed one nomination from each of the two largest non-Christian faith communities in Victoria; Buddhist and Muslim. We invited the Buddhist Council of Victoria and the Islamic Council of Victoria to each nominate a spiritual care representative from their community to be a part of the steering committee, to support in ongoing design and decision making around the program.]

This new steering committee has met on a quarterly basis since 2016. All committee members are expected to regularly attend the morning education sessions of the PDP, support in promotions, remain attuned to the broader systemic, cultural, economic, political and health sectoral currents which impact on the design and delivery of the PDP, and to be a part of strategic planning of each following year's curriculum. The impetus here has been to support increasing perspectival diversity in terms of culture, faith and professional history, in terms of curriculum and governance.

Data Sources for this Article

The analysis featured in this article is based on qualitative and quantitative data from the PDP, collated between 2013 and 2016. This analysis reflects the authors' experience in design, development, delivery and management of adult education programs.

To the credit of the Victorian Council of Churches (compared to the equivalent peak Christian organizations of the other states/territories), their progressive theologies meant that they were willing to actively divest themselves of Christian privilege and control to ensure that the future of spiritual care would be de-Churched, and that accountability would be to health systems and patients, rather than to some institution of God per se.

The first of the non-Christian organizations in Victoria to specifically develop a spiritual care volunteer and professional development program was the Buddhist Council of Victoria, who were then later followed by other faith organizations

(e.g. Islamic Council of Victoria, Hindu Community Council of Victoria, Sikh Interfaith Council of Victoria, etc.). All this occurred in collaboration with our organization, which is the state peak body overseeing ongoing professional development through these partnerships.

So it is strange to sit at this juncture in the evolution of a profession, especially when the fastest increasing demographic of the community at large is those who are atheistic/agnostic or non-religiously affiliated (while Christianity is proportionately decreasing, and Hindus are the fastest growing religious community according to the census).

PDP data has been collated from two primary sources:

1. Participant registration forms
2. Month-by-month Evaluation forms

Evaluation forms, which include both qualitative and quantitative information, are collected and collated after the morning education sessions.

Both forms ask participants for gender identity, religious affiliation and workplace. Post-evaluation forms solicit comments on learning and satisfaction from the day's programs, including the morning prayer and reflection sessions hosted by the host site's pastoral/spiritual care team.

Data analysis will be accompanied and followed by discussion and recommendations on further development of the PDP, and indeed, of other continuing professional education programs for spiritual care practitioners.

Limitations of the Data

There are a few limitations to our data sets.

a. Not all monthly attendees either fill out or return their evaluation forms.
b. Not all monthly attendees have registered for the PDP (either for the full year or as casual registrants for that particular month)

These may include individuals who may have been invited by the hosting site. These may include CPE students, other spiritual care practitioners from the hosting site team, or occasionally medical staff from that particular host hospital who have an interest in the topic.

c. Casual, institutional, and individual annual registrants are not differentiated in evaluation form responses
d. Demographic details of institutional representatives are not collected during the registration process (as the institutionally-nominated representative may vary from month to month)
e. We have not collected data on cultural identity or on the age of registrants/participants
f. Data is limited to the morning education sessions, and does not include information about afternoon clinical supervision or facilitated discussion sessions.

Again, while we stress that supervision is essential for professional practice, this article will focus on an analysis of the data from morning education sessions and will be specific to the PDP.

PDP Demographics

Over the period of 2013 to 2016, we had a total of 94 unique individual registrants (annual and casual) and 23 different unique institutional registrants to the PDP, totalling 117 unique registrants over four years. As mentioned in the data limitations section above, this number does *not* include attendees who may have been present as participants from the hosting hospital venue (e.g. other staff, CPE students, etc.), nor specific, named appointed representatives from institutional registrations.

Registrations

Table 1 shows Registrations for the PDP.

We note that individual annual registrants have remained approximately the same each year averaging 33 people per year. Institutional registrations have increased (from 9 in 2013 to 14 in 2016). All of this averages out at approximately 44 total annual registrants (not including individual casual registrants) per year.

Individual casual (month-by-month) registrants have also been incrementally increasing since this option was formally introduced in 2015, increasing by 165% between 2015 and 2016.

This trend may reflect the relative accessibility of the institutional and casual options for registrants who may be unable to commit to the full year, while also being a vehicle or stepping stone for new practitioners to test the waters of the PDP. This way, they can decide for themselves, given the challenges for practitioners in getting the amount of time they would ordinarily need for a monthly program, if they may wish to commit more fully to future years' programs. As an added incentive, this also keeps open the possibility of regular clinical supervision for them in the future.

Gender

Table 2 provides a breakdown of PDP participants by gender.

Gender of nominated institutional representatives are not reflected here. We can see in Table 2 that the PDP is disproportionately attended by women. There is a correlation between the new option of casual registration (starting in 2015) and the proportionate increase of men since then. In 2013–2016, in terms of *unique individuals* that have been accounted for via the registration process (n=94), just under one in five participants in the PDP (n=18) have been men.

Table 1. PDP registrations.

YEAR	2013	2014	2015	2016	TOTAL (2013–2016)
Individual Registrants					
Annual	31	35	34	30	94
Casual (since 2015	N/A	N/A	17 (over 21 sessions)	28 (over 30 sessions)	45 (over 52 sessions)
TOTAL INDIVIDUAL	31	35	51	58	94
Institutional Registrants					
Institutions	9	12	11	14	23
PDP Totals					
TOTAL	40	47	45	44	115
PDP ANNUAL (Individuals + institutions)			62 *(including casuals)*	72 *(including casuals)*	

Table 2. Gender of individual registrants.

YEAR	2013	2014	2015	2016	TOTAL (2013–2016)
Men	5	5	9	13	18
Women	26	30	42	45	76
TOTAL Individual Registrants	31	35	51	58	94
Percentages					
% Men	16.1%	14.3%	17.6%	22.4%	19.1%
% Women	83.9%	85.7%	82.4%	77.6%	80.9%

In April 2016, after a PDP education session on working with people from gay, lesbian, bisexual, transgender and intersex (GLBTI) backgrounds, the PDP steering committee decided that we would start collating gender differently in both our registration and evaluation forms, changing the "M" and "F" options to a blank line for participants to write in their own gender identity. It remains to be seen how this may influence gender identification for PDP participants from 2017 onwards.

Religion

Table 3 provides an outline of the religious background of PDP participants.

In Table 3, we can see that attendees have been overwhelmingly Christian, approximately four out of five registrants (81.9%) over the 4 years covered. At the same time, the proportion of Christian participants has been decreasing since 2013, when 31 out of the 32 attendees (96.8%) would have reported a Christian background. As with gender, a notable demographic shift occurred alongside the introduction of the casual month-by-month registration option in 2015, and the emerging shift in governance forms (which became consolidated in 2016 as the new steering committee). From 2015 onwards, more practitioners from non-Christian backgrounds started joining the PDP. This may reflect the accessibility of the casual registration option, when people from both under-represented and under-resourced faith communities are able to address their continuing professional education needs, while the curriculum itself, driven by the steering committee at a governance level, is increasingly reflective of a transparent and strategic inclusion of non-Christian perspectives.

Other factors to consider are those who are identifying with more than one religion. One participant in particular, since 2016, has begun identifying both as Christian and as "Zen" (which we have classified as Buddhist). Dual (or more) reported faith identities by any single registrant will influence how we collect and interpret data for the future.

Another participant, in 2013, began first identifying with the Uniting Church, before switching in 2016 to "Christian – Progressive" (which we have classified above under "Christian"). In 2016, one participant registered as "Wobbly Catholic" (recorded here as "Catholic").

Professional Contexts

The 115 total known individual and organizational registrants between 2013 and 2016 (Table 1) have been affiliated with 133 professional contexts in providing spiritual care (Table 4). If a single individual has worked for more than one institution (e.g. two different public hospitals), this has been counted twice. If two different individuals work at the

Table 3. Religion of PDP participants.

YEAR	2013	2014	2015	2016	2013 - 2016
TOTAL INDIVIDUAL	31 (96.8% Christian)	35 (94.3% Christian)	51 (82.4% Christian)	58 (82.8% Christian)	94 (81.9% Christian)
Christian	30 of whom: 7 Anglican 4 Baptist 7 Catholic 5 Uniting Church 2 Lutheran 4 "Christian"	33 of whom: 1 Anglican 4 Baptist 3 Catholic 1 Uniting Church 2 Lutheran 7 "Christian"	42 of whom: 7 Anglican 5 Baptist 10 Catholic 4 Uniting Church 2 Lutheran 12 "Christian" 1 Pentecostal 1 Presbyterian	48 of whom: 6 Anglican 4 Baptist 13 Catholic 2 Pentecostal 5 Uniting Church 1 Lutheran 2 Seventh Day Adventist 1 Church of Christ 1 Christian Science 13 Christian	77 of whom: 2 Seventh Day Adventist 1 Church of Christ 1 Christian Science 11 Anglican 8 Baptist 20 Catholic 3 Pentecostal 1 Presbyterian 8 Uniting Church 3 Lutheran 17 "Christian"
Jewish	1	1	3	3	4
Buddhist			2 of whom: 1 Zen 1 "Buddhist"	2 of whom: 1 Zen 1 "Buddhist"	3 of whom: 1 Zen 2 "Buddhist"
Muslim				2	2
Interfaith			1		1
Siddha Yoga			1	1	1
Unstated		1	3	4	7
Spiritual				1	1

Table 4. Professional Contexts of Participants (and of Registered Institutions).

Total = 133	Public Hospital	Private Hospital	Aged Care	Mental Health	Palliative Care	Religious / Congregational Care	Other	
Individual Registrants	66	18	7	4	3	7	5	
Institutional Registrants	13	3	3	0	0	2	2	
Individual + Institutional	79 *(59.4%)*	21 *(15.8%)*	10 *(7.5%)*	4 *(3%)*	3 *(2.3%)*	9 *(6.8%)*	7 *(5.3%)*	TOTAL = 133

same hospital, this is also counted as two different instances (Table 4).

A little more than half of participants (59.4%) work from public hospitals, followed by private hospitals (15.8%), and then aged care facilities (7.5%). The category "Religious / Congregational Care" includes individuals who are (at least partially) commissioned by specific religious communities to provide or coordinate spiritual care in hospitals (e.g. Lutheran Church representatives, or the chaplaincy coordinator for the Anglican Archdiocese), or who provide spiritual care within their own religious/faith community (e.g. a participant who works only within one particular Presbyterian church).

Of the nine individuals who provide religious care, two are from the Islamic Council of Victoria, and one is from the Buddhist Council of Victoria.

The 'Other' category includes representatives from disability service organizations, youth organizations, homelessness services, and one academic representative from a department of health ethics at a Victorian university.

Program Design: Discussion and Recommendations

This section provides a discussion of the program design, with recommendations for ongoing improvement of the PDP. These recommendations are based on analysis of the available literature, demographic data, and the qualitative feedback from PDP evaluation forms, which reflect participant responses to the morning education sessions.

Role of the Spiritual Care Practitioner

The use of the term 'spirituality' in spiritual care to refer to a values-driven exploration of a person's meaning-making in the midst of suffering, illness and death suggests that the role of spiritual care practitioners in hospital settings is both *dialogical* (as in via dialogue; i.e. a professional relationship between carer and patient) as well as *phenomenological*. For the latter, this is defined as the systematic and reflective methods that spiritual carers employ to attend to their own direct experience, subjectivity and structures of conscious experience (Menon, Sinha & Sreekantan, 2014, p. 172).

Wesley Carr frames some of the aspects of the responsibilities of spiritual care practitioners as the role of "Arbiter", "Facilitator" and "Interpreter" (Carr, 2001, pp. 29–30).

In order to enable high quality care in these senses, it may be helpful to briefly explore what these terms mean. In this case, spiritual care, rather than being directive, prescriptive or monological, is instead constructed as a form of arbitration, facilitation and interpretation, a process that is necessarily relational and dialogical. This is particularly an applied set of skills between patient and hospital staff (including medical specialists), between a patient's need for spiritual or religious specificity while within the context of a secular public health system which centralizes biomedical responses to illness, and indeed, perhaps even more fundamentally, in being an arbiter between the "other" (e.g. patient) and oneself (as a spiritual care practitioner). Spiritual care is, in significant part, the facilitation of a relationship in which inquiry into existential questions around suffering, illness, death and dying are given sincere and just consideration.

How is one inducted into this form of arbitration, facilitation and interpretation?

Linda Ross argues that, following the period of the European enlightenment in the 18th century,

> with the escalation in medical research and knowledge, care of the body and soul became separated. Greater emphasis was placed on disease processes and treatment that relied heavily on objective, measureable data and the attention given to the soul declined. Thus the biomedical model emerged with its focus on the physical processes of disease. (Ross, 2010, p. 6)

Here, Ross suggests the limitations of biomedical models of health in the reduction of the person to being a composite of "physical processes". The biomedical model has "failed to acknowledge the important part that other factors, such as the psychological, spiritual, social and individual, have on disease and illness" (Ross, 2010, p. 6).

Fortunately, some of the ways that this "failure of acknowledgement" has been addressed in other public health frameworks have been quite successful. For example, the emergence of the professionalization of health promotion as a method of public health practice is driven by attention to the social, cultural, political and environmental determinants of health, as described by the World Health Organization (WHO) (2015).

The first international conference on health promotion was held in 1986 in Ottawa, Canada, which led to the production of the first document intended to consolidate global health promotion responses, called the Ottawa Charter for Health Promotion (World Health Organization, 1989). The Charter defines the "fundamental conditions and resources for health" as being:

- peace,
- shelter,
- education,
- food,
- income,
- a stable eco-system,
- sustainable resources,
- social justice, and equity

The WHO elsewhere formally recognizes spiritual care as an integral part of health care in the International Classification of Diseases, version 10 (ICD-10). The ICD-10 the "standard classification scheme now used for reporting diagnoses in all Hospital statistical collections." The latest Australian Modification (ICD-10-AM) (Australian Government Department of Health, 2000) explicitly identifies five particular activities as integral parts of care in hospitals, which are largely conducted by spiritual care practitioners (Australian Consortium for Classification Development, 2017):

1. 96186-00: Spiritual Assessment
2. 96087-00: Spiritual counselling, guidance or education
3. 96187-00: Spiritual Support
4. 96240-00: Spiritual Ritual
5. 95550-12: Allied Health Intervention, Spiritual Care

We contend that spiritual care requires working both with others and with self, with others via the self, and with the self via others, as part of the circuitry of person-centred care. We therefore understand dialogical and phenomenological skills as essential components of this process in this induction into being "arbiter, facilitator and interpreter", or a spiritual care practitioner.

Professional Education

In the development of the PDP we have worked intentionally to deepen both theoretical and skill-based learning for spiritual care practitioners to ensure best practice among practitioners with patients, their loved ones, and their multidisciplinary care team. One issue in ongoing education is that the development of standards for best practice in this work is under-resourced, inconsistent, and often not (yet) explicitly applied to existing service standards (Cobb, 2001). Additionally, the professional field in the Australian context has its roots in Christian-specific language (e.g. "pastors" and "chaplains"), Abrahamic theologies, industrialized and post-industrial models of health care provision, and ongoing reliance on Church funding in the provision of spiritual care (including care for non-Christians).

As mentioned at the beginning of this article, with the rapidly changing religious and cultural demographics of the broader Australian population and of Victoria in particular, there has been a corresponding commitment, at all levels of the health sector, to properly attend to these shifts, a corresponding impetus to improve upon existing education and induction into basic spiritual health frameworks and basic spiritual care as a minimum integral part of the practice of health professionals. This properly reflects and accommodates the increasing diversity of the constituent population accessing health and care services.

At the same time, part of what has also been true, as reflected in our literature review, is the relative paucity of professional development for *spiritual care practitioners* as *professional health specialists* who, like other professionals within the health system, require continuing education.

In addition to adapting or designing new curricula, we argue that part of what is required in the development of professional education is some training in cultural change management, so as neither to alienate nor marginalize the significant cohort of Christian elders and leaders, who have been foundational to the field work for many decades, and who hold a significant amount of institutional, cultural and professional memory on behalf of the evolution of the sector. At the same time, we must also attend to these practitioners' evolving practice needs within hospitals and health networks in response to broader cultural, political, systemic, spiritual and demographic shifts.

As a case example, drawing from the PDP evaluation forms of May 2014, participants expressed a range of responses toward the guest presenter's specifically Jewish cultural and religious perspectives on the issue of family violence, which was the topic for that month.

- Was not expecting the Jewish focus, but really appreciated that. Connections across all faiths.
- I hadn't realised the topic "family violence" would have such a Jewish focus (it wasn't listed as such on the program) but much of what was raised resonates with the issue of family violence in general (e.g. Fear, shame, etc.)
- Great talk; this is not a criticism but I wasn't aware that the talk was going to be so selective from a Jewish perspective. I was expecting a more mainstream approach - I may have misunderstood, but I was not disappointed

We can read these as particular participants working through their ambivalence about moving out of a familiar, hegemonic and normatively Christian approach to the program, as indicated by the grammatical structure of "Jewish, but good", as if "...but good" was a necessary exceptional qualifier for "Jewish".

As another case example, in September 2014, the two guest presenters, who were both Christian, spoke about their experiences running Buddhist-specific and Jewish-specific CPE programs. One of the Christian participants for this month's program wrote in their evaluation form, "I thought this was only for Christians???" On the other hand, for this same month, another Christian participant wrote a much more deliberately favourable perspective on the involvement of non-Christians in the program, "I would have appreciated more Jewish and Buddhist components to the [morning reflections session] in keeping with our theme, and more silent reflection in between."

We affirm that Christian-specific models of professional spiritual care training remain relevant for training practitioners of Christian religious care, as under the umbrella of "spiritual care" per se. At the same time, as a state-funded organization providing education for practitioners within non-religious health services, we also note the importance for us to focus on developing pluralistic models of continuing professional education. We support practitioners in adapting to the cultural, linguistic and psycho-spiritual needs of new generations of people from all walks of life who profess a plurality of faith affiliations and spiritualities, including those who claim non-religious affiliation (as the fastest increasing group of people in Australia). What are the competencies required for this new world?

Existing ongoing education for best practice for practitioners as defined by the SHV Capabilities Framework include:

1. Developing *phenomenological capacity*
2. Developing *multicultural / systems thinking competencies*
3. Induction into the ongoing development of *competency standards*

We will define these and examine how each of these are currently addressed by the existing PDP, and will make recommendations for how each of these may be improved in the ongoing development of professional education.

1. Developing Phenomenological Capacity

The Stanford University Encyclopaedia of Philosophy describes phenomenology as

> [a] discipline of [that] may be defined initially as the study of structures of experience, or consciousness. Literally, phenomenology is the study of 'phenomena': appearances of things, or things as they appear in our experience, or the ways we experience things, thus the meanings things have in our experience. Phenomenology studies conscious experience as experienced from the subjective or first person point of view (Stanford University, 2013).

In the context of spiritual care, phenomenological capacity can be defined as the capacity to remain present to our own moment-to-moment experience, bringing critical affective capacity to the study of our own subjectivity, as a precondition of attending to others' existential concerns in challenging and complex hospital settings. Certain forms of group-based reflections, journaling, and training in contemplative, reflective, prayerful and meditative capacities (rather than, say, theological sophistication), including mindfulness-based awareness practices (Kabat-Zinn, 2013), can deepen compassionate ability and engender compassionate responsiveness to the needs of patients and loved ones during hospital visits (Condon, Desbordes, Miller and DeSteno, 2013).

2. Developing Multicultural / Systems Thinking Competencies

Sperry defines "multicultural competencies" as "the capacity to recognize, respect, and respond with appropriate words and actions to the needs and concerns of individuals from different ethnicities, social classes, genders, ages, or religions" (Sperry, 2016, p.287). As a provisional definition, we use the term "systems thinking competencies" to describe the ability to bring awareness to the ways that interpersonal interactions are necessarily conditioned by systems and histories, which go beyond a person's own *particular* life story. These may include gender, culture, religious/faith history, socioeconomic background, politics, and other contextual cues that delimit the possibilities for meaning making. In other words, this is a skill of finding the balance between fixating on difference, and completely ignoring it to grasp at a "goal" of our "common humanity", while failing to see that this common humanity also manifests precisely *as difference*.

Given the increasing cultural, linguistic and religious diversity of the Victorian population, it is imperative that existing spiritual care practitioners continue to develop and improve upon their ability to note their own inherited ontological, epistemological and theological assumptions about relationship and communication, which can manifest as unconscious bias. At a pragmatic level this also involves learning and demonstrating the wisdom of giving proper referrals.

Returning to the September 2014 comment, "I thought this was only for Christians???" We interpret this both as an expression of confusion, as well as a rhetorical expression of *preference*, rooted in a particular lifeworld that had come to be experienced as tenuous and precarious. To address this precarity, we planned our first session of 2015 to feature a presentation by Tom Symondson, then acting CEO of the Victorian Healthcare Association.[4] Symondson gave an overview of how spiritual care currently fits in broader health systems. This would support participants in *re-contextualizing* their place as part of an ecology of professional worlds; Symondson warned that if we chose parochialism and resistance to change, spiritual care may simply atrophy within health systems. He asserted the importance of responding constructively to demographic change, and attending carefully, lovingly, and strategically to the transitional needs of an otherwise ageing and historically Christian sector.

While pensive, feedback for this particular session was overwhelmingly positive, and included statements such as:

- Wasn't sure how relevant speaker's topic would be, but found it more so and interesting than expected.
- Welcome interaction with wider health sector
- Unexpectedly engaging, thought-provoking and relevant
- Engaging speaker who demystified health sector quite well

Another way SHV has addressed this need to increase multicultural and systems competencies was by working with SCA Vic and ASACPEV (associated organizations in the running of the PDP) to strengthen transparency and accountability processes for the governance of the program through a steering committee.

As per feedback from one of the participant evaluations to Symondson's talk, the metaphor of "demystification" works well, in considering how a broader systems awareness could come to be "unexpectedly relevant"; that is, how seemingly esoteric ideas from a place both wider than and outside of the familiar can inform the experience of "difference", in transition and integration into ordinariness.

3. Induction into Competency Standards

This third point builds on strengthening of abilities in context awareness and systems thinking. In other words, one's spiritual care practice is not only strictly about maintaining the integrity of one's individual spiritual autonomy, or only about charity and doing good, but is also a part of broader health systems that one is a part of. This particular induction is intended to be both for the purpose of accountability, as well as facilitating important transition – particularly for many people who are motivated by their

ties to specific religious institutions – into a sense of the care provided *as work* within a *health system rather than a religious one* (Puchalski et al., 2014).

The morning education session in our PDP addresses the above the in at least two segments:

1. Prayer/Contemplation/Reflection, led in the morning for 45 minutes by the pastoral care coordinator of the hospital where the session is being held, building phenomenological capacity;
2. Guest Presentations, featuring a guest speaker on a salient topic for attendees, increasing (multi)cultural competency.

Learnings and Recommendations for Improvement

This work is largely relational, affective and administrative, as long-term stakeholders and new industry members are often significantly culturally, professionally and religiously distinct from established industry leaders. Ongoing education will require further investigation of the ways that the sector is shaped and reshaped by changing federal and state government health priorities, so as to better advocate for and accommodate pluralist, secular, and professionalized understandings of spiritual care practice.

Based on feedback from participant evaluations over 2013 to 2016, which include suggestions for topics in developing successive years' monthly curricula, the steering committee of the PDP has committed to ensuring that the program will:

a. Increase representation of perspectival diversity

Include educators for the morning education sessions from a more diverse range of professional, faith and spiritual backgrounds who can speak and educate as whole persons themselves, not only as institutional representatives, or limited to speaking only on their specialist professional expertise.

b. See inclusion not as an "end goal", but as an *orientation to learning*

This means that we must also look at "barriers to inclusion". This frames our work as inherently part of the process of attending openly, generously, and respectfully, to the justice issues implicit in any work around "difference", e.g. immigration issues, family violence, anti-Semitism/anti-Muslim bigotry, colonization as it has impacted on Aboriginal spirituality, homophobia and transphobia, etc.

Another aspect of inclusion may also involve making continuing spiritual care education more accessible for broader health professionals, while centering spiritual care practitioners as the priority learners.

c. Collect age-specific demographic details

Unfortunately, we have not been collecting data for age in either our registration or evaluation forms. This data would be worth collecting for the future, as quantitative evidence of what, anecdotally, seems like a largely ageing workforce. As a largely religiously-identified profession, this would correlate demographically with the proportionate decrease of religiously identified people in the population at large, as a new generation of people forego religious affiliation. Considering age-related demographic data could provide evidence for increasing age-appropriate and spiritually-appropriate ways of inducting younger professionals into the field.

d. Pre-evaluation and outcome evaluation forms

Because evaluation forms collect participant information *after* the education sessions, we have not been able to track the success of each month's presentation as an "intervention" in the perspectives, attitudes and work practices of participants in relation to the topic(s) presented. To better reflect the efficacy of the PDP in actual "development" of professional abilities, it would be helpful to include pre-evaluation forms (to be filled in before the session) in addition to our existing (post-) evaluation forms. Collated data from both could then measure change, and the efficacy of the PDP education sessions could be fine-tuned. An end-of-year evaluation form could be drafted to send out as an "outcome evaluation" of each full year's program, with room for direct comment on how the year's program may have directly improved their practice of spiritual care.

e. Attending to the "spiritual but not religious"

Related to the above is considering further research and development of professional training in relating to the broader population that is increasingly unaffiliated with any religion, but who may nonetheless reflect particular spiritual needs and may draw from (ordinarily disavowed or disowned) religiously or culturally specific forms of spiritual practice in times of crisis (Glenister & Prewer, 2016). Indeed, part of the impetus behind transition from previously normative terms such as "pastoral care" and "chaplaincy" to "spiritual care" has been to purposely highlight the more humanistic aspects of this care which includes, and also goes beyond, the use of Christian-specific terms.

Young people in Australia are increasingly non-religious, with attendance at religious places of gathering/worship decreasing across the board. Indeed, in 2016, young adults (between 18 and 34 years of age) are more likely to report "No Religion" (39%) compared to the general population (32%) (Australian Bureau of Statistics, 2016). At the same time, there has been a corresponding increase in interest in non-Western spirituality and spiritual practices (Webber, Mason & Singleton, 2004). Part of this work requires increasing professional literacy in navigating the (seeming) tensions between religion, understood as discrete religious

categories as recognized by the Australian government and measured by the census (e.g. Christianity, Buddhism, Hinduism), and the more "mosaic" and heterodox expressions of spirituality expressed by increasing cohorts of an entire generation.

f. Research into Supervision

As we have mentioned, while we contend that clinical supervision is essential to professional development and include it as part of our PDP, we have not analysed this as part of our report. We would support further research into this space.

Conclusion

This article has explored the educational gaps in professional development in spiritual care, with comparatively little else written on continuing professional education for specialist spiritual care professionals within health systems, while limited evidence indicates a high desire, among practitioners, for ongoing education. SHV's PDP for spiritual care practitioners was then presented as a case example of a program addressing this need. We looked into the evolving demographic and professionalized contexts within which the practice of spiritual care and the PDP are situated, evolving and changing. This was followed by an examination of the demographic data from four years' worth of registrant information and a discussion based on qualitative analysis of participant evaluations of the monthly PDP. Issues were raised with recommendations made for developing continuing education programs for spiritual care practitioners in a rapidly changing world.

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Notes

1. For more information see www.spiritualhealthvictoria.org.au
2. For more information see www.spiritualcareaustralia.org.au
3. For more information see www.asacpev.org.au
4. For more information see www.vha.org.au

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Shinen Wong, BA; Gender Studies (comparative religion), Dartmouth College; Grad Dip Buddhist Studies (contemplative education & social justice), University of Sydney; M.Ed (Adult Learning) ongoing, Monash University, 2018 completion.Cert. Health Promotion, Curtin University. Public health professional, experience in health promotion and community development across culturally, linguistically and religiously diverse communities, locally and internationally; intersectional social and ecological justice, immigrant, refugee and asylum seeker advocacy and transformative andragogy, in USA and Australia.

Heather Tan, PhD; M Grief & Palliative Care Counselling; Grad Dip Education; Grad Dip Community & School Counselling; BSc; Clinical Pastoral Education. Experience in research (spiritual and psychosocial issues; death and dying) secondary and tertiary education (spiritual care and grief and bereavement counselling); supervision of higher degree students.

Appendices

APPENDIX 1 Program Curricula (2013 – 2016)
APPENDIX 2 Sample Registration Form
APPENDIX 3 Sample Evaluation Form

Appendix 1 Program Curricula (2013–2016)

2013 PROGRAMME
9 Sessions, 2nd Wednesday of each month

13 MARCH - ***Austin Hospital***
Jacqui Morse
"Issues of gender & sexuality in caring relationships"

Jacqui Morse is the Coordinator of the Bethel Pastoral Centre, the agency of the Uniting Church in Australia offering training and consultation for those assisting people who are dealing with abuse.

10 APRIL – ***Melbourne City Mission (Eltham)***
Jacqueline Taylor
"Spirituality in Aged Care"

Jacqueline Taylor is the Manager - Aged & Community Care at HCCVI. She has been working to develop capacity for spiritual care in Aged Care through a range of education and training initiatives.

8 MAY – ***Mercy Palliative Care***
Heather Dunning
"Creative Arts project"

Heather Dunning is the Coordinator of Pastoral Care at Ringwood Private Hospital. She has explored the integration of spiritual care into a creative arts project in that facility.

12 JUNE – ***Western Health***
Ian Breguet
"Being with: a model to enhance Pastoral Care self-supervision"

Ian Breguet is Coordinator of Pastoral Care at Casey Hospital in Berwick, and Director of Southern Health CPE Centre. He is passionate about the quality of spiritual care provided in healthcare, and looks for ways we can continue to explore development.

10 JULY – ***Royal Melbourne Hospital***
Centre for Culture Ethnicity and Health
"Cross-cultural conversations"

The **Centre for Culture Ethnicity and Health** is a unique agency that provides specialist information, training and support on cultural diversity and wellbeing.

14 AUGUST – *Royal Children's Hospital*
Peter Mangold
"Spiritual Care with Adolescents"

Peter Mangold is Chaplain at Brighton Secondary College, and is constantly engaged with exploration of ways to foster the spiritual development of teenagers in today's culture and society.

11 SEPTEMBER – *The Alfred Hospital*
Diep-Thanh Lee
"Pentecostal Christians and spiritual care"

Diep-Thanh Lee is a Social Worker at Caulfield Hospital, and is an active member of her local Assembly of God Church.

9 OCTOBER – *Baptcare (Camberwell)*
Palliative Care specialty group
"Specialised spiritual care in Palliative Care"

The **Palliative Care specialty Group** is comprised of pastoral care practitioners who work in palliative care contexts. They have been working together to identify the unique challenges and opportunities they experience in this work.

13 NOVEMBER – *Repat Campus, Austin Health*
Rev'd Deirdre Ragless
"Labyrinth and spiritual practice"

Rev'd Deirdre Ragless, previously part of the pastoral care team at The Austin/Repat, now lives in Adelaide. She has a deep awareness of the spiritual practice of the labyrinth and what it can offer.

2014 PROGRAMME
9 Sessions, 2nd Wednesday of each month
12 MARCH - *Repatriation Hospital*
Albert Peck
"A pastoral theology of anger"

Albert Peck undertook his CPE training at The Austin & Repatriation CPE Centre as part of his theological education, and has since completed Masters level qualifications. His thesis was on a pastoral theology of anger.

9 APRIL – *Western Health*
Anja Tanhane
"Mindfulness in therapeutic encounters"

Anja Tanhane is a qualified Mindfulness Based Stress Reduction (MBSR) teacher, registered music therapist, and Tai Chi instructor. She has also completed Professional Training in Buddhism and Psychotherapy.

14 MAY – *Calvary Healthcare Bethlehem*
Sheiny New, Taskforce Against Family Violence
"Family Violence"

The **Taskforce** runs a safe and confidential support line, trains rabbis about how to approach issues such as family violence and child sexual abuse, and runs information sessions for schools and the community.

11 JUNE – *Geelong Hospital*
Jason Scott
"National Disability Insurance Scheme"

The national disability insurance scheme is a new way of funding individualised support for people with disability that involves greater choice and control and a lifetime approach to a person's support needs.

9 JULY – *Mercy Hospital for Women*
The Compassionate Friends
"Parental Loss: How to care, what to say"

The **Compassionate Friends Victoria Inc**. is part of a world-wide organisation offering friendship and understanding to families following the death of a son or daughter, brother or sister. TCF offers support in the grief and trauma which follows the death of a child at any age and from any cause.

13 AUGUST – *Kingston Centre, Monash Health*
Dr Ranjana Srivastava
"Compassionate care"

Dr Ranjana Srivastava graduated from Monash University with a first-class honours degree and several awards in medicine. She was admitted as a fellow of the Royal Australasian College of Physicians in 2005 and started practicing oncology in the public hospital system.

10 SEPTEMBER – *Mercy Werribee*
Emil Neven & Marilyn Hope
"CPE with Jews & Buddhists: a learning experience for all"

Emil Niven is Coordinator of Pastoral Care at Monash Medical Centre, and **Marilyn Hope** has recently retired after managing the Pastoral Care Dept at The Alfred. Both

are CPE Supervisors, and have worked with participants from a range of faith traditions.

8 OCTOBER – *Royal Children's Hospital*
Megan Chapman
"The development of infant-parent relationships in the neonatal intensive care"

Dr Megan Chapman is a senior clinical psychologist and the co-ordinator of the Infant Mental Health program at the Royal Children's Hospital in Melbourne. Megan has a particular interest in very sick babies and their families in NICU.

12 NOVEMBER – *St Vincent's Hospital*
Panel
"Theological Reflection"

The panel will be made up of spiritual care practitioners with a passion for theological reflection.

2015 PROGRAMME
8 Sessions, 2nd Wednesday of each month
11 MARCH – *Heidelberg Repatriation Hospital*
Tom Symondson
*"**The Evolving Health Sector: What does it mean for Spiritual Care?**"*

Tom Symondson is the Acting Chief Executive at the Victorian Healthcare Association, an independent, not-for-profit peak body working to improve population health outcomes through the advancement of health service delivery across Victoria.

8 APRIL – *Northern Hospital*
Frith Luton
"Liminality: Encounters and Dialogues of Borderlands and Thresholds"

Frith Luton completed her training as a Jungian Psychoanalyst in Zurich, Switzerland. Her passionate interest in nature, literature and the symbolic life has been strong since childhood. Frith has also been a professional book editor for over 25 years and holds a B.A. (Hons) in History, a Diploma of Education, a Grad Dip in Editing and Publishing and a Master of Analytical Psychology. Frith is in private practice in Melbourne.

13 MAY – *The Alfred*
David Glenister & Martin Prewer
"Non-Specific Religion in Pastoral Care Work"

David Glenister is the Coordinator of Pastoral Care at Royal Melbourne Hospital, and the Director of the CPE Centre there. Formerly, David worked at St Vincent's, rotating through most care centres, and facilitating the palliative care art program at Caritas Christi under the auspices of the Pastoral Care department.

Martin Prewer is the Uniting Church Chaplain in the Pastoral Care Team at the Royal Melbourne Hospital, commencing in February 2012. Prior to that he was the UCA denominational Chaplain in Ballarat. He also has 30yrs experience as a Social Worker, Supervisor and Manager, and enjoys contributing his expertise in program planning, statistics and research alongside his love of pastoral listening, as well as being creative through poetry.

10 JUNE – *Royal Children's Hospital*
Lynn Gillam
"Ethical Challenges for Pastoral Care Workers in Healthcare"

Lynn Gillam is an experienced ethicist, originally trained in philosophy bioethics. Lynn is the Academic Director of the Children's Bioethics Centre at the Royal Children's Hospital Melbourne. She is also Professor in Health Ethics at the University of Melbourne, in the Melbourne School of Population and Global Health.

***** **JULY** – *BREAK* *****
12 AUGUST – *Peninsula Health, Frankston*
Cameron Cutts
"L'Arche: A Holistic Approach to Disability and Vulnerability"

Cameron Cutts is the Community Leader of the L'Arche Community here in Melbourne. L'Arche is an international federation of faith communities where people with and without intellectual disabilities share daily life together. Founded by Jean Vanier in France in 1964 L'Arche now consists of 140 communities in 38 countries.

9 SEPTEMBER – *St John of God Hospital in Ballarat*
Chris Kavelin
"Exploring Ways in which Indigenous Communities Honour the Spirit of the Dying/Deceased Person"

Dr. Chris Kavelin holds a PhD (Law) from Macquarie University ("The Protection of Indigenous Medical Knowledge: Towards the Transformation of Law to Engage Indigenous Spiritual Concerns"), a M. Theology (Hons) from the University of Sydney and a B. Theology (Hons) from Otago University. He and his family have lived and worked with Native American, Maori and Aboriginal communities and he has a deep passion for translating essential elements of the spiritual understandings of these communities for himself, his children and other cultures.

14 OCTOBER – *Royal Melbourne Hospital*
Graeme Gibbons
"Psychological First Aid"

Rev'd Dr Graeme Gibbons OAM is an ordained minister of the Uniting Church in Australia, and accredited Clinical Pastoral Educator by the Association of Supervised Pastoral Education in Australia. He is a Registered Psychologist and currently conducts a private practice in psychotherapy and supervision from a psychoanalytical self- psychology and process theology perspective.

11 NOVEMBER – *Heidelberg Repatriation Hospital*
Jenny McGuirk
"Remembrance and Disenfranchised Grief"

Jenny McGuirk has a background in education, working in the State School system and later for DHS training adults to work in community as volunteers. She has worked at Mercy Hospital for Women and Mercy Private as a UCA Chaplain and was the inaugural Chaplain for Pastoral Care and Counselling to the Victorian Liver Transplant Unit holding that position for 15 years. Her focus of work has been centred around grief and loss and her current work as a funeral celebrant allows her to bring together her pastoral care experience and her interest in designing liturgy to meet the needs of those who grieve.

2016 PROGRAMME
8 Sessions, 2nd Wednesday of each month
9th MARCH – *Heidelberg Repatriation Hospital*
Panel: David Glenister, Harriet Ziegler, Danni Moore & Geoff Wraight

"Let's talk about documentation: Writing notes in patient files, pain or possibility?"
David Glenister is the Coordinator of Pastoral and Spiritual Care services at Royal Melbourne Hospital, and Director of the Clinical Pastoral Education Centre. This is his third year in the role.

Harriet Ziegler has been Pastoral Care Coordinator/ Chaplain at Epworth Eastern Hospital, Box Hill, since May 2009. She coordinates a small team of staff and denominational volunteers and works closely with the multidisciplinary team. Harriet is currently president of the Vic branch of Spiritual Care Australia.

Danni Moore has been the Pastoral Care Coordinator at Castlemaine Health for over six years, working across two hospitals and six residential aged care facilities. Prior to her move to the country, she worked at Austin Health.

Rev Geoff Wraight (BTheol, MTheol) is the current Family and Community Services Chaplain Team Leader for Baptcare. Previously, Geoff has over 20 years' experience as a Baptist Pastor working extensively in community projects providing spiritual care and consultancy.

13th APRIL – *Peninsula Health, Frankston*
Matt Glover
"Sexuality and Embodiment"

Matt Glover holds a Master's degree in counselling from Monash University and is an accredited counsellor with the Australian Counselling Association and the Australian College of Supervisors. Currently he is the director of MGA Counselling services and is also the Executive Officer for Spiritual Care Australia.

11th MAY – *Caulfield Hospital*
Priscilla Robinson
"Spiritual Care, International Development and Epidemiology"

After a career in public health practice and teaching spanning four decades and many countries, **Priscilla Robinson** is currently trying to retire from gainful employment. She is a board member of CONCERN Australia and South Gippsland Health Service, and an editor on a couple of professional peer-reviewed journals. Her teaching is in the areas of epidemiology, research methods, and project management, and research in communicable diseases, and in the role of the Arts in Public Health.

8th JUNE – *Mercy Hospital for Women*
Julie Ramsay
"On a Journey with Fear of No End in Sight: Spiritual Care for People with Mental Illness"

Julie Ramsay is the Spiritual Care Coordinator at Thomas Embling Forensicare Hospital in Fairfield. Julie has held positions in Community Education and Development for a variety of agencies, as well as School

Counsellor in a large Grammar School. In addition she was Chaplain at Templestowe College for nine years, followed by two years with the Department of Justice in Corrections. Her current focus of work has been centred on trauma, grief and loss for Forensicare patients living with significant mental illness.

***** **JULY – *BREAK*** *****
10th AUGUST – *Austin Hospital*
Barbara Colliver
"Spiritual Care in Pregnancy Termination"

Barbara Colliver (BSW [Hons], BA, BD, BVA, GradDipSD) has been the Anglican Chaplain at Monash Medical Centre since 2012 (4 days a week) and a Locum parish priest at All Saint's Selby since February 2015.

Barbara has been ordained as an Anglican Priest for 23 years and has worked in the parish sector for 20 years. Barbara is currently the pastoral care representative on the multi-disciplinary Peri-natal Loss Committee at Monash Medical Centre, and is also an artist.

14th SEPTEMBER – *Baptcare Bundoora*
Elizabeth Pringle
"Spirituality: The key to caring for people living with dementia in healthcare settings"

Elizabeth Pringle brings over 20 years senior management experience in the areas of executive leadership, learning and development, standards and quality management in a range of industries such as aged care, community services and health. Working as a chaplaincy volunteer, researcher, educator and health leader in various governance roles.

9th NOVEMBER – *Royal Children's Hospital*
Lynn Gillam
"Courageous Conversations (Ethics and Spiritual Care)"

Lynn Gillam is an experienced ethicist, originally trained in philosophy bioethics. Lynn is the Academic Director of the Children's Bioethics Centre at the Royal Children's Hospital Melbourne. She is also Professor in Health Ethics at the University of Melbourne, in the Melbourne School of Population and Global Health.

Elizabeth has learnt first-hand about dementia from the many older people who have taught her what works and what doesn't.

12th OCTOBER – *St Vincent's Public Hospital*
Dr. Ruth de Souza
"Can Cultural Safety Improve Outcomes for Multicultural Patients in Hospitals"

Dr. Ruth de Souza is a Senior Lecturer with the School of Nursing and Midwifery at Monash University, and has a joint appointment as Stream Leader of Policy Research and Evaluation at the Centre for Culture, Ethnicity and Health (CEH), part of North Richmond Community Health. Ruth has an extensive background as a clinician, therapist,

APPENDIX 2 Sample Registration Form

PROFESSIONAL DEVELOPMENT PROGRAM FOR SPIRITUAL CARE PRACTITIONERS: EDUCATION AND SUPERVISION

Participation in the Professional Development Program (*previously the Continuing Education Conference*) is available to those employed as chaplains or pastoral care practitioners in a health or welfare context in the State of Victoria. Volunteers who wish to apply will be considered by the Committee if they are currently providing pastoral care ministry in a health or welfare context. An appointment for at least 2 days per week in a health or welfare context is required to participate in the afternoon sessions of the program.

Participants in the Professional Development Program may choose to attend the whole day program, or the morning sessions only. The *morning sessions* include shared prayer and reflection, morning tea/networking, an updating or news session, and a colloquium centered on a guest speaker. The *afternoon sessions* in small groups include peer reflection on pastoral ministry reports by members with supervision from accredited Supervisors, and time for sharing matters of pastoral concern with the group.

A Pastoral Care Department can apply for an **Institution Subscription**, which would enable any one member of staff each month to participate in the morning sessions only, and have lunch. The documentation required for individual membership applicants below are not required for Institution Subscriptions, but only the Application Form with the appropriate subscription category ticked.

Applications are due by Monday February 23rd this year, but late applications which include the afternoon sessions will be considered up to 1st April. This is because the afternoon small groups need to settle and form sufficiently to enable them to work effectively. Applications to participate only in the morning sessions can be received throughout the year.

If you are a first-time applicant

Initial applications should include, as well as the Application Form, the following further documents:

- **A letter from the applicant's employer supporting their application and indicating that the applicant will be free to participate in the program, *AND***
- **Documented evidence of satisfactory completion of one Unit of Clinical Pastoral Education (CPE), or current engagement in a Unit of CPE, *OR***
- **Written documentation demonstrating equivalence to a Unit of CPE where an applicant has participated in other supervised clinical ministry.**

If you have been attending before

Applicants who have participated in the full program (morning and afternoon sessions) previously need only complete and submit the Registration Form and make the required payment.

Applicants who have only participated in the morning sessions previously, but now wish to also participate in the full day program will need to provide the additional documentation required for new applicants above, as well as complete and submit the Registration Form and make the required payment. This is to ensure that they have experienced supervised practice before, sufficient to indicate they will be able to benefit from this part of the program, and that their employer is supportive of the further time involved.

Applicants who have attended in the morning only previously, and wish to continue with that, simply need to complete and submit the Registration Form and make the required payment.

PROFESSIONAL DEVELOPMENT PROGRAM FOR SPIRITUAL CARE PRACTITIONERS: EDUCATION AND SUPERVISION

SPONSORED BY
Spiritual Health Victoria Inc. [SHV] **ABN 70 495 240 053**
&
Spiritual Care Australia [SCA] (Victorian Chapter)

REGISTRATION FORM / TAX INVOICE

NAME:_____

ADDRESS:_____

_____POSTCODE:_____

PHONE: Home: _____Work / Mobile:_____

EMAIL ADDRESS:_____

(*for all notices & communication for the Professional Development Program*)

INSTITUTION IN WHICH YOU WORK:_____

DIETARY REQUIREMENTS:_____

YOUR FAITH / SPIRITUAL IDENTITY:_____

SCA MEMBER: Yes No (*circle as applicable*)

PAYMENT TO BE MADE BY MON FEBRUARY 23rd 2015
CHEQUES PAYABLE TO: Spiritual Health Victoria **OR**
DIRECT DEPOSIT to: Spiritual Health Victoria Inc.
NAB BSB: **083004**
NAB Account No: **515091167** for_____

*(Prices are **ANNUAL COSTS** inclusive of GST)*

Member SCA	Cost	Tick	Non-member SCA	Cost	Tick
Whole day *includes lunch*	**$330**		Whole day *includes lunch*	**$350**	
Whole day *no lunch*	**$245**		Whole day *no lunch*	**$265**	
Morning only *includes lunch*	**$290**		Morning only *includes lunch*	**$305**	
Morning only *no lunch*	**$200**		Morning only *no lunch*	**$220**	
Institution subscription, Morning only (any 1 person may attend and includes lunch)				**$400**	

RETURN TO: Education Officer, Spiritual Health Victoria, PO Box 396, Abbotsford, Vic 3067 (Phone: 8415 1144) or educationofficer@spiritualhealthvictoria.org.au

Appendix 3 Sample Evaluation Form

EVALUATION FORM
[MONTH] [LOCATION] [SPEAKER] [TOPIC]

1. Gender:_____

2. Religious / Faith / Spiritual identity (if any)_____

3. (a) Highest educational qualification (if any)? *(please circle)*
Certificate/s Diploma/s Degree/s Post graduate (Masters / Doctorate)
(b) Discipline *(e.g. Theology, religious studies, nursing, etc.)*:_____

4. Do you hold / have you held any professional registrations? *(tick all that apply)*
Spiritual Care Australia_____
ASPEA _____
Other *(please specify):* _____

5. What is your current professional role? _____

6 (a) Where are you currently employed? *(please tick all that apply)*
Public hospital _____
Private hospital _____
Aged Care facility _____
Mental Health _____
Other. . . *(Please specify)* _____
(b) How many years have you been working this area?:

7. What was the main reason you attended this month's program?

For the following questions, please use this scale:
(1 = Very Dissatisfied; 2 = Dissatisfied; 3 = Not Sure; 4 = Satisfied; 5 = Very Satisfied)

8. How would you rate this month's education (morning) session overall?	**1**	**2**	**3**	**4**	**5**
a) Relevance to Spiritual Care	**1**	**2**	**3**	**4**	**5**
b) Interest to you	**1**	**2**	**3**	**4**	**5**
c) Presentation	**1**	**2**	**3**	**4**	**5**
d) Morning Prayer and Reflections	**1**	**2**	**3**	**4**	**5**

Any Comment?:

_____

_____

_____

9. Please do give some feedback on relevant topics and/or speakers for future education sessions:

NAME **TOPIC** **CONTACT**

10. Is there anything else you would like to add?

_____

_____

_____

Please do use the other side of the form if you need more space
Thank you for taking the time to complete this evaluation form. . .