Catholic Health Australia

Current Issues for CHA Members in the Provision of Pastoral Care

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12 September 2011

Introduction

On 29 March 2011 Catholic Health Australia (CHA) hosted a meeting of senior managers and pastoral practitioners to discuss their concerns and challenges in providing effective pastoral services across the Catholic health and aged care ministry. Organizations represented included St Vincent's Health Australia, Cabrini Health, St John of God Health Care, Little Company of Mary Health Care, Mercy Health and Mater Health Services Brisbane, with apologies from Catholic Healthcare Services and Mercy Central Queensland. The meeting explored a range of issues which reflect concerns expressed for some years by mission leaders and pastoral practitioners and many of which were articulated during the development of the CHA *Pastoral Services in Catholic Health, Community & Aged Care (2010).* These issues have been reported to and discussed within the CHA Education and Formation Committee with a view to identifying actions and strategies to ensure pastoral care is secured as a key element of Catholic health and aged care service delivery.

This paper attempts to summarise these issues and possible ways of addressing them while recognising that many of the issues and solutions are interconnected. It also recognises that strategies for addressing concerns will be - and are - being developed that reflect the particular model and focus of service delivery and that this varies widely across the Catholic health, aged and community care ministry.

1. Articulating the philosophy and practice of Pastoral Care

In recent years CHA has developed two documents related to the pastoral dimension of Catholic services. The first of these, *On Being Pastoral* (2007) articulated the indispensable contribution towards holistic care provided by pastoral care while firmly locating the pastoral disposition as the responsibility of all staff. The second document *Pastoral Services in Catholic Health, Community & Aged Care* (2010) sought to articulate the range and variety of approaches to the provision of pastoral care services across the many diverse contexts within the Catholic sector. Issues remain which have yet to be addressed by either document.

It has been identified that there is a need to enhance appreciation among Catholic health and aged care leaders and managers of the central role of pastoral care in the Catholic services through the articulation of a theology of pastoral care. This statement needs to offer a clear expression of the scriptural and theological foundations of pastoral care as well as clarify the discipline of pastoral care and the diverse ways the discipline and practice may be understood and implemented. It needs to articulate how pastoral care relates to a holistic framework of

care and healing within an increasingly religiously diverse society. It also needs to address the growing diversity of meanings within the discipline as the concept of spiritual care becomes seen as a separate dimension to pastoral care. A theology of pastoral care will facilitate a clearer appreciation of what motivates our services and shape our response to the needs of those in our care. It will ensure a clear and unassailable place for the continuation of the unique contribution of pastoral care to the distinctiveness of Catholic ministries into the future. It will acknowledge the diversity of Catholic health, aged and community care across Australia, and hence the need for pastoral care service models that are responsive to this diversity.

2. Responding to the shift towards lay Pastoral Care staff

Lay people are often the main providers of pastoral care in Catholic services and this situation raises a number of strategic issues central to the sustainability and viability of pastoral care as a distinctive feature of the ministry of Catholic health and aged care. It has been suggested that in order to ensure there are suitably trained and well prepared personnel available to provide the ministry of pastoral care in future years it is necessary to enhance the professional status of the practice of pastoral care. A number of strategies will assist this.

(i) **Baseline qualification.** Currently there are a range of pathways to the practice of pastoral care. These include a variety of levels of study in theology, pastoral counseling and pastoral care from Certificate IV through to Bachelors' and Masters' degrees. In addition the Clinical Pastoral Education qualification which was once the practicum component of the academic preparation for Church ministry has been undertaken by many lay people as a basic introduction to pastoral practice. There is a perceived gap in the definition of an agreed baseline standard towards which member services might aspire when recruiting staff and that potential and current practitioners might aim towards achieving. There is also a perceived need among some organisations for an 'entry level' course or baseline competency or qualification level which would ensure a sufficient theological foundation alongside the required pastoral skills. Key learning areas would include pastoral theology, spirituality, ethics, liturgy, ritual and sacraments. Such a course or definition of competency/qualification level is seen as necessary to enhance opportunities for career development as well as facilitate alignment with relevant state awards (or equivalent) when determining appropriate remuneration. Any newly developed baseline course needs to incorporate the acquisition of academic as well as practical skills related to pastoral care, including those skills developed via formal CPE qualifications. It would need to accommodate a variety of learning needs eg

group based and distance education and it would need to be affordable. Recognition needs to be maintained of the different skills required for the different models of pastoral care utilised across health, aged and community care settings. Such models are influenced by a range of factors including resources, the particular ministry type and size, and geographic location which impacts on availability of workforce.

(ii) **Remuneration.** There is currently no national benchmark for remuneration of pastoral care staff. Practitioners generally experience reduced levels of income when working in pastoral care regardless of skills or academic or professional achievement compared to other allied health care professionals. This can make it difficult to attract suitably trained and qualified staff that reflect a wide age and gender demographic. There is also an absence of a career pathway. The lack of defined baseline competencies or qualifications is a barrier to benchmarking remuneration. It is also compounded by the difficulty of aligning with state awards for other similar professional disciplines and the differences between state awards. One possible step forward might be the development of guidelines which could guide negotiations of local workplace agreements or EBAs.

3. Defining a framework for Catholic pastoral practice – Standards and competencies

Enhancing the professional status of the practice of pastoral care will also be assisted through the development of agreed standards and competency guidelines.

(i) Standards for Pastoral Care. The articulation of agreed professional standards is common across most professions as a means of defining best practice and guiding the development of contemporary service provision. While the process of defining standards for pastoral care is currently being undertaken by Spiritual Care Australia it is recognized that there are aspects of the provision of pastoral care in a Catholic setting unique to our vision and faith tradition, particularly with respect to the sacramental dimension. There is a perceived need to develop standards which relate to the particular needs of Catholic services while providing sufficient scope to encompass the range of service models across health and aged care. Areas for the development of standards might include the assessment and care process, documentation and reporting processes, accountability, quality improvement, care coordination in a multi disciplinary context, cultural diversity, multi faith context,

ethics, credentialing, supervision and ongoing formation of staff, internal reporting structures and volunteers. Some of these areas have already been the focus of discussion.

(a) Supervision. There are different understandings about: what constitutes supervision; how (group and/or individual), by whom (internal or external) and how frequently, it might be provided; who should pay (employer or employee) and how to ensure supervision meets the expected outcomes of the individual and the organisation to achieve accountability. It would be helpful if guidelines were developed in this area.

(b) Reporting structures. In larger facilities where a formal pastoral care team exists this team has generally reported to the Mission Leader. However, in occasional situations historically pastoral care has reported to Allied Health. Some advantages have been identified in linking and facilitating collaborative relationships between pastoral care and allied health (as well as other grief and bereavement services) thus enhancing professional relationships and facilitating better coordinated patient care. There are advantages and disadvantages to management reporting and accountability within either structure. Any recommendations in this area need to take account of existing individual organisational structures.

(c) Role of volunteers. Some services utilise the expertise of volunteers in delivering some or many aspects of pastoral care. It would be useful to share guidelines to assist the management of pastoral care volunteers to: ensure appropriate scope of practice, that they are suitably equipped for the prescribed tasks, that effective support is provided, that liaison and integration with professional pastoral practitioners and other clinicians is maintained, so that the aims of further developing pastoral care as a professional discipline is not undermined.

(ii) Competencies for Pastoral Care practitioners. The articulation of desirable and expected competencies for pastoral care practitioners is considered an important step towards ensuring implementation of comparable standards of practice and care. The definition of competencies would contribute towards providing the necessary assurances for clinicians and managers about the expertise of pastoral care staff. This supports the effort to enhance the professional standing of the discipline. It also aligns with the issue of defining a baseline qualification. The availability of defined competencies would also provide guidance for recruitment, performance development, and ongoing formation processes. Competencies would need to be defined for the different levels and roles within pastoral care practice.

(iii) Catholic Chaplains. The provision of Chaplaincy services features as a significant element within the discipline of pastoral care. While most Catholic health and aged care services have access to a resident full time or part time Catholic Chaplain or local priests who visit the service regularly or upon patient request, access to such support varies considerably. Factors include geographic location, local availability of clergy, relationships with the local Ordinary, capacity of the ministry to remunerate. A range of mechanisms exist with regard to the appointment of Chaplains, and the subsequent accountability of the appointed Chaplains to the particular ministry they support as well as their responsibilities to the local Ordinary. These range from historically developed ad hoc and informal arrangements through to formal agreements and memoranda of understanding which are the subject of regular review. Formal arrangements would normally clearly articulate position descriptions, remuneration arrangements and dispute resolution similar to existing employer-employee contractual agreements. Clearly the availability of Catholic Chaplains to support a ministry impacts on access to Sacraments and to the overall model of pastoral care that might be delivered within each ministry.

(iv) Faith Group Representatives. There is considerable variation in the mechanisms through which health and aged care ministries might relate with and formally engage visiting faith group representatives. As with volunteers, organisational accountability around the engagement of faith group representatives and other visiting clergy demands consideration of a range of significant issues, for example, privacy, confidentiality, patient safety, quality, and accreditation.

4. Sacramental issues

The decline in the availability of clergy has had an increasingly significant impact on the provision for patients and residents of the sacraments generally and the Sacrament of Anointing in particular. This challenge is especially acute in regional areas. There is considerable variation in the availability and structure of clergy contributions to pastoral services.

One of the most pressing difficulties relates to the expectation of many Catholic patients and residents, especially older people and their families that the Sacrament of Anointing of the Sick be provided at the time their health deteriorates significantly and death approaches. In some dioceses in response to this broad challenge of declining clergy recruitment of priests from

India, Asia and Africa has been adopted as a partial solution. This can create new challenges for the delivery of pastoral care services especially around differing cultural norms and religious understandings.

Considerable effort is often expended by pastoral care staff to liaise with clergy as well as with clinical staff of many and no faiths, to meet the Sacramental needs of dying patients and residents. Creative solutions are being attempted to meet the demands of patients and residents in the form of the utilization of lay-led rituals of blessing. However the place of the Sacrament of Reconciliation within the Sacrament of Anointing precludes administration by lay people and church instruction precludes rituals using holy oils that may be perceived as simulating the Sacrament.

Consideration also needs to be given to the range of ways of providing a comprehensive ministry for providing the Sacrament of Communion.

5. Research initiatives

Evidence-based practice is foundational to quality health and aged care. There is potential to enhance the standing of pastoral care as a professional discipline through fostering quality research into all aspects of contemporary pastoral practice. There is a value in developing research which demonstrates the contribution of pastoral care in contemporary healthcare settings and its correlation with patient wellbeing. There is also a significant contribution to be made through research which seeks to evaluate contemporary models and practices in the range of service settings. Strategies need to be developed to encourage scholarly research in the Australian context as well as promote the outcomes. Many of the issues outlined above would benefit from the application of sound research which clarifies experiences, concerns and understandings, and highlights potential improvements in the practice of pastoral care.

Summary

Possible strategies for consideration towards addressing the issues identified in this paper include:

1. Development of a third resource specifically focused on articulating a theology of pastoral care to underpin and support the development of the discipline and appreciation by leaders and managers of its centrality in a Catholic service.
2. Comprehensively mapping currently available courses that provide suitable qualifications and competency, as well as progressing with relevant educational bodies

the development of a Graduate course in Pastoral Care or similar qualification. Such a course should encompass the development of the range skills both academic and personal, required for the role.

3. Mapping the provision of pastoral care services across the Catholic sector to provide a snapshot of the range of circumstances that exists across urban, regional and rural settings in terms of structures of reporting and accountability, models of practice, qualifications, staff ratios, age demographic, formation requirements, denominational profile, remuneration, recruitment issues and the role of volunteers.
4. Establish a Working Group to progress the development of Standards for Pastoral Care in Catholic facilities and agreed competencies for pastoral care staff.
5. CHA has the potential to be a valuable conduit between member services and the bishops and clergy by raising awareness about the practical impact of declining clergy on the delivery of pastoral care services. Initiatives to facilitate communication about these issues would facilitate mutual recognition of the challenges and a shared approach to the articulation of practical and acceptable solutions.
6. CHA and member organizations could actively promote the pastoral care research agenda with partner institutions as well as foster an internal research focus. CHA could develop a communication strategy to assist communication of research findings and outcomes.