Report on the

Buddhist Chaplaincy & Spiritual Care Project

Stage 1








THE BUDDHIST COUNCIL OF VICTORIA, INC

The Buddhist Council of Victoria Inc

Venerable Bom Hyon

December, 2011

Teach this triple truth to all:
A generous heart, kind speech,
and a life of service and compassion
are the things which renew humanity.

The Buddha

Acknowledgements

Our thanks and appreciation goes to all the volunteers from the Buddhist community who participated in the consultations and to the Pastoral Care Coordinators who took the time to complete the survey questionnaire - your combined responses have been immensely valuable in providing us with a clearer understanding of pathways and priorities for the future.

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A special thanks to the Healthcare Chaplaincy Council of Victoria for their far-sightedness in recognising Victoria's changing demographics and subsequent commitment to establishing multi-faith partnerships, with a more representative Council body 'on-board' to ensure delivery of best practice outcomes for chaplaincy and pastoral/spiritual care services into the future. A special thanks also to Cheryl Holmes for her unstinting time, support and enthusiasm for this project.

We wish also to acknowledge the Victorian Department of Health's commitment to provision of pastoral/spiritual care services and ongoing funding support.

This report contains the views of many people: Buddhist *sangha* and lay members, Pastoral Care Coordinators and other healthcare service providers, the Buddhist Council of Victoria, the Health Care Chaplaincy Council of Victoria, Spiritual Care Australia, and others. Our hope is that in a small way it contributes to the current knowledge base and provides a foundation for further development of services, practice models and training and accreditation pathways, to ensure provision of timely and effective healthcare chaplaincy and spiritual care services for Victorian Buddhists.

Introducing the Buddhist Council of Victoria Inc.

Established in 1996, the Buddhist Council of Victoria (BCV) is the representative body for Buddhist temples and centres in Victoria. After Christianity, Buddhism is the second most common religion in Victoria, with 132,634 people describing themselves as Buddhists in the 2006 Census. The number of Buddhists in Victoria continues to grow rapidly, as a result of migration, births and an increasing number of westerners taking up Buddhism as a practice.

The great majority of Buddhists in Victoria are from a variety of Asian ethnic backgrounds including Chinese, Vietnamese, Laotian, Cambodian, Burmese, Thai, Sinhalese, Tibetan and Japanese. Many Asian Buddhists have come to Australia as refugees and some have suffered persecution in their home countries as a result of their Buddhist beliefs. They often arrive in Australia with few or no material possessions or funds and work long hours in low paid jobs to make a home for themselves and their families.

There are more than 100 Buddhist temples and centres in Victoria, varying in size from large temple complexes with one or more resident monks or nuns, to small meditation groups who meet regularly in local community centres. Buddhists are widely geographically dispersed across Melbourne (and some parts of regional Victoria) but there are large concentrations of ethnic Buddhists resident in the south-eastern and western metropolitan regions.

The Buddhist community is thus extremely diverse in terms of ethnicity, language and culture. The BCV is a volunteer organisation of elected representatives from member temples and centres. We encourage recognition of the potential benefits of intrafaith cooperation in order to reduce isolation and strengthen overall capacity, so as to better serve the interests of both the Buddhist and wider community. The BCV facilitates ongoing programs such as, Buddhist education in primary schools and prison chaplaincy, and represents the Buddhist community on a number of interfaith advisory bodies. We regularly organise and participate in a variety of interfaith and intrafaith activities and events, to introduce the Buddhism to the wider community and to raise awareness among Buddhists themselves of the diversity and richness of our own, several, traditions.

Like all major religious and spiritual traditions, Buddhism places a strong emphasis on teaching practitioners how to face their own old age, sickness and death, without denial, and how to offer compassionate care to other people who are going through these inescapable stages of the human experience. For Buddhists living in Victoria, access to Buddhist chaplains in the healthcare system has been very ad-hoc up until now. BCV's participation in an interfaith approach to developing healthcare chaplaincy and spiritual care services for Buddhists is an important and exciting step for us, because it opens up the potential for building on our community's current capacities in this area, and the possibilities for developing spiritual care models and resources in a systematic way so as to ensure effective services are available in the future. We can now look forward to a time when appropriate spiritual care support can conceivably be offered to inpatients, their families and significant others, Buddhists and anyone else who wishes to access it.

On behalf of the Buddhist Council of Victoria, I wish to thank everyone who has been involved in Stage 1 of the Project, especially Venerable Bom Hyon, the Project Manager, who brought a rare combination of experience, skills and enthusiasm to this task.

I hope and believe that this Project Report will be of great value to everyone who has an interest in the further development of Buddhist chaplaincy and spiritual care services in Victoria – including government, health and aged care providers, Pastoral Care Coordinators, the Healthcare Chaplaincy Council of Victoria and, most particularly, members of the Buddhist community.

Alex Butler
Chair
Buddhist Council of Victoria

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Executive Summary

In January 2011 the Health Care Chaplaincy Council of Victoria (HCCVi) approached the Buddhist Council of Victoria (BCV) to undertake the development of chaplaincy and spiritual care services for hospitals and other major healthcare facilities. The BCV accepted an annual grant of $15,000 from HCCVi as contribution towards the project and appointed a project manager to begin the work. A project advisory committee[1] was appointed in March 2011, including member representatives of BCV, the HCCVi Education Manager, and other Buddhists with experience relevant to the project.

As this is the first time in Victoria to attempt a coordinated approach to Buddhist healthcare chaplaincy service delivery we felt it was important to initially consult with a cross-section of Buddhist communities, in order to get a better idea of current activities and future needs. The communities selected for consultation represent a breadth of cultural and linguistic diversity that makes up the Melbourne Buddhist population.

Between March and September, thirteen Buddhist communities, with representatives from the three main Buddhist traditions[2], participated in face-to-face consultations assisted by interpreters where appropriate, in order to gauge:

- support for the project
- current and future healthcare chaplaincy needs, *and*
- current healthcare chaplaincy activity

Concurrently, with the aid of a survey questionnaire we undertook to consult process with Pastoral Care Coordinators from major hospitals and healthcare services in metropolitan and regional areas, in order to better understand consumer needs and delivery protocols. A total of Survey questionnaires were mailed out to 44 Pastoral Care Coordinators[3] and 31 responses were returned.

The main findings of consultations with Buddhist communities indicated that:

1) Most communities already provide spiritual care support for their own members when seriously ill or hospitalized. About half have also attended hospitals in response to requests by staff or patients' families. A small number also visit other healthcare services such as residential aged care facilities. This work is mostly conducted by ordained *sangha*[4], some of whom work in-tandem with lay community members.

[1] See Appendix 1 for details of members
[2] Theravada, Mahayana and Vajrayana – see the section on "Buddhism Basics" in this report (p. 63)
[3] Questionnaires went to all members of the Pastoral Care Coordinators' Network (PCCN) – see Appendix 7
[4] Ordained clergy (monks and nuns)

2) Chaplains from cultural and language diverse (CALD) communities consistently reported multiple difficulties with providing an adequate chaplaincy service to hospital inpatients, including:

- language fluency
- lack of transport
- lack of convenient parking at reasonable rates
- difficulty in orienting to hospital layout
- difficulty accessing staff who can direct them and are willing to assist with information and introductions to patient and family
- difficulty accessing suitable space and conditions for chaplains to conduct crucial rituals for patients and families

3) Communities are very keen to assist with establishing a more formal network which can link them directly with hospital requests for services.

4) The majority of communities want to find out more about education and training opportunities and a few are keen to discuss possibilities for providing specialist training to their members such as, training for lay Theravada members[5] and training developed for a specific ethnic community.

Main findings of Service provider survey responses

The main findings of the survey completed by 30 Pastoral Care Coordinators indicated that:
1) Among hospital Pastoral Care staff there is a critical lack of applied knowledge about Buddhism which makes it difficult for them to identify and access suitable chaplains for patients' needs, when required.

Survey responses indicate that:

- Pastoral Care Services data collection is generally poor
- Most responses indicates inadequate collection of faith-specific data
- There is a lack of knowledge among Pastoral Care practitioners about differences across Buddhist traditions, and the relationship culture and language has to rituals, ceremony and other observances
- Most Pastoral Care Services do not have up-to-date and appropriate *cultural-specific* information to be able to identify a suitable Buddhist chaplain to 'fit' a patient's Buddhist and ethnic profile

[5] In traditional Buddhist communities, the ordained *sangha* usually have sole responsibility for looking after the religious and spiritual needs of their people, and in the *village* where the temples are located, they are often called upon to advise, mediate and instruct on a great range of topics such as, health, taxes, education, child-rearing and a multiplicity of other life and death concerns. Some of these same communities now living in Australia are opening to the possibilities for lay members to be trained as chaplains.

2) The majority of Pastoral Care Coordinators said they would like to learn more about Buddhist beliefs and practices, and have a better understanding of cultural and language diversity as it relates to religious and spiritual needs of Buddhists living in Victoria.

3) An overwhelming majority of Pastoral Care Coordinators indicated they would welcome assistance in accessing suitable Buddhist chaplains.

These findings, which are the outcome of our initial mapping of Buddhist communities and hospital pastoral care services, form the basis of key recommendations listed in the next section of this report. The recommendations will determine priorities for future project development, in order to strengthen competency among Buddhist healthcare chaplains and improve delivery of spiritual care services to Buddhists and their families in major hospitals and other healthcare facilities.

Some of the recommendations which inform the second stage of this project are already in a formative phase of implementation; section 3, (p.57) of this report provides more detail on this progress.

Although in this early developmental phase our efforts are concentrated on shaping and strengthening a "Buddhist" chaplaincy response, we must not lose sight of the fact that religion is only one view through the 'spiritual prism' humans use to find meaning and purpose. Each person's spirituality is unique, due to the singularity of an individual's life experience. Values, attitudes, relationships - questions concerning identity, suffering, hope and despair – these are just some of the spiritual indicators that may be important to us. Yet, more than a list of attributes, most important is how a person *expresses* his or her spirituality in a way that is particular to them. This is the real work of a spiritual carer, to gently hold and honour the sacredness of a person's experience and to *listen* and *affirm* their innate humanity and dignity. Religion is a "finger pointing to the moon" – while it offers us a map, at some point we must jump off alone into unknown territory, in order to find what is truly authentic for each of us. Beyond the "Buddhist" approach is the "spiritual care" approach that recognizes and supports each human being whether or not one professes to a particular faith affiliation.

We are mindful too that aged care is now a burgeoning industry in Australia, and here in Victoria we have our fair share of the ageing population. "The focus of aged care is now and increasingly will be, on higher care residents [with an] increasing incidence of new residents who have a complex history of chronic medical conditions. Many have experienced recent significant grief and loss..."[6] And although among Melbourne ethnic Buddhists, the population is still concentrated in the 45-60 year age group but a significant number are fast approaching more senior years. As with Australian born residents, they are living longer and with more complex medical conditions. Whereas the cultural response in these traditional communities has been to care for the elderly at home, this is no longer possible for a growing

[6] Spiker, J. Rev, (Nov 2011)

number of families, due to work and housing pressures and the lack of an extended family and community networks to support home-based care. The communities presently most affected (Chinese, Vietnamese, Sinhalese) are now beginning to give serious consideration to building resident aged care facilities for their members. Person-centred spiritual care is an integral and compassionate approach to supporting this increasingly frail and isolated population, and Buddhism has much to contribute to spiritual care praxis, as a means to ease suffering and support acceptance which supports peace of mind.

Recommendations

Recommendations have been categorized according to where we feel responsibility lies for implementing them. Accordingly, they are divided into three sections which include recommendations to (1) the Buddhist Council of Victoria, (2) healthcare service providers and (3) HCCVi - as the leading organization having overall responsibility for "providing quality leadership and education in the strategic development, promotion and provision of spirituality, chaplaincy and pastoral care in Victorian healthcare services."[7]

1. It is recommended that the Buddhist Council of Victoria, in consultation with the Project Advisory Committee and the Buddhist community:

Recommendation 1 : Prioritize provision of competency-based volunteer training and continuing education opportunities for Buddhist chaplains, with training to include input about understanding and valuing supervision, debriefing, and ongoing professional development.

Recommendation 2 : Ensure that participants of BCV-sponsored volunteer training are provided with a broad overview of the healthcare system and orientation to the specific healthcare workplace where people are volunteering.

Recommendation 3 : Where possible, ensure that spiritual care volunteers have access to regular supervision.

Recommendation 4 : Explore the need for and feasibility of offering volunteer training in key community languages.

Recommendation 5 : Further explore the needs and constraints associated with offering spiritual care training to Theravada[8] *sangha* and lay members.

Recommendation 6 : Coordinate and facilitate continuing education opportunities for Pastoral Carers, Allied Health staff and other clinicians, in order to gain a better understanding of Buddhism and the culturally-specific needs of some Buddhists.

Recommendation 7 : Ensure that Buddhist chaplains have access to information about training opportunities and pathways – via website, newsletter, and professional supervision.

Recommendation 8 : Explore the feasibility of producing print material (brochures, posters) in different community languages, for availability in public health facilities.

[7] HCCVi's Mission Statement, cited in the Strategic Plan 2012-2015

[8] The Theravada tradition recognises only men as ordained *sangha*. Generally Theravada monks in Australia come from Sri Lanka and the South –east Asian region inc. Thailand, Burma, Laos, Cambodia, and to a lesser extent, southern Vietnam.

Recommendation 9 : Support the develop of a sustainable infrastructure for delivering Buddhist chaplaincy services to major health facilities.

Recommendation 10 : Support the growth of 'solid' pathways and partnerships between Buddhist communities and hospital and healthcare services.

Recommendation 11 : Continue to develop a reliable database of chaplains who are willing to be on a contact list to respond to requests for 'one-off" and regular visits.

Recommendation 12 : Ensure healthcare service providers have access to information about Buddhism in various formats such as, direct education sessions, a dedicated web-site, temple visits, print material.

Recommendation 13 : Update the booklet: "Buddhist Care for the Dying"[9]

2. It is recommended that healthcare service providers, in consultation with the BCV and HCCVi, (where appropriate):

Recommendation 1: Work in partnership with the BCV in order to address some of the more common difficulties experienced by Buddhist chaplains when responding to hospital requests. Specific items include:

a) access to taxi vouchers to ensure availability of transport for Theravada monks between hospital and temple, as they are not permitted to drive nor to handle money, and lay community members are often not available to transport them

b) provision of a pre-midday meal for Theravada monks as they are not permitted to eat after midday, nor to prepare food for themselves

c) provision of assistance to locate urgent parking for (non-Theravada) chaplains who are requested to attend the hospital for an urgent matter, such as end-of-life support

d) provision of suitable spaces for performing rituals (before and after death)[10]
e) orientation of visiting Buddhist chaplains to the hospital campus

f) use of interpreters to assist hospital staff with more accurate identification of the spiritual needs of patients, their families and significant others.

[9] Di Cousens, D. (Ed) (2004)
[10] Mahayana and Vajrayana Buddhist traditions do not allow the body to be touched or moved for several hours and up to 3 days as it is believed that consciousness takes some time to exit the physical body. However, in a modern hospital context it is often not possible to have the deceased person remain on the hospital ward for very long. In such cases, it is requested that the body should remain accessible to family and attending chaplains for as long as is necessary, even if it means relocating to another place such as the hospital chapel or morgue, where rituals can still be performed by attending chaplains.

Recommendation 2 : Ensure a timely and adequate response to chaplaincy needs by commencing spiritual care screening with patients as early as possible -*before* the last minute need for a chaplain when patients are in medical emergency or are very close to end of life. While we understand this is not always possible, by committing additional resources to providing early spiritual care screening in key locations such as, A&E, ICU, Palliative Care, this will potentially improve outcomes for Buddhist chaplains attendance in reasonable time to support the patient and family – *before* death.

Recommendation 3 : Where possible, ensure that pastoral care staff have access to, and are encouraged to use, professional interpreters rather than family members.

Recommendation 4 : Assist with integrating 'other faith' chaplain volunteers into the pastoral care team. (Currently, there are a number of Buddhist volunteers who visit hospitals regularly but have no relationship with the Pastoral Care Department.)

Recommendation 5 : Regularly update the contact information for available Buddhist chaplains and make this information accessible to other hospital staff on a 24/7 basis.

Recommendation 6 : Routinely collect and record adequate data related to patients' faith and spiritual care needs so as to ensure an appropriate Buddhist chaplaincy service can be provided in a timely and professional manner.

3. It is recommended that *HCCVi in consultation with BCV and CPE[11] providers:*

Recommendation 1 : Advocates to ensure that inter-faith training occurs as part of CPE training.

Recommendation 2 : Explores ways that people from cultural and language diverse (CALD) communities can be supported to undertake CPE training, eg. financial assistance, English language support, orientation to the Pastoral Care culture, professional values, standards etc

Recommendation 3 : Advocates for Pastoral Care Services to receive additional funding for use of interpreters.

While in totality these recommendations may seem like a giant 'wish list', most are integral to ensuring a professional and accountable pastoral care service.

[11] Clinical Pastoral Education is a vocational requirement for pastoral/spiritual care professionals.

Foreword

Right from the moment of our birth, we are under the care and kindness of our parents, and then later on in our life when we are oppressed by sickness and become old, we are again dependent on the kindness of others. Since at the beginning and end of our lives we are so dependent on other's kindness, how can it be in the middle that we would neglect kindness towards others? We live very close together. So our prime purpose in this life is to help others.
HH Dalai Lama XIV

Buddhists have long been involved in hospital chaplaincy, visiting and supporting members of their own community, either at the request of an individual or family member, or in response to a request from a hospital. What is much less common is the presence of Buddhist chaplains serving as pastoral care members of hospital multi-faith teams or volunteers, although it is more likely in countries such as Britain and the USA.

Helping others can be an important part of a Buddhist's practice and personal development. Buddhism has a large body of teachings and practices that intersect with care giving: mindfulness, suffering, impermanence, non-attachment, emptiness and compassionate presence, the *brahma-viharas*[12] —loving kindness, compassion, sympathetic joy, and equanimity, etc. The Four Noble Truths which are the gateway to Buddhism, offer a reasoned explanation and practical response to suffering, while the Eightfold Noble Path offers a blueprint for relieving such suffering.[13]

There are many approaches to Buddhism, and these are evident in the diversity of traditions, schools and cultures across Victoria. While there is no one Buddhist view of illness and death the richness of each tradition offers a variety of helpful perspectives. One of the most useful resources we have to offer when someone is facing the reality of illness or death is our willingness to be present with them in an attitude of openness and compassion. In this regard, the purpose of a Buddhist chaplaincy service is similar to other faiths - chaplains are there to offer spiritual care to patients who are ill or dying, their families and significant others, and to hospital staff where appropriate.

A dimension of spiritual care may also be to perform specific religious functions where appropriate. And whereas both ordained and lay members have a role in supporting spiritual wellbeing, the ordained clergy have an additional responsibility to communicate the main tenets of their tradition and lineage and be able to perform the ceremonies and rituals required in the context of illness, death and dying. So, although only certain categories within the Buddhist community are authorised to perform 'religious' functions, lay members with appropriate training can equally fulfill the broader tasks that support spiritual wellbeing. For

[12] Sanskrit: "divine states of dwelling." Arousing these states permits one to overcome ill-will, gloating, discontent and passion.
[13] See "Buddhism Basics", page 63 of this report.

both ordained and non-ordained, the main work of a spiritual carer is to *be* rather than *do* - as only what is still in itself can impart stillness to others.

> "When we sit quietly with another person, we gradually become more aware of that person's presence. We begin to accept and appreciate him. Those two qualities, awareness and acceptance, are the ground of kindness."[14]

Faith communities have always provided chaplaincy support to their members, but it's only in recent years of globalisation and growing cultural diversity, and an increasingly complex healthcare system, that it's become necessary to introduce a more inclusive and professional training approach, in order to prepare chaplains to meet the changing physical, moral and spiritual challenges which confront them in a contemporary healthcare system.

Christians have been providing religious and pastoral support in Australian hospitals for more than a hundred years. But in recent times some among them have begun to question traditional definitions of 'pastoral care' as they become attuned to an emerging reality that spiritual identity is universally human rather than faith based. This new understanding has called them, perhaps out of a sense of Christian charity, to embrace the spiritual care concerns of all who are in need, whether or not a person has a specific faith affiliation. We are grateful for their vision and their commitment to scholarship which has informed a new approach in pastoral care praxis. The "pastoral care" approach, nevertheless, is embedded in a Judaeic-Christian ethos.

For this reason, the BCV has needed to give careful consideration as to whether it would be in the Buddhist community's interests to accept HCCVI's invitation and work in partnership with their vision. The BCV's membership comprises about two-thirds of the main temple communities and groups in Victoria.[15] Our membership is representative of a broad ethnic and cultural diversity and many Buddhists have come to Australia under refugee or family resettlement programs. Such diversity presents an interesting challenge for us as the representative peak body, to ensure effective communication with our members.

The BCV's decision to 'come onboard' with HCCVi's vision was premised as much as anything on the recognition that this was an opportunity for our members to gain experience and confidence and improve their opportunities for participation in mainstream cultural life. This initial decision certainly didn't reflect a consensus about the value of HCCVi membership, or a confidence in BCV's capacity to 'deliver' on the contract, however confidence and commitment continue to grow as the project unfolds.

For those who have come from Buddhist countries, many have had little or no direct contact with the Christian ideas and values which are the bedrock of our western reality. Many of these people are likely, at least in the first couple of decades after arriving here, to live, work

[14] Lief, Judith (May 2000)
[15] See the BCV website for details of membership (www.bcv.org.au)

and socialise within their own, sometimes quite isolated communities, often of necessity because they lack language fluency and may also initially be educationally and economically disadvantaged .

- For these reasons we anticipated that it would be difficult for some of our members to feel confident in accessing services, whether someone wanting hospital chaplaincy support for themselves or a family member, or ordained clergy trying to find their way around the hospital system in response to a request for a Buddhist chaplain. As expected, various stories about access difficulties (both funny and tragic) came to light during our community consultations, confirming our concerns. Surprisingly, these experiences had not 'soured' them, as most were very enthusiastic about the project and potential training opportunities and expressed a willingness to learn and adapt to new ways of thinking and working.

Our wish is that this project can offer a new pathway for Buddhists from cultural and linguistically diverse backgrounds to feel more welcomed and valued in Australian interfaith and cultural life, and that over time they will become more confident to share the richness and spiritual wisdom of our faith with pastoral care colleagues and with all throughout the Victorian community who seek pastoral and spiritual care support.

Our vision is for Buddhist intra-faith collaboration and commitment, to ensure establishment of a chaplaincy service that provides for all Buddhists in Victorian healthcare services to have access to appropriate and timely religious and spiritual care support. Our undertaking is to ensure that all Buddhists, including those from cultural and linguistic diverse backgrounds, are offered culturally-appropriate training and support to prepare them for entry-level as spiritual care volunteers in Victorian healthcare services.

We dedicate any merit obtained from this work to all who are sick and dying
- may they attain freedom from suffering.

Venerable Bom Hyon
Project Manager,
Buddhist Chaplaincy and Spiritual Care Project
December 2011

SECTION ONE: Buddhist involvement in healthcare chaplaincy

International models

The United Kingdom and United States offer two different but important models for Australia. Both countries have well-developed Buddhist healthcare chaplaincy frameworks and, like Australia, have experienced significant migration of Buddhists and a growth in Buddhism among non-Asians.

United Kingdom

The British-based Multi-faith Group for Healthcare Chaplaincy (MFGHC) was founded in 2003 and has representatives from nine major world faiths. Its object is "the advancement of multi-faith healthcare chaplaincy in England and Wales through facilitating a common understanding and support for healthcare chaplaincy amongst faith groups, chaplaincy bodies and users." The MFGHC works directly with the Department of Health to develop policy and standards to ensure best practice.

In Britain, where health services are more similar to our Australian system than in the US, each faith group is invited to form its own authorisation body and introduce an 'authorisation process' for healthcare chaplains within its own faith community. "'Authorisation" requires faith communities to indicate that chaplaincy candidates are "in good standing" with their faith community. This enables them to represent the faith community in their work, and implies that they have an understanding of their faith's teachings and will behave in accordance with an agreed code of conduct or similar agreement. Although the MFGHC is involved in ensuring that each faith community has systems in place for selection, training, authorisation and supervision of candidates, the individual faith groups contract directly with the National Health Service (NHS) bodies, but seek endorsement from MFGHC.

The Buddhist Healthcare Chaplaincy Group (BHCG) was established in 2005, relieving the London-based Buddhist Society of its somewhat *ad-hoc* attempts to respond to chaplaincy requests, usually by trying to find an appropriate chaplain in emergencies. In its formation stage, the BHCG initially sent out a questionnaire to 600 hospitals in England and Wales, of which they received 86 replies. Responses indicated that while there were no paid Buddhist chaplains, about 40 people were working as volunteers within chaplaincy teams. Most responding hospitals said they could contact a Buddhist to visit a patient if really necessary, such as in an emergency.

Initially, the BHCG focused on determining such things as:

- what competencies are required for a Buddhist chaplain
- what mechanisms would be necessary for a 'trainee' Buddhist chaplain to become accredited, and
- establishing a 'board' to authorise accreditation of Buddhist Chaplains.

- They also engaged in much discussion among the various Buddhist communities and agreed on a set of competencies and personal qualities felt to be important to the work of a healthcare chaplain, these include underlying principles such as:

  - Patient-centred
  - Non-harm
  - Being grounded in Buddhist practice
  - Not pushing unhelpful views
  - Not being dogmatic about personal views
  - Being aware of and open to the variety of Buddhist traditions
  - Being able to make good use of support and supervision
  - Developing reflexive practice; awareness of own learning process.

In addition, they identified seven competency areas:

- Quality of being
- Ability to establish initial relationships
- interpersonal and general communication skills
- ability to communicate Dharma knowledge and practice
- Skillful support around death and dying
- Understanding of procedures within hospital and wider support networks
- Ability to working in a multi-faith team[16]

United States

The United States is the original home of the Clinical Pastoral Education model which Australian auspice bodies, such as HCCVI and Spiritual Care Australia, recognise as an educational pathway for the training of spiritual care workers in Australia (currently named pastoral care workers in many cases).

The involvement of Buddhists in CPE varies but many Buddhist chaplains and their Centres are part of the national healthcare chaplaincy organisation. There are at least four institutions in the USA which currently offer Buddhism-centred graduate level training to candidates pursuing professional chaplaincy: Naropa University, University of the West, The Institute of Buddhist Studies, and Harvard's Master of Divinity program. The Upaya (Zen) Institute in New Mexico also offers a two-year program for certifying lay chaplains and Zen Buddhist chaplains. The New York Zen Centre for Contemplative Care is also a certified provider for CPE training, which is a requirement for chaplain certification.

[16] BHCG (Nov 2007) "Proposal for an accreditation process for Buddhist Healthcare Chaplains", Buddhist Healthcare Chaplaincy Group Newsletter, Nov 2007.

Australia

In Australia, Buddhist chaplaincy is less developed. For instance, the Buddhist Council of NSW helps to link chaplains to hospital requests, often in urgent situations. But while developments are still very nascent in some Australian states and territories, there are several local and state-wide training initiatives. Recently, *sangha* in Queensland organised spiritual care training in Brisbane for interested Buddhists. There has also been a long-standing involvement of Buddhist communities in Palliative Care chaplaincy – the most notable being Karuna Hospice in Queensland. Karuna offers volunteer training within a Buddhist framework of spiritual care specific to the palliative care context. Rigpa is another Buddhist organisation which delivers spiritual care training, some of which is now accredited training with a number of professional bodies. Individual Buddhist organisations are also training their members. Siddhartha's Intent recently conducted palliative care training for its members in NSW. These initiatives spring from Buddhist communities with a largely western following and are not necessarily reflected in culturally and linguistically diverse (CALD) Buddhist communities.

Earlier this year, a motion was put forward at the AGM of the Australian *Sangha* Association, that:
(1) a chaplaincy sub-committee be formed with a member of that committee to be appointed as an ordinary member of the ASA management committee,
(2) the sub-committee prepare a register of Buddhist chaplains around Australia with the purpose of developing support networks for them, and
(3) the ASA's annual conference in 2012 focuses on "Buddhist Chaplaincy and Clinical Pastoral Education: the Australian Experience."[17]

While these proposals were adopted unopposed, a lack of resources may make it difficult to initiate any significant actions in the near future.

Victoria

Despite the various initiatives taking place around Australia, it is still rare in Victoria to see Buddhist chaplains making regular visits in hospitals and healthcare facilities, even though they constitute the second largest religious community after Christians (Vic:132,634)[18]. When Buddhists enter a hospital (or other healthcare facility) they are much less likely to be offered, or to receive, spiritual care or chaplaincy support. This is despite the fact that Buddhism has a long history of providing spiritual support to the sick, and a rich heritage of teachings, meditations and spiritual practices designed to support people who are ill or dying. Moreover, in Buddhism it is regarded as very important that people are able to receive the appropriate spiritual support when they are unwell, and most particularly if they are approaching death.

[17] Minutes of the 2011Annual General Meeting of the Australian Sangha Association
[18] ABS Census 2006

A significant absence of visible Buddhist chaplains in the healthcare system is due to a number of factors, including lack of knowledge about Buddhism among pastoral care coordinators and other healthcare staff and lack of understanding of the healthcare system among Buddhists from cultural and language diverse backgrounds, particularly the ordained *sangha* who provide much of the pastoral support. The Australian Buddhist community is extremely diverse in terms of ethnicity and language; CALD[19] communities which are historically and culturally Buddhist, include Chinese, Vietnamese, Laotian, Cambodian, Burmese, Thai, Singhalese, Tibetan, Japanese and Korean. Increasingly, Australian born English speaking residents, who have selected to become Buddhists in adulthood, also contribute to this diversity.

There are well over a hundred Buddhist temples and centres in Victoria, many of which are run by and for members of a single ethnic community and are independent of any other Victorian Buddhist centre. Although all Buddhist practices are based on the teachings of the historic Buddha, specific teachings, forms and practices have evolved in different ways as the religion was spread across Asia over hundreds of years, and more recently into the West where this evolution continues. In contemporary Australia, most Buddhist groups continue to conduct their services and ceremonies in their native language and may have little or no knowledge of how their specific rituals and practices differ from those of other Buddhist groups.

The combined result of these factors is that even where a patient identifies as Buddhist (or requests a Buddhist chaplain) it may be exceedingly difficult for the Pastoral Care Coordinator to be able to identify the appropriate tradition or cultural orientation so as to ensure the patient, family and significant others have timely access to a suitable chaplain.

Demographic challenges of Buddhist communities in Victoria[20]

- Greater Melbourne is home to the largest concentration of Buddhists in Victoria.
- On the night of the 2006 Census, figures indicate there were 132,634 Buddhists in Victoria, with a slightly higher number of females than males.
- The main age concentration was found to be in the 15-54 year old age group.
- A significant number of Buddhists were either born overseas or have at least one parent who was born overseas.

Victorian Buddhists are representative of a broad ethnic, cultural and language diversity and the majority reside in Greater Melbourne, with Sri Lankan, Burmese, Laotian and Cambodian communities mainly concentrated in the South-eastern metropolitan region; Chinese and Thai in the Eastern metro region; while the Vietnamese are more concentrated in the Western metropolitan region.

[19] Culturally and linguistically diverse
[20] Statistics are from the ABS Census (2006). Other sources are local government websites including, Great Dandenong, Maribyrnong and Brimbank Councils' websites.

Apart from a relatively small number of Tibetan Buddhist refugees, most Tibetan Buddhist followers are likely to be Australian born and are more geographically dispersed across metropolitan and rural areas. Tibetan Buddhist centres are situated in various locations across Greater Melbourne, with rural centres in Bendigo and Geelong.

- The South-east metropolitan region has the highest concentration of ethnically diverse Buddhists in Victoria.
- The Western metropolitan region has the highest concentration of Vietnamese Buddhists.
- Residents of these two geographical regions are the most culturally diverse of the Greater Melbourne regions, with:
  - 56% of their populations born overseas, *and*
  - 51% from non English speaking countries.

These two regions are also the most disadvantaged in terms of access and equity issues:
- over half the population speak a language other than English at home and
- 17% (3 times more than metropolitan Melbourne) have limited English fluency.

The highest concentration of Buddhist temples is in the South-east metro region:
- many of these are located within the boudaries of Dandenong Council which is at the top of the SEIFA Index[21] list of disadvantage
- Brimbank Council in the Western metro region is second on the SEIFA list of disadvantage and has a high concentration of Vietnamese Buddhists

The 2006 Census tells us that, among residents of these two local government areas:
- 16% of young people leave school before starting year 11
- incomes are about two-thirds of the Greater Melbourne average
- unemployment was almost double the Greater Melbourne figure
- higher numbers of unemployed are from Thailand, Cambodia, China and Vietnam - all traditionally ethnic Buddhist populations
- South-eastern region also has a large concentration of iconic Buddhist architecture in Victoria.

Socio-economic, disadvantages such as limited access to services, transport and employment, problems with language fluency and education, make it difficult for people to experience social inclusion and be confident to participate in the broader mainstream cultural life of our society.

[21] SEIFA: Socio-economic indexes of disadvantage for areas (ABS)

Healthcare Chaplaincy Council of Victoria Inc

The HCCVI receives government funding to provide education, training and resources for the development of chaplaincy and spiritual care services in the public healthcare sector. It is the pioneer in initiatives to promote and resource developments that support the multi-faith spiritual care approach, but these efforts are relatively recent as until early 2011 they represented only Christian communities. And whereas the Christian involvement in healthcare chaplaincy has a long history in Australia, this all began to change in early 2011 when the Buddhist Council of Victoria was the first 'other faith' to join HCCVI, with the Hindu, Islamic and Jewish peak bodies joining shortly after.

Spiritual care: changing language and changing times

While there has been some 'other faith' presence in chaplaincy for many years, more recently there has been a philosophical 'shift' in the pastoral/chaplaincy field, away from the more traditional religious support model and towards a recognition that all people have "spiritual" needs (regardless of whether they profess affiliation with a particular faith or not).

This emergent understanding has given birth to a new 'breed' of chaplains who see their role essentially as spiritual carers who, with appropriate training can potentially support not only people of their own faith but people of all faiths and no-faith, on the basis of a spiritual dimension that is quintessentially human. The recent establishment of Spiritual Care Australia[22] also reflects this trend. Recognising the importance of faith diversity and the universality of spiritual needs, the Victorian Multicultural Commission has funded HCCVI to offset the training costs of people of non-Christian backgrounds who wish to train in Clinical Pastoral Education. A very small number of Buddhists are now working as spiritual care practitioners in the healthcare sector, including two CPE trained Buddhists.

The HCCVI's "Basic Training Program for Volunteer Pastoral Care Visitors"[23]states that "Spiritual Care is based on the conviction that all human beings are engaged at some level in a journey in life that can be named as 'spiritual'. We all make some meaning of our experiences of life, this can be quite tentative and provisional, even barely conscious. It can also be very highly charged as we face new and demanding experiences which challenge our previous attempts at making meaning of life… "Religion [on the other hand] is understood as those organised, communal expressions of spirituality which use shared points of reference such as charismatic figures, sacred texts, teachings, rituals and practices, and moral precepts, to express and make accessible the cognitive, affective/relational and ethical wisdom of a faith community for its members."[24]

[22] Spiritual Care Australia (SCA) succeeds the AHWCA which was folded at the same time SCA was inaugurated, at a conference held in February 2010 at Trinity College, University of Melbourne
[23] This training manual was produced in 2011and is available on the HCCVi website: www.hccvi.org.au
[24] Ibid (p.30)

The *Handbook of Religion & Health* defines spirituality as: "the personal quest for understanding answers to ultimate questions about life, about meaning, and about relationships to the sacred or transcendent, which may (or may not) lead to or arise from the development of religious rituals and the formation of community."[25]

Dr David Tacey, Australian writer and commentator on spirituality, states that "spirituality refers to our relationship with the sacredness of life, nature and the universe, and this relationship is [not] confined to formal devotional practice or to institutional places of worship." He equates religion, on the other hand, with formal religious practice.[26]

What do we mean by 'spiritual' in the healthcare context?

In the healthcare context an individual's view and relationship to their illness or disease, will be mediated by personal and collective beliefs and values about identity, community, meaning, connectedness, transcendence etc, and how these give coherence to their actions and experiences; in other words, the deeply unsettling existential questions concerning "self, other and cosmos" that drive our spiritual search for "meaning, connecting, being and transcending: "Who am I? Who are we? Why are we here?"[7]

The World Health Organisation defines health as "a state of complete physical, social and mental well-being, and not merely the absence of disease or infirmity… Today the spiritual dimension of health is increasingly recognised".[27] Wellbeing and associated quality of life is of particular concern for the spiritual care practitioner. We know that it is also of concern for other healthcare practitioners, but for the one who's primary vocational and professional commitment is 'caring for the spirit' it is a matter of primacy, so that in this sense other bio-psychosocial needs must be coherent with a person's spiritual needs in the context of their overall health and wellbeing.

Key definitions

As with any newly evolving or diverging discipline, in the initial transition period there are likely to be remnants of the 'old' as well as tentative traces of the 'new' (ideas, language, forms, practices). And so we find that some key descriptors such as 'pastoral care', 'spiritual care' and 'chaplaincy' are still undergoing a process of clarification. For instance the terms 'pastoral care' and 'chaplain' have Christian antecedents but are currently used as descriptors across all Faiths.

"Pastoral" however, comes from the Latin word *pastoralis* meaning 'shepherd'. The term "pastoral care" has traditionally been used in the Christian context to refer to a pastor *shepherding his flock* or congregation. Shepherding involves protecting, tending,

[25] Koenig, et al (2011)
[26] Tacey, D. (2003)
[27] WHO (1998, p. 1)

strengthening, encouraging, nourishing, shielding, restoring.[28] In modern times, pastoral care has come to refer to the ministry of care provided to persons of all faiths and none, within institutional settings such as hospitals, prisons, schools, police, juvenile justice and the armed forces; religious functions may or may not be an aspect of the care that is offered.

Pastoral care is still the designated term used in most Victorian healthcare settings but from a Buddhist and holistic care perspective, 'spiritual care' is a more appropriate term. Another word that's heavily value-laden in the Australian vernacular is the word 'chaplain'. Although it also originates in Christianity, many other-faith representatives are more familiar with this term than with 'pastoral' or 'spiritual care'. 'Chaplain' is a word commonly used in the United States to describe a range of faith traditions, for instance Buddhist chaplain, Christian chaplain and so-forth. However, in the Australian healthcare sector, and the Christian vernacular, the term "chaplain" is mostly reserved for Christian ordained ministers, the Austin Hospital being an exception.

For the purposes of this report I will use the term 'Spiritual Care' rather than 'Pastoral Care'. The term "spiritual care chaplain" refers to Buddhists who engage in providing spiritual care to patients, families and significant others, to support their overall spiritual, emotional and physical wellbeing. I use the term *sangha* to refer to ordained Buddhists – either a monk or nun. As mentioned previously, it is the *sangha* who are generally authorised to undertake specific Buddhist prayers and rituals on behalf of the lay community.

[28] Rowden, H. (p 227)

"Allowing suffering to permeate the chaplain creates a healing, compassionate presence. The hospital experience, while holding the patient in a caring, mothering model of nursing, can also be one of invasive care, lack of privacy, aggressive treatment to sustain life, and ultimate disregard for the human while caring for the body. This cries out for compassion (karuna). The chaplain is the only service in a hospital that won't be waking, haranguing, pricking, and prodding the patient. The chaplain brings compassion to the patient as a first priority. Compassion requires looking for one's own wounded place, turning toward the pain of others, committing to being with the suffering of others, and seeking out this sorrow in the world."

Chokyi Nyima Rinpoche *Medicine and Compassion* (2006),

SECTION TWO: The BCV healthcare chaplaincy project

Overview

As already mentioned, BCV receives a small grant from HCCVi[29] for the project. The project manager has extensive experience in clinical healthcare and project management and is contracted by the BCV to manage the project and complete certain tasks within agreed timelines. Her modest contract fees are paid with funds from the HCCVI's annual contribution of $15,000. As the BCV is not able to contribute any additional funds, she must 'down tools' from time-to-time in orderto do other paid work to pay the bills. She is also on-call 24/7 as first level response for requests from hospitals and other healthcare facilities to locate a suitable chaplain to visit a Buddhist inpatient and/or attend to their family. Most often, these are urgent requests, for example, a life support system is soon to be 'shut down', a patient is suicidal or nearing end of life, or has just now 'passed away' and the family are desperate for help. Often the hospital is requesting a chaplain from a non-English speaking background and so the hunt begins, in order to locate such a suitable person in the shortest time possible!

Project Rationale

Given the Buddhist Council's very restricted people and other resources and our limited knowledge of members' current chaplaincy activities, we felt the first stage of the project should be investigatory. Hence, a mapping process was undertaken in consultation with selected Buddhist groups, in order to begin building a picture of present and future chaplaincy needs and to get an idea of what was currently being offered.

Direct consultation was the favoured approach as it provided an opportunity to begin talking with people about the project and to begin dialogue around what might work, in the style of a community-based infrastructure, to ensure availability of skilled spiritual care chaplains in the future. Face-to-face contact has also helped with beginning to form relationships which will hopefully continue to bear fruit into the future. The visits have also given us a 'kick-start' in creating a database of Buddhist chaplains for future availability.

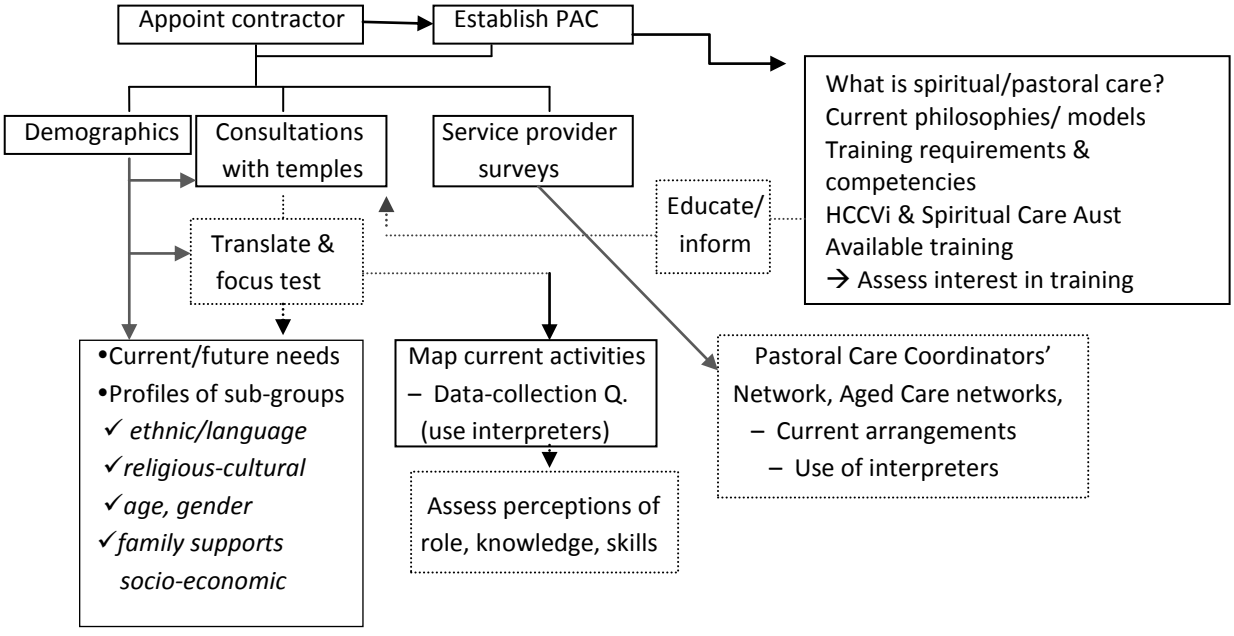
Consulting with healthcare service providers in order to get an understanding of their service needs and delivery protocols was another important activity of the project. And as with the community consultations, we anticipated that the links and relationships established early on would help us to develop partnerships for the future. Having a little knowledge of community demographics and being familiar with some more obvious cultural profiles, we were at least modestly equipped to make decisions about who to target first among the Buddhist communities. We decided to give priority initially, to those experiencing greater social isolation and disadvantage, hence our focus on the South-east metropolitan region.

[29] HCCVi receives a 3-year recurrent grant on a quarterly basis from the Victorian Department of Health, to disburse among members according to a percentage formula based on each Faith or Faith Denomination's Victorian population numbers, ABS Census figures (2006). The current tri-annual period is now up for review and it is hoped that the government will continue to provide for this work as well providing ongoing funding for the other excellent project work which HCCVi undertakes.

The main activities of the project included:

- *Analysing demographics of Victorian Buddhists*
- *Mapping current chaplaincy & spiritual care activities* in consultation with selected Buddhist groups and assisted by interpreters, using a purpose-design questionnaire to support the consultation process
- *Mapping current and projected needs* based on community demographics, profiles of sub-groups (ethnic, religious-cultural, language, age, gender, family supports, socioeconomic)
- *Assessing perception of spiritual care chaplaincy role*, training, skills, knowledge base, personal qualities etc
- *Informing Buddhist communities about contemporary spiritual care philosophy and practice*, including information about HCCVI and Spiritual Care Australia[30]
- *Assessing the level of interest in formal training and support* and providing links to training opportunities and resources
- *Consulting with hospitals and health services* using a purpose-design survey tool, in order to ascertain how chaplaincy and spiritual care needs of Buddhists are currently managed in their facilities. This included ascertaining whether pastoral care staff were confident in their knowledge about Buddhists' spiritual care and chaplaincy needs and had adequate information and contact details to enable them to contact suitable Buddhist chaplains, as and when required.

Figure 1. Flow Chart of Project Activities



[30] Spiritual Care Australia (previously AHWCA) was inaugurated in Jan. 2010 as the representative body for chaplains and pastoral carers who work as employees or volunteers in healthcare, justice and education, armed forces and other areas. As a national organisation, they seek to unify, consolidate, support, promote & encourage the development of chaplaincy, religious, pastoral & spiritual care within contemporary multi-faith Australia.

Consulting with selected Buddhist temples and groups

From March to September 2011, the BCV conducted face-to-face consultations with 13 temples/groups including: Chinese**,** Sri Lankan, Vietnamese, Burmese, Laotian, Thai, Cambodian, Tibetan, and including a Western Buddhist (non ethnic specific) group.[6] As previously mentioned, our focus in this initial stage was on Buddhists from cultural and language diverse backgrounds because they represent the biggest member populations and are most disadvantaged in respect of opportunities for social inclusion, access and equity in mainstream services.

Consultation process

All the main Buddhist traditions were represented in the consultation process and several groups identified as embracing more than one cultural identity. The 'spread' of cultural and language diversity (CALD) reported among members is usually indicative of different people who share common borders in their country of origin, or in the case of people identifying as culturally Chinese, originating in countries across the global Chinese *diaspora*.

Prior to scheduling a consultation, a letter[31] of introduction was sent. With the help of BCV committee members, the letter was first translated into 7 community languages (Laos, Thai, Vietnamese, Burmese, Mandarin, Sinhalese and Khmer Cambodian). The letter was addressed to the spiritual leader and posted to the temple address. This was followed up in 1-2 weeks by an interpreter-facilitated phone call to arrange for a meeting of members with the project manager and an interpreter. A questionnaire was used as a guide in the consultation process, both to facilitate discussion and to ensure a degree of uniformity in data collection. Community members were encouraged to ask questions and engage in discussion about any additional matters of interest or importance to them. The number of people attending the consultations varied from 4 to 28. There was great enthusiasm for the project and discussion was often lively. People understood very quickly that the project might 'open doors' for them to other kinds of opportunity and access, an outcome we would hope is a real possibility for them.

Summary: Thirteen temples/groups were consulted. The primary language and Buddhist tradition of the 13 participating temples/groups is outlined in Table 1. The majority of participants are evenly divided between the Theravada (n=6) and Mahayana traditions (6) with two of the Mahayana groups being also from the Vajrayana (Tibetan) tradition. Group 13 described itself as *Triratana,* drawing from all three traditions but not fitting into one traditional classification.

[31] See Appendix (3)

Table 1: Primary cultural and language identity of participating temples/groups

Centre	Buddhist tradition	1^0 Language	Other languages
1	Theravada	Laotian	Mainly Thai, also Vietnamese and a *little* English
2	Theravada	Thai	Laos and a *little* English
3	Mahayana	Chinese Mandarin	*Cantonese*
4	Mahayana	Chinese Mandarin	Cantonese, English
5	Theravada	Sinhalese	English
6	Theravada	Sinhalese	*Little English*
7	Mahayana	Vietnamese	Mandarin, Cantonese and a *little* English
8	Mahayana	Vietnamese	Lao, Mandarin, Thai, Japanese, French and English
9	Theravada	Burmese	English
10	Theravada	Khmer Cambodian	
11	Mahayana and Vajrayjana	English	
12	Triratana	English	
13	Mahayana and Vajrayana	English	

Age of Members

Most of the temples that participated in the consultations have large congregations, with between 200-500 supporters, with an exponential increase in numbers attending for popular

Buddhist and cultural events such as *Vesak* (Buddha's birthday), *Kathina* ceremonies to mark the end of the annual Rains Retreat, 'Mother's Day', Ancestors' remembrance, and various celebrations to mark the different New Year dates across cultures. The combined age range of members across all the temples is concentrated in the 25-60 year age group, with a majority of 40-60 year olds.

Several temples reported a sharp drop-off in children's attendance from late-teens onwards and so far there's been no significant return at a later age. Anecdotal evidence suggests that the greater number of 'temple-goers' are overseas Buddhists and their school-age children, the adults having arrived in Australia as refugees or migrants from family settlement programs. This raises concerns about the relevance of traditional Buddhist forms and social organisation for younger ethnic-Asian people who are born in Australia but are raised in Buddhist families and communities. Similarly, the 15-30 year old age group across other Faith populations and cultures may also be the most likely to 'bail out' of institutional religious practice, certainly some of the Christian churches have had to contend with this in recent decades.

Table 3: Concentration of age groups by temples

Summary: Results varied across age ranges but the most commonly prioritized age range was 40-60 years and the least priority was the 80+ years age range. The highest and lowest concentrations according to age range are listed in Table 3 below.

Centre	Highest concentration in age range	Lowest concentration in age range
1	40-60	0-15
2	25-40	0-15
3	40-60	80+
4	25-40	0-15
5	40-60	80+
6	40-60	15-25
7	25- 60	15-25
8	40-60	80+
9	40-60	0-25
10	40-60	25-40
11	40-60	0-15
12	40-60	60-70
13	25-40	80+

Table 2: Numbers of ordained *sangha* and lay members by temple/groups

Summary: The following table shows the numbers of ordained (monastic) *sangha*, lay members and occasional attendees. In every case, the number of core number members is

significantly smaller than occasional attendees. In the table below, column 3 shows the number of core members and the estimated greatest number of occasional attendees. These numbers are approximate only. The total numbers range from 20 to 1000 depending on the size of the temple/group. With the exception of those temples with mainly Western attendees, most had at least one resident *sangha* member, with an average of 3 and a majority of 7, the Chinese temples having the greatest number of ordained *sangha*. During important ceremonies and cultural events attendee numbers range from 100 to >2000 people, and here again, it is the Chinese who report the largest number of attendees.

Temple/group	**Resident ordained *sangha***	**Lay attendees**
1	2	20>100
2	5	100>1000
3	7	500>2000
4	5	200>400
5	4	300>1000
6	3	1000
7	4	300>400
8	4	30>200
9	2	60
10	6	70>1000
11	4	200
12	0	200>300
13	0	70

Current chaplaincy activity

The level of chaplaincy activity is varied among temples/groups but apart from two Western-style groups, all others offer some degree of chaplaincy support to members and their families.

- 10 temples/groups said they already offer some form of spiritual and religious support for members in hospital and for those who are unwell
- 6 also visit their members in local aged care facilities
- All said they provide some kind of temple-based support for unwell members
- 3 people indicated they already visit hospitals and health services regularly as volunteer chaplains, and 1 person said she had been doing this for more than ten years.

Most temples still have very small numbers of elderly members and have not yet been seriously challenged with the need for a generation of older people having to care for even older parents and other relatives. But some communities are already facing up to this possibility and have begun to talk about establishing ethnic-specific aged care facilities. Where at all possible, the elderly are cared for at home with great resistance to committing their loved ones to residential care facilities such as nursing homes. A small number of

elderly Sri Lankans are already living in residential care and the Vietnamese community are giving serious thought to the care of their increasingly ageing population.

Table 4: Location and type of chaplaincy activities - by temple/group

Summary: Most temples/groups already offer some form of healthcare chaplaincy, with the majority of chaplains being ordained *sangha* (n=10). However, 6 temples reported ordained *sangha* and lay members working in-tandem. Only 2 groups did not offer any healthcare chaplaincy service. Of the 10 temples that offer healthcare chaplaincy services, 8 service hospitals, 5 also attend aged care facilities and 1 person visits a hospice.
The main chaplaincy activities reported were chanting, blessings, prayer and Dharma teaching. However, chaplains at 3 temples also offer counselling activities including bereavement counselling, while 2 others concentrate on supporting an attitude of peaceful mind and loving kindness.

Which temple/group?	**Who does chaplaincy**	**Where does it occur?**	**What kind of activities?**
1	Ordained *sangha*	Home Funeral home	Chanting Prayer Dharma sermon
2	Ordained *sangha* Lay	Home **Hospital** Temple Funeral home	Chanting* Prayer* Dharma sermon Encouraging a peaceful Mind (*Ordained *sangha* only)
3	Ordained *sangha* Lay	Home **Hospital** **Aged Care facility** Disability service Meals on Wheels	Chanting Prayer Dharma sermon
4	Ordained *sangha*	Home **Hospital** Temple **Aged Care facility**	Chanting Prayer Dharma sermon
5	Ordained *sangha*	Home **Hospital** Temple **Aged Care facility**	Chanting Prayer Dharma sermon Loving Kindness (*Metta*)
6	Ordained *sangha*	Home **Hospital** Temple	Chanting Prayer Dharma sermon

7	Ordained *sangha* Lay	Home **Hospital** Temple	Chanting Prayer Dharma sermon Family support/counselling
8	Ordained *sangha* Lay	Home Temple **Aged Care facility** Other - unspecified	Chanting Prayer Dharma sermon Family support
9	Ordained *sangha* Lay	Home **Hospital** Temple **Aged Care facility** Juvenile justice	Chanting Prayer Dharma sermon
10	Ordained *sangha* Lay	Home **Hospital**	Chanting Prayer Dharma sermon Counselling
11	No	N/A	N/A
12	No	N/A	N/A
13	Lay	Home **Hospital** **Aged Care facility** Hospice	Prayer Spiritual support Bereavement counselling

Source of chaplaincy requests

Chaplaincy requests generally came directly from the family (n=9) or the person needing support (n=8):

- 10 said they had received calls from hospitals requesting a chaplain to visit
- 6 said Aged Care Facilities had contacted them
- in a few of these cases, contact was arranged by the family.

More than half of the temples were equally likely to respond to requests from members of their congregation (n=7), families (n=7) and hospitals (6).

Healthcare services access difficulties

Most of those who indicated they had experience with visiting hospitals and other healthcare facilities indicated some degree of difficulty or multiple difficulties in their role as chaplains.

The main difficulties they identified were:

- Finding one's way around the complex

- Knowing who to talk to (staff)
- Communication – being understood (language confidence and fluency)
- Getting information – about patients and families
- Getting there and finding out the patient was from a different tradition, culture, language and they could only offer minimal assistance, if any
- Not being contacted in time for appropriate religious/ spiritual support
- Lack of transport assistance to and from the facility
- Lack of parking availability or high cost of parking
- Appropriate access to a meal before-midday (Theravada monks)
- Lack of suitable space for ceremony/ chanting
- Not permitted to leave body untouched after death for reasonable time

Source of service provider referrals

When asked where most of their requests for a chaplain come from they all responded that the greater number of requests come from family members, and members of their congregation second, with a few requests from hospitals and healthcare services but these are often 'last minute' when patients and families are in crisis, such as planning to switch off life support systems, or when a patient is rapidly approaching end of life.

Chaplains' training needs & competencies

Many people contributed to discussion about what kind of education/training, life skills and experience which they think are important for Buddhist chaplains. Responses to this question were varied and so I've endeavoured to group them under the following headings:

Learning through practice

- Opportunities for cadetship, mentorship
- Dharma knowledge and skill
- Being a senior community member
- Life education
- Chanting skills
- Monastic training
- Counselling skills for monks
- Calm and robust personality

Communication skills

- Kindness and compassion
- Counselling skills
- Basic emotional support skills
- Specific sutras related to health & wellness
- Understanding of basic medical aetiology
- Cultural awareness & understanding

- Ability to listen and perceive other's needs
- Psychological understanding to support a person in the dying process

Supporting mind/body harmony

- Stress management, relaxation, comfort
- Skills to calm the mind
- Meditation, concentration
- Mindfulness
- How to reassure and reduce fear

- *Organisational*
- Knowledge of hospital/healthcare systems and cultures
- Understanding of organisational protocols

There was a tendency among those present at the consultations to focus on the '*doing for*' of spiritual care rather than the '*being with*', which indicates a clear training need. In the first instance, the training goal is probably to help people to recognise that they can gain something valuable from training.

Support for training volunteer chaplains, pastoral carers and other healthcare staff

- A number of people from CALD backgrounds said they wanted to access chaplaincy training and be properly introduced to the healthcare system.
- Several *sangha* expressed a willingness to contribute to developing suitable training models for existing Buddhist chaplains, and for others who are interested to volunteer.
- Some are also willing to assist with education programs for pastoral care staff and other healthcare clinicians.

Culturally-specific training and print media

The Vietnamese and Chinese communities were the most enthusiastic about training opportunities, both volunteer training and career-focussed, such as vocational pathways and CPE training. Some members of these communities have been visiting hospitals and aged care facilities in a volunteer capacity for many years.

- Both the Vietnamese and Chinese temples indicated they would like to have further discussion about the possibility of developing a volunteer training module for their specific communities.
- Both are interested to develop print media in community languages (pamphlets, posters etc) and assist with translating training material.
- Two of these communities already have training experience and may be willing to assist with developing modules and delivering training.

Although it's usually monks in the Theravada tradition who provide chaplaincy support, a number of the Theravada communities expressed interest in training, both for ordained *sangha* (cultural awareness and counselling skills) and for lay member volunteers.

Developing an infrastructure for delivery of chaplaincy services

There is a surprising level of interest among groups to offer a spiritual care chaplaincy service to health facilities in their local area:

- 7 temples want to offered to provide a regular service and also be available for 'one-off' requests
- 4 temples volunteered their availability for 'one-off ' local requests

A very supportive senior monk volunteered to attend ANY Buddhist requesting a chaplain, saying "even if there is a language barrier I can still chant!" Another supportive senior monk volunteered his temple as the primary contact and liaison for chaplaincy requests in his region.

"[Volunteers] will often be the first to respond to the spiritual needs of people whose health has deteriorated suddenly, or who are facing chronic illness or the approach of their death. They will also often be with the families and carers of those undergoing such experiences, and who are also facing new issues and questions, and the grief that can accompany them. …volunteers are trained particularly in staying with the experience of the person with whom they are working, to offer understanding, acceptance and [33]

[33] HCCVi (2011)

Consulting with service providers

A letter introducing the project[34] was sent to 44 Pastoral Care Coordinators[35] representing all major public and some private hospitals in the Greater Melbourne metropolitan region and a few in rural areas. A survey questionnaire[36] was enclosed along with a postage-paid envelope for return of the completed questionnaire.

The main purpose of the questionnaire was to:

- find out what demand there is currently for Buddhist chaplains in the healthcare sector
- how referrals are made
- what statistics and other data Pastoral Care Services maintain, *and*
- how the different services currently identify a patient's specific spiritual needs

Additionally, for those who have referred patients to Buddhist chaplains:

- how they went about accessing a suitable chaplain, *and*
- are they confident that pastoral care workers and chaplains have adequate understanding of the spiritual care needs of Buddhists, *specifically*
- the different traditions, and cultural and linguistic needs?

Who are the service providers?

31 surveys were returned from a total of 44 sent out, with a majority from the Greater Melbourne region.

Table 5: Healthcare services who completed surveys by geographical region[37]

Region	**Healthcare Service**
Greater Melbourne Eastern metropolitan region	Box Hill Hospital Epworth Eastern Cabrini Hospital Angliss Hospital Ringwood Private
Greater Melbourne Northern metropolitan region	The Austin Hospital The Northern Hospital Mercy Hospital for Women
Greater Melbourne Southern metropolitan region	St John of God (Nepean) Caulfield Hospital The Alfred Hospital

[34] See Appendix 5
[35] See Appendix 6 for list of Pastoral Care Coordinators who were sent a request to complete the survey
[36] See Appendix 7
[37] See Appendix8 for a MAP of the major hospitals and healthcare services in the Greater Melbourne region

	Dandenong Hospital St John of God (Berwick) Casey Hospital
Greater Melbourne Western metropolitan region	Western Health (Sunshine, Western & Williamstown Hospitals) Western Private
Greater Melbourne CBD	Royal Melbourne Hospital Peter MacCallum Cancer Centre Royal Children's Hospital
Other metropolitan services	Baptcare (12 sites) Benetas Aged Care Service Villa Maria St John of God (Pine Lodge Clinic)
Warnambool Health	St John of God (Warrnambool)
Peninsula Health	Peninsula Health
Barwon Health	Barwon Health (McKellar Centre) Geelong Hospital
Castlemaine Health	Castlemaine Hospital

What are the main services they provide?

- *More than half of respondents indicated their services are generalist*

- *A third also provide specialist services, including*:
  - palliative care
  - mental health
  - geriatric
  - rehabilitation
  - oncology/cancer services

- *Some provide singular specialist services, including*:
  - Trauma Unit
  - Transplants Unit

- Spinal Unit
- Liver Transplant Unit

- Approximately two-thirds provide acute care and half of these have an Accident & Emergency Service and Intensive Care Unit.

How do they get referrals and identify need?

Survey responses showed that very few services collect and maintain adequate data records:

- some said they do not keep any statistics
- approximately two-thirds indicated they keep a record of faith orientation

But only a very few collect information related to ethnic-cultural identity, language or specifics of Buddhist denomination.

Of particular concern is that figures indicate an extremely low number of Buddhists had accessed chaplaincy or spiritual care support in the previous 12 months. Survey results indicate that the number of Buddhists seen across the 30 services in the previous 12 months was less than 150. There may be a number of explanations for these low figures but the most likely is that the faith designation of Buddhist patients is not being captured statistically by health care databases, for previously stated reasons.

An anomaly was noted in the very high numbers of Buddhist contacts reported by two Oncology service providers, presumably accounted for by multiple attendances in a Day Oncology treatment setting. In respect of both these services, the figures may point to more sophisticated data collection and recording practices than other Pastoral Care services; Of note also, is that one of these services was among the few who indicated they use interpreters on a regular basis.

Spiritual care practitioner numbers

Survey results indicate a total of 99.2 (EFT) Pastoral Care practitioners across the 30 services:

- 89 (EFT) of these are 'generalist'
- 41.2 (EFT) are faith-specific chaplains who work on a regular basis

Only one current Buddhist was reported, an intern who has since completed her basic CPE training to qualify as an accredited pastoral care practitioner.

Do patients have access to a spiritual assessment?

About 45% of respondents said their service provides clients access to a spiritual assessment:

- In the majority of cases this is done on admission
- or less frequently, at a client's request
- and occasionally when a referral is received from another clinician.

One service said it is currently developing a new assessment model which will include a spiritual care assessment to be completed on admission by the social worker.

How does your service locate a Buddhist chaplain when required?

In response to questions about attempts to access a Buddhist chaplain:

- 14 said they had accessed, or tried to access, a Buddhist chaplain in the past
- only 5 knew which tradition/cultural background/language they needed to request
- 8 reported difficulties with language and time delays
- 4 said they had to rely on family members for contact, often when family themselves, were very distressed

Buddhists accessing pastoral carers were usually self-referred, or referred by another primary clinician at a point of crisis.

Are interpreters an important resource for your service?

- A number of services have access to interpreters but do not use them on a regular basis
- 26 services indicated they have access to interpreters, but only 7 who have access said they use them regularly

Anecdotal evidence suggests that budgetary constraints and a lack of knowledge about how to access interpreters may be contributing to low usage. One respondent said they can only access *Dinka* language interpreters, while another said they have access to some *Karen* Burmese interpreters, but for medical purposes only. Both these languages are representative of very recent refugee populations, does this mean therefore, that the linguistic needs of longer-stay populations are not being addressed? If so, this is unfortunate given the high percentage of the Greater Melbourne population who are from cultural and linguistically diverse backgrounds, with a significant number who have limited fluency in English.

Many services indicate they include ethnicity, language and culture as part of their assessment, and yet a much smaller number (7) use interpreters or know the ethnic, cultural and language backgrounds (6) of the Buddhists they might contact. This raises an important question about how many people are being missed, and how many who are not being missed are being suitably managed?

What does your service already know about the 'basics' of Buddhism?

- 13 respondents indicated they had sufficient understanding of "Buddhism basics' to be able to offer spiritual care support to Buddhist patients and their families
- 17 said they know about Buddhist practices around approaching end of life, after death, and handling and treating the body, probably in reference to the BCV

publication, "Buddhist Care for the Dying"[38] which was first published in 2003 and widely distributed to hospitals at that time; it is currently available on the BCV web-site. (See URL link on page 69 of this report)

- some said they know a little but "not enough"
- one "has access to guidelines but would like more"
- another felt "it's best to ask the family".

If you already have access to Buddhist chaplains, how much do you know about them?

- 15 said they have 'on-call' access to a Buddhist chaplain
- but only 6 said they knew which tradition they represent, or any further identifying information such as the chaplain's ethnic/cultural background, spoken language(s) and level of English fluency, including the language used in prayers and rituals, and whether the chaplain is able to confidently negotiate their way around hospitals and other healthcare services.

Have you encountered any difficulties when attempting to access a suitable chaplain?

The majority of respondents did not answer this question at all. A few said it was not relevant for them as they hadn't needed to access a Buddhist chaplain up until now.

- 5 respondents expressed difficulty in making contact with a Buddhist chaplain due to time delays and/or language problems
- 2 said they would contact the Buddhist Council or the Buddhist Society and ask for help, but unfortunately these organisations are run entirely by volunteers and their availability to assist, and knowledge about how to locate suitable chaplains, is very limited.

Other problems which were identified in relation to accessing suitable chaplains:

- need to pay for a taxi because unable to drive, and lack of public transport
- temple receptionist wanting to know the patient's details before deciding whether to accept the request (issues of confidentiality)
- relying on the family to make contact
- only one small Buddhist group in the locality

Would you like help with accessing Buddhist chaplains and spiritual care volunteers?

- 26 said they want help to access Buddhist chaplains
- 22 would like help to access chaplains for one-off visits
- 11 would like to have regular visits form a Buddhist spiritual care chaplain
- A majority would like access to a website where they can get help to locate a chaplain

[38] Cousens, D.(Ed 2003)

- 28 indicated they would like access to suitable print material to make available for patients/families and staff, with some material translated into key community languages.

Would you be interested to attend an education session to learn more about Buddhism?

- The majority of respondents (90%) indicated an interest in wanting to learn more about Buddhism (beliefs, traditions, cultural differences, relevant ceremonies and rituals)
- 23 expressed an interest to attend an information session at the HCCVi offices or other central Melbourne location
- 16 indicated they would like to have a session on-site, *and*
- 8 of the 16 indicated they may be able to interest >20 staff and volunteers for an on-site session
- the majority indicated they would prefer to participate in 'talk and chalk' and group discussion styles of learning
- most would also like printed information, power point presentations and DVDs, *and*
- 19 are interested in temple visits with instruction and discussion about religious and cultural practices.

Metta Sutta

Whatsoever living beings there are;
feeble or strong, long, stout or medium,
short, small or large, seen or unseen.

Dittha va yeva addittha
Ye ca dure vasanti avidure
Bhuta va sambhavesi va
Sabbe satta bhavantu sukhi-tatta

Those dwelling far or near,
those who are born and those
who are to be born.
May all beings, without exception,
be happy.

Just as a mother would protect her
only child at the risk of her own life,
even so let us cultivate a boundless heart
towards all beings

Mettanca sabba lokasmin
Manasam-bhavaye apari-manam
Uddham adho ca tiriyanca
Asam-bhadam avera, asa-pattam

Let thoughts of boundless love pervade the
whole world; above, below and across
without any obstruction,
without any hatred, without any enmity.