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A New Paradigm for Ministry in the World: Spiritual Care Services of Maine

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GEORGE FOX UNIVERSITY

PROJECT PORTFOLIO

A NEW PARADIGM FOR MINISTRY IN THE WORLD

SPIRITUAL CARE SERVICES OF MAINE

IN PARTIAL FULFILLMENT FOR THE DEGREE OF

DOCTOR OF MINISTRY

PORTLAND SEMINARY

BY:

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PORTLAND, OREGON

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CERTIFICATE OF APPROVAL

This certifies that the doctoral Project Portfolio of

Lori H. Whittemore

has been approved by
the Evaluation Committee on March 10, 2022
for the degree of Doctor of Ministry in Semiotics, Church, and Culture.

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Evaluation Committee Referee: Clifford Berger, DMin

DEDICATION

I dedicate this to my family whose support of my life-long learning and out of the box thinking, is beyond measure!

ACKNOWLEDGMENTS

I would like to acknowledge my small group in Semiotics, Church, and Culture, for their support through this process. A shout out to my project faculty advisor Dr. Phillip Newell for the guidance and encouragement along the way. I would also like to acknowledge my lead mentor Dr. Leonard Sweet for stretching my theological perspective and vision for ministry outside the church. I must also acknowledge Seth Jones and Abby Lynn Haskell who have leant inspiration, along with personal and academic support throughout.

I owe a great deal of gratitude to all the volunteer chaplains I have had the privilege to serve with and to those who raised their hands to bring this project to life. Thank you to First Parish United Church of Christ of Saco, Maine for seeing the vision and seeding the startup of the first iteration of this idea.

EPIGRAPH

Behold, I am doing a new thing;

now it springs forth, do you not perceive it?

I will make a way in the wilderness

and rivers in the desert. (Isaiah 43:19)

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LIST OF ABBREVIATIONS

ACPE	Association of Clinical Pastoral Education
AOC	Accreditation Oversight Committee
BIPOC	Black, Indigenous, People of Color
BOD	Board of Directors
CBO	Community-Based Organizations
CD	Clinical Director
CDC	Center for Disease Control
CEU	Certified Education Units
CISM	Critical Incident Stress Management
CPSP	College of Pastoral Supervision and Psychotherapy
CPT/E	Clinical Pastoral Training/Education
DHHS	Department of Health and Human Services
DMIN	Doctor of Ministry
ED	Executive Director
GFU	George Fox University
MOU	Memorandum of Understanding
MVP	Most Viable Prototype
NPO	Need Problem Opportunity
SCS Maine	Spiritual Care Services of Maine
SMART	Specific, Measurable, Achievable, Realistic, Timely marketing protocal
SIT	Supervisor in Training
UU	Unitarian Universalist

RESEARCH METHOD

This Project utilized a blended methodology that draws upon bibliographic resources, data derived from stakeholder collaboration, and human-centered design and iteration processes to create a heuristic-based, application-oriented Project.

ABSTRACT

With dwindling church attendance in the State of Maine, people's spiritual needs are often unattended to, especially in times of struggle. Clergy are serving shrinking congregations with shrinking budgets, leading to reduced hours. They don't often have time to provide pastoral care to their flock, let alone people outside of their flock. This project creates a mechanism to organize a chaplain team and make them available by contract to organizations and their staff and clients. I have conceptualized, designed, and birthed a community-based per diem chaplain/spiritual care organization that can match the world's soulful need with professional, competent chaplains.

The initial focus of the project identified this same problem but approached the solution by creating a training program that would place chaplain trainees in community-based organizations (cbos) to meet the need for ministry in the world. As I moved the idea from concept to design, a stakeholder pointed out that the need in the community-based organizations would continue after the chaplain trainee had completed their unit of training and moved on. I realized that my project could have a greater impact if it addressed placing professionally trained chaplains and spiritual care givers in organizations on a longer-term basis beyond the 400 hours of a unit of clinical pastoral education/training.

The project transformed into creating and launching a nonprofit organization to provide a contracting mechanism to place professional, compassionate, clinically trained clergy in service of outside organizations. The benchmarks were based on creating a nonprofit to act as a contracting mechanism to recruit and screen ministers and chaplains with clinical training to provide care in community-based organizations. This project portfolio will detail my journey from discovery, design, prototype, and project for launching Spiritual Care Services of Maine.

INTRODUCTION

Maine is one of the least churched states in the United States of America. Mainline churches are shrinking and dying. Current calls to mainline pastorates offering sustainable salaries are few and far between. Many ministers are serving additional pulpits or are bi-vocational. With reduced hours or multiple posts, ministers who provided pastoral care in their churches and in the surrounding community are no longer available as they once were to care for their flocks. That begs the question, "who will provide pastoral and spiritual care to those suffering from existential pain in the world?"

I have spent my ministry journey serving outside the four walls of the church. My ministry context has been the world. I have worked as a chaplain in a home hospice organization, spent years providing spiritual care in disasters and mass casualty events. My experiences led me to training other recruits on the national and local levels. Based on my experience in community-based ministry, I discerned a need to train clergy professionally for the unique challenges of serving in community-based organizations. I created a clinical training program to prepare clergy, seminarians a lay people to serve in community-based organizations.

Community-based organizations (cbos) have attempted to fill the void for caring for people in need. They are often able to meet a person's basic physical or medical needs. Many cbos work to provide psychosocial care in recovery programs, mental health intervention and to provide social services. That leaves a significant part of the client's needs not addressed. That is a wounding of the soul. Many of the moral injuries that are facing people today would benefit from the care of a responsible, compassionate spiritual care giver or chaplain. In the greater community, organizations often employ social workers to address people's social wounding. I believe there is a need to address a wounding of the soul that is often left uncared for.

My pre-ministry career was as a contracting officer for the government. During seminary I didn't imagine myself as a parish minister but couldn't fully articulate what that meant. I participated in interfaith and missional training programs and began to recognize my call to ministry in the world. I worked for a hospice program, and an interfaith organization. I volunteered as a chaplain for the American Red Cross. I recruited and trained other chaplains for the American Red Cross. I became a Board-Certified Clinical Chaplain while completing my clinical training hours in community-based programs and then went on to become a clinical supervisor for chaplain training as a part of the College of Pastoral Supervision and Psychotherapy (CPSP). I built a program that provides training to ministry students, clergy and lay people wishing to train while completing their clinical training hours in community-based organizations.

When I started the doctoral journey with George Fox, I began the journey of discovery having a firm idea of what I was going to do for my project. I envisioned my project as an opportunity to deconstruct the clinical pastoral training program that I had developed and identify and articulate the necessary components that needed to be present to provide consistent professional training. I would seek input about the core elements for the training from professors of pastoral care and directors, educators, and supervisors of clinical pastoral education/training programs. I intended to identify and articulate the framework for a community-based training program and create a replicable road map for educators and supervisors to have a resource for creating their own community-based clinical pastoral education/training program.

I invited former trainees, other supervisor's trainees, other supervisors, all from within the College of Pastoral Supervision and Psychotherapy (CPSP) cognate group. They confirmed the need, problem, and opportunity. Rather than brainstorming and discussing the content and

structural components needed to implement a program, they focused on the bureaucratic challenges to creating, implementing, and administering a program. For my one-on-one research, I broadened my inquiry to professors of pastoral care, supervisors of training programs in other cognate groups, as well as leadership from CPSP and leadership from other cognate groups. The professors of pastoral care appreciated the concept of community-based training and didn't have knowledge or feedback about the bureaucratic needs of a program. Conversations with cognate group leadership from outside of CPSP and hospital-based educators affirmed that their programs were viable due in large part to administrative and financial support for programs. If I wanted to provide framework for a community-based training program, I would have to take on the issues of administration and support.

During the design phase, the stakeholders in my workshop were supervisors who were trying to start community-based programs and supervisors in training who were trying to start community-based programs. All the stakeholders were from within the CPSP cognate group. CPSP is organized by chapters. Credentialling of chaplains and chaplain supervisors takes place in chapters by people who know the candidates well and can attest for their readiness. The chapters also provide recertification each year, attesting to the continued fitness of each chaplain and chaplain supervisor in their chapter. The organization prides itself on lack of bureaucracy or centralized governance. The challenge was and is that model provides little structure, support for guidance for noninstitutionalized programs. The participants identified the need to create a chapter in the organization for supervisors doing community-based training that would provide that administrative structure and support. This chapter would be comprised of people in the CPSP cognate group who would collaborate on creating programs and materials in supports of each other's community-based programs.

The one-on-one conversation during the design phase included conversations with additional supervisors and with leaders within CPSP. I shared the outcome of design workshop and received some pushback. Some couldn't understand how it would be helpful to add a new layer of governance. Leadership was concerned about how a new chapter of community-based supervisors may disrupt the current CPSP structure of governance. Those who were poised to start community-based programs did recognize the merit of the idea. I developed a prototype for a community-based chapter and pitched it to supervisors and supervisors in training and asked if they would join the chapter. All stated they would.

During the design phase, a significant and pivotal issue came up that shifted the course of my project. Discerning, articulating, and developing the necessary framework for a community - based training program would encourage and map a way forward for supervisors and supervisors in training to create community-based programs to launch their own programs within the CPSP organization. The need, problem, and opportunity to create a training program that would prepare ministry students, ministers, and lay folks to provide professional spiritual care in community-based programs had been affirmed. A path forward had been conceived. However, the student or trainee would complete their 400 hours of training in an organization and then be done. The students would then leave the community-based organization and leave a spiritual care hole where there had once been a resource. After a community-based organization accepted a chaplain trainee to complete their clinical hours for a specific unit of time, there would be a void of spiritual care once the trainee completed their unit in 12-24 weeks and left. The long-term need would be left unattended.

As part of my ministry journey, I left the traditional path toward ordination. I did so for many reasons. One reason was that I conceived of ordained ministry taking place in the world

with interfaith standards that would care for honor all individuals in their own understanding of God. This idea wasn't compatible with the polity of the denomination of my church. I began to visualize an organization that might be able to offer that kind of care. That might offer the kind of professional, responsible care is available in hospitals, hospices, and the military. I wondered how it might be made available in the world.

I had a vague yearning to create that organization. I had experience working as an interfaith chaplain from my work with hospice and as a volunteer chaplain with the American Red Cross. I had developed recruiting and training material for chaplains and spiritual care recruits for the American Red Cross and had consequently become acquainted with emergency response leadership for the state of Maine. During the course of my doctoral project, COVID happened. Maine Responds, and emergency response program affiliated with Maine CDC contacted me to create a spiritual care team to provide remote support to front line workers in congregate care facilities. Conceiving of and developing that team was consistent with the idea of developing a spiritual care organization to meet the spiritual needs of a diverse population. The idea from the stakeholder, my previous vision and the work creating the spiritual care corps for the State of Maine merged into what became my alternative prototype. A prototype of creating a nonprofit organization that would match professionally trained chaplains with community-based organization to provide spiritual care to people in need.

As I considered the idea of creating an organization to match per diem chaplains with organizations, the spirit moved. My pre-ministry career as a contracting officer for the government provided me a way of thinking about this from a bureaucratic standpoint. When thinking about creating a nonprofit for per diem chaplains, I conceived of contracting mechanisms, legal and fiscal requirements, and other necessary issues that would need to be

addressed. I had years of experience on boards of nonprofits, from aging in place organizations, civic development groups and interfaith organizations. I also had experience recruiting, training, and deploying chaplains for disaster response assignments. These experiences began to knit together a new vision. The DMIN program in Semiotics, Church and Culture at George Fox University, Portland Seminary gave me a process tool necessary to incarnate it.

As a result of the feedback in the design workshop from the rogue participant, I sketched out a prototype of what this concept would look like. I sketched out the legal framework for an organization that would recruit, vet, and insure chaplains. In conversation with the team of chaplains I was working with in the Spiritual Care Corps, we brainstormed a list of services we could provide. A vision for a new organized was born. The organization would recruit, screen, and orient contract chaplains with various skillsets. The organization would concurrently develop relationships with community-based organizations and present the idea and value of having a professional spiritual care giver available to provide spiritual and pastoral care for organizations serving the organization's clients and staff.

I pitched this idea to 5 community-based organizations. These organizations included a recovery community, an aids community center, a women's abuse shelter, a homeless shelter and resource organization, and a housing and support program for people with developmental disabilities. Most of them instantly saw the need for and value of what we could offer. All stated that financial resources would be the only roadblock to contracting with us. At that point I conceived that my project would include seeking a grant to pay a chaplain to offer individual and group support and provide support to clients and staff of these community-based organizations. I also understood that the project may be a volunteer effort.

Concurrently, the work I was doing with the Maine Spiritual Care Corps had evolved from being remote support for frontline care providers to providing support for vulnerable Mainers as a part of Maine Department of Health and Human Services COVID Social Support Services. I took the opportunity to present my prototype to the program coordinator for COVID Social Service Support. She indicated that if Spiritual Care Services of Maine was a nonprofit, DHHS would contract with us to provide emotional support we had been providing.

I realized this as another pivotal moment. I could use this opportunity to quickly form the spiritual care nonprofit I had conceptualized in my prototype. My project could be forming the nonprofit spiritual care organization, bidding the state contract, and providing professional care to those in need.

I shared my prototype with the volunteer team of chaplains. All were excited about the idea. I also shared the feedback from the State program coordinator about contracting with Spiritual Care Services of Maine if we were a nonprofit. I asked if anyone was interested and able to help bring the organization into being to bid for a state contract over summer of 2021 and/or to serve as chaplains if we were successful in our efforts. Nearly all chaplains were interested in helping form the organization and/or working for the organization or both. The project had grown from a pilot for a few small community-based organizations to a significant contract with the government. This ultimately became my project.

The scope of project for the following semester was clear. It was to put SCS Maine framework in place and bid the State contract. The groundwork was laid over the summer of 2021 to convert and broaden our volunteer work to contract per diem chaplain work. The State of Maine gave us a verbal notice to proceed September 13 for a contract covering September 1-December 31 of 2021. The project for the DMin project would become building the

infrastructure of the nascent organization, building a formal working board, fleshing out, developing our message and forward-facing identity, building a team of chaplains, negotiating the contract, and delivering care. In conjunction with many people, and because of the processes associated with this doctoral program, I have accomplished this.

The work we would be doing for the State was working with the people likely served by the organizations I had pitched my prototype to. The work would be funded by DHHS COVID social services support contract. It was aligned with my original prototype but on a much larger scale. Four members of our 12-person volunteer response team signed up to become a startup board of directors in May of 2021 to launch the project by September of 2021. The project began in earnest in September 2021. Spiritual Care Services of Maine began placing chaplains in service on September 1, 2021.

The project was very successful. The attraction of this doctoral program for me was that it is project oriented. It provided me with a container to consider my context and journey and blend those together using a discovery and design process with peers and colleagues to incarnate the Living God in a new way.

This portfolio details the specifics of my process. It shows the foundational work I completed for a project that I had anticipated doing. It also paints a clear picture of how the process worked to shift my focus to create the project I believe God intended for me to create. There is much more work to be done to move the project and the newly formed organization along. In addition to the specific benchmarks detailed in the project and the project the launch plan, I will need to move from a founder and from a clinical director managing workflow, to an executive director creating business, marketing, and fundraising plans to move the next level. The transition is happening so quickly it has been hard to stay present with it.

All the busyness and business of putting the organization together, presenting ourselves publicly, recruiting, hiring, and orienting chaplains, building business are ultimately just the springboard for the real purpose of this project. The reason for creating this organization is to provide professional, compassionate pastoral and spiritual care to those who need it. We have succeeded at this and are prepared to grow our business through marketing and outreach in these next months.

The energy, affirmation, and joy I have experienced during this project came when I surrendered to the process. When I let go of my tightly held concept for a specific project during the design phase, I was surprised how quickly the new design and prototype came together. I was happy when the prototype was well received and trusted that I had the capacity to turn the prototype into a project. Once I accepted the direction that I was being led in, the steps became clear. They seemed daunting, but they were clear. Because I had to let go of my original vision, I find that I have become more welcoming of feedback and shared vision. I recognize more fully that I am surrounded by people who are also inspired by Divine vision. Our collective energy broadens possibilities for sharing God's love.

I hope my labors conceiving, developing, and launching a spiritual care organization will inspire others to do this as well. The work after this project is to continue to build a thriving organization that can provide spiritual and pastoral care to God's people when and where they need it most. By doing so we create a roadmap of how to deliver pastoral and spiritual care in these secular times. My dream is to share the good news, not by my words, but by my deeds. In full recognition that others have their own understanding and relationship God whatever that name means for people.

I envision Spiritual Care Services of Maine will grow into an organization of chaplains and spiritual leaders of many traditions. We will grow our offerings to meet the needs of an increasingly diverse population. We will provide individual support, specialized group facilitation, such as grief groups and Critical Incident Stress Management debriefings. We will facilitate religious services and sacred text study groups. We will participate in community forums and events. Spiritual Care Services of Maine will be there when you need us.

FINAL PROJECT

Introduction

Maine is one of the least churched states in the country. Mainline, liberal churches are dying regularly, and full-time ministry is all but a thing of the past here. Clergy that provided care in their communities in addition to their own flocks, are not available in the ways they had traditionally been. People who had been fed and cared for by their churches are less likely to get their souls cared for in times of crisis, isolation and in other critical existential moments. In response to that I have created an organization that can provide access to professional spiritual care givers.

I have worked in hospice, volunteered for Red Cross spiritual response, and helped develop a spiritual care emergency response team for the State of Maine. I recognized the need for ministry in the world outside of the four walls of church and of hospitals. Homeless organizations, detox centers, days programs for the developmentally delayed, women's abuse shelters, all seemed like places that would benefit from professional responsible pastoral care. It is with this in mind, and because of the DMIN process of Semiotics Church and Culture, I conceived of a chaplain organization that would provide per diem chaplaincy care to organizations and people in need.

NPO

I will conceptualize, design, and birth a community-based per diem chaplain/spiritual care organization that can match the world's soulful need with professional, competent chaplains.

Project

My project is to design, create and launch a professional spiritual/pastoral care organization that provides professionally chaplain care on a per diem basis.

Project Scope

After determining the Most Viable Prototype (MVP) and successfully getting a grant to launch the idea, I built a diverse and skilled Board of Directors for SCS Maine, recruited and oriented chaplains, entered contracts to provide pastoral care, and ultimately delivered care to those in need.

Benchmarks

1. Build the infrastructure of an organization
2. Building a working Board of Directors
3. Build the message of our work by creating a professional website
4. Build our team by recruiting, hiring, onboarding and orienting chaplain contractors
5. Build our business by negotiating contract(s)
6. Provide effective and care infused interventions.

This paper details the steps I took to bring this organization to life. I share a job description for recruiting board members with pictures and bios of our current board members from our website. Included also are pictures of the main page of our website and the services page of our website. There is a copy of the job description for contract chaplains, a copy of the internal chaplain contract, the orientation for onboarding chaplains, the SCS handbook, website resources for the chaplains along with pictures and bios for the chaplains which are lifted from our website. I have also included copies of the current contracts we have put in place. Finally, I have included a copy of a chaplain referral from the State of Maine as well as a chart note from a chaplain visit.

Presentation of Project

Building the Infrastructure

For my project I initially intended to do an independent pilot by securing grant money to pay a per diem chaplain to support a drug and alcohol detox program and facilitate spiritually based recovery groups. This would require a simple agreement with a nonprofit organization. I anticipated that this might happen through volunteering or with a small grant. There was not too much forethought about creating all the infrastructure to run a full organization.

I was asked by Maine Responds, Office of Behavioral Health, emergency response program, to create a spiritual care volunteer team to provide remote support to various populations in the State of Maine. The team initially provided remote individual support to front line workers in congregate care facilities. The team provided remote Bible studies for jails in lockdown and remote spiritual support groups for organizations providing support during the pandemic. We were tasked with doing some of the things I had envisioned would be addressed by a per diem chaplain organization. The team was eventually asked to help the Maine

Department of Health and Human Services (DHHS), Center for Disease Control (CDC) by providing emotional support for people calling into the State Covid Support referral line. We were asked to provide remote chaplain care.

I took the opportunity to share my prototype with the director of DHHS COVID social support services. She told me that if the SCS Maine prototype was a nonprofit, she would contract with us to provide the care that we had been providing as volunteers. I shared that conversation and the SCS Maine prototype with the chaplains that had been on the volunteer team. Most wanted to be a part of launching the nonprofit organization. One chaplain pitched the idea to his church and got seed money to put infrastructure in place.

With the opportunity to bid a significant contract to provide emotional and spiritual support for those suffering disproportionately from COVID, the initial phase of the project was to take the very nascent organization to full functioning and operational status. This required building a working board that would establish and implement our policies and procedures for hiring and orienting chaplains. The board would set up financial policies, marketing, and fundraising strategies. The board would also set up our accounting and the insurance required to operate.

Building a Board of Directors

Prior to the official start of the project, I had 4 clergy as a founding board to help put the framework in place to get us ready to launch. We filed our organizational documents, created a mission statement, filed our non-profit application, and set a launch date of September 1, 2021. Upon the actual launch of the project, there were specific tasks to be done. We needed to build a more robust working board. With the possibility of a sizable contract on the horizon, we needed

board members with various skill sets that would help create our governing structure, business practices, hiring and orientation processes. I created the following board description.

SCS Maine Board of Directors Job Description

9.1.21
SCS is here if you need us

Spiritual Care Services of Maine (SCS Maine) provides professional, compassionate care to individuals, groups, and organizations with today's religious and spiritual landscape in mind. SCS Maine believes in the inherent worth and dignity of all people and offers nonjudgmental support in our encounters. Chaplains provide respect, loving kindness and honesty for people dealing with stress, fear, health issues and other challenges. We work as a part of integrated teams with other organizations to ensure holistic care for those we serve.

SCS Maine chaplains support all Mainers, especially those populations who suffer disproportionately in times of stress and crisis. We serve people with addiction; people who are isolated, abused, or incarcerated; people who suffer because of health and mental health challenges; folks without housing and Veterans. Recognizing that no person should suffer or walk alone, we intend to address human suffering by meeting people where they are and accompanying them wherever they are on life's journey. SCS Maine's vision is that everyone and anyone who needs our help will find compassion, comfort, assistance, and hope.

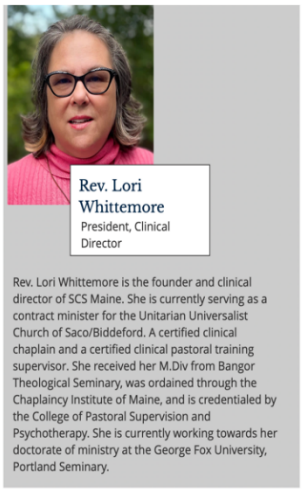
SCS Maine offers one on one support through empathetic listening. We offer group support, group facilitation, debriefing as well as the development and provision of community rituals. We will match organizations with a vetted chaplain or spiritual caregiver that can meet the organization's needs.

In the next 1-2 years, our focus is to build our organization. We will recruit and build a board, continue to build our infrastructure, cultivate relationships, market our services and recruit chaplains.

We are seeking board members who are interested in helping us build our organization and bring compassionate care to people. BOD members can anticipate offering 10 -12 hours per month. Our bimonthly BOD meetings are approximately 1.5 hours. Meetings are available by Zoom. Additionally, board members are expected to help on a working subcommittee, such as outreach, professional development, fundraising, recruiting, or marketing.

If you are interested in joining us in this exciting and important work, please contact Lori Whittemore at lori@scsmaine.org

After creating this job description, I asked each of the four founding members to approach at least two people to join the board. I asked them to think of people they knew who had board experience and would be interested in our mission. They were to pitch our organization, share this board job description, and put them in touch with me. We ended up pitching 10 people and brought on three additional board members to our team. Below are our current Board of Directors, minus one who is stepping on to become our secretary.



Rev. Lori Whittemore
President, Clinical Director

Rev. Lori Whittemore is the founder and clinical director of SCS Maine. She is currently serving as a contract minister for the Unitarian Universalist Church of Saco/Biddeford. A certified clinical chaplain and a certified clinical pastoral training supervisor. She received her M.Div from Bangor Theological Seminary, was ordained through the Chaplaincy Institute of Maine, and is credentialed by the College of Pastoral Supervision and Psychotherapy. She is currently working towards her doctorate of ministry at the George Fox University, Portland Seminary.

Rev. Sara Bartlett
Vice President

Rev. Sara Bartlett is an Ordained Minister in the United Church of Christ (UCC). Sara has served as a chaplain at Maine Medical Center, Bates College, Grace Street Ministry in Portland, and Chaplain of the Day for the Maine House of Representatives. Rev. Bartlett brings a compassionate, caring heart, and a buoyant embrace to those in need.

Diane Dicranian
Treasurer

Diane Dicranian is a Quaker and is currently Clerk of Midcoast Meeting of Friends. Diane attended Bangor Theological Seminary and was recently certified as a Youth Mental Health First Aid Provider. Diane serves on her Meeting's Ministry and Counsel as well as New England Yearly Meeting of Friends Ministry and Counsel.

Rev. Alley Smith
Board Member

Alley Smith is an interfaith chaplain at Maine Veterans Homes in Scarborough. She is also a funeral chaplain/clergy at Hobbs Funeral Home. Having served in the US Marines and Navy Reserve, Alley specializes in assisting military, veterans & their families. She also specializes in end of life care and mortuary affairs.

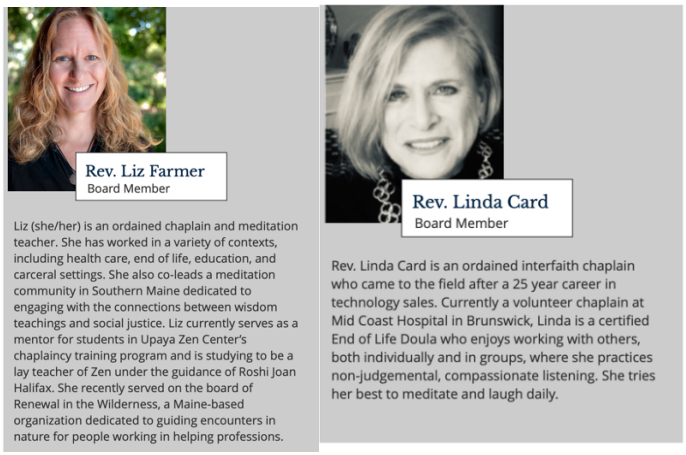


Figure 1—Board Members of SCS Maine

Building Our Message

We had to have a website to communicate who we were. Potential clients needed to see our mission, our chaplains, and the services we were proposing to provide. To bid the state contract even, we needed a website in addition to our employee identification number to establish our legitimacy. I hired a designer to design our site. I provided her with our mission statement, a list of services we envisioned providing, and pictures and bios of the chaplains we had recruited. The following is the front page, a page of our services, and a chaplain bio page.

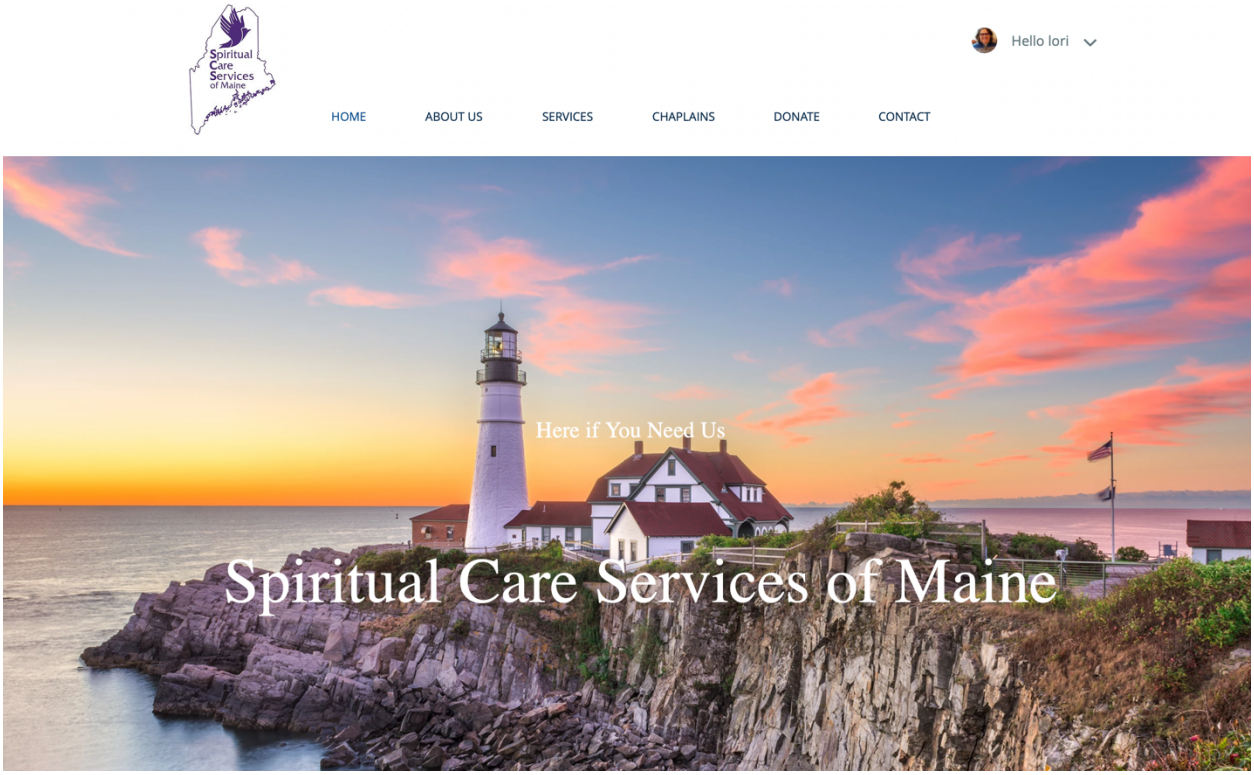


Figure 2—SCS Maine Website Front Page

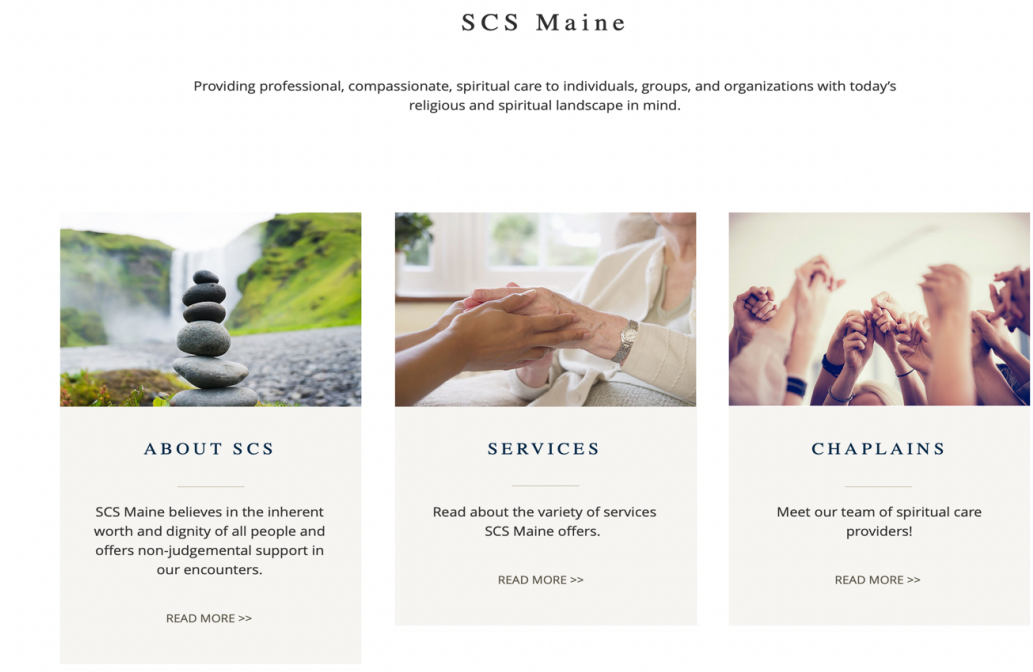
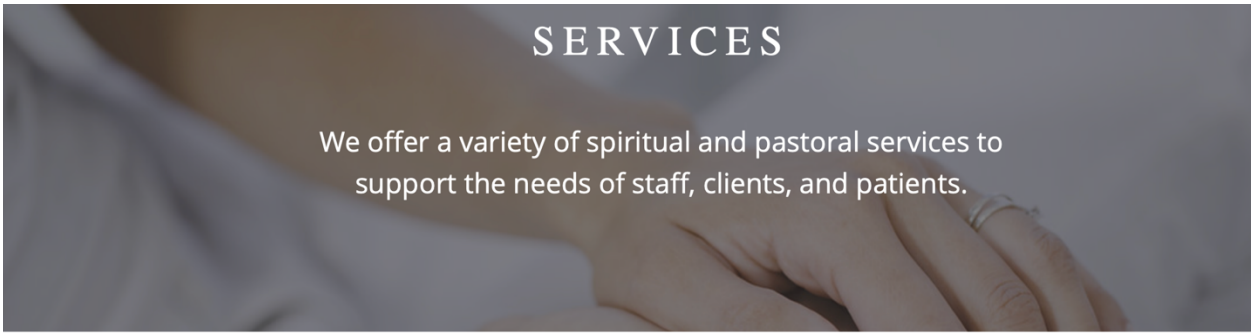


Figure 3—SCS Maine Home Page

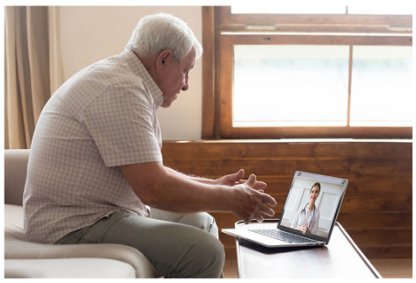


One-on-One Support

Chaplains provide individual conversations and support through reflective listening and non-judgmental presence. Chaplains are compassionate souls who provide a confidential level of support to people who are suffering.

Group Facilitation

Chaplains can provide group support by facilitating specific types of groups such as grief groups or spiritual wellness groups. Chaplains can also offer specific or traditional religious services or groups such as bible studies.



Grief Counseling

Chaplains can offer one-on-one grief counseling or other spiritual group processes to address peoples' struggles. Offerings such as soul collage, book reads, and singing are just a few of the ways chaplains can work with clients.

Critical Incident Stress Management (CISM)

Critical incident stress management is a modality for reducing PTSD. CISM can be modified and used after any stressful situation with staff, clients, or patients.

Figure 4—SCS Maine Services

Building Our Team

Initially, we had 11 chaplains agree to move over to become contract chaplains for SCS Maine in the summer of 2021. They had experience as volunteers for the state response. We needed to increase our chaplain resources, by number and areas of expertise to be able to market ourselves effectively to a variety of organizations and to have the capacity to provide compassionate care in more organizations. I developed a job description that communicated our requirements. I posted it on Zip Recruiter and shared it with the current chaplains and asked them to pass it to their contacts. We were able to attract 7 additional chaplains and have hired 5 to join our team.

Job Description for SCS Maine

Spiritual Care Services of Maine (SCS Maine) is recruiting per diem contract chaplains to provide care in community-based settings in the State of Maine. The chaplain will function as a part of the SCS Maine chaplain team and participate on the interdisciplinary team of the site or organization they serve. Chaplains provide spiritual and emotional support to clients, patients, residents, and referrals of all faiths and/or no recognized faith tradition. A chaplain may serve in a variety of ways. They may provide tele- chaplaincy support to folks who are shut in because of COVID. They may provide in person support to organizations that serve marginalized populations. They may serve people in congregate care facilities. Chaplains provide individual support of people and/or may provide support in the form of group facilitation as well. Chaplains must have one unit of Clinical Pastoral Education/Training. They must have advanced theological, cultural, or spiritual training. Ability to demonstrate empathic listening skills is a must. Chaplain must have access to a phone and a computer and be familiar with google docs/sheets to prepare chart notes. Chaplains must be able to use spiritual assessment tools and work collaboratively with interdisciplinary teams. If you are interested in providing spiritual care to people in their greatest hour of need as a part of a collaborative team. Work part time at a frequency that works with your schedule. If interested, please submit your resume or CV to Lori Whittemore at Lori@scsmaine.org.

Hiring Chaplains

The Board of Directors created criteria for hiring chaplains. Because our chaplains would be covered by clinical insurance, they would need to have at least one unit of clinical pastoral education/training. They would need advanced theological or spiritual training. They would preferably be ordained or sanctioned from their community. We required a background check, two references, and interview and proof of vaccination status. They would need to be willing to sign a contract with our organization to provide care for a specific contract. Included is a sample contract.

Sample internal chaplain contract

Independent Contractor Agreement

This Independent Contractor Agreement (hereinafter the "Agreement") is entered into this _____ day of _____, 2021, by and between **Spiritual Care Services of Maine**, a Maine nonprofit corporation having a mailing address of _____ (hereinafter sometimes referred to as "Corporation"), and _____, an individual with a mailing address of _____ (hereinafter sometimes referred to as "Contractor").

1. Independent Contractor. Subject to the terms and conditions of this Agreement, the Corporation hereby engages the Contractor as an independent contractor to perform the services set forth in the Scope of Work attached and incorporated herein as Exhibit A, and the Contractor hereby accepts such engagement.

2. Duties, Term, and Compensation. The Contractor's duties, term of engagement, compensation and provisions for payment thereof shall be as set forth in Exhibit B, attached and incorporated herein.

3. Performance of Services. The Contractor shall have day-to-day control over the performance of her services. The Contractor is expressly free to perform services for other parties while performing services for the Corporation. This Agreement shall not render the Contractor an employee, partner, agent of, or joint venturer with the Corporation for any purpose. The Contractor is and will remain an independent contractor in her relationship to the Corporation. The Corporation shall not be responsible for withholding taxes with respect to the Contractor's compensation hereunder. The Contractor shall have no claim against the Corporation hereunder or otherwise for vacation pay, sick leave, retirement benefits, social security, worker's compensation, health or disability benefits, unemployment insurance benefits, or employee benefits of any kind. If compensation paid to the Contractor exceeds $599 in a calendar year, the Corporation will file Form 1099-Misc with the IRS.

4. Confidentiality. The records and data of the Corporation are confidential to it, and the Contractor shall treat them in confidence. Upon the Corporation's request, the Contractor shall return any records or data to the Corporation upon termination of this agreement. The same level of confidentiality shall apply to any reports, findings and recommendations of Contractor to the Corporation, as well as all notes and written materials developed through the work performed under this Agreement. All information collected by Contractor, in the course of this work, shall be the property of the Corporation and may not be published,

distributed, disclosed or otherwise utilized by the Contractor without permission in advance from the Corporation.

5. Liability and Indemnification. The Corporation shall maintain clinical liability insurance policy for the duration of this Agreement, with coverage amounts of $1 million per occurrence and $3 million total. The Corporation shall indemnify, defend and hold harmless the Contractor to the extent any claims against the Contractor are covered by said insurance policy. The Contractor agrees to waive, indemnify, defend and hold harmless the Corporation from and against any and all claims, demands and actions not covered by said insurance policy. The Corporation's and the Contractor's obligations under this paragraph 5 hereof shall survive the termination, for any reason, of this Agreement.

6. Termination. Either party may terminate this Agreement at any time by 15 working days' written notice to the other party. In addition, if the Contractor is convicted of any crime or offense, fails or refuses to comply with the written policies or reasonable directive of the Corporation, is guilty of serious misconduct in connection with performance hereunder, or materially breaches provisions of this Agreement, the Corporation at any time may terminate the engagement of the Contractor immediately and without prior written notice to the Contractor.

IN WITNESS WHEREOF the undersigned have executed this Independent Contractor Agreement as of the day and year first written above. The parties hereto agree that facsimile signatures and counterpart originals shall be as effective as if a single original.

SPIRITUAL CARE SERVICES OF MAINE

CONTRACTOR

_____ _____

By: _____ Print name: _____

Its: President

_____ _____

Date Date

Onboarding, Orienting and Preparing Chaplains to Serve.

In fall of 2021, I worked with the Board of Directors to create an orientation to onboard chaplains to SCS Maine. In PowerPoint format, I created an orientation that provided background and origin of the organization; mission, vision, and values; continuing education requirements; expectations for contractors; current and anticipated contracts; policy and procedures; and terms of remaining in good standing. We provided the orientation to the initial chaplains in September of 2021. Upon recruiting additional chaplains, we held a second orientation in January of 2022 with another scheduled for February of 2022.

Figure 5—PowerPoint Slides from Orientation Part 1

Figure 6—PowerPoint Slides from Orientation Part 2

Additionally, we provided each chaplain with a handbook of our policies and procedures for working with SCS Maine.

Spiritual Care Services of Maine

SCS MAINE HANDBOOK




V 10.2.21

SCS Maine is here if you need us

Spiritual Care Services of Maine (SCS Maine) provides professional, compassionate, spiritual care to individuals, groups, and organizations with today's religious and spiritual landscape in mind.

SCS Maine believes in all people's inherent worth and dignity and offers non-judgmental support in our encounters. Our chaplains provide respect, loving-kindness, and honesty for people dealing with addiction, stress, fear, health issues, and other challenges. We work as a part of integrated teams with other organizations to ensure holistic care for those we serve.

SCS Maine offers one on one support through empathetic listening. In addition, we offer group support, group facilitation, debriefing, and tailored religious services community rituals. Our vision is that everyone and anyone who needs our help will find compassion, comfort, assistance, and hope.

Our dedicated chaplains support all Mainers, especially those populations who suffer disproportionately in times of stress and crisis. We serve people with addiction; people who are isolated, abused, or incarcerated; people who suffer from health and mental health challenges; folks without housing; Veterans, and other folks in need of spiritual care. Recognizing that no person should suffer or walk alone, we intend to address human suffering by meeting people where they are at and accompanying them wherever they are on life's journey.

Spiritual Care Services of Maine (SCS Maine) chaplains are grounded in a faith tradition, have gone through educational, clinical training, spiritual discernment, and have learned how to serve the spiritual needs of others. Chaplains hold themselves and others accountable to ethical standards and conduct. Chaplains contracted with SCS Maine to provide pastoral spiritual care as

directed by a memorandum of understanding (MOU) created between the SCS Maine and the agency or the institution. SCS Maine chaplains respect the dignity of all human beings and their life journey.

The policies listed in this *Handbook* are for Spiritual Care Services of Maine (SCS Maine). If a chaplain is contracted through SCS Maine to work with a company, agency, or institution, the chaplain is expected to follow the contracting agency's and the chaplain's own ordaining body's policies

INTRODUCTION

What is chaplaincy, and what does it mean to be a contractor?

A professional chaplain is a person clinically trained to be in a faith tradition and makes informed decisions based on their education, ethics, appropriate boundaries, and competencies. A chaplain is one who listens to another human being, and if need be, refers that person to a proper resource.

A contractor with SCS Maine is a chaplain who receives financial compensation for offering spiritual care for a contracting agency or client. The contractor is considered self-employed and is responsible to manage their state and federal tax reporting.

*SCS Maine does have insurance to cover work done by 1099 contractors and consultants that work for SCS Maine.

List of agencies and companies with whom we are working:

- The Cedars
- Department of Health and Human Services
    - Homeless Quarantine Shelter

- Amistad daytime program for unhoused
- Covid Social Service Crisis Referral Program

POLICIES

Confidentiality policy:

SCS Maine leans into the idea that all persons are to be respected and worthy of spiritual care. Conversations between a chaplain and the agency, institution, or individual(s) are confidential. Chaplains are also expected to follow their own ordaining body's expectations of confidentiality. However, confidentiality is not guaranteed if a person is threatening harm to themselves or others.

During supervision, it may be appropriate for the chaplain to share updates, successes, and challenges with their supervisor, and unless otherwise specified, these will remain confidential. Workgroups may also be a place where sensitive information is shared and chaplains will remain aware of what is contextually appropriate when in conversations with their colleagues in the SCS Maine.

Mandated Reporting:

Clergy are mandated reporters in the State of Maine, and this means that when abuse, neglect, financial exploitation, self-harm, or other ethical or safety violations are suspected, we are to follow the appropriate laws. These issues can occur between individuals as well as within any agency with whom we are working. If a chaplain suspects a report needs to be made, they will contact their SCS Maine supervisor, and in consultation, identify the next steps.

Masks and Vaccinations:

SCS Maine understands there are intricacies with illness and disease. We also recognize that we are working with vulnerable populations who may need extra protection. When serving their chaplaincy role in person, chaplains are to follow state laws and recommendations for mask-wearing. Contractors are required to be fully vaccinated against the Covid 19. They will be required to provide a copy of their vaccination record for their personnel file. They also follow the agency's, the institution's or an individual's requirement for masks and vaccinations.

Boundaries:

SCS Maine recognizes the importance tools have in the success of all professionals, with the most essential tool any chaplain holds is being themselves. As such, boundaries, including self-care, is of utmost importance to the SCS Maine chaplain's work and physical, emotional, and spiritual health. In addition, boundaries assist chaplains by establishing clear roles between chaplain and client/patient, and the chaplain holds all responsibility around the appropriate boundaries.

Since boundaries are sometimes found in the "gray areas" of spiritual work, SCS Maine chaplains are encouraged to take boundary training as available and use their supervision time to share any issues around boundaries. SCS Maine also encourages chaplains to hold each other accountable if/as needed.

Examples of potential unhealthy boundaries:

- Engaging with a client/patient in a certain way because of something in a chaplain's life circumstances/faith journey.
- Engaging with a client/patient in a certain way because the chaplain wants to relieve their anxiety over the person's circumstance(s).
- Working with a client/patient more hours than what they are paid to work.
- Providing resources and feedback outside of the chaplain's role, and training

- Looking to clients to meet friendship and/or emotional needs, including but not limited to sexual relationships.
- Exchange of money that falls outside of SCS Maine policies and procedures.
- Using the innate power dynamic to have any of their own needs met.
- Giving out personal information and details to patients/clients.
- Entering an independent contract with SCS Maine clients for at least a year.

Harassment:

Spiritual Care Services of Maine (SCS Maine) deeply values and is committed to diversity. Therefore, we honor the differences among us, knowing that those differences strengthen and enhance not only our experience while at SCS Maine but our community as well. In this way, we can utilize our diverse backgrounds, skills, and perspectives to create a culture of inclusion.

SCS Maine seeks people from *all* community segments for *all* job levels and volunteer positions and actively supports. It actively supports the development of employees and volunteers for personal growth and internal advancement opportunities.

SCS Maine is an equal opportunity employer and makes employment and volunteer decisions based on merit. Therefore, we want to have the best available individuals in every job and volunteer position.

SCS Maine strongly disapproves of and will not tolerate the sexual harassment and unlawful discrimination of any employee, visitor, customer, or volunteer.

SCS Maine believes all individuals have the right to work and volunteer in an environment free of sexual harassment and discrimination based on race or color, sex, sexual orientation, gender identity, pregnancy-related condition, physical or mental disability, religion, age, genetic information, ancestry or national origin.

Sexual harassment is a form of misconduct that violates *Section 4572* of the Maine Human Rights Act and undermines the integrity of the employment relationship or the volunteering environment. In any employment or volunteer context, sexual harassment can be defined as the attempt to control, influence, or affect the career, salary, or job of an individual in exchange for sexual favors or the creation of an intimidating, hostile, or offensive working or volunteering environment based on unsolicited and unwelcome sexual overtures or conduct, either verbal or physical. The following is the Maine Human Rights Commission's regulatory definition of sexual harassment:

Unwelcome sexual advances, requests for sexual favors, and other verbal or physical conduct of a sexual nature constitute sexual harassment when:

- submission to such conduct is made either explicitly or implicitly a term or condition of an individual's employment;
- submission to or rejection of such conduct by an individual is used as the basis for employment decisions affecting such individual; or
- such conduct has the purpose or effect of substantially interfering with an individual's work performance or creating an intimidating, hostile, or offensive working environment.

Examples of sexual harassment are: 1) repeated unwelcome sexual flirtations, advances, gestures, comments, or propositions; 2) continued or repeated verbal abuse of a sexual nature; 3) graphic or degrading comments about an individual or his/her/their appearance; 4) the display of sexually suggestive objects or pictures or jokes; 5) any offensive physical contact; and 6) any retaliation or threat of retaliation against one who has made a complaint of, harassment. In addition, no one should suggest, imply or threaten that an applicant or employee's "cooperation" of a sexual nature (or refusal thereof) will have any effect on the individual's employment, assignment, compensation, advancement, career development, or any other condition of employment.

Any employee, volunteer, director, board member, officer, visitor, or constituent of SCS Maine who feels that s/he/they has been subject to sexual harassment or unlawful discrimination, or who has observed or learned of such incidents directed toward others, should immediately report the incident or incidents to the President, or if the President is involved, they should report the incident to the Vice President. SCS Maine will make a thorough investigation of any alleged incident. The investigation will be kept confidential to the greatest extent practical, and as consistent with legal obligations. Any employee or volunteer who is determined, after investigation, to have engaged in sexual harassment or discrimination will be subject to appropriate sanctions up to and including termination or dismissal as a volunteer, including, if applicable, removal from the Board of Directors.

In addition, employees may file a complaint of sexual harassment or unlawful discrimination directly with the Maine Human Rights Commission at State House Station 51, Augusta, Maine 04333, (207) 624-6290 (see also https://www.maine.gov/mhrc/file for more information and a link to an online complaint form). Any employee wishing to make a complaint directly to the Maine Human Rights Commission must do so within 300 days of the alleged incident or incidents.

Although SCS Maine's policy on discrimination and harassment applies to volunteers, SCS Maine and its volunteers understand that SCS Maine is not extending any employee rights to volunteers, including the right to bring an action based on federal, state, or local discrimination or harassment laws.

Employees are protected by law from retaliation for filing a complaint of sexual harassment or discrimination with the Commission. Accordingly, no retaliatory measures will be taken against any employee who files a complaint of sexual harassment or discrimination.

Discrimination:

Spiritual Care Services of Maine does not discriminate on the grounds of race, color, religion, sex, sexual identity, sexual orientation, including transgender status, gender expression, national origin, citizenship status, age, disability, genetic information, employment education or housing status.

Smoking, alcohol, and substance use:

SCS Maine chaplains are human expressions of SCS Maine and often work with highly vulnerable people and situations. The choices chaplains make around smoking, alcohol, and substances while working can impact the health of those whom they are serving. As such, chaplains are to refrain from smoking both legal and illegal substances, drinking alcoholic beverages, and participating in substance use of any kind. In addition, chaplains are expected to follow all smoking, alcohol, and substance policies and individual(s) with whom they are working.

It is expected that SCS Maine chaplains will not engage in these activities with clients outside of the contracted activities while under contract through SCS Maine. SCS Maine also recognizes that spiritual care is challenging, demanding, and, at times, traumatizing work. Therefore, if at any time a chaplain finds they need resources for their own smoking, alcohol, or substance use, they are invited to reach out to their SCS Maine supervisor or a Board Member for support, assistance, and/or referrals.

Violence in the Workplace:

SCS Maine does not tolerate any form of violence in the workplace, and this can include but is not limited to verbal abuse, sexual abuse, physical abuse, intimidation by one person or group over another, and bullying. If a chaplain experiences violence in the workplace, they are to contact their SCS Maine supervisor. If they do not feel safe speaking with their SCS Maine supervisor, they may talk directly with a Board member who will work with them on the next steps.

If a chaplain is accused of violence in the workplace, the Board will use whatever information is available to develop the next steps. These steps could include immediate termination of the chaplain's contract with the agency and a referral to the chaplain's ordaining body.

Supervision Within SCS Maine:

SCS Maine chaplains will have monthly supervision with SCS Maine Supervisor. The purpose of this supervision is to share how the contract is going, how the chaplain is doing, overall, and to identify areas of growth and support that the chaplain might need. Supervision will be between 30-60 minutes and will happen by Zoom unless otherwise specified. A chaplain may also request additional oversight at any time.

SCS Maine will also offer group supervision and opportunities for contractors to meet quarterly for support and professional development.

Incident Reporting:

Chaplains should contact the SCS supervisor immediately by phone or Zoom and report in it writing by email, any incident that makes them uncomfortable is in conflict with SCS Maine standards or that has occurred at a contract location that has or may cause an issue with the site. SCS Supervisor may set up a meeting to discuss or have the chaplain fill out a more thorough form for the record.

Continuing Education:

Chaplaincy as a profession understands that continuing education is vital to one's personal and professional growth as such chaplains are to attend training opportunities and keep up six continuing education units (CEUs), or similar, per year. Additionally, SCS Maine will provide training opportunities for free, and chaplains will be invited and encouraged to attend.

Reasons for immediate dismissal/end of contract:

SCS Maine recognizes the importance of due process and care for all individuals. We also acknowledge that all persons make mistakes. However, specific reasons that can be cause for immediate dismissal/ contract termination with SCS Maine. This list is not all-inclusive but can be due to:

- Committing fraud with SCS Maine, a partnering agency, or an individual.
- Harassment or abuse, sexual or otherwise.
- Proselytizing
- Sexual/romantic relationship with a client

Conflict Resolution:

We are a people who work together with the best intentions, but there is also a recognition that sometimes conflicts, differing opinions, or perspectives may arise. Therefore, if a chaplain finds themselves in this situation *and they deem it safe for their well-being,* they are encouraged to speak professionally with the person they are experiencing tension.

If the issues continue or the person does not feel it is safe to speak to the person directly with their site supervisor, SCS Maine supervisor, or an SCS Maine Board member. The direct supervisor will work with all parties involved. If need be, the Board will participate in conflict resolution. If the conflict is with the supervisor, the chaplain is encouraged to contact a Board member who, with the chaplain, will determine the next steps.

Conflict of Interest:

SCS Maine appreciates the many ways we are all interconnected with each other, and it is often unavoidable that chaplains find themselves in a "dual relationship" with a client, agency, or institution. Therefore, when there is a potential conflict of interest, the chaplain is to notify their supervisor (and, if need be, their ordaining body) as soon as possible.

Conflict of Interest can be, but is not limited to:

- The chaplain pastoring to a neighbor or friend.
- The agency or institution employs a close family member of the chaplain.
- The chaplain has other employment which overlaps with a particular agency or institution.
- The agency, institution, or client has offered the chaplain goods or money.

Political Actions by Chaplains:

SCS Maine encourages all chaplains to lean into their faith traditions and speak to issues important to them. While engaging in any political or controversial activity, chaplains recognize they are not to speak for, on behalf of, or in any way represent themselves as ambassadors of SCS or any affiliated agency or institution. If a political or controversial activity arises and aligns with the mission of SCS, the Board will decide what, if any, actions SCS will address.

Media/Press Relations:

Unless otherwise directed by a supervisor or the Board of Directors, all media inquiries related to SCS Maine will be directed to the SCS Maine supervisor or assignee.

Advertising of Credentials:

Chaplains will represent their competencies earned from their training, background, education, and ordaining body. Chaplains will neither directly or indirectly lead agencies, institutions, or clients to believe professional competencies are met if the chaplain has not yet earned them.

Appropriate Attire

SCS Maine contractors are required to meet or exceed the dress code of their site placement. SCS Maine may provide the contractor with clothing with logos to identify them as an SCS Maine Chaplain or Spiritual Care Giver.

Coverage

If a contractor is unable to cover a shift, they should contact their SCS supervisor.

Chaplain Resource Portal

Other important resources were loaded into a chaplain resource portal on our website. Once a chaplain was onboarded, we gave them access to the portal and they could fill out their payroll data, access timesheets, chart notes, articles, team meeting minutes, and other helpful information.

Figure 7—Chaplain Resources

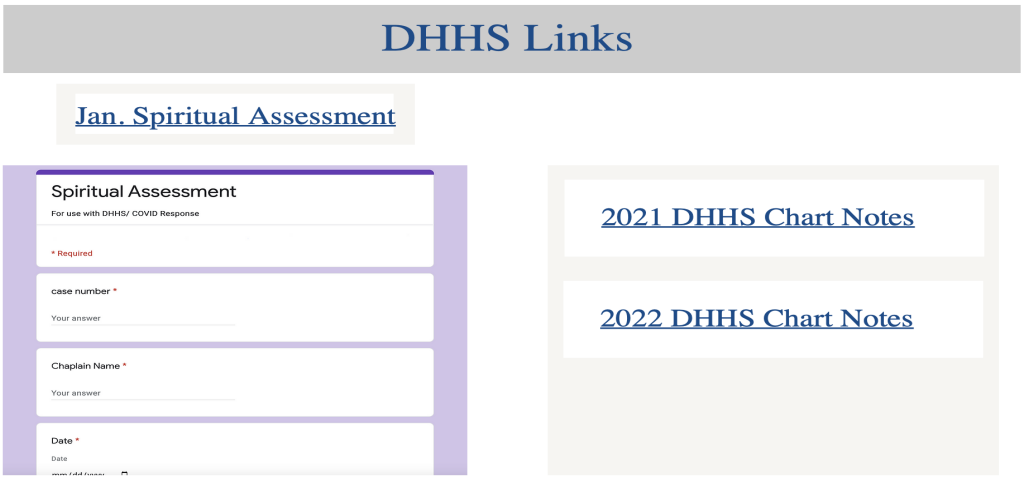
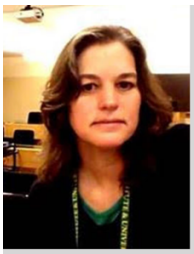


Figure 8—DHHS Links

Assistant Clinical Director, Chaplain

Rev. Jacquelyn Thornton

Jacquelyn Thornton is an ordained minister and Certified Maine Law Enforcement Chaplain. Jackie has additional training in Critical Incident Stress Management.



Chaplain

Dianne Dragon, MA, BCC

Chaplain Dianne is Catholic with a Buddhist Vipassana meditation practice. BCC Spiritual Care Association of NY. She holds a BA in Liberal Arts with a concentration in Family Systems Psychology and a Masters in Health and Wellness. Her doctoral work is an exploration of the essential teaching in Chaplain training and Spiritual Care leadership. Specialties include spirituality in behavioral health groups, trauma-informed spiritual care, and staff support.

Chaplain

Rev. Jake Fahey

Jake Fahey (he/him) is an interfaith chaplain and antiracism organizer living on Abenaki land (now known as Portland, ME). He is interested in building local structures for a spiritual and cultural transformation that address systems of oppression, and seed systems of liberation. He graduated from the Chaplaincy Institute of Maine (ChIME) in 2018 and has completed two units of Clinical Pastoral Training of Southern Maine. He is organizing with Community Change Inc. (CCI) and the Racial Equity Institute (REI).

Chaplain

Sally Thomas

Sally Thomas is a listener. Trained as a spiritual companion and chaplain, Sally's doctoral research focuses on how families and friends might care for one another spiritually in a practice called Wondering Together. Sally began her career as a nurse practitioner with a specialty in oncology, palliative, and hospice care and is an accredited trainer in the art of Godly Play.

Chaplain

Brian Wilcox

Brian is a vowed spiritual contemplative, writer, author, and interspiritual chaplain. His experience includes counseling, spiritual direction, hospice and corrections chaplaincy, pastor, professor in religious studies, teacher of meditation and mindful living, and facilitator of faith-based jail ministry. He sees himself as a companion presence alongside others regardless of their identity as religious, spiritual, or neither.

Chaplain

Rev. Thomas Kircher

Rev. Thomas Kircher is a Board Certified Clinical Chaplain ordained in the Interfaith religious tradition. His chaplaincy experience includes working with homeless veterans, low-income seniors, nursing home residents, and individuals facing challenges with mental illness and addiction. Rev. Kircher offers the skills of listening and reflection to individuals in need along their personal life journeys and enjoys facilitating group discussions.

Figure 9—Pictures and Bios of Select Chaplains

Building Our Business

Part of the impetus for building all that infrastructure in short order, basically over the course of 3 months, was to bid on a contractor the State of Maine COVID social supports. The project shifted from the idea of serving a few nonprofit organizations independently, to serving hundreds of people, as a part of one DHHS contract. The State of Maine created a coordinated referral system for people who have unmet needs because of COVID. In non-pandemic time, Community Action Programs (CAP agencies), and the community and ethnic community-based organizations work to meet the unmet needs in their own communities. When COVID happened, the need grew exponentially. The State received money from the Recovery Act and other federal programs to distribute through CAP agencies and community-based organizations to provide for unmet needs due to COVID. The DHHS program needed to coordinate delivery of care from a higher level to better distribute resources to the specific communities. DHHS created a referral system that people could access from all over the state, by phone or by computer, to report someone needed urgent assistance due to COVID.

One call to the state referral line would plug a client into a CAP agency that serves their area, or an ethnic community-based organization that could meet their needs. Federal money would be allocated to the agencies based on volume of referrals. A referral might come in for a family in quarantine and unable to work. They may not be able to pay rent or afford food or be able to leave the house to go grocery shopping. DHHS would direct the referral to the appropriate CAP agency to process a request for rental assistance and an appropriate community-based organization to provide them with two weeks of groceries. If they reported significant stress and anxiety, a referral for a chaplain call would be made.

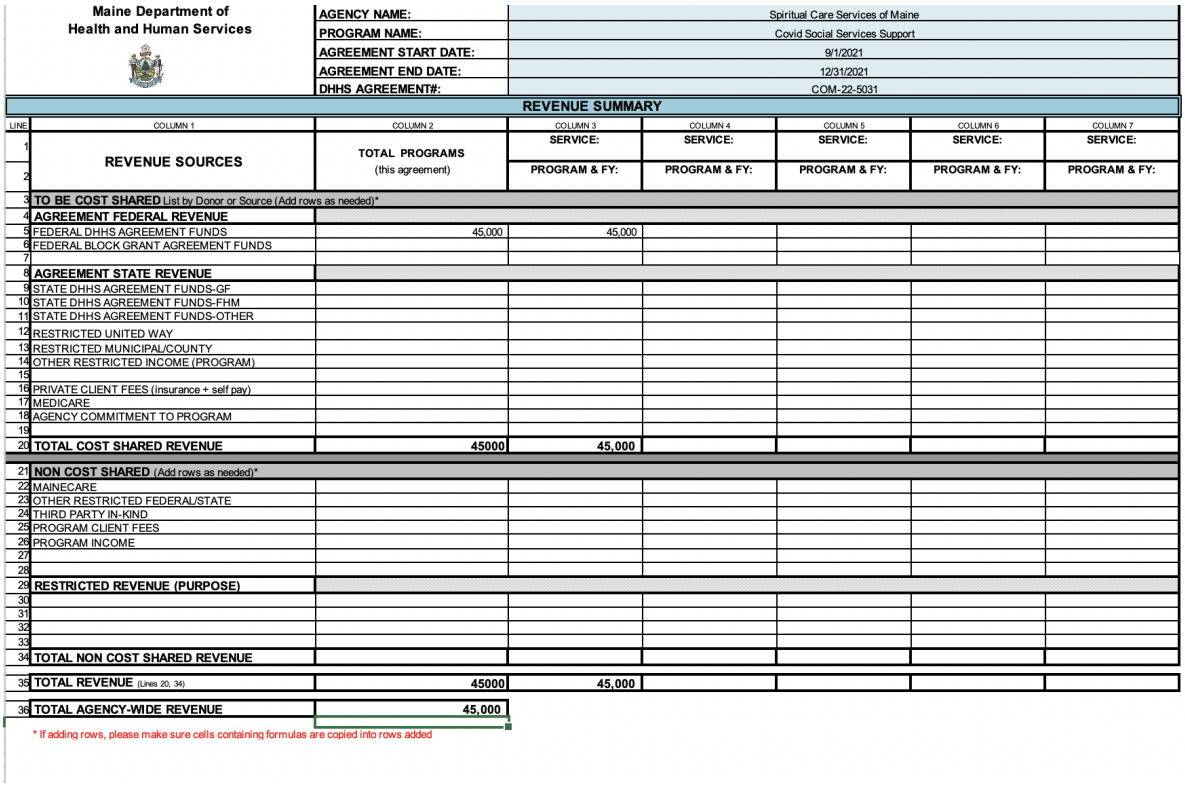
Once the physical needs of the client had been met, a SCS Maine chaplain would call to provide remote emotional and spiritual support. That is where the specific compassionate intervention was made. Since the initial contract, we have broadened our reach to provide COVID support in homeless quarantine shelters, and homeless day shelters.

The state contract allowed for the project to be fully executed in short order. We have a contract through the end of 2022 and are in conversation with the State to develop further opportunities to offer spiritual care to vulnerable populations via DHHS grants. I had envisioned seeking small grants to do work in individual nonprofits in support of their clients. The work on the state contract has allowed us to work under one broader grant to serve individuals in those same populations as it relates to COVID.

Building business for this SCS Maine been primarily targeted expanding the scope of the State contract so that the funding would cover us to provide care in disparately suffering communities. Besides responding to referrals, we have an opportunity to offer care to the organizations that we had originally pitched our model to if the care provided relates to COVID. Within the scope of the contract, we were invited to help identify people and organizations that would benefit from our services and offer them care.

In addition to the support for individuals being referred to DHHS, I was able to build programing and "business" to provide care in other ways. One way was to help organize and facilitate interfaith responses to COVID by creating a faith leaders forum. The forum was a panel discussion about the effects of COVID in different faith communities and how leaders were providing religious services, caring for their sick and confined and if or how they were encouraging their communities to get vaccinated.

Another program we offered was remote Bible studies in a jail that was closed to outside visitors. They had the capacity to Zoom in groups and requested the support from the state to get spiritual support by our chaplains. These are just two examples of how we were able to build business from within the contract itself.



	Maine Department of Health and Human Services	AGENCY NAME:	Spiritual Care Services of Maine				
		PROGRAM NAME:	Covid Social Services Support				
		AGREEMENT START DATE:	9/1/2021				
		AGREEMENT END DATE:	12/31/2021				
		DHHS AGREEMENT#:	COM-22-5031				
	REVENUE SUMMARY						
LINE	COLUMN 1	COLUMN 2	COLUMN 3	COLUMN 4	COLUMN 5	COLUMN 6	COLUMN 7
1	REVENUE SOURCES	TOTAL PROGRAMS (this agreement)	SERVICE:	SERVICE:	SERVICE:	SERVICE:	SERVICE:
2			PROGRAM & FY:	PROGRAM & FY:	PROGRAM & FY:	PROGRAM & FY:	PROGRAM & FY:
3	**TO BE COST SHARED** List by Donor or Source (Add rows as needed)*						
4	**AGREEMENT FEDERAL REVENUE**						
5	FEDERAL DHHS AGREEMENT FUNDS	45,000	45,000				
6	FEDERAL BLOCK GRANT AGREEMENT FUNDS						
7							
8	**AGREEMENT STATE REVENUE**						
9	STATE DHHS AGREEMENT FUNDS-GF						
10	STATE DHHS AGREEMENT FUNDS-FHM						
11	STATE DHHS AGREEMENT FUNDS-OTHER						
12	RESTRICTED UNITED WAY						
13	RESTRICTED MUNICIPAL/COUNTY						
14	OTHER RESTRICTED INCOME (PROGRAM)						
15							
16	PRIVATE CLIENT FEES (insurance + self pay)						
17	MEDICARE						
18	AGENCY COMMITMENT TO PROGRAM						
19							
20	**TOTAL COST SHARED REVENUE**	**45000**	**45,000**				
21	**NON COST SHARED** (Add rows as needed)*						
22	MAINECARE						
23	OTHER RESTRICTED FEDERAL/STATE						
24	THIRD PARTY IN-KIND						
25	PROGRAM CLIENT FEES						
26	PROGRAM INCOME						
27							
28							
29	**RESTRICTED REVENUE (PURPOSE)**						
30							
31							
32							
33							
34	**TOTAL NON COST SHARED REVENUE**						
35	**TOTAL REVENUE** (Lines 20, 34)	**45000**	**45,000**				
36	**TOTAL AGENCY-WIDE REVENUE**	**45,000**					

* If adding rows, please make sure cells containing formulas are copied into rows added

Figure 10—Cover Page for DHHS Contract

STATE OF MAINE | SERVICE CONTRACT

SERVICE CONTRACT

DATE: **11/1/2021**

ADVANTAGE CONTRACT #: **20211027000000001079**

DEPARTMENT AGREEMENT #: **COM-22-5031**

CONTRACT AMOUNT: **$ 45,000.00**

START DATE: **9/1/2021** END DATE: **12/31/2021**

This Contract, is between the following Department of the State of Maine and Provider:

State of Maine DEPARTMENT

DEPARTMENT: **Health and Human Services**

Address: **109 Capitol Street**

City: **Augusta** State: **ME** Zip Code: **04333-0011**

PROVIDER

PROVIDER: **Spiritual Care Services of Maine**

Address: **6 Ocean View Circle**

City: **Saco** State: **ME** Zip Code: **04072**

Provider's Vendor Customer #: VC0000250611

Each signatory below represents that the person has the requisite authority to enter into this Contract. The parties sign and cause this Contract to be executed.

Department of Health and Human Services

Signature **Benjamin Mann,**
Deputy Commissioner of Finance

Date 12/8/21

Provider

Signature **Lori Whittemore Executive Director**

Date 12.9.21

Figure 11—Signatory Page for DHHS Contract

Our other contract we entered during the project period was with a senior living community, the Cedars. Our contract was to provide spiritual support and religious services to their five different communities. Due to Covid, all programming was contracted to happen remotely by Zoom. The facility requested that we offer programming 2x per month and that we offer it to each of the communities simultaneously. We were able to meet that request.

Contract for the Cedars

Chaplaincy Services Agreement Between

Spiritual Care Services of Maine And Cedars

Effective Date: 9.1.2021

1. PARTIES
   1.1. This Chaplaincy Services Agreement (the "Agreement") is between the following Parties:
      1.1.1. **Spiritual Care Services of Maine** ("SCS Maine"), a Maine nonprofit corporation having a mailing address of 6 Ocean View Circle, Saco, ME 04072; and
      1.1.2. **The Cedars**, a Maine nonprofit corporation having a mailing address of _____.
2. PURPOSE

   The Purpose of this Agreement is for SCS Maine to provide chaplaincy services to individual clients, volunteers, and employees of The Cedars.

3. SERVICES AND RESOURCES
   3.1. SCS Maine agrees to perform the following services and to provide the following resources:
      3.1.1. SCS Maine shall provide services for the Chaplaincy Program in accordance with the Scope of Services and Fees set forth in Attachment A.
      3.1.2. SCS Maine shall provide chaplains to undertake the Chaplaincy Program at Cedars's place of business. SCS Maine's chaplains may be employees or contractors of SCS Maine, and shall agree to abide by SCS Maine's standards and codes of conduct as set forth in its Handbook.
      3.1.3. SCS Maine shall maintain good standing as a Maine nonprofit corporation. SCS Maine has applied for recognition of 501(c)(3) tax-exempt organization with the Internal Revenue Service, and expects such recognition shortly.
      3.1.4. Provide Chaplaincy Program intake and other administrative forms for individuals using the program's services.

   3.2. Cedars agrees to perform the following services and to provide the following resources:
      3.2.1. Provide facilities for the Chaplaincy Program at its property in Portland.
      3.2.2. Administer program intake and enrollment for the program participants.

4. INDEMNIFICATION
   4.1. SCS Maine agrees to defend, indemnify and hold harmless Cedars from and against all claims, damages, liabilities, costs and expenses (including reasonable attorneys fees and expenses related to the defense of any claims), joint or several, which may be asserted

against Cedars, or for which it may now or hereafter become subject arising out of or related to the services pursuant to this Agreement performed by SCS Maine employees, volunteers, directors, contractors, licensees, or agents.

4.2. Cedars agrees to defend, indemnify and hold harmless SCS Maine from and against all claims, damages, liabilities, costs and expenses (including reasonable attorneys fees and expenses related to the defense of any claims), joint or several, which may be asserted against SCS Maine, or for which it may now or hereafter become subject arising out of or related to the services pursuant to this Agreement by SCS Maine employees, volunteers, directors, contractors, licensees, or agents.

4.3. The provisions of this Section 4 shall survive the termination or expiration of this Agreement.

5. TERM AND TERMINATION

5.1. The term of this Agreement shall commence as of the date of execution, and terminate on August 31, 2022. This AGREEMENT shall be automatically renewed for successive periods of one (1) year each commencing on the day following August 31 of 2022 in accordance with section 8.2 below.

5.2. This Agreement and the SCS Maine contract may be terminated by either Party with thirty (30) days' prior written notice.

6. COMMUNICATION

6.1. The Parties will coordinate public information and work cooperatively on any press release or communication to the media regarding the services offered under this Agreement. Lori Whittemore at SCS Maine and _____ at _____- will serve as primary contract persons for the respective Parties.

7. CONFIDENTIALITY

7.1. SCS Maine leans into the ideal that all persons are to be respected and are worthy of spiritual care. It is understood that conversations between a chaplain and the agency, institution, or individual are held in confidence. During supervision, it may be appropriate for the chaplain to share updates, successes, and challenges with their supervisor, and unless otherwise specified, these will remain confidential. Work groups may also be a place where sensitive information is shared, but chaplains will remain aware of what is contextually appropriate when in conversations with their colleagues in the SCS Maine. Confidentiality is not guaranteed if a person is threatening harm to themselves or others.

8. MISCELLANEOUS

8.1. This Agreement may be signed in duplicate originals.

8.2. This Agreement will be governed by and construed under the laws of the State of Maine without regard to choice of law principles that would require the application of the laws of any other jurisdiction.

8.3. The headings of sections in this Agreement are provided for convenience only and will not affect its construction or interpretation.

9. AMENDMENT

This Agreement may be amended by written agreement of the parties and such written agreement shall be approved by each Party.

IN WITNESS WHEREOF, each Party, by its duly authorized representatives, has signed and sealed this Agreement as of the dates indicated below, the latter of which shall be the Effective Date.

Spiritual Care Services of Maine

_____ _____

Date By:

Its: Board President

The Cedars

_____ _____

Date By:

Its:

ATTACHMENT A

SCOPE OF SERVICES AND FEES

SCS Maine Chaplains can provide but are not limited to:

One on one counseling

Group facilitation

Religious services

Initial program for this contract is the preparation and facilitation of spiritual programing/group facilitation for residents of the Cedars. This will take place every other Thursday at 2:00pm, beginning September 2, 2021 for approximately an hour. An additional one hour will be paid for preparation and facilitation.

As full compensation for the services rendered pursuant to this Agreement, the Corporation shall pay SCS Maine at a rate of Fifty Dollars ($50.00) per hour, to be paid one time per month upon the timely submittal of billing invoices from SCS Maine. SCS Maine will submit and invoice by the end of each month and The Cedars shall have 10 days to pay the invoice.

Providing Care

The ultimate goal of all of this labor was and is to provide professional, compassionate care to God's people, whoever they are and wherever they are on their journey. For us to be activated for the DHHS contract, a referral would have to come in to the DHHS Covid Support that requested support for stress and anxiety. Below is a contract and referral sheet.

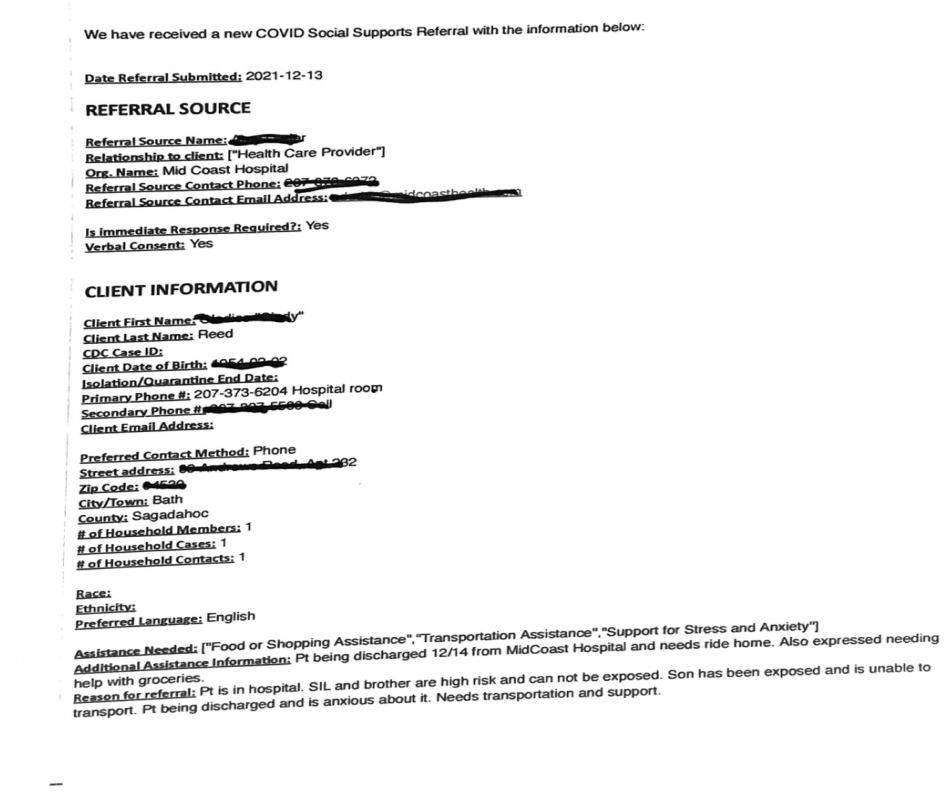
Good Afternoon CC & SCS Maine,

This is a new referral for a large household in Albany Township. They are requesting food support and support for stress and anxiety (SCS Maine). It is a self-referral and the end of quarantine date given is 12/13…. Let's double check on this date with them. If you can ask about their test positive dates, I'd be happy to help determine the quarantine period for the entire family.

Thanks!

Caroline F[redacted]
Community Care Officer
DHHS Covid Social Support & Vaccine Equity
207-441-9913

Figure 12—Referral



We have received a new COVID Social Supports Referral with the information below:

Date Referral Submitted: 2021-12-13

REFERRAL SOURCE

Referral Source Name: [redacted]
Relationship to client: ["Health Care Provider"]
Org. Name: Mid Coast Hospital
Referral Source Contact Phone: [redacted]
Referral Source Contact Email Address: [redacted]

Is immediate Response Required?: Yes
Verbal Consent: Yes

CLIENT INFORMATION

Client First Name: [redacted]
Client Last Name: Reed
CDC Case ID:
Client Date of Birth: [redacted]
Isolation/Quarantine End Date:
Primary Phone #: 207-373-6204 Hospital room
Secondary Phone #: [redacted]
Client Email Address:

Preferred Contact Method: Phone
Street address: [redacted]
Zip Code: [redacted]
City/Town: Bath
County: Sagadahoc
# of Household Members: 1
# of Household Cases: 1
# of Household Contacts: 1

Race:
Ethnicity:
Preferred Language: English

Assistance Needed: ["Food or Shopping Assistance","Transportation Assistance","Support for Stress and Anxiety"]
Additional Assistance Information: Pt being discharged 12/14 from MidCoast Hospital and needs ride home. Also expressed needing help with groceries.
Reason for referral: Pt is in hospital. SIL and brother are high risk and can not be exposed. Son has been exposed and is unable to transport. Pt being discharged and is anxious about it. Needs transportation and support.

Figure 13—Face Sheet

Our on-call chaplain would call back using *67 to block their number and offer a chaplain visit phone call. They would introduce themselves as a Chaplain with the Spiritual Care Services of Maine and that we had received a referral to contact the client who was reportedly feeling stress as a result of something related to COVID. Below is a chart note from a call.

R5617 Chaplain B Wilson

11/17/21	Client presented non-anxious. In recovery, 2 years clean. Strong suppot system. Cut off from family of origin, due to their addiction and use. Jesus her "higher power." Says the church saved her life, through a pastor who got her help when she was at the bottom due to addiction. Reported all needs being met. Says she appreciates all the help being given, admitting it is not easy for her to ask for help, it making her feel weak and unable to meet the needs of her family of 6. No referal. Chaplain provided mindful presence and listening, encouragement, affirmation, guidance on resources through DHHS, and affirmation of prayers for the family.

Figure 14—Example Chart Note

(not associated with the case above)

We also had another contract to facilitate a spiritual and religious group at a senior living community. The contract was to provide spiritual and religious care to five different pods of a senior living community simultaneously. The contract was from September through December, and they have asked us to continue. An example of her work was that she offered creative storytelling about the Old Testament and inquired if the people might see themselves in the story. She also provided a “prayers of the people” segment where she solicited prayer requests and provided a pastoral prayer.

ASSESSMENT

There were many key indicators that were successful. First was the process itself. The discovery, design, and project model helped me move beyond my initial ideas and assumptions, through to a dynamic and collaborative project. The process helped me broaden the vision and scope of the project.

There were several other important factors that made this project successful. Years of experience of building spiritual care teams for the Red Cross and the State of Maine and deploying them was essential for generating a vision for how to recruit, train, and build a team. From my experiences, I understood how to do a needs assessment in terms of spiritual care. I understood how to recruit, train and match and assign chaplains to care teams. I have specialized training to create integrated response teams. This was very helpful when conceptualizing what contract chaplaincy would look like on the ground. Through these experiences I have built a considerable network of clergy colleagues, and contacts in social services agencies. Relationships are key to creating this kind of organization. Relationships with other clergy and with people in the community are essential to establish trust and credibility. Relationships help find seed money, recruit chaplains, and make connections with potential clients.

There are several other indicators for making this a successful project. Financial support is needed to develop a legal and organizational infrastructure. While it is possible to do some of the administrative and legal work, it is more efficient and legitimate to have an attorney and accountant working with you to get your organization started efficiently. We used our initial grant money to do this. Once we had relationships with these professionals, we also had them

available to us to create budgets and contracts when we needed them. Our project took off so fast, this kind of support was indispensable.

We needed to have a diverse board with a variety of skills and contacts. It is helpful to have a board that represents several faith traditions and had people with nonprofit experience. This broadened our reach for chaplains, funding opportunities, connections, and client base. Having a working board with members having previous experience sped up the process of developing bylaws, setting expectations, processes for conducting business, and put sound policies in place.

Having a recognizable brand is also important. Before we even bid our first contract, we branded ourselves, created a logo, website, social media, and content. This was necessary to establish legitimacy and credibility and be a point of reference for potential clients. We could tell our story and show our faces and skills. We had a strong team of chaplains from our previous volunteer base and were able to recruit additional chaplains with various skillsets to care for a diverse client base. Communicating that was key.

Establishing standards for hiring contract chaplains, orienting them, placing them would be important factors for success. We needed to make sure that chaplains were clinically trained so that they could provide interfaith care and represent the organization well. We had the good fortune of drawing on the experienced volunteers that were known quantities. Having good standards helped us screen potential chaplains that may not be able to provide compassionate care to a variety of people of different belief systems. Having our legal counsel prepare and review our hiring practices, create overall procedures, draft a handbook, and internal and external contracts was critical for getting us started with a thorough foundation. Having these

professionals on board also helped us pay attention to other important considerations such as having insurance in place.

While we have succeeded in building a strong working board, we will benefit from intentionally building more diversity this spring. One set of potential clients that we wish to serve are the marginalized and those who suffer disproportionately when faced with adversity. We will benefit from expanding our board of directors that includes members on it that represent the populations we wish to serve. As we are also seeking to work with social service agencies and programs, we will benefit from seeking board members from those disciplines and programs. We do not want to limit our vision to marginalized populations. We want to be mindful and seek other opportunities in organizations that have not yet experienced the benefit of chaplains. We need to have a vision that include for profit companies.

We organized quickly to bid on a specific contract. That gave us resources to buildout the organization in short order. There is merit to seeking smaller clients more systematically. We would then have been more intentional about recruiting a more diverse team of chaplains and spiritual care consultants to provide a wider range of services. In this unchurched State in the Secular world, chaplaincy and spiritual care must meet the need outside of the four walls of a church. My project has successfully mapped a way to do this.

PROJECT LAUNCH PLAN

Project Description

Create a nonprofit organization that makes chaplains and spiritual caregivers available to other nonprofits and organizations on a per diem basis.

Audience

There are several audiences or organizations that would benefit from per diem chaplains. Initially the perceived audience for this project was small community-based organizations (cbos) working with marginalized populations. The initial cbos that were pitched the prototype were receptive to the idea. Funding was identified as a challenge for this audience. However, it may be possible to seek DHHS grants to do this work in the organizations that I had envisioned as the primary audience.

Development Timeline

We have a contract to provide care to people suffering disproportionately from COVID. That contract is effective through December 2022. We will continue to work with the State to develop future funding opportunities. We will also work with them to develop a scope of work for a Health Equities Grant over the first quarter of 2022 that they received as a part of the Recovery Act. The solicitation for offers for this new government contract will likely happen in early summer of 2022 and will be a 2–3-year grant. We will bid on that and if successful, will begin that work on January 1 of 2023.

This January I have hired and oriented 5 chaplains. I hope to recruit and orient at least 5 more by June of 2022. Our greatest success so far recruiting chaplains has been by word of mouth. Rather than costly advertisements, I will be shifting us to meeting with leadership of judicatories and attending/presenting at chaplain conferences to present the program and recruit new chaplains. That is an ongoing task for 2022. I hope that we can recruit chaplains with specialized training. I would like to bring people on board who have training in critical incident stress management, narrative chaplaincy, recovery and addiction, and moral injury. Once our budget permits, I will seek to bring that training to our chaplains.

A first goal of 2022 is to develop a 3–5-year budget that will include sustaining the administrative overhead of SCS Maine. That will take place in late January to be presented to the BOD at the February meeting. Once a budget is approved, we will create and launch a fundraising plan by April of 2022. We will plan to seek at least 5 grants and 50 donors to build our infrastructure.

An important goal of 2022 is to develop business and contracts in addition to our government contract. A goal is to secure 3-5 new contracts by the end of 2022. One of my first tasks of 2022 is to develop a marketing plan. I am working with a skilled board member to develop a SMART (Smart, Measurable, Achievable, Realistic, and Timely) marketing plan to present to our board in February. The SMART plan includes setting goals, establishing objectives, staying relevant, finding the right people, crafting a compelling message, and determining the best platform to distribute our message. The goal is to incorporate feedback from the board and have a plan in place by March of 2022 and kick it off in late March or early April. This includes developing materials and presenting to judicatories with the communities that were

a part of the original prototype process and seek funding opportunities for some shared programming.

We have plans to build an advisory board composed of organizational representatives from our client organizations. As we increase our contracts, we will invite a contact from each organization to join the board. The advisory board will meet 2x per year. It will serve as a way of both gathering evaluative feedback and building on best practices. It will also serve as a way of community building for organizations doing great work.

Iteration Process

In many ways the evaluation process will speak through the success of the organization. For the State contract, there are monthly narrative reports that detail the work to the contract manager with summary reports for the end of the contract. The Clinical Director (CD) will be in dialogue with the other clients on a 6-month basis to determine if the care is meeting the needs of the organizations and brainstorming additional programming that would benefit their clients. As a part of the Board of Directors, the CD will be a part of the dialogue for planning and growth of the organization. As SCS Maine adds clients, the Board will continue to recruit and orient chaplains to meet the needs of the organizations. After the footings of the organization have been secured, the CD will prepare documentation and presentations about the organization and formation to share with ministry colleagues and organizations.

APPENDIX A—MILESTONE 1 THE NPO CHARTER

Personal Research Manifesto

I will create a discovery session that invites stimulating brainstorming and sharing of experience, knowledge and ideas, independent of my pre-existing assumptions and biases.

NPO Statement:

I will assess the need, structure and modality for community-based Clinical Pastoral Education/Training (CPE/T).

NPO Scope:

This project will establish the need for community-based training in various geographies that is accessible to a variety of clergy, students, and laypersons from a broad spectrum of belief systems. The scope will include identifying the core structural components of CPE/T and exploring their applicability to a community-based program. The scope will also include examining the type and use of distance learning tools for addressing key elements of the training program.

NPO Context:

There is a need and opportunity to create a standardized community-based program that would provide professional training for candidates in a variety of locations from a variety of theological persuasions. The College of Pastoral Supervision and Psychotherapy (CPSP), an accrediting body for Pastoral Psychotherapists, CPE/T Training Supervisors and Clinical Chaplains, has expressed an interest in my development of a framework and tools for community-based Clinical Pastoral Education/Training. The Chaplaincy Institute of Maine the Marie San Damiano Spiritual Direction program have expressed a need for partnering with a CPE/T program to further prepare their students for ministry. The outcome of this project would

provide the basis and framework for establishing community-based CPE/T training programs which are consistent, professional, scalable, and replicable. A community-based distance learning program that is accessible to people from these types of programs would help train students to a professional standard and achieve a credential that could provide allow access to ministry jobs. It would also serve the institution of CPSP, the supervisors wishing to start their own programs, the trainees wishing to access training and the communities that would benefit from a pastoral or spiritual caregiver.

Root Causes:

The concern was raised that ministers and ministry students who live away from traditional clinics do not have the option to participate in clinical training. Another concern was raised that non-traditional, non-mainline ministry candidates are not admitted to some of the institutionally based CPE/T training programs. A further concern was raised that there are many community-based organizations in many geographic locations that would benefit from the pastoral and spiritual care provided by a clinical pastoral trainee. There were also concerns about organizations resisting or not wanting unknown trainees or clergy support for fear of trainees proselytizing or offering care that is steeped in religiosity. These root causes could be addressed by creating distance learning programs that admit trainees from a broader spectrum of ministry programs. Additionally, efforts could be made to cultivate relationships with various organizations to place clinical trainees in.

Discover Session Stakeholders:

Participants included former CPT trainees, Diplomate Supervisors of Clinical Pastoral Training and a training supervisor for Supervisors in Training.

One-on-One Interviews:

Participants in my one on one interviews included the General Secretary of CPSP, a Supervisor from a hospital-based CPE program, a faculty member from the Portland Seminary and a professor of pastoral care from Princeton Theological Seminary.

Academic Resources:

I will be researching several areas. I will research CPE/T framework including history, application and key structure of clinical pastoral training(Lawrence, Hemenway, Garlid and others). I will research and analyze how the Clinical Pastoral Education/Training model could be applied to non-traditional settings (Fleenor, Lee, Schoeder, Gaventa, Hover, and others). I will highlight the content and curricula of a CPT program (Lawrence, Cooper-White, Dykstra, Pruyser, and others). Furthermore, I will research and explore the efficacy of distance and electronic learning models and resources (Ross, Spratt, Chang, Oliveira, Doehring and others.)

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Appendix:

Rev. Lori H. Whittemore

DMin 750

Dr. Phil Newell

Discovery Session Description

I met for three hours with seven individuals by Zoom. The individuals participated from Maine, Rhode Island, New Jersey, New York, South Dakota, and Florida who have a vested interest in my research. Participants were CPT supervisors, supervisor-in-training, former trainees. All participants have engaged in distance-learning. The supervisors and supervisors-in-training are interested in how to frame up a community-based program.

We began with the 'Need, Problem or Opportunity' (NPO) *Assess the need, structure and modality for community-based Clinical Pastoral Education/Training (CPE/T).* The primary audiences identified in this session were clinical pastoral trainees without access to major institutions for training sites. Other audience members are supervisors and supervisors in training who want to serve clergy populations outside of institutional settings. Further audience for the purposes of the project are community organizations and their client's.

The NPO will require the examination of the need for pastoral and spiritual training by clergy and lay persons from a variety of locations. It will also require assessing community organizations need and willingness to accept pastoral and spiritual care trainees. Furthermore, the NPO will need the exploration and articulation of the major components of a CPE/T program. Lastly, the use and efficacy of distance learning for individual and group activities will need to be explored. We then discussed symptoms or 'pain points' around the three NPO's that were identified. Then we considered the root causes for each of the NPO's.

Distance/access emerged as the key NPO. Root causes were noted as trainees being located too far from major training sites, non-traditional ministry candidates not being welcome in traditional programs, and a desire to serve community-based clinics that are closer to the trainee. Also noted were cultural secularization as a push back against the term "chaplain" and

the fear of religiosity. We then discussed that if the *distance and access* problem was solved more clergy would have access to training which would prepare ministry personnel to provide professional spiritual care.

Discovery Statement

Considering there is a need for clinical pastoral training for clergy and laypeople outside of traditional training centers. W**e've discovered** there is a need for standardized, training programs in a broader geographical area, and for a variety of clinical settings that is accessible to traditional and non-traditional clergy candidates. **This is caused by** distance from the candidate to the major training centers, desire to serve community-based organizations, and lack of admission of non-traditional clergy to mainstream programs. **If solved, it would mean** that a greater number of pastoral and spiritual care trainees could participate in professional training while serving more people and in non-traditional clinics.

Key Insights from Discovery Session

The fact that *distance and access* emerged as an NPO was not surprising. It is common for clergy in training to live far from major CPE/T training sites, come from less traditional ministry paths and to want to train and serve in organizations that they are already connected to or that are relevant to their own community. Clergy trainees who have taken non-traditional paths toward ministry have often been turned away from major CPE/T training programs.

In addition to the possibility of clinical training hours being completed in a variety of locations and clinical sites, individual supervision and group process seminar would need to be accessible from a distance learning platform. Creating a distance learning cohort would allow for

diversity of candidates considering many variables, such as gender, theology, race and ministry setting.

One-on-One Interview Discoveries

There is a need for community-based pastoral training programs. Traditionally, and non-traditionally trained clergy, as well as lay persons would benefit from training programs. Clinical Pastoral Training (CPT) as a model for professional pastoral care training is an effective model for training pastoral care givers. CPT could be applied to any setting as long as there is a willing site supervisor in the specific clinic and a cohort large enough (>3) to provide adequate group processing of cases.

Community-based training could be offered in clinics relevant to trainee's community and context. This would benefit both the trainee and the community organizations that receive the benefit of having a pastoral care provider present to help their population.

Community-based programs are different from institutionally based in content but not in substance. They would be framed up with the basic constructs of a CPE/T program including, time in clinic, individual and group supervision, didactic instruction, reading and interpersonal relations group.

Time in clinic is translatable to any clinic as long as a trainee is allowed to present themselves as a chaplain or chaplain in training. This is necessary for them to create and live into a pastoral identity. It is also helpful to the clinic that benefits from an additional care provider and a care provider who attend to the soul of a patient or client.

Community-based training programs should provide a simple framework for offering training. Institutionally based programs have both institutional and program screening and hiring

practices. They also have additional regulations, as well as training, orientations, compliance and charting requirements than a community-based. All of these factors reduce time in clinic, group process and didactic time. A community-based program with less bureaucratic complexity could offer a more focused experience of CPE/T.

Distance learning is a logical model for creating programs to offer training to people from a variety of locations. This could create diversity in training groups across a number of variables. Distance learning may have a limiting effect on group dynamics and further study and consideration is warranted about this.

Synthesis

Both the Discovery Session and the 1 x1 interviews confirmed that community-based programs are a need for both trainees and community clinics/organizations. Clinical Pastoral Training (CPT) is a tried and true method of training pastoral/spiritual care givers. Further, it is a method that can be applied in any clinic. Training could take place for several trainees in the same community-based clinic. More than likely a community-based program would serve trainees in a variety of clinics and a variety of locations. This would necessitate using distance learning technology for individual supervision and group process seminar.

There is a basic format for CPT including clinical time, case presentations, didactic training, and reading. Clinical time could be accomplished in each trainee's individual clinic. Case presentations, including verbatims, would be presented using distance learning technology as could didactic training. A bibliography could be developed for trainees that includes standard pastoral care content and then content relevant to their ministry setting. This bibliography would be used as course reading during the duration of the units taken.

A community-based program would not have the institutional infrastructure to provide a framework for creating and administering a program. This would allow some flexibility in the screening and acceptance of trainees. There would need to be consistent standards and good practices in place to ensure quality of program. Some basic infrastructure would have to be created to organize and administer a program.

Next Steps

As a result of the Discovery Session and personal interviews there are a few areas that need further research and exploration. First, I need to identify and explore the key components for a community based clinical pastoral training program along with what form of basic infrastructure is necessary to administer a program. I will further explore and develop the content of a program including; site placement, written requirements, didactic trainings and bibliography. I will research the use of different distance learning modalities to discern a technology and methodology for offering distance learning.

Discovery Session Notes

Rev NS

Really need to create community for the trainees so they approach their ministry from a supported way. Very important to create a connected distance learning program. Many organizations that are not traditional clinics need spiritual care. Need to help address vast needs in larger community.

From Rev. Dr. FH

She felt that we should jump to working on the answer rather than talking about need, problem and opportunity. She did indicate that the greatest need is with getting training opportunities for people who live far away from training sites

From Chaplain AV

Concerned about having standard program requirements because we need to train people remotely but should make sure that we are doing it in an accountable way

From Chaplain TK

"Hi-jacked" the conversation to talk about creating an organization that would place per diem chaplains in organizations, like nursing homes, part time. Worried that there are not jobs for CPSP chaplains and wants to figure out a way to match the need in small institutions to contract with a reputable organization to hire chaplains for like 20 hours/month)

From Chaplain RW

Reflected on her appreciation of distance learning CPT as it allowed her access where should wouldn't have had it. Also, because she is a non-traditional spiritual care provider (spiritual direction certificate) as theological training.

From Rev. Dr. DS

Sees a need for both remote training and community-based training. Need to meet the current needs with technology that we have been given.

1x1 Interviews

RL, General Secretary of a Chaplain cognate group

10.4.19 1:00pm

With what do you agree? Why? What do you disagree with? Why? What is missing?Agrees with the premise that there is a need for community-based training. A little hesitant that group process works well distance. In terms of difference between community and institutionally based is different only in context not in substance. CLINICAL RHOMBUS

For screening…don't worry about it. Anyone with any theological bent who wants to chaplain should be welcome. Let the placement sites screen candidates. If they cant find a site then they cant do the program. Groups cant be smaller than 3..probably 4. Not bigger than 7. Tavistok for group process. Greatest tool of a supervisor is a good brain..penetrate, obfuscate…see into trainee. Books…exploration of inner world, Boisen. Nine Clinical Cases. Freud and Mans Soul, Minister as Diagnostician Recognizing how trainee is progressing…they'll tell you. Should be psychodynamic, totally. Not a fan of didactic training. Mostly cases and consultation. Very interested in being kept up to date on my process. Anton Boisen as theologian as influence. Freud as personality influence.

HW, Director of Spiritual Care at a Trauma I hospital 10.8.19, 2:00pm

With what do you agree? Why? What do you disagree with? Why? What is missing?

Agrees that there is a need for community-based training. Institutional training has a high level of compliance issues, including health screening, charting, patient privacy, etc. It would be freeing to supervise a community-based program but would also be challenging to manage the particulars. Screening process; seminarians or sanctioned candidates only, background checks, 3 references, theological education, two sets of interviews. Groups between 4-7. Essential elements to a program; verbatims, orientation, charting, learning goals, group process, book reads, didactics. Group process comes from Irving Yalom. Books Doering, Practice of Pastoral Care, Pamela Cooper-White, Shared Wisdom, Stephen Roberts, Pastoral Care. Greatest tool of supervisor is self. Hard to envision community-based from supervisor perspective because hospital pays salary. What kind of salary would community based program command. Charting is a critical piece of the program to help track outcomes AND as a reflective tool. Irving Yalom as theorist that she leans on.

Phone conversation with George Fox DMin instructor, LK 10.10.19 1:30

Conversation was set up to talk about tools available for electronic resources. Reminded that assumes my NPO is valid and am already trying to not only answer but with a specific answers. Maybe talk more next semester or the next. Questions might be around how to create sustainable community. May want to create a business model, guide, curriculum

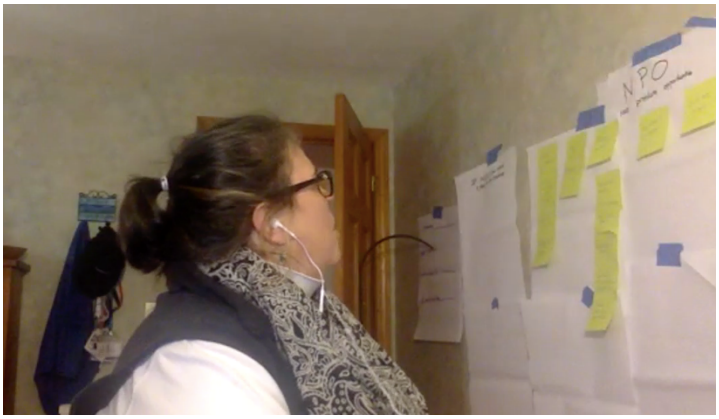
Phone conversation with RD, renowned authority on Pastoral Care, November 25, 2019, 1:30pm

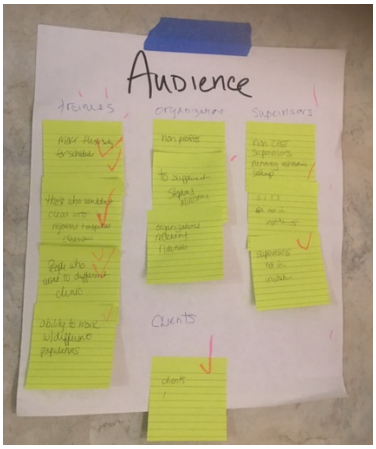
With what do you agree? Why? What do you disagree with? Why? What is missing?

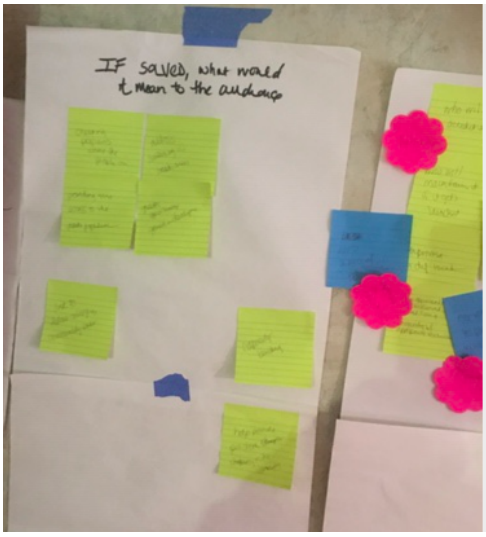
Definitely agreed with need and value of community-based training. Components of pastoral training; being curious, facing the shame in your past, being able to seek someone's

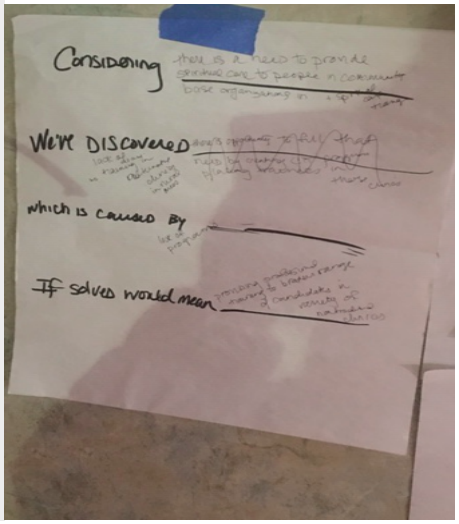
individual uniqueness. He is a huge fan of CPT and feels valuable for community-based training. Wonders about efficacy of distance learning but points me to **articles by Carrie Doehring.** CPT is great vehicle for engaging with one's own suffering. Helpful as it provides support for ministry in a variety of settings. CPT doesn't need to be limited to seminarians but candidates need to be aware of their pastoral identity. They need to be clear on how they represent themselves. Books: Donald capps, depleted self and child's song, friedman, family systems, Ronald Richardson, pastoral leadership in parish ministry. Theologian..donald capps..minister as agent of hope. Draws on William James, Erickson, Rogers and Winnicott as his personality theorists. Models of care are wounded healer, reading the living human document and, gentle shepherd. Key to it is self-awareness of own areas of shame and wounding

Pictures from Discovery Session









Appendix B—Milestone 2 NPO Topic Expertise Essay

INTRODUCTION-TEE

In USAmerica, less and less people go to the Christian Church. A recent Gallup poll indicates that only 52% of adults claim to be affiliated with a religious community while those who claim to be non-religious have doubled from 6% to 12% over the last 20 years.[1] While this may seem like a loss of the faithful, it may be in part a result of the factor that US America is a melting pot of people of diverse cultures and traditions and the Country is diversifying. It is, however, an opportunity for Christians to return to the community where ministry was first conducted. Reflecting on the Gospels, Jesus shows us what community ministry looks like. Clinical Pastoral Training reflects the ways Jesus cared for his community and for people outside of his own tradition. By exploring the history of chaplaincy and chaplaincy training along with the key voices, I will explore how Clinical Pastoral Training in community-based organizations prepares clergy to provide the care that Jesus did while he walked the earth.

SECTION 1: BIBLICAL AND THEOLOGICAL FOUNDATIONS

Community Based Chaplaincy in the Biblical World

Jesus was a Community Chaplain. His ministry was a preaching and teaching ministry. And his ministry was a healing ministry. He travelled around the villages of occupied Israel. “It is widely assumed that Jesus preferred to do his work in the villages and not the cities of Galilee.

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[1] Jeffrey Jones, “US Church Membership Down Sharply in Last Two Decades,” Gallup, April 18, 2019. https://news.gallup.com/poll/248837/church-membership-down-sharply-past-two-decades.aspx.

In effect he was a rural person."[2] Jesus knew the people he was preaching to and teaching and he knew the people he was healing. He lived in their community and context.

He healed individuals by restoring their agency. When sought out for healing, he did not preach to or at people. When people with afflictions presented themselves to him, he reflected back their faith as the source of their healing.[3] He offered forgiveness to those whose heavy burden of sin weighed them down. Jesus healed what Steven Davies calls somatization disorders and/or conversion disorders. These are syndromes that feature "recurrent and multiple somatic complaints, of several years' duration, for which medical attention has been sought, but that apparently are not due to any physical disorder."[4] These disorders were likely unconsciously learned behaviors that sprang from a personal or societal trauma. Jesus restores their sense of agency by virtue of acknowledging people's faith and capacity to heal This allows for the unconscious to be made conscious and released.

As a Community Chaplain, Jesus also addressed societal issues evident in who he chose to heal and how the Gospel shares that information. He chose to heal the marginalized. Healing the hemorrhaging woman in a public setting challenged his society's prescribed role for women as well as the Jewish ritual impurity laws. His healing of her by restoring her worth and dignity elevated her standing in the community and served as an example of how all marginal people should be treated. His extension of ministry to the daughter of the Syrophoenician woman

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[2] Donald Capps, *Jesus the Village Psychiatrist* (Louisville, KY: Westminster John Knox Press, 2008), xix.

[3] Robert L. Richardson, "Jesus as Healer: An Image of Holistic Care for the Sick," *Chaplaincy Today* 15, no. 2 (1999): 9.

[4] Steven L. Davies, *Jesus the Healer* (New York, Continuum, 1995), 71.

examples the inclusivity of his healing to people outside of his faith tradition, a healing that is not an evangelical faith healing, but rather a simple acknowledgement of her request of him.

By working in his community, empowering people and restoring their agency, and addressing the societal attitudes about those in the margins, Jesus offers an important paradigm for offering spiritual care in community settings.

Textual Discussions

The Gerasene Demoniac

Jesus was in Gerasa where he had healed a demoniac (Mark 5: 1-20NRSV). Gerasa, modern day Jerash, was in the Jordan valley and was occupied by mostly gentiles, clearly outside the scope of the Jewish religious authority of Jesus' day. This healing was a community healing, outside of Jesus' own community. He is approached by the Gerasene who initially asks to not be tortured. Jesus asks his/their name and what he/they want. These two actions establish a pattern of Jesus' healings. He first recognizes the afflicted by name, an acknowledgment of their person hood. He then acknowledges their stated needs. In this case, to not be driven out of the country, but to be put into swine. He grants Legion's request, and the demons are sent into the pigs and run over a cliff. Jesus travels to a community, meets someone in need of healing, acknowledges them, hears their request for healing and heals them by granting their agency in fulfilling their request.

The Hemorrhaging Woman

Jesus then returns from Gerasa to his own community where he heals a hemorrhaging woman (Mark 5: 24b-34, NRSV). The setting of this healing event is by the sea where Jesus is surrounded by crowds. Someone has pushed through, reached through the crowd to touch him and he feels his healing powers drain.

The material substance of this text is that a woman who has been bleeding for twelve years, most likely related to menses, touches the fringes of Jesus clothing believing that her condition would be ameliorated. This act highlights at least two forms of public indecency. First would be a woman deliberately reaching out to touch a strange man. Second and more importantly, a woman experiencing menses and touching a man would be forbidden, as she would be ritually impure. When the woman presents herself and tells her whole truth, he receives her truth and empowers her by recognizing that it was her faith that moved her to act. In confessing her action, Jesus' response, "your faith has made you well," is a way of acknowledging her agency. By receiving her touch, accepting the legitimacy of her outreach regardless of the taboo, and rewarding her faith, he demonstrates a break with the marginalization of women. In this way, he offers her healing and healing to the broader society through a corrective to gender-based social stigma.

"No other miracle story in the Gospels centers on the delicate question of a gynecological problem, which would be not only sensitive private matter for the woman but also a constant source of ritual impurity according to the laws of Leviticus. "[5] By choosing to heal her, he elevates her unclean status which is another form of empowerment. She has been failed by the healing community of doctors and most likely turned away by the religious authorities due to her ritual uncleanliness. Yet Jesus receives her and grants her healing wish.

The work of Jesus the Community Chaplain in the story of the hemorrhaging woman not only demonstrates how he heals individual people, but also addresses the social dimension of healing those who were stigmatized or marginalized in his community. In this way the story

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[5] John P. Meir, *A Marginal Jew: Rethinking the Historical Jesus,* vol II (New Haven, CT: Yale University Press, 1994), 709.

offers both individual and societal healing. Jesus heals in community, receives the afflicted woman, listens to her story and restores her in such a way that that she has requested for herself. Jesus' response to her restores her to community and challenges the norms of the community.

Blind Bartimaeus

The healing of Blind Bartimaeus takes place in a public place where crowds have gathered around Jesus (Mark 10:46-52 NRSV). They were near the gates of Jericho where the blind and lame normally beg. Bartimaeus yells out to Jesus and the crowds try to silence him, presuming he is going to beg for money.[6] Bartimaeus has to yell out a second time before he gets an audience with Jesus. N.T Wright suggest that, more than blindness, Bartimaeus suffered from a learned helplessness or self-imposed marginality that goes with blindness.[7] He suffers from a broken way of being relying on other's charity. His brokenness is more that he cannot see a place for himself in his world, an occupied land that has de-constructed the ordered life of Jewish Israel.

In the ultimate invitation to empowerment, Jesus asks, "what do you want me to do"? The real question from Jesus was, do you want to live differently, to work for a living, to have no reason to sit by the road begging? Bartimaeus proclaims he wants that, and Jesus honors the request and the faith it took to yell out twice. He affirms that it is Bartimaeus' faith that has made him well. Jesus restores Bartimaeus' agency by acknowledging the request, identifying what Bartimaeus really wanted, and establishing that it was Bartimaeus' faith that brought about that healing.

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[6] Capps, *Jesus the Village Psychiatrist,* 59.

[7] N.T. Wright, *Mark for Everyone (The New Testament for Everyone),* 2nd ed. (Louisville, KY: Westminster John Knox, 1994), 143.

A Paralytic

A healing or a paralytic in Mark 2: 1-12, took place in Jesus' home in Capernaum. Crowds, including religious authorities, were standing outside of his house blocking entry or exit to the door. This is the ultimate example of Jesus healing in his own community, outside of the established places of religious authority. There was such a desire for healing, four people had to raze the roof to lower the afflicted down to Jesus. Unlike the two passages previously discussed this man does not or is not able to get to Jesus on his own. He is not reaching out or shouting out to Jesus. He is lowered into Jesus' presence with the hope and expectation of being made to walk again.

Illness in the time of Jesus was often attributed to sin. This coheres with the idea that certain ailments have psycho-somatoform origin. Offering forgiveness relieves the person of the mental and emotional pain that triggers their affliction and they are made free of it. "Those who came to Jesus were not sinful people per se but people with physical and mental symptoms for which announcement of forgiveness by God's spirit was a helpful therapeutic intervention."[8]

On a societal level paralysis may have been a somatoform disorder resulting from a condition of being disenfranchised and under-resourced. Donald Capps suggests there is also a symbolic nature of the illness. "The fact that their symptoms took this precise form was symbolic, not only of their own personal psychological, but also of the psychosocial conflicts of the Jewish people, especially Jewish males."[9] The Roman occupied villages did not have access to jobs or healthcare. The outlying villages were mostly agrarian, with the majority of their spoils

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[8] Davies, *Jesus the Healer,* 147.

[9] Capps, *Jesus the Village Psychiatrist,* 50.

going to support the politically and economically powerful. John Dominic Crossan offers that being crippled in Jesus' day may have been an unconscious or conscious strategy of resistance for peasantry in their otherwise lack of powerlessness.[10] The sin was not that of the man on the mat. The sin was the brokenness in that society and the paralysis was the symptom. "To follow the image of Jesus as healer today means to go beyond the miracle worker to the hard work of social healing."[11] Healing in this instance was a symbolic way of empowering the community and re-establishing agency in their dispossessed place in society.

Synthesis of Themes, Values, and Commitments

Jesus' ministry of community healing in the Gospels offers a model of community chaplaincy that is relevant today. His example of meeting people where they are at figuratively and literally, illustrates how to provide care outside of religious institutions and hospitals. Today, with fewer people attending religious services or being a part of a faith community today, there is reduced access to pastoral care provided by one's faith community. The need for spiritual care is still present, just not the traditional pathways. Jesus' ministry calls us out of our buildings, onto the streets and into the community's to care for God's people, even if or especially because of their lack of presenting themselves in our communities.

Pastoral and spiritual care have also traditionally been provided in hospitals and on battlefields. Jesus' example calls us to broaden the range of where we care for those in need. We still find marginalized on the streets, and we also find them in rehabilitation clinics, prisons,

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[10] John Dominic Crossan, *The Historical Jesus: Life of a Mediterranean Jewish Peasant* (New York: HarperCollins, 1992), 127-128.

[11] Richardson, *Jesus as Healer,* 9.

senior living facilities, and hospices. These and many other organizations and settings would benefit from the kind of pastoral care that Jesus modelled for us.

Jesus healed people outside of his religion as exampled by the exorcising the Gerasene demoniac and healing the Syrophoenician woman's daughter. His method of healing was not specific to a tradition but was offered for cross culturally. This serves as the example of how to carry out ministry and chaplaincy in our communities today that have become much more diverse.

Jesus' approach to healing people outside of religious institutions, in the margins of society, from both inside and outside his community, establishes a model for community chaplains today. The need has broadened and is more complex. The community is larger and more diverse. Preparing to do this work is more nuanced. Therefore, there is a need for professional training for clergy and lay people to prepare them to provide spiritual care to a variety of people in a variety of places, given today's religious and spiritual landscape.

SECTION 2: TOPIC HISTORY AND KEY

Topic History

"Jesus served as a chaplain while He was on earth. He ministered to distressed people wherever he found them-in most cases outside of the church (synagogue) and met both physical and spiritual needs."[12] When considering how to prepare chaplains to serve as Jesus did, outside church buildings, it is helpful to reflect on the trajectory of chaplaincy after the life of Jesus along with the history of chaplaincy training.

Social Gospel Movement

Jesus' disciples continued his ministry early into the millennium as the Church was forming. Much of early Church written history focuses on the discussions and disagreements about theological constructs such as the nature of Christ. That early period was also dominated by creating power structures to establish Church doctrine. The Christian concept and articulation of Chaplain first appeared in the 4th century. The term chaplain is derived from the story of a compassionate holy man who share his cloak (*capella* in Latin) with a beggar. His cloak became a symbol of caring for people in need. Those tasked with guarding or caring for others were called *chapelain*.[13] This eventually was translated to English as chaplain. The term chaplain evolved to refer to a clergy person who provided care for people outside of the church setting. It was a clergy role primarily serving on the battlefield.

> The first English military-oriented chaplains were priests on board proto-naval vessels during the eighth century AD. Land based chaplains appeared during the reign of King Edward I, although their duties included jobs that today would come under the

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[12] Richard E. Geyer and Patricia M Geyer, *Chaplains of the Bible: Inspiration for Those Who Help Other in Crisis* (Greenville, SC: Ambassador International, 2012), 105.

[13] Naomi K. Paget and Janet R. McCormack, *The Work of the Chaplain* (Valley Forge, PA: Judson Press, 2006), 2-3.

> jurisdiction of military engineers and medical officers. A priest attached to a feudal noble household would follow his liege lord into battle.[14]

The work of the chaplain was to administer rites and offer care to the suffering, dying soldiers. There is no reference to how chaplains were trained for this work. It is likely that they were trained and ordained in their specific traditions and commissioned to serve. Beyond the middle ages, the role continued to be central to armed conflict. In the 18th-19th century, military chaplaincy in Europe expanded to include Jewish chaplains. [15] When the first Geneva Convention was held in 1863, chaplains were named as humanitarian workers exempted and protected from combat.[16] This trend continued through World Wars I and II.

Chaplaincy as pastoral care off the battlefield developed differently. Initially pastoral care that migrated and evolved in US America began treating maladjustment and maladies as the product of sin. Enforcing piety, preaching salvation as a path to healing and maintaining social order in service to a hierarchical institution was the care offered to those suffering from soul sickness.[17] In the mid-19th century, during a time of vast urban poverty, a Social Gospel Movement began. The Social Gospel Movement was a religious movement whereby Ministers, especially those belonging to the Protestant branch of Christianity, began to tie salvation and good works together. Pastoral care was offered from the pulpit *and* in the soup kitchens.

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[14] P. Middleton Brumwell, *The Army Chaplain: The Royal Army Chaplains' Department; the* duties *of chaplains and morale*. (London: Adam & Charles Black, 1943).

[15] Ron E. Hassner, *Religion on the Battlefield* (Ithaca, NY: Cornell University Press, 2016).

[16] "The Geneva Convention," History.com, accessed March 7, 2020, https://www.history.com/topics/world-war-ii/geneva-convention.

[17] E. Brooks. Holifield, *A History of Pastoral Care in America* (Eugene, OR: Wipf & Stock, 1983), 49.

Concurrent to this movement were the developing theories of Freud and the psychoanalytic movement. Freud conceived psychoanalysis to be an "impartial tool which both priest and layman can use in the service of the sufferer". [18] His ideas of working with patients/clients one-to-one challenged clergy to move beyond the pulpit to address people individually. However , clergy were unprepared to respond to people individually with the skills they had been learned in seminary.

During the 1920s a small group of American ministers began to construct a program of professional training. The recognized that "seminaries failed to train ministers to deal with a messy world, or even understand religion within it."[19] They conceived of modern-day chaplaincy and the need to train specifically for this kind of work. The evolution of the chaplain entered it's latest stage in the Clinical Pastoral movement in the 1920s. The new clinical tradition of training chaplains was applied to prepare clergy to serve in specialized ministry. This took place initially in psychiatric hospitals and hospitals and has since moved into a variety of social institutions.

"Many other types of chaplain ministry have developed as an outgrowth of military and hospital chaplaincy. As people quickly as people identify special interest groups that would benefit from spiritual care, chaplaincy is applied." [20] Just as Jesus the Community Chaplain ministered to those who suffered, where they suffered, chaplains began to meet people where they are in the midst of their suffering. Chaplains serve law enforcement, fire departments, and emergency responders, to name a few.

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[18] Allison Stokes, *Ministry After Freud* (New York: Pilgrim Press, 1985), 5.

[19] Holifield, *A History of Pastoral Care in America,* 231.

[20] Paget and McCormack, *The Work of the Chaplain,* 3.

The History of Clinical Pastoral Training (CPE/T)

Clinical Pastoral Education/Training was developed in part by a Unitarian lay person who founded medical social work in the early 20th century. Richard Cabot, a physician at Massachusetts General Hospital, recognized that treating illness required treating people beyond their symptoms. It required attending to their social systems as well. These social systems included the church. He included having clergy in the care of people in hospitals. He also identified the value of having ministry students train in hospitals as a part of their preparation for ministry. Along with Anton Boisen, he developed the case study method of learning for chaplains. [21] The initial clinical method of training consisted of "1) shared learning experience, 2) over time, 3) focused on professional functioning 4) under the watchful eye of a more experienced person, 5) in a setting receptive of ministry elements."[22] The focus on professional function and skill acquisition was always a core element of Cabot's framework.

The other minister credited with founding CPE/T, Anton T. Boisen, developed the full concept for Clinical Pastoral Training during his 3 year stay in a sanitorium. After recovering from an acute episode of mental illness, he initiated clinical training in 1925.[23] Studying Freud and William James while institutionalized, he adapted the case study learning method to study the "living human document". Using a theological approach to understand people, he helped midwife patients' experiences of mental illness and identify, their own path to healing. Boisen studied with Cabot and split from him theoretically on the point of skill acquisition. He felt that a

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[21] Roslyn A. Karaban, *Body and Soul; The Continuing Story of the Clinical Pastoral Education Movement 1992-2017* (self-published, 2019), xxi.

[22] Joan Hemenway, *Inside the Circle; A Historical and Practical Inquiry Concerning Process Groups in Clinical Pastoral Education* (New York: Journal of Pastoral Care Publications, 1996), 37.

[23] Karaban, *Body and Soul,* xxii.

key element of the training process was self-discovery. This gain of insight helped a clinician be present to those in need and help patients and parishioners have their own self-discovery.

Cabot went on to create the Institute of Pastoral Care, otherwise known as the New England Group, focused education with an emphasis on head training over heart training. [24]

Boisen aligned with the Council for Clinical Training, it's major premise was that pastoral competence comes from psychodynamic insight, and that preparation of clergy required a minister or chaplain to understand their own emotions. Boisen felt that trainees didn't need advance theological degrees to work with broken souls and advocated for standards rather than degrees as a way to measure a clinician's skills.[25] These differing approaches track the development of clinical pastoral training and influence varied approaches today.

Following the New England Group, Russell Dicks conceptualized the verbatim, a teaching tool in the education movement. While Cabot would advocate for education and evidence-based training to treat conditions, Boisen approached clinical training by treating the patient or individual as a living human document. He conceptualized the pastor as "physician of the soul" and also wanted physicians to participate in the training program. Founding scholars and theologians who worked with him include Helen Flanders Dunbar, and Steward Hiltner to name a few. This group studied and understood the theological nature of their subject's illnesses and offered care for the individual by caring for their soul. While Cabot's training program was directed at theological students in institutional setting, Boisen advocated for training anyone towards standards in and out of institutional settings.

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[24] Karaban, *Body and Soul,* xxiv.

[25] Karaban, *Body and Soul,* xxiv

The history from the founding of CPE/T to present weaves through these streams. The New England and New York Group developed separately until the 1950s. A movement towards unification began in 1951. The approaches to training were similar and merged their standards. By the late 1960s the American Association of Pastoral Counselors and the Association for Clinical Pastoral Education were formed. A basic framework was agreed upon. The current paradigm for training:

> Clinical Pastoral Education/Training is an educational methodology that combines knowledge of psychology (who we are) with knowledge of theology (what we believe) with process education (how we learn) in order to prepare seminarians, clergy and laypersons to provide effective interfaith spiritual care amidst the religious and social complexities of the world. [26]

I will explore more about the development of the movement by identifying the key voices in clinical pastoral education/training.

Key Voices

There are so many voices that have significantly contributed to the field of chaplaincy and pastoral care it is hard to select which ones are the major contributors. I will explore the voices of those founders that established the movement and basic elements of Clinical Pastoral Training. I will then explore the voices that have moved training and care outside of institutions and into the community.

Foundational Voices

As mentioned in the previous section, the two founding voices of the Clinical Pastoral Movement were *Richard Cabot* and *Anton Boisen*. It is important to view *Richard Cabot* in the

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[26] Hemenway, I*nside the Circle,* 323.

context of when and where he lived. He was a man of privilege when both the intersection of psychology and religion was being explored. He was also a cardiologist and neurologist and felt that ailing patients would benefit from having more than their physical needs attended. Cabot was the founder of the medical social work movement that added the study of character and social development as critical to the healing of a patient.[27] Additionally he felt that clergy would add another element to the healing of patients.

His career paralleled another important development. The development of the clinical pastoral training movement. This movement advocated for clergy training in hospitals alongside physicians to develop clinical skills for working with patients and parishioners. "Cabot felt that clinical training should give the clergy a realistic vision and moral toughness that would help them form and shape strength of character in their pastoral work."[28] Cabot also felt that the way to prepare clergy to serve both their parishioners and in people in hospitals was to train them using the clinical methods and clinical interventions used to train physicians.[29]

He advocated for adding a year to a standard seminary education in which seminarians would work alongside physicians in a clinical setting offering consultation and care to patients. Richard Cabot advocated for training clergy in pastoral competence.[30] His vision for clergy focused on developing their professional skillset. Within two years some broke off from this

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[27] Holified, *A History of Pastoral Care in America,* 233.

[28] Holified, *A History of Pastoral Care in America,* 234.

[29] Holified, *A History of Pastoral Care in America,* 233.

[30] David A. Steere, ed. *The Supervision of Pastoral Care* (Eugene, OR: Wipf and Stock, 1989), 23.

"New England" movement believing that the methods of training were sound, but the goal of training should be personnel growth of the theological trainee, rather than skill acquisition.[31]

Anton T. Boisen was a clergyman who trained for ministry starting in 1908. His early calls took him to Maine and the Midwest. During WWI, he enlisted with the YMCA and served in France. Upon returning from war, Boisen had a psychotic break. His contribution to the field of pastoral training from the inside out. After healing and leaving the sanitorium, he studied the clinical method with Cabot and then was hired as chaplain and training supervisor at Worcester State Hospital By 1930 he was a full partner in developing and advancing the method. He recognized the patient as a "living human document" to be read, studied and liberated from struggles with sin and salvation.[32] His approach to training and to pastoral care was therapeutic rather than prescriptive. He had his trainees listen to patients and look for patterns to point out and modelled that in individual supervision with the trainees and in group supervision with the cohort of trainees.

He appreciated the clinical method that was employed by Cabot. Boisen felt the emphasis of the training, however, should be on the personal growth of the minister rather than the acquisition of skills. He concurred that trainees should visit patients as physicians do. Rather than offer patients moral counsel or prayer, trainees should offer presence and observations of what the patient was sharing. Boisen believed "that one could be free and well only by bringing into the open and being clearly aware of whatever it is that causes inner turmoil." [33]

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[31] Steere, *The Supervision of Pastoral Care*, 23.

[32] Holified, A History of Pastoral Care in America, 245.

[33] Stokes, *Ministry After Freud,* 57.

Boisen worked together for a brief while with Cabot to form the Council for the Clinical Training of Theological Students. Very quickly it became apparent to him that Cabot held firmly to a medical model of care for patients and parishioners that prescribed moral intervention rather than therapeutic presence. Boisen soon broke off from Cabot to form the New York tradition of the clinical training movement. Boisen continued to approach training and indeed pastoral care from a psychodynamic, psychoanalytic paradigm, treating trainees and by extension their patient's, as "living human documents" to be read and engaged with.

Russell Dicks was Cabot's first student. He served at Massachusetts General Hospital as the first paid chaplain. Dicks developed what has come to be known as the verbatim. A verbatim is a recording of an encounter. A student would write up a script of an encounter with a patient as accurately as possible. The verbatim was then reviewed and critiqued by the supervisor to help improve the student's skills. In the clinical model, Dicks advocated for review and critique by the student's peer group. Dicks believed prayer was an appropriate intervention and had student's write down the prayers that they offered as part of the verbatim. This became a common practice among students subscribing to this paradigm. Dicks worked with Cabot to make the verbatim a teaching component of evolving clinical training. It is important to note that Boisen and others resisted the Dick's "growing emphasis on the analysis of verbatim reports, a teaching technique pioneered by Dicks, because of its lack of psychodynamics."[34]

Helen Flanders Dunbar was a renaissance woman. She was a physician, a psychiatrist, a theologian, a mathematician and a literary scholar on Dante. During her theological education she completed clinical pastoral education at Worcester Hospital with Boisen. "As a psychiatrist

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[34] Stokes, *Ministry After Freud*, 55.

herself, she understood and promoted the value of psychoanalytic perspective and it's integral relationship with religion."[35] She became a great supporter of Boisen's approach to training supervisors and to approaching care for patients.

A major focus of her work was on psychosomatic illness. "The fact is that one's state of mind is as critical to understanding disease as the discovery of germs. The implications for ministry of the psychosomatic unity of mind and body have great bearings on the healing of the individual."[36] She was a great advocate of clinical training and was successful in recruiting every major seminary to include clinical training for their students. [37]

Seward Hiltner was one of Boisen's first clinical trainees as well and was a powerhouse of theory and theology of pastoral care.[38] He expressed a contextualized theology of care that was never based on preaching or praying but on caring for the soul in front of the caregiver. Like Boisen, he felt that soul care was more about meeting the needs of the patient or parishioner rather than meting out prayer or moral advice. While Cabot and Boisen debated the best method of preparing theological students to care for their patients and parishioners, Hiltner was the first to articulate the theological underpinnings of pastoral care. He was the first to explore what the Gospel said about how to care for people. One of his initial writings was illustrating how the passage about the Good Samaritan in Luke 10 was about meeting someone's needs rather than

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[35] Raymond J. Lawrence, *Recovery of Soul: A History and Memoir of the Clinical Pastoral Movement* (New York: CPSP Press, 2017), 17.

[36] Stokes, *Ministry After Freud,* 89.

[37] Lawrence, *Recovery of Soul*, 20.

[38] Robert Dykstra, *Images of Pastoral Care* (St Louis, MO: Chalice Press, 2005), 18.

offering verbal testimony.[39] When considering his contribution to pastoral care his emphasis on meeting a person where they are and ministering to their prescient need is a legacy that he carried through his ministry and his work in the formation of supervisors and chaplains ever since.

Paul Pruyser was a clinical psychologist that worked with the Menninger Foundation in the late 60s and early 70s. He trained graduate and postgraduate students in the intersectionality of disciplines to address illness. Pruyser was interested in how religion and religious symbolism impacted people's health and viewed the minister's ability to address care as a part of responsible ministry. [40] Pruyser's significant contribution to the field of pastoral care was the development of theological categories of diagnosis for patients and parishioners. He felt that clergy should step fully into their identity and authority and take part in treating both patients and more often parishioners in the language and symbolism that clergy were conversant in.[41]

The different philosophies of pastoral care and pastoral care training were well established when *Joan Hemenway* joined the discussion. The participation in clinical work, individual and group critique in response to verbatims and the use of ministerial diagnosis were legs under the stool of pastoral training and pastoral care. When she entered the arena in the early 80's the Association of Clinical Pastoral Education (ACPE) was well-established and set standards for educationally focused training and care. Her primary contribution to the clinical training framework was her study and writing about group process.

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[39] Dykstra, *Images of Pastoral Care*, 19.

[40] Paul Pruyser, *The Minister as Diagnostician; Personal Problems in Pastoral Perspective* (Philadelphia: Westminster Press, 1976), back cover.

[41] Pruyser, *The Minister as Diagnostician,* 29.

Hemenway identified the need and benefit of training in group process. Hemenway studied Wilfred Bion, a developer of the Tavistock method of group process. “Bion theorized that certain patterns of unconscious behavior, such as pairing, were endemic to group life and that examining such behaviors is both education and therapeutic.”[42] Hemenway made the case for a group process paradigm in Clinical Pastoral Education/Training that “focused on unconscious material in the group itself with the supervisor commenting on her and now dynamics.” Use of this method translated to the group focusing on the unconscious material that was coming up in the group and the supervisor on ‘here and now’ dynamics.

Voices of those applying clinical training outside of institutions

Rev. Robert Nace was a Senior Pastor at the Zion Reformed Church of Christ when he wrote the article “Parish Clinical Pastoral Education: Redefining ‘Living Human Document.’” He was inspired by his first CPE supervisor to develop a clinical pastoral training program particular to the ministry in the church. His voice is significant as he addressed how the elements of a Clinical Pastoral Training program could be applied successfully. He advocated for Parish based Clinical Pastoral Training of ministry interns forming groups in geographic clusters of churches. While this application of Parish CPE would not necessarily be crisis oriented, there would be adequate ministerial encounters for a trainee to draw upon for individual and group supervision. Furthermore, Parish based CPE would offer supportive learning in a complex set of relationships. Not only would the ministry student draw on individual encounters with parishioners, he/she would have pastoral encounters with the whole congregation from the pulpit,

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[42] Lawrence, *Recovery of Soul*, 93.

with staff in the church and with the community as a whole. He concluded that "The distinction between the 'parish model' and 'institutional model' of CPE is in fact a distinction of the living human document around which CPE occurs."[43] The challenges to the model would be identifying an individual supervisor for the candidates, placing trainees in a cluster of sites to develop a learning group. Finally, a unit would have to be created at a sufficient length so that Parishes would be willing to invest time and resources to make the program feasible. Nace made a convincing case for translating CPE into a ministerial training program outside of the institutional setting. There is not a record if he accomplished this, but the argument was sound.

Retired CPE Supervisor *Larry J. Murtagh* was an advocate for community-based CPE. After retiring as a clinical supervisor from an urban hospital, he created a program on the prairies of South Dakota. "While the Clinical Pastoral Education method is usually employed in the health care setting and pointed toward the pastoral care of the sick, it can be adapted to the pastoral care and supervision of students doing ministry in the political, economic and cultural systems of the rural community."[44] Murtagh put a group together consisting of clergy from differing traditions. He tasked them with choosing an industry to explore and conducting visits, as a clergy person, to people in that industry to learn about the person and the industry. These visits were used to create verbatims and the verbatims were critiqued in individual and group supervision. Murtagh also encouraged clergy to carry some of their learnings into the pulpit. He offered several important points in support of community based pastoral care. First that there are

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[43] Robert K. Nace, "Parish Clinical Pastoral Education: Redefining 'The Living Human Document.'" *Journal of Pastoral Care* 35, no. 1 (1981): 59.

[44] Larry J. Murtagh, "Clinical Pastoral Education (CPE) on the Prairie." *Journal of Pastoral Care and Counseling* 60, no. 3. (2006): 287.

many settings that CPE can be effective. An approach that looks at community systems allows students to observe and understand the fabric of their local environment. Bringing people together in an ecumenical way enriches everyone involved. Enhancing one's listening skills is important and ongoing work of a pastor. It is important to get out of the church and out of the office to meet people where they work, play, live and conduct their everyday affairs. To minister to individuals, one has to know about the community they live in. CPE is training for discovering what God is calling us to do. God wants us to make our community decent places to live in. [45] He made a solid case for community-based training and ministry outside of institutions and churches.

Margot Hover, Clinical Pastoral Educator, has developed a program that extends CPE into different program configurations, sites and economic and occupational subgroups. She describes a community-based program that is designed to apply the elements of traditional training in rural and underserved populations. While the program was initially designed to give ministry students access to clinical pastoral education while serving in more remote settings, the program expanded to welcome people of different levels of education in organizations may not seem aligned with or accepting of pastoral care. Her work added onto Murtagh's in a few important ways. Because she entered the conversation in the information age, she added more electronic group and individual supervision components such as email conversations and emailed reporting requirements. She also conceived of each participant creating a local "CORE" (consultant, observer, reflector and evaluator) group to work with the trainee to offer feedback and guidance. Lastly, her program expanded on Murtagh's model by adding a social empathy

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[45] Murtagh, "Clinical Pastoral Education on the Prairie," 293.

project to be conducted over the course of the unit and presented at the end. The example she gave was the facilitation of a breast cancer survivor creating a breast self-examination program in her African American church. [46] Her articulation of how CPE can be translated into community ministry and enhanced by information age tools invites additional contextualization of CPE/T training programs.

SECTION 3: SYNTHESIS AND CONCLUSION

Jesus as the example of a community chaplain is made quite clear in the Gospels, yet there is no real indication specifically of how his followers should prepare themselves to minister as he did. In the almost two millennia that follow, the only example of the chaplain that minister's in the world is of a military chaplain. The preparation for which is that of preparing someone to administer sacraments to the fallen. The idea of a clergy person offering care in institutions outside of the church appeared in the late 19th to early 20th century. This movement became known as the Clinical Pastoral Training Movement and involved including clinical training as a part of clergy preparation.

There are two major streams of thinking that come out of the Clinical Pastoral Movement. These streams are attributed to the two "founding fathers" Richard Cabot and Anton Boisen. While both influenced the movement beyond measure, it is important to note that neither wrote books about their position on how to approach the training. Their approach took shape

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[46] Margot Hover, ""Diversity: Clinical Pastoral Education (CPE) in the Hinterlands," *Journal of Pastoral Care & Counseling* 61, no. 3 (2007): 180.

through their disciple's work and the models of training that were developed and applied. Most of this was written about in articles and presented through papers in symposiums.

Richard Cabot came to the application of pastoral care in hospital settings as the founder of medical social work. As a physician who was a committed UU during the social gospel years, he felt that addressing patients and peoples issues required addressing their social needs in addition to their physical needs. Part of the care included their religious needs. He put forth the idea that employing religious tools such as prayer would be helpful for a patient's care. He therefore thought that training clergy in these institutions brought in voices of those who pray.

The other camp was the followers of Boisen. He was a minister who felt that it was more important to be fully present to the patient rather than to pray for them. He believed the patient is a living human document to be read. Theology should be employed to think about the suffering and understand the theological significance of what was happening to the patient. He employed the ideas of Freud in terms of working with the unconscious, specifically with a theological lens. For him neither chaplaincy nor chaplaincy training held any prescriptive methods for intervention other than offering someone the opportunity for greater self-awareness.

While these two streams had fundamental differences, they did converge on training elements. Initially the elements consisted of making clinical visits, presenting clinical work to a supervisor and peer group for consultation. In later years, the addition of group process seminars became a part of both training approaches. A deviation occurred early that became more pronounced as time moved on. The deviation was specific to didactic training. Cabot's stream connected strongly to training as an education movement. There were specific educational components, some specific to the institution and some specific to the interventions conducted by the chaplain. The Boisen stream resisted the educational focus. The focus was on knowing

oneself as clinician and being able to be fully present to the patient. Training clergy was focused on psychodynamics and preparing them to develop a therapeutic relationship with the patients.

Boisen's approach within the Clinical Pastoral Training Movement reflects the ministry of Jesus. Jesus healed the sick by witnessing the brokenness of their soul and empowering them into their wellness. Boisen's training prepared clergy to offer care in the same way as Jesus did. Whereas Cabot was a doctor using a prescriptive model of chaplaincy to care for patients in hospitals, Boisen taught a therapeutic model of chaplaincy that prepares clergy to offer holistic care wherever the "patient" is found.

There has been a good deal of literature about chaplaincy training and chaplaincy. While the components of training have remained similar to the components of initial training, the images of care and caregivers have changed. At a time when clergy were predominantly male, the early disciples of chaplaincy conceived of a chaplain was that of a shepherd. Other images prevailed over the years, such as wounded healer. With the entry of women into the field of clergy and chaplain, other images appeared such as chaplain as midwife. [47] It is interesting to note that some of the earlier images reflect the action of the chaplain or chaplain trainee as the active participant in the patient's or persons healing whereas some of the images reflect the chaplain or chaplain trainee's role as both a witness to the patients pain and an empowerer of their healing.

Jesus' ministry took place outside of institutions with people in the margins. It makes sense that clergy would train outside of institutions while ministering to people in the margins. Training to work with people outside of institutions means meeting people where they are

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[47] Dykstra, *Images of Pastoral Care.*

geographically and theologically. While there are a few voices who speak to employing the CPE/T model to community ministry, there is room for more work in the area that would produce more writing on the methodology and efficacy of creating Clinical Pastoral Training programs in community settings.

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Appendix C—Milestone 3 DESIGN WORKSHOP Report

INTRODUCTION DWR

Clinical Pastoral Education/Training (CPE/T) is traditionally offered in hospital settings to people who are preparing for traditional ministry. For purposes of this project, I will use the initials CPT to denote a focus on training versus education. These programs are well-supported financially and administratively by the institution where the training takes place. This project seeks to apply the model of CPT to different institutions as well as non-institutional settings for people who are preparing for ministry from a multitude of spiritual pathways in a variety of settings. Creating a template or resources to establish and manage programs will make setting up and managing program in community settings straightforward and may offset some of the financial and administrative hurdles for running a program. This will encourage Supervisors and Supervisors in Training to create programs that serve their specific community organizations and/or non-traditional ministry candidates.

NPO STATEMENT-DWR

I will design a resource(s) or template to help create and manage a community-based Clinical Pastoral Training program.

NPO SCOPE AND CONSTRAINTS

Traditionally CPE/T program are established in hospitals and are supported administratively by the institution. Community-based CPT programs are by definition established outside of major institutions. As a result, they can lack access to standardized clinical time, and administrative resources for creating and managing programs. For purposes of this

design workshop, I focused on developing a resource(s) to help with setting up and administering a Clinical Pastoral Training program. There are no anticipated costs or obstacles to developing resources other than time.

NPO CONTEXT

CPT is a paradigm of learning that applies a clinical process to ministry training. It was originally established in hospital clinical settings to prepare mainline protestant ministry candidates for pastoral care duties. This project broadens the understanding of clinic for purposes of training and expands access to training to a variety of traditional and non-traditional ministry candidates. The ministry settings for this project are varied. CPT programs could offer parish-based training for people in a faith or spiritual community to serve the community by placing trainees in broader community settings such as prisons, recovery programs, or street ministry. A CPT program could also be created to offer training to a variety of trainees placed in a broad number of community settings.

ROOT CAUSES

There are several root causes that have prevented or discouraged supervisors from establishing and facilitating community-based and parish-based CPT programs. First there is ambiguity as to what constitutes clinical time, when the program is not in a formal institution. Another root cause is the lack of administrative support for small programs not affiliated with an institution. A third root cause is finding placement sites for potential trainees to complete their clinical hours.

THREE BIG IDEAS

The first idea is to speak with accreditation committees of chaplaincy cognate groups to determine the need and/or possibility of broadening the definition of clinic and clinical hours required to complete a unit of clinical pastoral training. The next idea is to determine if it is possible to create a shared administrative resource for community-based programs. The third idea is to create a resource that outlines setting up a program and share resources for administering the program once it is up and running. This would include materials for reaching out to potential clinics and creating community marketing workshops.

DEFINITION OF 'DONE'

This project will be complete when the three ideas have been addressed and a resource or resources have been created that can be published, presented, or shared with Clinical Pastoral Training (CPT) supervisors or supervisors in training to encourage the formation and management of community-based programs.

3 NAPKIN PITCHES

The first napkin pitch was to expand the idea of what is considered an acceptable clinic along with expand the idea of what constitutes a clinical visit. This idea is intended for training programs, clinical settings and trainees. It allows programs to expand what kind of setting constitutes a clinic for purposes of meeting the rubric of the training. It allows for a greater variety of community organizations to be served It also provides trainees the opportunity to serve in these varied organizations to meet the training requirements and allows trainees to complete their hours in non-traditional clinics in ways that benefit the organization and their constituency.

All benefit as the community organizations get additional support, the trainee gets the benefit of clinical training in their own community. I benefit as my program can be recognized and accredited so that my training would meet the standards for certification for those who participate. The challenge may be that the trainee cannot have enough 1x1 encounters to fully engage with the clinical process. Rather than track hours, I could test the quality and depth of this approach by gaging the case studies they bring to the group process seminar. This departs from the standard of tracking hours. The success of this approach would be measurable when the community organizations articulate the benefit they receive. It would also be measured by the personal and professional development of the trainee. The clearest metrics for this is feedback from the community organizations on the benefits they experienced by having a chaplain trainee. Another measure would be a trainee's articulation of meeting their own learning goals and objectives. A third indicator would be a trainee's successful progression through the certification process. There are different organizations emerging that are providing online training for people in remote areas that are serving in institutional settings. My approach broadens the type of setting that a trainee can serve in to included non-traditional institutions.

The second pitch was to establish a pooled administrative resource that could help support community-based programs. This resource would help supervisors of community-based programs receive the administrative help required to set up and administer a program. For supervisors who are not affiliated with institutions, there is a lack of administrative support to conduct their programs. Considering that these programs are not well supported financially, it is unlikely that a supervisor could afford to have an assistant. Pooling administrative resources for a few or several community-based programs would be an effective way of obtaining the resource in cost-effective way. What makes this particularly helpful is that when a specific assistant

becomes familiar with the specific needs of one program, the assistant would understand the needs of the other programs. There would be an economy of scale with their tasks. The risk is that there are not enough programs to support an administrative assistant. The testing for this would be to determine if there is enough interest by approximately 5-6 programs to pool their needs and resources to contract with an administrative contractor for a year. The alternative is for the supervisors to do their administrative paperwork, filings and obtain their own insurance.

A third napkin pitch was to create a workshop or resource to present pastoral training to community organizations in order to create potential placement sites. This workshop is intended for the community-based organizations. A well-prepared workshop or presentation would communicate to the community the benefits that spiritual care could bring to their clientele. A supervisor would canvas a variety of organizations and faith communities to determine interest. They would prepare a presentation and offer it to these organizations. I am not aware that this has been done before and it may not garner any interest. By marketing this to organizations, we will build contacts and possible placement sites for trainees. The success would be measured by attendance at the presentations and organizational contacts willing to accept chaplain trainees. Other community-based programs have relied on word-of-mouth connections to specific facilities and organizations that they may be connected to through their own faith tradition. This approach would develop more opportunities for service to a wider range of community organizations as well as for trainees to gain clinical experience.

DESIGN WORKSHOP STAKEHOLDERS

The design workshop stakeholders included:

Diplomate Supervisor engaged in prison ministry in New Jersey

Diplomate Supervisor currently offering CPT in Nassau County Hospital setting

Diplomate Supervisor in St John's Episcopal Healthcare in New York City

Supervisor in Training offering a hybrid program in New Jersey

Diplomate Supervisor currently offering units of CPT to members of the Muslim community in New York City

Diplomate Supervisor offering community-based CPT on Long Island, New York

ONE-ON-ONE INTERVIEWS

Professor of Pastoral Care and Counseling at a Seminary

Former director of Pastoral Care at Hospital

Diplomate in Clinical Pastoral Training, College of Pastoral Supervision and Psychotherapy (CPSP)

Leader in the Association of Clinical Pastoral Education, Association of Clinical Pastoral Education (ACPE)

Leader on the Accreditation and Certification, CPSP

3–5 KEY BIBLICAL TEXTS

Mark 5: 1-20	Jesus Heals a Man With a Demon
Mark 5: 24b-34	Jesus Heals a Hemorrhaging Woman
Mark 10: 46-52	Healing of Blind Bartimaeus
Mark 2: 1-12	Jesus Heals a Paralytic

ANNOTATED BIBLIOGRAPHY

Curry, Janel, McCallum, Margaret, and Rodriguez V, Jorge Juan. "Spiritual Care Education and Rural Systems in Swan River." *Journal of Pastoral Care & Counseling* 70, no. 1 (2016): 53-62.

This article talks about the establishment of a Clinical Pastoral Education/Training program in rural Canada. The authors explained how placing trainees in different community-based programs deepened their understanding of the social fabric of small community. Their presence in the community organizations often freed up over stretched resources and provided another layer of professional care. Patients and clients also seemed to open up to them more as they were a professional resource that was not prejudiced by relationships or politics from within the community. It would have been more helpful if it described the mechanics of how the program was put together and administered.

Hover, Margot. "Diversity: Clinical Pastoral Education (CPE) in the Hinterlands." Journal of Pastoral Care & Counseling 61, no. 3 (2007): 175-81.

This author claims that CPE/T would be a richer experience if it were contextualized in a variety of communities and community settings. The programs would be further enriched by broadening the candidates and caregivers who could participate. The author advocates for trainees completing a unique program or project in the ministry setting and presenting setting and project in addition to the standard CPE/T curriculum. The author missed giving a concrete example of what this would look like.

Murtagh, Larry J. "Clinical Pastoral Education (CPE) on the Prairie." *The Journal of Pastoral Care & Counseling* 60, no. 3 (2006): 287-93.

The CPE model can be contextualized in setting different from hospitals to offer training opportunities in ministry across political, economic and cultural systems in rural communities. In addition to CPE model, trainees embedded in communities would study and get to know the systems in those communities. They could thus support the work of the organizations and municipalities as well as specific people in the community. The article did not provide insight into how to organize across communities or develop cohorts for purposes of training.

Nace, Robert K. "Parish Clinical Pastoral Education: Redefining “The Living Human Document”." *Journal of Pastoral Care* 35, no. 1 (1981): 58-68.

The author explains the elements of a basic, traditional CPE unit as being: peer group interaction, facilitation by a trained and certified supervisor, participating in offering care to patients, and then an action reflection action model of reflecting on work. The author believes that this model is useful for training ministers and lay people in parish-based settings. The primary difference is the types of persons and situations that a trainee would encounter. It would have been more helpful if the author would have illustrated with a specific example of this model.

APPENDIX 1: Design Workshop

Design Workshop Invitation

Community Based Clinical Pastoral Training

Design Session

Thank you for offering your time, wisdom and energy to help me with my doctoral project of designing a community based Clinical Pastoral Training Program. Last year my discovery session led to the determination that there is a need for community-based CPE/T to offer clinical training to people of various traditions in a variety of community organizations and settings.

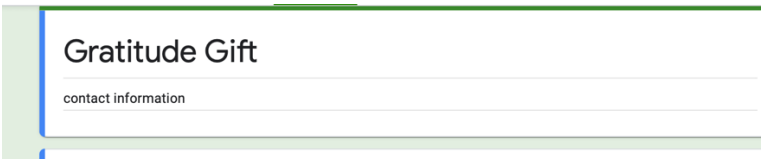
This fall, my research is focused on determining the challenges of starting a program and designing ways to overcome these challenges. I am so grateful for your time helping me design this in preparation for selecting and preparing a resource. The design session is scheduled from 2:30-5:30 on Sunday October 18 by Zoom.

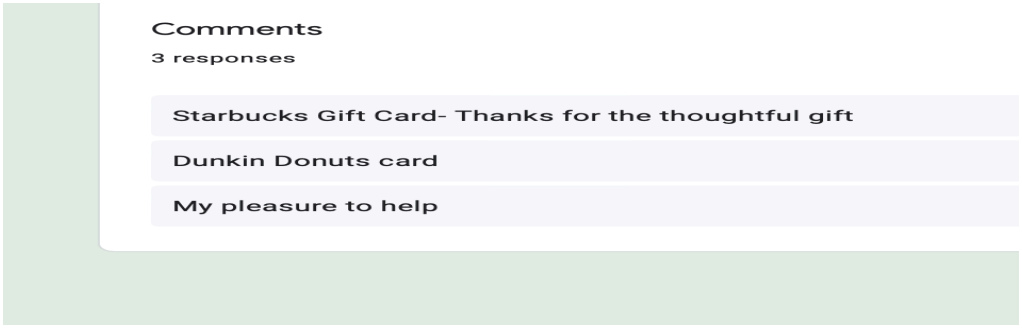
Prior to our Zoom Gathering on October 18 would you please:

1. Complete the appreciation gift survey
2. Acquaint yourself with the impossible question
3. Complete the pains and gains questionnaire

A token of my appreciation

I would like to send you a small token of my appreciation. Please click on the link below and indicate which you would prefer and provide me with your email, and snail mail address in case I need to send something the old-fashion way.





Dunkin donuts gift card

Starbucks gift card

Again, thank you for your time and wisdom!

Design Workshop Preparation

Mission Impossible

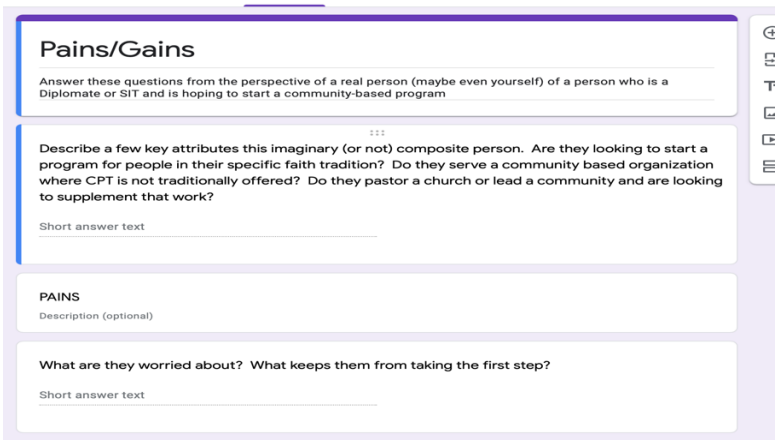
Would you prayerfully consider this, and let your subconscious mull on it? We will work on this more during the workshop.

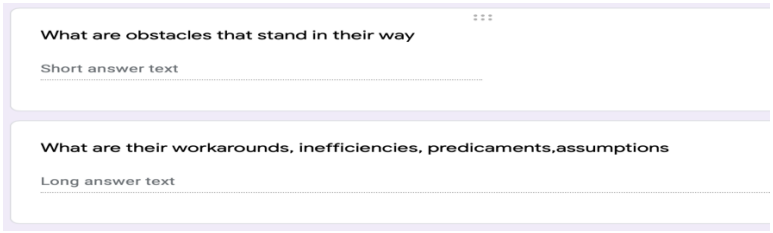
How do we develop a resource that will make it easier to create and manage a community-based Clinical Pastoral Training program?

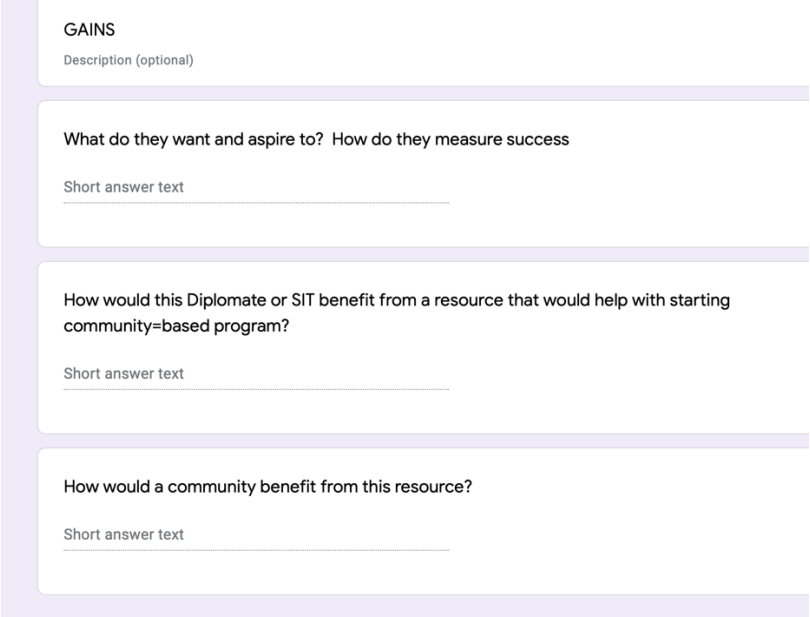
Pains and Gains-

- Pains identify fears, risks, frustrations, and obstacles, that need to be overcome to create and manage a community-based CPT program.
- Gains identify successes and how they were obtained. This will also include ambitions, passions, goals, wants and needs.

GOOGLE FORM


Pains/Gains
Answer these questions from the perspective of a real person (maybe even yourself) of a person who is a Diplomate or SIT and is hoping to start a community-based program
Describe a few key attributes this imaginary (or not) composite person. Are they looking to start a program for people in their specific faith tradition? Do they serve a community based organization where CPT is not traditionally offered? Do they pastor a church or lead a community and are looking to supplement that work?
Short answer text
PAINS
Description (optional)
What are they worried about? What keeps them from taking the first step?
Short answer text


What are obstacles that stand in their way
Short answer text
What are their workarounds, inefficiencies, predicaments,assumptions
Long answer text



This is what our day together will look like:

2:30-3:30 Welcomes, introductions, pains and gains responses

3:00-4:00 Mission Impossible Priority Ranking

4:00-4:15 Break

4:15-5:30 Napkin Pitch and debrief and conclude

Zoom Meeting-DMin project-Designing a community based Clinical Pastoral Training Program

Lori Whittemore is inviting you to a scheduled Zoom meeting.

Topic: DMin design meeting

Time: Oct 18, 2020 02:30 PM Eastern Time (US and Canada)

Join Zoom Meeting LINK

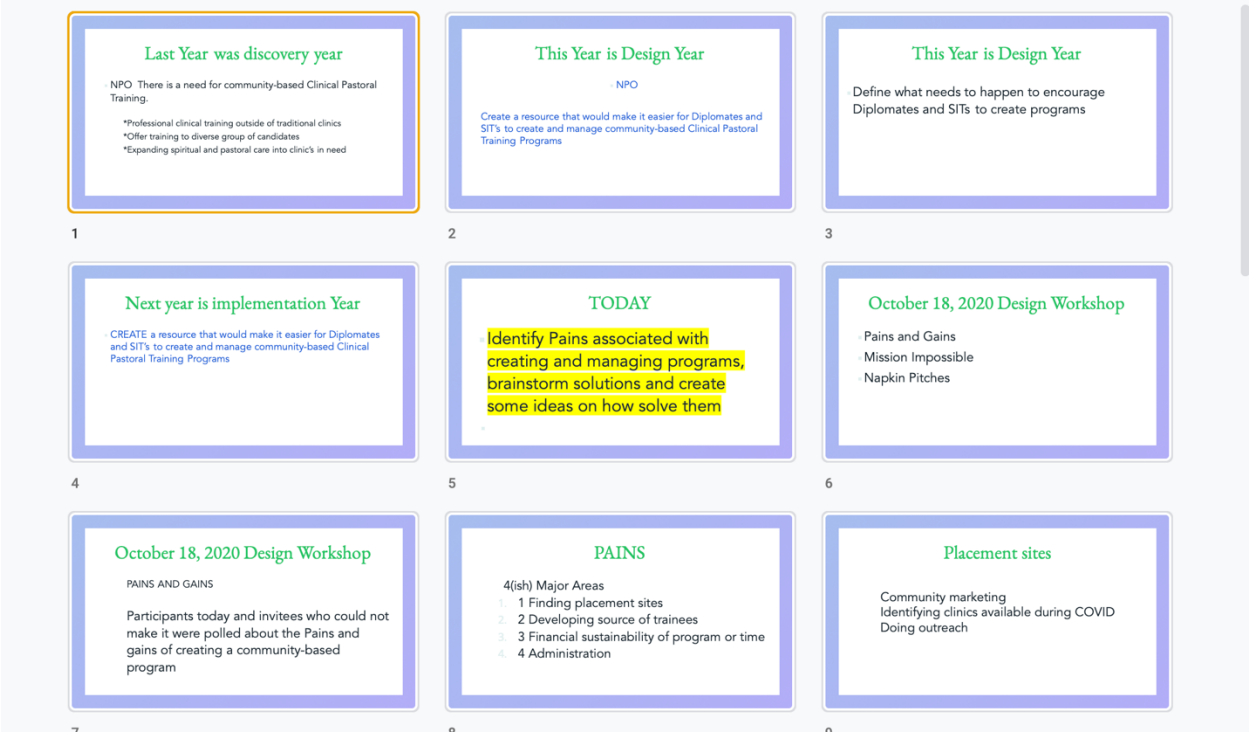
Design Workshop Description

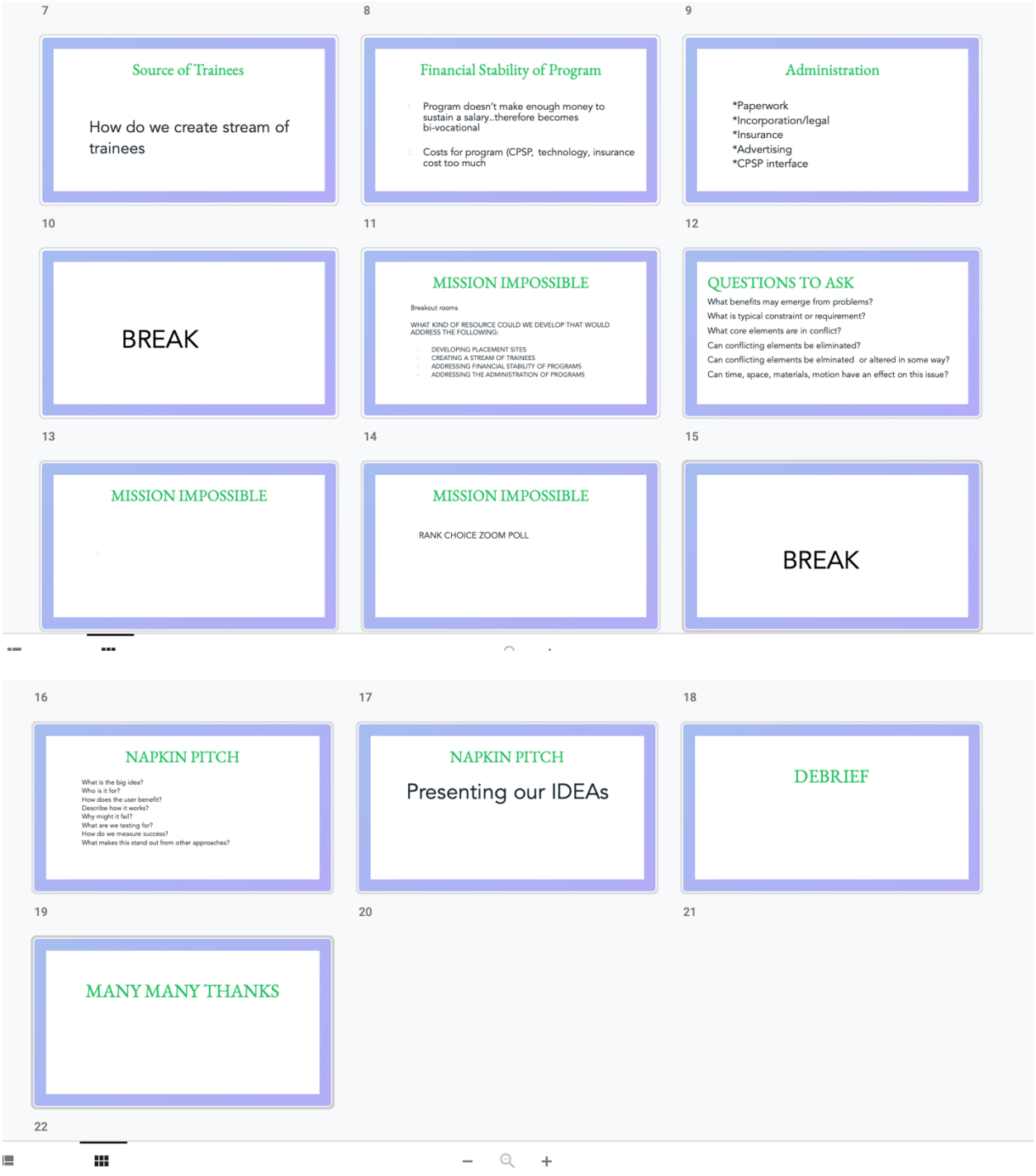
I conducted a design workshop on October 18, 2020 to design a resource (s) to help Clinical Pastoral Supervisors create community-based programs. We met from 2:30pm-5:30pm Eastern Standard Time via Zoom. The Stakeholders consisted of two hospital-based Spiritual Care Directors who are clinical pastoral training supervisors. The other participants were community-based training supervisors who are working on getting programs started. The workshop consisted of doing a pains/gains survey prior to the workshop by Google Forms. The day of the workshop I presented an overview of the workshop, the results of the pains/gains, we did a Mission Impossible exercise, a rank choice polling and then a napkin pitch. On a 1-5 Likert Scale of how I feel the workshop went; 1 being not well at all, 2 being somewhat bad, 3 being neither bad nor good, 4 being somewhat good, and 5 being excellent; I would rate my workshop at a 4. Logistically, I was able to navigate the technology to meet the requirements of the project. I had enough participants to get good data for pains and gains, mission impossible conversation, rank choice polling and for developing napkin pitches. What holds it back from being excellent is that my navigation was a little clunky. I would have benefited from an additional person to help manage the data. I wasn't able to keep separate notes from the technology and while the programs were able to capture the big picture, I didn't capture the nuances of having my own notes. I would also have benefitted from a few more diverse voices.

Design Workshop Documentation

I used a number of methods for collecting data. First, I used Google Forms to collect data about the pains/gains survey. Screen shots of the actual forms can be found in the previous section

I rolled up that data in a Google Sheets presentation for the rest of the workshop, which I used as a guide for our time together.

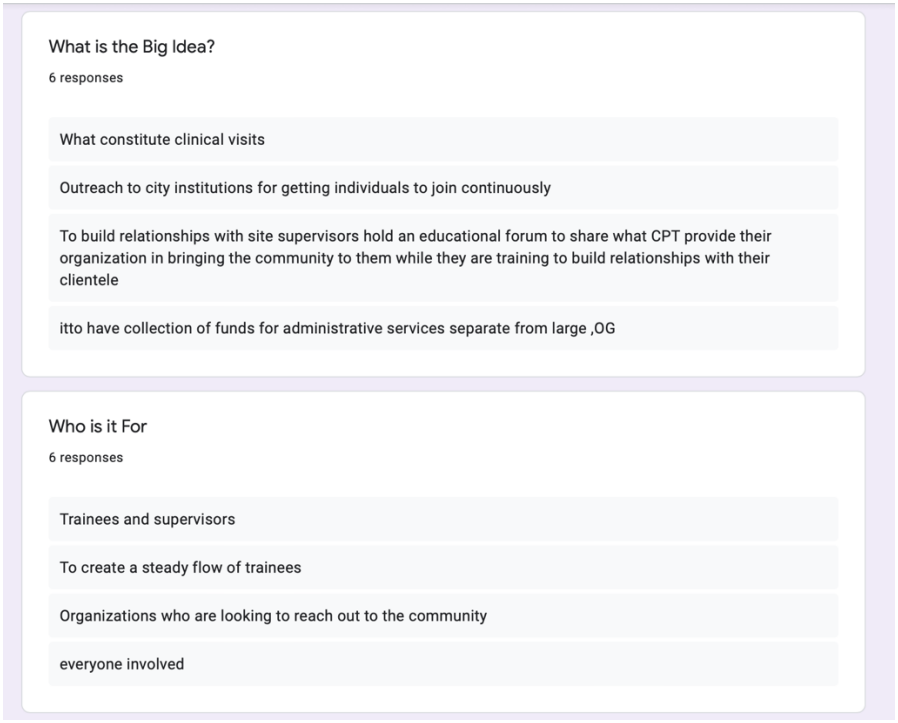




After completing the first segment of the Google Sheets presentation that took us through the pains and gains, we took a break and then returned to complete the mission impossible. The broad questions were listed in the Google Sheets. They decided as a group that they were interested in working on this together, so I let them work on it as one group. Since they worked

on this together the discussion about approaches rolled directly into reflective discussion. They listed their possible solutions in the Zoom chat function. I did not capture that list as an artifact.

At the next break, I rolled up the list into a Zoom poll and posted it for when they came back from the break. The polling function created a rank choice of the data. I did not capture this Zoom function as an artifact. I presented the data to the group. I explained the napkin pitch and directed them to a napkin pitch google form to complete.



How does the user benefit?

6 responses

Develop pastoral and interpersonal skills we rely on in ministry

Learning new ways to communicate.

Connects them in a different way to the community

it would free up supervisors to focus on training of both site personnel and

Describe How it works

6 responses

CPT experience in community based settings with the ability to do meaningful clinical work that would elicit verbatim in group process

Sending letters to all institutions explaining the benefits of people taking Community CPE.

Introduce organization to the trainee you are assigning to this organization so they can build relationship with them and by extension to CPT

may be dues, depending on monthly of training cycle

Why might it fail

6 responses

- Not clinically based and no accountability from a site supervisor
- People not recognizing the benefits of the program.
- When organizations hear Pastoral Care the assumption may be that proselytizing may be the underlying reason for bringing in trainee - hence the need for the educational forum
- not everyone participates or failure to participate in units.

What are we testing?

6 responses

- People and sites
- Not understanding the question
- Placing the right trainee with a specific organization and how we vet our trainees for this kind of assignment
- ?

What would measure our success

6 responses

- Growth of trainees
- Enrollment of trainees
- The organization sees the benefit of what we offer
- The efficiency of the program running

What makes this stand out from other approaches?

6 responses

- Clinical Pastoral Care vs Pastoral Care from anywhere
- Not sure as of yet.
- Clinically based and not religiously based which organizations who protect their clients from 'religious' people who may do harm. Listening as opposed to preaching to
- never been done

Design Workshop Follow up:

Thank you email sent to 5 participants

Thank you so much for participating in my design workshop for creating resources to help Diplomates and Supervisors in Training (SITs) to create and manage community-based Clinical Pastoral Training.

We identified several challenges for Supervisors and SITs who are trying to establish community-based programs and also brainstormed some great approaches to addressing the challenges. These are three ideas that were articulated both in the session and from people unable to attend the session.

First, there is a challenge defining and tracking hours in a non-institutional setting. Rather than track time in clinic, it may be more useful to track the number of clinical encounters that a trainee has in a week to ensure that they have enough clinical interactions to provide for creating case studies and critical incident reports for engaging the clinical process. This would be measured by acceptance of this as a standard for certification. Further exploration with standard setting bodies would need to be done to affect this change.

Another big idea came from a challenge of having enough administrative support for community-based programs. The idea was to have part of the small program dues set aside for administrative support that might include record keeping, web support, bulk insurance purchasing, state filings, cognate group paperwork, advertising and other program administration. Success would be measured by setting this up.

A third idea was identified to address building relationships with community organizations in order to place chaplain trainees. The idea put forward is to create a workshop, meeting or template for the purpose of organizing a workshop for community organizations to

educate about clinical pastoral training and the benefits of having a trainee to support organizations.

Having someone conduct a workshop would test if this is an effective tool. I would appreciate any additional feedback you have about these or other ideas discussed! I know that you are very busy and am grateful for your time helping me with my research.

Peace and Blessings

Lori

APPENDIX 2: One On One Interviews

Invitation Email

I sent the following email to four 1x1 interviewees:

Thank you so much for agreeing to meet with me to discuss my project of creating a resource for Supervisors and Supervisors in training (SITs) to help create and manage community-based training programs

On October 18, 2020 I conducted a design workshop with 5 Supervisors and SITs to discuss challenges of creating and managing programs as well as develop ideas on how address them. These are three ideas that were articulated both in the session and from people unable to attend the session.

First, there is a challenge defining and tracking hours in a noninstitutional settings. Rather than track time in clinic, it may be more useful to track the number of clinical encounters that a trainee has in a week. This would effectively ensure that they have enough clinical interactions to create case studies and critical incident reports thus engaging in the clinical process. This would be measured by acceptance of this as a standard for certification. Further exploration with standard setting bodies would need to be done to affect this change.

Another big idea came from a challenge of having enough administrative support for community-based programs. The idea is to have part or all of the small program dues used for administrative support that might include record keeping, web support, bulk insurance purchasing, state filings, cognate group paperwork, advertising and other program administration. Success would be measured by setting this up.

A third idea was identified to address building relationships with community organizations in order to place chaplain trainees. The idea put forward is to create a workshop, meeting or template for the purpose of organizing a workshop for community organizations to educate about clinical pastoral training and the benefits of having a trainee to support organizations.

Having someone conduct a workshop would test if this is an effective tool.

I look forward to our conversation. I am curious what you agree with and what you disagree with. I am also curious about what other areas we may have missed.I look forward to speaking with you soon.

Peace and Blessings

Lori

One On One Interviews

I interviewed four people for purposes of this project. Interviews took placed October 26-28. The first interview was with a seminary professor whose expertise is pastoral care. She believes that Clinical Pastoral Education/Training (CPE/T) is a formula that can be applied anywhere in any setting. For her the critical piece is that you must be able to function in that role, publicly as a spiritual caregiver as opposed to another helping role. A need for interreligious competency and a sense of one's own theology. Many are spiritually fluid right now but trainee should have a sense of their own theology before caring for others. In terms of business plans or costs to set up a program, she suggested that is a critical piece to address as theology students come out of seminary with significant debt and are not stepping into positions that cover the cost of the loans. She suggests that community-based programs should be a cooperative of community organizations that form their own non-profit or sponsor the program so that the supervisor can be compensated. She suggested that there should be a greater focus on social justice right now and finding a way to weave CPT with social action organizations. One example might be a chaplain for BLM to work with the organizers. There could be trainees of a small cohort that serve different organizations or that serve a full community that includes municipal offices, social service agencies and other organizations so that it is an integrate "clinic"

The next interviewee is a Clinical Pastoral Supervisor that works in a hospital. He is affiliated with the College of Pastoral Supervision and Psychotherapy (CPSP), the same group I am affiliated with. After reading the email he offered some suggestions about counting hours. He offered that he would have trainees keep a journal of their encounters. They could either log hours or track encounters and document that with a journal. In terms of administrative model, he suggested creating a chapter of community-based supervisors. The chapter could incorporate and

bulk-buy administration including insurance, and other administrative support. The chapter could be a nonprofit or any other type of business. The supervisors would act as an advisory council as well as a business board for the community-based programs. He had some suggestions regarding developing relationships with community-based organizations. He suggested creating a prototype of a program to seek a grant for and to pitch to potential placement sites. The prototype would include an overview of what a chaplain does, how a chaplain can support both the internal employees and the clients they serve. He suggested seeking a grant, through the chapter of community-based supervisors to provide for tuition, so that trainees wouldn't have to pay for their training.

The third interviewee was a head of a chaplaincy cognate group. He offered several contacts to community-based programs within his organization. He suggested I speak with the directors of those organizations to get a clearer picture of how they track hours and what business model they use as well as how they market their program. For specific ideas he suggested approaching several towns to form a consortium for chaplain placements; seek a grant that would cover the salary and travel of a supervisor, focus on a specific issue, like seniors who are aging in place, seek a grant for 2 years and collect a bunch of data, or socialize the community to having spiritual care and at the end make the case to the constituency to fund the program. Possible organizations would be first responders, community health clinics, recovery programs, affordable housing projects. Get clear on who the pitch is to and establish a reasonable timeline. He stated that the emergence of community-based chaplaincy is the religious expression in America as Churches decline.

The final interviewee is the supervisor of community-based training program. Her perspective is that there should be no concern of how to get hours. There needs to be someone

designated by the “clinic” who can sign off on hours. The agreement of how the trainee completes those hours are between the site and the trainee. Parish based is easy, there is also emerging tele-chaplaincy, and nursing homes. She keeps all of her administration on google drive. She sets up a Google file for each trainee along with a google library for her trainees. She buys her own insurance and has a locked file cabinet for paper copies. She is a CPSP diplomate supervisor and creating a curriculum is part of the process, so curriculum, bibliography and setting up a program is a part of be a supervisor in training. The administrative piece is easy to manage once it is set up. She is not in it for the money so having a business model is not a concern to her. Her trainees come with placement sites in mind. They must find a site and be vetted by the site before she accepts them into her program. She does not get placements for her trainees. Her training is a word-of-mouth training and she has never had to advertise.

Appendix D: Milestone 4—PROTOTYPE ITERATION REPORT

INTRODUCTION OF PROTOTYPES ITERATION REPORT

Based on the discovery and design projects for the Doctor of Ministry program at the George Fox University, two prototypes emerged and were presented to stakeholders for feedback and to assess viability.

PROTOTYPE #1 SUMMARY AND FINDINGS

The first prototype explored was creation of a chaplain services organization that would make per diem chaplain services available to non-profit social service organizations to supplement care to clients, staff and patients. The participants were presented with a Powerpoint presentation that explained the benefit a chaplain could add to their organization, along with idea that an organization is being established to allow them to access chaplain services on a per diem basis to meet their need. The prototype was presented to assess if organizations both understood the value and would contract for chaplain or spiritual care services. A benchmark for this prototype is if they would agree to contract for these services. Participants for the prototype presentations were executive directors, clinical directors and program coordinators for social service organizations. The organizations included a recovery program, an HIV/AIDS program, a homeless advocacy program, a council on aging, and a domestic violence emergency shelter program. The participants clearly understood the value of adding spiritual care for their clients and especially their staff. Cost was clearly a concern, as well as making sure that the providers did not proselytize to anyone. For one of the five organizations, they indicated that if they had the financial resource to obtain additional support, they would likely spend it on additional case

work to support their primary mission. I learned that there are more faith-based grants available now for the kinds of services I am imagining.

PROTOTYPE #2 SUMMARY AND FINDINGS

My second prototype explored the possibility of establishing a chapter of supervisors who run community-based programs in the College of Pastoral Supervision and Psychotherapy (CPSP). CPSP is a cognate group that provides certification and accreditation for clinical chaplaincy training programs. It organizes itself in chapters of supervisors and clinicians. Chapters are often formed based on geography. My idea was to organize 1-2 chapters for supervisors and supervisors in training who offer community-based training. The participants were presented a Powerpoint presentation outlining the benefit and a possible process for organizing a community-based chapter. The question explored was would they be willing to join the chapter if it was formed. The participants in my prototype presentation were supervisors and supervisors-in-training who run community-based programs. They immediately saw the value and potential of this idea. What mattered most to the participants was the reduction in time, effort and money that they would need to invest if they could share resources. I discovered that people were not only receptive but were ready to engage with the idea right away.

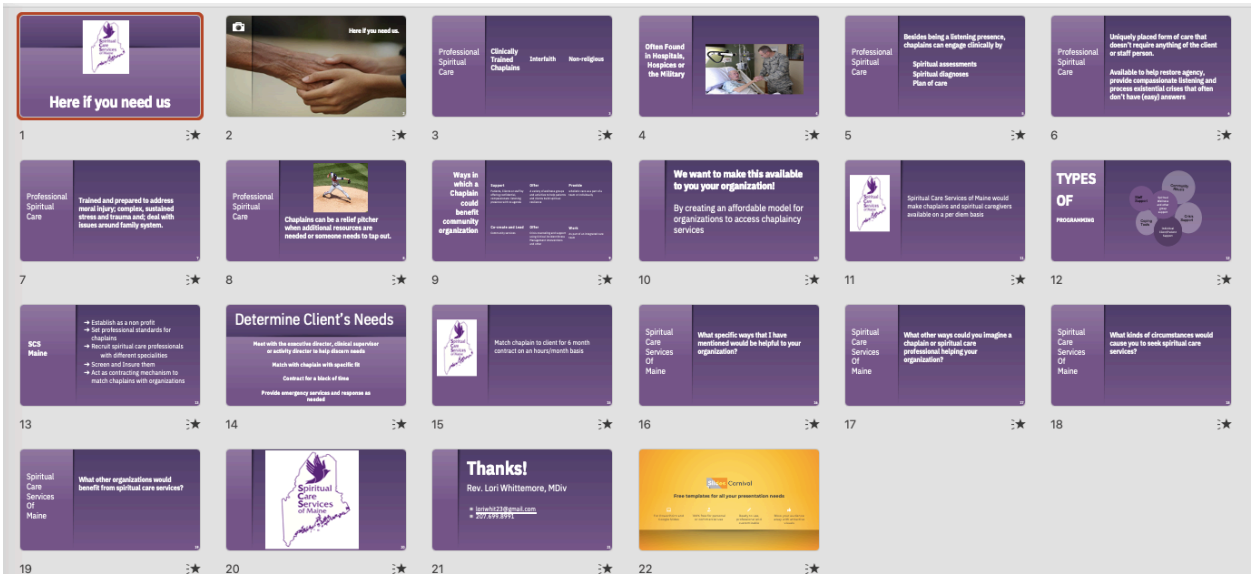
MOST VIABLE PROTOTYPE

I found both prototypes to be viable. The first prototype forming a per diem chaplain organization is viable. If I can get a grant to support the formation of the infrastructure, I will attempt a pilot it this fall. The making of a chapter is also viable and simpler to pursue. Because no financial resources are required for this prototype, I will attempt to do this as well.

APPENDICES

APPENDIX 1:SPIRITUAL CARE SERVICES OF MAINE

Storyboard for SCS Maine



Recruiting Screener for SCS Maine

Who do I want to talk to	What specific criteria will identify the people I want to talk to	What screening questions will I ask?
Executive Directors of non-profit social service agencies	They have decision making authority for making contracts for care services (1-2)	Do you feel that spiritual care would add value to your organization?
Clinical Supervisors in social service agencies	They have responsibility for direct care planning for patients and clients. (1-2)	Do you feel that spiritual care services would enhance the care you can provide to your patients or clients?
Activity Directors in long term care facilities, senior living communities, community centers.	If they are responsible for programming for an institution or organization (1-2)	Do you see a need for spiritual programming or services and rituals at the place that you work?

Who should I exclude	What exact criteria will identify the people I want to exclude	What screening questions will I ask?
Organizations that don't allow religious personnel or services.	People who work in institutions, like public schools, where separation of church and state prevent them from engaging with spiritual care.	Are there any restrictions to working with spiritual care professionals in your organizations?
Organizations whose decision makers are people who are opposed to religion at all and any level.	People who are unreceptive to having a chaplain or spiritual caregiver involved in their organization.	Are you opposed to having chaplains or spiritual care givers available to your staff, patients or clients?
Organizations that have chaplains of specific traditions already serving their needs.	Do they have employees or volunteers that are filling the need of spiritual care	Do you have staff or volunteers that are meeting the pastoral or spiritual care needs for your organization?

Interview Script for SCS Maine

For my first prototype, I asked several questions. I ask them if they understood what a clinical chaplain was and if they had ever encountered a chaplain and what that experience was like for them. After presenting the ways in which a chaplain could support patients, clients and staff I asked what ways they could imagine a chaplain or spiritual care giver adding to the quality of care they offered to client or staff. I then asked what other organizations might benefit from chaplain or spiritual care services.

Documentation of Prototype for SCS Maine

Interview notes and video observations are presented together for each interview.

One-on-one interview notes/observation notes for SCS Maine (green indicates affirmative feedback and red indicates negative

2.16.21, 1:30 Recovery Community that serves homeless and marginalized addicts- Interviewee (executive director) has had interactions with police chaplains and had a positive experience. Sees the value of having chaplain services available for staff and clients. Staff have high burnout especially now with escalation of opioid clients and overdoses of clients and former clients. While he acts a support for them, he feels they would benefit from having a neutral support person. Probably as an on-call chaplain or someone who can come in and do debriefs.

For clients he sees an absolute need. They offer 12 step recovery programs but no specific development or guidance or insight into what higher power means. While he would be concerned if a particular tradition would come in to convert, he stated a need to have spiritual wellness groups as part of long-term residential program and even in short term recovery.

Shelter is a wet shelter and he could see a chaplain as a drive by chaplain checking in with people. He could see a need for ongoing chaplain support as a part of the detox program. Loved the idea overall. No idea of how to fund as their resources are so tight. Can imagine a faith-based grant for this and would connect me to his development person to seek and write a grant for a pilot. He referred me to Amistad, Preble Street, Shalom House and Opportunity Alliance for places that he felt would benefit from Spiritual Care Services

He was my first interview. In review of video, my demeanor was tentative and open and not particularly confident. I asked him about them before getting into my presentation and he was very willing and receptive to sharing with me. He seemed very open and responsive to me. Almost encouraging me through my tentativeness.

2.17.21-11:30 HIV/AIDS Community Services organization:

She shared a good history of their offerings and what they offer today

She had not encountered chaplains in her life and is not a member of a faith community. As I described what a chaplain can do, she initially had a hard time envisioning how we could be helpful. My open questions did elicit positive input.

She could see chaplains working with clients and case managers with end-of-life cases. She indicated that her case workers get one on one supervision monthly, but would benefit from additional "supervision" with a neutral party who is not responsible for evaluations of them or their colleagues. She indicated it would be helpful to have chaplains offer in-service trainings on grief and spiritual coping tools. She felt that a number of her clients came from broken family systems and group and individual work around that would be helpful. Her desire would be to have a specific chaplain get to know them and become known by them and then develop their

need over time.Doesn't have resources for this but offered the help of her development person to seek a grant for a pilot as well.

She referred me to Portland Adult Ed and Amistad as places that would be good points of entry. In review of the video, my demeanor was inquisitive and very humble. She seemed wanting to be helpful to me as much as interested in what I was presenting. I asked a lot of open-ended questions and she seemed pleased to tell their story. She was also generous to offer resources to help my project along.

2.22.21 1:30-Council on Aging: Executive Director

I have encountered this contact from my work as a part of the Spiritual Care Corps (SCC), a volunteer organization activated to support people during Covid. She was open to my questions about her organization which is a broad multidisciplinary that offers guidance and policy advocacy for over 100 organizations supporting older people. She seemed more policy focused than care focused.

She had encountered chaplains on a high level. Chaplain for Warden Service at a talk and the ED of Maine Council of Churches. All ceremonies and advocacy events. Not as encountered through care they offer.

She felt that these kinds of services would be beneficial to private pay nursing homes and in maine care nursing homes if the service was billable. She felt if it could be coupled with Meals on Wheels, it would be excellent. Helpful to offer this as visits to homebound folks.

There is no money for this and unless it comes through medicare services, she cant imagine people would pay for it.

In reviewing the video, I was much more confident in my presentation and also referenced some of the work I am doing for SCC. I felt my confidence was NOT well received. She was less open to explore possibilities with me. I also made a gaff of referring to people as (elderly) and after that happened she completely shut down.

2.24.21 9:30-Homeless Community Resource Organization: Clinical Supervisor:

Started by asking her about her role and the myriad of services offered.

Understood what a chaplain is and is active in a faith community. Their organization benefits from volunteer clergy from the community. Is concerned about proselytizing and only welcomes volunteers who can offer non-judgmental unconditional positive regard. To her relationship is everything.

There is a specific organization that has offered ministry presence for staff and clients and has become their "ministers." This organization offers support and ceremony when there are deaths. She mentioned that they get what I was presenting for free from this organization and wouldn't need what I am presenting. She also said that her staff would be very resistant to working with someone they didn't know. This other ministry had been around for 13 years and the staff only began accepting them about 4 years in. In terms of outside grief groups or even on-call they would go to that other ministry. And if they had ANY extra money for anything they would seek additional case management. They would not be interested in taking advantage of services even if a grant made it available.

She referred me to Amistad, the Recovery Center, Shalom House and Opportunity Alliance.

In the interview, the woman was initially curious. I was pretty matter of fact and confident with her and she was initially open when telling about their organization. When I shifted to my presentation she shut down and became defensive as if I was selling her something. The second part of our talk seemed uncomfortable.

2.24.21 11:00-Shelter volunteer: women's abuse emergency shelter:

The woman I spoke to was not the ED that I had contacted. The ED had this woman "pre-screen" me to see who I was. She was happy to share what their work was. They offer emergency shelter, long term shelter, legal advocacy and education to law enforcement. They have several offices across the city of Portland.

She was quick to point out that she wasn't the right person to talk to and she couldn't see the usefulness at all. She wouldn't think it would be helpful in the crisis shelter. me to present to the Board of Directors and that will take place in early April.

I was open and friendly. Not too confident and not too reserved. She was clearly uncomfortable from the get-go. She was quick to point out that she had been thrown into this by ED and didn't feel like she could offer anything to me. As an addendum, she reached back out to me after this report was written and asked me to share my Powerpoint with the Director of Operations at the organization. So the Spirit did move! They have since contacted

FEELING LIKE I NEEDED TO FOLLOWUP WITH PLACES I HAD BEEN REFERRED TO I REACHED OUT TO SHALOM HOUSE, AMISTAD AND OPPORTUNITY ALLIANCE. As of today, I have had another interview.

3.2.21 1:30- Clinical Supervisor for organization caring for people who are homeless living with mental illness:

Has had positive connection with chaplaincy through an experience of hospice. Had a previous employee that was a retired pastor who was so helpful beyond his job description providing an extra layer of compassionate listening and creating community rituals when there was a loss in the community. He retired a few years ago.

Staff is focused on keeping people alive and resourced and doesn't have a great deal of time to provide emotional support. Staff doesn't do well with death, which is on the rise from opioid addiction. When there is a crisis, she would be the first line of support and feels like there is a little resistance for full disclosure of feelings. She was very interested in the idea of trying this out. She could see the benefit of this as an on-call resource and for staff development and support. Possibly also as a 12-step supplemental group as many of the clients are dual diagnosis. She felt clients may find it invasive and some suffer from psychotic disorders that involve religious ideations and so this may actually activate their disease. BUT she sees merit and would be interested in continuing the conversation should we take this to a pilot.

She referred me to Amistad with a specific referral and Opportunity Alliance emergency suicide response team. I have since reached out to the specific referrals and may not have data in time for this reporting.

The video showed her as very contrite as she had forgotten our scheduled meeting from last week. She was very present and welcoming to what I had to share. I was very forgiving and didn't come across as confident. We seemed to make a very good working conversation from my presentation and next steps.

APPENDIX 2: Making of a Chapter for Community-

STORYBOARD FOR THE MAKING OF A CHAPTER FOR COMMUNITY BASED PROGRAM SUPERVISORS

Recruiting screener for Making of A Chapter

Who do I want to talk to	**What specific criteria will identify the people I want to talk to**	**What screening questions will I ask?**
Diplomates in CPSP who direct community-based programs	If they are directing or want to start a community-based program(1-2)	Do you administer or supervise a community-based program?
Supervisors in training in CPSP who direct community-based training programs	Same as above(1-2)	Same as above
The Chapter of Chapters in CPSP that administers Chapters and Chapter life	If they are currently serving on the committee that establishes and supports CPSP chapters (1)	Do you make decisions about whether or how chapters are formed?
Accreditation and Oversight Committee of CPSP that oversees programs	Committee members responsible for accrediting programs (1)	Do you make decisions about whether programs are accredited?

Who should I exclude	**What exact criteria will identify the people I want to exclude**	**What screening questions will I ask?**
Hospital Based Diplomates and SITs	If they have only served in an institutional setting	Have you ever served in a community-based CPE/T program
People who are opposed to community-based programs	Don't believe this training should take place outside a hospital	Are you opposed to community-based training programs?
People who are not familiar with Clinical Pastoral Training/Education	People who have not heard about CPE/T	What do you/do you know about Clinical Pastoral Education/Training

` Interview Script for Making a Chapter

I begin my interviews checking in with each interviewee personally and then transition to a conversation about if they are running a group and if so, how it is going? I ask what challenges they have with their program. After presenting my prototype of a community program-based chapter, I ask if there are other ways that a chapter of supervisors could support each other. I ask if there are other resource sharing opportunities that I may have missed. I finish my interview inquiring if they would join the chapter.

Documentation of Prototype of Making a Chapter

The interview notes and observation notes will be share together for each interview.

ONE ON ONE INTERVIEW NOTES / OBSERVATION NOTES

CPSP chapters are how the organization is organized. Each member has to be part of a chapter and they are accountable to the chapter for their work. Members credentials and authorization of programs are all the work of the chapter.

3.1.21, 3:30-Member of Chapter of Chapters, Diplomate/Supervisor

I presented my storyboard an African American heterosexual male in his 30s. He supervises an institutional program and has a community-based program on the side.

He was very supportive of the idea. He felt there were several issues that could be addressed through a Community Based Program Chapter. First, he felt that there could be a

library built of didactic training, and a standard for onboarding new trainees into the program. He mentioned that hospital programs have orientations to the specific institution that include confidentiality, malpractice and that these should be addressed in community-based programs. Having a standardized orientation could be developed for all programs and held in a common file system. Also, if there were diplomates or SITs that were particularly interested in that aspect of training, they could volunteer to train for the different programs.

He felt the idea of incorporating and bulk buying fiduciary products like insurance would be a big help. He felt that creating this as a mechanism for deep collaboration would be helpful to the organization of CPSP. He noted that there is a culture of competition between programs, and this would help foster collaboration and support for each other in new ways.

He offered that if there was a way to offer a group accreditation, that would benefit diplomates financially and save a great deal of time and energy. It would also reduce work of the accreditation committee.

He firmly supported this endeavor. He recommended taking this to the Governing Council to seek guidance on starting this. He implied that this should be mandatory but took the thought back. He wasn't sure if it should be a chapter in and of itself or if it should be an additional resource chapter that people could participate in. He also felt that this would be where a distance learning program should be held. He was completely supportive of the idea and interested in working with me to map out next steps. He indicated that he would be interested in joining.

In review of the video, I observed that I was collegial and easy going. We are colleagues in a chapter already, so I had no reservations and was not nervous about presenting this idea. I presented it as a part of my doctoral program and presented it as a query. I left good space and

unfinished sentences in the interview/conversation. Towards the end of the interview, we began a creative discussion about how this would benefit the organization and I feel like it became less of an interview. However, I was able to get even more information and expand the vision from that conversation.

3.5.21 10:30, Supervisor in Training (SIT)

I presented this prototype to an SIT. She is a white, female, lesbian trainee in her 40s. SIT was generally supportive of the idea. Admitted not knowing the intricacies of running a program so could not imagine all of the ways that this might be helpful.

SIT felt that creating a collective recruitment process for new trainees would be very helpful. SIT felt a huge part of this endeavor should focus on created true fellowship between the members and she felt that having a chapter of people doing running the same kind of programs would lay that foundation.

She offered concern that adding another chapter in CPSP might add a layer of bureacracy that doesn't exist at this time versus more relational and collaborative.

Other than this the trainee had very little feedback and was interested to hear about GFU and Portland Seminary and why I chose this program over the CPSP program. She was also interested in my journey with CPSP.

My presentation was direct and courteous. The SIT seemed excited that I invited her opinions. She didn't have much to offer and I attribute that to her lack of experience in this role and to the organization in general. She seemed more interested in getting to know me and have a friendly conversation rather than answer questions. In the video, I had a hard time circling us

back to topic and visibly gave up at a certain point. She did indicate that she would be interested in joining this chapter.

3.10.21, 1:30pm, Member of the Authorization and Accreditation Committee

I presented my prototype to a member of the AOC. He is a white, heterosexual male in his early 60s. This man is a long-standing member of CPSP and one of the original founders. I was greatly interested in his feedback.

He was very interested and support of this idea. He felt that a chapter of community-based programs would be helpful in many ways and in particular mutual advertising and marketing to potential trainees, as well as clinical placement sites. He also brought up the idea that this would foster collaboration over competition. Administratively he thought that organizing this way would cause CPSP to develop and maintain a list of programs and work with one chapter to interface with community-based programs, rather than having to chase individual diplomates and SITs down in their specific chapters. DP liked the idea of creating an economy of scale by enabling one chapter to buy single resources and policies to cover all members. He felt that this would increase and enhance accountability.

He raised the concern that this might disrupt the current internal governance of the organization. He felt that creating something other than a chapter within the organization might be better. Chapters are limited to 12 members and if there were more than 12 members a chapter is required to split. While there are currently 8 active programs and this wouldn't be a problem, it may cause issues down the line.

In review of the recording, I was friendly and very matter of fact. He was pleased to be asked for his opinion and very open to sharing it. He was also curious about the GFU

program and why I chose it over the CPSP program. He wanted to be kept apprised of my work and offered to be helpful in any way that he could to take this to Governing Council. He doesn't currently run a program and had experience in hospital-based supervision. His interest in this project is strictly from a governance perspective

3.22.21, 10:30am, SIT

I presented this prototype to a 50ish white male who is training to be certified as a diplomate supervisor for Clinical Pastoral Training. This person missed our previously scheduled meeting and was very apologetic. I assured him that I was not upset and grateful that he made time for me again. It was hard to get him past his discomfort. As I am a member of the Certification Review Panels, I wondered if there was a power imbalance in this situation. He is still in training and will have to come before the Panel. Based on his demeanor as I moved from friendly talk into the interview, I got the feeling that he was overly concerned with his error and that it affected the interview.

He was very supportive of the prototype. He stated that developing a set of standards around confidentiality and a common, consistent orientation would be helpful to him. He was very affirming of the idea and also wondered if it might also be possible to have a chapter of parish-based chaplains or pastors who are clinically trained to offer spiritual care.

He deviated from the presentation to wonder if it might be possible to create a path to credentialling for trainees who lack and Mdiv or even education beyond the high school level. He is a leader in a non-traditional church in inner city Brooklyn and has several African American faith leaders without the benefit of higher education that he feels do an equal job to those with higher degrees who have been closed out of the system.

When brought back to the presentation he summed up this idea has merit. That he sees 4 specific areas of benefit. First that the sharing of resources takes the burden of accrediting and managing a program off one person's shoulders. He felt that created resources for community outreach and streams of trainees would enhance his ability to focus on the training program itself. Finally, he felt that the personal and professional support from colleagues that are experiencing the same challenges would be most helpful.

This SIT missed our first scheduled meeting and then was hard to pin down. I finally was able to schedule and complete my presentation. In review of the video, I seemed gracious and friendly, and he seemed overly contrite. It was initially hard to shift him into the topic. Once he refocused he was very supportive of the idea and had good feedback and suggestions. When asked if he would join, he clearly stated that he would.

3.27.21, 4:00pm, Diplomate/Supervisor

I presented this prototype to a white, heterosexual female in her 60s. She was trained in a hospital program and now trains people who serve in jail settings. She retired from hospital training . It was very hard to explain the big picture to her. When presenting the big ideas, she immediately asked how it would work and sought to translate the idea to her situation rather than engage with the idea theoretically. For instance, she stated that a certain person she knows in CPSP would never go for this as they are stuck in their ways and would never help her.

I guess I would say she was not receptive to this idea overall. She could only understand this idea as a professional consortium of supervisors and stated many times that she didn't see the larger picture. In reviewing the tape, I noticed that I grew a bit impatient when she stated several times that she didn't understand what I was proposing. I think the more impatient I grew the more she picked up on the negative energy and pushed back against the ideas proposed.

So I am left wondering if I was clear enough in my presentation and compassionate enough to listen to her feedback graciously. We left the interview script before we got to the question as to whether she would join or not.

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