Part 1:
The Member Care Context

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Going Global: A Member Care Model For Best Practice

Kelly O'Donnell

Is a user-friendly, transcultural framework possible for understanding and practicing member care? And what are some of the core best practice principles that are relevant across many national and organizational cultures? I launched out to explore these questions, pulling together some of the consolidated learning in this field and calling upon 25 reviewers from around the globe to help refine the resulting best practice model for member care. This model can serve as "a grid to guide and a guide to goad."

Member care is going international! Over the past five years (1997–2001), for example, interagency consultations on missionary care have taken place in India, Pakistan, Singapore, Malaysia, the Philippines, the Netherlands, Germany, France, Hungary, Côte d'Ivoire, Cameroon, New Zealand, USA, Peru, and Brazil. It is especially encouraging to see caregivers emerging from the Newer Sending Countries and their efforts to develop culturally relevant resources. Email forums, websites, written materials, interagency task forces, and missions conferences enable these and other member care personnel around the globe to communicate and contribute. The member care field is truly maturing. It is developing as an interdisciplinary and international handmaiden to promote the resiliency and effectiveness of mission personnel, from recruitment through retirement.

Best Practice and Member Care

In this article, we will take a fresh look at the basic contours of care needed in missionary life. The aim is to present a practical, "best practice" model to support mission personnel from different organizations and nations. The ideas that I present are based on the shared, practical experience of many colleagues working in this field. Although the article is conceptual in nature, most readers will find the material easily applicable.

"Best practice" is a term used by many human service organizations. An equivalent term also in use is "good practice." The term refers to recognized principles and performance standards for the management and support of staff. These principles are written, public statements which are formed, adopted, distributed, and reviewed by several or-

ganizations. Each organization voluntarily signs and holds itself accountable to these principles. Organizations can further adjust the principles according to their settings and ethos. "Key indicators" are also identified which serve as criteria to measure the extent to which each principle is being put into practice.

As an example, consider two of the seven principles from the People in Aid's (1997, pp. 9, 10, 23) *Code of Best Practice*. A few key indicators follow in parentheses.

> **Principle 1:** The people who work for us are integral to our effectiveness and success.... Human resource issues are integral to our strategic plans. (The Chief Executive or Chair has made a written and public commitment to the Code; the agency allocates resources to enable its managers to meet staff support, training, and development needs.) ...
>
> **Principle 7:** We take all reasonable steps to insure staff security and well-being. We recognize that the work of relief and development agencies often places great demands on staff in conditions of complexity and risk. (Programme plans include written assessment of security and health risks specific to country or region; the agency maintains records of work-related injuries, accidents, and fatalities and uses these records to help assess and reduce future risk to field staff.)

Best practice per se has been spearheaded by various sources, one of them being the humanitarian aid community. It emerged from the felt need for agreed-upon guidelines to raise the work quality of non-governmental organizations (NGOs) as they provide relief services, relate to one another, and care for their staff—often in stressful/dangerous situations (Leader, 1999; McConnan, 2000). Best practice also arose within the national and international health care communities, where guidelines for providing health care services were needed, based on research and expert consensus (Beutler, 2000). One example is the *Guidelines for Assessing and Treating Anxiety Disorders* (1998) by the New Zealand National Health Committee. Another is the *Practice Guidelines for the Treatment of Patients With Schizophrenia* (1997) by the American Psychiatric Association.

Best practice is a relatively new term within Evangelical missions, although the underlying emphasis on the quality of care has been part of Evangelical missions thinking and practice for some time. Specific examples would be the emphasis on providing proactive care to all mission personnel (e.g., Gardner, 1987) and the need to develop ethical guidelines for member care practice (e.g., Hall & Barber, 1996; O'Donnell & O'Donnell, 1992). What is new and quite helpful, though, is the emphasis on publicly stating specific commitments to staff care in the form of written principles and evaluation criteria (key indicators), to which a sending agency voluntarily subscribes and is willing to be held accountable. This, in my estimation, is the greatest contribution of the current best practice context to member care in missions.

One example of best practice in missions is the best practice document (consisting of 15 principles and several key indicators) which emerged from the 2000 Roundtable Discussion in Toronto, sponsored by the Evangelical Fellowship of Canada Task Force for Global Mission and the Tyndale Intercultural Ministry Centre (see chapter 26). Another good example is the *Code of Best Practice in Short-Term Mission*, developed in 1997 by Global Connections, the main association for Evangelical missions in the United Kingdom. This code has been embraced by several mission agencies in the United Kingdom. Being a signatory is not an indication of current achievement in meeting the code, but rather of one's aspirations to fulfill the principles. Table 1 is taken from section 3 of the code (see chapter

Table 1
Field Management and Pastoral Care Principles (Global Connections, 1997)

- Clear task aims and objectives and, where appropriate, a job description will be provided.
- There will be clear lines of authority, supervision, communication, responsibility, and accountability. Communication and reporting will be regular.
- Pastoral care and support structures will be established. The respective responsibilities of the sending church, sending organization, host organization/local church, and team leader/job supervisor/line manager/pastoral overseer/mentor will be made clear to all parties.
- Opportunities for personal and spiritual development will be provided.
- Participants will be given guidelines on behavior and relationships.
- With reference to above items, culturally appropriate ways of fulfilling these matters will be sought.
- Procedures covering health care and insurance, medical contingencies, security and evacuation, stress management and conflict resolution, misconduct, discipline, and grievances will be established, communicated, and implemented as appropriate.

26), covering field management and pastoral care.

I see best practice as being rooted in the example of the loving care offered by Christ, the "Best Practitioner" (O'Donnell, 1999a). Our Lord's model of relationship with us serves as a foundation for our interaction with others and for the best practice principles that we develop for member care (see Figure 1). The middle two dimensions of being comforted and challenged are normative for us and reflect many of Christ's encounters with disciples in the New Testament. Jesus is both tender and at times tough in His relentless love for us. The extremes on the continuum would represent "worst practice" and do not represent Christ's relationship with His people. Likewise, they should not reflect our relationship with mission personnel—that is, overly protecting them and not sufficiently challenging them (coddling) or blaming them for having needs and frailties (condemning). Member care, then, is as much about comfort as it is about challenge. It involves lots of hugs with some kicks (culturally appropriate forms) and lots of affirmation with some admonition (1 Thess. 5:11, 14).

Overview of the Member Care Model

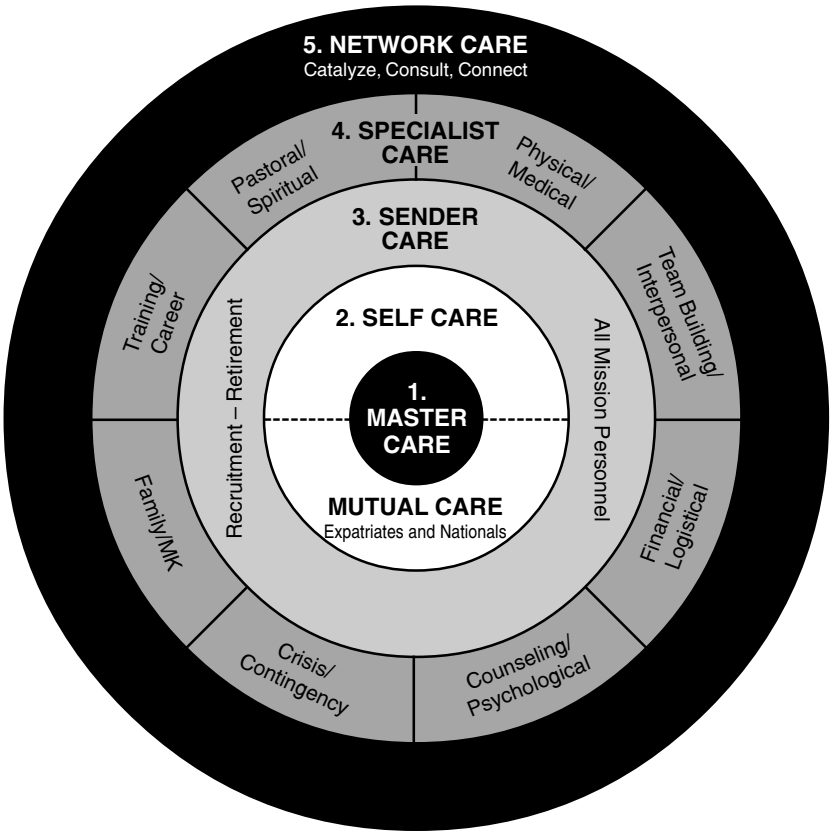
The basic member care model was developed by Dave Pollock and me, with some initial help from Marjory Foyle. It consists of five permeable spheres which are able to flow into and influence each other (see Figure 2). At the core of the model are the two foundational spheres of *master care* and *self/mutual care*. These are encircled by a middle linking

Figure 1
Christ's Love Relationship With Us: A Foundation for Best Practice

JESUS CHRIST AS BEST PRACTITIONER

Coddler	COMFORTER	CHALLENGER	Condemner
Placater	PEACE-GIVER	PROVOKER	Punisher
(worst practice)	(best practice)	(best practice)	(worst practice)

Figure 2
A Best Practice Model of Member Care



sphere called *sender care* and then surrounded by the two outer spheres of *specialist care* and *network care.* Member care specialists and networks stimulate the care offered by the other spheres.

Each sphere includes a summary best practice principle related to the overall "flow of care" needed for staff longevity (Pollock, 1997): *the flow of Christ, the flow of community, the flow of commitment, the flow of caregivers, and the flow of connections*. Note that the flow of care is initiated by both oneself and others and that it is always a two-way street. Supportive care thus flows into the life of mission personnel, so that effective ministry and care can flow out from their lives. Such a flow of care is needed due to the many cares and the assortment of "characters" in mission life!

The model includes the *sources* of member care, such as pastors from sending churches and mutual care between colleagues, and the *types* of member care, such as medical and debriefing care. Think of it as a tool that can be used by individuals, agencies, service organizations, and regions. The model is a flexible framework to help raise the standards for the appropriate care and development of mission personnel. Use it as "a grid to guide and a guide to goad." Here is an overview of the

model along with the five best practice principles:

Sphere 1: Master Care

Care from and care for the Master—the "heart" of member care.

- *From the Master*—the renewing relationship with the Lord and our identity as His cherished children, cultivated by the spiritual disciplines (e.g., prayer, worship) and Christian community, which help us run with endurance and enter His rest (Heb. 12:1, 2; Heb. 4:9-11).
- *For the Master*—the renewal and purpose that derive from trusting/worshipping the Lord, serving Him in our work, often sacrificially, and knowing that we please Him (Col. 3:23, 24).

Best Practice Principle 1: The Flow of Christ

Our relationship with Christ is fundamental to our well-being and work effectiveness. Member care resources strengthen our relationship to the Lord and help us to encourage others in the Lord. As we serve/wait on Him, He in turn promises to serve/wait on us (Luke 17:5-10; Luke 12:35-40). A "look to God only/endure by yourself" emphasis for weathering the ups and downs of mission life is not normative, although it is sometimes necessary (2 Tim. 4:16-18).

Sphere 2: Self and Mutual Care

Care from oneself and from relationships within the expatriate, home, and national communities—the "backbone" of member care.

- *Self care*—the responsibility of individuals to provide wisely for their own well-being.
- *Expatriate, home, and national communities*—the support, encouragement, correction, and accountability that we give to and receive from colleagues and family members (see the "one another" verses in the New Testament—a list of these is in Jones & Jones, 1995) and the mutually supportive relationships that we intentionally build with nationals/locals, which help us connect with the new culture, get our needs met, and adjust/grow (Larson, 1992).

Best Practice Principle 2: The Flow of Community

Self care is basic to good health. Self-awareness, monitoring one's needs, a commitment to personal development, and seeking help when needed are signs of maturity. Likewise, quality relationships with family and friends are necessary for our health and productivity. Relationships require work, and they are not always readily available nor easy to develop in various settings. Nonetheless, staff are encouraged to form/maintain close and accountable friendships with those in one's home culture and in the host culture. Colleagues who love and are loved form a key part of the "continuum of care" needed for longevity, ranging from the informal care offered by peers to the more formal care provided by professionals.

Sphere 3: Sender Care

Care from sending groups (church and agency) for all mission personnel from recruitment through retirement—"sustainers" of member care.

- *All mission personnel*—includes children, families, and home office staff, in addition to the "primary service providers" such as church planters, trainers, and field-based administrators.
- *Recruitment through retirement*—includes specific supportive care coordinated by the sending church/agency throughout the life span and significant transitions:
  - Pre-field—recruitment, selection/candidacy, deputation, training
  - Field—first term, additional terms, change in job/location/organization
  - Reentry—furlough, home assignment, returning to the field later in life
  - Post-field—end of service, retirement

Best Practice Principle 3: The Flow of Commitment

An organization's staff is its most important resource. As such, sending groups—both churches and mission agencies—are committed to work together to support and develop their personnel throughout the missionary life cycle. They demonstrate this commitment by the way they invest themselves and their resources, including finances, into staff care. Sending groups aspire to have a comprehensive, culturally relevant, and sustainable approach to member care, including a commitment to organizational development, connecting with outside resources, and effective administration of personnel development programs. They thus root member care in organizational reality and vice versa. Sending groups also solicit input from staff when developing/evaluating policies and programs related to member care.

Sphere 4: Specialist Care

Care from specialists which is professional, personal, and practical—"equippers" of member care.

- *Specialists*—missionaries have a special call, need special skills, and often require various specialist services to remain resilient and "fulfill their ministry" (2 Tim. 4:5).
- *Eight specialist domains of care*—these can be understood and remembered under the rubric: **PP**ractical **TT**ools **FF**or **C**Care. These domains and specific examples are as follows:
  - **P**astoral/spiritual (retreats, devotionals)
  - **P**hysical/medical (medical advice, nutrition)
  - **T**raining/career (continuing education, job placement)
  - **T**eam building/interpersonal (group dynamics, conflict resolution)
  - **F**amily/MK (MK education options, marital support group)
  - **F**inancial/logistical (retirement, medical insurance)
  - **C**risis/contingency (debriefing, evacuation plans)
  - **C**ounseling/psychological (screening, brief therapy)

Best Practice Principle 4: The Flow of Caregivers

Specialist care is to be done by properly qualified people, usually in conjunction with sending groups. Specialists need to capitalize on their strengths—working within their competencies and maximizing contributions. They also need to capitalize on their "stretches"—going beyond familiar/convenient comfort zones in order to provide services in challenging contexts within professional ethical limits. Specialist services are "investments" which build character (virtue/godliness), competence (cross-cultural/professional skills), and compassion (love/relationships) in culturally relevant ways. The goal is not just care but empowerment—to help personnel develop the resiliency and capacities needed to sacrifice and minister to others. Specialist services collectively include four dimensions of care: prevention, development, support, and restoration. They are essential parts of an effective member care program and complement the empowering care that staff provide each other.

Sphere 5: Network Care

Care from international member care networks to help provide and develop strategic, supportive resources—"facilitators" of member care.

- *Networks*—the growing body of interrelated colleagues and groups which facilitate member care by serving as catalysts, consultants, resource links, and service providers.
- *Resources*—the network is like a fluid that can flow into the other four spheres and different geographic regions to stimulate and help provide several types of resources:
  - Sending groups—special member care services/personnel from churches/agencies.

- Member care affiliations—national, regional, or special task forces, such as Member Care/Europe and Member Care/Asia (see chapter 48 and O'Donnell, 1999b).
- Consultations/conferences—examples include the national member care consultations in Malaysia and India, the Pastor to Missionaries Conference and the Mental Health and Missions Conference in the USA, and the European Member Care Consultations.
- Service organizations—see chapter 49, updated from the listing of member care organizations in *Too Valuable to Lose* (Taylor, 1997).
- Workshops/courses—interpersonal skills, crisis response, pastoral care, etc.
- Email forums/websites—the European and Asian member care email forums and the World Evangelical Fellowship website for member care (www.membercare.org).
- Facilities/hubs of member care—Link Care and Heartstreams in the USA; Le Rucher, Bawtry Hall, and InterHealth in Europe; the care networks in Chiang Mai, Thailand, and Singapore, etc.
- Additional resources.

Best Practice Principle 5: The Flow of Connections

Member care providers are committed to relate and work together, stay updated on events and developments, and share consolidated learning from their member care practice. They are involved in not just providing their services, but in actively "knitting a net" to link important resources with areas of need. Partnerships and close working relationships are required among member care workers, service organizations, sending agencies, and regional member care affiliations. Especially important is the interaction between member care workers from different regions via email, conferences, and joint projects.

Applications

This best practice model is relevant for two main reasons. First, it is biblical in its core concepts, with its emphasis on our relationship with Christ and with each other, along with the role of self care. Second, the model is general enough to be both culturally and conceptually applicable across many national and organizational boundaries.

Different sending groups will emphasize different aspects of this model, yet each sphere is important to consider. There is so much to learn from each other with regards to how we "do" member care! Sending groups, for example, represented by Sphere 3 in the diagram, play a significant intermediary role in linking staff with the resources from the other four spheres. Other groups emphasize different mixes between the self care and mutual care which comprise Sphere 2. Some opt more for the individual's responsibility for his/her well-being, and others emphasize the community's role. For many sending groups, there is much overlap between self care and mutual care; hence, both have been listed in the same sphere.

The importance of mutual care cannot be overstated. Social support and good relationships come out in the research over and over again as being key to adjustment. Mutual care, though, can be a two-edged sword. When done well, it pays rich dividends. But when done poorly or not at all—especially in cultures where there is a high expectation for such care—it can break the relational bank! In addition, mutual care in international settings is tricky, especially if a person/family is part of the less dominant culture. For example, there can be a hesitancy to share concerns and needs because of language limitations (especially where the main language of the setting is one's second or third language) and because of cultural differences (especially where one's values of harmony and respect take precedence over the prevailing setting ethos of openness and directness or vice versa).

Perhaps the biggest potential disparity between member care approaches lies in the use of and emphasis on a variety of specialized resources (Sphere 4). These can be viewed as being too Western, an excessive luxury, or just not possible to develop in one's situation. For instance, it has been difficult for financial reasons in some of the Newer Sending Countries to fully provide medical insurance, MK educational options, and retirement provisions. It can also be hard to think in terms of things like possible pension plans, when the villagers in one's setting do not even have enough to survive on a daily basis. Perhaps a more reasonable and helpful goal, then, would be to ensure that a certain standard of care is being provided, rather than a whole host of resources which may not be relevant/possible in various settings. In this sense, the better term would be something like "basic" practice rather than "best" practice.

As for training, many "specialist" caregivers may be qualified more from on-the-job experience than from formal academic study/certification. A corollary is that many professionals, with all due respect for their expertise "at home," would be better equipped to serve in missions if they had additional cross-cultural and missions experience.

Challenges for Developing Member Care

The main challenge continues to be providing the appropriate, ongoing care necessary to sustain personnel for the long haul (O'Donnell, 1997). A common practice is to share member care resources creatively with other groups and also tap into the growing international network of caregivers. Help with pre-field training, crisis care, tropical medicine consultation, and MK education needs are examples. Sharing resources can be especially important for personnel from Newer Sending Countries and smaller sending groups with limited funds and/or experience, as well as for those serving in isolated settings. It is thus not necessarily up to one organization to provide all of its own member care by itself. In spite of any group's best practice efforts, though, we must realistically expect that at least a few gaps will be present in the overall flow of care that it provides for its staff.

Another challenge is to help discern when it might be time to "attrit"—to find a new position in missions or to leave missions altogether. Longevity is not always a desirable goal. Thankfully, both life and God's will are bigger than the Evangelical missions world!

Still another challenge is simply to raise the awareness of member care needs in certain sending churches and agencies, along with the responsibility to help provide jointly for these needs. Unfortunately, there are still a number of settings where member care is either overlooked or misunderstood. Towards this end, it is my hope that this model will serve as a framework to help assess and address member care issues and that it will be a robust, fluid model for fostering staff resiliency. The model's five spheres and five best practice principles can be used as both a "guide and a goad" to better care. As a further aid, Figure 3 lists some strategies that can help develop member care in different settings.

Another help is to review periodically one's involvement in member care. As an example, here are four best practice "check points" that can be used by member care workers, sending groups, national mission associations, and regions/partnerships (O'Donnell, 1991).

- *Acceptability*. How available/accessible are our member care resources—are we meeting felt needs in relevant ways?
- *Building*. To what extent are we building member care into our settings—forming sustainable, comprehensive resources and an ethos of mutual support and spiritual vitality?
- *Cooperation*. In what ways are we networking with others who are involved in member care—sharing resources, ex-

Figure 3
Strategies and Settings for Developing Member Care

Member Care Strategies	Member Care Settings
■ Write/conduct research ■ Do needs/resource assessment ■ Resource conferences ■ Provide training ■ Convene consultations ■ Participate in email forums ■ Form service teams ■ Form service organizations ■ Set up resource centers/hubs ■ Connect with "secular" resources	Church/Agency, Interagency, Nation, Region, Global

changing information/updates, working on joint projects?

■ *Priorities.* To what extent have we identified our guiding principles and priorities for member care—best practice statement, clear focus, at-risk groups, designated budget?

Final Thoughts

Life does not always work according to our best practice models. Likewise, our best efforts for providing a flow of care can only go so far. We must remember that God is sovereign over any member care model or approach. His purposes in history often take precedence over our own personal desires for stability and order in our lives (Jer. 45:1-5). This is frequently the case for missionaries, where hardship, disappointment, and unexpected events have historically been part of the job description.

Irrespective of the struggles and strains of life in general and of missionary life in particular, we know that there is still much joy in the Lord! Joy and pain are not mutually exclusive. Joy is refined by and often flows from life's challenges and pains.

Member care is important not because missionaries necessarily have more or unique stress, but rather because missionaries are strategic. They are key sources of blessing for the unreached. Member care is also important because it embodies the biblical command to love one another. Such love is a cornerstone for mission strategy. As we love, people will know that we are His disciples.

Reflection and Discussion

1. How is your sending group's approach to member care similar to and different from the model presented in this article?

2. List a few of the greatest issues/struggles for mission personnel in your setting, organization, and/or region.

3. Identify how you could work with others in order to improve member care in your setting—e.g., review your member care approach, form/apply best practice principles and key indicators, develop additional specialist resources, read/discuss additional materials.

4. In what ways do your skills/gifts and interests/preferences fit into the model presented—how do you contribute to member care?

5. Which parts of the model seem most relevant across national and organizational cultures?

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