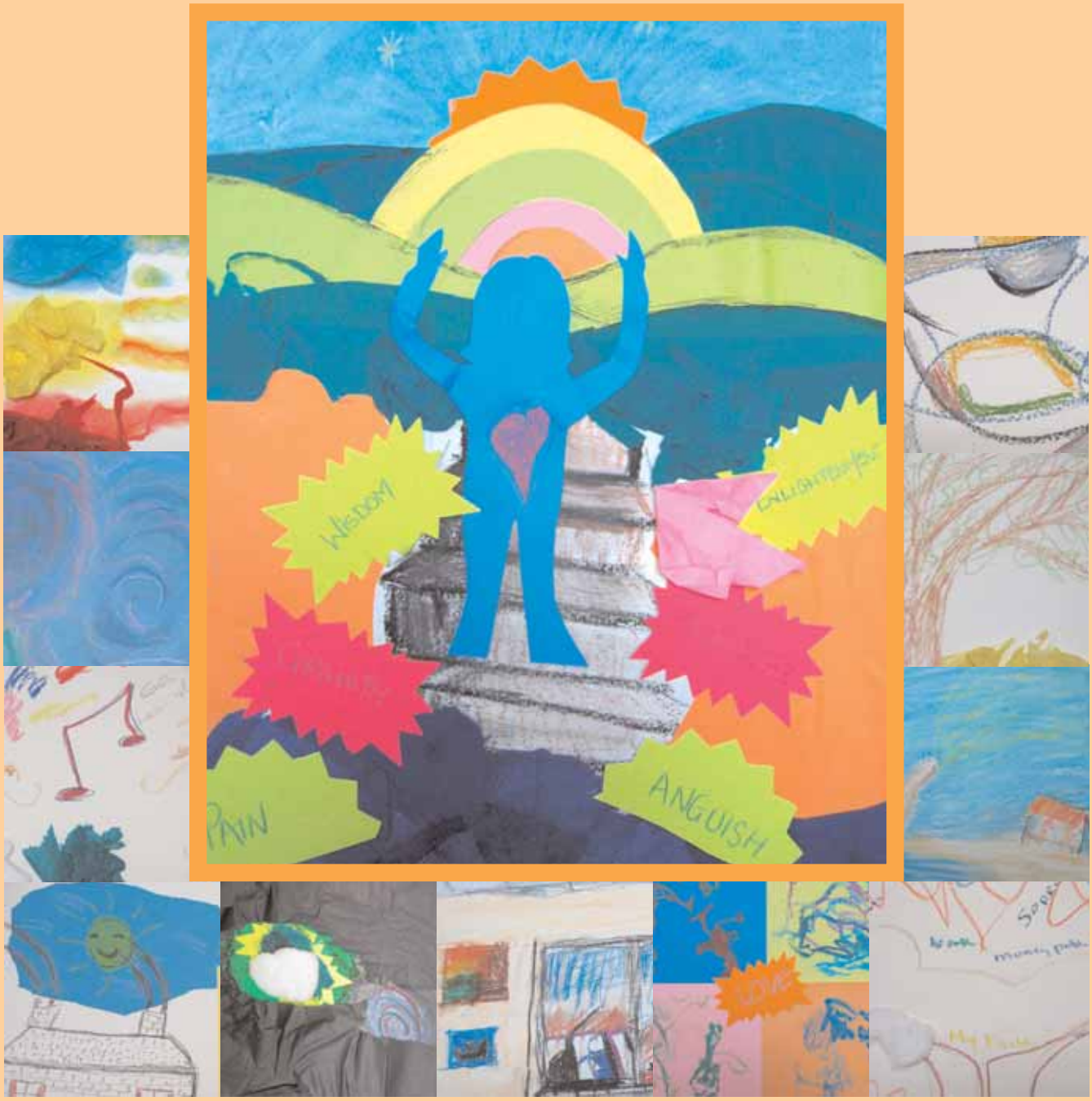
Reaching the Spirit

Social Perspectives Network Study Day paper nine



Social Perspectives Network
for modern mental health

Social Perspectives Network is a unique coalition of service users / survivors, carers, policy makers, academics, students, and practitioners interested in how social factors both contribute to people becoming distressed, and play a crucial part in promoting people's recovery.

Reaching the Spirit is a paper from one of our study days aiming to share work and information looking at mental health from a social perspective.

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Reaching the Spirit

Social Perspectives Network

2006

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Foreword

Vicky Nicholls

> *"The spiritual dimension tries to be in harmony with the universe, strives for answers about the infinite, and comes especially into focus in times of emotional stress, physical and mental illness, loss, bereavement and death" (Murray and Zentner, 1994).*

The launch of the Government's Social Inclusion Report on Mental Health in the summer of 2004 raised the profile of the need for organisations to consider Whole Persons and Whole Systems Approaches. These approaches recognise the importance of taking into account the many different influences on a person when working with them to try and offer the best possible care. Social Perspectives Network has particular strengths to offer in relation to this agenda in its unique partnership of practitioners, service users / survivors, carers, policy makers, and academics specifically concerned with social perspectives and social models in mental health.

The aim of the study day reported on in this paper was to bring together a diversity of people and perspectives to consider, reflect on, and celebrate some aspects of spirituality and mental health. There is an increasing weight of research evidence showing a positive correlation between physical and mental health and longevity, and membership of an inclusive and supportive faith community[1]. While some churches have declining attendance, a number of Hindu, Moslem and Sikh communities, and Christian churches (many from the black minority ethnic communities), are growing and investing in new centres of worship. This Study Day aimed to consider spirituality that might be religious or non-religious, embracing beliefs that are focussed on the inner spirit and spiritual life equally with those that focus on the external and include a belief in a deity.

Spirituality, including both religious and non-religious spiritualities, is one of the areas that many people with direct experience of mental or emotional distress have long been saying is important to them (see, for example, Mental Health Foundation, 1997; 2000; 2002). The last few years have seen a blossoming of 'spirituality and mental health' initiatives that aim to work across these sensitive and complex areas, including notably the National Institute for Mental Health's National Project headed up by Peter Gilbert and the inter-faith-and-no-faith National Spirituality and Mental Health Forum led by Martin Aaron from the Jewish Association of Mental Illness.

The National Project has succeeded in putting spirituality on the map. It has established pilot sites across England which are learning from one another about what can help in supporting people's spirituality in mental health services. It has supported an exploration of existing practice through research carried out by the Mental Health Foundation. The Forum has provided a vital space for diverse perspectives on religion, faith, spirituality and mental health to be opened up and explored at regular open meetings. These projects have been instrumental in bringing together the work of previous projects such as the Mental Health Foundation's Strategies for Living Project, Rethink's work highlighting the spiritual needs of people with severe mental health problems, and Mentality's work in coordinating a booklet on spirituality and mental health and producing a resource for local Church of England parishes across the country.

Black and Minority Ethnic service users, and in particular African Caribbean service users, have reported the importance of their faith and beliefs. The Framework for Delivering Race Equality, published by the Department of Health in October 2003, emphasises the need to work on this issue:

> *"...The value of spirituality in the treatment of mental health problems (a particularly important issue for understanding and aiding the recovery of many Black and Minority Ethnic patients)". (para 217).*

While definitions of spirituality abound, they almost all include the idea of a quest for meaning and a search for something beyond the tangible realities of everyday life. In the Mental Health Foundation's Strategies for Living report (2000), many service users said that their faith and beliefs gave them a sense of meaning or a purpose to their lives, a theme that crossed faith boundaries and applied equally to nonreligious spiritual beliefs. Many said that they sensed God's presence through praying, through a feeling of unconditional love or through feeling that they had the ability to heal.

The Social Perspectives Network's Derby-based Study Day held in April certainly had a warm and welcoming atmosphere felt by all who were there. The day, described by Chair the Venerable Arthur Hawes as 'a milestone', brought together a wide range of people – from psychiatrists to poets, from service users to chaplains – who were keen to explore the positive aspects of spirituality, as well as many having an awareness of the sometimes darker and more fragmented nature of people's spiritual experiences when in distress, and of the hesitation of many mental health services to engage with people's spiritualities, or to support them to find ways to engage with their spirituality themselves. Hawes urged those present to:

> *"consider where are we going, in both our professional and personal lives. We should seek to develop and encourage the spiritual agenda."*

In his workshop 'Faith perspectives in a post-modern multi-faith society' he further indicated that in the turmoil and change of postmodernism, spirituality had a bridging role between faith communities and the post-modern world. Many sought spiritual experience and religious community as a way of coping with alienation. This was why spirituality was regarded as so important in the mental health world, he said, because the limits of medication and psychotherapy were recognised.

Many people and groups have been creative in finding ways to nurture and express the positive aspects of their spiritualities, and an inspiring combination of individuals, projects and approaches was present at the study day. These included Odi Oquosa, a shaman, artist and survivor who experiences his voice-hearing as connecting with his Ancestors, whereas mental health services interpreted this as being a symptom of madness. One of Odi's ways of working with his experiences is through sculpture and visual art, and some of the beautiful results of his workshop are on the front cover.

Peter Gilbert, lead for the national NIMHE Spirituality and Mental Health Project, gave a colourful opening presentation grounded in respect for every person's humanity. He touched on, among other things, people's need for an explanation of why things happen which sometimes religion can help to provide, its more supportive forms offering help 'up the rockface' while more oppressive versions can be constraining and suffocating. Peter spoke of spirituality as being about how we channel desire, and was passionate about the need for people to join or create 'communities of the common good'.

Manjula Sood, Councillor and International Woman of the Year for Rutland and Leicestershire, gave a moving talk about her personal experience of disjuncture and loss, including the sudden death of her husband in 1996.

> *"I did not have time to grieve. People said to me 'you have to carry on his legacy'... My faith was there but I was very angry with God. I thought God had deceived me. I did not want sympathy. I wanted support. The journey for spirituality came into my self. It was like an invisible force holding my hand and trying to guide me forward. One day I walked into a chapel, and I felt a sense of belonging. I felt so tranquil."*

There was a recognition throughout the day of the deeply personal nature of spirituality, as well as the importance of connecting with others. Dr Christopher Cook from the Royal College of Psychiatrists ran a workshop exploring the work of the College's Spirituality Special Interest Group, whose materials emphasise the importance of encouraging people to discover 'what works best for you'. They suggest that a routine daily practice involving three elements can be helpful:

- regular quiet time (for prayer, reflection or meditation);
- appropriate study of religious and / or spiritual material;
- engaging in supportive friendships with others sharing similar spiritual and / or religious aims and aspirations [2].

The idea of integrating the various aspects of experience and supporting others to do this, was highlighted by Dr Albert Persaud, Senior Policy Advisor for Care Services Improvement Partnership East Midlands, who outlined the history of modern western society in his keynote presentation, including the emphasis on rationality, which can arguably lead to de-valuing the more feminine and creative aspects of each person. He highlighted to a rapt audience how we tend to forget the ways in which our cultural and historical backgrounds dictate our belief system and faith. Dr Persaud drew a clear distinction between spirituality, religion and culture, in which spirituality was defined as a dimension that 'encompasses human needs, meaningful answers and personal experience'; religion 'outward practice, beliefs, values, conduct and rituals', and culture the 'embodiment of spiritual, religious, customs, traditions, values etc.' He pointed to research that had found quite a distinction between different cultural and religious groups in their relationship with God. Some groups were deferential and placed their trust in God whereas others felt they were able to endure anything sent from God. For practitioners, questions arise from this about the nature and origin of somebody's coping, when a relationship with God might be harmful or a sign of mental health, and how practitioners can support spiritual or religious coping or at least not undermine it.

The role of loss and bereavement in precipitating breakdowns where there are insufficient support networks was discussed in the afternoon plenary. Dr Persaud bemoaned the shift away from allowing space for grieving in recent mainstream western culture, and stressed the importance of such space in potentially preventing crises. He proposed that the role of personal stories and journeys needs to be systematised so that it can gain equal status in policy planning with more quantitative forms of research.

Kenneth Blanton, a mental health chaplain working for Berkshire Healthcare Trust, led a workshop on chaplaincy and holistic models of mental health, during which he reminded participants that the need to embrace the spiritual was not a new phenomenon. He quoted a case from the 1950s where doctors had consistently ignored the meaning of a young woman's voices, such that she lost her 'soul' and will to be through repeat admissions.

He cited the work of the Somerset Spirituality Project, a partnership research project involving service users, clergy and mental health professionals in Somerset, which found that half of all mental health professionals and clergy saw a link between mental health, spirituality and religion (Foskett, 2003). Yet neither group felt confident enough to take the lead, and both felt unqualified to enter each other's territory (Macmin & Foskett, 2004). While mental health chaplains were the exception to this, they were scarce, and their resources little used (Macmin & Foskett, 2004).

Kenneth Blanton also spent some time mapping out a 'geography of spirituality', distinguishing between negative and positive 'poles' of spirituality wherein moves towards fear and disunity take us towards one pole while moves towards love and harmony move us in the other, more positive, direction, which is also associated with curing and healing, good habits, integration and life.

In a completely different interpretation of spirit, Rob Gee led the entire auditorium-full of people in a rousing chorus pitting hugs against drugs and 'mental' against 'spiritual' ('you say mental! I say spiritual!) in a lighthearted exercise which had most people laughing out loud and created a dynamic positive energy which continued throughout the rest of the day.

The challenge of course is for people to be able to sustain that energy in their own individual lives scattered across the country. I would echo Peter Gilbert's encouragement for people to join or create communities of the common good and suggest that these include the 'virtual communities' of the internet where discussion groups and websites on spirituality abound. Those which can be of particular encouragement and support at the moment include the Royal College of Psychiatrists Spirituality Special Interest Group pages [3] which incluses lists of resources and publications; NIMHE's spirituality project pages (www.nimhe.org.uk); and searching under 'spirituality' on the Mental Health Foundation (www.mentalhealth.org.uk); and Rethink (www.rethink.org.uk) websites.

SPN will of course continue to seek to develop and encourage the spiritual agenda including promoting this crucial paper and supporting initiatives which recognise the vital importance of the human spirit.

References

[1] Cited by P. Gilbert, framework for pilot sites, www.nimhe.org.uk and follow leads to 'spirituality'.

[2] Culliford and Powell, http://www.rcpsych.ac.uk/mentalhealthinformation/therapies/spiritualityandmentalhealth.aspx

[3] www.rcpsych.ac.uk/college/specialinterestgroups/spirituality.aspx

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Vicky Nicholls has worked in the voluntary sector since 1987. Her seven years' work at the Mental Health Foundation began as a result of personal experience of spirituality linked to mental health, which was a key theme of the user-led Strategies for Living research Project based at MHF. She then supported user-led research into the role of mosque in the lives of Muslim men with a diagnosis of severe mental health problems; the Somerset Spirituality Project exploring spirituality in the lives of service users across the county; and, most recently, coordinated a national Project on spirituality and mental health in partnership with NIMHE with Professor Peter Gilbert as the lead.

Chair's address

Venerable Arthur Hawes: Archdeacon of Lincoln

Arthur's association with mental health began forty years ago when he was a theological college student undertaking course work in Psychiatric And Learning Disabilities Services. Since then, as well as gaining qualifications in London and Birmingham, he was Chaplaincy Team Leader for the Psychiatric Services in Norwich where he established an annual lecture and co-edited the publication of these lectures. From 1986 to 1995 he was a Mental Health Act Commissioner chairing the Section 37 Group and co-ordinator for the team visiting East Anglia and North East Thames. From 1997 he has been a Non-Executive Director of the Mental Health Trust in Lincolnshire, from 2003 to 2005 he chaired the NIMHE East Midlands Regional Development Centre and continues to be a member of the NHS Confederation Mental Health Policy Committee. He has lectured widely on mental health issues particularly legislation and spirituality. He is currently a member of the National Inter-Faith Forum for Mental Health and chairs the Church of England Mental Health Advisory Group.

Note taker: Rowena Harding

The national network of spirituality and mental health is building rapidly. Today is about making new friends and renewing old ones.

Some people say that spirituality is a recent discovery. Others say that spirituality was rediscovered at the end of the 1990s. But there are people working so that spirituality is always in our memories. John Swinton, with his book Spirituality and Mental Health Care: Rediscovering a 'Forgotten' Dimension, is one such person.

There is more to humans than mind and bodies. Spirit life takes different forms for different people.

There is a growing number of people who are working with and talking about spirituality, especially in psychiatric services. Peter Gilbert is one person who has been instrumental in raising the spirituality and mental health agenda.

This SPN Study day is an important opportunity for considering where are we going, in both our professional and personal lives. We should seek to develop and encourage the spiritual agenda. This Social Perspective Network study day today is a milestone because it seeks to undertake the following:-

- address the dimension of social perspectives which link with Peter's responsibility as national lead for social care
- enhance and develop the whole network system within spirituality and mental health
- provide a whole variety of workshops which would not have been considered ten years ago
- support and help the initiative to ensure that spirituality is taken seriously by those responsible for the diagnosis of mental illnesses.

I hope you will all feel able to participate actively throughout the whole of the day.

I hope that everyone feels welcome and safe within the conference environment and the very excellent facilities. Everyone with a mental health problem seeks to be able to feel safe and secure both within themselves, with other people and the environment. Given this need to feel safe, it is ironic that the government's proposed Mental Health Bill (which thankfully has been shelved) stresses the need for public safety. The point has been missed that if people with mental illnesses feel safe, this goes a long way to ensuring public safety.

I would encourage you all to continue the work of developing this massive agenda of spirituality and mental health.

The best source for the work around spirituality which provides an historical context is for you to pick out examples from the pilot projects which Peter has been promoting. There is a vast amount of information there.

Welcome to the day

Raza Griffiths, SPN Joint Project Co-ordinator and Convenor for Reaching the Spirit

Raza is one of the two SPN Network Co ordinators. As a survivor of the psychiatric system and of life, he believes that effective services need to better understand the social context in which people experience mental distress, and must engage with people as people rather than a set of symptoms.

He is also currently on the Advisory Board of SHIFT, the five year government anti-stigma campaign, with a special interest in media. His interest in anti-discrimination work is further developed by being the South East Regional Co-ordinator for Open Up, a project aiming to galvanise local service users to challenge stigma and discrimination in their area.

Previously Raza was a Training Officer at Media Bureau, a survivor led project within Mental Health Media.

On behalf of SPN I would like to welcome you all, whatever your personal and professional background. The diversity we have here today is amazing, even by SPN's standards – we have survivors, carers, practitioners from many disciplines, academics, researchers, trainers. People from all faiths, spiritual paths, or none…

Like a tree in summer SPN has many 'leaves' – our members. Just as the leaves of a tree capture the energy of the sun and enable it to grow and produce a seedling, so SPN holds study days where people contribute towards a future SPN Paper – which aims to capture all the goodness of our shared knowledge, insights and experiences.

SPN is about bringing together people to think 'outside the box' about mental health, specifically, to think about mental health holistically, away from purely biomedical models, so that they can consider all the social factors which impact on us, such as membership of social networks, access to services, housing, employment, and experiences of discrimination. For many people, spirituality is an important factor in their overall well-being and sense of who they are, that's what we're here to look at today. This is your day, I hope you will feel able to share something of yourselves.

Breathing out - Breathing in

Peter Gilbert, Professor of social work and spirituality at Staffordshire University
NIMHE project lead on spirituality and mental health

Peter Gilbert is NIMHE/Social Care Institute for Excellence Fellow in Social Care (Policy and Practice), Project Lead for the National Institute on 'Spirituality & Mental Health and Professor of Social Work and Spirituality at Staffordshire University. A former Director of Social Services for Worcestershire and Social Worker with thirteen years of direct practice, Peter is also on the Executive of Social Perspectives Network.

As Professor at Staffordshire University and Visiting Research Fellow at the University of Sussex, Peter is committed to ensuring the integration of theory with practice. He co-authored a pack on Supervision and Leadership with Professor Neil Thompson, and runs regular workshops at Worth Abbey, in Sussex, on 'Spirituality in the Workplace'. In June 2003 Peter published: The Value of Everything: Social Work and Its Importance in Mental Health, with Russell House Publishing, and is now working on a book on leadership (Leadership: Being Effective and Remaining Human, was published in October, 2005), and an edited work on Spirituality.

The Spirit Moves

You can usually tell the importance of a concept by the amount that words related to it crop up in everyday speech. We often hear people talking about someone inspiring them; and perhaps this is somebody they work with (somebody using or somebody providing a service), or perhaps an historical figure from a political, social and healthcare, religious, sporting, or military dimension (for example see Gilbert, 2005). We also find ourselves catching our breath at a particularly gorgeous sunset; a mountain pass; a seascape; and declaring that it is inspirational. When services fail, those who use services; frontline staff, managers, inspectors, may often declare that someone needs to breathe some new life into this service.

Some commentators say that 'spirituality' is a relatively new word, but spirit certainly isn't. The latter is found in many languages, e.g. in the Greek *pneuma*, which denotes air, breath and spirit; the Hebrew word *ru'ach*, which means both spirit and breath, and its Islamic equivalent *ruhaniyya*; the Latin *spiritus*, etc. These words are not necessarily connected with religious experience. The Ancient Greeks believed intrinsically in the congruence and inter-dependence of mind, body, heart and spirit. The philosopher Plato said that there was no point in trying to heal the mind without the body, or the body without the spirit, for "the part can never be well unless the whole is well" (quoted in Ross, 1997). Professor John Swinton, in his seminal work on Spirituality and Mental Health, reminds us that:

> *"The word Spirit is derived from the Latin spiritus meaning breath. An analogy would be human respiration, by which oxygen is taken in to sustain and maintain the existence of the person. The spirit provides a similar sustaining and maintaining role on a more ontological level."*
>
> *Swinton, 2001.*

In Classical times *spiritus* also meant inspiration, denoting those invisible, but real qualities, which shape the life of a person or a community, such as love, courage, peace or truth – "and the person's or community's own spirit is their inner identity, or soul; the sum of those invisible, but real forces, which make them who they are." (Mursell, 2001).

But the world religions also talk in similar terms. From the earliest times, female or male priests have been credited with an ability to link the dimensions of the natural universe, human beings and The Other (God, gods, or a Divine Spirit) and the natural world (see Coyte, Gilbert and Nicholls, 2007, forthcoming). It was the Holy Spirit which descended on Jesus' disciples after his death, and turned them from a frightened group of men hiding in an attic, (NB. it is the women disciples who seem to have shown more nous and 'get up and go' at this stage!) and inspired them to go out and spread their beliefs. In the Qu'ran it is stated that "God blew his own soul into humanity" (15:29). There are many issues around organised religion, which we will come on to, but if you are in the midst of a physical or emotional crisis, then, if you do have a religious faith, the idea of a divine entity expressing empathy for your condition and an interest in your recovery, is a very powerful concept!

People often get caught up on the word 'Spirituality', thinking it is synonymous with religion. This is clearly not so, despite the fact that they are connected; everybody has a spiritual dimension (although a number of people do not connect with it), while not everybody has a religious faith (for a fascinatingly different angle on this, see Jamison, 2006). For many people, the spiritual question may be quite simply, "what makes you tick?"; "what gets you up in the morning?"; and "what keeps you going when life gets tough?". In addition to this might be the question "what are your values, and do you live them out in your daily life?"

A personal pilgrimage

Buddhists believe that human suffering, an essential part of the human condition, and how we cope with it, is the essential life path. I am increasingly impatient with professionals who claim that their professionalism is such, that they cannot display any human emotions, or declare human weakness, or uncertainty. I am equally impatient with members of the public who see humanity as a failure and not a strength; and with those service users who find it easier to place professionals into a professional ghetto. Increasingly, the leadership of services seems to be about the "bland leading the bland" (see Gilbert, 2006), where poor practice isn't challenged, and the only thing people are interested in is the tick box of performance targets, so that bad practice is allowed to wait until 'the inspector calls' and it's all too late for the people who suffer!

In Social Work there used to be a term called 'facilitative self-disclosure'; a ponderous phrase, but one that gets at an essential truth that human beings who use services wish to be treated as human beings (surprise, surprise!) and they wish to be related to by human beings, the professionals working with them. To be human with each other, we need to share something of ourselves in an appropriate manner. Six years ago I suffered an episode of organisational chicanery, which led to me experiencing a bout of clinical depression. As an extroverted optimist, this came as quite a shock. The nearest I had ever come to anything like it before, was when I fell off a mountainside in Italy in my early twenties and found myself looking at rocks 2,000 feet below, dangling helplessly. Learned helplessness seemed to be a part of the depression, and it took a number of skilful people 'pulling on the ropes' to get me out.

What helped me?

- A sympathetic and human GP, who reacted to my distress in a very human and humane manner, and who gave me a measure of control over when she would prescribe me anti-depressants (which I am pleased to say, worked without side-effects!). In the current debates about choice in the NHS, I think it is important that we should not forget the issue of control, which is often much more important.
- A friend who absorbed both my sorrow and my anger, and I was both very sad and very angry! Modern society finds it very difficult to cope with emotions, especially anger, which is very frightening; but also, with sorrow, as we are always asking people – either explicitly or implicitly – "aren't you better yet?"!
- I had a place of spiritual asylum – Worth Abbey (see BBC2's The Monastery, May 2005 and May 2006). The Abbot there offered me lots of listening time, and the rhythm of the prayer life soothed my soul.
- A friend who had been through similar experiences, and was able to talk me through it.

- Running with my running club, Worcester Joggers, where the physical effects of the release of endorphins, is complemented by a sense of community and common purpose (see 'Keep Up Your Spirits', Open Mind September/October 2005).

- Lastly I have to thank Professor Antony Sheehan, then Chief Executive of NIMHE, who had faith in me and invited me to take on the Social Care Lead role in the setting-up of NIMHE.

Are we on a spiritual journey or a religious one?!

People use different words and concepts to describe their spirituality at a time of crisis or, indeed, something that is for many people a spiritual crisis in itself. Somebody once said that: "Spirituality is the wellspring within and religion the edifice to cover it" (Mental Health Foundation, 2000). The late Jeremy Boutwood, a great champion of spiritual care, talked about all of us being "valuable people seeking to discover the true ground of our being below all the symptoms and pains of our wounds." (quoted in NIMHE/Mental Health Foundation, 2003).

One of the participants in the beautiful DVD Hard to Believe (Croydon MIND, 2004) speaks of spirituality being "an anchor to my soul", and a number of definitions that have been published speak thus:

Some definitions of spirituality:

- "It can refer to the essence of human beings as unique individuals – what makes me, me and you, you?"

- The power, energy and hopefulness in a person.

- What is deepest in us – what gives us direction, motivation, and enables us to survive difficult times?

- Spirituality is about what we do with the fire inside of us and how we channel desire.

- The origin of the word 'spirit' derives from a number of ancient languages where it means 'breath'. Therefore it is the oxygen of life taken in to sustain and maintain the existence of the person.

- It is associated with the human quest for meaning, purpose, identity, self-transcending knowledge, meaningful relationships, love and a sense of the holy.

- It may or may not be associated with organised religion or a personal belief in a transcendent deity.

Religion:

- Religion encompasses most, if not all, of the aspects described above, usually in the context of belief in a transcendent being or beings, and with a meta-narrative which seeks to explain origins of the world and those living in it and the questions which face human beings around life, suffering, death, and re-awakening in this world or another.

- Religion can provide a 'world view', which is acted out in narrative, doctrine, symbols, rites, rituals, sacraments and gatherings; and the promotion of ties of mutual obligation. It creates a framework within which people seek to understand and interpret and make sense of themselves, their lives and daily experiences.

- Faith communities can be welcoming, integrative and supportive; while some others can be exclusive and stigmatising of people experiencing mental ill-health.

It's humanity stoopid!

As somebody who has worked as a practitioner and manager in a range of environments and services with all user groups, it strikes me more and more that failures in our human service systems are based on a tragic failure to recognise each other's common humanity, and also the incredible unique qualities of each individual. When Dr. Joanna Bennett was asked to comment on the publication of the report into the death of her brother David 'Rocky' Bennett in care, she said quite simply: "Just get the humanity right"! I recall working for six years in one of the old hospitals for people with learning disabilities, and surviving and thriving in that environment, for users and frontline staff, was an exercise in courage. Despite all the lessons of the last century, especially the traumas of the holocausts, we still seem to find it difficult to relate to difference.

The Chief Rabbi, Dr. Jonathan Sacks, states how important it is that we relate to people as people. That:

> *"We see as the basis of our humanity, the fact that we are all ultimately the same. We are vulnerable. We are embodied creatures. We feel hunger, thirst, fear, pain. We reason, hope, dream, aspire. These things are all true and important. But we are also different. Each landscape, language, culture, community, is unique. Our very dignity as persons is rooted in the fact that none of us – not even genetically identical twins – is exactly like any other".*
>
> *Sacks 2002*

Don't mention the God!

Just as the manic hotel owner, Basil Fawlty, mutters to himself, "Don't mention the War", our services mutter, "Don't mention God". Everywhere I go across the country, Service Users tell me that they dare not mention their spiritual or religious beliefs for fear of being seen as in a deteriorating mental state and having their medication increased. Because the NIMHE Spirituality Project has taken care to work closely across with programmes on race equality, stigma, values, workforce, social inclusion and others, there is an increasing recognition of the need to take seriously some people's religious beliefs and the rituals, e.g. regular prayer, that accompany them. There is still a tendency though, where this is not related to race, that services do not take a spiritual or a religious belief seriously, whereas all spiritual beliefs, whatever the cultural context, will be important to the service user. The poem that makes this point most forcefully for me, is that by Sue Holt:

> "I was excited: today was the Lord's birthday
> and I was going home for dinner.
> I masked my emotions
> otherwise they would keep me.
> I have to behave myself today;
> no talking of God and of his plans for me
> and the future of the world.
> My family came for me ...
> I spoke of God's kindness and his plans for the future.
> All too soon the fun had to stop;
> I had to return to the ward on the hill
> with others of my kind".
>
> *Extract from 'Year 2000 on a Section 3' from Sue Holt (2003) Poems of Survival (by kind permission of the author and publishers).*

For many people, their spirituality and/or religion, is the wellspring of their entire life. If we in services do not take this seriously, we cannot hope to keep people well, or work with them to aid recovery if they become ill.

Why Spirituality?

So many initiatives in Health and Social Care in this country are top down impositions, so it is good to see an initiative in which grass roots desires and creative thinking from the top has actually met in the middle! The NIMHE Spirituality and Mental Health Project was set up by Professor Antony Sheehan, as a creative response to the ramifications of the tragedy of 9/11, and a growing awareness that spirituality was something that service users and carers wish to speak about and have recognised. Service users, carers and staff, across the country have said that it has been very helpful that NIMHE has recognised this as an issue that is important to people, and that it has given them 'permission' to engage at a national, regional and local level, in a way that they had not felt able to do before. This has also coincided with a growing body within the Royal College of Psychiatrists (building on the creative work of Dr. Andrew Powell and others; see the website at www.rcpsych.ac.uk/college/sig/spirit) and an increasing number of universities setting up Centres of Spirituality (e.g. Aberdeen, Staffordshire, the University of Glamorgan etc.).

There are some major reasons why spirituality is seen as so important in the field of Mental Health:

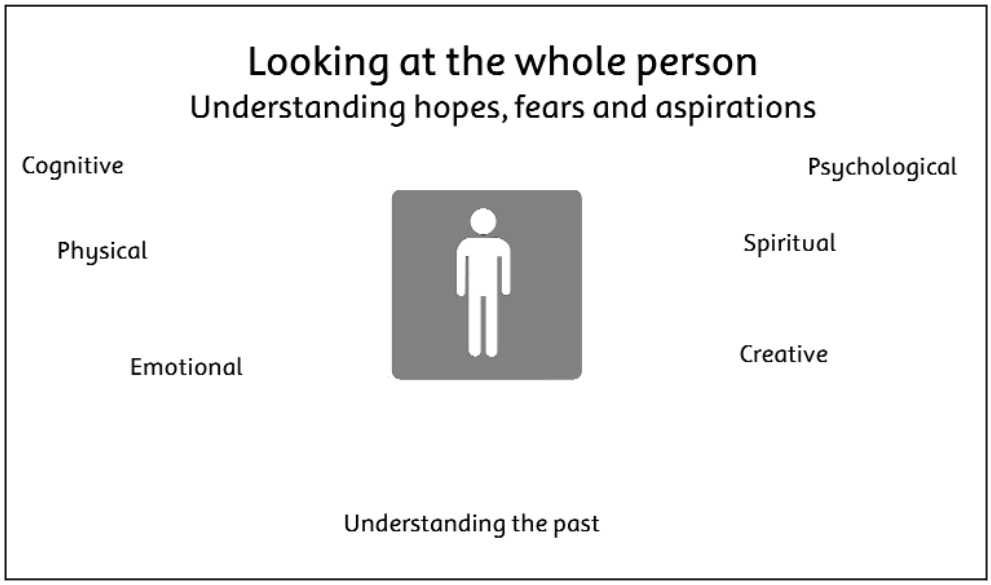
- Because service users tell us it is important in a number of ways.
- New lines of research are demonstrating its importance in physical as well as mental health. (See Swinton and Patterson, 2001).
- Because the world in which we live is, in many ways, prejudicial to well-being.
- Britain is a multi-cultural society with a number of complex belief systems.
- Many people with Asian ethnicity are now wishing to define themselves by their religious affiliation, not their ethnicity.

If the events of 9/11 were a catalyst, then the bombings in London on 7th July 2005; the riots in France and Australia, flagging up issues around marginalisation and misunderstandings; and what The Times called: 'Cartoon wars and the clash of civilisations' (The Times, 3rd February 2006) have augmented the imperatives and the urgency of cultural, spiritual and religious sensitivity, and respect.

It is often rather thoughtlessly stated, that religion is in decline in the West, and this may be true for some religious traditions. If you head down the Hagley Road in Birmingham or, indeed, some of the major entry roads in any of our major cities, one can see that religion is anything but in decline. While some churches have been turned into restaurants and bookshops, there is a growth of mosques, Sikh gurdwaras and Hindu temples, pentecostal and evangelical community churches. Pope John Paul II's dignified journey to his death last year, appeared to strike a chord, far beyond adherence of his own faith, and beyond organised religion itself. Deborah Orr, writing in The Independent, spoke of a recognition of "a huge yearning for meaning and for Spirituality in the human heart" (5th April, 2005). Commentators such as Martin Kettle from The Guardian, though not sympathetic to organised religion, felt that John Paul's journey had reached out to others in their journey on other pathways.

A goad to the public sector is the strides being made by the private sector to address issues around spirituality and meaning in the workplace. The private sector management college, Roffey Park, undertakes a management survey every year. In the late 90's, it noticed a phenomenon of people talking about a search for meaning, in a work environment, which was becoming pervasive of all aspects of life (see Bunting, 2005). As a response, Roffey produced an excellent booklet: In Search of Meaning at Work (Holbeche and Springett, 2004). The challenge for the public sector, is to recognise that service users and carers are whole people within an environment of community, housing, leisure, work, creativity, spirituality, etc. and that they have a past which affects their present; and hopes, fears and aspirations for the future (see Gilbert, 2003).

It is vital that we include staff in this. One of the real insanities of our current 'human service system' is that organisations demand that staff behave humanely to users/clients/customers, and yet don't treat them so themselves! Every time I go to a leaving 'do' of a long-standing member of staff and hear how wonderful everybody thinks Fred, Jane, Sanjit, is, I wonder whether anybody has told them what a wonderful job they are doing over the past 25 years?! We are not good at giving either the positives or the negatives and being honest with people.



Travelling identity

A few hundred years ago, very few people would have a problem surrounding their identity. Most people were fixed in a particular locality, role, trade or profession, religious belief or unbelief, etc. Nowadays, sociologists such as Zygmunt Bauman speak of a 'fluid' society, which he graphically describes as 'Liquid Modernity' and 'Liquid Life' (Baumann, 2000 and 2005).

The NIMHE Project: achievements and work in progress

The National Institute for Mental Health England was set up by Professor Antony Sheehan. NIMHE now forms part of the Care Services Improvement Partnership - CSIP - which incorporates a number of agencies promoting and developing good practice for a number of user groups. NIMHE has a small central hub, but most of its activities take place in eight Regional Development Centres, which relate to the government offices of the regions, thus reinforcing the vitally important point that services to promote health and well-being must be linked into local government and governance. The NIMHE Spirituality Project, therefore, draws in the NIMHE representatives from the eight Regional Development Centres, so as to ensure strong links between what is happening nationally, regionally and locally. The Project Lead (Peter Gilbert) and the Director of the lead Development Centre (Paddy Cooney from South West) meet with the NIMHE Reps and a widely-based Steering Group on a bi-monthly basis. The Steering Group consists of service users, carers, professionals from various disciplines (including the Chair of the Spirituality and Psychiatry Special Interest Group from the Royal College of Psychiatrists), academics and researchers, development workers, faith representatives, etc. The Steering Group sets the tone and direction for the Project, and links very closely with the independent national Spirituality and Mental Health Forum (Chaired, at present, by Martin Aaron from the Jewish Association for Mental Illness (JAMI) who has brought together a consensus of groups promoting mental health within the Jewish community). There is a Survivors Advisory Group, which inputs advice to the Steering Group.

While the NIMHE Project maintains a balance between issues around individual Spirituality, not necessarily appertaining to a specific religious faith, and faith traditions, the Forum tends to concentrate more on issues around the major faiths; (the Department of Health liaises with leaders from nine major faiths: Baha'ism, Buddhism, Christianity, Hinduism, Islam, Jainism, Judaism, Sikhism and Zoroastrianism). A symposium is being set up in partnership between the NIMHE Project, the Forum, Staffordshire University's new Centre for Spirituality, and the national Inter-Faith Network, to consider aspects of mental well-being and mental illness and 'pastoral care' in relation to the nine major faiths and Humanism. This is thought to be the first time this has been attempted, and will hopefully give many pointers to work in the future. The NIMHE Project has already worked closely with the Church of England and Mentality to produce a Parish Resource Pack, launched in 2004 which aims to promote understanding of Mental Health and mental illness amongst parish communities, and improve relations between that faith community and Mental Health services. The pack has been very well received and used, and other major faiths are considering a similar project in the future.

The purple booklet: Inspiring Hope: Recognising the Importance of Spirituality in a Whole Person Approach to Mental Health was published in 2003 and that sets the style and framework for the whole Project. Since then, a number of articles and chapters for books have been produced, perhaps the most accessible being 'Breathing Space' for Community Care. A chapter will appear in a new book by Professors Cox, Fulford and Campbell, on Paul Tournier, the French pioneer of spirituality in health care, to be published by Jessica Kingsley this year. A book is currently in production (Coyte, Gilbert and Nicholls, 2007) which will focus on where spirituality and mental health has progressed since Professor John Swinton's seminal work in 2001.

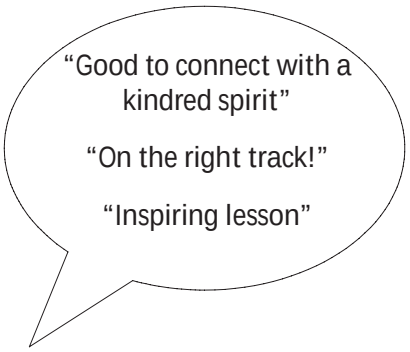
Two national conferences: Breath of Life (2003) and Drinking from the Wells of Our Humanity (2004), have drawn people together from across the United Kingdom and set a tone for further work, but the accent in 2005 and 2006, has been much more towards regional and local events, and working with partners nationally on conferences, such as today's study day set up by the Social Perspectives Network. The Pilot Sites, launched in the spring of 2005, have been instrumental here. It is very encouraging, that in a target-driven culture, and huge pressures on health and social care organisations (both statutory and voluntary) to deliver on a range of issues, that many leaders, at all levels, have chosen to support their organisation being a Pilot Site for spirituality (these are often linked across with the Focussed Implementation Sites (FIS) on Race Equality). The Pilots focus on a number of issues relating to the assessment of and attention to, people's Spiritual and/or religious needs; creating an empowering and supporting culture; effective links with Spiritual and faith communities; the support and development of staff; and attention to issues of culture, diet, language, rituals, etc. (see Flying High: the NIMHE Spirituality Project and Lessons from the Pilots, 7th June 2006, at the Centre for Spirituality at Staffordshire University). The NIMHE Pilot Sites will meet for the first time at the University of Lincoln on 3rd May, to discuss where people are at and where we want to go (see also 'Don't mention God', Day in the Life, Pavilion Journal by Peter Gilbert, forthcoming).

The Project has liaised across with all the other NIMHE Programmes, e.g. Race Equality, Acute Care, Recovery, Values, Experts by Experience, Stigma, etc. and the Spirituality Project is specifically mentioned in the BME framework document of October 2003, as a crucial area in constructive work with people from ethnic minorities. Government departments have been liaised with; also the Prime Minister's Personal Faith Advisor John Battle MP, as have organisations such as the Police Service. The Project contributed to the DH Policy Document on Chaplaincy Services (autumn 2003) and is also in liaison with the Welsh Assembly Government. Work has taken place with the Governments and voluntary organisations in both Jersey and Guernsey. Commissioning guidance is being worked on for commissioning authorities.

It is very interesting to see how the subject has become more high profile in academic institutions. It is well known that spirituality and religious faith forms an important part of Health and Social Care, and the training of professionals in North America and Australasia. In recent times, what Professor Swinton calls the 'forgotten dimension', has been rediscovered in the United Kingdom and now there are a growing number of centres for Spirituality at, e.g. Aberdeen University, Staffordshire University, the Maudsley, the University of Glamorgan, etc. and others in the process of being initiated.

Staffordshire University has launched a seminar series, bringing in a number of distinguished speakers, such as Professor Leslie Francis and Professor Pat Thane. There will also be the launch of a MSc. in spirituality and health and social care in the autumn of 2006 (www.staffs.ac.uk). A Research Forum spanning the UK and the Republic of Ireland is in the process of being set up, under the leadership of Professor John Swinton from Aberdeen University.

At the base of most tragedies that have happened in Health and Social Care, is a lack of appreciation of our solidarity as human beings, facing similar challenges of personal development, trauma, illness and loss, in our own unique way. It is very encouraging that so many people are focussing on aspects of Spiritual recognition and Spiritual care, but time will tell whether it has the desired effect.



Life story

Councillor Manjula Sood

Councillor Manjula Paul Sood arrived in England in 1970 and since then has lived in Leicester. Manjula supported her late husband Councillor Paul Sood in his political career as well as the local MPs including The Right Hon Patricia Hewitt MP, The Rt Hon Keith Vaz MP, Late Jim Marshall MP, and Lord Janner QC. Manjula is the only Ethnic minority (Asian) female councillor on the Leicester City Council. Manjula is Director of the Leicester Council of Faiths which promotes a better understanding among faith communities, has been a non-executive director for the NHS, has chaired National NHS conferences, is chair of NARILETS Women's Project and secured funding from the National Lottery. Manjula hold very busy advice surgeries for constituents and helps to organise visa surgeries for the High Commission of India. She has been involved in fundraising for various charities locally, nationally and internationally like the Great Ormond Street Children's hospital, Loros (The Leicestershire and Rutland Organisation for the Relief of Suffering), and for poor children in the third world.

Manjula was awarded a National Merit Award by the Prime Minister, and the International Woman of the Year for Rutland and Leicestershire 2006.

Manjula believes that the only way to achieve unity among diversity is through spirituality, and that hands that help are holier than lips that pray.

Note taker: Rowena Harding

I would like to start this presentation by saying that I am not against the medical profession. What I am about to tell you is only my own experiences over the last 28 years.

I moved to England in 1970. It was the beginning of my journey. I would not work in a factory, I wanted to do better than that. So I became the first female teacher in Leicester. At that time I experienced a lot of discrimination and racism. So I said to my husband, you must become a policy maker where you can change some of these things.

I developed cancer and became close to God. In 1979 I had a still birth child. It was at that point that my mental health went 'berserk'. I was shattered. I did not want to live.

I went to the Mental Health Unit and got some support. They were very positive. 1n 1996 I suffered from a blow of faith. My husband never came home. He died in a meeting.

We had plans and dreams. And they were all shattered.

I did not have time to grieve. People said to me 'you have to carry on his legacy'. I put a lot of trust in the 'extended family' and it was not always the right decision. I was not thinking.

I suffered from dejection, depression. I was hurt and I was feeling guilty.

I was given Prozac and Valium by the Mental Health Unit. It did not help. We had a creative writing workshop and I was asked to write a piece. I was told that there was nothing positive in my writing. I thought 'that's why I am here! Because I am not positive!' I would end up coming back from the group more depressed than before.

Then I got a counsellor. She was an angel. I found faith in Sai Baba at this time and he became my spiritual guru. With each session my counsellor worked in spirituality and how to use it to deal with different aspects of my life. I thought to myself 'if she's trying to help me, then I should try.

I tried to cut down on medication. But the GP wanted me to carry on.

My faith was there but I was very angry with God. I thought God had deceived me. I did not want sympathy. I wanted support.

The journey for spirituality came into my self. It was like an invisible force holding my hand and trying to guide me forward.

One day I walked into a chapel, and I felt a sense of belonging. I felt so tranquil. When the minister came to me, I cried. He invited me come on Sunday. And I became one with God. It had such a positive impact on me.

I dismissed the idea of widowhood as a curse. In Indian custom you wear a certain colour when you are a widow. But it doesn't matter the colour you wear on the outside, inside, the pain is the same.

There is divinity in all humans. Inside, the knowledge of my soul guides me towards services to humanity and God. All religions are the same.

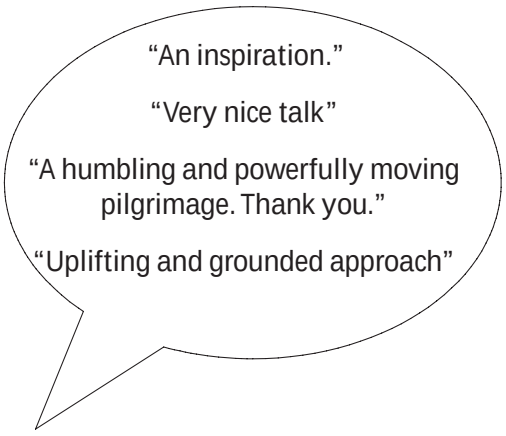
It's a privilege to be human. It's an honour to be a woman.

Until the medical profession see mind, body and soul as one then we won't be able to solve mental health problems easily. Services need to consider faith when providing a care plan. Nobody has the right to be suppressed. Community cohesion is very important.

Do not suffer in silence. Empower yourself. The well being of society depends on healthy human beings. Build up your social and spiritual networks.

More resources are needed in mental health. We need more one to one time. More time than five minutes. We need less emphasis on prescriptions. We need people to listen.

The self is the highest teacher.



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Culture and Spirituality: An international overview

Albert Persaud, East Midlands Development Centre, Department of Health and Director, Care International Foundation.

Albert Persaud has worked in various clinical settings, management, research, training and policy development in mental health and public health. He joined the Dept of Health Mental Health Policy branch 4 years ago and is one of the principal architects of Inside/Outside- Improving Mental Health Services for Black and Minority Ethnic people, led the development of the perinatal section of the Women MH Strategy and contributed to the development and consultation of the MH Bill.

Albert Persaud was a core member of the group that established the National Institute for Mental Health in England (NIMHE); he currently leads the NIMHE East Midlands programme on the Mental Health Act, Traditional Medicines and International Mental Health , as well as being a strategic advisor on the national anti- stigma programme.

He is a recent member of the Mental Health Act Commission and has been a trustee for the Long Term Medical Condition Alliance, (LMCA) Acting Vice-Chair of the Depression Alliance (DA) and is a founder member of Primary Care Mental Health and Education (PRImhE).

He has researched and published in the areas of culture and mental health, postnatal depression and law and practice and is Director and Co- founder of the CARE International Foundation.

Text from powerpoint presentation

Cultural roots:

Ice Age cities:	8,000 BC
Indus Valley civilisation:	5-2,000 BC
Vedic Culture:	2,500-1200 BC
Vedantic Culture:	1200BC
Hinduism:	200 AD. revival of Vedic values

Traditional Chinese Medicines

- Aims to rebalance energy systems - heals itself
- Origins - 2,000 years ago
- Wisdom - knowledge - experiences
- Natural - no synthetic drugs
- Causes rather than symptoms
- No distinction between - mental health, physical health - stigma

Western thoughts

- Man is separate from nature
- Body, mind and spirit are not one
- Personal God is over man
- Rational thoughts are encouraged
- Science and technology are useful for standard of life
- Man must have competitive spirit

Eastern thoughts

- Man and nature are one
- Spiritual and physical are one entity
- Recognise the basics of nature, spiritual and the mental connections
- Science and technology create an illusion of progress and development
- Meditation for quiet contemplation and essential for enlightenment

Culture and Spirituality:

Spirituality: Dimension, encompasses human needs, meaningful answers, personal experience.
Religion: Outward practice, belief, values, conduct and rituals.
Culture: Embodiment of spiritual, religious, customs, traditions, values, etc.

Discrepancy in religiosity between patients and professionals suggest that clinical care may be improved if mental health professionals were more religiously sensitive in consultation

(Koenig et al 1991; Neeleman & king 1994; Dein 2004)

Religion and Spirituality:

- Religious coping used a great deal by Black Caribbean Christians and Bangladeshi Muslims
- Quite a distinction in the relationship with God ranging from deferential and placing trust in God and being able to endure anything sent from God (Muslims)
- Emotional turmoil seen as a sign of not being sufficiently religious
- Prayer
- Religious radio
- Amulets used
- Asking for help 'I messed up'

RELACHS study: Cultural Identity and Mental Health

- 2,623 adolescents from year7 and year 9
- 28 out of 42 schools.
- Age, gender, ethnicity, deprivation
- 9 ethnic groups.
- SDQ
- Bangladeshis most traditional- 50%
- Indians most assimilated - 30.8%
- White, Black Caribbean, Black African and Black British were the most integrated...40%
- 'Bangladeshis seems to have a better protective factor against mental distress'.

Spirituality and Clinical Practice

- Cultural Competence:
- Cultural sensitivity
- Cultural knowledge
- Cultural empathy
- Cultural relevance
- Cultural guidance
- Embedded in assessments
- Formulated in diagnosis
- Constructed in careplans
- Relevant to outcomes
- Respected in the quality of life

Spirituality and Clinical Practice - Practitioners Model:

- Evidence - facts vs myths
- Case histories - testimonies and self
- Training - attitude and behaviours
- Validation - under/post graduate
- Clinical governance - standards and quality

C.A.R.E - International Foundation

- Respect the tradition and values systems of distinct world societies and culture.
- St Barts Med School. MSc, E-learning, Cultural Competency, NGOs Gamian Standards, Leonardo Programme, RELACHs Study, Law and Clinical practice.
- China, Egypt, New Zealand, Bangladesh, Saudi Arabia, Malta, W.I, Gamian, Sichuan, Peking, Dhaka, Ain Sham,
- Patrons, Sponsors, International Fellows, International Volunteers.

Questions

- ☐ Religious or cultural coping?
- ☐ Religious beliefs embedded in lay beliefs?
- ☐ Spiritual or Religious coping when no religious identity is explicit?
- ☐ When is relationship with God harmful or a sign of mental health?
- ☐ How can we support spiritual/religious coping or at least not undermine it?

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Showing Our Similarity

Differences, Diversities and Similarities

Buddhism (Unanavarga, 5,18)
Hurt not others with that which pains yourself.

Christianity (Bible, St Matthew, 7.12)
All things whatsoever ye would that men should do to you, do ye even so to them.

Confucianism (Analects, 15.23)
Do not unto others what you would not they should do to unto you.

Hinduism (Mahabharata, 15.1517)
This is the sum of duty; do nought to others which if done to thee, would cause thee pain.

Islam (Traditions)
No one of you is a believer until he loves for his brother what he loves for himself.

Jainism (Yogashatra)
In happiness and suffering, in joy and grief, we should regard all creatures as we regard our own self, and should therefore refrain from inflicting upon others such injury as would appear undesirable to us if inflicted upon ourselves.

Judaism (Talmud)
What is hurtful to yourself do not do to your fellow man.

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Morning Question and answer session

Note taker: Vicky Nicholls

Odi Oquasa (OO) – I am an artist and a shaman. I came to the UK fifteen years ago. I have spoken out before, about the high percentage of Black people in the mental health system especially men. The speaker talked about reaching into the past to understand the present: as an African, I have an awareness of the ancestors. My madness was an initiation into the ancestral realm. In 1899 the Royal Niger Company and the Jesuit priests from Ireland initiated another Christian King in Onicha as a rival against the Royal Family. I hear voices of the ancestors and comrade spirits and this is condemned as demonic, I'm told I am mad by the church. I have worked in textiles in Asia and Europe, but now my madness has led me into sculpting in wood and stone and painting and crafting and writing poems. This will help you to understand where my consciousness is coming from.

My question is, is the high percentage of Black people in the mental health system due to the fact that they can't reach into the past, or talk of Voodoo or Obiah or their past? Why isn't our past being listened to? And what about Christianity, what is its relationship with art and the issue of voodoo?

Peter Gilbert (PG): I will try and respond. We need to listen to people's story without making assumptions, to start where people are. When you speak of voices, what you are hearing, this is a big debate in mental health where this comes from: is it ill-health or are people in touch with other worlds? We need to work with people who might say 'I've always heard these and I'm a shaman.'

Woman at front (no name) – I have only heard voices twice. These are often seen as part of manic depression or depression. I want a study into how many people are 'clair-audiant'. Also I wanted to say, about hearing voices – Joan of Arc would have been labelled schizophrenic.

PG – What is important is connecting up with communities of meaning, for people not to feel so alone. People need to get together in groups where they feel safe and can share these experiences. For example I belong to a running club where people now feel open enough to share issues of sorrow and pain.

Manjula Sood (MS) – Yes, share in small groups, but not in a big group. The brother's experience of hearing voices, it can be a negative experience. I talked to my guru, I wrote down my experiences and I started to shift towards the positive. You need a one-to-one, to start having a healthy dialogue with one other person, this is when things start to shift as they did for me. I have seen mediums in the past, but not now. I did get some messages that turned out to be true and I'm still confused about this – but work in a small group, a one-to-one to get help from the distress.

OO – I've working with a Hearing Voices group. I've helped people to come off medication and understand their voices because some of the people who go to Hearing Voices are clairvoyant and some people with negative experiences bring that into their voices and I helped them to understand where their negativity was coming from. Mental health services don't like me because of this. The people who've stopped their medication, they start to get clairvoyant, some with negative experiences. The Government needs to invest more money, to get users involved in a high level dialogue. I have one friend who, when he stops the medication, gives things away. He gave away his wedding ring to a Buddhist nun. I asked him how she reacted – she didn't say anything! I said, I would have asked you why you were doing that, I would have been worried and understood something was not right

Hilary Pegg (HP) – You talk about reaching the spirit. The speaker said that on the beach he had a sense that the depression lifted, but the sort of experience many service users talk about is about other worlds and connections with these. We have what we call spiritual crises. We hope to hold an event in Norfolk.

MS – I agree there is another world. But medical professionals are not willing to accept these straightaway. GPs don't have the time to spend. Don't be ashamed. I still feel I have spirits guiding me, this is one of the things that needs to be in the recommendations. Don't be afraid of them they're there to help you, to guide you, be positive. In time you will feel bliss. They are like guardian angels, listen to that.

Rob Gee, performance poet and ex-psychiatric nurse

Performance poet, comic and reformed psychiatric nurse, Rob has performed over fifteen hundred live shows, toured internationally, and been published in numerous anthologies. He's performed with Harold Pinter, Sue Townsend, Adrian Mitchell, Tony Benn, Michael Rosen, Jimmy Carr, Jo Brand and Linton Kwesi Johnson. Appearances at festivals include The Glastonbury and Edinburgh Festivals, The Cheltenham and Hay-on-Wye Literature Festivals, The Sydney International Poetry Festival, The Canadian Festival of Spoken Word and The Austin International Poetry Festival in Texas. Rob has been commissioned to write poetry for Leicester City Football Club and BBC Radio, and won several live poetry slams. He also facilitates performance poetry and comedy workshops for users and survivors of the mental health system.

Email: robgeepoetry@hotmail.com Phone: 07980 996258 Website: www.robgee.co.uk

Warm up poem

(Lines in italics to be shouted by audience)

You say mental
I say spiritual
Mental...
Spiritual...
Mental...
Spiritual...
You say lock and key
I say talk to me
Lock and key...
Talk to me...
Lock and key...
Talk to me...
You say Prozac
I say panic attack
Prozac...
Panic attack...
Prozac...
Panic attack...
You say I'll come to grief
I say self belief
Come to grief...
Self belief...
Come to grief...
Self belief...
You say what a waste
I say keep the faith
What a waste...
Keep the faith...
What a waste...
Keep the faith...
You say delusional
I say I'm beautiful
Delusional...
Beautiful...
Delusional...
Beautiful...

You say ECT
I say be nice to me
ECT…
Be nice to me…
ECT…
Be nice to me…
You say Section 3
I say harmony
Section 3…
Harmony…
Section 3…
Harmony…
You say OCD
I say thorough
OCD…
Thorough…
OCD…
Thorough
You say mental
I say spiritual
Mental…
Spiritual…
Mental…
Spiritual…

The Messiah

He sits with His back to a soft lilac wall
and cherishes the dry food on his beard with a woollen tongue.
Mumbling about the triumphs and mistakes of the past,
His mouth opens without a sound as He silently laughs
to himself at the absurdity of His situation.
His stained fingers cradle a cigarette,
smoked down to the filter; dead.
His stomach protrudes offensively from a swollen shirt
and His leg vibrates with an excitable conviction of its own.
Two thousand years ago,
they appeased Him with the satisfaction of martyrdom.
Today He is frustrated by the arrogance of disbelief.
And miracles are out of the question
when you're on anti-psychotic medication.
And in the nursing office,
the care-tired staff mull ponderously over His case history:
the grandiose ideas and auditory hallucinations,
religious ideation and perceptual responses;
Jesus has a problem with His neurotransmitters;
but nobody can explain the holes.

Cares for Life Service, South London and Maudsley NHS Trust

A Culturally sensitive approach to engaging communities

Workshop led by Afua Nketia and Fuschia Peters

Afua Nketia joined the Cares of Life Service in 2004 as the project manager and now manages the newly mainstreamed service. Since 1993 Afua has worked in a variety of NHS management roles including managing advocacy and hospital patient services. Afua is Psychology graduate with a Masters in demography.

Fuschia Peters joined Cares of Life in 2003 as a community health worker. Fuschia has degrees in Psychology and Contemporary dance. Prior to working with Cares of Life, Fuschia worked at St Georges Hospital, south-West London as an assistant group facilitator and student counsellor.

Notes by Afua Nketia

The Cares for Life Service was set up almost four years ago as a short-term project for people who described themselves as Black African and Black Caribbean, aged between 16 – 65 years of age. The service offers "one-to-one" therapy for people with the generalised disorders of anxiety and depression, often referred to as emotional anxiety. In addition to the "one to one" service, Cares of Life offers a 'time bank' community where local community members can join and become volunteers, services users can join and thereby regain confidence. The time bank, as with all other time banks, offers time credits for exchange of skills within the time bank community. It has the prime function of helping people get back on their feet after a period of being unwell or feeling socially excluded, for example, as a result of illness or unemployment.

The Team consists of -

Volunteers
Director – who is a consultant psychiatrist
Manager
2 Link workers Psychiatric Nurse / Social Worker
2 Community Health Workers
1 Time Bank Co-ordinator
1 Administrator

So where are we now?

The Cares of Life Service is a community-based service, that is part of the Maudsley Hospital. The project achieved mainstream status in April 2005. The strength of Cares of Life is the way it reaches out into the community. The use of cultural sensitivity /spirituality within the service is 'married up' in the way services are provided.

Services offered include;

- "One to one" therapy with trained workers using a variety of therapies such as Cognitive Behaviour Therapy and Solution Focussed therapies. The service accepts referrals from GPs, Community Mental health teams, self-referrals and referrals from friends and family and voluntary organisations. Cares of Life Service therefore places great emphasis on establishing good links with local General Practitioner surgeries. This one to one service is often offered in satellite clinics; offices and user-friendly spaces in the community. e.g. rooms made available by churches / GP surgeries, local education units, local authority cafes. Home visits are also possible.
- Group sessions

- Time Bank skills exchange: for example, one hour of baby sitting for one hour of decorating - this has proved a wonderful way of helping people build their self esteem and confidence
- Health Promotion – This has been a wonderful way of over-riding stigma about mental health. It was found that initially people did not want to talk about mental health issues due to the stigma and discrimination. A double-decker health bus provided health checks including blood pressure checks. It is often found that discussion around reasons for an abnormal blood pressure reading opened up further discussion around emotional or mental health issues.
- Organisational learning. Team members would share with each other and other departments in the South London and Maudsley NHS Trust and organisations around best practice and their knowledge of cultural sensitivity.
- Building bridges between statutory services and voluntary services in this specific population
- Negotiating best care

Hypothetical Scenario

Participants were given the following scenario for comment.

History:

A 38-year-old African Caribbean woman takes her toddler to the GP, explaining that her toddler had fallen onto an electric pressing iron and sustained a nasty burn on the arm. Her husband had left the iron on by accident. The GP surgery contacted Cares of Life, as the woman appeared depressed and thought she could benefit from our service.

'Annie' explained that she, her husband and the five children had no space in the one-bedroomed flat. She kept saying her husband was a good man although absent throughout the assessment. There was no space in the flat yet it was clean and presentable; she had lovely well-framed family pictures in the flat.

During the assessment when asked if she ever felt worthless 'Annie' became very emotional. 'Annie' later composed herself and expressed a wish to continue, she mentioned she had taken an overdose to end her life six months earlier. She had not sought anyone for help at the time but her husband had called his best friend from church to come and talk to her. 'Annie' said she had felt worthless as a Christian. She said she knew she should not be contemplating suicide but she had felt so depressed due to her poor housing and education.

'Annie' had very little education as a result of suffering leprosy as a child and confided that she could not understand why her husband had asked to marry her knowing this. She believed that if she were well trained she could have helped provide her family with a better home. 'Annie' had enrolled on a course to get a better job she also worked part-time in the local supermarket. She said she did not have many close friends in the church and neither did she want anyone from church to know her business.

Throughout the assessment she would lose and regain control of her emotions, whilst correcting her children on their manners when they entered the room. Her home was clean, but it was quite clear the family did not have enough space.

Action:

Imagine you are the key worker assigned to 'Annie'. Choose a service you are familiar with or want to represent: Social Services, Voluntary Organisation, Church, National Health Service etc.

What would you see as the psychosocial domains of need for 'Annie'? What order would you place them in, how would you prioritise? How would you go about addressing some or all of them? Is a risk assessment necessary?

The group identified the following points needed consideration as a response to the Case Study:

Housing needs - help with written applications for housing
Possible social services contact
This would free up Annie's time
Help with children
Life skills management – time management
Risk Assessment a priority due to Annie's history
had attempted suicide before
Education needs
Possible solutions Learn Direct
Identify which course she had done/completed
Social networks
Involvement of the whole family
Meet the husband
Links with friends
Only church mentioned – other support networks – need to be explored, or for Annie to explore
Befriending service
Contact with General Practitioner
Health of children
Education of children
Referral to Community Mental Health Team
Poor psychological state
Self worth – didn't see own worth
One-to-one work required
Classic signs of self-harm
Occupational Therapy assessment
Leprosy may have left Annie with restrictions and may need additional help
Group Help
Help from outside
Possibility of volunteering work to build self-esteem
Cultural aspects of husband's role, may be other issues to consider

This case study was build upon a real case, where referral was via the GP, Housing services was a helpful intervention, access to a consultant psychiatrist and therapy was given for depression, the team worked on the client's self esteem and identify when to ask for help. The client was with the service for eight weeks

The group asked why Social Services were not contacted by Cares of Life.

The Cares of Life response was that the General Practice had contacted Social Services and Cares of Life joint works with several agencies, so social services were already involved thanks to referral by their GP.

As the client was very worried about her Church not approving of the emotional state she was in, the role Cares of Life took was to work on her self esteem and explain to her the function of the other statutory services already involved. The client had already started taking care of her housing issues and Cares of Life simply added support to her case.

Experiential art workshop

Odi Oquosa, survivor, artist and Shaman

Odi Oquosa is a Community Artist and a member of South Downs Patient & Public Involvement Forum. Odi was born in 1969 in Onitsha, Southern Nigeria in the Niger Delta region and is an active member of Onitshan Royal lineage.

From the age of 18, he travelled extensively around Asia and Europe working in textiles where he says he gained a far better education then ever he did at Poly!

He is a sculptor, painter, clothes-designer, textile technician, gemologist, musician, scholar, philosopher, dancer, historian of his people, cook, healer, shaman and medicine man. He has been described as a man of many parts, a man of many arts.

The artwork and sculptures displayed around the room are all the work of Odi and the poems that he writes draw to some extent on the traditions and philosophy of the Onitsha nation and although he always allows freedom to his own originality, he remains faithful to the traditions of his ancestors and contemporary Onitsha.

Odi can be contacted via e-Mail at: odiado10@yahoo.co.uk or, for more on Odi's background and some of the difficulties he faced in his native Nigeria, check out Odi Okaka Oquosa via any Web Search Engine.

Odi led an art workshop, in which participants were invited to create art works, a selection of which are displayed on the cover of this paper.

"Revealing"

"Very honest"

"How therapeutic! Self expression and interpretation were wonderful. Lovely way to end the day."

"Lovely to have the opportunity to tap into my unconscious creativity – a rarity!
Nice energy from Odi. Thanks. Jane"

"Fun and light"

Faith Perspectives on Mental Health in a Post-Modern Multi-Faith Society

The Venerable Arthur Hawes

Note taker: Terry Bamford

In addition to his excellent chairing of the conference Arthur Hawes led a workshop which was repeated in the afternoon. Despite the title Arthur was quick to point to the concept of spirituality as preceding all the great world religions. It dated back at least 70,000 years. As a concept it encompassed religions and faith communities.

Contemporary writers had broadened the definition of 'spiritual' beyond religion. People were finding their own sense of what was spiritual in concern for the environment, in tackling world poverty and famine, or in global public health concerns. Friedman had written that 'we choose our own supernatural'.

Given the salience of the parent role in psychoanalysis and in many religious beliefs, the vast numbers of children without a father both in British society and globally meant that new roles were being explored in the sibling society. Forty percent of households were single person households in some areas so in many ways we were becoming more private.

In a typology of modern and post-modern societies, Hawes suggested that this was part of a move from institutional societies to private. Bowling Alone had captured in its title this trend. Values were seen as relative with a suspicion of absolute values. Post modern societies endorsed and approved bottom-up decision making rather than top down. Choice was more important than prescription. The search for meaning was internalised rather than being found outside an individual.

This led to a different approach to morality and the divine. Instead of morality being the result of an ethical code, it was defined in terms of personal behaviour. Needs had been subordinated to wants. The transcendent made less appeal than the immanent. The concept of the Supreme Being was replaced by a God created by man.

In this turmoil and change Spirituality had a bridging role between faith communities and the post modern world. Many sought spiritual experience and religious community as a way of coping with alienation. This was why spirituality was regarded as so important in the mental health world because the limits of medication and psychotherapy were recognised.

Drawing on the struggle between demons and the character 'Legion', he suggested that lessons could be drawn with parallels for the post modern world: the importance of healing, education and recovery based on mutual confidence between the healer and the healed.

This presentation provoked a stimulating discussion in its multi-faith audience. Abraham was noted as a father figure for three major world religions. There was far more to unite us than to divide us despite the current emphasis on a clash of cultures and traditions.

Spirituality and Psychiatry today: the work of the Spirituality Special Interest Group in the Royal College of Psychiatrists

Professor Christopher Cook – Professorial Research Fellow Durham University

The Reverend Professor Chris Cook is a Professorial Research Fellow at Durham University where he is working to establish a project in Spirituality, Theology and Mental Health. He is also working as a consultant psychiatrist for County Durham and Darlington Priority Services NHS Trust and as a team member at St Antony's Priory, an ecumenical spirituality project in Durham. He is an executive committee member of the Spirituality Interest Group of the Royal College of Psychiatrists. He has worked previously as a Professor of the Psychiatry of Alcohol Misuse at the University of Kent (1997-2003) and has published widely in the addictions field. His forthcoming book, published by Cambridge University Press, is entitled "Alcohol, Addiction and Christian Ethics".

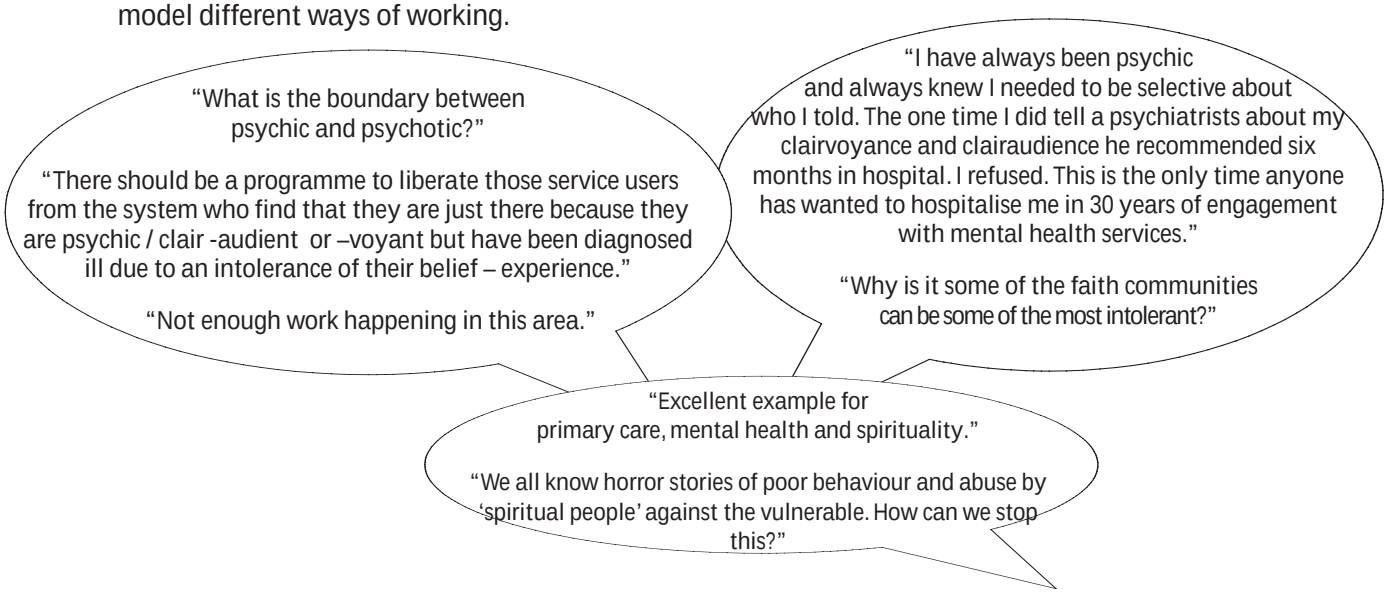
Note taker: Judy Foster

A dozen people came to hear Chris describe the development of the Royal College's special interest group from 100 people at the first meeting 7 years ago to over a thousand now. He explained that since religion became a private matter with the enlightenment 200 years ago, spirituality has been treated as a bit suspect, and we need to learn a new set of boundaries now.

One dilemma that several members faced was the conflict they felt between their view of the value of spirituality - one member had had her benign experience of being spoken to by spirits during psychosis recognised and validated by a member of the special interest group - and more fundamental actions that some churches and psychiatrists would encourage like fire walking or exorcism. Where was the boundary?

Another participant described successful work with a young Punjabi user who through believing her mental distress was a curse found her family back home in hock to the medicine man. Over a period of months, the worker was able to help her back to health by starting her accepting where she was at. The speaker pointed out that it is not only Black and Minority Ethnic communities who need cultural understanding, as he is often being asked for the names of Christian psychiatrists. While recent training puts psychiatry in a cultural context, practice lags behind.

The needs of adolescents were also highlighted – even more of a struggle and even more vital. A participant urged the rest of us to influence each of our work communities through education – for example make presentations to the Local Implementation Team. She felt that for any progress to be made, staff needed to be confident and mature enough to be vulnerable and let go of their authority to have some shared humility with users. Chaplaincies could be a training resource in the trusts and model different ways of working.



Spirituality and Psychiatry Special Interest Group of the Royal College of Psychiatrists

Andrew Powell and Chris Cook

The Special Interest Group was set up in 1999 to provide a forum for psychiatrists to explore the influence of the major religions, which shape the cultural values and aspirations of psychiatrist and patient alike. The spiritual aspirations of persons not identifying with any one particular faith are held to be of no less importance, as well as the viewpoint of those who hold that spirituality is independent of religion. Membership is open to Members, Fellows and Inceptors of the College, but the group holds open meetings from time to time and guests are also invited to its other meetings. It is one of the most popular Special Interest Groups within the College, with a current membership of over one thousand.

The meetings of the group are designed to enable colleagues to investigate and share without fear of censure the relevance of spirituality to clinical practice. The Special Interest Group aims to contribute a framework of ideas of general interest to the College, stimulating discussion and promoting an integrative approach to mental health care. It contributes actively to College life in a variety of ways, including planning of sessions on spirituality at College meetings, writing of material for service users and professionals, and (recently) input to the revision of the curriculum for psychiatrists in training. It offers an annual essay prize for members, publishes a regular newsletter, and maintains pages on its interests and activities within the College website. It also aims, directly or indirectly, to help the service user feel supported in being able to bring spiritual concerns to the fore.

Spirituality & Psychiatry

Over recent years, there have been a number of calls for an approach encompassing mind, body and spirit. The College was urged to do so by its patron, HRH the Prince of Wales in 1991. Professor Andrew Sims raised the issue again in 1993 in his Presidential Valedictory Lecture, as did Professor John Cox, the incumbent president of the College, at the Annual College meeting of that same year. In 1997, the Archbishop of Canterbury addressed the Joint Conference of the College and the Association of European Psychiatrists. There has been growing interest in the series of Religion and Psychiatry Conferences held at the Institute of Psychiatry and other regional individual initiatives have been taking place. In 1998, a survey by the Mental Health Foundation revealed that over fifty per cent of service users hold religious or spiritual beliefs, which they see as important in helping them cope with mental illness, and highlighted the need expressed by many patients for encouragement in discussing such concerns with the psychiatrist.

Psychiatric diagnostic and classificatory systems have historically tended not to include specific categories for spiritual or religious problems, and yet have often included spiritual or religious content in examples of delusional or other psychotic and pathological phenomena. The Diagnostic and Statistical Manual of the American Psychiatric Association introduced for the first time in its fourth edition (DSM IV) published in 1994, in the chapter on 'Other conditions that may be a focus of clinical attention', a category (V62.89) of "Religious or Spiritual Problem".

Spirituality can be as broad as 'the essentially human, personal and interpersonal dimension, which integrates and transcends the cultural, religious, psychological, social and emotional aspects of the person' or more specifically 'concerned with soul or spirit'). The Special Interest Group has a correspondingly varied and wide-ranging agenda, including consideration of protective factors that spiritually sustain the patient in crisis and otherwise contribute to mental health. It is thus concerned with both normal and pathological experience of a spiritual or religious nature.

Spiritual values have a universality which brings together all involved in mental health care. The Special Interest Group is therefore supporting an important educational initiative launched by the Janki Foundation on 'Values in Healthcare'. The Special Interest Group also supports the exploration of such fundamental questions as the purpose and meaning of life, which are so important for mental health, as well as the problem of good and evil and a wide range of specific experiences invested with spiritual meaning including birth, death and near-death, mystical and trance states and varieties of religious experience. Both pathological and normal human experiences are considered in order to understand better the overlap and difference between the two.

Recent meetings

Jan 2000 What do we mean by spirituality and its relation to psychiatry?

Apr 2000 Fear and Faith - the quandary of the psyche under threat

Oct 2000 Avenues to peace of mind

Jan 2001 Forgiveness and reconciliation

May 2001 Engaging the spiritual mind

Nov 2001 The healing power of love

Feb 2002 Good and Evil - the Challenge for Psychiatry

Jul 2002 Integrating Mind and Body: psycho-spiritual therapeutics

Nov 2002 Pathways to Peace - East meets West

Jan 2003 Invited or not, God is here: spiritual aspects of the therapeutic encounter

May 2003 Minds within Minds: the case for Spirit Release Therapy

Oct 2003 Spiritual Issues in Child Psychiatry

Jan 2004 Prayer in the Service of Mental Health

Oct 2004 A Fatal Wound? Who and What does Suicide destroy

Jan 2005 What Inspires the Psychiatrist? Personal; beliefs, attitudes and values

Oct 2003 Special needs, special gifts - learning disability and spirituality

Dec 2005 Spirituality and Religion in Later Life

Open conferences have included:

2002 The Place of Spirituality in Psychiatry held jointly with the Royal Society of Medicine

2004 Beyond Death - Does Consciousness Survive? at Kings College Hospital, London

2005 Healing from Within and Beyond - the Therapeutic Power of Altered States held jointly with the Royal Society of Medicine

Finding Meaning on the Journey

Dr Hugh Middleton - Senior lecturer in Psychiatry, University of Nottingham
CSIP East Midlands

Hugh Middleton has been a Senior Lecturer at the University of Nottingham and an Honorary Consultant Psychiatrist with Nottinghamshire Healthcare Trust for some twelve years. External links include examining for the Royal College of Psychiatrists and contributing to CSIP, regionally and nationally. Home life includes involvement with the community who worship in, and support, the Nottinghamshire Diocesan Cathedral, Southwell Minster.

Despite, or perhaps because of an academic career, his experience as a medical practitioner and a healthy scepticism have taught him to respect what we don't know. This is particularly true in mental health where so many of our "treatments" are only partially effective in restoring people to wellness. Mental health services and practitioners can learn a lot from approaches which respect the essence of the individual, in the way that respect for their spiritual self does. Quite often people change in a helpful way not because they have received evidence based treatment, but because they have been enabled in personal or spiritual growth. Through CSIP, the Recovery Network and other means Hugh is interested in bringing forward a fuller realization of this amongst formal mental health services.

Note taker: Vicky Nicholls

At the start of the workshop Hugh Middleton and Vicky Nicholls introduced themselves, then went around the group for everybody else to introduce themselves.

Hugh explained that he was going to run through a scenario of somebody encountering an increasingly stressful situation and finally breaking down, and the reactions of those around him. We would look at the relationships and how people interact during the story, with a break at the end of each of five 'chapters' to ask for people's views.

The scenario was about Joe and Josephine. Joe had been working at a company which produced Funny Twirly Things for a long time. He had been called in by the Chief Executive who informed him there was a financial crisis and people would have to be made redundant. Joe's job was to be to break this news to people, some of whom were his mates and who he had known for many years.

Hugh gave examples of the sorts of stressors that can be encountered at home or in the workplace.

Common Causes of Stress

High workload / Unrealistic deadlines
Financial pressures
Boredom
Relationship problems
Conflict between work and personal life
Environmental and cultural conflict
Uncertainty about the future / fear of change
Feeling unappreciated
Lack of purpose in life.

What appears like a 'molehill' to one person may seem like a mountain to someone else, pressures can turn into stress.

Joe had faced two experiences of redundancies: the first time was clear, 90-day notice. But the second time there was uncertainty, it happened in sizeable chunks so everyone was diving for cover and ultimately wanted to look out for themselves. It was hard because everyone was in the same boat. Joe began to find it increasingly difficult to deal with what he was faced with.

In our society people either have too much or not enough to do. The case study situation is an everyday one. When a situation is fluid it is more difficult to deal with. When the stress increases, the ability to deal with it effectively decreases, and this can become a mental health problem.

Hugh put up a list of stress pointers; observable indicators for when someone is becoming overwhelmed by challenge:

Increased comfort eating
Decreased appetite
Increased intake of alcohol, illicit drugs, tranquillisers/sleeping pills
Smoking more (or starting again)
Aggression towards colleagues or family members
More insular
Irritable
Absenteeism from work
Sleeping badly
Turning to the doctor with a variety of physical complaints
Marital or family conflict.
Subjective experiences might include:
Feeling isolated
Feeling guilty
Feeling unable to cope
Loss of sense of humour
Marital or family conflict
Uncomfortable sensitivity to criticism
Feeling unimportant
Feeling ill in various ways.
Which in turn can lead to:
Loss of motivation
Lack of confidence
Shortened attention span
More prone to accidents
Less resistance to illness
Pressure on relationships
Breakdown.

The slides then went into the family scenario, with suggestions of the sorts of thoughts Josephine might be having.

First Discussion

One participant explained that she had had a terrible depression, but she didn't think her husband had realised. He had called her a bad mother after years of her supporting him, mothering was her job so what he said really hurt her. She had wanted to seek marriage guidance but he hadn't. She had later had another relationship which broke up, and this had led to the illness returning.

Another workshop participant had been given a sick note for 30 days after having worked without a single day off work for fifteen years. This had felt like a holiday! Society puts pressure on people to be able to work. Everyone has their own metabolic rate for working, he said he worked best at night but hadn't been allowed to go back on shifts after the break. There are lots of things other than work that society could put value on.

Hugh returned to his presentation and posed a series of questions:

How do others respond to stressed and/or unwell people?

If stress is as a result of work, is it easy to get a better balance between work and personal life?

If stress is a result of the home situation, how can we find someone to confide in?

What sorts of reaction from others helps, and which hinder?

What can others do to help avoid that stress leading to mental illness or a nervous breakdown?

Hugh highlighted how sustained stress is likely to result in depression or a mental breakdown. At this stage the person suffering is unable to rationalise and even the most trivial challenge appears impossible. They are likely to feel low self esteem and a failure and sometimes see little or no purpose to life.

Hugh picked the story up again, describing Joe waking up one morning, hearing the Radio Four 'Today' programme and feeling as if he had no interest in getting out of bed. At this stage, he explained, often the only way out of the situation is to do something desperate:

- Take an overdose in order to be admitted to hospital
- Withdraw into depression
- Act violently
- Adopt the role of "disabled person"
- Walk away from responsibilities.

He commented that we are all connected and that when someone behaves in an out of order way it makes it more complicated. He gave suggestions of what Josephine might be thinking and feeling, comparing this with other circumstances when Joe might have wanted to stay in bed: for example, because he had had too much to drink. He may have been better understood then as not pulling his weight.

At this stage an individual will be incapable of getting back to good health without social, medical or spiritual help. However, they are confused and don't know where to turn to for help. They may be unable to face work or maybe even other family members. How difficult is it to come alongside someone in these circumstances?

Second discussion

One woman gave an example of how hard it can be to provide help at times of distress: you don't know because you don't know. There is a fine line between helping and gossiping, it is a fragile time. If someone is feeling depressed it doesn't help that people say 'you're looking well' (because you don't feel it).

She said that when she was first in hospital she should have been given something calming instead of being put on anti-depressant tablets.

Another participant commented that he was on a long road to getting better. Tablets aren't the be-all and end-all. Nobody can know how the person is unless you communicate, it can be self-isolating. Hugh added that an alternative is someone getting alongside.

The female participant who had previously been speaking said that she was four years in to her journey so she knew what helped. 'I know better than any psychiatrist what helps me'.

Hugh returned to the story of Joe, and highlighted how the need to ask for help can be suppressed by the shame perceived in asking for it. One third of people who are referred to a psychiatrist never get to an appointment, and he saw this as positive because it meant that those people had found their own ways of coping.

In Joe's story, eventually the doctor is called and Joe is given a sick note and some anti-depressants. The anti-depressants make him nauseous and he doesn't take them, but when colleagues at work learn that he is unwell an old friend calls to see how he is. Josephine pours her heart out. Joe and his colleague begin to share stories of bad management at the Funny Twirly Thing factory.

Hugh commented that at last there is some human contact when the friend comes to visit and this is when things start to move. One thing that is central to recovery is healthy interactions with other people. One innovative thing is how we can help people to break out of where they are.

One participant said that the support for Joe should be equal, you don't communicate well when you're under stress. Hugh reflected that confiding in a friend in circumstances such as these can be a more effective means of support than turning to professionals. Another participant said that you learn not to take on other people's problems, that in the project she went to they supported each other. She envied moody people because they had energy whereas she self-harmed. She believed in the Christian faith so was disappointed in herself. Hugh said that it is important not to beat yourself up.

He returned to the list of observable indicators pointing to the need for change:

- Increased comfort eating
- Decreased appetite
- Increased intake of alcohol, illicit drugs, tranquillisers/sleeping pills
- Smoking more (or starting again)
- Aggression towards colleagues or family members
- More insular
- Irritable
- Absenteeism from work
- Sleeping badly
- Turning to the doctor with a variety of physical complaints
- Marital or family conflict

Once someone suffers from severe depression or metal breakdown they will need help and human contact. Recovery can take a considerable length of time and the person suffering and the people around them need to be patient.

During the recovery period people require constant reassurance that they are making progress. This is true both at home, work and elsewhere. During this time people need the help and support of all those around them. They need both spiritual and practical support.

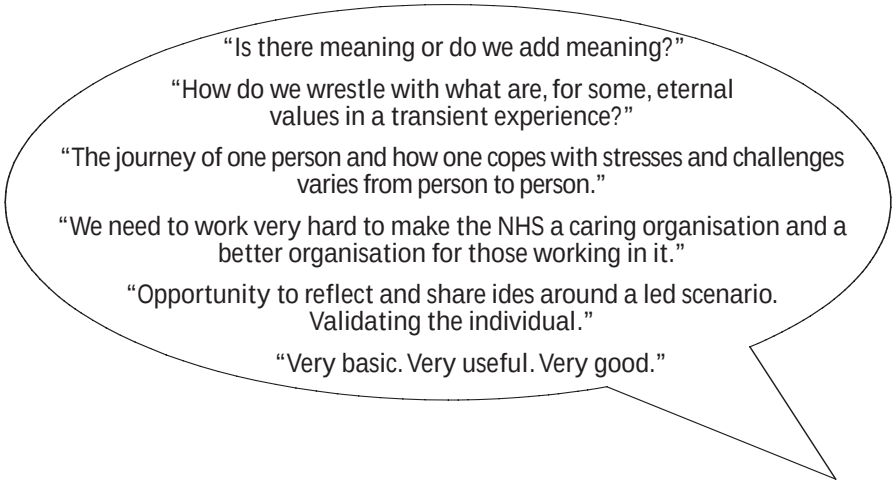
Hugh said we should not forget the needs of the family of those suffering, as they will probably feel drained and sometimes frustrated and pressured themselves. Full recovery involves leaving the episode and its stigma behind and returning to old roles or adopting new ones

The man who had been talking previously raised the question of whether we need all our material possessions. He had once had a job, four cars and a holiday – but now thinks what does it matter? He is now on Incapacity Benefit and much happier than the people with these things. He raised the question that you set off on this journey because it's been laid down since childhood, but why?

Hugh concluded the workshop with a series of reflections, including that:

- An episode of stress, breakdown or depression usually signals a need to reflect upon why spiritual, work or domestic issues are not "working out".
- The process of recovery inevitably involves personal change.
- How can/do we accommodate people faced with the need to change?

In Joe's story, by the time he was up and about there was no Funny Little Twirly Things factory to go back to. The company was bankrupt. He and Josephine were living on less but were closer to one another than they had been for years. Son Harry didn't have a new bike but he did have a new Dad.



Chaplaincy and holistic models of mental health

Kenneth Blanton – Mental health chaplain specialist Berkshire Healthcare Trust

Kenneth is an ordained URC minister and the mental health chaplain specialist for Berkshire Healthcare Trust, based at Prospect Park Hospital, having completed studies in Pastoral Theology at Yale University, Clinical Pastoral Education, Pastoral Counselling and Psychotherapy at the University of California (Berkeley), and Psychology of Religion at the University of London.

Ken promotes a holistic approach to healthcare and plays a very active role in Berkshire's mental health service, including the provision of one to one sessions with both in-patient and out-patient service users, co-facilitating ward talk therapy groups, group supervision of staff and multi-professional teams, instruction of junior doctors, and collaboration with consultant psychiatrists in the research of spirituality and religion's role in mental health issues, most recently as it relates to post traumatic stress disorder.

Berkshire Healthcare Trust is a pilot site for NIMHE's Spirituality and mental health project.

Afternoon workshop note taker: Judy Foster

Discussion took place as Ken showed his slides and described his role in the hospital. As an introduction he said he saw spirituality as a 'struggle for meaning' in mental health. He prefers to consider 'transformative' health care rather than 'recovery', which suggests getting back to something – but you have inevitably changed, but it's a process of using the crisis to transform ourselves. One participant commented that most staff in the service lack the language and spiritual experience to talk to their patients. Ken quoted a case from the 1950s where the doctors had consistently ignored the meaning of a young woman's voices, that she lost her 'soul' and will to be, through repeat admissions – it's not a new phenomenon.

He went on to talk about three areas of change he had brought about in the ward:

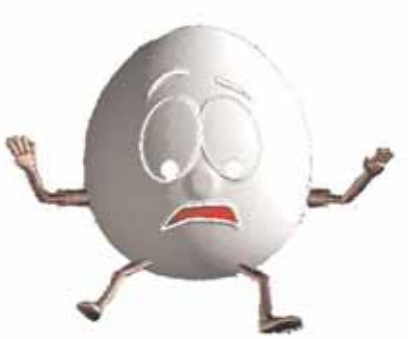
His user consultants are redesigning the Care Plan Assessment form in the first person so it now reads 'my strengths and weaknesses' and this is a shift towards a more person centred approach. We were all impressed at how empowering this change seemed and in one move had changed the patients' status and increased social inclusion.

A participant emphasised the importance of nursing assistants as they were the ones with most direct contact with the patient. Ken described how he had encouraged them to be empowered, trained and given regular supervision. Only through this did he think they could develop and maintain non-judgemental attitudes and self-awareness. Supervision also provides essential containment for staff so that patients then receive optimum care.

He brought about major change in the ward by supporting them in drawing up a 'ward constitution' that said 'everyone here is treated with dignity'. This empowered the group with an ethos that enabled them to challenge behaviour that was detrimental to patient care. They now have one hour a day when no-one is in the office, but all the staff spend this therapeutic hour with the patients. The staff group meets regularly for coffee and doughnuts – and combines this with group discussions which facilitates more healthy interaction between staff, and service users.

Berkshire Healthcare Trust and The Chaplaincy present Holistic Healthcare

Slide content (in 'quotes') by Kenneth Blanton.
Additional notes: Rowena Harding



We currently have a system of Humpty Dumpty healthcare. What we need to be doing is catching people before they fall.

'One day a young boy (from the Seminole tribe in Florida) was brought to A & E after falling from his bike and breaking his ankle. The doctor on duty set the ankle, put a cast on it, and sent the boy home.

'Later in the day the doctor went to talk to the medicine man of the village, who had just come from visiting the boy. The medicine man had asked the boy the reason behind breaking his ankle, and the boy had explained that he was not really sure.

'The medicine man then asked the boy about his relationship with his mother, as every part of the universe is represented by a part of the body. The left ankle in Seminole is female, and the boy understood. Thus, the doctor concluded, while he had brought "cure" to the boy, the medicine man had brought "healing."'

We need to see health holistically and understand the physiological, psychological (or spiritual) and sociological (or cultural) aspects. Ignoring any of these can lead to further ill health. Practitioners need to be aware of cultural dynamics, e.g. a Hindu family from Slough has a member with depression. Culturally, the family thinks the member is dishonouring the family so they lock the person away. This affects the person's physiological and spiritual well-being.

'Historic Healthcare:
Platonic Balance (Mind = Brain)
Cartesian Dualism (Mind / Brain)
Holistic Integration (Mind : Brain)'

In the history of healthcare, Plato said the mind and body is the same thing. Then Descartes challenged this with dualism. What we need now is a model which sees the holistic integration of mind and brain.

'What is holistic health care?

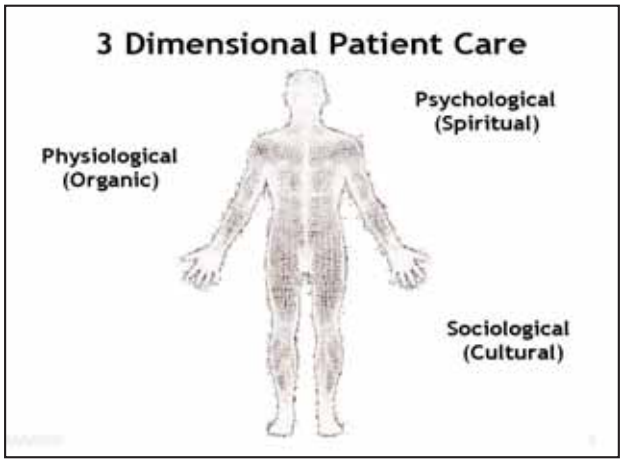
'Approach to medical care that emphasizes the study of all aspects of a person's health, including physiological, psychological, social, economic, and cultural factors.'

'To be holistic we need to incorporate all three elements:

Physiological / organic

Psychological / spiritual

Cultural / sociological'



'What exactly is spirituality?

'From the Greek pneuma or spiritus, meaning breath, Spirituality may be defined as the tendency (found in all of us) to move toward love, hope, meaning, connectedness, and wellness. It is therefore recognised as a factor that contributes to health in all cultures and societies, and therefore includes both you and I. In other words, we are all spiritual beings!!!'

What is spirituality? Care teams need a common definition. A sense of belonging to community and self. A struggling for meaning - an ultimate meaning. Ultimate meaning can be skewed by death or the end of a relationship. We need to be sensitive to the fact that different people create a variety of different meanings.

'Mental Health and Spirituality

> *"The definition of mental health has much in common with the definition of spirituality, as both experiences are concerned with the experience of self. One reaches into dimensions of space to discover self, as the other realises freedom through the acceptance of self."*
>
> *Dr. Julie Liebrich, Psychiatrist*
> *21st World Assembly for Mental health, 2001 Rees Memorial Lectures, Canada.'*

There is a flaw in the NHS because it is geared up to making people function 'properly' and to conform. But the NHS does not engage on the level of individual subjective meaning, which is very important in terms of peoples' well being.

Example: a Kenyan goes to the UK to become a mechanic, something he really desired. But the whole time he feels the need to go back to his community and help them. He says he hears the voices of his elders. Is this the voice of culture and conscience or madness? In this case, the NHS condemned it as a voice of madness.

'Some Facts and Figures:

- 76% of UK claimed spiritual/religious affiliation ('01 census).
- High level of utilisation of spirituality & religion amongst patients coping with mental illness (Weaver 1998).
- UK patients claim that GPs either don't listen or overemphasize biomedical model and ignore spiritual aspects of care (Foskett, 2003).
- Historic tendency to devalue experiences common to spirituality & cast them into the pale of psychopathology (Richardson, 2000).
- Service users still remain very clear about a desire for spiritual care as part of treatment (Macim & Foskett, 2003).'

How do we pay attention to the cultural? To the spiritual? We are not comfortable asking people about culture. We should try to enter a dialogue and share information about ourselves.

'What exactly is spiritual care?

'Spiritual Care is a response to the spiritual needs of a person, understood through that person's life events, beliefs, values and meaning.

'Spiritual Care is a means of therapeutic support designed to enable a person challenged by illness, trauma, or bereavement, to find meaning in their experiences of vulnerability, loss, and/or dislocation.

'Spiritual Care addresses the dimensions of illness, disability, suffering and loss that go beyond the immediate and the physical.'

'We need to think about what things mean for people in terms of their cultural, spiritual and personal. For example if a man loses his leg in the factory in which he has been working for fifteen years, what does it mean for him to no longer be the breadwinner? We need to respect people's different needs. Everyone has a spiritual dimension regardless of whether they belong to a religious faith and we need to enter into a dialogue with that spiritual dimension.

'Spiritual care also contributes to healing and rehabilitation in respecting the integrity of the person, and by attending to wholeness in the midst of what seems to be brokenness. ...may include psychological and social issues, not just religious ones, and therefore involves care for all persons, not just church goers or 'religious people'.'

The key is - how do I sit with someone's anxiety whilst I sit with my own?

'More facts and figures:

- Latest edition of DSM – IV TR recognises "religious & spiritual difficulties as distinct, and deserving treatment" (APA, 2000).
- 52% of nurses, 33% of psychiatrists, 30% of GPs now see Spiritual Care as equally important forms of care (Green, 2004)
- One third of psychiatric medical officers & nurses desired more training in field of spiritual care (Green, 2004).
- 50% of all groups felt that mental health professionals were not best people to assess and provide spiritual care (2004).'

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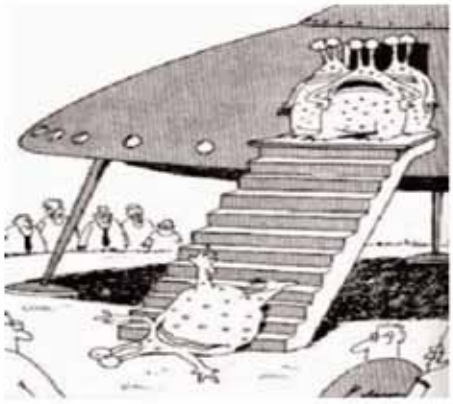
'What exactly are chaplains?

'Chaplains are unique among the health professionals in that their caring task is primarily focused upon spiritual care.

'Chaplains, through understanding the interface of spirituality and psychology, and recognising that values, meanings and beliefs play an important role in mental health, know that spirituality is integral to the life and work of the NHS.

'Chaplains, with this distinctive perspective are empowered to be sensitive towards, and supportive of, the diverse spiritual and religious needs of patients, carers, and staff, as well as able to incorporate a "psycho-spiritual" approach to care.'



"Wonderful! Just wonderful!... So much for instilling them with a sense of awe..."

'The idea is not to give people advice, because that does not empower them. We have to get people to reflect as well.

'Try different approaches - ask people why rather than telling them what to do.'

'Unstumped - the sequel

- Team effort is required
- What would it look like? Practical vision needed
- How would we model it?
- Agreement - how would we ensure it?
- Guide for making connections
- How would we maintain it?'

Well, lemme think... You've stumped me, son. Most folks only wanna know how to go one way.

'Inner Self:

'Refers to associations that exist at psyche level:

- states of consciousness
- affective states
- Spiritual beliefs
- Religious beliefs'

'We align ourselves with these in order to:

- feel good about ourselves
- empower or dis-empower others & nature '

'Social self:

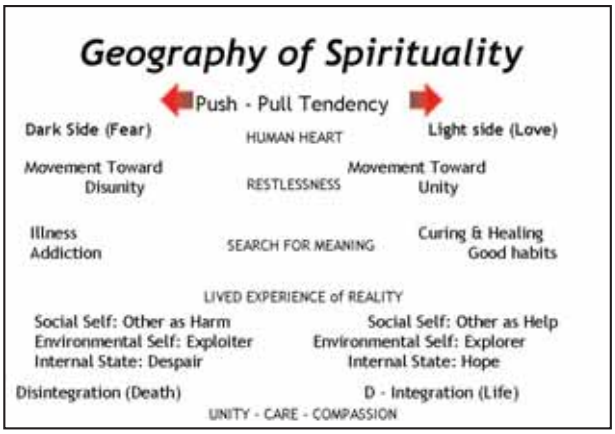
'Refers to fact that "others exist, therefore I am."

- I feel about me how I act toward others
- Expressed anger signifies loss of meaning
- Social self is broken by illness (alienation)'

'Environmental self:

'We are not outside environment looking in.

- Geography of place is critical
- Includes hospital room
- Must invite healing'



'All three aspects of self are crucial to wholeness, to ignore one is to contribute to spiritual death.'

'Where to begin:

'With Self – awareness (self-centred):

- Develop own spirituality'

Cannot do for others what I can't do for self. Supervision, journal, explore meaning.'

'With compassion (person centred):

- In caring for others I care for self
- Be real (compassion meted with reality)
- Reflect back – actively listen
- Strategise (Develop individual narrative)'

We need to take a holistic approach to others, our self, and our work mates and patients. Jung: "Knowing your own darkness is the best method for dealing with the darkness of other people."

'With Unified approach - assess, assess assess. And continue . . .

- Team-building approach
- Culture of Support
- Always listen for meaning'

So Humpty may fall.. but not hit and split.

"Excellent. What more can I say?"

"But does everyone have the language for spirituality?"

Sitting beside you

Peter Gilbert

Note taker: Rowena Harding

Peter Gilbert's workshop was a lively debate looking at how people's spiritual needs could actually be addressed.

There were many issues that immediately came out of the initial topic:

- Why assess spiritual needs and what is the context of that?
- How do we want our need assessed?
- What are the elements of spiritual assessment?

People do want their spiritual needs taken into account but do not want over-professionalism. Assessment can often be seen as looking down on people. And, in the present mental health systems we tend to look at only the present and not people's future aspirations. Sometimes there was too much looking at the past and not the whole.

The workshop discussed how people who performed spiritual assessments also needed to look at themselves first. Staff could not treat people as individuals if the staff themselves were not treated as individuals. We need to look at professional attitudes that make people defensive and consider why that is. We need to engage and not challenge people's belief systems. As professionals, we need to assess ourselves first and consider what it is that is important to us.

Competence was a key issue discussed by participants as it was acknowledged that such an important assessment needed to be done well if it was to be any use.

Who does the assessing? Who has the experience, training, knowledge and competence? Historically spiritual needs have only been assessed through someone like a chaplain. It was felt that there was generally incompetence when asking people about their spirituality and religion. Competence needs confidence.

An assessor should be someone people could trust and who could appreciate another person's values even if they didn't understand. People needed to be both competent in assessing someone and competent to act on that knowledge. The assessor needed to support people to identify how to meet their needs but not actually deliver those needs. It was important to make the distinction that the person assessing spiritual needs wasn't the person who had to deliver them and this should give the assessor greater confidence.

Practitioners should not show prejudices. They should value spiritual history. If someone is vulnerable we need to recognise the position of power held by those assessing. The language used to talk about spiritual issues should not be reluctant or reticent. Discussion of spirituality needs to be built into qualifications and training. Training also needs to look at where people come from.

It was felt that a person's entire spiritual and social history was important to understanding them and their needs. A proper social history should be taken for each service user, and this would include their spiritual history. There needed to be qualitative ways of assessing people in practice. It was acknowledged that the first assessment of a person was the most important. A person's contact with services the first time therefore should be via the most competent person because the history and assessment that is recorded is with them for the rest of their life. Importantly, standards should sit alongside competence.

How to assess, what words to use and how to start a discussion on spirituality was also debated. What are your sources of strength and hope – was a sample of a key question that could be asked even if it was a tick box to indicate that someone had sources of strength and hope they wanted acknowledged. What has helped the person through what they have been through? This question was also felt to be a good question to ask the practitioner teams as well.

Influencing commissioning and the people who made decisions "at the top" was seen as important if spiritual needs were going to be assessed and valued.

There had to be find ways of educating "the top floor" about the value of spirituality. It was mentioned that outcomes don't always help because this focuses too much on at numbers. Attitudes and issues needed to change – not only commissioning. There needed to be political will. Some of the political environment where commissioning takes place also needed to be challenged.

Finally, it was mentioned that carers' spiritual needs also needed to be addressed. This is especially important with people with learning disabilities. It needed to be considered that caring for someone is different from helping someone and that carers could influence the spirituality of someone in their care.

Example: Practitioners should know why they are performing a spiritual assessment:

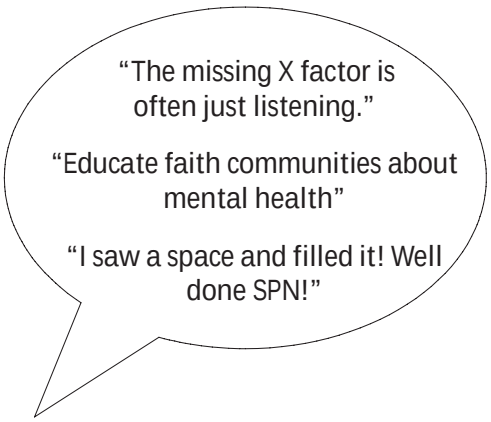
A Mental Health Primary Care Trust had spirituality as something that should be assessed on care assessment plans. In a crisis day centre, a service user was asked by a nurse "do you have any spiritual needs?" The service user was suspicious and asked why. The nurse could not answer, so the service user did not answer either.

Example: How do our systems cope with the basic principles of people's spirituality?

A taxi driver was telling a customer that, as a Muslim, he prayed five times a day. The customer commented that the taxi driver would earn less as a result. The driver said that was true, but his spirituality was important to him. How would our mental health system cope if a person whose faith was as important as the taxi drivers was admitted? Would they be able to pray five times a day and practice the elements of their spirituality that was important to their recovery?

Example: Valuing the subject even if not understanding it:

When a service user mentioned a loss of spirituality or faith to a social worker it was not addressed in the same way as other losses, such as a bereavement or divorce. However the loss of spirituality is a significant loss that should not be ignored. Personal faith can be people's life and the impact of this loss was discounted because the subject of the loss was misunderstood.



Sitting beside you

Peter Gilbert

Text from slides

"My spirituality is intensely personal and one of the few things I can really call my own. I fear professionals invading my personal space. It is important that those who are meant to care for me do not take over aspects of my identity".

Service User talking to Peter Gilbert.

Assessment

- Assessment is from the Latin: "Assidere" - to sit beside
- Working with - not doing to
- Compassion - means suffering with
- Empathy and respect.

What human issues need to be attended to in spiritual care?

Some issues:

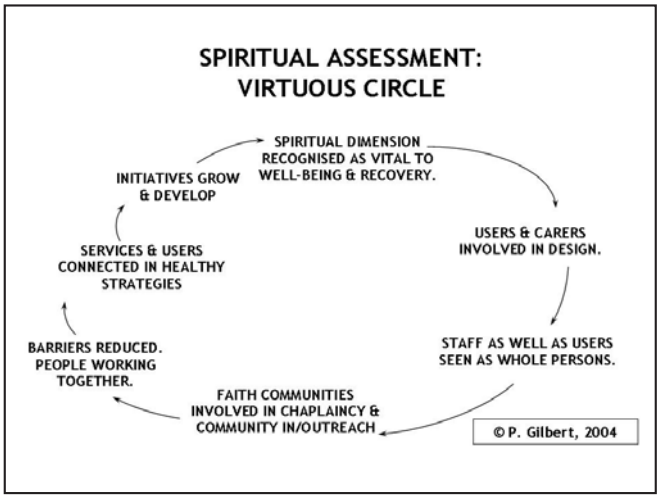
Meaning
Relationships
Identity
Travelling Identity
"Lost and found" Identity
Community
Beliefs
A sense of the holy
Language
Diet
Rituals
Space
Relationship with "the Other"

How can we involve faith communities appropriately?

What is good practice locally?

How would we want our spiritual needs assessed by services?

Spiritual Assessment:

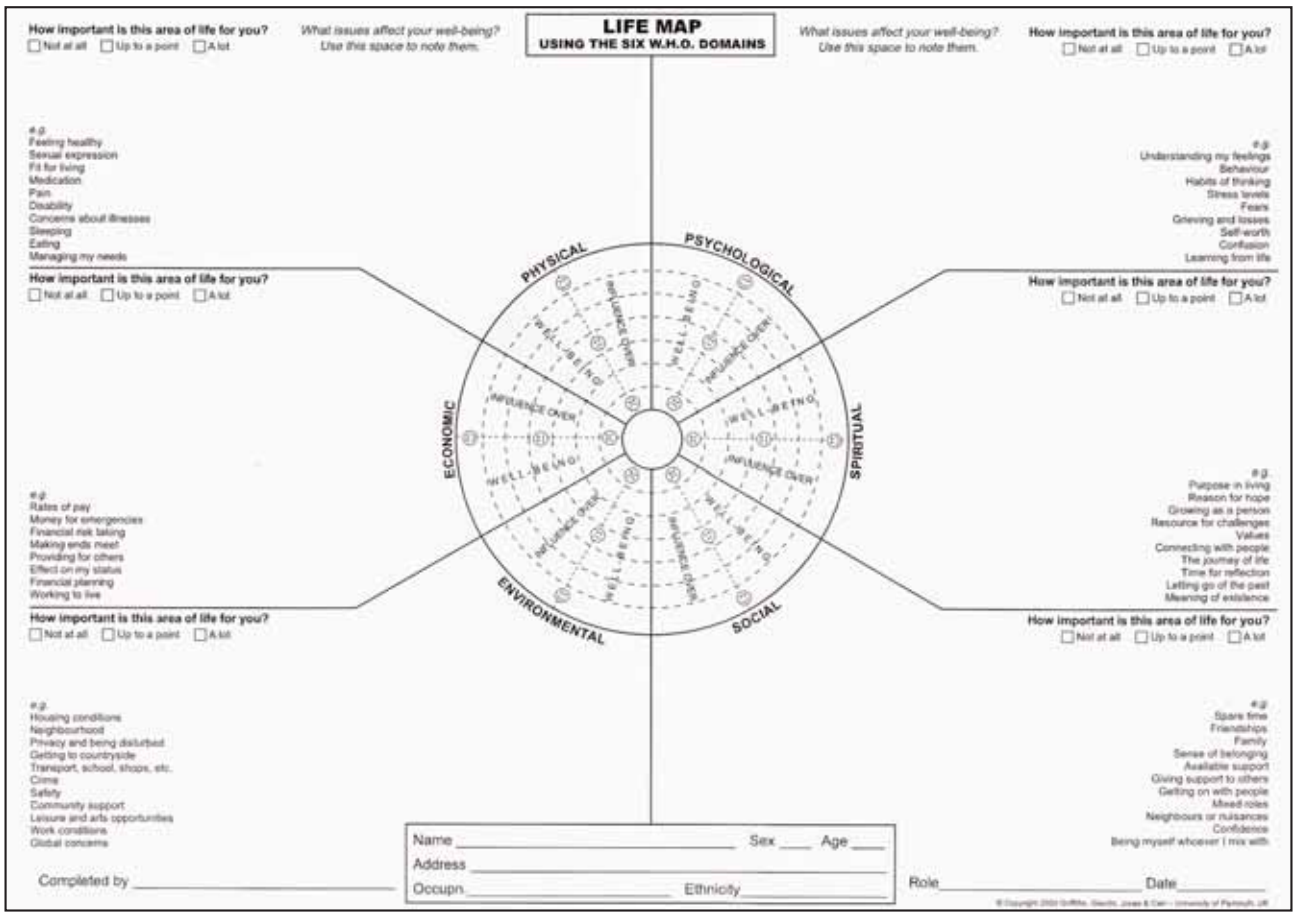


A possible assessment framework:

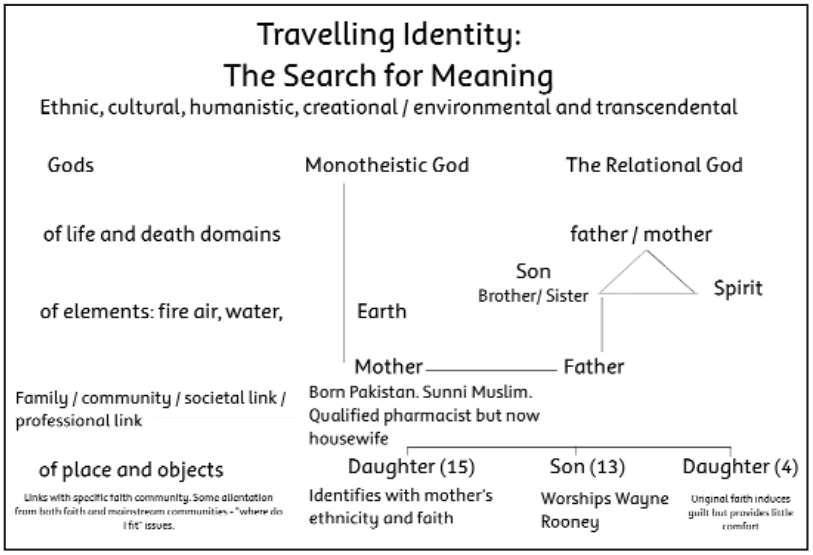
This framework for spiritual assessment, adapted from G. Fitchett, can be used as a means of analysing the spiritual narrative, or helping the client to reflect on his/hers.

- Belief, Meaning and Purpose: What are the ideas/beliefs [not necessarily religious beliefs] that give meaning and purpose to a person's life, and what are the important symbols and images that reflect them?
- Do any aspects of the person's narrative and her/his present situation come into conflict with this life meaning? How far is the world-view consciously articulated or simply implied in the narrative?
- Attention to such details will enable the practitioner to reflect back what she/he hears and so enable the explicit meaning of the narrative to be developed.
- Sources of Strength and Hope: where does the individual derive their strength from, and what gives them hope? Are these derived from individuals, groups, places, current or past experiences? What helps the individual draw strength and hope at a time of crisis?
- Vocation and Obligation: questions of importance here include, what sense of calling and obligation does the individual have in their life, and how are these expressed in relationships? How does this relate to their present illness?
- Love and Relatedness: how does the individual relate to those intimate with them, family, relatives, friends and others? Assumptions that families will be helpful or unhelpful are particularly dangerous here. Are there fractured relationships which need healing?
- Experience and Emotion: how does the experience of illness and the associated feelings relate to the individual's life meaning?
- How do the internal and external worlds of the individual relate to each other? How are 'negative' feelings handled, e.g. anxiety, guilt and anger?
- Courage and Growth: this axis involves questions about how the person has coped with crises in the past and how adaptable are their views/beliefs now.
- Rituals and practices: this explores the rituals which support the person's life meaning, and asks how they are being used in the present situation. Is, for example, the individual having difficulty in praying, if they have derived comfort from this practice previously; are they disconnected from rituals [e.g. sacramental practices] from which they have derived comfort and meaning?
- Community: this theme asks questions about the faith community of the individual. Who is the core community who give life meaning to him/her?
- How does the person relate to that community - as an active or passive member? How does the faith community relate to this experience of illness? Are there particular theological components here which need to be addressed, i.e. what does the manifestation of mental distress signify to that faith community?
- Transcendence: what is the spiritual dimension beyond the individual self? If there is a belief in transcendence [either God, gods, or some other transcendent form] what spiritual pathways does the individual use to accomplish transcendence? Can this be done individually, or are formal structures required?
- Authority and Guidance: where does the individual look for guidance about life meaning in moments of stress? Is this fixed or flexible? If there is a need for 'mediation' e.g. through an imam or priest etc., is such a person available e.g. through chaplaincy services?

Peter Gilbert, adapted from Narayanasamy, 2001, Fitchett, 1993, and Robinson, Kendrick and Brown, 2003.



Above: Life Map from Dr Trevor Griffiths and colleagues.



***Right*: Travelling identity: the search for meaning**
Ethnic, cultural, humanistic, creational /environmental and transcendental.

Spiritual and religious needs

Relationships

- ☐ The need for meaningful relationships
- ☐ The need to feel valued
- ☐ The possibility of intimacy
- ☐ The need to care and be cared for

Transcendence

- ☐ Dimensions other than physical/mental
- ☐ Assurance of the presence of the Other (God, Gods, the Moving Spirit etc.)
- ☐ Affective feeling
- ☐ Imagination
- ☐ Reassurance
- ☐ Comfort
- ☐ Peace
- ☐ Happiness

Meaning and Identity

- ☐ Gaining a sense of our essential self.
- ☐ Understanding the meaning of our lives in relationship to others and the Other.
- ☐ Having a sense and spirit of place.

Coping with desire(s)

- ☐ Understanding our desires.
- ☐ Coming to a balance between being and becoming, acceptance and striving.
- ☐ Detachment from material things while retaining openness to and joy in the senses.

Communication

- ☐ Talking with others and with the Other.
- ☐ Listening and being listened to. Being heard.

Religious needs:

- ☐ Prayer
- ☐ Reading from religious texts
- ☐ Lectio Divina
- ☐ Confession
- ☐ Catharsis
- ☐ Facilitation of discussions about the transcendent aspects of human existence
- ☐ Values / structures of meaning within a faith context
- ☐ Hope
- ☐ Faith
- ☐ Search for meaning/purpose to life in a faith context
- ☐ Dealing with guilt

P. Gilbert, adapted from J. Swinton, 2001

Rowan Williams' New Year message, 1 January 2005:

"What's the difference I can make to this situation, this person, to myself, to someone close, to someone whose face I know? The biggest picture we could ever hope for is the sight of what the human heart is capable of when complete love and trust are allowed to touch it. Think global, act local they say. What's the difference only I can make, however small, at this place, at this time?"

An Introduction to Meditation

Don Boyle - Day Services and Employment Co-ordinator, Oxleas NHS Trust

Don is a qualified Social Worker with more than 11 years experience as a manager of mental health services in local government, the NHS and the voluntary sector. He is Day Services and Employment Co-ordinator with Oxleas NHS Trust. He is also a management coach and Director of Doing-it Personal and Corporate Coaching which specializes in coaching applications in mental health. He has provided coaching input to people from many walks of life including business, education, health care, sports, art, theatre and cinema. He has been meditating for eight years and is a trainer with the World Community for Christian Meditation.

His contact details are 01322 356142 don.boyle@oxleas.nhs.uk

What is Meditation?

Every great religious tradition has meditative practice at its heart. Through meditation we learn to be wholeheartedly in touch with our great potential as human beings. Regular meditation helps our bodies to function more efficiently by dealing with stress and negative states of mind and it can have a profound effect on our well being and our health. Medical evidence shows that it lowers blood pressure and enhances the immune system. But the greatest significance is enhancing our sense of wholeness in body, mind and spirit. Meditation is simple, robust and practical.

The Mantra

A mantra is a word or phrase, usually ancient and sacred in origin, which is used in meditation to still our thoughts and focus our attention. The word "mantra" in Sanskrit actually means "mind protection". While we are engaged in the act of saying a mantra our minds are protected from negative thoughts and states of mind. Mantras exist in every tradition. There are Native American, Hindu, Buddhist and Christian chants and mantras. The repetitive and often sacred nature of these mantras can have a calming and focussing effect on our conscious mind and over time a profound stabilizing and empowering effect on our unconscious mind and our bodies. When used regularly they can be stabilising and empowering in stressful and challenging situations.

Examples of Mantras:

Tibetan:	OM MANI PEME HUNG
	OM AH HUNG VAJRA GURU
	PEME SIDDHI HUNG
	OM TARE TUTTARE TURE SVAHA
Christian:	MARANATHA
	JESUS
Hebrew:	SHALOM
Secular:	PEACE, LOVE, CALM

How to Meditate

Find a quiet place. Sit down with your back upright. Sit still and relaxed but alert.

Gently close your eyes and begin to recite your mantra, silently, interiorly and lovingly throughout the time of your meditation. Do not think about the meaning of your mantra. The speed at which you say the word should be fairly slow, fairly rhythmical. Some people say the mantra in conjunction with their breathing. Just give your attention to the sound of it throughout the time of your meditation, from beginning to end.

Whenever thoughts or images come, these are distractions at the time of the meditation so simply return to your mantra. You do not have to think or imagine anything, spiritual or otherwise. Do not use any energy in trying to dispel a distraction. Simply ignore it and the way to ignore it is to say your mantra.

The optimum is 30 minutes every morning and evening. You may find it helpful to start by meditating for five minutes at a time and build up.

Further Thoughts on Meditation

When we are meditating the integration and harmonising of our whole person is gradually taking place. The relaxation created by meditation allows the energy in us to flow more freely. Meditation helps us to live with more attention and, at a deeper level, with more sensitivity and compassion.

To Find Out More About Meditation

The Buddhist Society
58 Eccleston Square,
London, SW1V1PH
020 7834 5858

World Community for Christian Meditation
St Mark's, Myddleton Square
London EC1R 1XX
020 7278 2070
uk@wccm.org

Note from the study day organiser

Raza Griffiths

I am extremely grateful for the support from so many remarkable people who collectively helped make this study day the success that it was. I would like to thank Philip Douglas, NIMHE East Midlands Social Care Lead, for his unflagging enthusiasm and behind the scenes involvement as a private individual at all stages of planning; Asha Day, NIMHE East Midlands Race Equality Lead, for her brainstorming and emphasis on involving local communities; Rebecca Cowell, former SPN Administrator, in providing such capable and efficient administrative support, Venerable Arthur Hawes for his sensitive and able chairing of the day. I would like to thank presenter Peter Gilbert, for being a pioneer in this field, and for having got to the heart of the matter in his keynote presentation, which so eloquently set the tone for the day, Albert Persaud, for sharing his learning and wisdom drawn from many cultures with us in such a personal way, and for highlighting the issues involved around mental health for everyone in our multi ethnic multi faith society; Manjula Sood, for providing inspiration from her own story and speaking from the heart; Don Boyle for his bravery in leading a mass meditation session at 4.30pm; Rob Gee, for using a light-hearted approach to a serious subject in a way which made us think and Odi Oquosa, for enabling participants to connect with their dreams and healing energies through the medium of art.

Respect to Ken Blanton, Afua Nketia, Chris Cook, Hugh Middleton, Arthur and Peter (again) for providing us with such a dazzling array of interesting workshops covering so many different and complementary aspects of spirituality and mental health. We need more people like you to ensure that services engage with people's spirituality, because it is an integral part of who they are as human beings.

Thanks to all those note takers out there who did such sterling work in providing the write ups for this Paper – Terry Bamford, Rowena Harding, Vicky Nicholls, Asha, Judy Foster and Rebecca.

I would like to thank the current members of the SPN team. My fellow Co-ordinator, Vicky, for writing the Foreword to this Paper and for having been a guiding light through her earlier initiatives which helped put spirituality in mental health on the map. Thanks to Rowena, ex SPN Co-ordinator, for reappearing at SPN in the nick of time, designing this Paper and ensuring we were kept on track despite her busy international lifestyle, thanks to Terry, SPN Director, for taking the long view and determining that the day should go ahead as an SPN funded day, when other organisation's competing priorities made them decide to pull out.

The success of the day was in no small part due to the staff at the Riverside Centre - which was such a spacious, welcoming and itself spiritual venue. Thanks for all your patience with my obsession for organising every aspect of the day - the cheque's in the post!

Finally, I would like to thank all the delegates – the most important element of the day - for sharing their knowledge, insights and experiences so generously and helping to create such a unique buzz. Here is some of the general feedback about the day:

> "Great to have seen genuinely diverse turnout."
>
> "The warm up was a great ice breaker, a really good idea."
>
> "Good to not be in London and so accessible."
>
> "I really appreciated the opportunity to join you. Met many interesting people and learning much I didn't know before and will take it back to my community and use it."
>
> "Pity it wasn't a two day event. I could have attended all the workshops!"
>
> "I'm certainly following up my workshop and furthering my study on the subjects raised."
>
> "A very useful and reflective study day." "Both inspiring and challenging."
>
> "I did learn much from the participants questions and input."
>
> "More of the same please. We have to drive home that this is the way forward."
>
> "I liked it because of the equality felt by all delegates and the opportunity to network in different areas of the country."
>
> "Well done on a new topic in mental health – the day was very inspirational."
>
> "A well organised day with a good balance of speakers, activity and entertainment."

This Paper is SPN's way of trying to capture something of the spirit of the day, I hope we have gone some way to achieving this.

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Compiled by Vicky Nicholls

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About the Social Perspectives Network

The Social Perspectives Network is a unique coalition of service users / survivors, carers, policy makers, academics, students, and practitioners interested in how social factors both contribute to people becoming distressed, and play a crucial part in promoting people's recovery.

We aim to share work and information looking at mental health from a social perspective; to support people to put social perspectives into practice; and influence the development of mental health policy from a social perspective.

SPN's work takes the form of study days, published papers, media campaigning, and information provision through our website. SPN is committed to working alongside regional and local projects and promotes links to NIMHE Regions.

Through links with the National Social Inclusion Programme and the New Ways of Working for Social Work group SPN seeks to promote that the importance of social care and social work.

To become a member - for free - and receive our regular e-newsletter, simply join via our website.

To find out more about us, or to download our annual work plan, please visit www.spn.org.uk

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Social Perspectives Network's study day papers

1. Modernising the Social Model in Mental Health

Written in 2002, Maria Duggan's discussion paper on modernising the social model in mental health is just as valid today. The paper argues for policies and services that engage with the inner worlds and experiences of individuals and communities as well as with external social, economic and environmental factors. This paper is supported with references and case studies.

Maria Duggan 20 pages Study day: January 2002

2. What is the knowledge base and where does it come from?

Resulting from SPN's first study day, this paper looks at shared knowledge and territory of services users, practitioners and the public and how social factors can influence the delivery of mental health services.

Maria Duggan 16 pages Study day: 1 May 2002

3. Start making sense: Developing social models to understand and work with mental distress

A range of authors, including service users, explore different elements of the social and how to apply this to working in mental health. BME issues, gender, sexuality and user perspectives are presented in this well-referenced paper. Contributors: Jerry Tew, Peter Beresford, Sally Plumb, Jan Wallcraft. Jennie Williams, Sarah Carr

Jerry Tew et al 36 pagesStudy day: 11 November 2002

4. Where you stand affects your point of view: emancipatory approaches to mental health research.

A comprehensive look at the wider social and political contexts that exist and influence mental health research. Presents a number of approaches that try to redress the imbalance of power between the researcher and the researched. Topics include: race, user involvement, gender, research history, personality disorder. Contributors: Jeanette Copperman, Peter Ferns, Jerry Tew, Jan Wallcraft, Frank Keating, Angela Sweeney, Phil Alsop, Heather Castillo, Eleni Hatzidimitriadou, Amanda Harris, Tony Glynn, Stephanie Wells, Sarah Wright.

Jeanette Copperman et al 80 pages Study day: 12 June 2003

5. Falling through the gaps: looking for ways to fill the spaces between mental health services for children, young people and adults.

Written at the time of Every Child Matters, this report explores ways that children and young people's mental health can be supported into adolescence and adulthood. Covers crime, inter-agency co-operation, case-studies and good practice. Contributors: Rachel Hetherington, Judy Foster, Judith Trowell, Sheena Foster, Tina Foster, Keren Corbett, Ben Smith, Marie Diggins.

Rachel Hetherington et al 51 pages Study day: 24 October 2003

6. Integration of Health and Social Care: promoting social care perspectives within integrated mental health services.

With health and social work positioned to work together, this paper looks at the reality of joint working, issues of integration – including for service users, and learning from services already integrated in practice. Contributors: Tony Gardner, Peter Gilbert, Ann Davis.

Ian Redfern et al 36 pages Study day: 20 April 2004

7. Women's Mental Health: Turning rhetoric into reality

Containing speakers' and workshop notes as well as presentations, the report gives insight to a range of perspectives including survivors, women-only wards NIMHE strategy, prisons, violence, and suicide and honour in the Asian community. Informative, inspiring and accessible. Contributors: Jeanette Copperman, Jenny Willianms, Jolie Goodman, Gurpeet Virdee, Shirley McNicholas, Angela Linton-Abulu, Sally Plumb, Fiona Hill.

Jeanette Copperman et al 110 pages Study day: 2 March 2005

8. Work for Health?

Who supports people with mental distress back into the workforce? Are government benefits supportive or detrimental? How best can an employer support someone back into employment? And how important is work to people with mental illness? These are some of the questions tackled in this paper. Contributors: David Morris, Raza Griffiths, Don Boyle, Mina Sassoon, Laura Lea, Richard Frost, Stephen Robinson, Sheila Barrett, Conny, Simon Francis.

David Morris Et al 45 pages Study day: 7 June 2005

9. Reaching for the spirit

Spirituality is of fundamental importance to many peoples' lives, but is often overlooked, undervalued or seen as difficult to engage with. This paper looks at the role of spirituality as part of a faith or a more personal quest for meaning and how we can more effectively assess, support and discuss the spiritual dimension.

Peter Gilbert, Albert Persaud, Manjula Sood et al 45 pages Study day: 4 April 2006

Values and Methodologies for Social Care Research

There is still room for improvement when service users are asked to work with and be involved in research into mental health / service users, carers and survivors are still not being involved in social research in the best way possible. SPN seeks to redress this with the publication of a new book looking at how research can be conducted that involves service users in an effective and meaningful way. Contributors: Jerry Tew, Nick Gould, Deian Abankwa, Helen Barnes, Peter Beresford, Sarah Carr, Jeanette Copperman, Shulamit Ramon, Diana Rose, Angela Sweeney, Louise Woodward.

Jerry Tew, Nick Gould et al 45 pages Published: July 2006

Reaching the Spirit

Spirituality is of fundamental importance to many people's lives, but is often overlooked, undervalued or seen as difficult to engage with. This paper looks at the role of spirituality as either part of a faith or a more personal quest for meaning, and how we can more effectively assess, support and discuss the spiritual dimension.

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