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Seeking inspiration: the rediscovery of the spiritual dimension in health and social care in England

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Not so long ago Western society assumed that its citizens would get progressively richer and more leisured, and that inequality would not matter. There was also an assumption that health and social care services would simultaneously become more technically proficient and more concerned with a person's dignity and their individual needs. This paper considers this theme, looks at the current state of health and social care and the need to bring a sense of the spiritual back to revivify the service.

Keywords: society; consumerism; spirituality; happiness; faith communities

The mind without the soul?

So many of our concepts of “Western” society in general, and health and social care in particular, derive from the ancient Greek philosophers and Abrahamic faiths, though this may be increasingly tempered by changes in migration patterns and a growing attraction to Eastern philosophies and religion. The “credit crunch” which swept through not only the financial world but that of our domestic economy in 2008/2009 and the breakdown in political trust over Members of Parliament's expenses in the UK's House of Commons in 2009 have profoundly shaken civic life. There is an assumption that citizens of the Western world would become richer and thus happier; but in fact economic uncertainty and anxiety have risen; and it has also become evident that social mobility has decreased while economic inequality has increased, producing a detrimental effect on human health and happiness (see Atherton, Graham, & Steedman, 2010; Marmot, 2010; Wilkinson & Pickett, 2009; Wintor, 2009). Politician, and economic commentator, Vincent Cable speaks pithily of “Hubris” “giving way to nemesis” (Cable, 2009); and it is sign of our lack of proportion that there is talk of recovery when the banks profits start to rise but ordinary people face the bleak outlook of unemployment and homelessness. A cartoon in July 2009 captured this sense of irony neatly when pictured two homeless people sheltering under newspapers bearing the message of: “green shoots of recovery!”

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Rates of mental illness have risen in the “developed world” at a significant rate, and perhaps the most worrying aspect is the declining mental health and well-being of children (see Alexander, 2007; Layard & Dunn, 2009). As Layard and Dunn put it in their book of The Children’s Society report: “How can we raise confident, happy and creative human beings if we do not have some shared ideas about what human maturity and happiness look like?” (p. 172). As liberal capitalism, or what Madeleine Bunting calls “the narcissism of consumer society” (Bunting, 2009) fails, it is often the religious traditions who remind us of the benefits of social solidarity as opposed to what Layard and Dunn term: “excessive individualism.” Chief rabbi, Dr Jonathon Sacks, asks how we can take steps *To Heal a fractured World*,” and calls for the “ethics of responsibility” (Sacks, 2005), while Pope Benedict XVI, in his *Caritas in Veritate* (Benedict XVI, 2009), urges that globalisation should be about a cycle of moral consequences for “the common good,” rather than an exercise in exploitation to serve the privileged few, those whom sociologist, Zygmunt Bauman has called the new “absentee landlords” exercising “unanchored power” (Bauman, 1998, pp. 3 and 9).

Aristotle stated in his *Nicomachean Ethics* that: “Happiness is the meaning and purpose of life, the whole aim and end of human existence.” The constitution of the United States, aping ancient Greece and Rome, enshrined the dictum that we should be pursuing: “life, liberty and the pursuit of happiness.” But, in his recent work, Richard Schoch states that:

Unhappy is the story of happiness. More than 2000 years ago, when the ancient Greeks first thought about what constitutes ‘the good life’, happiness was a civic virtue that demanded a lifetime’s civilisation . . . We have lost contact with the old and rich traditions of happiness, and we have lost the ability to understand their essentially moral nature . . . We settle, nowadays, for a much weaker, much thinner, happiness: mere enjoyment of pleasure, mere avoidance of pain and suffering. Somewhere between a Plato and Prozac, happiness stopped being a lofty achievement and became an entitlement (Schoch, 2007, p. 1).

We tend to associate the origins of medicine with Hippocrates of Cos, a contemporary of Socrates (fourth century BC). Even at that stage, there was already an impressive body of empirical data on most aspects of medicine, with a great deal of emphasis on aspects on what we might call public health: diet, exercise regimes, etc. Interestingly, although the medical guild officially came under the protection of the God Asclepius, Oswyn Murray remarks that: “There is virtually no recourse to divine explanations for illness or cure,” though, Murray goes on to remark that: “Perhaps the two attitudes to medicine coexisted in much the same way as orthodox medicine and homeopathy today” (Murray, 1986, p. 231).

It would not be surprising if they did exist co-operatively. The Greek ethos was essentially holistic, with the individual’s mind, body and spirit being seen as parts of the whole; with the individual citizen, as a member of civil society and political activity (the Greek *polis* being the word for city), abjured to lead the virtuous life. For Aristotle (see Annas, 1986) happiness was not merely individual contentment, least of all the seeking of pleasure, but the flourishing of an individual in the wider society, with an injunction to live our lives on a virtuous basis. Some of this approach is being rediscovered in “leadership” literature in the search for authenticity (see George, 2003) and ethical leadership (see Gilbert, 2005).

Plato and Aristotle are often placed in opposition. In the famous painting by Raphael, Plato holds a book on abstract metaphysics and points to higher things, while Aristotle clutches his *Ethics* and indicates we should keep our feet on the ground. But in fact

Aristotle argued strongly against a crude materialist approach. While one of Plato's famous quotations is:

As you ought not to attempt to cure the eyes without the head, or the head without the body, so neither ought you to attempt to cure the body without the soul . . . for the part can never be well unless the whole is well (Phaedrus, quoted in Ross, 1997).

Of course, there were many deficiencies in Ancient Greek society, but what the philosophical tradition seemed to effect is intellectual and material progress for the individual citizen without, as Murray points out, "causing him (sic) to lose his social identity" (1986, p. 232).

Psyche and separation

In Greek the word *psyche* is used for soul, mind and spirit. It has connotations of breathing and life, and speaks of the individual spirituality; while the other Greek word, *pneuma*, wind or breath, relates to a transpersonal, cosmic soul (see King, 2009). This combination of the physical and the ephemeral runs through Western civilisation. But it is often brought up short by humankind's tendency to want to have one conceptual landmark to cling to. Considering the individual without looking at the society in which he or she lives; being cognisant of the human species without other species or a wider cosmology; looking purely at idealised forms or what we can ascertain with the naked eye are just not sensible attitudes, and yet we do them all the time. When Oxford professors are reduced to placing slogans on buses, one knows that evolution is not a smooth and upward path. Christianity and Islam are sometimes criticised for concentrating far too much on the transcendent than the material. And yet it was Arab thinkers who kept the torch of Greek philosophical thought alight, Muslim thinkers such as Averroes, the Christians Aquinas and Anselm, and the Jewish, Maimonides formed a dialogue which rekindled thought in the post Hellenic period. As the ethos of the age degenerated from enquiry to inquisition, it is hardly surprising that the Enlightenment sought a greater accent on rationality through philosophers such as David Hume and Dennis Diderot. In the Middle East, Islamic reform movements pushed the more mystical Sufism to the margins (see Armstrong, 1999).

With the Enlightenment came a range of technological and social innovations, and perhaps a subtle move to see happiness as material improvement. As Karen Armstrong puts it: "Specialisation was crucial to this Western technical society: all the innovations in the economic, intellectual and social fields demanded a particular expertise in many different fields" (Armstrong, 1999, p. 345). This was a considerable move away from the more rounded approach of the Socratic Greeks, and even from the Renaissance, in the sense that we still call people with multi-talents: Renaissance men or women.

Perhaps one of the major problems with the concept of rational humankind is essentially the same as seeing human beings as purely spiritual. Humanity is much more complicated than that, and to create a civil society, and a mentally healthy community, which works for all requires a secular, legislative framework; a concept of citizenship; and ethical frameworks which may be humanistic and/or religious. At the time of writing, Maximilien Robespierre, one of the French leaders at the time of the 1789 Revolution, is arousing fascination. Robespierre was much influenced by the writings of Jean-Jacques Rousseau, and his novel *Emile*, which postulated that human beings were naturally good. It is one of the paradoxes of history that Robespierre, with his image of "a democracy for the people, who are intrinsically good and pure of heart," (Scurr, 2007, p. 11) eventually

created the Terror. Robespierre, initially had a revulsion against the death penalty, but ended up using it almost casually. Scurr's (2007) description of his nature as "fatal purity" captures the way that apparent rationality can turn into fanaticism.

In the nineteenth and early twentieth century, the Eugenics movement of Francis Galton and others, argued for a forcing of evolution through racial purification. Many social reformers were swayed by this idea, and the sterilisation of people with learning disabilities and mental health needs was brought into a number of European and North American states. In fact, the United Kingdom missed this by a hairs breath (see Jones, 1993, chap. 7).

Writing about the little known Austrian dictator of the 1930s, Engelbert Dollfuss, A.D. Harvey points out that ironically, although Dollfuss' Catholicism "was a religion of order, obligation and discipline and was as authoritarian as Hitler's national socialism . . . it was precisely because he (Dollfuss) was Catholic that he could not have countenanced the racial eugenics of Hitler's Third Reich" (Harvey, 2009).

If medicine as a whole was moving into a more mechanistic mode, there was even more pressure on psychiatry to be as scientifically rigorous as possible. Psychiatrists Patrick Bracken and Philip Thomas, taking a broad historical sweep, speak of a dominant post-Enlightenment discourse of a technological and reductionist approach which tends to relegate issues of context to secondary status, and to try and attempt "to explain aspects of our meaningful reality in terms of non-meaningful entities such as genes and neurotransmitters," resulting in a three-fold approach of:

- The importance of experts who hold privileged accounts of what is occurring
- The technological framing of problems
- Methodological individualism – focusing on decontextualised aspects of a person's behaviour, for example, symptoms (Bracken & Thomas, 2005, p. 6)

Men and women in suits

Charles Webster's *The National Health Service: A Political History* (Webster, 2002) starts with Aneurin Bevan's famous quotation: We ought to take a pride in the fact that, despite our financial and economic anxieties we are still able to do the most civilised thing in the world – put the welfare of the sick in front of every other consideration (House of Commons, 9 February 1948, Webster, 2002, p. 1).

Issues around public and acute health; the place of mental health in society; public versus private provision and a sensible way of managing a complex service are still live issues in the United Kingdom, especially as public spending is likely to be cut following the 2010 election. There are also crucial issues in America as President Obama moves to try and get his health care reforms through the United States legislature in 2009/2010 (see Gorsky, 2010; McGreal, 2009).

Eric Midwinter in his overview of the development of social welfare in Britain speaks of four recurring themes through British social policy in welfare:

- The public/private compromise, the balance does not always appear to run entirely predictably in political terms, especially with New Labour's drive towards PFI and Foundation Trust status since 1997.
- The central/local compromise, where citizens in many ways favour local solutions, but also kick against "postcode lotteries." The shape of health service

commissioning and regulation has changed markedly over the last 10 years, leaving the public largely at a loss as to who to look to when things go wrong.

- The domestic/institutional compromise with an accent on domestic and community solutions widely welcomed: but some nostalgia for group initiatives and some suspicion of the move towards personalisation. Ivan Lewis MP, when Health Minister, coming from his Jewish background, spoke of the importance of “interdependence” as well as “independence” and these sometimes move in opposition to each other.
- The services in cash or kind compromise – also an issue in personalisation.
- One might add another compromise: the equipoise between liberty and safety, especially in mental health services, where the changing legal framework since the mid-nineteenth century has seen constant shifts between the liberty of the subject and the safety of the subject and the safety of others. The major reason that the 2007 amendments to the 1983 *Mental Health Act* took so long to come to the statute book, following the initial investigative committees in the late 1990s, was the debate around public safety and individual liberty.

These tensions are easy to describe but very difficult to resolve. A further one is that around leadership and management. I worked as a Principal Social Worker in one of the old learning disability hospitals between 1981 and 1987. The hospital was run by a highly authoritarian and traditional consultant psychiatrist with an alcohol problem, and a senior nurse who was a bully. The administrator had sound values but was ineffective. Patients were moved around to suit the needs of the service not their individual needs. There were a number of nursing, social work and psychology staff who remain heroes to me to this day for championing their service users against the system. At one point the powers that be demanded that the Council remove me because I was too challenging. Fortunately, the council refused! The Griffiths management reforms, following his report to Government in October 1983 (see Webster, 2002, pp. 167–174) brought in general management. This was resisted by many professionals, but in many ways was a sensible and sound approach to running a complex service. One clear failure, however, has been the lack of sympathy and partnership between managers and clinicians in many health situations. There has also been a failure to appreciate the wider public health agenda and partnerships with other agencies. Someone with severe mental health needs, or an elderly person coming out of an acute general hospital following a hip operation, are not just people with clinical needs, they are human beings with personal, spiritual and social needs. Unless the health service is able to effect, not only treatment, but a plan that incorporates their rehabilitation and resettlement back in their home and home communities, then it becomes an “ill-health” service (see The Patients Association, 2009).

The organisational changes from health authorities to primary care group to primary care trusts of varying sizes, combined with a move from regional health authorities to strategic health authorities (SHA’s) has left the public confused and many clinicians, especially General Practitioners, alienated from changes that are meant to effect a “world class commissioning service.” A recent Healthcare Commission report referred to the “loss of organisational memory at an SHA, which had impacted on local services” (HCC, 2009). With the move towards Foundation Status, many designated leaders in both acute general hospitals and mental health services have in effect been marooned in their offices poring over paper chases rather than concentrating on what Lord Darzi terms: “High quality care for patient and the public” (Darzi, 2008). Darzi’s concern was to focus on quality;

create better partnerships both within health organisations and with vital partners; and to improve clinical leadership. A vivid example, however, of what constant organisational change had created, was shown in the BBC2 2007 series: *Gerry Robinson saves the NHS*. In a northern acute general hospital, Robinson found disgruntled patients; frustrated staff; and expensive plant lying idle. He had to persuade the Chief Executive, who was clearly at heart a man with expertise and good values that it was important for him to get out of his office and see what was going on, on the ground. This is so blindingly obvious that it points to a blinkered mindset in too much of acute sector health management – fortunately less so in mental health and in social care.

Charles Webster directs attention to New Labour making “A serious error of judgement in adopting the hospital inpatient waiting list as the main yardstick of improvement.” While this did in fact reflect an issue of public concern, when in Government, the policy was confused and “When put into practice it risked doing more harm than good” (Webster, 2002, p. 221). In 2009, a scandal erupted around the disclosure of between 400 and 1200 unnecessary deaths at the Mid Staffordshire NHS Acute Hospital Trust in the three years to March 2008 (see Gould, 2009). The Health Care Commission (now superseded by the Care Quality Commission) pointed to an obsession with targets and finances over the care of patients. Strangely, Monitor, the body set up to approve NHS trusts for Foundation Status, had apparently failed to consult either the Regulator or the Strategic Health Authority before awarding the Mid Staffordshire Trust Foundation Status. An extraordinary example of non-joined-up governance.

At the end of her revised history of mental health services, Kathleen Jones, points to a policy of “Drift and don’t care” serving “a number of very powerful vested interests” (Jones, 1993, p. 254). Since the mid 1990s, major programmes of work through the National Service Framework, the creation of NIMHE, and a powerful coalition of service users, carers, and professionals, has carried mental health forward. But with the credit crunch, we are also now at a situation where Jones on her wider work on social policy in Britain, signposts a move to a greater US-style individual autonomy, without perhaps the necessary safety net (Jones, 2000).

Service users, carers and professionals are increasingly wanting a more personal service, with greater control and choice (but not necessarily unlimited and complex choice which they don’t understand!) As Jenni Russell pointed out recently:

What we all prize in our encounters with others is a sense of our value. We are social animals, alarmed by the uncertain world in which we live, with a profound need to be recognised, respected and responded to. We want public services to respond to us as people, and to give us the sense that we matter. It is the deepest human need. (Russell, 2009)

Personal, however, does not necessarily mean “personalised.” Not only, do we not want what Russell calls a “robotic calculus,” but we also do not want the politics of abandonment.

The recent BBC 2009 Reith lecturer Michael J. Sandel brings us back to Aristotle. In his contention that there are moral limits to the market, Sandel reminds us that “Severe inequality undermines freedom by corrupting the character of both rich and poor and destroying the commonality necessary to self-government” (Sandel, 1998). As Aristotle put it, a society of extremes “Lacks the spirit of friendship” self-government requires. “Community depends on friendship,” he wrote, “and when there is enmity instead of friendship, men (sic) will not even share the same path” (Aristotle’s, *The Politics*, 1946 translation).

Rediscovering *psyche*

The Greek work *psyche* encapsulates within it soul, mind, spirit, breath and life. As Andrew Sims and Christopher Cook, in the recent Royal College of Psychiatrists publication: *Spirituality and Psychiatry* (Cook, Powell, & Sims, 2009) point out that: “Historically, much psychiatric care has been provided within a spiritual or religious context” (p. 1), and that religious foundations, such as the Quaker Retreat at York have often provided a gentle challenge to current orthodoxies. Taking a line not dissimilar to Bracken and Thomas’ approach to nineteenth and much of the twentieth century, Sims and Cook state that:

By the middle of the 20th Century, with science dedicated to material realism and with the arrival of modernism in philosophy, reductionism had come to dominate medicine. Man was ‘nothing but’ an excessively cerebral erect ape; human behaviour was ‘nothing but’ Pavlovian conditional or Skinnerian operant conditioned responses. Sigmund Freud had asserted that belief in a single God was delusional and that all religion is a mass neurosis (p. 3).

During the 1990s an increasingly strong user voice, often looking to America and Australasia, and concepts such as Recovery, with its accent on service user control and hopefulness, became increasingly a force for change. At the same time a phenomenon that had happened in the United States and Canada began to happen in the United Kingdom. In North America practitioners from a number of professions, when leaving their educational establishments and entering practice, had found that many service users wished for an attention to their spiritual dimension which the practitioners did not feel equipped to undertake. While North America is a much more ostensibly religious country, with a much higher recorded attendance level at churches, mosques and temples than in the United Kingdom; still census results in Britain show that many people like to affiliate themselves in some way with a faith, perhaps as a means of expressing that they are not simply a statistic?

In the United Kingdom, the Royal College of Psychologists formed their Spirituality and Psychiatry Special Interest Group in September 1999 and two years later Professor John Swinton, from a nursing and chaplaincy background published his influential *Spirituality and Mental Health Care: Rediscovering a “Forgotten” Dimension* (Swinton, 2001). Since then, publishers have found a ready market for a wide range of publications around the issue of spirituality, including: *Spirituality, Values and Mental Health: Jewels for the Journey* (Coyte, Gilbert, & Nicholls, 2007) which is based very strongly on the user and carer experience.

The Royal College uses the following as a working definition of spirituality:

Spirituality is a distinctive, potentially creative and universal dimension of human experience arising both within the inner subjective awareness of individuals and within communities, social groups and traditions. It may be experienced as relationship with that which is intimately ‘inner’, immanent and personal within the self and others, and/or relationship with that which is holy ‘other’, transcendent and beyond the self. It is experienced as being of fundamental or ultimate importance and is thus concerned with matters of meaning and purpose in life, truth and values (Cook et al., 2009, p. 4).

As disillusionment with a mechanistic approach to health and social care increases; and it is increasingly evident that both those who use and services and those who provide them must find a mutual sense of meaning and purpose in the journey of diagnosis, treatment, cure and/or care, a spiritual approach becomes more and more persuasive and prevalent. A stress on those who care is also a major factor, with repressive and bullying approaches coming to light whenever there is a scandal in the health and care sector

(see Gilbert, 2005; Rogers, 2009). As Cook et al. (2009) point out the word “psychiatry”; contains both the word *psyche* (soul or spirit) and *iatros* (doctor). This highlights the integrated approach and partnership between the provider and the user, and the fact that those who provide services must to integrated individuals. At a retreat, that I was running recently at the Benedictine Abbey of Worth, in Sussex the following exchange occurred:

“‘Jim’ (a lawyer): well, if I’ve got a ‘nasty’ I want you, as the doctor, to ‘zap’ It!”
 “‘Ben’ (a doctor) “I quite understand that and I would use the best of my knowledge to ‘zap’ ‘your nasty’. But it is really important for me to say, that if I don’t treat you as a *whole* patient, I cannot be a *whole* doctor.”

There is still evidence of an overemphasis on mechanistic approaches, with concerns in the United States of misdiagnosis of hyperactivity in children as bipolar disorder, and issues in the United Kingdom of the prescribing of certain antidepressants to pregnant women resulting in birth defects (Bosely, 2009). One can understand the fascination with forensic approaches, but there is a danger of “CSI-psychiatry.” The new UK governmental policy on mental health: *New Horizons* (DH, 2009) brings with it a broad vision of mental health which reaches beyond services into attitudes, health promotion and prevention.

“No talking of God”

“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 “Twisted Mind,” Sue Holt, 2003, my emphasis)

This poem by Sue Holt, and its ringing phrase “no talking of God” in many ways encapsulates the whole ethos of the National Spirituality Project which commenced in September 2001. While the Project was founded intuitively, and for me it was an addition to my main role within the core group of the National Institute for Mental Health in England (NIMHE) on social care, I quickly learnt that this was a major subterranean issue just waiting to burst to the surface and flood expressively. Once a project on spiritually had been announced, people immediately began to ask, in sessions across the country: “Are we allowed to speak about this issue?” Perhaps very naively I asked why they needed to pose that question, and their response, unanimously was that: “In mental health services if you mention God or your spirituality, they up the medication!” The actual founding of a specific project under the aegis of NIMHE actually granted, what I came to call “strategic permission” to open up this subject. The interest from service users, carers, professionals and communities has been overwhelming.

Engaging the spirit: the NIMHE spirituality and mental health project

It was Professor Antony Sheehan, then Chief Executive of NIMHE, who intuited the need for an approach to spirituality, as a response to the traumatic and iconic events of 9/11 in America and the widespread effects on a huge range of people, especially, of course, Muslims in western countries; and also, a groundswell of opinion from service users, carers and survivors, that their spirituality should, in the words of the Somerset Spirituality Project, “be taken seriously” (Mental Health Foundation, 2002).

The Project (now managed by the National Mental Health and Spirituality Forum) focuses on two main issues:

- Spirituality as an expression of an individual’s essential humanity, and the wellsprings of how they live their lives and deal with the crises which can leave us drowning, rather than waving! It is, therefore, an essential element in assessment, support and recovery, for users and carers in a whole-person and whole-systems approach. It is also vital in the approach to staff, in order to create genuine person-centred organisations (see Aris & Gilbert, 2007)
- The establishment of positive relations with the major religions, at a time when a harmonious construct between statutory agencies and faith communities is essential; and when research studies are indicating the benefits to physical and mental health and longevity, for those who are members of inclusive and supportive faith communities.

This is aligned with the imperative for greater social cohesion and the positive role faith communities can play in family and community life (see Cox, Campbell, & Fulford, 2007).

The aims and objectives of the Project (see NIMHE/Mental Health Foundation, 2003) follow closely on the two main foci, in that the Project aims to:

- Chart what is known about the role of spirituality in mental health; the role of religion; and the role of faith communities;
- Identify areas of good practice;
- Build coalitions of individuals and groups;
- Develop and create linkages with other NIMHE programmes;
- Set up Pilot Sites/Collaborative, linked to regional development centres, which would learn from, test, develop and promote positive practice.
- Bring together the growing body of research evidence on the importance of spirituality in mental health and stimulate further research;
- Influence curriculum formation for all professional groups and to strengthen staff development at a front-line level;
- Support the role of chaplains (from all faiths), as part of the multi-disciplinary team.

Over the years, the Project has built constructive links with religious groups and foundations. It has been important to liaise with national umbrella organisations, such as the Inter-Faith Network and the Three Faiths Forum. Maintaining effective links with the Church of England’s Home Affairs Advisor, has been crucial, not least because of the national church’s links with other faiths. Relationships have been patiently built with the nine major faiths with which the Government liaises: Baha’i, Buddhist, Christian, Hindu, Jain, Jewish, Muslim, Sikh, Zoroastrian and also the Humanist Society. A multi-faith conference (*Nurturing Heart and Spirit*) was held at Staffordshire University in November 2006, which engaged all 10 belief systems, with a strong user voice to focus

on the difficult issues around mental health and belief, for example, suicide, possession, etc; and also consider the synergies between belief systems (see Gilbert & Kalaga, 2007). A second conference was held on 8 January 2008 (see Gilbert, 2008, DVD), on end of life issues (*From the Cradle – To Beyond the Grave?*) and a third in January 2009 on *The Flourishing City: The role of spirituality in regeneration*. A colloquium on meaning in dementia is to be held in March 2010 at the Nishkam (Sikh) centre in Birmingham (hosted by Sikh and Roman Catholic organisations).

Considerable work has been done on individual spirituality and engaging in faiths, through the National Spirituality and Mental Health Forum (Co-Chairs Dr Sarah Eagger and Ven Arthur Hawes), which had its provenance back with the health promotion charity, Mentality, and became a registered charity in 2006 (see Aaron, 2008). The Project also kept in touch with the then Prime Minister's Adviser on Faiths, John Battle MP.

The Project never forgets that many people will not be signed up to a specific belief system. They may, in fact, have a faith in The Divine/Cosmic Spirit, but no adherence to a particular religious system. Many people move in and out of belief and different communities. One of the products of a diverse cultural society is that people will move from one faith to another or one denomination of a faith to another; or from faith to no faith and back again – especially at times of crisis! Some of the most desolate stories are from those who say that they have lost their faith and desperately want to believe, but belief is no longer with them.

In 2004 the Project produced a framework for what were called Pilot Sites, or the Spirituality Collaborative (see www.nimhe.org.uk), which involved Mental Health Trusts and their community partners signing up to a permissive framework, stressing adherence to local needs and culture. Bradford Care Trust, for example, has a project around those Muslims who feel that they are possessed by a *jinn*, or spirit, while such an approach may not be so relevant in other parts of the country. A national symposium was held for the Pilot Sites/Collaborative at Lincoln University in May 2006. Regional events, to provide mutual support and shared good practice, have also been held, and there are some robust regional networks.

Work has been carried forward at a Government level in England, Scotland and Wales. In England work has been taken forward with the Department of Health and the Department of Communities and Local Government; liaison is maintained with the Scottish Executive, which has followed up its 2003 policy document with an update in October 2006 (NHS National Services Scotland, 2002, 2006), and the Welsh Assembly Government is working on a policy on spiritual care.

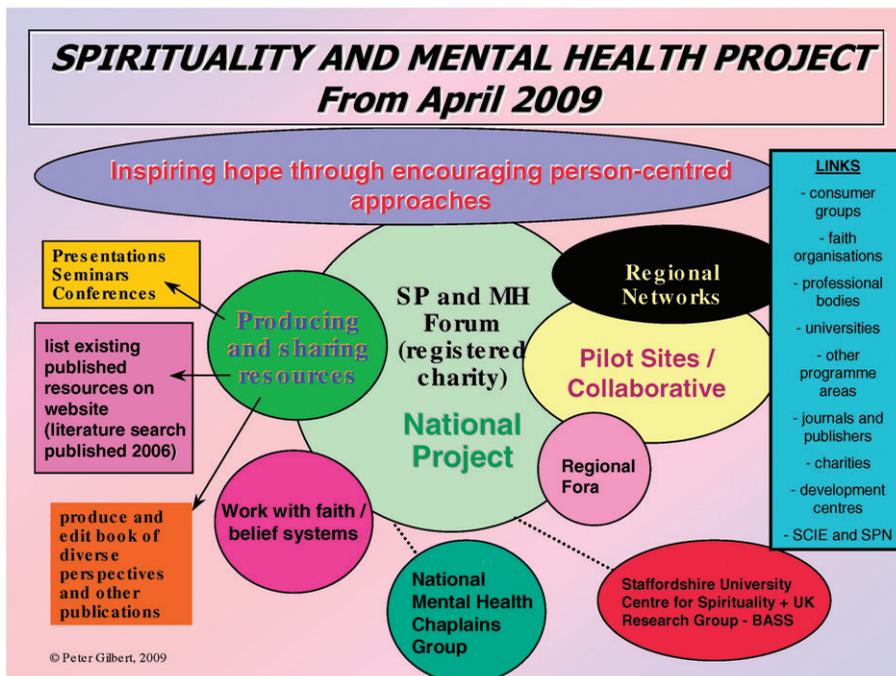
A growing number of university centres interested in spirituality, are now joining together to form a research association: the British Association for the Study of Spirituality (BASS), launched in January 2010. Research from America (see Swinton, 2001, 2007) indicates considerable benefits in terms of mental and physical health and longevity from being a member of a faith community. Recent research from the United Kingdom (King, Weich, Nazroo, & Blizard, 2006) is more equivocal, and raises issues for further study; one being whether a heightened sense of spirituality, with no affiliation to a community, either faith-based or secular, leaves an individual prone to, what Lewis Wolpert calls, "malignant sadness" (Wolpert, 2006). The partnership work between NIMHE and the Mental Health Foundation led to a literature review in 2006 (Mental Health Foundation (Cornah), 2006).

Support has been provided to professional groups wishing to bring the spiritual dimension into their curricula. The Royal College of Psychiatrists is moving on this, and spirituality formed a part of the Chief Nursing Officer's review of mental health nursing

in 2006 (DH, 2006b para. 5.4.7 and recommendation 10). Social work's more de-centralised arrangement for education and training has meant some detailed work by Professor Bernard Moss from Staffordshire University, Professor Margaret Holloway from Hull University and others (see e.g. Holloway & Moss, 2010; Moss, 2005). Christine Mayers, from Occupational Therapy, has also written extensively (see Johnston & Mayers 2005).

Productive working relations were maintained with other NIMHE programmes and projects, for example, delivering race equality, values, recovery, workforce, whole life, etc. In the autumn of 2008, guidance on spirituality was produced for staff in acute mental health services, in collaboration between NIMHE/CSIP and Staffordshire University (CSIP/Staffordshire University, 2008).

The spirituality and mental health project



Since April 2008 the National Project has come under the umbrella of the National Forum (see Aaron, 2008). One of the National Project's main aims under the Forum, which since April 2009 has a three-year grant from the Department of Health to continue its work, is to ensure there is a positive and supportive connection with the head of spiritual and pastoral care/chaplaincy in each mental health trust; and to sustain and create networks in the eight regions of England. Some Trusts (e.g. Sussex, Birmingham and Solihull, Sandwell, East London) have sophisticated spirituality strategies (see Parkes and Gilbert, and Harlow in this edition); others are making great strides in that direction; while others again have a very low investment in spiritual and pastoral care, with isolated chaplains struggling bravely to make headway. Most regions have groups, through the College of Healthcare chaplains, which encompass all sections of health and social care chaplaincy. Some others have additional mental health networks (e.g. East Midlands, the North East

and West Midlands) which bring together spiritual and pastoral care, delivering race equality workers, faith communities, voluntary groups and other interested parties.

As an evidence-base is vital, and Swinton has charted the essential differences between research in the United States and in the United Kingdom (see Swinton, 2007) the new BASS will play a vital role in looking at the interaction between spirituality and health care generally, and there will be an international conference in May 2010. As can be seen in a further article in this Edition, Birmingham and Solihull Mental Health Trust are looking specifically at that relationship within mental health (see Parkes et al. in this issue).

On a personal note, being involved in the Project has been an intense personal journey, a pilgrimage, which has led to my feeling extraordinarily privileged to be working with people who have bared their souls to make mental health services a more meaningful and personal experience (see Bolam, Carr, & Gilbert, 2010; Gilbert, 2010), as Kathleen Jones, puts it: “The mental health system always has a tendency to degenerate into the *System*” (Jones, 1993), it is not easy to infuse new life into services and maintain it. It is, however, the challenge, and we must continue to weave our stories and create meaning with those we serve.

Conclusion

The recent scandals around poor care and treatment in hospitals (Asthana & Campbell, 2009) have added to a feeling that, despite investment in health services in the United Kingdom we have somehow lost the plot.

True leadership is required to being a sense of vocation (see Parkes, Carr, & Gilbert, 2010) and an holistic view of the person back into services so that the spirit of the age is not simply reductionist and material, but both personal and transpersonal.

References

- Aaron, M. (2008 November). Spirituality, the heart of caring. *A Life in the Day*, 12(4), 23–26.
- Alexander, R. (2007). *The primary review: Children, their world, their education*. Cambridge: Cambridge University, The Esmée Fairbairn Foundation.
- Annas, J. (1986). Classical Greek philosophy. In J. Boardman, J. Griffin, & O. Murray (Eds.), *The Oxford history of the classical world* (pp. 234–254). Oxford: Oxford University Press.
- Aristotle. (1946). *The politics* (E. Barker, Trans. and ed.) London: Penguin.
- Aris, S., & Gilbert, P. (2007). Organizational health: Engaging the heart of the organization. In M.E. Coyte, P. Gilbert, & V. Nicholls (Eds.), *Spirituality, values and mental health: Jewels for the journey* (pp. 228–242). London: Jessica Kingsley.
- Armstrong, K. (1999). *A history of God*. London: Vintage.
- Asthana, A., & Campbell, D. (2009, November 29). The worst NHS wards... where safety is a lottery. *The Observer*, pp. 8–9.
- Atherton, J., Graham, E., & Steedman, I. (Ed.). (2010). *The practices of happiness: Political economy, religion and wellbeing*. London: Routledge.
- Bauman, Z. (1998). *Globalisation: The human consequences*. Cambridge: Polity Press.
- Benedict XVI. (2009, July 11). *Caritas in Veritate* [The Tablet].
- Bolam, S., Carr, S., & Gilbert, P. (2010). Learning from experts by experience in mental health services. *The International Journal of leadership in Public Services*, 6, 54–67.
- Bosely, S. (2009, August 8). Women given antidepressant which can cause birth defects. *The Guardian*, p. 19.

- Bracken, P., & Thomas, P. (2005). *Postpsychiatry: Mental health in a post modern world*. Oxford: Oxford University Press.
- Bunting, M. (2009, July 27). The narcissism of consumer society has left women unhappier than ever. *The Guardian*, p. 25.
- Cable, V. (2009). *The storm: The world economic crisis and what it means*. London: Atlantic Books.
- Cook, C., Powell, A., & Sims, A. (Eds.). (2009). *Spirituality and psychiatry*. London: Royal College of Psychiatrists.
- Cox, J., Campbell, A., & Fulford, K.W.M. (Eds.). (2007). *Medicine of the person: Faith, science and values in health care provision*. London: Jessica Kingsley.
- Coyte, M.E., Gilbert, P., & Nicholls, V. (Eds.). (2007). *Spirituality, values and mental health: Jewels for the journey*. London: Jessica Kingsley.
- Darzi, Professor the Lord Darzi of Denham. (2008, June 30). *High quality for all*. London: Department of Health.
- Department of Health (DH). (2006b, April 20). *From values to action: The chief nursing officer's review of mental health nursing*. London: Department of Health.
- Department of Health (DH). (2009, November). *New horizons: A shared vision for mental health*. London: Department of Health.
- George, B. (2003). *Authentic leadership: Rediscovering the secrets to creating lasting value*. San Francisco: Jossey-Bass.
- Gilbert, P. (2005). *Leadership: Being effective and remaining human*. Lyme Regis, UK: Russell House Publishing.
- Gilbert, P. (2008, January 8). 'From the cradle to beyond the grave? A multi-faith conference'. Stafford, UK: Staffordshire University TV Centre.
- Gilbert, P. (2010a, forthcoming). The bridge of sighs and the bridge of love: A personal pilgrimage. In T. Stickley & T. Basset (Eds.), *Voices of experience*. Oxford: Wiley/Blackwell.
- Gilbert, P. (2010b, forthcoming). Mental health, spirituality and religion. In J. Atherton, E. Graham, & I. Steedman (Eds.), *The practices of happiness: Political economy, religion and wellbeing*. London: Routledge.
- Gilbert, P., Hayes, J., Merchant, R., & Moss, B., for CSIP/NIMHE Staffordshire University. (2008). *Guidelines on spirituality for staff in acute care services*. Leeds, UK: CSIP.
- Gilbert, P., Kalaga, L. (2007). *Nurturing heart and spirit*. Proceedings of the 2006 Multi-faith conference held at Staffordshire University, Stafford.
- Gilbert, P., & Nicholls, V., for NIMHE/Mental Health Foundation (2003, November). Inspiring hope: Recognising the importance of spirituality in a whole person approach to mental health. Leeds, UK: NIMHE.
- Gorsky, M. (2010, February). Good health for America? *History Today*, pp. 21–22.
- Gould, M. (2009, April 1). Running out of patience. *Society Guardian*, p. 3.
- Harlow, R. (2010). Developing a spiritual strategy-why, how and so what? *Mental Health, Religion & Culture*, 13(6), 615–624.
- Harvey, A.D. (2009, July). Austria's diminutive dictator. *History Today*, pp. 41–47.
- Healthcare Commission (HCC). (2009). *Investigation into mid Staffordshire NHS Foundation Trust*. London: HCC.
- Holloway, M., & Moss, B. (2010). *Social work and spirituality*. Basingstoke, UK: Palgrave Macmillan.
- Holt, S. (2003). *Poems of survival*. Brentwood, CA: Chipmunk Publishing.
- Johnston, D., & Mayers, C. (2005). Spirituality: A review of how occupational therapists acknowledge, assess and meet spiritual needs. *British Journal of Occupational Therapy*, 68(9), 146–154.
- Jones, K. (1993). *Asylums and after: A revised history of the mental health services—from the early 18th century to the 1990s*. London: Athlone Press.
- Jones, K. (2000). *The making of social policy in Britain: From the poor law to new labour*. London: Continuum.

- King, M., Weich, S., Nazroo, J., & Blizard, B. (2006). Religion, mental health and ethnicity. EMPIRIC – a national survey of England. *Journal of Mental Health, 15*(2), 153–162.
- King, U. (2009). *The search for spirituality*. Norwich, UK: Canterbury Press.
- Layard, R., & Dunn, J. (2009). *A good childhood: Searching for values in a competitive age*. London: Penguin with The Children's Society.
- Marmot, M. (2010). *Fair society, healthy lives*. London: IDEA.
- McGreal, C. (2009, July 22). Obama drives ahead with healthcare reform. *The Guardian, 14*.
- Mental Health Foundation. (Debora Cornah), Mental (2002). *Taken seriously: Report of the somerset spirituality project*. London: MHF.
- Mental Health Foundation. (Debora Cornah). (2006). *The impact of spirituality on mental health: A literature review of the evidence*. London: Mental Health Foundation.
- Moss, B. (2005). *Religion and spirituality*. Lyme Regis, UK: Russell House Publishing.
- Murray, O. (1986). Life and society in classical Greece. In J. Boardman, J. Griffin, & O. Murray (Eds.), *The Oxford history of the classical world* (pp. 204–234). Oxford: Oxford University Press.
- NHS National Services Scotland. (2002). *Spiritual care in NHS National Services Scotland*. Edinburgh, UK: NHS Scotland.
- NHS National Services Scotland (2006). *Spiritual care in NHS National Services Scotland: Statement of Intent*. Edinburgh, UK: NHS Scotland.
- Parkes, M., Carr, S., & Gilbert, P. (2010). Vocation, vocation, vocation. *The International Journal of Leadership in Public Services*, June.
- Parks, M. & Gilbert, P. (2010). Gods and gurdwaras: The Spiritual Care. Programme at the Birmingham and Solihull Mental Health Foundation NHS Trust. *Mental Health, Religion and Culture, 13*(6), 569–583.
- Rogers, J. (2009, August 6). Snakes on the make. *Health Service Journal*, p. 17.
- Ross, L. (1997). *Nurses' perceptions of spiritual care*. Aldershot, UK: Avebury.
- Russell, R. (2009, July 15). Where, they ask, is the gratitude? Well its the experience, stupid!. *The Guardian*, p. 27.
- Sacks, J. (2005). *To heal a fractured world: The ethics of responsibility*. London: Continuum.
- Sandell, M.J. (1998, May 11). What money can't buy: The moral limits of markets. The Tanner Lectures on Human Values, Brasenose College, Oxford.
- Schoch, R. (2007). *The secrets of happiness: 3000 years of searching for the good life*. London: Profile Books.
- Scurr, R. (2007). *Fatal purity: Robespierre and the French revolution*. London: Vintage.
- Sims, A., & Cook, C.C.H. (2009). Spirituality in psychiatry. In C. Cook, A. Powell & A. Sims (Eds.), *Spirituality and Psychiatry* (pp. 1–15). London: Royal College of Psychiatrists.
- Swinton, J. (2001). *Spirituality and mental health care: Rediscovering a 'forgotten' dimension*. London: Jessica Kingsley.
- Swinton, J. (2007). Spirituality and mental health – a perspective from the research. In M.E. Coyte, P. Gilbert, & V. Nicholls (Eds.), *Spirituality, values and mental health: Jewels for the journey* (pp. 292–305). London: Jessica Kingsley.
- The Patients Association. (2009). *Patients, not numbers . . . people not statistics*. London: The Patients Association.
- Webster, C. (2nd ed.). (2002). *The National Health Service: A political history*. Oxford: Oxford University Press.
- Wilkinson, R., & Pickett, K. (2009). *The spirit level: Why more equal societies almost always do better*. London: Allen Lane.
- Wintor, P. (2009, July 22). Britain's closed shop: Damming report on social mobility. *The Guardian*, p. 4.
- Wolpert, L. (3rd ed.). (2006). *Malignant sadness: The anatomy of depression*. London: Faber & Faber.