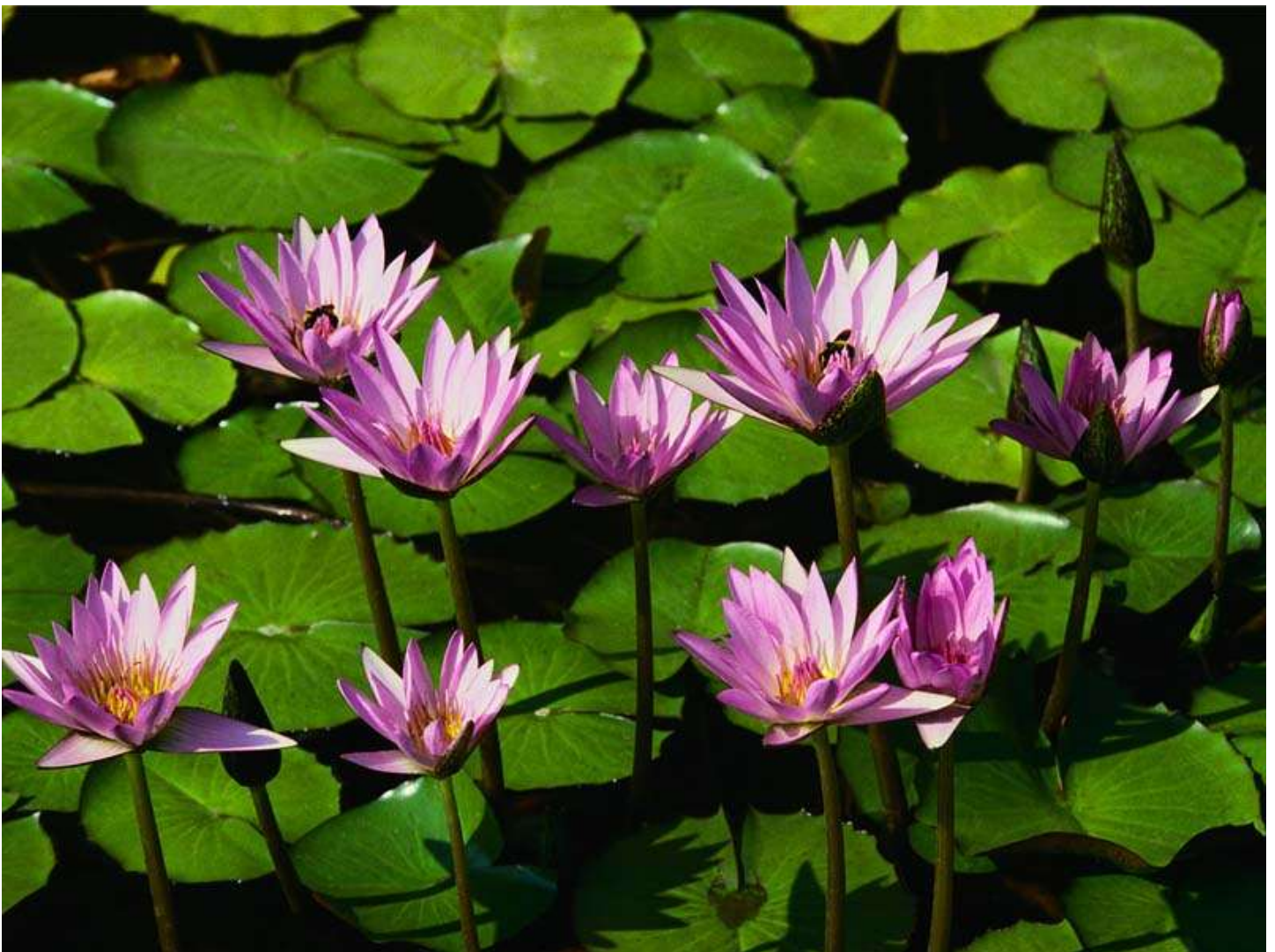




SpiritualityForum
THE NATIONAL SPIRITUALITY AND MENTAL HEALTH FORUM

A REPORT ON THE PLACE OF SPIRITUALITY IN MENTAL HEALTH 2011



Presented by Professor Peter Gilbert and researched by Madeleine Parkes

Joint Chairs: The Venerable Arthur Hawes and Dr Sarah Egger
Hon. Treasurer Rashida Karim, Hon Secretary Revd Peter Richmond
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Report on the Place of Spirituality in Mental Health

February, 2011.

Commissioned by **the Venerable Arthur Hawes and Dr Sarah Egger, Co-Chairs of the Forum**

Note on the Authors – **Madeleine Parkes** is a researcher at Birmingham and Solihull Mental Health Foundation Trust (BSMHFT). The Spirituality Research Programme hosted by BSMHFT is service user led and seeks to provide an evidence base for spiritual care interventions for NHS mental health services.

This report was written in consultation with service users and survivors, academics and Chaplains; and **Professor Peter Gilbert**, Emeritus Professor at Staffordshire University, Visiting Professor at the University of Worcester and National Project Lead for the National Spirituality and Mental Health Forum.

Note on the readership – this report is intended for managers, Spiritual and Pastoral Care leads, chaplains, NHS Trust directors, National Spirituality and Mental Health Forum members, and those interested in an overview of the field.

All sections suggest main resources and good practice examples, although many others exist and could be included. The paper aims to give a succinct overview of spirituality in mental health, with key pieces of evidence, for the inclusion of spiritual care in services.

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Service User View – the relationship between spirituality, mental illness and healthcare

“Spirituality is something that gives you meaning and purpose in life.

This can be a religious faith, but it can be anything or anyone from which you derive purpose, hope and self-acceptance.

Mental illness affects all aspects of life.

You may lose all motivation, and you may have difficult thoughts, experiences and social problems.

The aim of spiritual care is to help you with these things, and regain your sense of connection, hope and purpose. Spiritual care involves being shown personal respect and understanding, and your spiritual dimension nurtured. It includes talking about spiritual matters with an appropriate person, and the opportunity for spiritual practices of your choice.”

Quote from BSMHFT service user, 2009

OVERVIEW

Swinton, J. (2001) *Spirituality and Mental Health Care: Rediscovering a ‘Forgotten’ Dimension*, London: Jessica Kingsley Publishers

Gilbert, P., (ed) (2011) *Spirituality and Mental Health*. Brighton: Pavilion

1 in 4 people will suffer with mental illness at some point in their lives. (Mental Health Foundation, 1998). Medication is only one component of an holistic approach to mental health care, of which spirituality is an essential part. There are calls from service users, carers and staff that a person’s spiritual needs should be incorporated into their routine care (Mental Health Foundation, 1997). This paper will overview the following:

1. Definition of spirituality in relation to mental illness and health care
2. Relevance of spirituality and religion to UK mental health service users
3. Service user need
4. Policy around spirituality in mental health
5. Research evidence for religion and mental health
6. Service delivery of spirituality in mental health care
7. Examples of integrating spirituality into the work of mental health Trusts

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1. DEFINITIONS

A service user who works in research in this field offers the following definition of spirituality: 'one's beliefs about the world and one's place in it, and how one lives out these beliefs, through reflection and conscious actions'.

All literature in this field states that there are a wide range of definitions about spirituality, and no one definition will be all-encompassing.

As a straightforward guide, spirituality is generally considered to involve one or more of the following key aspects:

- Expresses the deepest part of our inner self
- Gives our lives meaning, purpose and grounding
- Highly subjective and personal (but can be shared in a religious/faith community)
- The source and focus of a person's hope, values and worth
- Anything or anyone from which a person derives purpose, hope and self-acceptance
- Connecting with ourselves, other people and a sense of the 'other'

Religion or Spirituality?

A point of confusion for many is the terminology used – are we talking about religion, spirituality, belief or faith? Generally speaking 'spirituality' is used to define the field in a wide way that encompasses but goes beyond religion, and is inclusive of alternative faiths and more secular beliefs. The Oxford English Dictionary defines 'spirit' as the 'animating or life giving principle'.

In order to differentiate between religion and spirituality, we can refer to a 2-tier definition:

- **Spirituality** – something that arises from within us (internal). A personal quest for understanding and meaning around the big questions of life and death (Koenig, 2001, p. 18)

A person's own sense of their place in the universe and how they relate to it: maybe but not always with reference to an idea of a 'higher power'. Thus people may identify themselves as 'spiritual' but not 'religious' – they have not got a label or identity that neatly falls under a religious faith (and this can be a deliberate choice or because they have not yet found a religious system that fits comfortably with their own spirituality). Spirituality encompasses religion and belief, but can be broader than this.

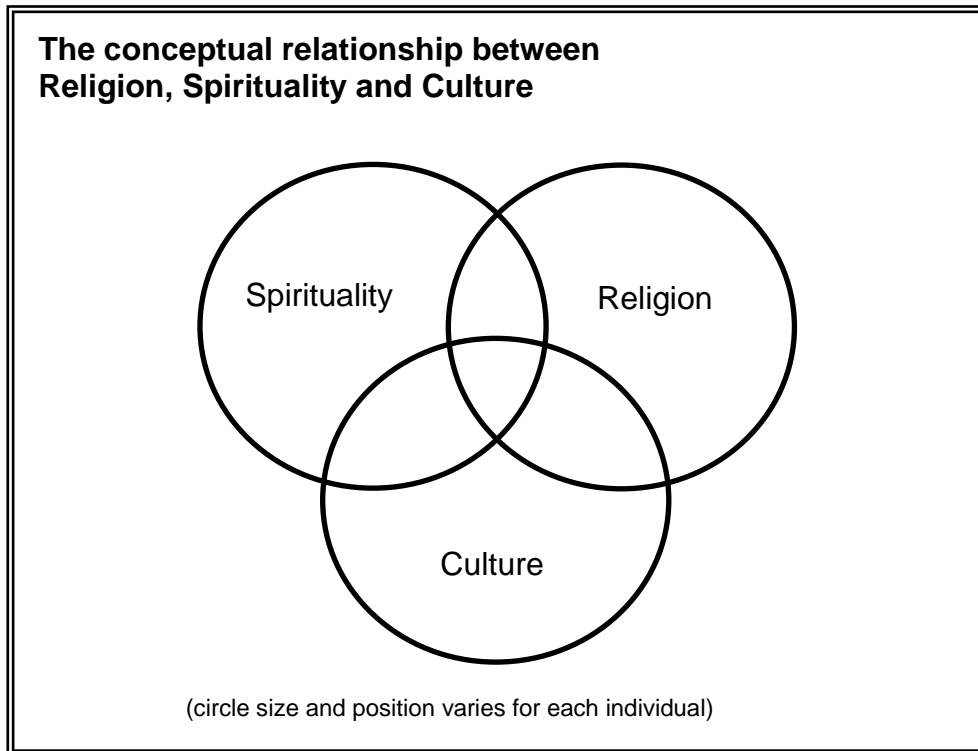
- **Religion** – the way people organise their way of relating to what they hold to be sacred and transcendent.

An organised form of spirituality often characterised by a faith leader, holy scripture, a definitive concept of a higher power/God, and/or set moral codes and ethics. Examples include Baha'i, Buddhism, Christianity, Hinduism, Islam, Jainism, Judaism, Paganism, Rastafarianism, Sikhism, Zoroastrianism, etc.

The word 'religion' derives from a Latin word meaning 'binding obligation', and this demonstrates how much it is to do with a sense of community and social cohesion (Gilbert, 2011)

Often a person's spirituality and religion are part of their culture. For this reason, spirituality can sometimes

be addressed as part of transcultural psychiatry. As the UK becomes increasingly diverse, many people will move across cultural boundaries and move between faiths or from belief to unbelief and then back to belief when a crisis occurs.



For some, spirituality refers to more secular and independent ideas of values, identity and humanity. Some people will not use the label 'spirituality' to describe these things.

Thus, "spiritually healthy individuals stand in right relationship with themselves, with other people, with the world in which they live, and with the transcendent, however they conceive it. Spiritually healthy individuals build purposeful lives, develop sound relationships, and take responsibility for the world around them." (Mental Health Foundation, 1998).

2. RELEVANCE OF RELIGION AND SPIRITUALITY TO UK MENTAL HEALTH SERVICE USERS

UK scene

Research into the presence of religion and spirituality in the UK has demonstrated that although affiliation to recognised religious institutions has declined over twenty years, there is an increase in interest in *spirituality*, (Hay, 2000) indicating that whilst many people may not be religious, they still have interests in the spiritual dimension of their lives. Research indicates that even those not reporting any particular religious faith often

wish to discuss spiritual support in general, or support from some form of 'god', whilst under the care of mental health services. (Sproston, 2002, p. 148).

It must be noted that although there is a decline in religious attendance noted in the UK, this is only for certain faith groups and denominations. With a continuing flux in migration and out-of-date Census data, it would be fair to say that some faiths and denominations are increasing in number.

Spiritual healthcare

Coyte, M.E., Gilbert, P. and Nicholls, V. (Eds) (2007) *Spirituality, Values and Mental Health: Jewels for the Journey*, London: Jessica Kingsley

Spirituality can influence a person's life in many ways. This is why it is considered an important part of healthcare.

Central Features (Swinton, 2001):

Meaning: the significance of life; making sense of life situations; deriving purpose in existence

Value: beliefs and standards that are cherished; having to do with the truth, beauty, worth of a thought, object or behaviour; 'ultimate values'

Transcendence: experience and appreciation of something beyond the self; expanding self boundaries

Connecting: relationships with self, others, God/higher power, the cosmos and the Environment

Becoming: an unfolding life that demands reflection and experience; includes a sense of who one is and how one knows

The aim of spiritual care is to help a person with some of the key characteristics described above. At its best, it facilitates the service user's ability to regain a sense of connection, hope and purpose.

Ancient philosophies acknowledge the importance of spirituality in health and healing. As Plato wrote: "The cure of the part should not be attempted without treatment of the whole. No attempt should be made to cure the body without the soul. Let no one persuade you to cure the head until he has first given you his soul to be cured, for this is the great error of our day, that physicians first separate the soul from the body." (Plato, trans by Jowett, 1892, pp. i, 11-13)

Who is spirituality important to in healthcare?

- Those with a practising religious faith, who may wish to discuss its relationship to their illness, or to access and express services, rituals and festivals related to the faith whilst in hospital/in care.
- Those who have previously had a religious faith but have since moved away from it – they may be prompted to re-visit and re-explore it due to illness and crisis.

- Anyone searching to find meaning in their illness and life situation; purpose in life as a result of their illness and hope for their future recovery.
- Anyone whose coping mechanisms involve ritual and religious practices; belief in a higher power or force; any expression or hobby they consider to be spiritual in nature.
- Anyone who welcomes the support of a faith community.
- Those who wish to express personal pain.
- Those who wish to deepen their compassion for others.
- Those who are suffering complex symptoms of psychosis that may have confusing religious elements

Research demonstrates the members of BME communities explicitly express their religious needs more than members of white communities. (Sproston, 2002, p. 148). There is a danger that White Caucasian Christians' spiritual needs are overlooked as spirituality and culture can sometimes be mistakenly seen solely as a BME issue.

3. SERVICE USER VIEWS

Key reference: Mental Health Foundation (2002) *Taken Seriously: The Somerset spirituality project*, London: MHF. *The Somerset Spirituality Project documents the interviews of 27 service users, from faith and no faith groups, around their spiritual needs in mental health. The document is significant as it allows service users to speak freely of their experiences of mental health care at various stages (inpatient, community services, the role of faith groups) and also gives suggested guidance for different professionals.*

The views of service users and carers are increasingly recognised as important to ensure mental health services positively improve.

Particularly around spirituality and religion, service user views are significant in explaining the relationship between belief, and recovery from mental illness.

Service users find they rely heavily on their own inner resources, strengths and motivations during mental illness (Basset and Stickley, 2010). This can include drawing on values, a sense of 'inner spirit' that provides strength, hope and resilience, as well as using worldviews and beliefs to give meaning to what is happening during times of illness.

Over half of service users have explicitly said that they have some spiritual belief that is important to them. (Mental Health Foundation, *Knowing Our Own Minds*, 1997)

The Mental Health Foundation found that service users were asked to describe the role spiritual and religious beliefs and activity had in their lives. Themes that emerged included the importance of guidance; a sense of purpose; comfort; grounding; the allowance of expression of personal pain and the development of an inner love and compassion for others (Faulkner, 2000).

Service User Voice – Somerset Spirituality Project

“I did know enough (Buddhism) to know that ‘om’ was a good word to help you relax, and I found that a great lifeline”

“Whilst I was there (on an acute unit) we discussed having a place, a private place, where somebody who had faith could go and be quiet... I voiced my opinions on how important I thought that it was within that setting”

“People who to all intents and purposes had no faith, who spent time with the chaplains and actually sat down and talked to them, found a time when they could re-find a faith that they had lost”

“Whatever I had to sort out was a religious existential problem and to them it was classic schizophrenia”

“The community psychiatric nurse was terrific. Although he was not a Christian, he asked me very, very pertinent questions about how I could reconcile my faith with what was happening to me and what God meant to me.”

“..to invalidate a person’s spirituality no matter how distorted that is, is to invalidate that real core sense of self and I think once you do that you risk doing untold damage to somebody”

4. POLICY DRIVERS

There are an increasing number of policy drivers around Spirituality and Religious faith. As a legal and policy framework around equalities develops, and the cultural make-up of British society grows ever more diverse, there are a significant number of major policy imperatives set by Government, and also expressed needs set out by people who use mental health services:

The Department of Health recognises the importance of spiritual and religious needs in healthcare. Evidence for the NHS commitment to spirituality is its funding of chaplaincy since its inception. The DoH recently produced a report highlighting the value of religion and belief in health, and the duty of professionals to respect and value belief systems in care planning and delivery (Department of Health, 2009)

The Human Rights Act (Article 9) outlines the legal obligation organisations have to ensure people can freely express their religion, whatever this may be and look like. In a hospital setting, this would include providing resources, space and time for religious expression such as prayer, meditation and worship. This may include designating a room as a multi-faith or reflective room, providing religious texts, prayer facilities (mats and wudu), or ensuring personnel can escort patients to religious services (Gilbert, Kaur and Parkes, 2010). To deny a person the opportunity to practise their religious and spiritual faith in any way is an infringement of Human Rights Law and is therefore illegal.

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CQC Standards highlights the need to provide appropriate space for religious expression. Standard C20b, element one, states “The healthcare organisation provides services in environments that are supportive of patient privacy and confidentiality, including the provision of single sex facilities and accommodation, **access to private areas for religious and spiritual needs** and for confidential consultations. This should happen at all stages of care and during transfers”.

The 2001 revised Patient’s Charter states that: NHS staff will respect your privacy and dignity. “They will be sensitive to and respect your religious, spiritual and cultural needs at all times” (p29).

Recovery Approach

The Recovery approach, as set out in e.g. the CSIP/RCPsych/SCIE document on Recovery of 2007. Importance of the recovery approach: “It is based on the core belief that adopting recovery as a guiding purpose for mental health services favours hope and creativity over disillusionment and defeat” (2007, p. vi.)

Diversity, Culture and Race

Religion and spirituality is relevant to the following policies around diversity, culture and race:

- The importance of ethnicity and of faith in individual and group identity. The recent Leeds University research (July, 2010) indicates a rise of ethnic diversity from 8% in 2010 to 20% in 2051.
- The Delivering Race Equality policy (DH 2004) notes that “NHS organisations responsible for commissioning and performance monitoring, and local authorities, should ensure that mental health services identify and record users’ ethnicity (and other relevant data for the planning of care, such as *religion*, language, or gender).

Wider Policies

Religion and spirituality can be relevant to the following wider policies around patient care, dignity, community and personalisation. All Department of Health policies and papers can be found on their website:

- Personalisation, through the White Paper: *Our Health Our Care, Our Say* (2006), the 2007 Commissioning Framework for Health and Well-being, and *Putting People First* (December, 2007), the Government concordat to transform adult social care.
- The need to create greater social cohesion and community well-being, as set forward in: *Our Shared Future* (2007).
- The Equalities legislative and policy agenda (‘Delivering Race Equality’ now placed within a broader Equalities agenda, which includes *Religion or Belief* (DH, 2009).
- Increased cost benefit analysis achieved through working with the motivations of individual service users, carers and community groups. These motivations can include existential meaning-making, spirituality and religious belief.
- *No Health without Mental Health: Delivering better mental health outcomes for people of all ages* (DH, 2.2.2011) the new Government’s strategy, following the previous Government’s *New Horizons* (November, 2009). This has an accent on prevention and early intervention. This approach is supported by the Future Vision Coalition for Mental Health report in October 2010. Research suggests that increased spiritual practices have a positive impact on resilience and recovery (please see next section).
- DH White Paper (July, 2010): *Equity and Excellence: liberating the NHS*, speaks of a “genuinely patient-centred approach”, including the value-based approach: “Nothing about me without me”.
- United Nations recommended that the WHO definition of health should be modified so as to recognise that religious and spiritual practises are inherent to individual and collective health. It also

recommended that “because prayer and other religious and spiritual practices in different parts of the world are so common a response to illness, researchers and health experts have a responsibility to investigate it” (United Nations, 2005).
(See Gilbert, 2010 and 2011).

5. RESEARCH EVIDENCE

Key reference: Koenig, H.G., McCullough, M.E. and Larson, D.B. (2001) *Handbook of Religion and Health*. Oxford: Oxford University Press. *This handbook contains a comprehensive literature review of thousands of clinical research studies in to religion, spirituality and health in North America. It overviews many studies around different diagnoses and religious interventions. (an updated version is due to be published in 2011).*

Other references: Loewenthal, K.M. (2007) *Religion, Culture and Mental Health*: Cambridge: Cambridge University Press

Swinton, J. (2001) *Spirituality and Mental Health Care: Rediscovering a ‘forgotten’ dimension*. London: Jessica Kingsley.

Two books covering work in the UK and other countries, the first dealing with work on spirituality, religion and mental health in a wide range of cultural and religious contexts, and the latter focusing particularly on mental health care.

Pargament, K.I. (2007) *Spiritually Integrated Psychotherapy*. New York: Guilford Press. *An important work based on rigorous empirical work and clinical material, giving details on the helpful and dysfunctional ways in which religious beliefs and practices can impact on mental health, and how spirituality may be addressed in the therapeutic process.*

From comprehensive clinical trials, to the testimonies of service users and carers, there is a wealth of evidence to support the notion that attention to religious and spiritual needs can improve the recovery of service users of all diagnoses.

Important considerations for research evidence

The complexity of people’s religious and spiritual beliefs, and a lack of ability to measure these in any way that would be theologically acceptable, complicates approaches to clinical research (Parkes, 2010). People’s religion and belief is a very complex concept and reductionist quantitative studies do not fully explore the meaning behind the spiritual activity. Therefore all quantitative studies need to be understood as part of a larger evidence base that incorporates qualitative research studies. Qualitative studies can better elucidate the relationship between spirituality and well-being, as well as distinctions between religion and spirituality where applicable (Cornah, 2006, and Swinton and Parkes in Gilbert, 2011, chapter 2).

Many comprehensive and quantitative research studies have been carried out in North America. Whilst the results are broadly translatable, there are some differences that need to be considered. In most of the studies there is very little distinction between religion and spirituality. As explored above, UK definitions of these two concepts note some differences between them, whereas the USA studies, whilst using both terms, are actually often focusing on religion, particularly around religiosity, or how often and much people participate in religious rituals and activities. Religiosity *may* be a good indicator of faith and commitment, but it does not measure intrinsic religious commitment.

Evidence Presented in this Paper

This section will highlight the quantitative evidence of the relationship between religion (or more specifically religiosity) found in North American and other clinical research studies. Ongoing research in the UK and other countries is regularly reported in the journal *Mental Health, Religion and Culture* (see special edition on the UK experience, September, 2010), and a recent overview appeared in Cornah (2006).

The scope of this paper only permits a brief overview of the wealth of research evidence that has been produced in the field of spirituality, religion and mental health. For a systemic review of work in this field, particularly in the USA, see Koenig et al (2001). Other work is covered in Loewenthal (2007). Both works consider different diagnoses and address the role of religious community, practices, beliefs, coping mechanisms and formal religious interventions in healthcare. Therefore to provide a brief overview of research in this field is difficult as there are many factors to each study. The results documented below are overviews that highlight the broad trends and conclusions from research.

Research Evidence

There is a slight variation in the results for each diagnosis or religious intervention, but over 75% of the studies reviewed support, using high quality data and evidence, the positive role religion has in wellbeing, recovery and resilience in mental health.

In the majority of studies, religious involvement is positively related to:

- Wellbeing, happiness and life satisfaction
- Optimism and hope
- Purpose and meaning in life
- Self esteem
- Adaptation to bereavement and loss
- Greater social support, less loneliness
- Less anxiety.

The studies also demonstrate the positive role religious faith and practice can have on physical health benefits – such as being less likely to smoke and engage in heavy drinking, decrease in risk of stroke and heart disease. The relationship between physical and mental health is fundamental, with new research demonstrating the effect that diet and exercise can have on mental well-being.

Measurable improvements for psychiatric diagnoses

Each diagnosis has complex studies associated within its research field, and those interested should consult specific studies as required. A brief overview of some main diagnoses are given below.

Depression (Koenig p.135; Loewenthal, p.55):

- I. Those involved in religious community, and those who value their faith, are at a reduced risk from depression (those involved for self interest are at a higher risk). Even those who do get depressed recover more quickly than those without religious faith.

- II. Both personal/private religious practices and involvement in organised/community based religion offer resilience to depression, although organised/community religion offers more.
- III. Many forms of religious coping are related to lower likelihood of depression during or after stressful life events
- IV. Less depression amongst the religious, and reduction in depressive symptoms for those who participate in religious or spiritual activities, are consistent findings in large research studies.

Schizophrenia (Koenig p. 165; Loewenthal, p.11):

- I. Data on religious involvement as a predictor of *new cases* of schizophrenia is inconclusive, and there have been no large scale prospective studies. We cannot say if religious belief is *causally* linked to schizophrenia. However given the influence of genetics and biology on the aetiology of schizophrenia (70%) the weighting given to socioeconomic causes, that includes religion, should not be over-represented.
- II. Many studies show that religiosity amongst schizophrenic patients is not associated with schizotypal thinking, psychotic symptoms or psychotic personality traits, despite religious delusions being a presentation for some psychotic patients. Studies demonstrate a significant *inverse* relationship between religiousness and psychotic tendencies.
- III. It can be definitively stated that religion provides a powerful source of comfort and hope for many with chronic mental illness, based on prospective data studies.
- IV. Studies with schizophrenic patients of different religious faiths found a reduction in readmission to hospital if the person was encouraged to pray once daily (vs. more often). Those who did not have a religious faith were more likely to be readmitted.
- V. Studies into religious and spiritual interventions demonstrate these can help a person utilise their own spiritual resources that improve functioning, reduce isolation and facilitate healing.

Addictions (Koenig p. 179):

- I. Nearly 100 studies suggest religion may be a deterrent to alcohol or drug abuse in children, adolescents and adult populations.
- II. The greater a person's religious involvement the less likely they are to initiate drug or alcohol use, or have problems with these substances if they are used.
- III. Religiously-integrative programs (such as 12-step programme) and private spiritual practices have a significant impact on the rehabilitation of those with substance abuse problems.

A note on suicide

Research into religious adherence and suicide is complex and therefore only tentative conclusions can be made. It can be confidently said that religious involvement (measured by frequency of religious attendance, frequency of prayer etc) is negatively associated with suicide, suicidal ideation and suicidal behaviour. This is likely to be because of social support offered by faith communities and moral objections to suicide on religious grounds. (Koenig, p.142)

Neuroscience

Research into the biological and chemical changes in the brain during religious practice (specifically prayer and meditation) is emerging. Prayer and meditation increases activity in the anterior cingulate area of the brain, which helps people feel compassion and empathy. Daily meditation has been demonstrated to improve the neuroplasticity of the brain (the brain's ability to physically rearrange itself at a neurological level). This in turn has had a dramatic effect on people's memory. Although other activities can also affect neuroplasticity, meditation (both based on God and secular meditation) affects particular parts of the brain that increase social awareness, empathy and compassion. (Newberg, 2010)

Negative features of religion

Although there is strong evidence to support religion and spirituality as a positive factor in health, there are some cases where religion can have a negative impact. This is the result found in the minority of studies but does have

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some impact on care. This has been particularly documented in Pargament (2007 and elsewhere).

- There have been some trends of increased religiosity (e.g. frequency of prayer and service attendance) with anxiety and guilt (Koenig pg. 74), but possibly not at pathological levels.
- Negative effects on attitudes and cognitive thought processes have been demonstrated in some studies. Religion can promote an overdependence on laws and rules, overlooking personal autonomy, and damaging beliefs include the idea that God is punishing, angry or neglectful (Pargament, 2007).
- Some religious dogma can be ostracising and alienate others.
- Negative effects on coping resources and behaviours. Some patients will have conflicts of taking medication if they believe their faith should be sufficient to help them cope with negative emotions (see case study in Gilbert, 2010, pp114-115).
- Many religions value the importance of health and wellbeing and encourage medical intervention alongside religious/spiritual. However some patients will delay seeking medical help in order to explore religious/spiritual alternatives. Cultural ideas about the causes and treatment of mental illness may be superstitious in nature but persuasive. There may also be a genuine fear of religious experiences and expression being diagnosed as mental illness.
- Involvement in religious cults can promote excessive emotional dependence on one individual and alienation from society.
- For an overview of ecclesio-genics (or illnesses that are caused or exacerbated by faith communities) (please see Hawes, 2011).

Research into the distinction between religion and spirituality – a British Study

“A 2006 research study in Britain (King et al, 2006) compared six ethnic populations and arrived at complex results. While there was no difference in the prevalence of common mental disorders between those who were spiritual/religious and those who were not, when the groups were split into those who professed to being religious and those who professed to being spiritual, the latter group was found to have a greater likelihood of mental disorder than those with a formal religious belief system but also than those with no religious belief whatsoever.” (Casey, 2009)

A similar finding has been replicated in a Canadian study. We can tentatively conclude that participation in religious activities, as distinct from the more generic ‘spirituality,’ has a greater benefit on psychological and social adjustment. This may be in cases where a person’s spirituality is ultra-individualistic and provides little or no social support. Again due caution in making large conclusions in this field has to be exercised. The issue of how spirituality was classified and measured has to be taken into consideration, and further, as a cross sectional pilot study, the nature of the influence of religion on mental health (cause or effect) could not be established.

6. SERVICE DELIVERY

Key reference: Mowat, H. (2008) The Potential for Efficacy of Healthcare Chaplaincy and Spiritual Care Provisions in the NHS: A Scoping Review of Recent Research. Aberdeen: Mowat Research Limited
See also Egger, S, Richmond, P, and Gilbert, P., (2009) "Spiritual Care in the NHS." In *Spirituality and Psychiatry*, by Cook, Powell, and Sims, (Eds) London: Royal College of Psychiatrists

There is a need for services to acknowledge and utilise the spiritual dimension of a person during their care. Many Trusts are putting into place Spiritual Care and Chaplaincy Resources. These can include the following:

- **Chaplaincy/ Spiritual Care Strategy**

A board endorsed strategy for the promotion and delivery of spiritual and religious care. Board level support has been noted as a key factor in the development and promotion of spiritual care (Coyte and Nicholls, Sep 2010, Harlow, 2010)

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- Promoting awareness about spirituality

This can be achieved as part of equality and diversity training, or as a slot in mandatory Trust induction days for new staff. Further, posters and leaflets can be displayed on wards and in outpatient clinics over viewing the Chaplaincy/Spiritual Care service and how to access it. Comprehensive training in assessing spirituality and integrating it into a care plan is being developed and produced by numerous Trusts (see below) in addition to awareness- raising events.

- Development or utilisation of Spiritual Assessment Tools.

There are multiple assessment tools available to aid the assessment of spiritual needs, ranging from simple mnemonics to prompt questions (e.g. HOPE) as well as more comprehensive and formulaic assessment tools. (Edwards and Gilbert, in Coyte et al, 2007, Eagger 2009, Eagger, Richmond and Gilbert, 2009, pg 185, McSherry and Ross, 2010, and Gilbert (Ed), 2011, chapter 10)

- A dedicated Chaplaincy/spiritual care team can provide some or all of the following services:

- Weekly faith-specific services
- Festival-specific events
- Responding to referrals (from staff and service users, intranet based and/or paper based)
- Provision of resources and rooms for expression of spirituality and faith
- Positive connections with faith and other spiritual communities

“A companion document for healthcare managers *NHS Chaplaincy: Meeting the Religious and Spiritual Needs of Patients and Staff* (Department of Health, 2003) addresses the risk and cost issues involved in providing chaplaincy services and gives advice on staffing levels, making appointments, confidentiality, working with volunteers, providing worship space, training and development, bereavement services and major incident planning” *Eagger, Richmond and Gilbert, 2009, p. 180*

7. OVERVIEW OF TRUSTS INTEGRATING SPIRITUAL CARE

Key reference: C. Cook, A. Powell and A. Sims. (Eds) (2009) Spirituality in Psychiatry. London, Royal College of Psychiatrists Press. Spirituality in Psychiatry is a recently published book that explores the nature of spirituality, its relationship to religion, and the reasons for its importance in clinical practice. In this evidence-based text, the authors discuss the prevention and management of illness, as well as the maintenance of recovery. Different chapters focus on the key subspecialties of psychiatry, including psychotherapy, child and adolescent psychiatry, intellectual disability psychiatry, substance misuse psychiatry and old age psychiatry.

See also Staffordshire University/NIMHE/CSIP (2008) Guidelines on spirituality for staff in acute care.

Spiritual care is the shared responsibility of all who work in the NHS (Eagger, Richmond and Gilbert, 2009). It can be incorporated into existing models of care and also stands alone as a service in itself: Chaplaincy.

Professional bodies within mental health care recognise the role of spirituality, religion and belief, in line with providing holistic and person centred care to all patients. For example **The Royal College of Psychiatrists** have a Spirituality

Special Interest Group. This group produces papers and guidance around the relationship between spirituality and psychiatry, and the practicalities of addressing spirituality in psychiatric care. Their recent publication, *Spirituality and Psychiatry* discusses these further and the Special interest Group has an active website (www.rcpsych.ac.uk/spirit) with resources available. There are some overlaps with transcultural psychiatry, which discusses the person's cultural context, including religious tradition.

Spiritual Care in Occupational Therapy

Occupational therapy recognises the spiritual dimension of the person as the core of the model they operate to. The Canadian model of occupational therapy has 'spirituality' at the heart of the person. Spirituality can be expressed in everyday activities; it is the *meaning* behind these activities' expressions that make something spiritual (Howard, 1997). For those recovering from mental illness, their ability to find meaning in their day-to-day life has been lost, thus their own sense of spirituality has been lost. Occupational therapy can be used to rediscover meaningful activity, thus the two can overlap.

There are examples of occupational therapists successfully running patient spirituality groups in collaboration with Chaplains and other members of the team, for example at Sandwell Mental Health NHS Foundation Trust (Louis *et al*, 2007).

Nursing has brought spiritual care into the centre of practice (see Cash and McSherry, 2006), while **The British Psychological Society** has a transpersonal special interest group (see Aris, 2011). Spirituality can easily fit into Positive psychology ideas and frameworks. **Social Work**, despite its holistic approach, has been somewhat slow to embrace spirituality as a concept, probably because of issues with some aspects of organised religion, but is now producing works aligning the profession with spiritual care (see Holloway and Moss, 2010).

Chaplain integrated into a Clinical Multi-disciplinary Team

The presence of a Chaplain during the review of service user cases in a multi-disciplinary team meeting can bring a holistic presence to the clinical group. The Chaplain's views on spiritual and religious needs can greatly aid the clinical team in making appropriate care decisions. This was trialled at Birmingham and Solihull Mental Health NHS Foundation Trust, with well-received support from the clinical team. There is prima facie evidence to support a reduction in medication and improved user satisfaction.

Faith Links Project – Bringing Faith Volunteers onto Inpatient Wards

At the Brent site of Central and Northwest London NHS Foundation Trust, volunteer faith visitors were identified from faith groups. Volunteers were trained in mental health awareness and complete CRB clearances. Previously a male and female Muslim representative and a Hindu representative make weekly visits of the wards, with additional support provided for festivals. A representative from the Jewish Association for the Mentally Ill also visit regularly and provide support for Jewish festivals. There is currently support from a C of E and a Catholic priest. The faith visitors provide one-on-one support and facilitate particular festivals and events throughout the year.

Themed Group Work

A common method of delivering spiritual care is through themed group work. This may be in collaboration with nursing or occupational therapy staff, or may be staffed solely by the Chaplaincy team. This format of spiritual care occurs in many Trusts. Feedback from a themed group in Nottingham NHS Trust demonstrated service user satisfaction and self-reported feelings of improved relaxation, self-esteem and peace.

Staff Training in Spiritual Care

Training packages for clinical staff have been developed in line with NHS KSF standards at Trusts across the country, including Sheffield Health and Social Care NHS Foundation Trust and Birmingham and Solihull Mental Health NHS Foundation Trust. These training packages address issues in spiritual healthcare, such as what it means, assessment and how to address it in care. Training also address working with the Chaplaincy team, as well as issues around professional boundaries. It is often relational with an examination of personal spirituality (Raffay, 2010).

Spirituality Healthcare Worker

This is a pioneering new role within the NHS, and has been developed at Nottingham Healthcare NHS Trust. It involves promoting the importance of people's spirituality, and belief in mental health care and recovery, and includes the development of spiritual interventions and staff training. It is not based in a specific faith, is different from a Spiritual Care Advisor role and is a new way of working in spiritual care.

Staff support around spirituality, resilience and values

The Janki Foundation's programme called 'Values in Healthcare' (see <http://www.jankifoundation.org/valuesinhealthcare/index.jsp>) is an educational programme that seeks to provide an opportunity for healthcare staff to explore their own sense of spirituality, and the values and resilience that may come with it. It is based around seven core values that many healthcare staff rely on for motivation and inspiration whilst caring for others. These include peace, positivity, compassion, co-operation, valuing the self and spirituality in healthcare. Spiritual tools of meditation, visualisation, reflection, listening, appreciation, creativity and play are used to experientially explore these values (Egger, Desser and Brown, 2005). Multiple workshops at Nottingham Healthcare NHS Trust and South Staffordshire and Shropshire NHS Foundation Trust (SSSNHSFT) have been run with excellent feedback from participating staff (Parkes, Milner and Gilbert, 2009). There are other Trusts utilising this approach.

Spirituality Research Programme

Birmingham and Solihull Mental health NHS Foundation Trust have been conducting research into religion, spirituality and mental health care in the NHS since 2006. There have been numerous pilot studies that have explored qualitatively, with some small quantitative pieces of evidence, different expressions of delivering spiritual and religious care. The main study has been to develop 2 new psychometric assessment tools that measure holistic psycho-social recovery, and spiritual wellbeing. The tools are service user designed and seek to incorporate a diverse understanding of spirituality and recovery. The diverse multi-faith Chaplaincy/Spiritual Care Team are also involved in its development. The whole research programme is service user led. A large randomised control trial to evaluate quantitatively specific spiritual care interventions has been planned.

Conclusion

The call for the spiritual dimension to be addressed in assessment, treatment and care has come primarily from service users and carers, as part of a broader movement towards dignity, empowerment, personalisation, cultural identity and recovery.

There is now a clear legal imperative for services to address these issues, but even more vitally a service which fails to address a person's "animating or life-giving principle" may be hitting a target, but missing the point. For long term mental health, people need to be able to engage with their whole person and whole life situation. Spiritual care is humane, ethical and effective.

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The National Spirituality and Mental Health Forum is a Company Limited by Guarantee and a Registered Charity

Registered Office is situated at: 24, Brookland Rise, London, NW11 6DP

Registered in England Company Reg.No.5830532 Registered Charity No. 1118286.

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5th February, 2011.

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