

Continuing Issues in Mental Health

Report by the Mission and Public Affairs Council

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CONTINUING ISSUES IN MENTAL HEALTH

Introduction

1. This report comes exactly five years after the Synod debate on the report *Emerging Issues in Mental Health* (GS 1491 – hereafter *Emerging Issues*) in February 2003. The choice of title indicates that the issues identified in that report are still very much with us, but also that there have been developments, both positive and negative, which deserve to be taken into account. Accordingly, this report traces the continuing quest for mental health services which will meet the needs of service users, carers and society as a whole. It reviews the outcome of proposals for a new Mental Health Act, which was finally passed in 2007 after nearly ten years of intense debate. It then surveys the intractable problems surrounding the treatment of people with mental health problems in the criminal justice system. Finally, it recounts the progress made in tackling questions of spirituality in the field of mental health, including the production of the training resource for which Synod called in its 2003 resolution. But first, some theological considerations are offered to frame the discussion.

1: Theological Reflections on Mental Health

What is mental health?

2. When we use the language of ‘mental illness’, it is easy to regard it as applying to a relatively small, untypical or abnormal group of people – even though it is estimated that at least 1 in 4 people in the UK will experience some kind of mental health problem in the course of a year. When we speak instead of ‘mental health’, it becomes clearer that it is an issue affecting everyone. One short definition, offered in the resource *Promoting Mental Health* (p. 29) is:

Mental health is the emotional and spiritual resilience which enables us to enjoy life and to survive pain, disappointment and sadness. It is a positive sense of well being and an underlying belief in our own worth and the dignity and worth of others.

This definition has several merits: it implies that mental health relates to experience over time; that it encompasses the negative as well as the positive; and that it involves both our fundamental self-understanding and our attitude to others.

3. A Christian understanding grounds this definition in the human relationship to God our Creator and Redeemer. Mental health can be seen as one manifestation of the divine image in human beings, and as an element in the quest for meaning, hope and love which finds its fulfilment in God. In the famous words of St Augustine at the beginning of his *Confessions*, “Thou hast made us for Thyself, and our hearts are restless till they find their rest in Thee.” The divine image entails both inalienable dignity and the potential for transformation, so mental health is not a static possession but a life-giving orientation in the midst of change and challenge. And just as the divine image finds expression in relationships, mental health is both rooted in, and productive of, life-giving relationships.

4. Conversely, mental ill-health, in its milder and more severe forms, is a manifestation of the disorder and suffering of creation. This is not of course to assert that it is a mark or consequence of sin, any more than is physical suffering, but it can be seen as part of the ‘spoiling’ of creation, contrary to the divine purpose. Because mental health is bound up with human perceptions, beliefs

and values, the meaning of mental disorder is open to interpretation. While there are physiological causes and organic effects of mental illness, diagnosis and treatment will depend partly on the meaning given to the experience both by the person themselves and by others. Attitudes to mental illness are also conditioned by social and cultural factors which contribute to systems of explanation and management. There are traditions in the Bible which attribute mental disturbance to the activity of evil spirits, while dominant approaches in modern Western psychiatry employ different interpretative tools, in which the demons have been internalised.

God's way to wholeness

5. Christians believe that the disorder and suffering of creation, and the alienation experienced by human beings, have been decisively overcome by Jesus Christ in his ministry, death and resurrection. In him, God's purpose of restoring wholeness to human beings is worked out through forgiveness, healing and deliverance from evil. It is crucial that this activity is carried out through empathy and self-giving in personal relationships, and not by purely external power or impersonal authority. A significant part of Jesus' ministry to the outcast is to those isolated and oppressed by mental disorder. In these cases the key element is less the attribution of demon-possession than the gift of divine compassion and liberating power, with the effect of restoring the disordered both to their right mind and to their communities. The man known as Legion (Mark 5:1-20), who exhibited symptoms of what contemporary psychiatry might label an associative disorder, was perhaps the most striking case – brought symbolically from among the tombs and returned to the circle of his friends, the emphasis being on “how much the Lord had done for him”.

6. The Incarnation involves both the exercise of power and the assumption of weakness on the part of Jesus. His identification with needy and troubled human beings embraces acts of healing and deepening participation in rejection and suffering – “a man of sorrows and acquainted with grief”. The agony of Gethsemane and the endurance of the Cross enact God's identification with human desolation and his containment of the forces of evil and destructiveness – a truth which we recognise only through the vindication of the Resurrection. The knowledge that Jesus experienced and endured human darkness has always been central to the good news of salvation, and a potent source of consolation to those who suffer. People with mental health problems continually recognise the outcast Christ as a companion in affliction, remembering that among his own people he was regarded as “beside himself”. “I am under the same condemnation as my Saviour”, wrote the eccentric and volatile 18th-century poet Christopher Smart (once surprisingly identified by Dr Johnson as his favourite partner in prayer).

7. Mental ill-health therefore is an area in which the redemptive work of God in Christ is experienced. However, as in other areas, the way to wholeness is neither simple nor unambiguous. Christian faith does not offer an instant cure but a journey of healing. It is the testimony of Christians with mental health problems that, as with St Paul's “thorn in the flesh” (2 Corinthians 12:7-9), God works through their condition and makes it a vehicle of grace rather than simply abolishing it. It is also true that such people can plumb depths of experience not otherwise accessible, and find God in strange and unexpected places.

Some implications

8. These convictions carry important and challenging implications. First, people with mental health problems, like others considered “foolish” or “weak”, may have God-given wisdom or strength to offer to others, and those who are considered “wise” or “strong” must train themselves to be receptive to, rather than dismissive of, such offerings. Many creative and spiritually profound people have suffered from mental instability. Second, it is not always easy to draw a clear line between profound religious or spiritual experiences, including seeing visions or hearing voices, and

pathological states. The mental health of some of the biblical authors, such as the prophet Ezekiel and the Seer of the Book of Revelation, has for understandable reasons been questioned. We refer again to the social and cultural elements in diagnosis of mental illness, which give major cause for concern today in the handling of mental health service users from minority ethnic groups.

9. Third, the problem of contested interpretations of experience underlines the need to pay attention to the perceptions and needs of service users and to involve them in their own diagnosis, treatment and care. *Emerging Issues* traced the recognition of this as a major development in recent decades. Fourth, attention to the perceptions and needs of users has highlighted the importance to them of religious and spiritual issues, in contrast to a deep-rooted reluctance on the part of mental health services to acknowledge them. This subject will be taken up in ch. 5.

The Church's ministry: giving and receiving

10. The Church's ministry to people with mental health problems is therefore a two-way process. The good news of salvation addresses mental disorder and the suffering which flows from it with the promise of acceptance, healing, integration into God's purposes and final redemption – there will be no mental illness in heaven. Participation in the life of the Church has the potential to give access to God as the ultimate source of love, hope and guidance and to provide stability and support within a Christian community. There is a considerable body of empirical research which suggests that church membership and religious practice are generally positive in their effects on mental health.

11. The other side of the process is the receptivity of the Church to people with mental health problems. Despite the liberating promise of the Gospel, churches are not immune from ignorance, misunderstanding and negativity about mental ill-health. Sometimes people seeking help and acceptance are met with attitudes of fear and rejection. Inadequate forms of theology and spirituality may deepen problems such as depression or anxiety by blaming them on personal sin or lack of faith, or produce dangerous reactions by attributing psychosis to demon-possession. The Church faces a learning process in order to shed harmful attitudes, to become sensitive to actual needs and to co-operate with both service users and mental health professionals. It was to give confidence and guidance to parishes in discussing mental health issues and providing pastoral and spiritual care that the training resource *Promoting Mental Health* was commissioned in 2003 and produced in 2004 - it is available online at <http://cofe.anglican.org/info/socialpublic/homeaffairs/mentalhealth/parishresource.pdf> Feedback indicates that the material has been found useful in assisting silence to be broken and experience shared within congregations in these areas of deep vulnerability.

12. The Church's engagement with people with mental health problems also requires an 'advocacy' role. Knowing that people with mental health problems are loved by God and are capable of contributing positively to society should commit Christians to countering stigma and discrimination towards them, and promoting the effective care and treatment that they need and deserve. The biblical and Christian tradition is full of examples of speaking for, and acting with, the powerless.

2: Mental Health Services

13. Part 1 of *Emerging Issues* traced the evolution of services since the 1959 Mental Health Act, which signalled a major shift from treatment in hospitals to care in the community. In particular it reviewed the entrenchment of patients' rights in the 1983 Act, the rise of the user movement in the 1980s and 1990s in protest against paternalistic treatment, the development of the Care Programme

approach under which health and social services co-operate to plan and deliver care in consultation with service users and carers, and the introduction in 1999 of the National Service Framework for Mental Health.

14. The National Service Framework, covering the needs of adults up to 65, defined seven standards for the delivery of care under key headings: mental health promotion, including issues arising from discrimination and social exclusion; primary care and access to services for people with common mental health problems; effective services for people with severe mental illness; caring for carers; and preventing suicide. The Framework established a ten-year programme for reform. The principles and the procedures set out are laudable but the real problem lies in providing the resources and organisation to implement them fully. The Government points out that since 1997 the number of consultant psychiatrists has increased by 55%, clinical psychologists by 69% and mental health nurses by 24%. Nevertheless, it is clear that mental health services are now facing severe cuts as a result of the funding crises in NHS Trusts.

Community health services

15. Under the NSF, the shape of community care has shifted from small mental health teams coping with diverse needs to specialised community services. Over 700 new mental health teams are offering home treatment, early intervention or intensive support. *Crisis resolution teams* offer treatment at home as an alternative to hospital admission, and in 2006 almost 100,000 people were treated. This would appear to be a promising development, but there are concerns that home treatment, while it avoids the traumas of admission, provides too restrictive an environment for recovery and fails to meet many of the social needs of the patient.

16. *Assertive outreach* teams provide intensive support in the community to people who might otherwise drift out of care and discontinue their medication. These are usually people with complex health and social needs, frequently involving drug misuse and offending against the law. Working with them is a challenge because they are not always motivated to co-operate with mental health services, and the multiplicity of their needs often leads to their falling between different agencies. In the last five years the number of people served in this way has virtually doubled, from about 11,000 to over 20,000. This is clearly a vital area of engagement, not only in meeting mental health needs but thereby preventing some people from entering the criminal justice system. If anything, it deserves an even higher priority than it has at present.

17. *Early intervention* teams have been introduced since 2001 in recognition of the need to deal as promptly as possible with young people who have developed a severe mental illness for the first time. They seek to provide rapid assessment and treatment, and in the last five years the number of young people served has risen from under 1,000 to over 12,000. The initiative is welcome, but the effectiveness of such services depends on the availability of age-appropriate assessment and treatment in hospitals, staffed by suitably qualified professionals. This need was recognised in amendments by the House of Lords to the Mental Health Act 2007 (see para. 40).

Treatments

18. The treatments available for mental illness offer a mixed picture. In terms of drug treatments, the last twenty years have seen a decline in the use of the older antipsychotic drugs which can have severe side-effects, and a corresponding increase in the use of so-called “atypical” antipsychotics which until the 1990s were rationed on account of their expense. The proper balance to be struck between drug and non-drug treatments is a matter of controversy, but there is general agreement that the latter ought to be expanded considerably. Despite the introduction of primary care therapists trained to deliver psychological therapies, a review of 174 mental health teams by

the Healthcare Commission in 2006 found that access to “talking therapies” (such as counselling and cognitive behavioural therapy) for people with schizophrenia was limited (only 50% of those questioned in a survey had access and in some parts of the country this dropped to 20%). There is some justification for the claim that such therapies are the victims of their own success, but this underlines the need to increase provision.

Mental health and social disadvantage

19. The 2004 report from the Social Exclusion Unit *Mental health and social exclusion* demonstrated in detail how mental health problems are interwoven with other forms of social disadvantage. The mention of contact with offenders in para. 16 draws attention to one of the major areas of omission and failure in mental health care. The stark reality is that between 1985 and 2007 the number of beds in psychiatric hospitals fell from 140,000 to 30,000 and the prison population rose from 40,000 to 80,000. 5,000 prisoners are reckoned to have a serious mental illness, while in 2002 70% of sentenced prisoners were estimated by the Social Exclusion Unit to be suffering from two or more diagnosable mental disorders. The relation between the two factors is complex, but it is inescapable that failures in community mental health care have a significant impact upon offending behaviour. The issue of mental health care in the criminal justice system will be taken up in ch. 4.

20. An area of concern for many years has been the relation between mental health services and members of black and minority ethnic communities. Within these communities there may be assumptions that mental health problems are the concern of families, and suspicion of the intrusiveness of mental health services, based on negative experiences of care and treatment. It has long been recognised that people from an African-Caribbean background are massively over-represented in diagnoses of severe mental illness and in admissions to secure psychiatric institutions, and they are less likely to be prescribed “talking therapies”. In 1997 a group of mental health charities highlighted the barriers of culture and language faced by BME groups in gaining access to services.

21. In 1998 the subject was dramatically brought into focus by the death of David ‘Rocky’ Bennett, a 38-year-old African-Caribbean man, after being restrained by staff in a medium secure psychiatric unit in Norwich. This was the subject of an independent inquiry which reported in 2004 and made damning criticisms of mental health services as institutionally racist and culturally insensitive. This spurred the Government to tackle the problem more vigorously. Its ‘Inside Outside’ programme of 2003 has been followed by a report and action plan ‘Delivering Race Equality in Mental Health’ (January 2005). There is a huge challenge to be faced in moving from diagnosis to effective action, which cannot be achieved without greater involvement of people from BME communities in service planning and delivery.

The balance sheet

22. The last ten years have seen substantial investment of resources and staff in mental health care, and some success in areas like the prevention of suicide (a reduction of 7.4% in the general population and 29% among mental health in-patients, and a welcome fall among men aged 20-35 in five consecutive years). National patient surveys by the Healthcare Commission have reported high levels of satisfaction with care. However, the services face a huge reservoir of need, and their concerns are not high on the list of political priorities. Even with new initiatives in community health care, there are still major problems of access, particularly for those with low-level mental health problems which have not become severe or enduring. The Healthcare Commission found in 2006 considerable dissatisfaction with out-of-hours crisis care. The Government’s National Director for Mental Health, Professor Louis Appleby, has quoted Dr Matt Muihen, Head of mental

health in Europe for the World Health Organisation, as saying that the services are subject to a “culture of criticism”. However, despite much excellent and dedicated work, from the point of view of those who suffer there are weighty and painful reasons for criticism.

3: Mental Health Legislation: Replacing the 1983 Act?

Mental health and public safety

23. For ten years the Church of England has been involved in the debate on mental health legislation. Since 2000, it has been an associate member of the Mental Health Alliance, an unusual coalition of 80 organisations set up in to campaign against the Government’s proposals to alter the conditions for compulsory detention and treatment of people with mental disorders. *Emerging Issues* traced the earlier stages of the debate. The official review of the 1983 Mental Health Act, chaired by Professor Genevra Richardson and published in 1999, took a wide-ranging approach which stressed the importance of improving access to services and advanced a set of principles to safeguard the rights and interests of patients. However, it was overtaken by governmental and public concerns about public safety in the light of some well-publicised failures in the 1990s to manage people with severe mental illness who went on to commit murder. Much of the controversy, arising particularly from one notorious case, centred on a category of people with so-called “Dangerous Severe Personality Disorders” (probably fewer than 1,000 who need secure accommodation) who apparently could not be detained under the 1983 Act because their condition was regarded as untreatable.

(1) The Bill of 2002

24. The Government issued a consultation paper in 1999 entitled *Managing Dangerous People*, which proposed to relax the conditions for compulsory detention by removing the “treatability” condition from the 1983 Act. This was followed by a White Paper in 2000 and a draft Mental Health Bill in 2002. The Bill aroused strong opposition from psychiatrists, service users and carers and many other groups on the ground that it required mental health services to undertake preventive detention rather than health care. The response of the Church of England Board for Social Responsibility to the 2002 draft Bill was appended to the report *Emerging Issues*. Soon afterwards the draft Bill was withdrawn and a new version prepared in an attempt to meet criticisms.

(2) The Bill of 2004

25. The second draft Bill was published in October 2004, accompanied by the establishment of a Committee of both Houses of Parliament to undertake pre-legislative scrutiny of the Bill. The Mission and Public Affairs Council, on the advice of its Mental Health Interest Group chaired by the Ven. Arthur Hawes, made a submission to the Joint Scrutiny Committee reiterating its opposition to the changes proposed to the conditions for detention and expressing concern that the proposals for compulsory treatment in the community might threaten rather than improve the engagement of vulnerable patients with mental health services. The submission welcomed the proposals in the Bill to strengthen detained patients’ rights through appeal to Mental Health Tribunals, but questioned whether the Tribunals would be adequately staffed and resourced.

26. In March 2005, having taken a large volume of evidence, the Joint Scrutiny Committee, chaired by Lord Carlile of Berriew, published a comprehensive report on the Bill. This endorsed most of the arguments put by the Mental Health Alliance in criticism of the Bill and made a large number of recommendations for improving it. There followed a long period of campaigning and further argument while the Government decided what action to take. Eventually, in April 2006, the

Department of Health announced that rather than proceeding with a wholly new Bill, the Government would seek to achieve its objectives by amending the 1983 Act on a limited number of points. This outcome was a considerable triumph for the Mental Health Alliance, but it meant that many positive features of the draft Bill were now lost, and while the remaining proposals were an improvement on their predecessors, they remained questionable in some respects.

(3) The Bill of 2006

27. The new Bill was introduced into the House of Lords in November 2006. At Second Reading the Bishop of Manchester delivered a speech setting out the Church's reservations, and during the Committee stage bishops made a number of interventions in support of key amendments, many of which were carried. Broadly speaking, the House of Lords amended the Bill in line with the recommendations of the Joint Scrutiny Committee and against the wishes of the Government. In addition a number of uncontroversial changes were agreed, such as those relating to the assessment and treatment of children and young people. On the passing of the Bill to the Commons, most of the significant Lords' amendments were reversed in Committee, a development which caused some frustration to campaigners but was only to be expected. However, the efforts of MPs concerned for mental health issues ensured that some issues were re-opened and debated on the floor of the Commons at Report stage, and a number of compromises were achieved, notably on the vexed question of "treatability". The Bill received Royal Assent in July 2007 and became the Mental Health Act 2007. In its final form it neither fulfilled the original intentions of the Government nor met all the concerns of its critics, but it was the product of a sustained and searching debate without which it would have been much less satisfactory.

Liberty versus safety

28. Central to the Act is the re-definition of the conditions under which people may be subject to compulsory powers for assessment and treatment. The Government's argument was that many people with severe mental disorder who needed treatment, and might be a danger to themselves or others were denied it, on account of the inadequacy of the conditions laid down in the 1983 Act, and the way in which they were sometimes interpreted by clinicians. Broadly speaking, the Government, supported by some mental health professionals and carers, held that the existing conditions were weighted too strongly towards the liberty and autonomy of the patient at the expense of the need to protect the welfare and safety of the patient and other people. Conversely, a majority of mental health professionals and service users held that the conditions for compulsion should not be loosened, because the rights and interests of the patient must be safeguarded against the application of highly intrusive powers.

Patient autonomy and compulsory detention

29. A normative concept which has lain behind these debates is that of patient *autonomy*, which plays a key role both in medical ethics and modern liberal accounts of human personality. Because modern theology has often been critical of the concept of autonomy used by liberal thinkers, it is worth commenting here on its use in the field of mental health. The word "autonomy" means "self-direction" or "self-determination" and in the 18th century expressed many of the ideals of the European Enlightenment. In practical terms, it is used to refer to the unconstrained right of the individual to make their own decisions on matters where their own rights and interests are paramount. The principle of patient autonomy is generally accepted in decisions about medical treatment as a consequence of recognising the individual's right to determine what should be done to their own body, and operates through the process of consent (which in mental health was first introduced in the 1983 Act).

30. It is useful to distinguish between autonomy or self-determination as an overriding moral or political value (in which case it has severe defects and limitations) and as a corrective concept designed to protect the individual from the unjustified exercise of power over them by others. It is this second usage which is relevant to the treatment of people suffering from mental health problems, because such people (and their carers) are subject to institutional and professional power. To detain someone against their will in order to force them to accept a process of assessment and treatment is a serious infringement of liberty, and it should be sanctioned only in cases of strong necessity, and with safeguards.

31. The key legal criteria for compulsory detention for assessment or treatment are first, that they should be suffering from a mental disorder of such a nature or degree that they need to be assessed or treated in hospital, and second that such detention is necessary in the interests of their own health or safety or with a view to the protection of other people. Further legal conditions are a refinement of the two basic criteria. Under the 1983 Act, “sectioning” (that is detention for 28 days for assessment and treatment under Section 2, for 6 months for treatment under Section 3) is made on the basis of an application supported by two medical recommendations. It is limited in time and is subject to various safeguards such as appeal to Mental Health Act Managers or Mental Health Review Tribunals.

The definition of mental disorder

32. The 2007 Act substitutes a single definition of mental disorder for the fourfold categorisation in Section 1 of the 1983 Act to “severe mental impairment, mental impairment, psychopathic disorder and mental illness”. This is a gain in clarity, and one potential disadvantage was removed by the Government’s agreement to make explicit, as did the 1983 Act, that a learning disability could not itself constitute mental disorder unless accompanied by “abnormally aggressive or seriously irresponsible” conduct.

33. Also at issue was the specification of “exclusions”, that is, conditions which may co-exist with mental disorder, but do not themselves constitute mental disorder or provide grounds for use of compulsory powers. The 1983 Act specifies “promiscuity or other immoral conduct, sexual deviancy or dependence on alcohol and drugs”, in an attempt to avoid using detention as a means of social control. The 2006 Bill originally abandoned exclusions on the ground that they could be used to deny treatment to people with “dual diagnosis” (e.g. the co-existence of mental health problems with alcohol and drug misuse). Attempts were made in the Lords to reintroduce exclusions (disorderly conduct, sexual orientation, and religious, cultural and political beliefs – the last attempting to deal with problems such as over-diagnosis of schizophrenia among people from black and minority ethnic backgrounds). These were finally defeated, but alcohol and drug dependence were reinstated. Ministers promised that the operation of other exclusions would be dealt with in the Code of Practice. It is critically important that the Code should make clear that paedophilia is not to be regarded as a mental disorder.

Medical treatment and “therapeutic benefit”

34. The most hotly-contested part of the Act was the re-definition of the meaning of “medical treatment” as it bears upon the criteria for use of compulsory powers. Section 3 of the 1983 Act required that in the case of psychopathic disorder or mental impairment, treatment given under compulsion should be “likely to alleviate, or prevent a deterioration in, the patient’s condition”. It was because the application of this test to people with so-called Dangerous and Severe Personality Disorders led to the use of compulsory powers being refused on the ground of untreatability that the Government desired to substitute a simple requirement that appropriate medical treatment should be available. It was now feared that the broadening of the definition of treatment to include forms of

nursing without any prospect of “therapeutic benefit” would remove the clinical justification for detaining people and would result in psychiatrists and mental health services becoming agents of detention for the sake of public safety alone, a function that should belong to the criminal justice system.

35. At a late stage, an amendment moved by Chris Bryant MP and approved by the House of Commons (now Section 7 of the Act) provided that “medical treatment” should include “psychological intervention and specialist mental health rehabilitation, rehabilitation and care” but also that any reference in the Act to medical treatment should cover “treatment the purpose of which is to alleviate, or prevent a worsening of, the disorder or one or more of its symptoms or manifestations”. This has the merit of meeting the Government’s concern about misuse of the treatability test while preserving the requirement of therapeutic benefit, although defined more broadly (by including symptoms and manifestations of the disorder) than some critics of the Bill would have wished. It was close to the approach recommended in the 2004 MPA submission to the Joint Scrutiny Committee, and it should be noted that as a consequence of the single definition of mental disorder it extends the treatability test to all patients, not solely those with psychopathic disorder or “mental impairment”.

Impaired decision-making

36. Critics of the Bill sought to add “significant impairment of decision-making in respect of medical treatment” to the criteria for compulsion. This is a feature of the 2003 Scottish Mental Health Act and reflects a strong commitment to patient autonomy. It would have the consequence of making it impossible to apply compulsory powers to anyone who was mentally disordered but retained the capacity to refuse treatment. It was asserted in favour of the change that a mental disorder sufficiently serious to warrant assessment or treatment in hospital would normally entail significant impairment of decision-making, but the Government argued that while it is always preferable for treatment to be given by consent, in some cases the two conditions would not coincide, giving rise to unacceptable risk of harm to the patient or others. The amendment was defeated in the Commons.

Supervised community treatment

37. The other highly controversial part of the Bill was the provision for supervised community treatment, which was a response to major defects in community care leading to the relapse of service users, whether from failure to continue taking medication or for other reasons. Community treatment orders are used in many countries, and their effectiveness is a matter of debate. Much research suggests that a disproportionate amount of compulsion is required to prevent a relatively small number of relapses, and that use of it results in a deterioration in the patient’s condition. Nevertheless, there was considerable agreement that some extension of compulsory powers to community treatment was required to address the needs of so-called “revolving-door” patients and to relieve pressures on families and carers who too often feel powerless, burdened and anxious as they witness the unchecked deterioration of their loved ones and those for whom they are responsible. The argument concerned how to make such measures effective.

38. Proposals for supervised community treatment had progressively been shifted in a less draconian direction in successive versions of draft legislation, and the Joint Scrutiny Committee had called for the conditions of community treatment orders to be tightened so as to be applicable only to a clearly defined group of “revolving-door” patients, and it was argued by many in the Mental Health Alliance that CTOs should be applied only to patients who had undergone prior compulsory admission to hospital and then relapsed as a result of failing to take medication. The Bill of 2006 restricted the use of CTOs to those who had been detained in hospital for treatment or had received

a hospital order through the courts, but allowed the imposition of conditions with very little restriction, so that orders were described by the Alliance as a “psychiatric ASBO”.

39. These defects were mitigated by amendments during the passage of the Bill giving the responsible clinician power to recall a patient to hospital should there be a risk of the patient’s condition deteriorating, and requiring that conditions attaching to a CTO should only be imposed to achieve certain objectives: ensuring that the patient receives medical treatment, preventing harm to their health or safety and protecting other persons. As with other aspects of the legislation, much will depend upon the specification of the operation of CTOs in the Code of Practice guiding the implementation of the Act and, as always, clarification in future legal judgments.

Other issues

40. A number of other significant improvements were made during the passage of the Bill. After initial reluctance, the Government conceded that independent mental health advocates should be available for all patients liable to be detained, for discussion of the most serious forms of medical treatment, and for adults making decisions about the provision of electroconvulsive therapy (ECT). Another major advance was the statutory requirement for appropriate treatment to be provided for patients under 18. This intended to prevent anomalies such as the admission of children or young people to adult wards, to ensure the availability of relevant expertise in the assessment process and to guarantee age-appropriate facilities and staff training (much of this to be worked out in the Code of Practice). It was agreed that patients taken to a place of safety under Sections 135 and 136 of the 1983 Act should be able to be moved to another place of safety and should not be held for more than 72 hours unless, after assessment, another Section is imposed. The Code of Practice will provide that police stations should be used as places of safety only in exceptional circumstances.

41. Many critics regretted the absence of guiding principles on the face of the Bill, as recommended by the Richardson Committee. However, Section 8 which governs the Code of Practice requires that the Secretary of State should include in the Code a statement of fundamental principles to inform decisions under the Act, and in doing so should address the following matters: respect for patients’ wishes and feelings; minimising restrictions on liberty; involvement of service users in planning, developing and delivering care and treatment; avoidance of unlawful discrimination; effectiveness of treatment; views of carers and other interested parties; respect for diversity, patient wellbeing and safety; and public safety. These are potentially important levers for the improvement of services, and their expression in the Code of Practice rather than statute may enable them to develop in response to changing needs.

A missed opportunity?

42. The overall assessment of the 2007 Act must therefore be mixed. As a result of persistent and determined campaigning, it was a good deal better than it might have been had the earlier draft Bills proceeded. However, it still contains some provisions whose effects remain to be seen, and the decision to amend the 1983 Act piecemeal has meant that the opportunity was lost to craft a new framework of legislation appropriate to the 21st century – in particular, to reflect the reality that most people with mental ill-health are now treated in the community rather than in hospital. One major omission is the principle of “reciprocity” championed by the Richardson Committee – that if mental health services users are to be subject to compulsion for their own good, they should also have a right to assessment of their needs. The difficulty of obtaining timely assessment is at the root of many failures in services, and to remedy it would reduce the seriousness of many situations further along the line.

4: Mental Health and the Criminal Justice System

Care in custody?

43. Martin Narey, the former Director General of the Prison Service, said in 2002, “Since the late 1980s, the proportion of the prison population who show signs of mental illness has risen seven-fold. For them, care in the community has become care in custody.” That statement shows a necessary awareness of the wider context of the problem. Many recent studies have confirmed in detail what people working in prisons already knew from experience: that the incidence of mental health problems of all kinds in prison is strikingly higher than in the general population. As was suggested in paras. 16 and 19, this reflects the fact that the mental health of offenders is bound up with various forms of social disadvantage and complex personal needs, notably substance dependence. In her introduction to a recent thematic report *The mental health of prisoners* (October 2007), the Chief Inspector of Prisons, Anne Owers has summed up the need for a “twin-track” approach: “There are still too many gaps in provision, and too much unmet and sometimes unrecognised need, in prisons...the need will always remain greater than the capacity, unless mental health and community services outside prison are improved and people are appropriately directed to them: before, instead of, and after custody.”

44. The first full survey of the mental health of prisoners, in 1998, showed high rates of personality disorder: 78% for male remand prisoners, 64% for male sentenced prisoners and 50% for female prisoners (compared with 10-13% in the general population). 7-10% of male prisoners also displayed functional psychosis (e.g. schizophrenia or a bi-polar condition). Similar results are reported for young offenders. Female prisoners are more likely than male prisoners to have been treated for a mental health problem and to have been admitted to a psychiatric hospital. One survey found high rates of psychosis (14%) and neurosis (13% sentenced and 27% remands) among women prisoners. Mental health problems are associated with increased risk of suicide or propensity to self-harm, particularly among young people and women. And while members of black and minority ethnic groups are less likely to have mental health problems identified by a GP, people from African-Caribbean groups are twice as likely to be referred to mental health services by both police and the courts.

45. Since the 1996 report from the (then) Chief Inspector of Prisons, *Patient or prisoner?*, determined efforts have been made to improve mental health care in prisons. Prisons have always suffered from their lack of integration into mainstream health services, so it was in principle a welcome move, from 2002 onwards, to transfer responsibility for commissioning and provision of health care to NHS primary care trusts. This did however have the disadvantage that services were commissioned from mental health trusts unaccustomed to the environment of prison and the high level of primary health care needs, by PCTs for whom mental health was not necessarily a high priority. The result has been a rather steep learning curve for all concerned.

Mental health in-reach teams – not a panacea

46. Even before the switch of commissioning, the NHS began to fund psychiatric nurses to offer in-reach services to prisoners as part of the implementation of the National Service Framework in prisons. This led to the deployment of *mental health in-reach teams* (MHIRTs) whose function is to offer wing-based primary care and to be involved in transfer arrangements and suicide prevention. By 2007 80% of prisons had such teams. Typically, a core group of psychiatric nurses liaises with other professionals such as psychiatrists, occupational therapists, drugs workers and counsellors. Their intended client group is prisoners with severe and enduring mental illness, and they seek to offer training in mental health awareness to prison staff. Interestingly, in many prisons a great deal of counselling is provided by the Chaplaincy.

47. The thematic report from the Inspectorate confirms what other observations and surveys have suggested: that MHIRTs find the scale and intensity of mental health need beyond their ability to meet. A report on the London prisons in April 2006 by the Sainsbury Centre for Mental Health found that team members were diverted from their task of dealing with severe and enduring illness by a myriad of basic demands, and that communication with other staff and support structures were inadequate. The Inspectorate found unclear relationships between MHIRTs and the GPs responsible for primary health care, and reluctance by some MHIRTs to receive referrals from prison staff. It also found that commissioning failed to take account of the high incidence of learning disabilities in prison (at least three times that in the general population).

48. The effectiveness of mental health care is dependent upon co-ordination with other processes in prison. The Inspectorate found that reception screening for mental health needs was variable. Information from outside prison about psychiatric history was not always sought, and disclosure of a history often failed to evoke a recorded response or to lead to referral to the MHIRT. Requests for mental health support were not always followed up, and there were strong indications that screening underestimated the actual level of mental distress. Information was not always passed on when transfer between prisons took place. Within prisons there was sometimes a lack of teamwork in managing at-risk prisoners and care programmes. Two-thirds of MHIRTs attempted to co-operate with substance misuse teams, but there was no evidence of shared work with psychologists and probation staff. There was also inadequate connection between mental health care and resettlement teams, including contact with community mental health teams in preparation for release.

Women's needs

49. In the survey by the Inspectorate of mental health needs on reception, women had higher levels of previous and current mental health problems than men, but were less likely to receive a secondary health screen. They had higher levels of drug use than men, but lower levels of alcohol dependency, and about one-third were referred on arrival to a doctor for substance misuse problems. Two-thirds exhibited signs of psychological distress. There were high levels of medication, but also a wider range of interventions available for female than male prisoners.

BME prisoners

50. There was evidence of a lower level of engagement of MHIRTs with BME prisoners. Mental health issues identified on reception were less likely to be followed up for BME than white prisoners, and fewer underwent detoxification. Although BME prisoners appeared to exhibit similar levels of psychological distress on reception, fewer were referred to a GP or the MHIRT. This seems to reflect the situation in the community, and suggests the need for more culturally sensitive service provision.

51. The Inspectorate also interviewed 66 MHIRT clients, nearly half of whom were suffering from depression or self-harm, and a smaller proportion from psychosis. 50% had physical health problems and 70% suffered from substance dependence. Two-thirds had a care plan, and 57% said they had been given some choice about their treatment. They expressed appreciation of the value of out-of-cell activity and personal support from staff and other prisoners, but the main elements of treatment were medication (77%) and regular appointments with a mental health professional (58%). Only 58% had a key worker or regular contact with families.

52. There is therefore a need for considerable improvement in the system of mental health care in prisons. The Inspectorate has recommended better planning of services to deal with complex

needs, including the specific needs of women and BME prisoners, and has called on the Department of Health and the National Offender Management Service to ensure that commissioning arrangements support joint working between mental health care and other services. It calls for more effective reception screening and sharing of information on psychiatric histories, and makes a large number of detailed recommendations on the organisation and management of primary and secondary care.

Offender health in the community

53. However, changes in this area need to be accompanied by improvements in care in the earlier stages of the criminal justice process. There is clearly a danger of resources from PCTs being channelled into prison health care at the expense of preventative and diversionary measures. The need for multi-agency working to deal with complex needs of offenders is as applicable in the community as in prisons. NACRO has argued that PCTs, Regional Offender Managers, local authorities and the voluntary sector should co-operate in order to review and commission services for offenders with mental health needs, with PCTs acting as the lead agency for offender mental health care across the whole criminal justice system - not least in the youth justice system, where health care provision in Youth Offending Teams appears to be sparse. It proposes that these arrangements should aim to expand the range of treatments available through community health services, and to provide treatments for personality disorder and people with a dual diagnosis. At the same time, every effort should be made to move offenders with serious and long-term needs to secure hospital units for treatment.

Diversion through liaison schemes

54. Since the late 1980s, repeated attempts have been made to divert people with mental health needs from the criminal justice system through mental health liaison schemes based in police stations or magistrates' courts and staffed by a community psychiatric nurse. The aim has been to identify and provide assessment for mentally ill people at an early stage and either to place them with acute services or to organise care in the community. The Prisons Inspectorate has pointed out the importance of being able to assess both mental health needs and risk to the public. However such schemes have been fragmented and diverse in operation, without adequate planning, resourcing or co-ordination between mental health and social care agencies. Where they have been evaluated, they have frequently improved outcomes both in terms of health and prevention of re-offending, but they have been impeded both by the shortage of NHS acute beds and the difficulties of liaising with community services. It also appears that many PCTs are not well-informed about liaison and diversion schemes in their area. It is time for a thoroughgoing attempt to create a national system of diversion.

Neighbourhood policing

55. In its analysis of early interventions in offender healthcare, the Revolving Doors Agency, which works with offenders with mental health needs, has drawn attention to the importance of mental health awareness at an even earlier stage in the process: that is, in neighbourhood policing. The police are in a unique position to work proactively with other agencies to identify mental health problems in potential or actual offenders and to direct them to appropriate services. Unfortunately, many neighbourhood policing teams seem to be encouraged to deal with disorderly behaviour through the imposition of ASBOs (Anti Social Behaviour Orders) and PNDs (Penalty Notices for Disorder). These have the effect of dealing with the immediate impact rather than the causes of disorderly behaviour, and may impede engagement with underlying problems, which often have a mental health dimension. A balance needs to be struck between enforcing the law for the sake of the community and providing support for individual with aim of preventing future offending.

Revolving Doors cites examples of local schemes in Buckinghamshire, Northamptonshire and Westminster in which groups work to tackle anti-social behaviour proactively and co-operatively with attention to emerging mental health problems. Research into the use of the power of arrest under Section 136 of the 1983 Act indicates that police identify mental illness in 2 out of 3 cases.

Mental health community orders

56. Anne Owers spoke of directing people to mental health and community services “before, instead of, and after custody.” While action “before” is always preferable, it is important to explore the scope for alternatives and aftercare. NACRO points out that where courts in sentencing make a decision in favour of treatment rather than custody, they tend to follow the option of a hospital order rather than treatment in the community, even if this might be more appropriate to the offender’s needs and more effective in reducing re-offending. In investigating the use of community orders, the Centre for Crime and Justice Studies found that the community order carrying mental health requirements was under-used in comparison with drug treatment requirements (591 as opposed to 11,361 in the year from August 2005 and July 2006). As with other policies, the use of mental health community orders would require greater liaison between local agencies, but it is an option worth encouraging.

Resettlement needs

57. Mental health is part of one of the official “pathways to resettlement” of prisoners, but it is clear that much remains to be done to make it a reality. Once again, we are in the territory of managing “complex needs”, with the danger of “boundary exclusion” between different services. The model of offender management, with the planning and delivery of co-ordinated services, offers a good framework in theory but its success depends on effective communication between the prison and the area to which the prisoner is discharged (usually involving different PCTs) and between agencies in each area. It will be instructive to see how the voluntary sector (including faith-based organisations such as Community Chaplaincies) can aid statutory agencies in this work.

Time for action

58. There is a widespread feeling in the criminal justice sector that the time has come for analysis to end, and for serious action to begin, in diverting people with mental health problems from custody. Nearly 40 years after the need for regional secure units was recognised, fewer than 60% of them are in existence. Improving services for offenders will make heavy demands on resources, but the human and financial costs of failing to act will be massive. In 2004 the Health and Offender Partnerships Directorate was established to develop an Offender Health Programme, and during 2006 the Department of Health and the Ministry of Justice entered an Offender Health partnership. Currently a consultation on a health and social care strategy for people subject to the criminal justice system (*Improving Health, Supporting Justice*) is being undertaken jointly by the Departments of Health and Children, Schools and Families, the Ministry of Justice, the Youth Justice Board and the Home Office. It was also announced in November 2007 that the Labour peer Lord Bradley will conduct a review of mental health in the criminal justice system and will report in the summer of 2008. It appears that change is in the air, and it is profoundly to be hoped that this will prove to be a new beginning rather than another false start.

5: Mental Health and Spirituality

59. Part 3 of *Emerging Issues* highlighted the huge recognition given to spirituality in the field of mental health since the mid-1990s through initiatives undertaken by mental health chaplains,

voluntary organisations, faith communities and members of the Royal College of Psychiatrists, whose special interest group on spirituality has grown steadily and is now the largest group within the College. That these initiatives have flourished and received endorsement from the NHS and from government is the result of many factors, but three deserve particular mention.

“Over-medicalisation”

60 First, attention to the spiritual dimension of mental health and mental health care has to some extent come as a reaction against the over-medicalisation of mental health. There has been increasing awareness that mental health problems cannot be understood satisfactorily apart from the meaning which human beings give to their experience, the beliefs they hold, the values they aspire to and the hopes they entertain. This has been supported by empirical evidence of the positive effects of religious and spiritual practice upon mental health and recovery from mental illness (though negative effects must also be acknowledged).

The user perspective

61. Second, the so-called “user revolution” which has sought to give greater weight to the perceptions, interests and wishes of mental health service users in relation to their own care and treatment, has reinforced the rediscovery of spirituality. This is a reflection of the fact that many service users have an active faith or spirituality and see it as integral to their self-management of illness and recovery. Those who take this view tend to oppose what has been called above “over-medicalisation” of mental health and over-reliance on medication in treatment. It is also true that many service users have had negative experiences of organised religion and have developed an individual and eclectic spirituality which is an expression of their hard-won identity. Some would describe themselves as “survivors” of involvement with mental health services, and even with religion. Many of these issues are discussed, with examples, in the recently-published book, *Spirituality, Values and Mental Health: Jewels for the Journey*, edited by Mary Ellen Coyte, Peter Gilbert and Vicky Nicholls (Jessica Kingsley, 2007).

Spirituality: gateway and umbrella for co-operation

62. Third, the focus on spirituality has enabled faith communities and people with non-religious beliefs to work together on mental health issues without surrendering their own distinctiveness. It is true that from one side “spirituality” is a term with a rich history in the Christian tradition, and from the other that generic uses of the term to describe common concerns shared between many religious and non-religious traditions will inevitably fall short of the full meaning given to the term by Christians, who understand spirituality to denote the activity of the Holy Spirit who is the Spirit of God and Spirit of Christ. However, it is rightly described as a “gateway term”: the concept provides an overarching description of diverse experiences and orientations to ultimate reality which in practice enables people from a variety of backgrounds to contribute to shared enterprises with integrity and confidence. For example, the National Spirituality and Mental Health Forum includes representatives from the nine faiths recognised by the NHS, the British Humanist Association and others without a specific religious affiliation.

The impact of spirituality

63. We may therefore adopt as a working definition of spirituality that formulated by John Swinton and Stephen Pattison, consciously bringing together health and theological perspectives:

Spirituality can be understood as that aspect of human existence which relates to structures of significance so as to give meaning and direction

to a person's life and helps them deal with the vicissitudes of existence. It is associated with the human quest for meaning, purpose, self-transcending knowledge, meaningful relationships, love and a sense of the Holy.

(Swinton & Pattison, *Health Service Journal*, 2001)

64. This makes it clear why spirituality is deeply relevant to mental health: it shares much of the same territory, but seeks a holistic approach to life and recognises in some form an "extra" dimension of transcendence or depth. While spirituality may be associated with religion, and very commonly is, it is not confined to it. The term must be guarded against misunderstandings which restrict it either to the individual as opposed to the social, or the inward as opposed to the outward. The definition includes a reference to relationships, and indeed the whole of it may be construed in terms of interaction with others. Similarly, the centrality of finding meaning and direction in life precludes too narrow an account of the matters with which spirituality engages – in principle, nothing human is alien to it. Christians, for whom the Spirit of God is the Spirit of fellowship and the Creator Spirit, should sympathise with this wide-ranging interpretation.

Spiritual care

65. The main purpose of securing a place for spirituality on the agenda of mental health planning is to make spiritual care a normal part of mental health care. In seeking this, there are a number of desirable outcomes in view. First, it is part of respecting the beliefs and values of the patient that their spiritual needs are acknowledged and incorporated into the process of assessment, treatment and recovery. Second, there are good reasons to believe that spiritual care will assist recovery. On the basis of her work with black service users, Dr Joanna Bennett has set out four elements of recovery, to which faith and spirituality can make a powerful contribution: the awakening of hope, the re-establishment of identity, the discovery of meaning and the assumption of responsibility. Conversely, the denial or suppression of spirituality may be detrimental, as many have found. Third, spiritual care may help services to work with carers, particularly if they share the same religion or spirituality. Fourth, spiritual care should assist co-operation between mental health services and faith communities.

66. That said, there are considerable practical issues to be resolved in mainstreaming spiritual care rather than leaving it to chaplains or religious "professionals". Where is the responsibility to be placed for assessing and delivering spiritual care, and how is it to be done? For understandable reasons many NHS staff are wary about their ability to become involved in patient spirituality, which calls for enhanced training. There are various systems for assessing spiritual needs, which try to avoid the superficiality of a "tick-box" approach while allowing staff to ask and record answers to questions in ways which are within their competence. The practice of spiritual care requires a change of culture within health care services, and developments are still at an early stage.

Work in progress

67. *Emerging Issues* recounted several examples of pioneering national work in the field from the mid-1990s onwards, and it is appropriate here to bring the story up to date. The multi-faith Spirituality and Mental Health Forum has gone from strength to strength in bringing together representatives of faith communities, mental health professionals and service users to discuss matters of common concern in mental health care. Chaired by Dr Martin Aaron, the Forum meets about five times a year to receive and discuss presentations from various standpoints. In addition to those who attend the meetings it has more than 1,000 contacts on its mailing list who receive by e-mail the material which is presented, with accounts of the discussions. The Forum is seeking to expand its work by meeting outside London (so far, in Birmingham and Stafford) and is encouraging the formation of regional "chapters" across the country. In 2006 it formalised its status

by becoming a Company Limited by Guarantee. It now has a 24-strong Board of Trustees, of whom the Chair is Dr Aaron and the Vice-Chair the Ven. Arthur Hawes.

68. Reference was made in the earlier report to plans for the National Institute for Mental Health, as a development agency of the NHS, to sponsor a Spirituality and Mental Health Project. These plans came to fruition in 2003 with the appointment of Professor Peter Gilbert, Professor of Social Work and Spirituality at Staffordshire University and a former director of social services, as NIHME project lead on spirituality. Backed by a Steering Group, Professor Gilbert has developed an extensive and highly successful network which has promoted a wide range of initiatives relating to the incorporation of spirituality into the commissioning of mental health services, processes of assessment and treatment, and training of NHS staff. The Project has supported the institution of a number of “pilot sites” in local NHS trusts where innovative ways of relating spirituality and mental health care have been introduced and evaluated. Unfortunately, the Project will shortly come to an end, and there are anxieties that without national leadership and co-ordination, much of this pioneering work will be dissipated and will not develop as it should.

69. A highlight of the work of both the Spirituality and Mental Health Project and the National Forum has been the joint sponsoring of two multi-faith symposia, hosted by Staffordshire University. The first, in November 2006 took as its theme *Nurturing Heart and Spirit*, and invited prepared statements from the nine NHS-recognised faiths and the humanists on their understanding of mental health and mental illness, as the background to a day conference. These proved to be rich and illuminating. At the conference further searching contributions were made by service users, and representatives of the faiths took part in stimulating discussions on case studies. The occasion was notable for the honesty, openness and respect with which participants spoke and listened to one another in dealing with difficult topics and deeply-held convictions. The conference papers have been written up in a PDF document, and it is hoped that they will be published in permanent form. The second symposium took place in January 2008, on the subject of mental health in relation to death and end-of-life issues. Entitled *From the Cradle to Beyond the Grave?*, it too was well-attended and much appreciated.

Promoting Mental Health: the resource pack

70. A direct outcome of the 2003 debate was the production of the pack *Promoting Mental Health: a resource for spiritual and pastoral care*. Commended by Synod, it was commissioned jointly by the Mission & Public Affairs Division (including the Hospital Chaplaincies Council) and NIMHE, and written by Mary Tidyman and Linda Seymour of the charity Mentality. After being piloted among a number of church groups, it was revised and launched on World Mental Health Day, 10th October 2005. Since then, work has continued in dioceses, deaneries and parishes to disseminate it and encourage its use. A group of eight “ambassadors” has spoken to about half of the Diocesan Synods as part of publicising the topic of mental health, and in many places diocesan social responsibility and mental health groups have promoted it.

71. The aim of the pack is to enable local churches to explore mental health issues through bringing together service users and carers, church members and mental health workers in structured workshops and activities. It is available online (see para. 11) to be downloaded and used as needed. The pack is not a ready-made course, but a recipe book to be used by local groups of people interested in mental health who want to set up discussion and training events. The first part of the

pack consists of guidance for setting up events, with a stress on the need to involve service users in planning, delivery and debriefing. There are two sets of resources: first, an outline of programmes for different events (discussion evenings, day conferences, etc) on various topics, and second, ten information sheets on different themes which can be used either by facilitators or participants in the events. Those who organise the events should not feel they need to know everything about the topic: the purpose of the process is to bring together people with the relevant experience, knowledge and wisdom so that it can be released and shared in a safe and relaxed setting.

The crucial resource: people

72. This leaves us with the concluding thought that the Church's key resource in dealing with mental health issues is *people*: people who know what it is to suffer from mental health problems, and those who seek to be with them, to support them and learn from them. There is a great deal of experience and expertise within the Church on which we all may draw. There are mental health chaplains, centres such as the St Marylebone Centre for Healing and Counselling and Holyrood House at Thirsk in North Yorkshire where Christian spirituality and ministry and mental health needs are brought together, and lay Christians who work in mental health services in various roles. However, those with such ministries would agree that the real "experts" are those whose learning has taken place in their own lives.

73. From 1841 until his death in 1864, the manic depressive "peasant poet" John Clare was confined in the Northampton General Lunatic Asylum. At some time in the mid-1840s he wrote this poem:

"I Am"

I am – yet what I am, none cares or knows;
My friends forsake me like a memory lost: -
I am the self-consumer of my woes; -
They rise and vanish in oblivion's host,
Like shadows in love's frenzied stifled throes: -
And yet I am, and live – like vapours tost

Into the nothingness of scorn and noise, -
Into the living sea of waking dreams,
Where there is neither sense of life or joys,
But the vast shipwreck of my life esteems;
Even the dearest, that I love the best
Are strange – nay, rather stranger than the rest.

I long for scenes, where man hath never trod
A place where woman never smiled or wept
There to abide with my Creator, God;
And sleep, as I in childhood, sweetly slept,
Untroubling, and untroubled where I lie,
The grass below – above the vaulted sky.

It is in the crucible of experience that we gain the deepest insights, both into what it means to be human "in sickness and in health" and into the goodness, mercy and faithfulness of God, who walks with us in the valley of the shadow and promises to bring us home to himself.

Dr P.J. Giddings, Chair, Mission and Public Affairs Council

(This report was drafted by the Revd Christopher Jones with the assistance of the Venerable Arthur Hawes, Archdeacon of Lincoln, and draws upon the latter's extensive involvement over many years with mental health issues)