Rehabilitation and Social Psychiatry Faculty Newsletter

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Theresa Tattan

A word from the editors

Times are a' changing, as they do; and now is, it seems, a time for hope for Rehabilitation and Recovery services. The Government's agendas of social inclusion and the NSF for long-term conditions are completely consistent with core rehabilitation principles. Sarah Davenport and Frank Holloway - in their outgoing and incoming Rehab and Social Faculty Chair's reports - summarise for us what has recently been achieved and where we aim to go, in the short term at least. Having partners like Rethink on the Exec has certainly been very helpful in keeping us focused on what is important for users of our services and their carers, as well as helping us to learn the politics of facilitating change.

This edition is about ideas, essential in Rehab services; how to do it guides to commissioning; the Clinical Excellence Awards proces; and an introduction to your new Executive committee. Peter Lepping's Douglas Bennett Prize-winning paper is here and Larry Culliford has given us a book review. SAS doctors, do contact Bridget – we need to have your input! Mimmi has been permitted to rant (again), albeit belatedly, and Steffan Davies keeps us up-to-date with news from Trent.

Alison Gray and Lindsey Kemp will be your co-editors for the winter edition. We would like to thank you for the ideas, articles and support you have given us.

P.S. The textbook is (in publishing terms) IMMINENT!!!

Louise Petterson and Theresa Tattan

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Chair's Report - from the outgoing Chair

This is my last report for the Newsletter, and a welcome opportunity to summarise some of the discussions of the Faculty Strategy Day, held on 2nd June, 2005. It was a good day and included both the outgoing and incoming officers and committee members. It was very well facilitated by Michele White (an independent consultant). This made a lot of difference; I think almost everyone had the chance to express a view about the past four years and their aspirations for the next four!

We had a good opportunity to rehearse our elevation to Faculty status, which has endorsed the path to raising our profile within the College; we are now the vanguard for social inclusion and recovery. It may be worth reminding you that our track record on inclusion is strong. We were the first Faculty to include service users and carers regularly within our executive committee. Our commitment here has to be learning how to do it even better and more effectively.

Our executive committee has modelled inclusion in other ways; we have strong elected representation from the independent and private sector and from the important group of SAS psychiatrists. There has also been a real recovery within our local professional networks, led by David Hughes, Chair of the Regional Representatives Group. This particular aspect of professional recovery remains central to the support of rehabilitation psychiatrists everywhere, especially those who are isolated practitioners.

Educational activities have been resurgent over these four years: the new Gaskell *Textbook of Rehabilitation and Recovery* is now complete and with referees prior to publication. The Newsletter has been a regular triumph, the academic network has been born and all our conferences have positively burgeoned and included users and carers! The educational task now is about influencing the wholesale changes in postgraduate medical education and training, to emphasise the central importance of rehabilitation and recovery.

This very positive output seems to have consolidated core competences. Energy and optimism have led to the maturity and authority required to define ourselves, our services and our partners in recovery.

Our continuing task is to be creative: the development of working alliances and a functional definition of what it is that we do that is unique and vital in the care of people and their families with severe mental illness. (They are likely to tell us; we need to listen.) This is the task that I happily pass on to Frank Holloway, who takes over as Chair of the Faculty in June 2005, and to the very welcome new executive committee members.

We decided on 2nd June that we have had some fun along the way and that we have both enthusiasm and commitment for the next four years.

I certainly have, and I thank you, the Faculty members, for your interest, contributions and support over this last term. Good luck with the next!

Sarah Davenport
Chair of Rehabilitation and Social Psychiatry Faculty

The long awaited new textbook for Rehabilitation is well on its way! Entitled
'"**Enabling Recovery, the Principles and Practice of Psychiatric Rehabilitation'**
we hope it will be available at the end of the year (Gaskell).
Congratulations to Glenn Roberts et al from the Academic Subgroup!

Chair's Report - from the incoming Chair

Rehabilitation and Social Psychiatry Faculty Strategy Day 2005: Looking Forward

Our strategy day, as well as celebrating past achievements, identified key issues for the future. Four were discussed in some detail: (1) the future training of rehabilitation psychiatrists; (2) issues surrounding out-of-area treatments (OATs); (3) empowering the consultant rehabilitation psychiatrist and (4) working with commissioners.

A paradoxical situation is apparent: some local rehabilitation services are under threat, while there is overwhelming evidence of an explosion of expensive OATs, which threaten to undermine the financial viability of a significant number of local mental health services. Commissioners of mental health services seem to lack cogent information about the particular needs of people with the most severe disabilities. This is in part a result of a surprising lacuna in UK mental health policy, which does not explicitly acknowledge the significance of rehabilitation and continuing care (although paying a good deal of attention to the concept of recovery). Additionally, for complex and poorly understood reasons, more individuals are moving from adult mental health into specialist Forensic provision.

The role of the consultant in rehabilitation is both rewarding and demanding. In contemporary services the consultant is often an isolated practitioner, working with consultant and managerial colleagues who have little understanding of the complexities surrounding the long-term care of those who are most disabled by their mental illness. A wide range of skills are required of the effective rehabilitation consultant that go beyond the specific therapeutic skills involved in treating people with a severe mental illness. These relate to influencing the local service system and working effectively within a multi-disciplinary and multi-agency environment. This wide range of skills should logically form the training curriculum for the rehabilitation specialism (and inform the continuing professional development needs of established consultants).

The issues of effective working with commissioners, and the implications of the rapidly expanding OATs market, demand a clearer statement of the range of needs experienced by patients/clients/users of rehabilitation, recovery and continuing care services. Here the lack of a Policy Implementation Guide for Rehabilitation was felt to be a severe handicap: by not being on the list of commissioners' 'must-do's' it is difficult to get rehabilitation onto the commissioning agenda. Although there are serious gaps in the evidence base surrounding rehabilitation practices (and a peculiar disinterest at both a policy and research level in the needs of individuals who are most disabled by their severe mental illness), much is known. There was felt to be clear need to bring together existing evidence in a brief but authoritative series of texts that could be used to make the case for service provision to local commissioners and managers.

In addition to the continuing, very important, work of the regional representatives and refinements to the Faculty's position on OATS and on forensic rehabilitation, two new work-streams were identified. Firstly, a Faculty working group on training is to be set up, focused on the specific rehabilitation elements of the revised curriculum for specialist training in psychiatry. Secondly, a Faculty working group will be established to agree an outline description of a comprehensive local rehabilitation service (and additional elements that are likely to require OATs). In the longer term, more

detailed position papers may be produced by or commissioned by the working group.

The importance of improving the evidence base underlying rehabilitation, recovery and continuing care services was repeatedly emphasised, although as yet no clear strategy for addressing this issue has emerged. Throughout the day it was acknowledged that the Faculty could not and should not seek to work in isolation: already important strategic alliances are in place and others should be sought.

The incoming executive committee have an exciting task in building on the work of the past four years, and much reason to thank those members of the executive who have now left office, and most particularly Sarah Davenport, our outgoing Chair.

Frank Holloway
Incoming Chair
Rehabilitation and Social Psychiatry Faculty

Top tips

Louise Petterson

- If like me, you have completely forgotten how to calculate the BMI – especially important in these days of 'the metabolic syndrome' and (finally) attention focused upon the physical health of users of our services – then read the *Weekend Guardian*! (28/05/05 p. 49).

  BMI = weight in kilos divided by height in metres squared.

  18.5 – 24.9 is OK: up to 29.9 is overweight and 30+ is obese, basically. Waist measurement IS more convenient – more than 100cm (39.4inches) in men and 88cm (34.7inches) in women represents a 'significantly increased medical risk'. (Personally, I am banning tape measures from the house).

- See also 'Consensus Development Conference on Antipsychotic Drugs and Obesity and Diabetes' in *The Journal of Clinical and Applied Research and Education*, V 27, No 2, Feb. 2004, pp 596-601.

  Available at www.diabetes.org/diabetescare . US consensus statement with relevance for us.

- Apparently, many of us read *Advances in Psychiatric Treatment* more than the College journal. In case you missed it, there is now good evidence that good supported employment schemes work well with users of early intervention teams as well. (Rinaldi et al in Psychiatric Bulletin (2004), **28**, 281-284).

- See also 'Practice Guidelines for Clinicians Working in Programs Providing Integrated Vocational and Clinical Services for Persons with Severe Mental Disorders', Torrey W. C. et al in *Psychiatric Rehabilitation Journal*, Spring 1998; 21, 4; Proquest Psychology Journals. Good clinical common sense advice!

Putting rehabilitation services on the commissioning map

Some ideas from the Faculty of Rehabilitation and Social Psychiatry Faculty Executive's strategy day on 2nd June, 2005.

Rehabilitation services across the UK vary.

1. **Consider your local situation**: k**now where you are now.**

   - Map, with numbers, by financial year, your care pathway - how people get in (source of referrals) and out of your service and where they go (accommodation/day services/education/work etc).
   - Collect and process data on outcome eg acute ward length of stay, use of the MHA and cost of OATs, support/housing - before and after rehabilitation.
   - Collect data on impact on other mental health services (eg inpatient bed days, delayed discharges from acute beds, crisis team work load of rehabilitation patients, OATs).
   - Be aware that you may need to 'prove' why people need to remain where they are in high-cost community or inpatient rehabilitation/ longer term 24-hour nursed care.

2. **Use the above to describe what your service does**, where it fits in the local network and where the gaps are. You may need to explain in lay language the effect of negative symptoms, cognitive disorganisation and distressing positive symptoms on a person's ability to function independently.

3. **Include local stakeholders** (PCT/borough commissioners as well your team, users and carers leads AND health colleagues eg acute mental health service leaders) in the process.

   Some ideas that may help include:

   - Joint delayed discharge and accommodation/day services panels.
   - Case conferences to explain to local teams what you do.
   - Local positively framed annual reports, widely circulated.
   - SWOT analyses.

4. **Work out where you need to go…**in consultation with your local stakeholders. Remember your ideas must have face validity, be based on data, be consistent with the political agenda and performance targets, and have broad agreement within your Trust as well as the local network.

   Consider how the functions of each part of the local network fulfils needs and how local needs can be met by the network (see the NSF for longer-term conditions). Your threshold for providing direct care will depend partly local need and on what other services do or could, with support, provide.

5. **Consider how to get there**

   Remember to make your objectives SMART: specific, measurable, achievable, and realistic and with time frames.

   Your plans MUST be consistent with the DH agenda (for rehabilitation-friendly phrases in National Standards, Local Action e-mail me Louise.petterson@nelmht.nhs.uk)

Consider the commissioners' agenda:

a. Money (therefore OATs…it is possible to develop a service by bringing one expensive (up to £250K) long-term OATS person back at a time).

b. NHS 'must dos' - eg **Healthcare Commission** Core standards (see National Standards, Local Action) and **The NSF for Long-term conditions.**

Focusing on **functions** of services, rather than on specific service arrangements, and people's needs - this notes the need for skilled staff (experts) working with people in particular settings, re-integration into the community (social inclusion) and vocational rehabilitation.

Users and carers can work with local politicians in ways that we cannot. Get to know the people who sit on the local LIT.

Time: ensure you have time within your job plan to do what is required and work with your managers, bearing in mind their time constraints.

Louise Petterson

The Douglas Bennett Prize

Awarded annually for the best paper on Rehabilitation Psychiatry presented by a psychiatrist*
(maximum length 2000 words)

For further information contact:
Michelle Braithwaite, Conference Office,
Royal College of Psychiatrists
e-mail: mbraithwaite@rcpsych.ac.uk

Closing date for applications:
1st October 2005
Please send 3 copies per submission

*To include consultants within two years of appointment, basic and higher trainees and non-career grade psychiatrists.

The Rehabilitation and Social website discussion group still exists!

Apparently not much discussion is going on and a 'rethink' maybe required.

If you want to be included or have changed your e-mail address please contact Lindsey.kemp@icc.wkentmht.nhs.uk.

The following extract is taken from one of the joint winners of the Douglas Bennett Prize 2004. This was presented at the Faculty CPD Institute Day at the Royal College of Psychiatrists' Annual General Meeting in Edinburgh in June 2005.

Ethical implications of the Mental Health Bill 2004

As you are all aware, the draft Mental Health Bill 2004 was published this summer. Although it was not in the Queen's Speech this year (2004), there are some suggestions that the Government plans to introduce it by 2007. The draft Bill 2004 has few changes compared to the Bill published in 2002. It has provoked unprecedented criticism that it may undermine patients' rights by excessive coercion and may exaggerate the focus of psychiatry on the protection of the public.

The Bill has to be understood in the context of new government priorities, since 1997, with the publication of the National Service Framework for Mental Health, the NHS Plan and the response to media coverage about psychiatric patients committing crimes. With the introduction of the Human Rights Act in 1998 (full implementation in 2000), a need for a new Mental Health Act was identified, to make current legislation comply with human rights legislation as well as bringing it up-to-date with 21st century psychiatric practice, in particular community treatment. In my talk for the Section Conference in York I wanted to analyse the Bill from an ethical point of view. To do this, one needs to look at the premises (the arguments) for the new legislation given by the Government. These are, according to the Department of Health, the failure of community care, the need for new legislation and new community treatment realities. It is then necessary to look at the proposed changes, and the direction they take, before looking at the consequences. In a sound philosophical argument, the consequences need to arise from their premises and need to be likely to achieve the stipulated aims.

Any ethical analyses must be based on premises and consequences following from these. In medical ethics, we usually deal with different philosophical ideas which sometimes have opposing directions. On the one hand, there is utilitarian or consequentialist thinking, which tries to achieve the greatest happiness for the greatest numbers, even though this may occasionally neglect the rights of individuals. On the other hand, Kantian principles or rights-focused approaches seek to protect individual rights and duties and are less concerned with outcome. The present Mental Health Act is relatively rights-focused. It endeavours to protect autonomous decision-making with the help of concepts such as consent and capacity.

Any ethical analysis starts with the premises put forward by the supporters of the proposals. The Government states that care in the community has failed, although there is very little evidence to support this, and it is remarkable that the Government's cornerstone of mental health care is: care in the community. The Government focuses largely on risk, despite little evidence that risk assessments are reliable or that risk has increased due to community treatments. The Government claims that the present legislation is not adequate for modern 21st century psychiatry, but there is little evidence that these problems could not be solved with amendments. The Government is driven by media concerns about safety. The media imply that the mentally ill are potentially dangerous, despite lack of evidence that community care has increased violence by the mentally ill.

An analysis of the proposed changes shows that some changes are moving into a more utilitarian or consequential direction, whereas others move into a more rights-focused direction. The introduction of community

orders to enable compulsory treatment in the community is a clear move towards more utilitarian approaches. So is the broad single definition of mental disorder. The detention of patients with DSPD clearly points towards a more utilitarian thinking, even though the evidence as to whether this is going to make any difference is very ambiguous. In fact, the priority of safety is such that the Government, in its own words, states, 'safety considerations must be paramount in clinical management'. Safeguards for patients with long-term incapacity move towards a more rights-focused approach, as do the extension of children's rights and tribunals to be held within seven days. The increased disposal powers for courts, including community disposals, are a more utilitarian approach. My own research has shown that mental health tribunals without psychiatrists on the panel, as will be commonplace under the new proposed legislation, may skew panel decisions against compulsory admissions. This can be seen as utilitarian or rights-focused, but the consequences are still very unclear. Easier prosecution of staff, without any need for additional proof, has been suggested, and appears to be a move towards more rights-focused thinking, but may be counter-productive in that staff may become much more defensive in their treatment, which is not necessarily going to benefit patients. The specific inclusion of substance dependency into detention criteria is a move towards more utilitarian thinking. Particularly worrying, and potentially counter-productive, is the fact that the Bill generates a duty co-operate with other services, which erodes confidentiality. In summary, there is a clear ethical shift towards more consequentialist thinking or, in other words: outcome-oriented thinking, away from rights-focused approaches.

When analysing the consequences, the community orders have ambiguous evidence behind them. There is evidence from the United States that community orders may suit some patients but may deter others from seeking help. Community orders exist in a third of countries in the European Union, but very little research exists that would allow an analysis of their usefulness. With regard to the detention of people with substance abuse, there is very little evidence that inpatient care works, but this will certainly create a burden on services. It is very unlikely that the proposed legislation will reduce violence by mentally ill offenders. Society is likely to feel equally unsafe because of media coverage, regardless of whether this new focus is implemented or not. Psychiatrists are pressurised into a policing role which many of us detest, and which may have an adverse effect on recruitment. DSPD provisions may still be challenged under the Human Rights Act; the proposed legislation is by no means certain to avoid challenges. There is a high likelihood of increased stigmatisation of mental illness due to the legislation.

In summary, the proposed legislation in the draft Mental Health Bill 2004 means an ethical shift away from rights-focused approaches to more consequentialist thinking. The changes are politically legitimate, but from an ethical point of view any shift away from rights-focused thinking would only be desirable if there were overwhelming benefits to society. Any ethical analysis needs to be based on the overall premise (is the driving force for change justifiable?) and consequences (will things improve for patient and the public?). Currently the consequences do not follow logically from their premises. Therefore the Mental Health Bill 2004 establishes questionable consequences, which do not follow from the underlying premises. The premises themselves are little supported by evidence. This is an ethically unacceptable approach and should be resisted on ethical grounds until premises and consequences can be more reliably analysed.

Dr P Lepping, MRCPsych, MSc

Consultant Psychiatrist/Honorary Lecturer

News from the regions - Trent Division

Trent consultarnts with an interest in rehabilitation psychiatry have been meeting every six months for the last three years. We started out in Nottingham, which has several rehabilitation consultants and is centrally located, but now alternate the venue with other regional centres, including Leicester and Lincoln. Staff grades, associate specialists and SpRs are also welcome, as are consultants with a rehabilitation special interest and those working in AO and EI.

Our early meetings were informal as we got to know each other and described our respective services. Recently, we've added a more formal educational element, with invited speakers talking on dual diagnosis and other topical issues. Our next meeting will be about employment. The meetings remain informal and are followed by lunch.

We welcome all interested medical staff; there are currently about 25 people on the e-mail circulation list.

If you would like to know more please contact me – drsteffand@aol.com

Steffan Davies, Trent regional representative.

We need a new SAS doctor on the Rehabiliation and Social Executive!
Bridget Everett has been co-opted to help out elsewhere with College business, and as a specialty benefiting greatly from SAS doctor input, we need your views! If you are an SAS doctor interested in joining the Executive, please contact Bridget to talk about what the role entails, at: bridgeteverett@hotmail.co.uk

More top tips

Looking for a detailed toolkit for users and carers on how to work the mental health system? Rethink has recently launched '**Make a Fresh Start. An action pack for the forgotten generation'** (59pp). This provides clear information on accessing primary and secondary care services; self-management; physical health care (including a dietary advice sheet and tips on reducing substance misuse); benefits (including how to fill out the forms); returning to work; and carers assessments. The standard letters and checklists are likely to be very helpful for all of us! Copies should be in ALL team bases, I think. Available from Rethink (£4 post & packaging for 10-20; £12.50 for 60) or download from www.rethink.org.

'Go to' www. nelh.nhs.uk/emergency to find the UK ambulance service national clinical guidelines (v 3.0), June 04 pp 7-11 of 340+ , to read a straightforward discussion of consent plus decision tree. You could also try the DH website, but my printer and brain had died, by then (Ed.).

If emigrants from Asia and China are more likely to experience shame rather than the guilt often felt by people from white Anglo-Saxon (and probably other) cultures, may it be something to do with experiencing oneself as part of a group, rather than as an individual?

Mimmi's Moans (AGAIN)

On targets and working with consultant colleagues…..

The DH has apparently suddenly decided that AOTs (in parts of London at least) MUST be open 24/7. This is despite the fact that our punters have retired to their beds/crack dens by 4.00 am…The edict is out…a MUST do….team not happy, having been appointed to business hours posts, despite the fact they work 7.30 am to after 11.00pm (occasionally, trips to West End shows with assembled multitudes...), as required to meet the need/get people back into mainstream activities.

The European Working Time Directive is apparently irrelevant, as are team meetings (how to do the whole-team approach without?), CPD, whatever else people do to keep their sanity while trying to engage a whole lot of people who don't want to know about mental health professionals? Fortunately, I signed the new contract so can't be MADE to work every second Sunday at 2.00 am.

I am not at all sure that having one's care co-ordinator visit at 1.00pm or whatever time they are on duty to see one is a good idea...If it was me, I'd probably tell them (impolitely) to go away…If they were sleeping after the night shift when I needed them to help me at the benefit office/take me to the new place to hang out, I would be doubly cross.

Three times per week observed medication-taking seems to work for our punters who need it…a bit of a chat also seems to help prevent re-admissions. along with serious help to sort the arrears/state of the place...Clozapine is different, of course..the 48-hour rule… but so far, so good…We are only in the first two years.

We are also instructed that we must double our caseload in the next five and a half months to meet the DH estimate of need. The expressed need has been somewhat problematic...If one follows PIG guidelines for AOTs, do people who are not allocated within CMHTs, have moderately complex needs (eg not keen on medication, smoke a bit of dope, have huge rent arrears, are not claiming benefits, not in for the second visit) qualify as AOT clients???.. (I would be seriously interested in comments from elsewhere.) We have done all the obvious things to get referrals, including visiting the local night shelter...We decided not to camp out in A& E to collect data on recurrent attenders…

What is it with consultant colleagues?? I recall empathic discussions with paediatricians at Clinical Director Learning Sets, but let's not go there…

AOT consultants usually do not 'have their own beds' and often do the job as a part-time commitment, with Rehab. or AMH. There is no way that we can have a detailed, personal knowledge of all our patients...I aim to keep up with the Section 37/41 and Section 25 people plus the 'most difficult'…Bit like the Rehab job.

We listen to the team with which we work, hear about the deteriorating behaviour, know about the history (from data the team have collected), know that if the police are told the true history it may take some weeks to get a hit squad together (they are probably more sensible about risk than us)… then, after the admission, the inpatient RMO decides to discharge them from Section 3 because they no longer reach the criteria under degree...WHAT about nature??? …What about the Section 25??... Seems to help, with appointeeship for some people. ..We don't have the legal constraints that are available in Australia and Madison, Wisconsin.

Apart from providing a detailed summary and risk assessment on admission, having AOT staff review our inpatients' mental states and attend every decision-making inpatient team meeting, and advertising my mobile number, I'm not sure what else to do...Ideas would be appreciated…Agreed treatment plans negotiated before admission, possibly???

Consultant Anonymous, London

Faculty of Rehabilitation and Social Psychiatry Residential Meeting

Radisson Hotel, Glasgow
17th – 18th November 2005

Contact College Conference Office
Tel: 0207 235 2351 x 145
mbraithwaite@rcpsych.ac.uk

Clinical excellence awards - everything you wanted to know……..

The Rehabilitation and Social Faculty is keen to encourage rehabilitation consultants to apply for national Clinical Excellence Awards.

In order to facilitate the process, the Executive thought it would be helpful for eligible consultants to have a guide to the process for selecting candidates for support by the College. Candidates have the best chance of being awarded national CEAs if supported by their Trust (essential), their Division and the College. Be aware that deadlines get very tight in November, when the new CV form becomes available at www.doh.uk/accea/awards.htm, so preparing by filling out the previous year's form in advance is wise. However, beware – actually submitting last year's form results in automatic disqualification from consideration! Be sure you do not exceed the answer space by as much as one letter. There is rigorous BME and gender monitoring.

In 2004, by my calculations, of 306 Bronze awards, 29 psychiatrists were recommended; of 149 new silver award holders, 11 were psychiatrists; and there were 5 psychiatrists of 89 gold winners. (We are obviously not over-achieving enough!!!) See website above or type accea into Google for details.

Louise Petterson, Consultant Psychiatrist

Annual Procedure for Rehabilitation and Social Faculty Clinical Excellence Awards

	Action	Timescale	Responsibility
1.	Regional representatives will lead a discussion within their local group to identify suitable candidates. The latter should have been in post for more than five years and have significant discretionary/CEA points (usually 5).	July	Regional representatives assisted by existing award-holders
2.	Identified candidates should be informed and then ascertain whether they would receive Trust support.	July	Regional representatives, identified candidates
3.	Regional representaitives should liaise with Chair of Division (or Regional Clinical Excellence Award Representative) so that each is aware of suitable candidates.	July/ August	Regional representatives, Chair of Division
4.	Identified candidates should practise completing previous year's CV and receive feedback from colleagues/regional representatives.	August/ September	Identified candidates
5.	Regional representatives should prompt identified candidates to transfer information onto current year's CV as soon as they become available on the website.	Early November	Regional representatives, identified candidates
6.	Candidates must complete forms and obtain signature and grading from CEO or Trust and then send back to Faculty Chair.	Mid-November	Candidates
7.	Faculty Chair and sub-committee rank-order submitted CVs and complete citations (pre-agreed rating system to be used within committee).	Early December	Faculty sub-committee
8.	Faculty Chair submits top 3 rank-ordered candidates to College.	Mid-December	Faculty Chair
9.	College Clinical Excellence Award Committee held to rank order all submissions.	January	Faculty Chair attends

Book Review

The Spirituality Revolution: The Emergence Of Contemporary Spirituality

By David Tacey

Hove: Brunner-Routledge, February 2004

256 pages £45.00 hbk, £14.99 pbk ISBN 1-58391-873-6 hbk 1-58391-874-4-pbk

Rating: ****

It is sometime possible to recommend a book without hesitation. This is such a book. It is exceptionally intelligent, readable, timely and full of hope.

David Tacey is Associate Professor in Psychoanalytic Studies and Reader in Arts and Critical Enquiry at La Trobe University, Melbourne. Drawing on a broad range of authorities, such as Blake, Yeats and William James, Freud, Jung and Nietzsche, contemporary researchers and writers including David Hay, Thomas Moore and Mercea Eliade, as well as surveys of his students, he puts his thesis before us persuasively and with great clarity.

The relevance for medicine is that Tacey is writing about, 'A spontaneous movement in society, a new interest in the reality of spirit and its healing effects on life, health, community and well-being'. Spirituality is about a seamless link between the one and the (divine) whole, providing people, at both individual and collective levels, with a sense of meaning and purpose, with feelings of belonging and community; providing equally a sacred link between people and nature. He has grasped the essentially subjective nature of the spiritual experience and is unabashed that it seems to defy investigation by scientific methods.

Tacey found that whereas only eight per cent of students were following formal religions, over 90 per cent expressed a significant degree of personal concern for spirituality. The book asserts that this is a genuine, emotional and urgent reaction to widespread alienation, disempowerment and disillusion. The spirituality revolution, according to Tacey, reflects, 'A secular society running on empty, restoring itself at a deep, primal source at the very core of human experience.' 'People,' he says, 'have outgrown the ideals and values of the early scientific era, which viewed the individual as a sort of efficient machine. We now have to revise our concepts of life, society, and progress, while preserving the advances that technology and science have given us.'

Tacey writes: 'To call for spirituality is to call for healing and reconnection. It is to admit that we are divided and long to become whole. It is to acknowledge that our lives are fragmented, and we hope for some mystery that will fit the broken parts together. A sceptical part of the mind sees that hope as vanity and delusion, while a deeper part of us sees it as the wellspring of personal sanity and public health.' This is not an irrelevant discussion for doctors and mental health care professionals. It is a vital one; and this book is a brilliant guide through this exciting terrain.

He describes his own spiritually formative experiences. Raised in a Christian milieu in Central Australia, he was attracted by the quite different aboriginal spirituality of the adjacent culture. His ideas of divinity and reality were challenged and transformed, he says, by the local indigenous traditions and the concern of tribal peoples for a spiritual relationship with the earth. This is an attitude that he finds reflected in heightened ecological awareness among his students. Some of the most engaging passages in the

book are quotes from student essays. Here is Mandy, aged 19: 'After an argument with my family, I went on a nature camp. One night, I walked along the beach, listening to the sound of the waves. The moon rose above the horizon. A deep peace came over me and I forgot about the strife at home. I felt connected with the sea, sky and moon, and this filled me with joy.'

In healthcare and perhaps especially mental healthcare, we professionals have begun learning to listen to our patients as Tacey has been listening to his students. The book itself mentions a 'spirituality gap' between psychiatrists and psychiatric patients. Large numbers of the latter have been speaking about their spiritual lives and problems, to be met often, sadly, with a response that is ill-informed, indifferent and therefore destructive. We now know that we have a great opportunity to help people find and benefit from inner spiritual strength, from powers of healing and endurance, simply by being more open to and accepting of them.

This book not only assists us in engaging with and helping our patients. It could also support and enlighten us on our own spiritual paths towards wisdom and equanimity. At the end of the book, you may not yet be able to define spirituality very precisely, but you will understand the subject much better. You will have a new yardstick for your own belief systems and values.

Dr Larry Culliford

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Website: www.rcpsych.ac.uk
Click on The College, then Click on College Structure, then click on Faculties.

We warmly welcome contributions to the Newsletter. These could include letters (up to 200 words), articles (300 – 700 words), short tips, cartoons etc., etc. Suggestions for articles include topical issues, recent developments, personal views, career experiences, articles from users and carers, book reviews or summaries of conference presentations.
If possible, please send contributions to the above e-mail address with the article as an attachment in a Word document. Alternatively, send a hard copy to us by post at the above address, preferably with a copy on disc as a Word document. Thanks.

This is a publication of the Faculty of Rehabilitation and Social Psychiatry. The views expressed here are not necessarily those of the Royal College of Psychiatrists.

Faculty of Rehabilitation and Social Psychiatry:

List of executive committee members and regional representatives from June 2005 (E = elected C = co-opted O = observer RR = regional representative)

Chair Dr Frank Holloway

Honorary Secretary Dr Robin Arnold

Finance Officer Dr Tom Harrison, RR West Midlands

Members:

Alex Acosta-Armas	CTC representative (alternate)	C; Bristol
Jed Boardman	G&C faculty link	C; London
Mary Creaby	RR, Wales	C; Welsh Division
Sarah Davenport	Ex-officio (immediate past chair)	C; Preston
Steffan Davies		E; Notts
Bridget Everett	Affiliates and SAS representative	C; Bradford
Alison Gray	Co-editor of the newsletter	C; Birmingham
Linda Heaney	SpR representative	C; Bristol
Anna Higgitt	Department of Health	O; London
David Hughes	Chair, regional representatives	C; RR North West; Salford
Lindsey Kemp	Co-editor of the newsletter	E; Maidstone
Helen Killaspy	Academic Secretary	E; London
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Moira Ledger		E; Southampton
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Debbie Mountain	RR, Scotland	C; Scottish Divisin; Edinburgh
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Rob Pugh		E; London
Brian Robinson	Curriculum working group	C; Bristol
Theresa Tattan		E; Bristol
Jane Throssell	RR, Yorkshire	E; Bradford
Ollie White	CTC representative (alternate)	C; Nottingham