editorial

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SHEILA HOLLINS

Understanding religious beliefs is our business. Invited commentary on . . . Religion and mental health†

In his review, Harold Koenig challenges us to take our patients' religious beliefs more seriously. The questions he poses and the recommendations he makes are challenging, so what are we doing and what should we do?

During recent discussions at the College with leaders of a number of different faith communities, the following question was raised – which is the greater taboo: consideration of people with mental illness in faith communities or support for religious belief in mental health services? While people with mental disorders receive varying degrees of acceptance and support in the former, service users consider it unusual for their religious beliefs to be understood and supported by mental health professionals (Mental Health Foundation, 2007). This is a surprising state of affairs given our espousal of biopsychosocial approaches as integral to effective clinical pathways. Empowering individuals to self-direct their care and supporting them to be more fully included in society is recognised as a core competency in our training. Perhaps this training should include some joint learning with chaplains from different faiths, and we should review whether we, as psychiatrists, are culturally and religiously attuned to work in a particular service.

In this regard, the role of the College's Spirituality and Psychiatry Special Interest Group deserves particular mention. It has undertaken numerous initiatives, including several publications, and had a very positive response from many British psychiatrists, with membership standing at over 1600 – the second largest in the College. In the Group's recommendations on the curriculum they suggest the need for psychiatrists to value and explore their own spirituality in order to enable empathy with that of the patient. Important also is the General Medical Council guidance to all doctors on personal beliefs and medical practice: 'for some patients, acknowledging their beliefs or religious practices may be an important aspect of a holistic approach to their care. Discussing personal beliefs may, when approached sensitively, help you to work in partnership with patients to address their particular treatment needs.' (General Medical Council, 2008).

While visiting forensic in-patient services in New Zealand I was impressed by the care taken to ensure that Maori patients were being supported to learn more about their own history and traditions, in part to help them become more rooted in their own cultural and religious beliefs. The preliminary outcomes from this treatment programme are excellent and in large part are being attributed to the contribution of the cultural advisors employed to work with the clinical team. There are examples of similar innovations in the UK described in the Mental Health Foundation review of *Spirituality and Recovery from Mental Health Problems* (Mental Health Foundation, 2007). I hope that Koenig's paper will encourage more psychiatrists to exercise leadership in their own services to develop this aspect of our work.

References

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Sheila Hollins c/o ElenCook, PA to President, The Royal College of Psychiatrists, 17 Belgrave Square, London SW1X 8PG, UK, email: ecook@rcpsych.ac.uk

†See editorial pp. 201–203, this issue.