The Methodist Church

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Valuing Mental Health: A matter of concern, hope and inspiration

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Introduction

Thank you for the opportunity to give the Beckly Lecture and to spotlight mental illness, often treated as a taboo subject.

In this Lecture I hope to give you a glimpse of past, current and future provision of care for people with mental health problems; discuss the relationship between spirituality and mental health; and to challenge you to consider how faith communities might support individuals and influence improvements in mental health services.

What is mental illness or mental health? The general public's view of mental illness is often based more on myth than reality. Mental illness and mental health are about all of us. Anyone can develop mental illness, from incapacitating depression to schizophrenia, anxiety or drug and alcohol problems. It really does touch every family in the land. Its causes may be partly biological, most often these combine with adverse life events and social factors. Stressful events may trigger a psychotic experience in those who may have a genetic predisposition. Conversely, biological vulnerability to depression does not make it inevitable, especially if strong social support is received during difficult times. Whilst there are many complexities, it can be asserted, that in most instances, with the right attentive and compassionate care and service user involvement, the majority of people can live satisfactory and productive lives, participating in the main stream of community life.

Many people do not realise the extent of mental illness or the impact it has on the individual, society and the economy. The figures speak for themselves. At any given time nearly one sixth of all adults experience depression or anxiety. One in ten mothers experience post-natal depression. Mental illness accounts for one third of all illnesses in Britain and 40% of all disability. More than 1.3 million older people have a mental illness such as depression, and this figure will rise as the age of the population increases. One million people are on incapacity benefit as a result of mental ill health. The total cost to the nation of mental ill health is billions each year. But the true cost to a person's life is almost incalculable in terms of unemployment, homelessness, destroyed relationships, pain and anguish both to service users, and those who care about them. These are just some of the potential consequences of mental illness.

The development of mental health services

I started working in mental health services in 1965. I was strongly influenced by Christian values and teaching at home and had a real sense of vocation, wanting to serve the disadvantaged. Aged 18 I applied to work at the Whittingham Hospital, a large Victorian asylum caring for 3,000 patients, seven miles outside of Preston. It was an isolated and stigmatised place. My aunty bought me my first suit for the job interview and I was very anxious about how I would do. The interview was held on the front steps and consisted of the question "When can you start, lad?" My self-esteem was deflated and the job was devalued.

My job interview demonstrated the state of Mental Health Services in 1965. It was difficult to recruit into a profession not valued by society, caring for those who were valued even less. Many of the senior staff had been recruited after the war, when you had to be a sportsman or musician. Care, compassion and a positive regard for vulnerable people were not priority qualities in the personnel specification. It was about control and containment with incredibly low expectations.

I did meet some outstanding people who proved to be exemplary role models. I also met others who had no place in caring for vulnerable people. Many of the patients had been there for 30, 40 years, and longer, some were severely ill, some were there as they just didn't fit in with society. Wards had between 90 and 100 beds pushed together. In some of the wards there were no doors on the toilets, so no privacy or dignity. It was dehumanising. Very few treatments were available, many of them controversial. Electro-Convulsive Therapy was given without anaesthetic. Experimental drugs produced very unpleasant side effects,

Whilst many of the staff were decent and kind, they too had been neglected in terms of leadership, inspiration and education. As a consequence they were not up-to-date with current thinking or able to respond meaningfully to needs of patients. Patients smoked in excess and were given cigarettes to pacify them; not surprisingly many died early from physical conditions. Many of the patients had been damaged more by the institution than their original presenting symptoms. It is best described as a warehouse rather than a greenhouse – containing rather than nurturing and growing.

Subsequently, in the more enlightened 1970s it became clear, that many people didn't need to be in hospital and fared better in a more stimulating, homely environment, closer to their own homes, in settings that were free of stigma. Large asylum, psychiatric hospitals were seen as outdated and damaging to recovery.

The 1983 Mental Health Act tightened safeguards for patients and made statutory organisations responsible for the care for people after discharge. The most profound changes were the opportunities for service users and their carers to be involved in care and treatment, with their views being sought over service design and evaluation. Treatment and support was provided in

people's own homes with an increase in mental health community teams supporting GPs and offering outpatient treatment in hospitals, enabling people to remain in touch with their locality and networks during treatment.

Finance was tight during the 1980s and 90s as, although existing institutions were being wound down, they were still being funded in parallel with the new community services. Funding didn't match need.

We also faced many problems in creating services in the community. Whilst many people were sympathetic, others did not want facilities in "their back yard", a response which is still rife in many places. In one instance we had to stop a development as local residents were threatening to burn it down.

Unfortunately, the image of community care had become sullied by a few tragic incidents, which the press emblazoned and distorted with sensational headlines. This had a harmful impact on the confidence of the public and the morale of staff. By the late 90s, Frank Dobson, Secretary of State for Health at the time, asserted, "*care in the community has failed*"[1]. But many disagreed with him. In actual fact, there had been many superb instances where people had been resettled, had grown and flourished, and moved to a better life.

Elsie was one of those who benefited. After years in an institution she was moved to a shared home where she had her own room. I visited her shortly after she had moved in and saw she kept her soap in a handkerchief in her handbag. After years of dormitory living she was institutionalised, terrified that every possession would be stolen. After time, and with support, she was able to integrate into the local community, attending church, doing her own shopping and going to the bingo. There are hundreds of others like Elsie who found a new richer life in the community.

In 1997, the new government, as it was then, identified mental health as a priority, and followed this through in 1999 with a blueprint of the National Service Framework for Mental Health (NSF) and NHS plan, with improved resources. This led to a substantial shift in service philosophies and the range of new services now available to service users. The NSF, took forward overreaching values of social inclusion, care in least restrictive settings, service user choice, carer support and consideration for the needs of ethnic minority groups. It set out some standards and how they would be delivered. These are outlined in some detail below to demonstrate the change in approach to mental health service over the past couple of decades.

National Service Framework Standard One addressed mental health promotion and discrimination or social exclusion associated with mental health problems.

Standards Two and Three covered primary care and access to services. These standards had a focus on minimising risk and early detection to reduce

[1] Department of Health press notice, 28 July 1998

the severity of mental illness. Early onset services, designed to ensure rapid access to help young people were central, as well as maximising recovery through optimising drug and talking treatments, supporting parents and tackling associated problems of drugs and alcohol.

Standards Four and Five covered effective services for people with severe mental illnesses. Two significant specialist models of care and treatment were introduced with care closer to home. Firstly Assertive Outreach Services were developed for people with enduring and complex mental health problems, who have difficulties in managing their daily lives and had frequent admissions to hospital. The aim is to give close proactive support to enable individuals to lead fulfilling lives. Secondly Crisis Resolution introduced home treatment services to provide a rapid response team to provide assessment, support and treatment to people experiencing acute problems. These teams act as gatekeepers to hospital or find alternatives to hospital admission and have reduced the need for unnecessary admission to inpatient care.

Standard Six recognised both the strains and pressures experienced by family members caring for people with mental health problems as well as their importance in maintaining the wellbeing of their loved one and signalling signs of early relapse.

Standard Seven drew together actions necessary to reduce suicide. The overriding aim of the new approach was to ensure we had a single system of hospital and community care with far less chance of people falling through the net. In addition, we were keen to restore the confidence of the public and professionals in Mental Health Services. There has been a year on year fall in the suicide rate. However, suicide has now replaced Road Traffic accidents as the main cause of death in young men and is associated with the rise in drinking and substance misuse amongst young people. Some young people use alcohol and drugs as a means of anaesthetising their despair. In reality it has the reverse effect.

Eight years on I can confidently assert that we are experiencing an unprecedented transformation of care, with a significant increase in staff, working in new and different roles. But has life got better for those who use Mental Health Services? The only people who can tell us whether life is better now than before are those who use mental health services. The Health Care Commission 2004 survey of 27,000 mental health patients in England, found 76% rated as good or better. Respect, dignity, being listened to, given time and feeling confident in professionals, emerged as strong themes.[2] These are encouraging signs of improvements and are positive indicators of hope for the future.

Future challenges

We live in a world which has changed so much and so rapidly over the past 25 years. Change brings opportunities, but also threats and uncertainties, which can unsettle and directly contribute to mental health problems.

[2] *Patient Survey Report 2004 – mental health*, www.healthcarecommission.org.uk

There is increasing concern over the effects of globalisation, and many of the world's spiritual leaders have spoken of their concern that people are being turned into 'mere consumers', devaluing humanity.

Life expectancy will increase - by 2060 average age expectancy is predicted to be 100 years. More elderly people will increase competition for scarce resources. Will younger people be prepared to pay extra taxes? Will we have sufficient numbers of staff to care for them? The development of new treatments and expensive drugs will raise issues of equality of access.

Changes in migration patterns will impact on service demand, workforce, language and communications. Crime, violence, drugs and alcohol are a catalyst for additional mental health and physical problems. There is a deadly rise in gang allegiance shootings and knifings amongst young people who appear to have a disregard for life. Camilla Batmanghelidjh, founder of the Kidscompany, a charity that attempts to rehabilitate disaffected children, commented:

> "It's frightening. We are seeing children who have grown up as victims of so much violence and neglect. It feels like their souls have been killed off".[3]

Modern life is increasing strains on families with indicators that childhood anxiety and depression is becoming more prevalent. There are many social factors behind this, ranging from family breakdown and abuse, exam pressures and teenage drunkenness. Many children face the problems of looking after parents with a mental illness. Emotional stress and the demand for child-care therapy interventions are ever increasing. Social Services departments are struggling to meet their obligations and have raised the bar for referrals, so many families don't receive the scrutiny and support they need. The World Health organisation estimates that the global incidence of psychiatric disorders will rise by 50% by 2020 and become one of the five most common causes of childhood morbidity, mortality and disability.

The traumatic effects of 9/11 impacted on our consciousness and on faith communities. Along with the London bombings, the increased fear of terrorism and violence are seen as raising levels of anxiety, as well as fear within minority faith groups. It is clear that all faith communities should work constructively together to combat extreme fundamentalism.

All of these will ensure changes in our social, economic and health conditions. What mental health and social problems are we stacking up for future generations, and can the churches help us to be better equipped to meet them?

[3] Report in London Evening Standard June 07

Mental health, faith and spirituality
According to the 2001 Census three-quarters of the population are religious, with 41 million of us defining ourselves as Christians. Whilst some commentators claim formal church going is sharply declining, many black and evangelical churches are expanding at a considerable rate, especially in urban areas. The immigration of Poles has invigorated many inner city Roman Catholic parishes. Muslims, Hindus and Sikhs are building Mosques, Temples and Gurdwaras to cope with demand, in a way reminiscent of the construction of Cathedrals in the middle ages.

Enlightened health services recognise that focusing on meeting the faith and cultural needs of people with mental health problems can impact on well-being, and help to prevent mental illness. Service users say this is important, wanting a holistic, humane and spiritual approach to health and social care that recognises them as a whole person. One commentator described the human spirit as, "the essential life force that undergirds, motivates and vitalises human existence".[4]

What is "spirituality"? It is a broad and complex term, sometimes associated with religion, but not necessarily so. 'Spirit', meaning breath or wind, is a translation of Greek and Hebrew words. In Christian usage, 'spirituality' denotes the experience of human beings as they relate to God, and seek to fulfil the purposes of God, the divine life and power, from which human life is derived and depends. To some, it is imagination in a quest for meaning beyond our current experience. I like another interpretation, "Spirituality is an expression of an individual's essential humanity, and the "well springs" of how they live their lives, and deal with crisis, which can leave us drowning rather than waving".[5]

The Bradford Care Trust (one of the Mental Health leaders in this field) states that spirituality "Can refer to the essence of human beings as unique individuals. What makes me, me, and you, you? So it's the power, energy and hopefulness of a person. It is life at its best, growth and creativity, freedom and love. It is what is deepest in us, what gives us direction and motivation. It is what enables a person to survive bad times, to overcome difficulties, to become themselves".[6]

Many people confuse the concept of spiritual care and religion. For some, though not all, they are the same. Spirituality covers areas of human experience, where we feel connected to a larger dimension of meaning and understanding. Whilst faith and religion are important elements, spirituality extends beyond the boundaries of formalised religions and comes more sharply into focus in times of emotional stress, illness, loss and bereavement. Spirituality also has a wider secular expression, which can relate to nature,

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[4] Swinton J (2001) *Spirituality in Mental Health Care: Rediscovering a forgotten dimension*; pub Jessica Kingsley, London
[5] Gilbert P (2007) Engaging hearts and minds…. and the spirit. *Journal of Integrated Care* Vol 15 Issue 4, pub Pavilion Journals (Brighton) Ltd
[6] Bradford Social Services/ Bradford Community Health Trust/ Bradford Interfaith Education Centre (2001) *Spiritual well-being: policy and practice*

visual and musical arts, expression, exercise, sacred spaces and feelings of supreme human experience.

Various religions also encompass many of these aspects, usually in the context of belief in a transcendent being or beings, which uses language to explain the origins of the world, and those living in it, and the questions which face human beings, around life, suffering, death, and reawakening after death.

Many religions can provide a 'World View', which is acted out in narrative, doctrine, symbols, rites, rituals, sacraments and gatherings, and the promotion of ties of mutual obligation. Religions create a framework, within which people seek to understand, interpret and make sense of themselves, their lives and daily experiences. The reality for many people is that, in times of distress, their main help is a sense of *divine empathy* and a sense of partnership with a supreme being who loves them.

Spirituality – the challenges for mental health services
How can mental health services understand the role of spirituality in mental well-being?

Whilst there are many recent positive developments, it is still an uphill struggle in getting Services to be responsive to issues of spirituality. The reality is that many staff do not have faith or religious convictions. They may fear spiritual dimensions, as they cannot always explain it themselves or may not appreciate the benefits.

A further difficulty is we now live in a target driven, performance managed public sector. Some people argue that there is too much reliance on biomedical models, or rationalistic mechanistic approaches. Staff themselves, often feel that their sense of vocation is driven underground, so that their ability to act creatively is constrained.

Peacock and Nolan speak about a tension at the heart of modern health care:

> "It is about the increasing trend towards replacing caring with scientific technologies designed to meet the needs of populations rather than individuals. Whilst such technologies have brought immense benefits…they should not marginalise caring. At a time when the ethics of health provision are constantly under scrutiny, too little attention is paid to '*care*', as part of an ethical relationship and `Caring as an expression of our humanity'".[7]

Staff often do not know how to react and respond, when users relate their most precious stories, their deepest fears and aspirations. Some individuals feel their beliefs have been ignored, or they have been reluctant to share

[7] Peacock J and Nolan P (2000) Care under threat in the modern world, *Journal of Advanced Nursing* 2000 32(5) pp1066-1070

openly their faith, fearing scorn or misinterpretation of their expressions of faith.

This has been graphically described by Sue Holt in the extract from her poem, "*I masked my emotions otherwise they would keep me in. I have to behave myself today, no talking of God*". [8]

Returning from a meeting with Afro Caribbean communities in London, a senior nurse remarked to me, "They were asking for something really radical of the NHS. They were asking for love!"

Faith Groups and mental health

Christianity shares with other religions the potential either to enhance or to diminish mental well-being. Faith can have a strong positive effect; through traditions of worship and prayer it offers access to God as a supreme source of love, healing, guidance and inspiration. Through its communal life it provides friendship, support and a sense of purpose to people experiencing stress and adversity. Through its support of families it seeks to reinforce the elements of care and stability in peoples lives. Through its social and international connections it sustains a broader sense of human solidarity and obligation. It commends as pleasing to God, many patterns of behaviour and self-control, such as, abstention or moderation of alcohol, drugs and gambling.

Research informs us that some people are significantly comforted by believing that events are God's will, and having a sense of divine empathy and trust, is what gets many people over their despair. Faith can give strength and hope in the face of anxieties, through reinforcing positive thoughts, and protecting a person's recovery. Christians believe in God's restorative action as seen in the actions of Jesus, in healing the sick, and associating with the outcasts of society. At its best, Christian life has given new hope to those who have failed, and has built up the esteem to those who have lacked it or lost it.

However, on occasions, religious belief may not always be for the good, and we need to be alert to the negative effects on mental health. Many faith communities can be welcoming and supportive, however some can be exclusive, insular and stigmatising of people who experience mental health problems. Whilst forgiveness and freedom from guilt and shame is at the heart of the Christian faith and good news, it's not always the reality for many.

For instance, the experience of severe depression or other mental illnesses may make it difficult for a person to follow the precepts of their faith. They may feel that they have been unfaithful to God in expressing unhappiness during their depression. They may have had thoughts and heard voices which derided and undermined their faith. In some people, their faith and beliefs may cause them to consider that their human shortcomings and wrongdoings make them a failure, worthless and estranged, and that they are not worthy of forgiveness or compassion.

[8] Holt S (2003) *Poems of Survival*. London, Chipmunka Publishing

The Hebrew word ‘shalom’, is usually translated as ‘peace’, and frequently used as a Christian greeting, denoting an inclusive state of well-being. It has been adopted into Christian thinking and practice, to indicate a right and harmonious relationship, the gift of peace with God, and the call to live at peace with other human beings. There is a mental health dimension to this, which involves being at peace with oneself, free from guilt and shame. Peace is inseparable from the attitude and activity of love, which Christians believe is a gift from God. I suspect that this underpins the popularity of the hymn “*Dear Lord and Father of Mankind*”.

Positive and healthy relationships with others are both conditions and consequences of mental wellbeing. In some instances the opposite has occurred, and guilt and shame is being reinforced as a result of harsh or insensitive theologies, distorted interpretations of scripture, or a failure to practice forgiveness and acceptance. Some individuals’ Christian upbringing has led to them having irrational and heightened feelings of guilt, which may torment them as being punished by God or not deserving to live. Some argue that the church has often exploited human vulnerabilities in order to create a sense of spiritual need, which could never be met. This is contrary to Christian teachings and aspirations for a mature faith.

Some church communities have often displayed ignorance, indifference or hostility towards people with mental health problems. They have sometimes blamed those problems on personal sin, a lack of faith or demonic possession. When they have tried to help, they may have lacked awareness or been destructive in resisting co-operation with mental health professionals. In some, albeit rare, instances the pastor has promoted the view that the individual is possessed and encouraged them not to take their medication, instead, exhorting them to repent. In so doing, they have sabotaged their treatment.

All faith groups need to re examine their pastoral and spiritual care both in the light of the Christian vision of restoration and healing, and of current good practice in mental health care and be conscious of avoiding the negative aspects.

> A short case study to illustrate issues, which a church encountering a person with mental health concerns, would need to take into account. A Christian young woman presents as extremely depressed and suicidal. She discloses a key factor in her distress that her father and her brother abused her, and her faith in God the father has been seriously undermined. She cannot come to terms with a loving God, whom she perceives as a man.
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> The response of the church would need to have a clinical/social dimension as well as a faith dimension.
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> The woman would need protection from further harm, and the impact on her mother and other family members would need to be taken into

account. She should be encouraged to make contact with mental health services and the police, and supported through these contacts. She would need support, helping her to make sense of her experience, and deal with feelings of self-loathing, disgust, anger and embarrassment. The process of starting to build up trust again would be slow and the church would need to recognise the gender issues – if she perceives all males as abusers she may not relate best to male therapists or church leaders.

Her faith has been shaken by the experience of abuse. Images of God which might be helpful include Christ as a victim alongside those who suffer; God as the Good Samaritan; the God of love. The question of why a loving God allows abuse to happen may be a live one for her, as will the understanding that Christians are not exempt from problems or vicissitudes of life, but by the grace of God are given the resources to deal with it. It will be too early to consider forgiveness of her abusers, but later on she might be able to explore understandings of human frailty and what it means that Christ died for our sins.

Spirituality and recovery

If religion and spirituality have a place in the assessment of mental health problems, the same is true of recovery. Recovery is facilitated by dreams, hopes and by having contact with people who value you and believe in you. There is good evidence that religious beliefs and affiliations can positively affect the incidents, severity and duration of at least some mental illnesses, such as depression.

Faith and religious groups can provide internal resources to strengthen the positive attitudes and motivation of the person recovering, and external support through the community of faith. Dr Joanna Bennett has helpfully set out four elements of recovery: the awakening of hope, the re-establishment of identity, the discovery of meaning, and the assumption of responsibility.[9]

Religion can make a positive contribution to all of these. Inspired by the ministry of Jesus, Christianity has its own practices of healing, particularly prayer with the laying on of hands and the anointing with oil. Its central act of worship commanded by Jesus, Holy Communion, is itself a ritual of forgiveness and healing. These practices should be viewed as complimentary and not alternative to professional forms of care and treatment.

Future challenges for faith communities

So how can church and faith communities help and make a difference? The insightful leaflet, *Out of Solitary Places*, is a good start.[10]

[9] M E Coyte, P Gilbert and V Nicholls (2008, forthcoming) *Spirituality, values and Mental Health: Jewels for the Journey*. London, pub Jessica Kingsley

[10] Copies of *Out of Solitary Places*, a 4 page leaflet offering resources and signposts for churches on mental health, are available from mph or at www.methodist.org.uk/downloads/life_pc_mental_health_0707.pdf

Firstly churches can create and strengthen a sense of fellowship, connectedness, belonging and opportunities for prayer and worship. All too often depression can isolate people from friends and communities. Problems can be aggravated by a lack of understanding and unsympathetic attitudes. Therefore Church members can assist in recovery by being non judgemental, a good listener and opening up to the distressed person the love and compassion of the Christian faith, all of which can give a sense of hope. Prayer and worship may allow the unburdening of negative emotions and add to the process of healing. One area of church life that is of particular importance to me is the fellowship. The church already scores well in bringing different ages and genders together for growth and to have fun. In doing so, we are building our personal resilience and positive protective factors. We should consider how best we could enable people to connect with the life around them, if they are damaged by isolation, or have limited human contact. We all need positive strokes, caresses and hugs. Some people are afraid of, or uncomfortable with physical contact; however, many who want it don't receive it. A further unrealised potential is for the more mature members to share their life skills, and experiences in mentoring or coaching families or individuals who are struggling. Sharing a meal together or within a group is more than feeding our faces. It's about conversation, humour, and getting to know others better.

Secondly we can seek out the best ways of helping. It's by working amongst people that the church will stand or fall. Like other organisations or providers, the Church must accept the obligation to engage people with mental health problems and their carers in discussion, to listen, to find out how better the Church can meet their spiritual and pastoral and fellowship needs, and then seek to implement them.

Thirdly we must work in partnership. Hold conversations with local Mental Health organisations, the local hospital trust, universities and service user Representatives, how to increase awareness of mental health issues. This has the potential for discussion and training opportunities, enhancing pastoral care, by involving church members, professionals, service users and their families. We should ask: "are we effectively using our buildings for the benefit of the wider community?" One initiative worth replicating is one in Solihull, where the church worked with the local police, and had two WPCs seconded to them in working with youngsters involved in anti-social behaviour.

Fourthly we can raise the profile of mental health issues and bring about change. We shouldn't just stand by and allow the disintegration of some of our communities and the deadening of the potential of many young people. Think of the range of skills, talents and connections within a church family - what a powerful lobbying and influencing force it could be in local and national communities. If churches united with other faith groups to campaign for improvements in attitudes and for better services, to challenge ignorance, indifference and exclusion, and for greater social justice, what a difference we could make! If members each wrote to councillors, MPs and health organisations, to express concerns and urge them to commit funds for initiatives we could generate a political will for real change.

Fifthly pastoral visitors must be trained to better prepare them to respond to the needs of those to whom they provide support. The forthcoming Methodist training resource, *Encircled in Care*, should be a good starting point.

Sixthly we should challenge cynicism and anti-faith attitudes. It seems to me that there is a worrying increase of cynical views and attitudes towards faith groups and their beliefs. These can chip away insidiously at established values and ways of doing things. An example of this was at this year's Royal College of Nursing annual conference. For the first time ever, the church service, which starts the proceedings, wasn't held. Some members expressed their dismay, and I was shocked to read letters others had written in response, dismissing the importance of religion. The comments included:

> "There is enough of religion running the country".
>
> "The RCN should be about pay not about religion. Where has it got us up to now?"
>
> "Religion is the cause of wars."

I feel that this is indicative of wider views in society, and there is a danger that Christian values and aspirations may be trampled on and lost. So, faith groups need to challenge these views and articulate the positive messages and benefits reminding them about the ultimate and themes across all religions of love and compassion.

Seventhly we can incorporate issues of mental health into our worship. This could be done by holding specific services, for example a commemorative service if a death had been sudden or unexpected, and people may be struggling to handle their grief or loss. It may be a way of opening up alternative fears and thoughts about suicide, death and loss.

Conclusion

Creating change and bringing about improvement is never easy. It will be very challenging, but it matters because mental health is an issue about which all of us should care. It is also, something to which we can all make a contribution, be it through changing our mindset or taking action, big or small. None of us should ever doubt that we can make someone else's life that little bit better.

Finally, a story and a quote to stir you into action. A man was walking along a beach. The sun was shining, it was a beautiful day. In the distance he could see a young child going back and forth between the surf's edge and the beach. As the man approached, he could see that there were hundreds of starfish stranded on the sand, and the child was taking them, one by one, back to the water. He was struck by the apparent futility of the child's task: There were far too many starfish – many were sure to perish. When he reached the child, he said, "What's the point of what you are doing? There

are thousands of miles of beach covered with starfish. You can't possibly make a difference".

The child just looked up, stared at the man, and then stooped to pick up another starfish. As he set off to carry it back to the ocean, he turned back to the man and said, "I can at least make a difference to this one".

The last words belong to Anne Frank, and were found in her diary.

"How wonderful to know that nobody need wait for a single moment before starting to improve the world".

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