Values and working relationships

While the application of a social approach to working with mental distress requires the development of models of understanding and strategies for bringing about change, effective practice depends more than anything on developing an appropriate value base and establishing relationships that are affirmative and supportive. This may require some rethinking of more traditional notions of ‘professionalism’ and any assumption that the practitioner can somehow deliver ‘evidence-based practice’ without engaging in the complexities of developing a working relationship.

**Personal and professional values**

Values may be defined as beliefs, attitudes and expectations which can define how we see ourselves and other people, what we see as important, what we aspire to, what we like and dislike, and how we behave and expect others to behave towards us. While our values are personal to us, they may be strongly influenced by the social, cultural and moral contexts in which we are brought up and within which we are currently situated.

Overlaying (and sometimes conflicting with) personal values are the explicit and implicit professional value systems into which practitioners are inducted. These can:

- influence practitioners’ basic attitudes and ways of relating to service users, families and carers;
- define a professional identity;
- determine what may be seen as important or unimportant in people’s lives;
- inform judgements as to what is ‘normal’ or ‘acceptable’;
- construct implicit models of mental distress.
What can become firmly embedded within professional value systems – social as well as medical – are constructions of ‘us’ and ‘them’ which place a distance, and a power relationship, between practitioners and service users and carers (and also between different professional disciplines). Fundamental to a social approach is overcoming such distinctions – and seeking to establish relationships of partnership and co-production.

In learning to discuss and reason about values, it is important to recognise that values are not absolutes and may sometimes be in contradiction to one another (for example, where may a duty to protect override a commitment to self-determination?). Thus a professional value base is by no means straightforward or static – practice involves a continual balancing of different values and how they link to a particular situation.

**Service users and carers as experts by experience and agents of their own recovery**

Over recent years we have seen a major change in how service users and carers are situated within the discourses of mental health service provision. Instead of service users being seen as passive recipients of plans of treatment and care devised by professional experts, and carers being marginalised as onlookers, those who have lived experience are starting to be recognised as experts on the basis of this experience: they may know, better than anyone else, what may actually be going on, and may also have built up a unique expertise in terms of ways of understanding and developing coping strategies (Beresford, 2003).

This starts to challenge the notion that professionals ‘know best’ and that their theories and evidence are inherently superior to any insights that those directly involved may have about their situation. It fundamentally changes the terms of the relationship to one in which everyone’s voice is valued, and differences in perspective are not seen as ‘difficulties to be overcome’ but as opportunities to develop a deeper understanding of the situation and possible ways forward. Such an inclusive approach to understanding, which is rooted in an ongoing dialogue with those who have firsthand experience of their situation, is fundamental to a social approach.

People with lived experience of mental distress have been at the heart of the recovery movement which seeks to put people in the ‘driving seat’ of their own recovery – and situate practitioners as allies or enablers of this process. Their primary role is not to ‘treat’ or ‘care’ for people, but to enable them to regain control over their
lives and find a way of living that is meaningful and satisfying to them. This approach foregrounds the importance of the social, and potentially fits well with the idea of self-directed support which is becoming central to the philosophy of social care.

**Valuing evidence and evidence-based practice**

Somewhat in contradiction to the valuing of service user and carer expertise has been the emergence of a particular version of evidence-based practice which has become dominant within medicine and which privileges certain forms of evidence over others. Within this, practitioners are expected just to apply a repertoire of standardised interventions that have been validated on the basis of Randomised Controlled Trials (RCTs). Evidence that relates to people’s subjective experience or to the complex interactions between their inner world and their social situations can therefore be excluded from consideration (Tew et al., 2006).

While evidence-based practice can be helpful in some contexts in questioning practices which may be damaging and promoting alternatives that may be more effective, its somewhat over-zealous application may also have certain more damaging consequences in terms of:

- inviting practitioners (of all disciplines) to take on the role of a technical expert who can remain distant from any personal engagement with people’s distress;
- avoiding the complexity of the whole person in their social situation and looking just for standardised solutions to simplified problems;
- bracketing out any consideration of social diversity and the impact of discrimination and cultural factors on mental health.

Clearly, the use of evidence is crucial in guiding practice. However, a social approach requires a more sophisticated use of evidence, one which includes sources such as personal narratives and longitudinal studies in order to tease out what may actually make a difference within the complexity of ‘real-world’ settings. Furthermore, evidence should not be imposed on people and their situations in order to come up with some formulaic response in terms of predefined interventions. Instead, it should be used to augment and develop the insights that people may already have into their situations – perhaps to explore why certain coping strategies may not be working and to suggest alternatives that might work better.
Box 1.1  The languages of biomedical and social models

<table>
<thead>
<tr>
<th>Biomedical</th>
<th>Social</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mental illness</td>
<td>Mental distress</td>
</tr>
<tr>
<td>Symptom</td>
<td>Experience</td>
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<tr>
<td>Diagnosis</td>
<td>Meaning</td>
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<tr>
<td>Treatment</td>
<td>Action Planning</td>
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<tr>
<td>Cure</td>
<td>Empowerment</td>
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<tr>
<td>Care</td>
<td>Self-directed support</td>
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</tbody>
</table>

**Interdisciplinary working and values-based practice**

Professional values have a major influence, not just on how practitioners act and the decisions that they take, but, even more fundamentally, in how they perceive and interpret people’s mental distress and their wider circumstances. Colombo et al. (2003) identified a range of implicit models of mental distress that were more or less prevalent across different professional groups, service users and carers. An apparent adherence to a biopsychosocial approach as an integrative framework can mask serious incompatibilities between the different theoretical orientations and fundamental ontological differences as to what is mental distress (see Chapter 2) – and social perspectives may often become subordinated within practice discourses that are dominated by a biomedical approach (Tew, 1999).

This is exemplified in the tendency for medical rather than social forms of language to frame interdisciplinary case discussions – in ways that can easily invalidate the direct experience and perspectives of service users and carers (see Box 1.1).

Values-based practice involves making explicit our differences in values and language and how we perceive and interpret people’s mental distress and their wider circumstances. Within this, it is important for social workers and other socially-minded practitioners to act as champions of social values and perspectives in multidisciplinary teams. Such a championing must be within the spirit of an inclusive dialogue: the assertion of the social should not mean devaluing other perspectives, or trying to compete with other practitioners in a professional ‘bubble’ that excludes service users and carers.

Good practice involves centring the discussion on the unique experiences and perspectives of those who are living through a
mental health difficulty: a core commitment to empathetic understanding provides a sound (and ethical) basis for exploring the relevance and potential contribution of different professional values.

Underpinning all elements of values-based practice are principles of dialogue and mutual respect – whether between practitioners, service users and carers or across professional disciplines. However, establishing this in practice is far from straightforward, given current inequalities in power and status between practitioners of different disciplines and between practitioners, service users and carers. Unless this is acknowledged and addressed within the discourses of multi-disciplinary teams, or in the discussions that take place with service users and carers in ward rounds or reviews, it can be hard to see how values-based practice can be more than rhetoric in many contexts. Nevertheless, it is an important aspiration which, if carried forward, has the potential to transform the culture of mental health services to one which is much more genuinely user and carer centred, and where different disciplinary perspectives may come together in creative ways. Achieving this requires developing practice skills such as awareness, reasoning and communication (Woodbridge and Fulford, 2004).

Core values for mental health practice

While there are clearly strengths in such a pluralist approach to values, there is also a danger that it leads to a lack of coherent focus within mental health services – or to implicit domination by one particular value system. This suggests the need for shared core values that would underpin the practice of all mental health practitioners – values that need to be driven by needs and aspirations of service users and carers rather than by the vested interests of professional groups.

Within the UK, the introduction of the Ten Essential Shared Capabilities (Box 1.2) provides a useful framework for starting to define what this core should be. Although it was not developed as a value base as such, it signals a shift in emphasis in mental health services away from a more traditional medical–clinical ethos to one which aims to be more socially and recovery-oriented, and one which values a ‘doing with’ rather than a ‘doing to’ style of working.
Box 1.2 The Ten Essential Shared Capabilities

The Ten Essential Shared Capabilities are:

1. **Working in Partnership.** Developing and maintaining constructive working relationships with service users, carers, families, colleagues, lay people and wider community networks. Working positively with any tensions created by conflict of interest or aspiration that may arise between the partners in care.

2. **Respecting Diversity.** Working in partnership with service users, carers, families and colleagues to provide care and interventions that not only make a positive difference but also do so in ways that respect and value diversity including age, race, culture, disability, gender, spirituality and sexuality.

3. **Practising Ethically.** Recognising the rights and aspirations of service users and their families, acknowledging power differentials and minimising them whenever possible. Providing treatment and care that is accountable to service users and carers within the boundaries prescribed by national (professional), legal and local codes of ethical practice.

4. **Challenging Inequality.** Addressing the causes and consequences of stigma, discrimination, social inequality and exclusion on service users, carers and mental health services. Creating, developing or maintaining valued social roles for people in the communities they come from.

5. **Promoting Recovery.** Working in partnership to provide care and treatment that enables service users and carers to tackle mental health problems with hope and optimism and to work towards a valued lifestyle within and beyond the limits of any mental health problem.

6. **Identifying People’s Needs and Strengths.** Working in partnership to gather information to agree health and social care needs in the context of the preferred lifestyle and aspirations of service users, their families, carers and friends.

7. **Providing Service User Centred Care.** Negotiating achievable and meaningful goals; primarily from the perspective of service users and their families. Influencing and seeking the means to achieve these goals and clarifying the responsibilities of the people who will provide any help that is needed, including systematically evaluating outcomes and achievements.
8. Making a Difference. Facilitating access to and delivering the best quality, evidence-based, values-based health and social care interventions to meet the needs and aspirations of service users and their families and carers.

9. Promoting Safety and Positive Risk Taking. Empowering the person to decide the level of risk they are prepared to take with their health and safety. This includes working with the tension between promoting safety and positive risk taking, including assessing and dealing with possible risks for service users, carers, family members, and the wider public.

10. Personal Development and Learning. Keeping up to date with changes in practice and participating in life-long learning, personal and professional development for one’s self and colleagues through supervision, appraisal and reflective practice.


Recovery values and working relationships

As will be discussed in more detail in Chapter 9, the current concept of recovery is one that has emerged from the experiences of those who have gone through mental distress. It shifts the emphasis away from a medical discourse of symptom reduction to a more holistic perspective in which ‘recovery’ is seen as a journey of discovery and empowerment in which people reclaim valued identities and social roles, irrespective of whether they may continue to have certain unusual mental or emotional experiences. It also focuses on people’s strengths and resources, rather than having a preoccupation with their ‘deficits’ and what they may (temporarily) be unable to do.

The implications of recovery are profound in terms of overturning conventional cultures, perceptions and attitudes within mental health services (Slade, 2009). It involves challenging the implicit message that runs through much of current service cultures to the effect that ‘You will never be quite well again and we will do our best to look after you’, and substituting a message of hope that ‘You can change your situation and how you feel about yourself – and find your own ways of leading a meaningful and satisfying life.’
Recovery values have major implications in terms of the structuring of therapeutic relationships, transferring the locus of control from the practitioner to those dealing at first hand with their mental distress (see Box 1.3).

**Box 1.3 Recovery values**

- Working with a person is a privilege.
- Recovery practice values the ability for a person to be a locus of their own control.
- Recovery is a mutual and equal process.
- Recovery values ‘use of self’.
- Recovery espouses validation of experiences.
- Finding meaning, and a reason to recover or change, is integral to the recovery process.
- Recovery acknowledges the value of helpful relationships and connections
- Recovery practice demonstrates hope.
- Recovery practice values the skill of balancing when to do for someone, do with someone, or support them to do for themselves.
- Recovery involves the challenge and extension of comfort boundaries.
- Recovery outcomes are individual and cannot be predetermined.

*Source: Glover, 2003.*

Getting alongside people who are experiencing mental distress is not always easy. They may be frightened, confused or distrustful – and aspects of what they say or how they are acting may be hard to understand on first encounter. Being guided by some basic values and orientations may make all the difference between establishing the basis for a partnership that will support someone towards recovery, and (however inadvertently) taking on a position of professional superiority that may be fundamentally disempowering and may serve to trap people within mental health services.

Constructing relationships on the basis of ‘care’ or ‘treatment’ can be problematic as this can tend to imply a model of ‘doing to’ which presumes an ongoing polarity between a superior person who possesses competence and expertise, and a relatively passive (and potentially inferiorised) person who receives the help that they are given. Thus, however useful the care or treatment may be in the
short term, it may carry with it a very powerful message that takes away control and responsibility and invites the person to see themselves as a ‘patient’ who must wait for others to sort out their mental distress for them.

Alternative approaches which fit better with a recovery orientation are ‘doing with’ and ‘being alongside’. ‘Doing with’ implies an active partnership with a shared responsibility for setting the direction. ‘Being alongside’ takes the shift in power and control even further and situates the person experiencing mental distress in the ‘driving seat’, with the worker as facilitator, ally and supporter – a shift in orientation and power dynamics that may be quite challenging to those used to more traditional professional roles:

The challenge within recovery focused practice is to ‘be alongside’ as service users take the lead in constructing their own recovery journey … [This] goes against our human and professional instincts to ‘help’ or ‘sort out problems’, particularly when someone is experiencing distress. Taking a step back from this more active role takes skill and patience and requires us to have trust in, and respect for, the service users we work with. It is only through demonstrating this faith in the individuals we work with that they in turn will develop confidence in their own abilities to manage the situations that they find themselves in. (Alexander, 2008, p. 21)

Models for working relationships, such as coaching and mentoring, which have been imported from fields such as adult education and sport science, can offer more of an ethos of equality between service provider and service user, and can give the service user a greater sense of control over the terms of the working relationship (Green et al., 2006). These are proving both more acceptable to service users and more effective in terms of supporting people’s recovery – and people with their own lived experience of mental distress can often find that they have something special to offer in such roles.

Nevertheless, many professionals can remain locked into an approach which is founded on maintaining superiority and distance – playing the role of an ‘expert’ who can assess a situation and decide which of a range of pre-designed and validated interventions should be applied. However, the evidence shows that what actually makes the difference in promoting recovery is not so much the effectiveness of particular techniques as the quality of working relationships (Gilbert and Leahy, 2007; Keijsers et al., 2000; Schon et al., 2009). It is a human-to-human relationship that can provide the acceptance, affirmation, respect and connection which can be key to reclaiming one’s identity and place in the world (Holley, 2007). Such a relationship can only work on the basis of a working partnership which is not
skewed by differences of power and status, and where practitioners can be open about their feelings and experience, and allow themselves to be moved emotionally by what people may express to them.

**A value base for a social approach**

Using the Ten Essential Shared Capabilities and recovery values as starting points, and drawing upon some of the practice values of social work, we may develop a statement of the values and orientations that are central to a social approach to mental health practice. These include:

**Working collaboratively**

Although there can be many attempts to dilute the meaning of ‘partnership’ within services that have traditionally been organised along hierarchical lines, a partnership approach overturns cultures of professional superiority that are grounded in ‘us’ and ‘them’ thinking. Instead, it foregrounds the importance of mutuality and respect within therapeutic relationships and links with the idea of co-production in which outcomes are achieved collaboratively by pooling resources and expertise (Needham and Carr, 2009). This has major implications in terms of how we approach areas such as safeguarding, assessment and Action Planning.

**Respecting diversity and challenging forms of oppression**

This involves recognising the degree to which discrimination and disadvantage may both contribute to people’s mental distress and result in their unfair treatment within mental health services – and making a commitment to ensure that differences in identity are valued and forms of oppression are challenged (Dominelli, 2002; Thompson, 2006).

**Empowerment, inclusion and citizenship**

Emancipatory practice involves enabling people to reclaim control over their lives, direct their own support and become more confident in developing positive forms of power for themselves (Braye and Preston-Shoot, 1995). Beyond this, it also involves enabling them to become involved, as full and equal citizens, in whatever aspects of mainstream society that they choose (Sayce, 2000).
This suggests an orientation towards practice which is as much about promoting social change as it is about enabling individual recovery. It is also implies a profoundly democratic approach in which knowledge and information is shared and people are given the tools they need in order to direct and achieve their own recovery.

Looking for meaning

It is important to start with the assumption that all expressions of mental distress are ways in which we may be trying to express ‘the meaning of our lives’ (Plumb, 1999, p. 471). So, instead of writing them off as ‘symptoms’ of a ‘mental illness’, distress experiences should be respected and taken seriously as an attempt to communicate something – perhaps about an injustice or a ‘problem of living’ – which may be very hard to express by more conventional means.

Seeing the person-in-context

A social approach privileges a systemic rather than a reductionist way of viewing distress: it aims to see a person in relationship with their social and cultural context, rather than seeking to abstract a specific symptom or disease entity that can be treated in isolation. Their wider social situation and their inner experiences are equally important – and inextricably linked.

Over and above these specific values, other more general professional values are important within mental health work, such as honesty, integrity and respect for individuality and personal dignity. In some (often quite limited) situations there can be an overriding duty to protect those who may be vulnerable or in danger. However, more often, it can be important for practitioners to take a step back from this position, with its implications of professional authority over others, in order to be alongside people as they struggle to resolve their difficulties in their own way – which is likely to involve an element of positive risk-taking (see Chapter 10).
Summary of key points

- Personal and professional values shape the ways in which we see the world and our ways of relating to others.
- Discussing differences in values are important if we are to work collaboratively with others (values-based practice).
- Working relationships that are effective in supporting recovery are based on:
  - ‘being alongside’ rather than ‘doing to’;
  - developing human-to-human personal relationships;
  - valuing service users and carers as experts by experience.
- The value base for a social approach emphasises:
  - working collaboratively;
  - respecting diversity and challenging forms of oppression;
  - empowerment, inclusion and citizenship;
  - looking for meaning in people’s experiences;
  - seeing the person-in-context.

Further reading

Exploring values and practice:

Putting socially oriented values and capabilities into practice: