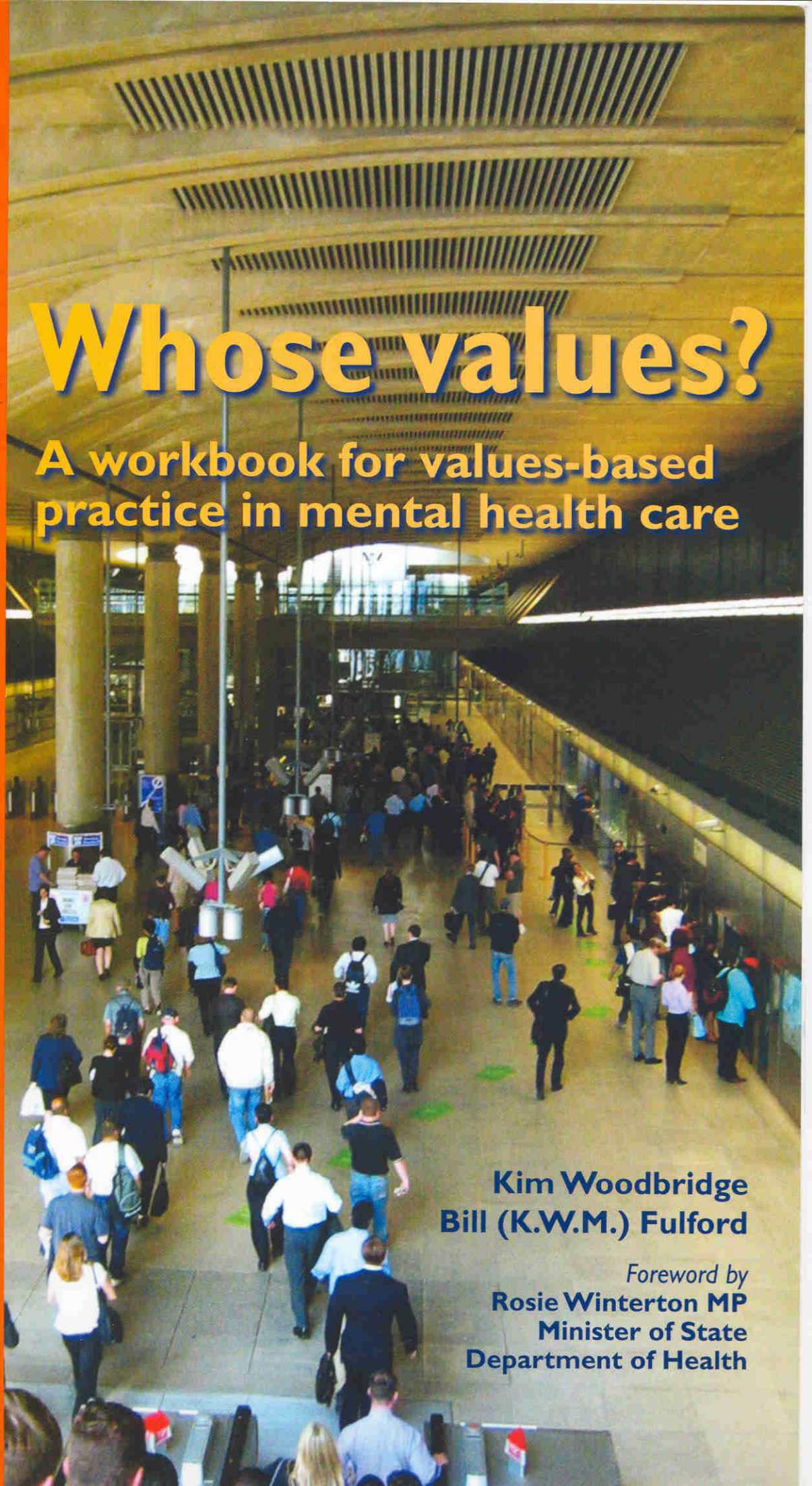

Whose values?

A workbook for values-based practice in mental health care

Kim Woodbridge
Bill (K.W.M.) Fulford

Foreword by
Rosie Winterton MP
Minister of State
Department of Health

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Contents

Acknowledgements *page 4*

Foreword by Rosie Winterton MP
Minister of State, Department of Health *page 5*

Introduction *page 7*

Part 1: **Overview of values-based practice** *page 11*

Section 1: Values and values-based practice *page 13*

Section 2: Ten Key Pointers to values-based practice *page 19*

Part 2: **Practice skills** *page 33*

Section 3: Awareness *page 35*

Section 4: Reasoning *page 45*

Section 5: Knowledge *page 61*

Section 6: Communication *page 75*

Part 3: **Putting skills into practice** *page 83*

Section 7: Bringing together values-based practice and evidence-based practice *page 85*

Section 8: Running a training session on values-based practice *page 89*

Section 9: Review and action planning *page 97*

Part 4: **Resources** *page 101*

1. Information for running a values-based practice workshop *page 103*
2. Additional value statements *page 109*
3. Training development tools *page 111*
4. Policy context of values-based practice *page 115*
5. Further reading *page 117*
6. References and useful websites *page 119*

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Foreword

Rosie Winterton MP
Minister of State, Department of Health

> ‘When I lost my baby her spirit came to me and I was singing to God but they said I was crazy …’
>
> (Bereaved African-Caribbean mother)

> ‘They teach us what values we should have … but we never have space to talk about our own values … and so we don’t think about our clients’ values’
>
> (Student social worker)

> ‘The doc asked me what I wanted to call him, Doctor Smith, or Alan, or just ‘doc’ … he’s the first person I’ve been able to talk to’
>
> (User of services in Medium Secure Unit)

> ‘I’m caught between the psychiatrist who’s only interested in injecting people and the social worker who’s only interested in counselling … who’s right? … what’s my role?’
>
> (Community mental health nurse)

> ‘They ask me if everything’s ‘OK’ and I say it is … but my psychiatrist and social worker are both women so how can I tell them that the injections are making me impotent?’
>
> (Young male service user in long-term community care)

It is the hundreds of messages like these, posted on the National Institute for Mental Health in England (NIMHE) pre-launch website, that explain why the Government has put values and the skills for working with diverse values right at the heart of our policies for developing modern mental health services.

This is why I am delighted to welcome this workbook in values-based practice. As the first of its kind in the world, and the product of a unique collaboration between the Sainsbury Centre for Mental Health and Warwick University’s Department of Philosophy and Medical School, the workbook will bring an exciting and innovative resource to support training in a range of skills essential for working effectively with values, alongside evidence, in all areas of mental health.

I am grateful to all those involved in this important project and to the many individuals and organisations, in both statutory and voluntary sectors, who have contributed to making the workbook a practical and effective training tool.

Values are about individuals and the workbook has been designed for individual study. There will also be support for training in values-based practice through the NIMHE Workforce Programme and the NIMHE/Sainsbury Centre Joint Workforce Support Unit, working in collaboration with the regional development centres and voluntary organisations.

Values are also about partnership, about a shared understanding of the different needs, expectations and hopes of those involved in mental health care. Mental health is above all an area in which effective care depends on partnership between stakeholders – between those who use services, as service users or as informal carers, and those who provide them, as clinical professionals or in management roles, in health and social care, and in allied services such as education and housing.

This workbook, and the training that it will support, will make a tremendous contribution to delivering mental health services, focused on the values of each individual user and family, and delivered through genuine partnership between all stakeholders.

> ‘Looking back I’m glad they made me accept treatment … but if I needed to go to hospital why did they call the police to take me and not an ambulance … I still can’t face my neighbours …’
>
> (Head teacher with bipolar illness)

> ‘Now we have better mutual understanding with our clinical teams, our resources go much further … our patients get to be seen more quickly and everyone has more job satisfaction … so everyone’s a winner!’
>
> (Health services manager)

> ‘I love Dad to bits … but it’s great that the social worker now understands my needs … a few days to myself occasionally will make all the difference.’
>
> (Carer)

Introduction

People's values differ enormously – what may be important to one individual may be of little significance to another. In order to work towards good practice in mental health care it is necessary to understand the importance of the role of values. The aim of this workbook is to provide a framework for the analysis of values in practice. It is intented to raise awareness of how diverse values relate, interact and impact on experiences, actions and relationships in mental health care.

Why do we have to work with values?

Why not just agree what the 'good' and 'right' values are and work towards achieving them in practice? In real life situations, it is rarely that simple:

> "I'm constantly working in an environment of lots of people's different values and trying to make some sense of that. For example, I'm working with a service user who has very different values to me; not only that, but his values are very different to his parents'. I'm juggling with these values, struggling to tease out the issues and bring some clarity to my own thinking.
>
> I try bringing issues to the CMHT [community mental health team] but sometimes their anxieties get in the way. I work in a fragmented way; I see a service user, I see a carer, I see the team. It would be useful to have an arena where I could bring out these values safely, where I could bring clarity to my own thoughts and see other people's perspectives."
>
> (Community psychiatric nurse)

This is what values-based practice aims to do – to provide a framework and skills to enable people to work in a respectful and sensitive way with the different values and perspectives present in practice.

Who is this workbook for?

It is designed for anyone working in mental health services including professionally qualified and non-professionally qualified staff, those with a background as a service user or carer, and voluntary staff, who may be working in a variety of roles, for example as managers, as team leaders or in front-line services.

Capable practice

The skills and knowledge described in this workbook are designed to support capable practice in mental health care.

The workbook will provide you with a framework and skills for responding to the varied and changing situations and relationships you may experience at work. The activities and information it contains facilitate and deepen the reflective process and will help you to develop key capabilities for mental health practice.

Competence and capability

In today's complex world we need not only competence but capability. We need to have the capabilities for working effectively with unfamiliar situations in unfamiliar contexts.

Competence – what individuals know or are able to do in terms of knowledge, skills and attitudes.

Capability – the extent to which individuals can adapt to change, generate new knowledge and continue to improve their practice.

(Adapted from Fraser & Greenhalgh, 2001)

How should the workbook be used?

This workbook is not a textbook on values. It is based on practical activities that will increase your understanding, knowledge and skills in relation to working with values.

Two main themes run through the workbook – one of reflection, the other of application. Each section takes you through a series of reflective activities aimed at building understanding and skills, and then finishes with ideas and activities for applying what you have learned to your practice.

You should complete the sections in sequence so that you build up your experience as you go along. When working on the activities it is important that you find somewhere comfortable where you will not be disturbed. Always write down your answers for your own reference as you work through the book.

The activities can be used in many different ways and we include information on running a values-based practice (VBP) training session in Part 3, and an illustrative workshop schedule and tips for running a workshop in Part 4.

Do I need peer support?

Before starting it may be helpful to find a colleague, friend or mentor who is willing to share your experiences with you as you go through the workbook. If at any time you find an activity unsettling, please discontinue it and talk to someone from whom you usually gain support.

Should I work on my own or with others?

The workbook has been designed so that it can be used by an individual working on their own. However, in many of the activities you will get extra benefit from sharing them with others, for example in supervision or as a team-building exercise.

If you are working with others, make sure that you are in an environment where everyone feels safe to share their experiences. It is important that you work with trusted colleagues and peers who are willing to give their time and ensure privacy in discussing any issues that may arise.

How long does it take to complete the workbook?

There are rarely set time limits for the activities in the workbook, though there are often guidelines. Where there are no guidelines, the activities should be completed in your own time – they will probably take from ten minutes to one hour.

You should try to find a balance between:

- leaving enough time between completing parts of the workbook to 'process' what you have learned, particularly by thinking about it in the context of your day-to-day work; and
- leaving it so long that you lose continuity.

One way of working is to find a morning or afternoon each week when you can focus on one section of the workbook. There are nine main sections. On this timetable, with extra reading and so on, you should be able to complete the whole workbook comfortably in three months.

Are the activities hard work?

In piloting the activities in training sessions, we have found that most people find them liberating and fun to do. Here are some of our students' reactions:

> *"Challenging and difficult subject but the activities really helped me to think. Very enjoyable day."*
>
> *"I felt that something had been missing from my work – thinking about values brought back the meaning to my practice. Thank you."*

There may be many new ideas here, so the activities will work best for you if you are able to give them your full attention. This is why it is so important to have 'quality time' to use the workbook. We hope that you find the experience of completing this workbook worthwhile and beneficial to your practice.

List of abbreviations/acronyms

BME	black and minority ethnic
CAMHS	child and adolescent mental health services
CBT	cognitive behavioural therapy
CPA	care programme approach
CPF	capable practitioner framework
CPN	community psychiatric nurse
EBM	evidence-based medicine
EBP	evidence-based practice
ESC	essential shared capabilities
KSF	knowledge and skills framework
NICE	National Institute for Clinical Excellence
NIMHE	National Institute for Mental Health in England
NOS	Mental Health National Occupational Standards
NSF	National Service Framework for Mental Health
OT	occupational therapist
VBP	values-based practice

PART I

Overview of values-based practice

Introduction

Part 1 of the workbook introduces you to some of the key ideas on values-based practice in preparation for the more detailed work on clinical practice skills in Part 2.

Section 1: Values and values-based practice

This section outlines the key ideas behind this approach to working with values in mental health care.

Through a series of activities we look at:

- what values are;
- why they are important in all areas of health care; and
- how values-based practice has been developed to stand alongside evidence-based practice (EBP) in mental health care.

Section 2: Ten Key Pointers to values-based practice

This section gives more details of the practicalities of the approach. The Ten Key Pointers are pointers to good practice in mental health care, where there are differences and sometimes conflicts of values.

At the heart of good values-based practice are four particular clinical practice skills – awareness, reasoning, knowledge and communication. These are Pointers 1 to 4 of values-based practice.

In Part 2, each of these clinical practice skills has a whole section to itself. The activities in Part 1 will prepare you for the more detailed work in Part 2. You should therefore complete this part before working on Part 2.

SECTION 1

Values and values-based practice

Aim

In this introductory section we outline the key features of values-based practice (VBP) as a decision-support tool for mental health care.

Learning outcomes

By completing the activities in this section you will understand:

- more about what 'values' means;
- the premise or starting point of VBP – respect for differences;
- the working methods of VBP – based on 'good process' not 'right values'.

Topics covered in this section

- What are values?
- Values are complex
- Values are like an extended family
- What is values-based practice? A thumbnail sketch
- The starting point – respect for differences
- The practice – from outcomes to process

What are values?

Everyone has them. Most organisations claim to have them. But what are they?

Activity 1: Word associations – what do you associate with the word 'values'?

Question 1

Make a list of any words or short phrases that you associate with the word 'values'.

Don't think too hard about this. Write fast. And write for yourself. Don't try to guess what other people might say are the 'right' answers. Your list should reflect what you associate with the word 'values'. Spend a maximum of five minutes on this. Then,

Question 2

Compare your list with the three lists in Figure 1.

- How similar is your list to the sample lists in Figure 1?
- What does this two-step activity tell us about what values are?

Figure 1: What are values? Three lists

LIST 1	LIST 2	LIST 3
■ Core beliefs	■ Concepts that govern ethics	■ What you believe in
■ Your perspective on the world	■ Right and wrong	■ Self esteem
■ Principles – cultural, individual	■ Belief systems	■ Principles
■ Justice	■ Ideals and priorities	■ Integrity
■ Anything that's valued	■ Govern behaviour and decisions	■ Openness/honesty
■ Integral to being human	■ Community health – individuals, society, culture	■ Personal motivating force
■ Quality of life	■ Ideals	■ Primary reference points
■ Right to be heard	■ Morals	■ Ethics
■ Social values	■ Principles	■ Virtues
■ Self respect	■ Standards	■ Sharing
■ Valuing neighbours	■ Conscience	■ Touchstones/bases
	■ Fluid/changeable	■ Willing to sacrifice for
		■ Self-interested tenets
		■ Areas of negotiation in relationships

Values are complex

Most people find it easy enough to come up with a list of words/short phrases that they associate with 'values'. When we *compare* lists, however, they usually turn out to be very different.

The three lists in Figure 1 were produced in feedback sessions with three different groups in workshop-style introductions to values-based practice. The lists thus represent pooled ideas about values. Even so, they are very different lists. There are words that occur in all three ('principles' and 'beliefs', for example), but you have to look hard for them. Your own list may be very different again.

So, one thing we can learn from our word associations in Activity 1 is that values are *highly complex.*

This activity also brings out some of the many different ways in which values are complex. Thus:

1) Values come in many varieties

- In health care, values are often synonymous with ethics. The close association of ethics and values is reflected particularly in the second list in Figure 1. But the first list includes 'rights' and the third includes 'virtues', etc.
- Values, however, are much wider than just ethics. As the first list puts it, 'values' covers 'anything that's valued'. This includes not only ethical values – about justice, best interests and so on, as included in ethical codes, for example – but also wishes, desires, needs, etc., as reflected in 'quality of life' (the first list again), self-fulfilment values (the 'self-interested tenets' noted in the third list), and so on.
- There are many other kinds of values. Your list may have included aesthetic values, for example, such as 'beauty'.

2) Values vary with time and place (but are also eternal)

- People have conflicting associations here. Especially in the case of ethical values, we tend to think of them as eternal: 'core beliefs' (first list), 'ideals' (second list), and 'touchstones/bases' (third list). Political and religious leaders often claim to defend 'core' values that transcend the mores of the moment.
- Yet values are also variable from person to person, from place to place and at different historical periods: they are a matter of 'your perspective' (first list), they are an individual's 'personal motivating force' (third list) and, as such, 'fluid/changeable' (second list).

3) Values vary from person to person

Some of the specific values in the lists also reflect the personal and individual nature of values.

– The first list includes 'justice', 'right to be heard', 'self respect', 'valuing neighbours'.
– The second list, although emphasising the variability of values at 'individual, social and cultural' levels, mentions no specific values.
– The third list notes 'openness', 'honesty', 'sharing'.

Values are like an extended family

But now we hit a problem: if values are so complex, how is it possible to have a coherent approach to them? If, as shown by Activity 1, everyone has a different set of associations with the word 'values', won't everyone have a different 'values-based practice'? Activity 2 helps us to answer this question.

Activity 2: What are values? Combining our associations

For this activity you will need to refer back to the list of words you produced in Activity 1 and to the three word-association lists in Figure 1.

This time, instead of comparing our different associations with the word 'values', we are going to pool them.

Question 1

Combine your list with the lists in Figure 1.

The aim is to try to produce a composite list, i.e. a list of associations that, even if you didn't think of them first time around, you would accept once they had been suggested by someone else.

Question 2

Note how easy, or difficult, this is.

In other words, do you find it easy, or difficult, to agree what words or phrases should go into a composite list compiled by pooling different associations with the word 'values'?

As in Activity 1, finish by reflecting on what your experience of pooling our individual associations tells us about values.

You will probably find it is easy to decide what should go into a composite list of values – everything! Sometimes you may disagree about a particular word or phrase: "that's not what 'values' means to *me!*" But mostly, other people's associations, even if different from our own initially, make sense when we think about them.

This may seem surprising. Having produced very different associations in individual lists, you might expect that people would disagree about what should go into a composite list. However, instead of disagreeing with each other, we find that lists can be pooled rather easily.

This shows that our different lists represent not competing interpretations of what values are, but complementary aspects of a highly complex concept. One set of word associations (i.e. one person's list) picks out one aspect of the complex concept of values; another set of word associations picks out another aspect, and so on.

Complex concepts like values can be thought of as being in some ways like extended families. Values, though complex, are not chaotic, but coherent, in the way that an extended family made up of many different members is coherent:

- In Activity 1, in producing lists of associations, we were picking out different members of the extended family of ideas which make up the complex concept of values. Then,
- in Activity 2, when we found it relatively easy to combine lists of associations, we were recognising the resemblances and relationships between different values that make them all members of the same family.

These two insights – the complexity of values and their coherence – are the keys to understanding values-based practice. The remainder of this section gives a thumbnail sketch of values-based practice (VBP), and then looks at the starting point of VBP – respect for differences of values – and at how VBP works in practice.

What is values-based practice? A thumbnail sketch

Activities 1 and 2 have shown us that the term 'values' has many different connotations – it can therefore be difficult to define exactly what 'values' are. Values-based practice can also be defined in different ways. Figure 2 offers a definition which may seem rather terse, but which brings out the central aim of values-based practice to translate philosophy into a practical set of tools to support policy and practice in mental health care.

Figure 2: Definition of values-based practice

> "Values-based practice (VBP) is the theory and skills base for effective health care decision making where different (and hence potentially conflicting) values are in play."
>
> (Fulford, 2004)

Figure 2 defines the aim of values-based practice as supporting effective health care decision making. As a set of practical tools, values-based practice gives us the skills to respond in a positive and problem-solving way to the increasingly complex values that are involved in every aspect of modern health care. Values-based practice is in this respect similar to evidence-based practice. Both aim to support health care decision making.

There are also differences, of course. Evidence-based practice relies on objective evidence derived from research. With evidence, objectivity (freedom from bias) is important. Values-based practice, by contrast, relies on subjectivity. It seeks to get as close as possible to the values, the points of view and perspectives of those directly concerned in a given decision.

We will see later that the differences between values-based practice and evidence-based practice make them strong partners as support tools for health care decision making.

The starting point – respect for differences

Many policies in mental health care are based on respect for differences (see Part 4, Resource 4). The three lists of word associations in Figure 1 were all different and your list may have differed from these. Values-based practice starts by embracing our differences and then asks "where do we go from here?"

Faced with the complexity of different people's values, we may feel more inclined to ask, "But, who is right?" Much of ethical regulation is based on prescribing 'right' values. Embodied in codes and guidelines, these ethically 'right' values define outcomes by which people's decisions are judged to be good or bad. This 'regulative' response is more natural because, faced with the complexity of values, if someone can tell us who is right; we feel we know what to do. This works well for science where often there is just one right answer, at least on current best evidence.

The problem with saying whose values are 'right' is that everyone else's values are then excluded, as being 'wrong'. Of course, there is such a thing as 'right and wrong'; there are limits beyond which many of us would not be prepared to go. We come back to the importance of these limits, which we will call 'framework values', in Section 4, when we look at the skills for reasoning about values. Framework values are those values that, for a given group, are genuinely shared: such values are the concern of ethical codes, for example, as we will see.

Within this limiting framework of shared values, however, there is all the wide diversity of values that we uncovered earlier in this section. And this is where values-based practice comes in. This is where values-based practice says, "Let's stop endorsing some values and excluding others. Let's embrace this diversity; let's start from respect for this diversity and see where it takes us."

Respect for differences of values could, of course, lead us to confusion. Values-based practice avoids this by relying on 'good process' as a working method. We will be looking in more detail at what this means in a moment. You can get an overview of this by thinking of values-based practice as being rather like a political democracy and considering how this differs from totalitarian regimes and other kinds of dictatorship.

Totalitarian regimes seek to prescribe 'right' values and to make everyone work to them. This can start out with the best of intentions. Communism started out with the intention of giving everyone freedom. But in practice, 'right' values, if imposed from above, always end up becoming hardened and distorted into ideologies.

In a democracy, by contrast, the principle of respect for all voices, although vulnerable in other ways (it can be hijacked by pressure groups, for example), means that there is a constant process of balancing, in order to avoid any one interest or perspective becoming too dominant.

Like a political democracy, and unlike a dictatorship, values-based practice relies on 'good process' to achieve a balance of values in health care decision making.

The practice – from outcomes to process

We now look in more detail at how values-based practice really works. As noted above, values-based practice relies on good process to support health care decision making where differences of values are involved. We now need to consider what this means in practice.

Activity 3: Whose values are whose?

Look again at the three lists of word associations in Figure 1.

As we noted earlier, they were produced by three different groups in workshop-style introductions to values-based practice. Participants were each asked to write down three words or short phrases that they associated with the word 'values'. We then took feedback, producing a composite list on a flip chart.

One of the groups was a mixed audience including many users of services, at a one-day conference on recovery; another was a group of trainee medical psychiatrists in a teaching seminar; and the remaining group was of senior NHS trust managers and other chief executives at a conference in Whitehall in London.

Question

Which list do you think belongs to which group?

Take some time to think about this question before moving on. Look carefully at each list. Are there clues to their identities in the words and phrases each group used?

There are some obvious clues to the origins at least of lists 1 and 3:

- *List 1* is from the conference on recovery. The emphasis on 'quality of life', 'social values', 'valuing neighbours', the 'right to be heard' and 'justice', reflects the concerns of users of services.
- *List 3* is from the managers' and chief executives' conference in Whitehall. Again, the concerns of this group are reflected in 'integrity', 'openness/honesty', 'personal motivating force' and 'areas of negotiation in relationships'.
- By exclusion, then, *List 2* is from the trainee psychiatrists' seminar. This group mentions no specific values, but their list particularly emphasises links with ethics. Values, this group said, are 'concepts that govern ethics'; 'right and wrong', 'morals', 'principles', 'standards', etc. These associations reflect the way in which many health care practitioners feel themselves to be increasingly hedged around with ethical codes and regulations.

The three lists, then, are not only different, as we saw when we looked at the lists in our first activity. They also reflect the different value perspectives of these three groups: users of services, practitioners, and managers, respectively.

So, if we ask "who is right?", meaning that one group's values have to be right and the other's wrong, this is a recipe for conflict. In Activity 2, however, when we brought the lists together, we found that such lists, despite the differences between them, are relatively easy to combine: they form, as we put it, an extended family. So, looking at what we have just learned in Activity 3, when we identified whose lists were whose, together with what we learned in Activity 2, we see that the extended family of values in health care includes the values of service users, practitioners and managers.

Extended families work well when they provide mutual support and the various family members can work in partnership. But families do fall out – differing values will inevitably sometimes be in conflict.

It is in resolving conflicts of values, while always starting with the values-based practice principle of respect for differences, that the skills and other elements of good process in VBP come into play.

In the next section we look in more detail at these elements of good process in terms of Ten Key Pointers to good process in values-based practice.

SECTION 2

Ten Key Pointers to values-based practice

Aim

This section gives an outline of ten key ideas, summarised as Ten Key Pointers that together make up the 'tool kit' of good process in values-based practice (VBP).

Learning outcomes

By completing the activities in this section you will:

- understand in outline the Ten Key Pointers to good process in values-based practice;
- understand how values-based practice and evidence-based practice (EBP) work together to support health care decision making;
- understand how values-based practice supports other policy and practice initiatives in mental health care.

Topics covered in this section

- Practice skills
- Models of service delivery
- VBP and EBP
- VBP and partnership
- Frequently asked questions about values-based practice

The Ten Key Pointers to good process in VBP – which are summarised in the 'arrow diagram' in Figure 3 – provide a framework around which the rest of the workbook is structured. The Ten Key Pointers cover four main areas: practice skills, models of service delivery, VBP's relationship with EBP, and partnership.

The Pointers are broken up with explanations and activities about their context and application in health care decision making.

Figure 3: Ten Key Pointers to good process in values-based practice

Practice skills

1 **AWARENESS:** of the values present in a given situation. Careful attention to language is one way of raising awareness of values.

2 **REASONING:** using a clear reasoning process to explore the values present when making decisions.

3 **KNOWLEDGE:** of the values and facts relevant to the specific situation.

4 **COMMUNICATION:** combined with the previous three skills, this is central to the resolution of conflicts and the decision making process.

Models of service delivery

5 **USER-CENTRED:** The first source for information on values in any situation is the perspective of the service user concerned.

6 **MULTIDISCIPLINARY:** Conflicts of values are resolved in VBP not by applying a 'pre-prescribed rule' but by working towards a balance of different perspectives (e.g. multidisciplinary team working).

VBP and EBP

7 **THE 'TWO-FEET' PRINCIPLE:** All decisions are based on facts *and* values (EBP and VBP thus work together).

8 **THE 'SQUEAKY WHEEL' PRINCIPLE:** We only notice values when there is a problem.

9 **SCIENCE AND VALUES:** Increasing scientific knowledge creates choices in health care, which introduces wide differences in values.

Partnership

10 **PARTNERSHIP:** In VBP decisions are taken by service users and the providers of care working in partnership.

Practice skills

At the heart of the good process on which VBP depends are four particular areas of clinical practice skills:

- Awareness
- Reasoning
- Knowledge
- Communication.

We will look briefly at these in this section. These skills are explored in greater depth in Part 2.

VBP Pointer 1 Awareness

Values are not always evident – like the air we breathe, we couldn't do without them, but because they are everywhere, they often go unnoticed.

An essential first step, then, to good process in VBP, is to raise awareness of values.

The word association activities in the first section were aimed partly at raising awareness. We introduce a number of further activities in Section 3.

VBP Pointer 2 Reasoning

It is often thought that values are 'subjective' and hence not something we can reason about. In fact, there are many powerful ways of reasoning about values, including revealing the values present in our own reasoning.

Section 4, on reasoning skills in VBP, explores how these ways of reasoning give us the skills to identify and explore the different values bearing on a given situation.

VBP Pointer 3 Knowledge

There is a growing resource of information on the values likely to be important in different contexts, including:

- first-hand narratives
- surveys
- media reports
- social science research.

In values-based practice we try to get as much information as possible about the values involved in a given situation. This is one of the many ways in which values-based practice is strongly linked with evidence-based practice. Section 5 further explores this Key Pointer.

VBP Pointer 4 Communication

Good communication skills are essential to values-based practice. The relevant skills, which are illustrated in Section 6, include:

- individual-perspective skills: skills of listening and empathy aimed at understanding the values of the individuals – users of services, families, professionals, etc. – involved in a given decision;
- multi-perspective skills: skills such as negotiation and conflict resolution, concerned with resolving conflicts between different value perspectives.

Models of service delivery

The models of service delivery in current government policy aim to be user-centred and multidisciplinary. These two principles correspond directly with Pointers 5 and 6 of VBP.

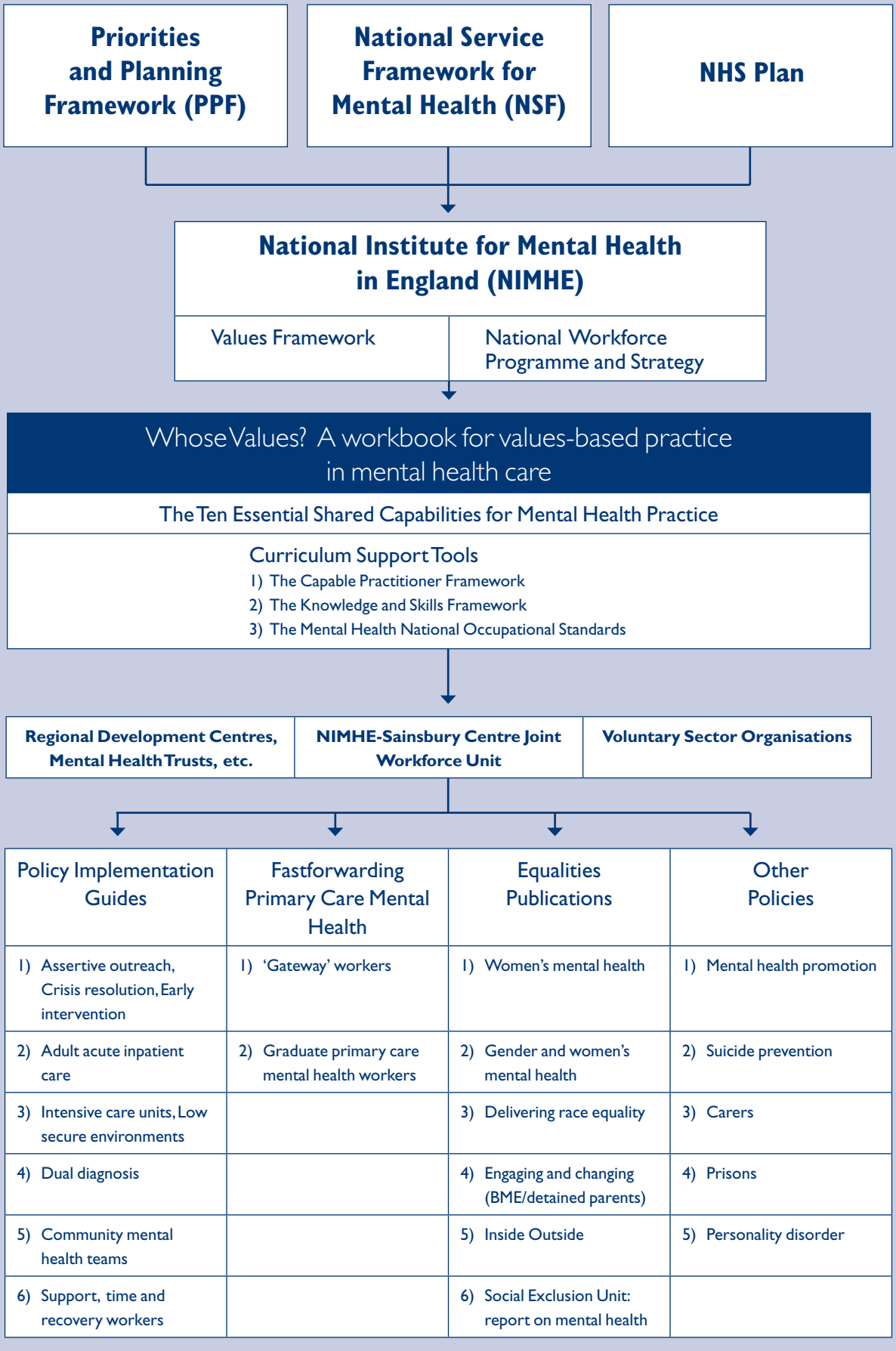
The relationship between these policies, values-based practice and this workbook is shown in Figure 4. At the top of the Figure are three key policy documents: the *National Service Framework for Mental Health* (NSF) (DoH, 1999), the *NHS Plan* (DoH, 2000) and its more recent update, the *Priorities and Planning Framework* (PPF) (DoH, 2002).

The body responsible for implementing mental health policy in England and Wales is the National Institute for Mental Health in England (NIMHE). The values workbook, shown shaded in Figure 4, builds directly on two specific NIMHE initiatives, the Values Framework (shown in full in Figure 5) and the National Workforce Programme and Strategy. The workbook will in turn support training through curriculum developments building on the Ten Essential Shared Capabilities for Mental Health Practice and other training curriculum support tools (for details, see Figure 6).

The bottom half of Figure 4 shows the roll out of VBP. In addition to take up by individuals, this will be through statutory bodies such as the regional development centres and mental health trusts etc., and voluntary sector organisations, co-ordinated by the NIMHE-Sainsbury Centre Joint Workforce Unit. Exactly how this workbook is used will vary according to the different needs of each organisation, but VBP is relevant to a wide range of specific policies, as listed in the Figure.

Further information on the Ten Essential Shared Capabilities for Mental Health Practice and a full list of references can be found in Part 4 – Resources 3 and 4.

Figure 4: The policy context of the workbook



VBP Pointer 5 User-centred services

The diversity of human values makes it essential that policy and practice in mental health care start from the values of the individual or group involved in a given decision.

The values driving policy at all levels – whether in national frameworks, local strategies, or individual care plans – are not always explicit.

The activities described in Part 2 – on the VBP practice skills of Awareness, Reasoning, Knowledge and Communication skills – can be combined in processes aimed at identifying and clarifying the values in policies at any level.

VBP Pointer 6 Multidisciplinary models of service delivery

Values-based practice is based on mutual respect. Hence, while starting from the values of the user or user group involved in a given decision, VBP also attends to the values of others concerned – informal carers, clinical staff, managers, etc.

Values-based practice can help to convert the different value perspectives of members of multidisciplinary teams from being a source of misunderstanding and friction into a positive resource for balanced decision making.

Combining user-centred and multidisciplinary approaches in VBP carries a well-defined set of strong policy implications for mental health care. These are spelled out in a national framework for values-based practice that was developed by the Values Project Group in the National Institute for Mental Health in England (NIMHE). This Framework is shown in Figure 5. It summarises three key aspects of VBP and links between VBP and other policy objectives, such as anti-racism and recovery practice.

Figure 5: The NIMHE Values Framework

The National Framework of Values for Mental Health

The work of the National Institute for Mental Health in England (NIMHE) on values in mental health care is guided by three principles of values-based practice:

1) **Recognition** – NIMHE recognises the role of values alongside evidence in all areas of mental health policy and practice.
2) **Raising Awareness** – NIMHE is committed to raising awareness of the values involved in different contexts, the role/s they play and their impact on practice in mental health.
3) **Respect** – NIMHE respects diversity of values and will support ways of working with such diversity that makes the principle of service-user centrality a unifying focus for practice. This means that the values of each individual service user/client and their communities must be the starting point and key determinant for all actions by professionals.

Respect for diversity of values encompasses a number of specific policies and principles concerned with equality of citizenship. In particular, it is anti-discriminatory because discrimination in all its forms is intolerant of diversity. Thus respect for diversity of values has the consequence that it is unacceptable (and unlawful in some instances) to discriminate on grounds such as gender, sexual orientation, class, age, abilities, religion, race, culture or language.

Respect for diversity within mental health is also:

- *user-centred* – it puts respect for the values of individual users at the centre of policy and practice;
- *recovery oriented* – it recognises that building on the personal strengths and resiliencies of individual users, and on their cultural and racial characteristics, there are many diverse routes to recovery;
- *multidisciplinary* – it requires that respect be reciprocal, at a personal level (between service users, their family members, friends, communities and providers), between different provider disciplines (such as nursing, psychology, psychiatry, medicine, social work), and between different organisations (including health, social care, local authority housing, voluntary organisations, community groups, faith communities and other social support services);
- *dynamic* – it is open and responsive to change;
- *reflective* – it combines self monitoring and self management with positive self regard;
- *balanced* – it emphasises positive as well as negative values;
- *relational* – it puts positive working relationships supported by good communication skills at the heart of practice.

NIMHE will encourage educational and research initiatives aimed at developing the capabilities (the awareness, attitudes, knowledge and skills) needed to deliver mental health services that will give effect to the principles of values-based practice.

www.connects.org.uk/conferences

(In: NIMHE, The Sainsbury Centre for Mental Health & The NHSU, 2004)

VBP and EBP

As a decision-making support tool for health care, values-based practice, as we noted earlier, has to be paired up with evidence-based practice.

This pairing up is reflected in three VBP Pointers:

VBP Pointer 7 → **The 'Two-Feet' principle**

All decisions depend on values as well as facts. (In VBP, this includes decisions about assessment and diagnosis.)

VBP Pointer 8 → **The 'Squeaky Wheel' principle**

We notice values only when they cause problems (e.g. when they conflict – this is sometimes called the 'squeaky wheel' principle).

VBP Pointer 9 → **Science and values**

Scientific advances increase the complexity of values in health care as well as the complexity of evidence.

Pointers 7 and 9 are explored in Section 7: Bringing together values-based practice and evidence-based practice. Pointer 8 is explored in Section 6: Communication.

Pointer 7 emphasises that all decisions rely on values as well as on facts, including decisions about assessment and diagnosis. People often assume that diagnostic assessment is 'purely' scientific, i.e. only about facts, but assessment is based also on the values of the assessor.

Here we will look briefly at two important overview issues concerning Pointers 7, 8 and 9:

- training and curriculum design that combines VBP and EBP;
- the future relationship between science and values in health care.

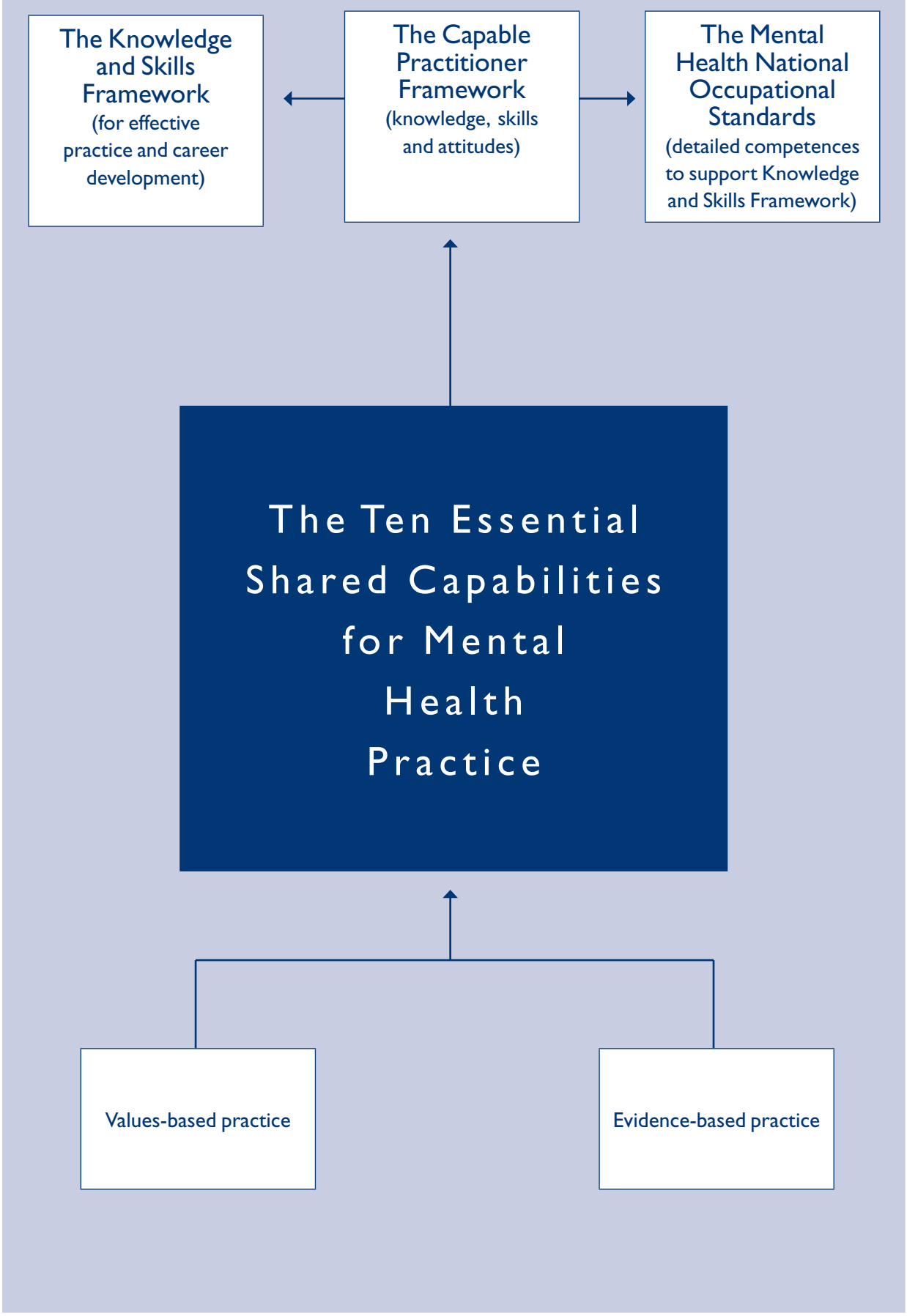
The role of VBP and EBP in training

The importance of combining VBP with EBP in all areas of training is reflected in a number of recent policy initiatives around the Ten Essential Shared Capabilities, the capabilities that all mental health care workers need in their practice.

The essential shared capabilities have been defined in a joint programme of work between NIMHE and the Sainsbury Centre. These draw on both values-based and evidence-based practice. The flow diagram in Figure 6 shows how they inter-relate. The three curriculum support tools, shown at the top of the Figure, can be used to develop and adapt the essential capabilities to the specific training needs of different groups (nursing, social work, psychiatry, management and advocacy, etc).

A full list of the essential capabilities and background information on the curriculum support tools can be in found Part 4 (Resource 3).

Figure 6: Flow diagram of the roles of VBP and EBP in training



Science and values in health care

Pointer 9 explains the future relationship between science and values. It can seem to run counter to our understanding of both science and values, so it is worth examining further.

We are familiar with the idea that scientific and technological advances give us an ever-more complex evidence base for health care decisions. But scientific advances have traditionally been assumed to make health care *less* value-laden, not more so. Yet, as we also saw earlier, the need for values-based practice arises directly from the fact that health care is becoming *more* value-laden, not less so. In the next activity we look at the reasons for this.

Activity 4: Science and values

Spend some time thinking about Pointer 9 and its claim that progress in medical science and technology will increase the complexity of the values involved in health care decision making.

Question

Do you think that Pointer 9 is right or wrong?

Do you disagree with Pointer 9 and think that when we have enough evidence to support a health care decision, we will not need to worry about values? If this is your conclusion, write down in note form your ideas about why science will eventually make values less important in health care.

Or do you agree with Pointer 9, and think that scientific advances will increase the importance of values in health care? If you agree with Pointer 9, write down briefly your reasons for believing that scientific advances will increase the complexity of the values involved in health care decision making, and hence the importance of values-based practice alongside evidence-based practice.

People come up with very different ideas about science and values. The short answer to the questions in Activity 4, from the point of view of values-based practice, is that Pointer 9 is right; science does indeed increase the complexity of values in health care.

Scientific and technological advances open up an ever-wider range of choices in health care, and with choices come values. Thus, so long as I have no choice about what happens to me, my values are irrelevant – what will be will be. But as soon as I have a choice, then my values are what will determine my choice. The wider the range of choices I have, the wider the range of my values that are likely to be relevant.

This is important not only in mental health care but in all areas of health care: in reproductive medicine, for example, and the value-laden choices opened up by new techniques in assisted reproduction. Mental health care, in being first in the field in developing VBP alongside EBP, is leading the way for the rest of health care.

VBP and partnership

At the heart of good process in VBP is a shift in health care decision making from outside experts to a partnership between the stakeholders – users, carers, clinical professionals, managers – directly involved. This idea is captured in Pointer 10 of VBP.

VBP Pointer 10 **Partnership**

Decisions should be made in a partnership between those directly concerned, not by outside 'experts'.

This brings us back to the last activity in Section 1, when we identified the three lists of word associations with 'values' as coming from three groups: users/carers, professionals and managers.

Partnership is at the heart of good process in values-based practice, but it is also, perhaps surprisingly, at the heart of good process in evidence-based practice.

EBP is widely thought to be only about explicit evidence as derived from research trials. But it is not. Writing of Evidence-Based Medicine (EBM), David Sackett and his colleagues (2000) define EBM as the integration of three key elements:

1) best research evidence
2) clinical expertise, and
3) patient values.

Figure 7 shows the complete definition.

Figure 7: Definition of evidence-based medicine (EBM)

Evidence-based medicine (EBM) is the integration of best research evidence with clinical expertise and patient values.

- By *best research evidence* we mean clinically relevant research, often from the basic sciences of medicine, but especially from patient-centred clinical research into the accuracy and precision of diagnostic tests (including the clinical examination), the power of prognostic markers, and the efficacy and safety of therapeutic, rehabilitative, and preventive regimens. New evidence from clinical research both invalidates previously accepted diagnostic tests and treatments and replaces them with new ones that are more powerful, more accurate, more efficacious, and safer.
- By *clinical expertise* we mean the ability to use our clinical skills and past experience to rapidly identify each patient's unique health state and diagnosis, the individual risks and benefits of potential interventions, and the patient's personal values and expectations.
- By *patient values* we mean the unique preferences, concerns and expectations each patient brings to a clinical encounter and which must be integrated into clinical decisions if they are to serve the patient.

When these three elements are integrated, clinicians and patients form a diagnostic and therapeutic alliance which optimises clinical outcomes and quality of life.

(Sackett *et al.*, 2000)

This is a powerful statement of the importance of the twin-track 'evidence plus values' approach to health care decision making summarised in Pointers 7–9, an approach that combines evidence with values, EBP with VBP.

In practice, EBP is mainly about the first of these three elements (explicit evidence), and VBP, as covered in this workbook, is mainly about the third (individual patient's values). But the bottom line of both is partnership.

In EBM the required partnership, according to Sackett *et al.,* is between "clinicians and patients". In VBP, the corresponding partnerships are more widespread and involve all stakeholders. This is especially so in mental health care, where, as we have seen, partnership involves:

- *users of services,* whether as patients or clients, or as families or informal carers;
- *practitioners* from each of the wide range of health and social care disciplines, in both statutory and voluntary sectors, and from related disciplines such as law and education; and
- *policy makers,* team managers, chief executives and politicians, at local and national levels.

The aim of this workbook, then, as a workbook on values-based practice, is to help build genuine partnership between all stakeholders in mental health care.

Frequently asked questions about values-based practice

Many of the questions that people ask about VBP revolve around some of the risks that arise, particularly when we try to take VBP out into practice.

Doesn't VBP mean anything goes?

One risk associated with taking VBP out into practice is that, in giving up the concept of 'right' values, in starting from respect for differences of values, health care decision making will descend into relativism and hence become chaotic and unmanageable. In fact, the risk of relativism is no greater in the democracy of values represented by VBP, than it is in a political democracy.

In VBP, moreover, the risk of relativism is limited by the following:

- *shared values:* differing human values are not in any sense chaotic – we have many shared values and many that are complementary;
- *good process:* as detailed in the Ten Key Pointers, good process in VBP supports a balanced approach to decision making where values conflict;
- *framework values:* there are clear limits, or 'framework values', derived partly from shared values, partly from the democratic premise itself (racism, for example, as shown by the NIMHE Values Framework [Figure 5] is inconsistent with respect for differences).

What are the risks of VBP?

If there is little or no risk of relativism in VBP, are there other risks in taking it out into practice?

Activity 5: The risks of values-based practice

Spend some time thinking about the risks that might be associated with values-based practice in your own working environment.

Question 1

Write down your own ideas on the risks of VBP.

Figure 8 gives the concerns identified by one of the groups involved in a consultation exercise on the draft NIMHE Values Framework. Look carefully at the concerns of this group and then think about the following questions.

Question 2

Are the group's concerns similar to yours? Is there a common factor among the risks identified by this group?

Question 3

What can be done to manage risks of this kind?

Figure 8: Risks of VBP identified by one group in a consultation exercise on the NIMHE Values Framework

- The Framework would be taken over by interest groups.
- It would reinforce anti-science attitudes and would generally attack the methods of western medical science.
- It would give managers an excuse for yet more monitoring and control.
- It would produce yet another layer of ethical/legal rules and regulations.
- It would provide a loophole for cults and other extremist groups to impose their values on others.

Just as everyone has different ideas about values, so people come up with very different risks of VBP. Your list may be similar to or different from the list in Figure 8. This will depend on your own values and your own working environment. The important thing is to be aware that introducing VBP, like any change, carries risks as well as rewards, and effective change depends on being aware of the risks in your own context and working out ways of managing them.

The common factor among the risks identified by the group in Figure 8 is the concern that 'right' values, as perceived by this or that group with a particular vested interest, will be promoted in the guise of VBP. As the first comment in the list in Figure 8 puts it, the risk is that VBP will be "taken over by interest groups".

Just what is an 'interest group' and what is not, is subjective. The groups that the respondents in this particular consultation exercise were concerned about, as listed in the figure, included those who are 'anti-science', managers, ethicists and lawyers, cults and 'other extremist groups'.

However, in values-based practice, no group, no particular interest or point of view, has any automatic priority. The premise of values-based practice is respect for differences. In the words of the NIMHE Values Framework (Figure 5), this means that decision making in health care must be both 'reciprocal' and 'balanced'. This is the answer to Question 3 of Activity 5. The key to avoiding any particular value becoming dominant, is to maintain a balance. The Ten Key Pointers of VBP are all concerned with this balance.

Isn't values-based practice anti-science?

This concern goes back to the widespread assumption that we considered earlier, in Activity 4, that values and science are, somehow, in opposition.

The stereotypes are all too familiar: that those who are concerned with values are against science; that 'scientists' have no values; that science itself, even in an applied area like health care, is 'value free'.

These are indeed just stereotypes; as we saw from Activity 4, science and values are inextricably connected. But like all stereotypes, they can be very damaging. They can cause some groups of people to lose confidence in their own values.

This is nowhere more evident than among researchers themselves. Respondents to the consultation on the NIMHE Values Framework who were from the research community talked of a "propaganda" war against the methods of medical science being fought with the "weapons of jargon and political correctness". Faced with such propaganda, the risk is that researchers themselves may internalise the attacks on them and end up thinking that they must have the 'wrong values'.

So what's the benefit of VBP to me?

The increasingly embattled position of researchers is symptomatic of a wider loss of trust between stakeholders in health care – between users of services, practitioners and managers. VBP seeks to rebuild trust through shared decision making in which evidence and values, science and individual human needs, are equal partners.

It is to this end that the materials in this workbook, supporting the Ten Key Pointers to good process in VBP, are all directed. EBP, as shown in Figure 7, can also help to rebuild this trust. Part 2 looks in detail at the clinical skills needed to work more effectively with values as well as evidence in mental health care, and thus to contribute to the process of rebuilding trust between stakeholders.

PART 2

Practice skills

Introduction

Part 2 covers the practice skills of values-based practice in detail. We start with Awareness in Section 3, followed by Reasoning in Section 4, Knowledge in Section 5 and Communication in Section 6

After taking you through each skill we then integrate it with the Ten Key Pointers and ask you to apply it to your practice.

These sections are probably the most challenging and comprehensive of the workbook; they provide a very practical focus on the development of your values-based practice skills.

SECTION 3 Awareness

Aim

This section aims to develop the skill of becoming more aware of values in mental health care through a series of activities. These activities include applying this skill in your own practice.

Learning outcomes

When you have completed this section you will have:

- understood the need for the skill of awareness of values;
- used this skill in the activities provided;
- used it in activities in your practice;
- become more aware of the values underpinning policies.

Topics covered in this section

- Raising awareness of values in your own practice
- Policy values and personal values
- Raising awareness of policy values
- Raising awareness of personal values
- Shared values and differences of values
- Applying values awareness in practice

Raising awareness of values in your own practice

To understand how the need for raising awareness of values relates to your own practice, please take some time to complete Activity 6 (overleaf) – it should take about 30 minutes.

Activity 6: Putting awareness of values into your own context

Think of a time at work when you felt uncomfortable about a decision that you had to make.

Question 1

What was most important about the decision?

For example: getting it right, protecting myself, or avoiding conflict.

Question 2

What did you base your decision on?

For example: guidelines set by employer or professional body, colleague's advice, or it just felt the right thing to do.

Question 3

What was the most difficult part about making the decision?

For example: not having enough information, upsetting other people, or the responsibility.

You may have found the questions in this activity quite difficult to answer and it is unlikely they were questions you asked yourself at the time. You may have found that just trying to answer the questions has increased your understanding of what was happening.

We will be coming back to the answers you gave to these questions at the end of this section. For the moment, we are going to concentrate on the difficulty you may have encountered in answering them, and what this tells us about the need for raising awareness as a first step to working more effectively with values in our everyday practice.

There are many important aspects of our daily lives that, so long as they don't cause problems, usually go unnoticed. For example, breathing: it is unlikely that you could give a detailed account of your breathing for yesterday, yet your continued existence depends on it. We may only become conscious of such things when something goes wrong or when our routine experience is changed in some way. We notice our breathing when it becomes difficult. The same is true of our emotions and feelings. We may become more aware of how we are feeling through major life events such as a serious illness, the loss of a loved one or of a job. You may have noticed this in yourself or in a colleague, friend or family member, or, in your working life, in a service user or client.

All of us 'run on automatic' most of the time, particularly if the activity engaged in is familiar and routine, and values are no exception. However, there are times when it is necessary to take deliberate steps to raise our awareness as part of increasing our understanding and informing our decisions and actions. Becoming more aware of values is particularly important when working with people such as service users, other significant people in the service user's life, colleagues, other professionals and the general public.

Raising awareness is what Pointer 1 of values-based practice is all about. At the heart of many problems with values in practice is what might be called 'values blindness'. Problems arise not so much from direct conflicts as from a failure to recognise values for what they are. This is why a key skill underpinning VBP is a greater awareness of where, what and how values come into practice.

To use the skill of values awareness in practice we need to start by mapping out some basic ideas about values.

Policy values and personal values

We have already explored the issue of diversity of values. In the next activity, we want to concentrate on an aspect of that diversity that is central to us in mental health care – how our personal values connect up with (or may disconnect from) the values that we have to work with in practice, as defined by policies, professional codes, and so on.

Activity 7: Policy values and personal values

For the next 15 minutes think back to the first two activities you completed in Section 1 of this workbook that asked: 'What are values'?

Then consider the following questions and note down the answers that come to mind. Don't worry about 'getting them right' as there is no one right answer. The aim of this activity is to raise awareness of your own values.

Question 1

What do you think are the current values in mental health care, in such areas as policy, service delivery, and professional practice?

Question 2

What values do you bring to your professional work?

It may be helpful, in answering this question, to come back to the concept of defining the term 'values', even if this is a difficult and subjective process. We give a few examples of definitions in Figure 9. You may want to add others that you come across, or work out your own. As you will see, although different in style and detail, there are common themes, for instance about values guiding decisions, helping us to make choices and driving actions. This is why Pointer 7 of VBP emphasises that all decisions are guided by values as well as by evidence.

Figure 9: Definitions of 'values'

> "Standard of behaviour"
>
> (Oxford Dictionary Thesaurus, 2001)

> "Persons are not indifferent to the world… they are continually regarding things as good or bad, pleasant or unpleasant, beautiful or ugly, appropriate or inappropriate, true or false, virtues or vices. Values serve as criteria for action; they become criteria for judgement, preference and choice."
>
> (Rokeach, 1979)

> "Values are a term used in different ways. One is relating to a thing's fitness for purpose, for example a 'good' pen or a 'good' computer."
>
> (Sharpe, 1997)

> "By patient values we mean the unique preferences, concerns and expectations each patient brings to a clinical encounter and which must be integrated into clinical decisions if they are to serve the patient."
>
> (Sackett *et al.*, 2000)

The questions in Activity 7 concentrate on the policy values of mental health care and the values that guide our own decisions, choices and actions in mental health care.

Figure 10 gives an example of values underpinning policy and services. You may have given some of the same values when you answered Question 1 of Activity 7.

Figure 10: The value base that underpins the National Service Framework for Mental Health (NSF)

- The centrality of the service users and those who support them
- A proper focus on the diversity of need amongst those who use mental health services
- A full acknowledgement of the importance of our workforce in all its diversity – people taking forward excellent and essential work in not only the statutory provider sector but also in the voluntary and independent sectors, the service user movement, primary care, and indeed all areas of the 'whole system'
- The need to value the lessons we learn from each other and the need wherever possible to avoid the blight of the 'not invented here' syndrome.

(DoH, 1999)

There are several other sources for finding the values underpinning services. Your employers are likely to have a mission statement which includes a statement of values. The particular team you work with may have a list of values in their operational policy.

You may have found Question 2 in Activity 7, about your own values, easier. However, many people need quite some time to be really clear about what their own values are before they can write them down for the exercise. Again there is no right answer but we have listed some of the values that people often give in answer to this question. These are:

Raising awareness of policy values

Are policy values and personal values the same or different? What do any differences mean for us in practice?

For most of us the answer is that policy values are partly the same as our own, but that there are also important differences. The NSF values (Figure 10) may seem important but remote and prescriptive, whereas our personal values are familiar to us – we feel a sense of ownership and we are aware of their personal relevance to us in relation to our upbringing and experiences.

Values guide our decisions, choices and actions. So, if there are differences between policy values and personal values, does that mean that our decisions, choices and actions will always be in conflict?

The answer from values-based practice is that differences of values certainly lie behind many difficulties in practice. We will be looking in detail at these differences in multidisciplinary teamworking in Section 5, on knowledge of values. But much of the difficulty, according to values-based practice, comes from the differences of values *not being fully recognised for what they are*.

The following activity will help you to become more aware of the diversity of values in a policy context.

Activity 8: Raising awareness through language

Please read through the following extract, which is an example of the sort of text that can be found in many policy documents, and then answer the questions below:

"This Trust is supporting the change and reconfiguration of services to best meet NSF and other guidance for both adult and older mental health service users. There are some common themes for services throughout the Trust. These include:

- Developing effective management structures to lead and support change.
- Developing organisational structures in each area to support clinical governance, risk management and health and safety requirements.
- Implementing financial structures to ensure balanced budgets.
- Establishing cross area development groups to take forward required service developments in adult, older people, CAMHS and drug and alcohol services.
- Ensuring services provide fully integrated health and social care teams.
- Providing single points of access to services to ensure effective referral pathways and to support the targeting of resources.
- Reconfiguring where required to organise adult services to support functional models, to target skills and resources against standard and enhanced CPA levels of care.
- Developing minimum standards for CPA.
- Progressing approaches to provide a workforce fit for purpose, concentrating on training, modernising roles and responsibilities and supporting staff at work (including compliance with NHS Plan and Improving Working Lives standards).
- Influencing workforce planning Trust-wide with direct access of senior Trust representatives into workforce planning decision making, where previously local services have been isolated and with little influence on the mental health agenda.

- Establishing joint commissioning approaches and reaffirming Local Implementation Teams as the key commissioning groups for each area.
- Progressing service developments and/or monitoring arrangements to maximise the repatriation of expensive out-of-area private placements and minimise the use of private sector services.
- An acceptance that resources currently available are significantly insufficient, but a key objective that services will be targeted and arranged to be as effective as possible within those limited resources.
- The argument for additional resources will be best made once services are configured, as far as possible, to match best-practice models, NSF and performance targets.
- Limited resources should mean the targeting of services and not the arrested development of skills, training, roles and support systems."

Question 1

Underline any value judgements (for example: effective, limited, best).

Question 2

What values are apparent throughout the extract? What is seen as desired, important, a priority?

Question 3

Whose are these overall values? What are the implications for the values identified? Do they conflict in any way?

Question 4

Are there any values missing or that you would like to be emphasised?

When completing Question 1 it is likely that you highlighted the following evaluative words among others: *effective, risk, balanced, required, expensive, limited, best practice*. Each of these words requires someone to make a judgement and evaluation of a situation. These terms, although generally familiar, may mean different things to different people. One person's judgement of 'effective' may be another person's 'average' practice. It is therefore important to be aware of these different interpretations. This is particularly important in a document which aims to communicate with a wide and diverse audience.

In your answers to Questions 2 and 3, you may find that the overall values include the achievement of policy directives such as *NHS Plan* (DoH, 2000), *Improving Working Lives Standards* (DoH, 2000) and the NSF (DoH, 1999). The focus of what is being valued is the achievement of organisational and change agendas. This would suggest that these values are those of managers and those who have an interest in policy implementation.

What is missing is the human perspective: the people that this document relates to – the service users', carers' and staff's values. You may have identified many other missing values.

It often takes some practice to recognise value words and what is being valued in a text. The more time you spend looking for values in different documents, the more obvious they become. If you struggle with Activity 8, discuss it when you are in supervision or with a trusted colleague. Discussing it with some else can improve your understanding and observation. You might like to try the same exercise on some of the policies you have at work, then try to rewrite them, making any improvements you have thought about while completing the exercise.

Raising awareness of personal values

Activity 9: Thinking about personal values

Most people work in a team of some sort, from a loose collection of people that you come into contact with to a well-established and clearly identified team. Before completing this activity, decide who you consider to be in the 'team' that you work in.

Imagine you have just been talking to Errol, a service user that you are working with. He is forty-two years' old and currently living with his parents. He would like to move out and wants your help in finding suitable accommodation and in learning to live more independently.

You have spoken to his parents in the past and they have often raised their concerns about their son moving out. They believe he will be safer living with them. The members of the team that you work with are also concerned about the risks involved and are not optimistic about Errol's ability to cope.

Errol has been well for some time and you have noticed that he is really enjoying his visits to an art studio which has a drop-in for people with mental health problems. His art work is very popular and he has become more confident and hopeful for his future.

You want to help him with his plans but you feel under pressure from his parents and your team. It is possible that Errol could live more independently but it would involve a lot of work in arranging support and developing his skills. You are also aware that he may become unwell and fail.

Question 1

How would you go about clarifying your own thinking and understanding of the perspectives and values of the other people involved?

Question 2

What would you do in this case?

Question 3

How aware are you of the values of the different people you work with?
Write down a list of the values you are aware of for each member of your team.

As you would by now expect, there may be a range of answers to these questions. For some people it may have been quite easy but for many it would have been very difficult. Many situations in everyday practice are similar to the scenario in Activity 9 in that they call for a 'trade-off' between the different values involved in a case. In this scenario one 'trade-off' is between risk and quality of life/wellness. If you found resolving the situation straightforward it may be because you shared the majority view – that is, the view taken by the team and the parents. If your values differed, then it is likely that you found the decision more difficult. As we have mentioned previously, it is easier to be aware of values when they are conflicting rather than when they are in agreement.

You may have found in your everyday practice that it is hard to clarify your own thinking about a situation when you are tired or feeling pressurised to get on with other work. Taking time to reflect can be seen as an optional luxury, but it can also be a good investment for your practice. Once you have thought through a situation, your judgements, decisions and actions may be more positive and successful, saving you time and stress.

How well do you know the values of the people you work with? It is unlikely that you were able to do this easily and without needing to spend some time reflecting and thinking through the question. Once the values in a situation – your own, those of each team member, and those of the other individuals involved – have been openly raised, then it is important to provide equal opportunity and time to discuss all values present, even if they are not representative of a majority view. The activities in Section 4, on reasoning, will further explore these issues.

Shared values and differences of values

Many of the activities so far in this workbook are about diversity of values. However, there are many situations in which people's values, at least within a given group, are really very similar. There is a range, from very diverse to closely shared values. The next activity helps to illustrate this range.

Activity 10: Shared and diverse values

Question 1

List three words or brief phrases that describe for you: a good apple.

For example, red, crisp, sweet.

Question 2

When you have your list, repeat the process for: a good social worker (you can replace this with good nurse, occupational therapist, psychiatrist, psychologist or even team).

For example, team player, accessible, knowledgeable.

Question 3

Now compare your lists: what do you notice about your answers?

Which one was easier to complete? Is one list more evaluative and less factual than the other?

Question 4

If possible ask another person – a colleague or service user – to complete the activity, and compare your lists. What do you notice about your answers? What are the implications?

It is likely that:

- you found it easier to complete the 'good apple' list;
- if you did ask others to do this activity, their lists for 'good apple' were not too dissimilar from your own;
- the phrases or words you used to describe a good social worker were more evaluative and less factual, for example, 'good at engaging clients'. This would make it harder for others to know precisely what you meant by a 'good' social worker;
- if you did ask others to complete the exercise, their list for 'good social worker' may well have been very different from yours. The more people you do this with, the more differences you will notice.

These differences of values are quite natural and all part of being human. However, they do raise difficulties when making shared decisions, especially about what is the right thing to do in certain situations.

We have largely shared values about apples, but many different values about social workers. 'Good apple' is simpler than 'good social worker'. As a team, therefore, it would be easy to make a decision about what apples to buy. But agreeing about what to expect from a social worker (or nurse, or psychiatrist, etc), is likely to be a lot more difficult.

Applying values awareness in practice

You are now ready to start applying the ideas in this section to your own practice. We are going to do this by thinking about a particular mental health worker, Mary, and one of her clients, Jed. But you may want to do a similar activity with someone from your own experience.

The next activity will help you to incorporate your skills regarding awareness of values, with the other Ten Key Pointers. Please start by reading through the brief scenario in Figure 11.

Figure 11: The story of Mary and Jed

Mary is discussing Jed with her colleagues; she is trying to engage him in services. Jed is 35 years' old. Until recently his girlfriend and one-year-old daughter lived with him in his flat, but he now lives alone. He is currently unemployed.

There is concern from the GP about Jed's ability to take care of himself and the possibility that he may cause disturbances in the community. The information Mary has from a GP referral suggests Jed may be experiencing hallucinations and has been demonstrating bizarre behaviour, neither of which is substance induced.

She has tried to discuss treatment with Jed when she has visited him at his flat, but he gave very few answers and made it clear he was uncomfortable talking to her. Little is known of Jed's history prior to his moving to the area two years ago from his native country of Mauritius.

Mary wants to understand the problems Jed is having and needs to decide what to do next. She asks her colleagues for help. The suggestions are:

Colleague A: "Why don't you talk to the health visitor who looked after his daughter? She might be able to tell you something about his illness."

Colleague B: "Maybe he doesn't want us involved because he doesn't think he's ill, or doesn't understand our service."

Colleague C: "Talking to the health visitor wouldn't help. You know, in the past she and the GP haven't always agreed on things."

Colleague D: "Maybe Jed isn't ill – we don't know if this is his usual behaviour. We don't know much about him at all."

Colleague E: "He isn't taking prescribed medication; he could be taking street drugs."

Colleague F: "We need to know more about him, and it would be best if he could tell us himself. Do you know if he needs an interpreter? It would help if we knew what he makes of the situation – the fact that he split from his girlfriend, how he feels about living here, not working, etc. Do you know if he's very spiritual? Has he any other family here?"

Mary decides to try using an interpreter, and to find out whether Jed has any family here that he finds supportive. She has found out by accident from information volunteered by Jed's neighbours that he is very spiritual and has a spiritual role in the local community.

Now re-read the story of Jed and Mary more slowly, thinking about which VBP Pointers are particularly relevant.

Summary Table 1A shows the Ten Key Pointers to good practice in VBP (for further details of these you may want to refer back to the arrow diagram in Figure 3). When you have made your selection, tick the relevant Pointers in the table. Then write your reasons for choosing the particular Pointers in the Comments section. You might place only one tick on the table, or many, depending on which Pointers you see as most relevant.

Summary Table 1B shows our suggested answers. However, do complete Summary Table 1A before you look at our answers.

Summary Table 1A

1 Awareness	☐	**Comments**
2 Reasoning	☐	
3 Knowledge	☐	
4 Communication	☐	
5 User-centred	☐	
6 Multidisciplinary	☐	
7 'Two-Feet'	☐	
8 'Squeaky Wheel'	☐	
9 Science and values	☐	
10 Partnership	☐	

Summary Table 1B

1 Awareness	☑	**Comments**
2 Reasoning	☐	
3 Knowledge	☑	Although many of the Pointers of VBP could be ticked, Pointers 3, 4 and 5 were particularly relevant. It was noticeable in the discussion that there was a lot of information Mary didn't know. She needed this information to make her decision about what to do. Although other colleagues speculated what might be the problem, Mary decided to find ways to understand it from the perspective of Jed's values, and to try to improve the channels of communication by using an interpreter – this brings in Pointers 3 and 4.
4 Communication	☑	
5 User-centred	☑	
6 Multidisciplinary	☐	
7 'Two-Feet'	☐	
8 'Squeaky Wheel'	☐	
9 Science and values	☐	
10 Partnership	☐	

How did your answers compare with ours? Your own answers may be the same or very different – remember that values-based practice is very individual. If they are different, this just means you viewed the scenario from a different perspective.

The key idea here is that raising awareness of values is important. In Mary and Jed's story, Mary realised that the key to helping Jed was to get closer to what really mattered to him. Raising awareness of his values was thus the essential starting point.

However, although we have worked on awareness of values particularly in this section, it is clear that in practice this skill has to work as part of the full package of ideas about values-based practice summarised in the Ten Key Pointers.

We will be coming back to the Ten Key Pointers at the end of each of the next three sections, dealing with reasoning, knowledge and communication respectively, as a way of applying what we have learned about each of these areas of VBP skills in our everyday practice.

SECTION 4 Reasoning

Aim

The aim of this section is to understand more about your own reasoning and to practise ways of reasoning about values.

Learning outcomes

By completing this section you will have:

- increased your knowledge of your own reasoning processes;
- used the framework of case-based reasoning;
- used the framework of principles-based reasoning;
- applied these frameworks to your own practice.

Topics covered in this section

- Case-based and principles-based reasoning
- Case-based reasoning in practice
- Principles-based reasoning in practice
- Connecting codes of professional conduct to values-based practice
- Applying reasoning about values in practice

You meet someone for the first time. As you are talking to each other you conclude that this person is in distress and decide that you will stay longer to listen to them, even though this will make you late for your next appointment.

Your conclusion and decision have been reached in an instant and are strong enough to affect your behaviour. Yet the probability is that if asked, you would need some time and thought to be able to give in detail your reasons for what you decided to do, although you believe this to be right. In the same situation others may also decide to stay and listen longer, but for different reasons. You may have stayed for reasons of compassion and because you hoped to help the person in distress. Other reasons for staying could be, concerns about the risk of self harm, or even in some cases seeing it as a way to avoid going to the next appointment.

This is another example of how skills become more or less automatic as we become more knowledgeable and experienced in a particular area. When you are new to using a skill you will be very self aware and will think through what you are doing in obvious steps and stages, but as time passes this process becomes more automatic and less conscious.

The ease with which our established skills of reasoning normally support our decisions, choices and actions, however, means that when we run into difficulties we may have no immediate strategies for dealing with them.

This is especially so with values. As we saw in the last section, we are using values all the time and mostly without being aware of them. This is the 'squeaky wheel' principle of values-based practice (Key Pointer 8) – that we only notice values when there is a problem. When this happens it can be helpful to have strategies for reasoning about what to do.

In the rest of this section we will be looking at a number of strategies for reasoning about values. We will start by considering two of these strategies in detail – case-based reasoning and principles-based reasoning.

Case-based and principles-based reasoning

Case-based and principles-based reasoning offer two strategies for reasoning about values:

- Case-based reasoning is bottom-up – it starts from particular cases. Case-based reasoning says, "Never mind general principles, codes, etc. If we think carefully enough about the details of a particular case, we can solve most problems of values."
- Principles-based reasoning is top-down – it starts from general principles (such as 'respect autonomy', etc.) and applies them to particular cases.

Case-based and principles-based reasoning are both derived from ethical theory. They are ways of reasoning that many people find particularly helpful in health care. Ethical theory also has many other useful approaches. Here are just two examples:

- Utilitarianism – The slogan of utilitarianism is "the greatest good of the greatest number". This approach is used in health care economics, for example. It offers a fair and balanced way to approach resource allocation. Its downside is that it risks disadvantaging minorities who, by definition, are not the 'greatest number'.
- Rights-based reasoning is used particularly in codes of practice and in health care law – the Human Rights Act is a recent example. The idea is to ensure that key rights are enforceable by law. This can be particularly helpful in protecting minorities and thus provides a counterbalance to utilitarianism. The downside to rights-based approaches is firstly the impossibility of defining rules to cover all situations (this is why our 'Codes of Practice' tend to become fatter and fatter), and secondly the risks that decision making may become too legalistic (leading to defensive practice, for example, and negative risk management).

However, reasoning approaches should be used differently in values-based practice from how they are applied to ethics. In ethics, reasoning skills are used with the aim of establishing the 'right' values. In values-based practice, the same reasoning skills are used with the completely different aim of exploring the differences of values that may be involved in a given situation. Ethics seeks to close down, where values-based practice seeks to open up, different value perspectives.

These two approaches – closing down in ethics and opening up in values-based practice – fit together as complementary ways of reasoning about values in health care.

Case-based reasoning in practice

Activity 11 is designed to help you to apply case-based reasoning to a sample case. It is divided into a number of vignettes. In each vignette, key information about the person in the case concerned is changed.

The idea is to think about each vignette separately, i.e. think about the information provided at each stage, and answer the questions about it, before going on. In this way you will be experiencing case-based reasoning. After the activity, we will reflect on some general points about the strengths and weaknesses of this case-based, bottom-up approach.

Activity 11: Case-based reasoning

Vignette 1

A 55-year-old man has been found by his GP to have serious heart abnormalities. The GP has referred the man to a specialist for further assessment and treatment of his heart condition.

The man refuses to attend the outpatient appointment with the specialist as he does not accept that there is any problem with his heart. He also expects to be told to stop smoking, change his diet and take more exercise, and he does not want to do any of these.

The GP is very concerned for the man's life and believes the situation is serious.

Question 1

What do you think should happen?

Question 2

Why?

What reasons do you have for your conclusions at this stage, based on the limited information available?

Vignette 2

Consider the following information in addition to the information supplied in Vignette 1:

The man has a history of depression and has had several inpatient admissions to the local psychiatric hospital when he has been identified as a risk to himself.

Question

Does this information change your conclusions? If so, how?

Vignette 3

Consider the following information in addition to the information supplied in Vignettes 1 and 2:

Antidepressant medication has been effective but has led to the man gaining excessive weight. This increased weight has put more strain on his heart.

Approaches to the man with regard to attending his outpatient appointments have led to him becoming increasingly distressed and withdrawn. He says nobody listens to him or takes him seriously.

Question

Does this information change your conclusions? If so, how?

Vignette 4

Consider the following information in addition to the information supplied in Vignettes 1, 2 and 3:

The man is a retired GP.

The man's wife is 35 years old and they have just had their first child. The baby is six months old.

The man's ethnicity is Black African and his extended family is in South Africa and America.

Question

Does this information change your conclusions? If so, how?

The information has now changed more radically; in particular, does the change in the man's ethnicity make any specific difference to your thinking?

Vignette 5

Now consider the following information, in addition to the information supplied in Vignettes 1, 2 and 3, but not Vignette 4:

The man lives alone and has been unemployed the majority of his life. He has had several brief stays in prison for petty theft and other minor offences. The man also has a problem with alcohol abuse.

Question

Does this information change your conclusions? If so, how?

Vignette 6

Now imagine that the focus of the vignette is a woman.

Re-consider the information provided in Vignettes 1, 2, 3 and 5 in light of this change.

Question

If you were to be asked the same questions again, would your answers be different?

What effects, if any, does this change in gender have on your thinking?

Vignette 7

In the final part of this activity, think of a situation where you had to make a difficult decision similar to the one given in Vignette 1 – a situation where the service user has not agreed with advice given by professionals.

Now ask yourself if the decisions and actions you took in that situation would have been changed by any of the following factors:

(Please note, not all these questions will apply – just select those relevant to the situation.)

1. The reason the service user gave for disagreeing with the advice was to do with their spiritual/religious beliefs or their faith?
2. The service user had no previous history of mental health problems/had a long history of repeated admissions?
3. They had disagreed about treatment before/had never disagreed before?
4. The service user was in their 20s/they were over 60 years old, for example?
5. They had a family and young children/they were single without children?
6. The service user held a responsible job such as that of a GP or university lecturer/was unemployed?
7. The service user was a White English person, White Irish person, Black American person, or Black African person, for example?
8. The service user was male/female?
9. The service user had a prison history/did not have a prison history?
10. The service user had a history of substance abuse/did not have a history of substance abuse?

Question 1

Which of the points above would have changed your decisions and actions?

Question 2

Why would they have changed your decisions and actions?

Finally, look at your responses to Vignettes 1–6 and to Vignette 7, a situation drawn from your own practice, and reflect on your responses. What do you notice about your reasoning, what influenced you most in the scenarios. Would a colleague give the same response?

For most people, their answers to Activity 11 swing widely as the information given about the 'case' is varied. What we learn from this is important. It shows how in case-based reasoning that no matter what our general principles (values) are, our reasoning is, in practice, always strongly influenced by the details of a given situation.

In ethics, the way our conclusions are driven in this way – by the real details of real cases – means that people can often agree on what to do, provided they have enough information. We will be looking in detail in the next section at how we can get information about values.

Reasoning in values-based practice is about opening up our thinking, to explore our own values and those of the people around us. There are two ways of doing this:

1. **Vary the details of the case**
   This is what we were doing in the activity up to Vignette 6. By varying the details of the case, we noted our different reactions. This gives us a way of 'mapping out' what is important to us as it bears on the case.

2. **Compare cases**
   This form of case-based reasoning involves comparing, in an imaginative way, the 'problem' situation with a range of other cases, some similar, some different. Again, this is a way of 'mapping out' the relevant values. Vignette 7, the final part of Activity 11, gave you the opportunity to try out the second form of case-based reasoning.

Case-based reasoning is particularly powerful in health care because we are dealing with 'cases', i.e. real people in real situations, all the time. But if used in isolation it can be driven too much by our own values. We therefore need a different approach as well – an approach that helps us to open up our thinking and to identify values that we may not think of unaided, but that are nonetheless relevant to the problem we are trying to resolve. This is where principles-based reasoning can help.

Principles-based reasoning in practice

The idea behind principles-based reasoning is that, however diverse our individual values may be, there will be a number of general values that are always relevant to a greater or lesser extent in a given context. Where case-based reasoning is bottom-up, principles-based reasoning is top-down.

In a landmark publication, an American philosopher, Tom Beauchamp and a theologian, James Childress, defined four of these general values, or 'prima facie principles' as they called them, that are particularly relevant to health care. We set these principles out in more detail in Figure 12 as they apply to people working in mental health care. The names given to the four principles by Beauchamp and Childress in their book, Principles of Biomedical Ethics (1994), are:

- Beneficence – Doing good as far as possible.
- Non-maleficence – Minimising or preventing harm.
- Justice – Fairness and equal access to care.
- Autonomy – Respect for individual self-determination.

Figure 12: Four principles relevant to mental health practice

"Do good (also known as beneficence)

The mental health worker should seek to promote the service user's welfare.

It is the mental health worker's responsibility to act for the benefit of others. The mental health worker's primary obligation is to provide a service for the service user and the public at large. The most important aspect of this responsibility is the competent delivery of care, within the circumstances of practice and for the benefit of the individual service user with 'benefit' being defined primarily by reference to the specific needs, desires and values of the service user.

Do no harm (also known as non-maleficence)

The mental health worker should seek to refrain from harming the service user.

It is the mental health worker's responsibility to avoid causing the service user harm. This involves, among other things, keeping our knowledge and skills up to date, knowing our limitations and when to pass the service user's care onto others.

Justice and fairness

The mental health worker should seek to treat people fairly.

It is the mental health worker's responsibility to be fair in their work with service users, colleagues and society. This involves dealing with people justly and without prejudice. In some situations it also means actively helping to improve access to care and treatment.

Autonomy and self governance

The mental health worker should seek to respect the service user's rights to choose.

It is the mental health worker's responsibility to treat the service user according to their wishes and desires within the boundaries of care. It also involves protecting the service user's confidentiality. This can be a particularly difficult principle where questions of involuntary treatment are raised."

(Beauchamp & Childress, 1994)

Activity 12 explores how these four principles can help with reasoning about values by applying them to a specific case. It takes you through the stages of reasoning about values using Beauchamp and Childress's four principles, much as we would in practice. As with all our activities, you may want to do this activity with one or more stories from your own experience.

Activity 12: The story of Mohammed

Mohammed is a 22-year-old man who has been seen by his GP. The GP believes urgent action is needed. He says Mohammed has been behaving in a bizarre manner, isolating himself, spending time alone in his bedroom, talking to himself and not eating, as he feels the family is poisoning his food. Mohammed is not sleeping and has been playing his music very loudly at night and has threatened his brother and father.

The family say Mohammed has been like this for six months. They always make sure someone is at home with him. They have taken him to Pakistan to a faith healer but it has not helped. Mohammed's 18-year-old sister appears to be the only person he trusts. Mohammed has not had any previous contact with mental health services.

Last night Mohammed attacked his older brother because he said his brother had been telling people Mohammed was homosexual. His brother denies this. A mental health worker visited this morning and had difficulty in engaging Mohammed in discussion. The mental health worker says Mohammed seemed preoccupied and is hearing voices, to which he responds (auditory hallucinations). The mental health worker also says that Mohammed seems very hostile towards his family.

Question 1

What do you think should happen next and why?

Question 2

Look through Figure 12 and identify which principles you are using to make your decision.

Question 3

Are there conflicting principles in the case? Which one is getting priority?

Question 4

If the situation were different, for example, if Mohammed were less hostile towards his family, would the principle(s) that has/have priority change?

Question 5

If you were Mohammed's mother, father, brother or sister, would your decision be different? How?

Question 1 – What do you think should happen next and why?

As in all our activities, people give different answers to this. Values-based practice, after all, is about difference of values. However, this of course means that there may be disagreements in practice about what to do.

Question 2 – Look through Figure 12 and identify which principles you are using to make your decision.

This question is about principles-based reasoning as one way of resolving conflicts of values. Here, in values-based practice, we are using the four principles, at least in the first instance, not so much to resolve as to explore the relevant values as a step towards coming to a balanced decision. Again, particular responses vary. But the idea behind principles-based reasoning is that, faced with a conflict or

difficulty about values, people tend to focus on one value while neglecting others, and this can lead to unnecessary conflicts. A framework of the values likely to be relevant helps us to avoid this and opens up our thinking.

Question 3 – Are there conflicting principles in the case? Which one is getting priority?

Exactly which values you take to be conflicting here will depend to some extent on your own values. If you are someone who tends to think in terms of 'beneficence' (doing good), you may have missed or not thought about 'autonomy' (the client's freedom of choice). Or, if you are a natural risk taker, you may not think carefully enough about 'non-maleficence' (avoiding harm). Again, when you are close to a particular problem, you may focus on that problem and forget about 'justice', being fair in giving your time and attention to other problems and responsibilities.

But what if, despite becoming fully aware of the relevant values, there are still conflicts between them? The point of Question 3 is that, in a sense, there are always conflicts. That is what a problem of values is about – a conflict of different values, each of which may be legitimate in its own right.

We have summarised the conflicts of principle as we see them in Mohammed's story in Figure 13. As you will see, all four principles come into play. This is why Beauchamp and Childress suggested these particular principles as a foundation for reasoning about problems of values in health care. All four are likely to be relevant to some extent in any health care scenario.

The idea, then, is to think through what to do by balancing these different principles (or values) rather than allowing your decision to be driven in an unbalanced way by whatever value particularly reflects your own perspective.

The second part of Question 3 asks which principle should get priority. Again, there are many different responses to this question. One person may incline towards avoiding harm, i.e. close monitoring of the situation and being prepared to use a 'section' under the Mental Health Act if, despite support having been obtained from colleagues (in the advocacy service) from Mohammed's own cultural group, he still refused to accept help. Another person may feel that we are still a long way from such drastic measures and that respecting Mohammed's autonomy and giving him 'space' to build up confidence in the mental health worker, will pay dividends in the long run. Your responses may be similar to one of these, or different from both – once again, it is a matter of individual perception rather than of the 'right' answer.

Principles-based reasoning thus gives us a well-structured way of drawing out different value perspectives as a key step towards balanced decision making.

Question 4 – If the situation were different, for example, Mohammed were less hostile towards his family, would the principle(s) that has/have priority change?

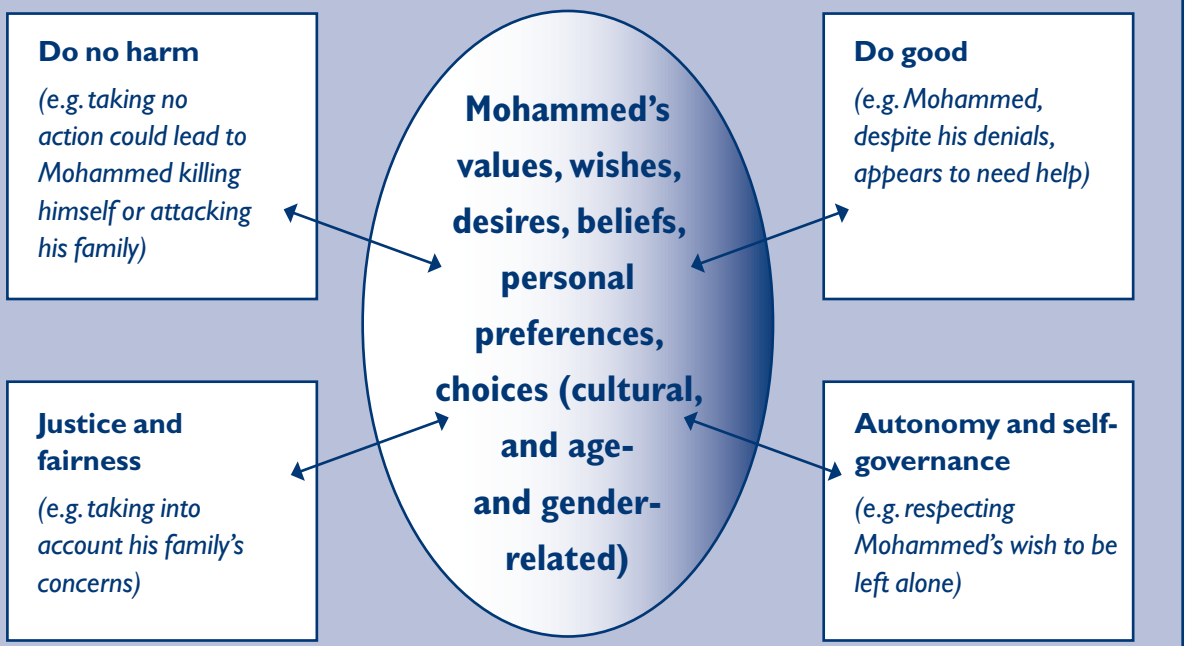
You will probably have noticed that with Question 4, in asking a 'what if?' question, we reverted to our case-based reasoning. This shows that these two approaches – case-based (or bottom-up) reasoning, and principles-based (or top-down) reasoning – are complementary. Having drawn out key value perspectives using the four principles, case-based reasoning can help us to come to a balanced conclusion.

This is one way in which a multidisciplinary team can play a key role in values-based practice. As we noted in Section 2, Key Pointer 6 (Figure 3), the different value perspectives of members of multidisciplinary teams are a positive resource for balanced decision making. We return to this in detail in the main activity in the next section, on knowledge.

Question 5 – If you were Mohammed's mother, father, brother or sister, would your decision be different? How?

Question 5 brings us back to diversity of values, the starting point of values-based practice. It really *does* make a difference *who* you are in a situation and what *your* values are.

Figure 13: Demonstrating the complex and conflicting nature of Mohammed's situation



Connecting codes of professional conduct to values-based practice

So far in this workbook we have been concentrating on values and have said relatively little about ethics. However, ethical codes now play an important role in all health care professions. Codes prescribe 'right values', whereas values-based practice starts from respect for *differences* of values. We therefore need to think carefully about how values and ethics are connected.

Figures 14, 15 and 16 show three particular codes for different groups in mental health care. Activity 13 reflects on these codes and how they relate to the reasoning skills we have been working on in this section.

Figure 14: Professional code for social work practice

Social work is committed to five basic values:

- Human dignity and worth
- Social justice
- Service to humanity
- Integrity
- Competence

Social work practice should both promote respect for human dignity and pursue social justice, through service to humanity, integrity and competence.

(http://www.basw.co.uk/articles.php?articleId=2)

Figure 15: Professional code for medical practice

The duties of a doctor registered with the General Medical Council (GMC):

- Make the care of the patient your first concern.
- Treat every patient politely and considerately.
- Respect patients' dignity and privacy.
- Listen to patients and respect their views.
- Give patients information in a way they can understand.
- Respect the rights of patients to be fully involved in decisions about their care.
- Keep your professional skills and knowledge up-to-date.
- Recognise the limits of your professional competence.
- Be honest and trustworthy.
- Respect and protect confidential information.
- Make sure your personal beliefs do not prejudice your patients' care.
- Act quickly to protect patients from risk if you have good reason to believe that you or a colleague may not be fit to practice.
- Avoid using your position as a doctor.
- Work with colleagues that best serve the patients' interest.

(General Medical Council, 2004)

Figure 16: Professional code for nursing practice

As a registered nurse, midwife or health visitor, you are personally accountable for your practice. In caring for patients and clients, you must:

- respect the patient or client as an individual
- obtain consent before you give any treatment or care
- protect confidential information
- co-operate with others in the team
- maintain your professional knowledge and competence
- be trustworthy
- act to identify and minimise risk to patients and clients.

These are the shared values of all the United Kingdom health care regulatory bodies.

This Code of professional conduct was published by the Nursing and Midwifery Council in April 2002 and came into effect on 1 June 2002.

http://www.nmc-uk.org

Activity 13: Codes and values-based practice

Compare the codes illustrated in Figures 14, 15 and 16.

Question 1

Codes are often presented as though they express 'right values' that are absolute and universal. But if the codes governing healthcare professionals are all so different, does this undermine their authority as guides to decision making?

Question 2

If we are governed by a 'code' expressing particular values, how can we work in a values-based way that starts from respecting differences of values?

If codes really were expressing absolute values, we would have to ask, "So, which code is right?", and this, at the very least, would lead to conflicts between different members of multidisciplinary teams – social workers, doctors and nurses – because each group would be claiming to have the 'right' values.

In fact, codes should be regarded as an attempt by a given group to define and spell out what we can think of as 'framework values' that are all shared by the group in question. This is why each group – nurses, social workers, doctors, etc. – has to work out their own code. Only then, when a code is 'owned' by the group concerned, can it provide an authoritative guide for decisions and action.

This means that the values expressed by a code will vary from group to group. This is clear from Figures 14, 15 and 16. There are crucial differences of emphasis and even of detail. The nursing code, for example, given in Figure 16, although claiming to represent the "shared values of all United Kingdom health care regulatory bodies", includes at least one value – "co-operate with others in the team" – which is absent from the other two codes. The other professions would not necessarily disagree with this, but they do not actually mention it in their own codes.

Question 2 of Activity 13 asked you to recognise the crucial role of values-based practice when it comes to applying any given code in practice. There are two ways in which VBP can help us – by helping to resolve conflicting values, and by helping to interpret complex values.

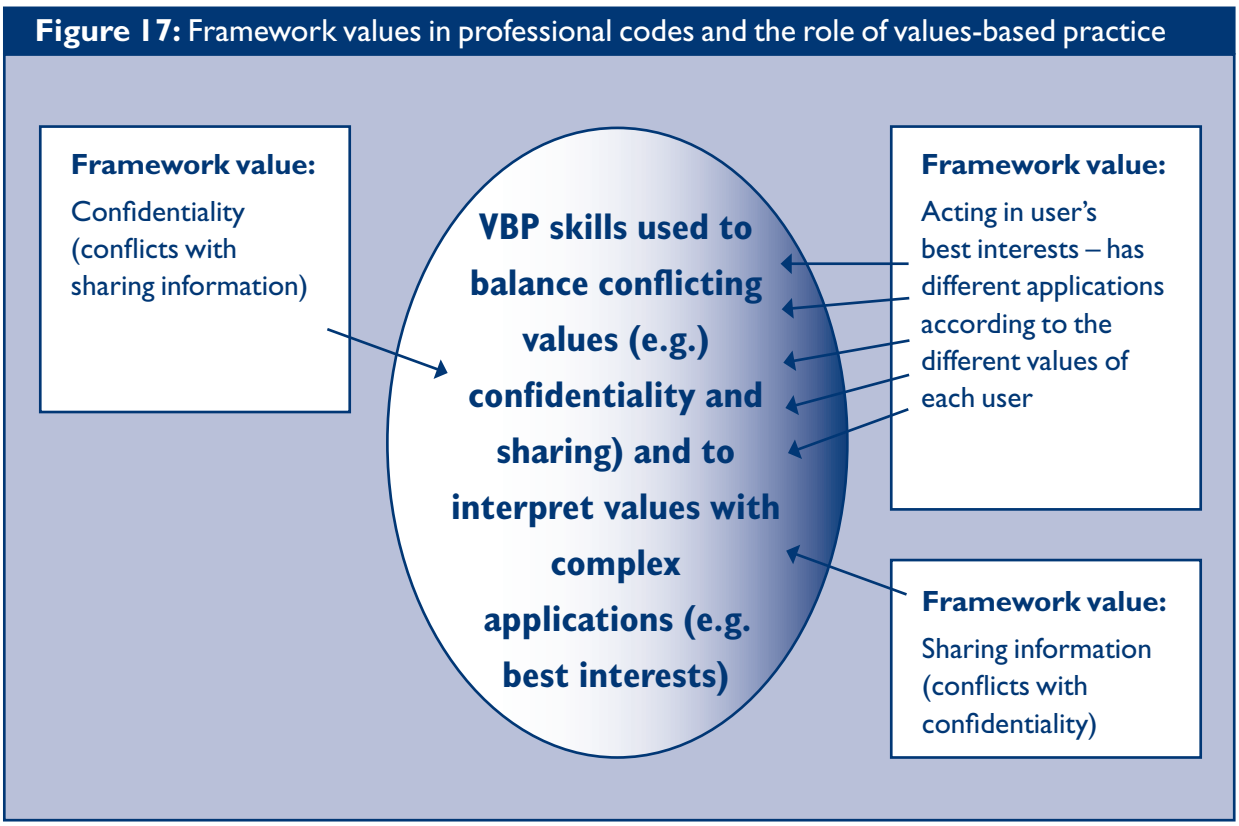
For any set of framework values, there will always be some that are potentially in conflict. We saw such conflicts in Mohammed's story (Activity 12): all four of the Beauchamp and Childress principles were in conflict to a degree in his case. Similarly, 'confidentiality' and 'sharing of information', both important values in their own right, often conflict in mental health care.

In values-based practice, these differences in codes, far from being grounds for conflict, provide a balance of different value perspectives which allow decisions to be appropriately matched to the individual values of the particular service user affected by a given decision. Since the codes themselves cannot determine exactly how we can strike a balance, values-based practice provides a theory and a set of skills for turning the different values expressed by different codes from a source of conflict into a positive resource for balanced decision making.

There are also complications arising from the complexity of some values. For example, acting in someone's 'best interests' – an important value underpinning much of what we do in health care – means very different things according to the values of the particular person in whose interests you are acting. Just as values-based practice gives us the skills to balance conflicting values – for instance in different codes - it also helps us to interpret the complex values (such as 'best interests') that arise when any given code is applied in practice.

The relationship between the framework values expressed in codes of practice and the skills of 'good process' on which values-based practice is based, are summarised in Figure 17. As this shows, far from being incompatible, codes provide frameworks of values. Within these frameworks, values-based practice gives us the skills to respond to particular cases in a given group. It also gives us the skills to convert value conflicts between groups into a balancing resource for health care decision making.

Figure 17: Framework values in professional codes and the role of values-based practice



Applying reasoning about values in practice

We have now tried out two ways of reasoning about values – case-based and principles-based – and looked at how these fit together with our codes of practice. In the last part of this section, we are going to apply these ways of reasoning to actual practice. We will also be considering how the skills of reasoning that we have focused on in this section fit together with all the other values-based practice Key Pointers.

Activity 14: The story of Lorraine

Lorraine is a 23-year-old woman living with her boyfriend of nine months and her two-year-old daughter from a previous relationship. Sometimes Lorraine's mood is very 'high' and at these times she spends a lot of money, has a lot of energy and doesn't sleep or rest. At other times her mood is very 'low' and she finds it difficult to get out of bed or do any work. She has recently been told that she has 'manic depression'. Her relationship with her boyfriend and her daughter are very important to her, and, she says, "keep her sane".

The mental health worker has noticed that when she takes mood-stabilising medication Lorraine feels better and she is better able to get on with her life. However, Lorraine's boyfriend doesn't like her taking tablets all the time. He wants her to be 'normal'.

This has led to conflict and an increase in tension and arguments in her relationship with her boyfriend. Lorraine wants to be well but doesn't want to lose her boyfriend. This is particularly important to her because she feels that since she has been with him, her daughter has become more settled, and is sleeping, eating and playing more.

Question 1

What are the value issues in this scenario for each of the people involved?

Question 2

How would you attempt to resolve this situation using ethical codes of practice?

If you are a social worker, doctor or nurse, try using your own code first; then see if another code helps more or less than your own.

What conflicts and complexities of values arise when you try to do this?

Question 3

What ways of reasoning about values could you use to resolve these conflicts and respond to the complexities?

Try out both case-based and principles-based approaches.

This story, which is likely to be familiar, raises all kinds of value issues. From Lorraine's point of view, there is a tension between her desire to remain well and her concern about losing her boyfriend, a concern which is fuelled by the positive effects their relationship is having on her daughter.

From the mental health worker's point of view, this of course presents a difficult dilemma. Question 2 asks how a code of practice might help in resolving this dilemma. We will look at each of the codes in turn to see how each could help, as well as exploring the limits of each.

All the values in the social work code (Figure 14) are relevant (dignity, justice, service to humanity, integrity and competence), but they are so general that in themselves they provide no practical guidance about what to do. This is not, at least from the perspective of values-based practice, a criticism. Rather, each of these values is recognised to be complex, each will mean something different in practice, according to those concerned in a given situation. "Human dignity and worth", for example, the first of the social work values (Figure 14), applied to Lorraine's case, has to be interpreted according to what Lorraine, and indeed her boyfriend regard as "dignity" and "worth". On the question of medication alone, Lorraine and her boyfriend are at odds on "dignity". And this in turn means that, for Lorraine, given her values, the problem is precisely her internal conflict of values about what is "worth" doing, i.e. whether it is worth taking medication and feeling well but at the risk of losing her boyfriend and putting her daughter's good progress in jeopardy.

By contrast, If you are a doctor, you might be led by the "prime directive" of the GMC code (Figure 15), that you should "make the care of the patient your first concern", to insist on medication. The code does not specify medication, of course. But this is what, by and large, is the special area of clinical care reserved to doctors as a profession. Of course, you will "listen to [Lorraine] and respect her views" (the fourth GMC value) and involve her fully in the decision (the sixth GMC value). But at the end of the day, from a medical point of view Lorraine has an illness (manic depression). Given the risk of suicide this carries, you may feel your duty of care is clear, and that you must insist on medication even if this means using the powers society has entrusted you with under the Mental Health Act.

The nursing code, by contrast, makes consent an explicit precondition for treatment (Figure 16). So as a nurse, if you relied on your code, while you are expected to "co-operate with others in the team", your own prime directive, to "respect the patient or client as an individual," may lead you to conclude that you cannot give Lorraine medication without her full consent. But that leads back to Lorraine's own dilemma, so you risk throwing the burden of decision back on to her, thus increasing the risks to her and her daughter, which conflicts with the last value in the nursing code, to minimise risk.

We have outlined some of these considerations in detail to show the limits of codes when it comes to practical decision making. As we have said, codes do set limits, and limits are important. But the practical usefulness of codes is limited by:

- tensions between codes (as between medical and nursing codes in Lorraine's story);
- the conflicts between values written in each code (between "consent" and "minimising risk" in the nursing code when applied to Lorraine's story); and
- the complex interpretations of many of the values considered individually (each of the values in the social work code being complex in this sense).

Question 3 in Activity 14 asked you to try out both case-based and principles-based approaches as a way of providing solutions in real-life health care decision making, where codes cannot. Although codes are important, these values-based practice skills can help to fill in the 'gaps' which result from the limitations of codes of practice. It is worth taking some time on Question 3 and, if possible, working through your reasoning with one or more colleagues.

Using case-based reasoning, you might consider how your views would change if, say, Lorraine had made a suicide attempt during a depressed phase, or even harmed her daughter in a manic phase. This kind of imaginative re-framing of Lorraine's story can help you to come to a balance between, in social work terms, respecting dignity (no treatment without consent) and service to humanity (giving treatment, if necessary, without consent). Again, principles-based reasoning may help you to come to a balanced view. As a social worker, your first concern may be whether Lorraine's daughter is at risk. This may lead to an emphasis on avoiding harm (non-maleficence) which, without consciously balancing this against other important values (especially autonomy, in this case), could lead to unbalanced decision making.

But these are only examples. As with any skill, you need to work through such thought processes, practise your reasoning skills and, if possible, work with a colleague or friend to share ideas and feedback.

However, reasoning about values will never provide a way forward in practice in isolation. As in the previous section, we provide you here with a Summary Table (2A), showing the Ten Key VBP Pointers (for further details of these you may want to refer back to the arrow diagram in Figure 3). Think about what other VBP Pointers could come into play when dealing with Lorraine's case. When you have made your selection, tick the relevant Pointers in the table. Then write your reasons for choosing the particular Pointers in the Comments section.

Summary Table 2B shows our suggested answers. However, do complete Summary Table 2A before you look at our answers. As always, your answers may be the same as, similar to, or very different from our answers, depending on your perspective on the situation.

Summary Table 2A		
1 Awareness	☐	**Comments**
2 Reasoning	☐	
3 Knowledge	☐	
4 Communication	☐	
5 User-centred	☐	
6 Multidisciplinary	☐	
7 'Two-Feet'	☐	
8 'Squeaky Wheel'	☐	
9 Science and values	☐	
10 Partnership	☐	

Summary Table 2B		
1 Awareness	☐	**Comments**
2 Reasoning	☑	Although many of the VBP skills could be applied to this case – knowledge (e.g. of the actual risks of harm if Lorraine's manic-depressive illness is left untreated, which in turn brings in evidence-based practice), and communications (especially a process of engagement with Lorraine and her boyfriend) are both clearly relevant. And in this case, teamworking is likely to be crucial to a successful outcome.
3 Knowledge	☑	
4 Communication	☑	
5 User-centred	☑	
6 Multidisciplinary	☑	
7 'Two-Feet'	☐	
8 'Squeaky Wheel'	☐	
9 Science and values	☐	
10 Partnership	☐	

SECTION 5 Knowledge

Aim

This section outlines and illustrates some of the many ways in which we may learn more about people's values.

Learning outcomes

By completing this section you will:

- learn about the wide range of methods available for increasing our knowledge of people's values;
- understand the difference between people's express beliefs and values and what may be really guiding their decisions and actions;
- use a particular method for gaining understanding of people's underlying beliefs and values;
- recognise the importance of differences of team values as a resource for user-centred practice;
- apply some of the above ideas in your own practice.

Topics covered in this section

- The importance of knowledge in VBP
- Sources of knowledge
- The story of Tom – six ways of understanding mental distress
- What we say and what we do
- Differences of values, team functioning and user-centred practice
- Applying knowledge about values in practice

The importance of knowledge in VBP

There are three ways in which knowledge is important in values-based practice. We need to know:

1. the values that are actually present in a specific situation; failing that,
2. the values that are likely to be present; and
3. what else (besides values) is relevant to the situation?

In some cases, it is possible to understand the values present within a given case without prior knowledge – the skills you have learned in communication, awareness and reasoning will sometimes enable you to come to understand the values actually present. Often, though, you may not be able to get reliable information on the specifics of the case and will then have to rely on your knowledge of the values that are likely to be present in a similar situation.

It is with knowledge of this indirect kind that we will be mainly concerned in this section. We will be looking in a moment at a detailed case study.

First, though, we will start by looking briefly at the variety of ways in which we can increase our knowledge about values.

Sources of knowledge

Information about the values that are likely to be important in a given context in health care can be derived from many sources. These range from individual narrative to more formal social science and other empirical methods. There are also a number of philosophical approaches that can be helpful.

The following are just examples. As you read them, think how you might use similar approaches in your own work, particularly drawing on local resources.

Individual narrative

There is a growing body of literature from users and carers based on their personal experiences. Clearly this is not always representative but it gives vivid illustrations that are based on first-hand knowledge.

Here is an example from Peter Campbell's account of his own first episode of mental illness. Peter Campbell has written and talked widely about his experiences as somebody with repeated episodes of manic-depressive disorder. He is somebody who has found medication helpful but in this extract he describes how, in focusing too strongly on a medical intervention, people were missing what was most important to him.

"My first crisis admission was not a medical event. For me, it was a moral event, a moral failure. All my subsequent admissions have contained shadows of that first failure. None of the important implications have been medical ones. In my view, the crucial questions about mental health crisis services are to do not with locations and technology but with understandings." (Peter Campbell, 2002)

Social science and psychological methods

There is a wide range of empirical methods for finding out about the values likely to be involved in particular situations, for example:

- ethnographic studies
- participant observer methods
- surveys.

Examples of these and other methods are given in Fulford *et al.* (2002).

Philosophical methods

Various philosophical approaches can help us to understand values. In fact, the exercises in Section 3 on raising awareness of values, are based directly on a philosophical method – 'linguistic analytic' philosophy.

The idea behind this approach is that we can get a really powerful insight into meanings by focusing on the words and phrases used, i.e. on how the message is delivered rather than the message itself. With ideas like 'values' and 'time', we are all able to use them, and can easily come up with lists of associations, even though we would have great difficulty agreeing on an actual definition. Thus, when looking for values in a policy document in Section 3 – by highlighting value words, we revealed all kinds of values that were

hidden in the document and that were not made explicit in the policies. The American psychiatrist John Sadler, has used a similar approach to draw out the values implicit in psychiatric classifications of mental disorder (Sadler, 1996).

Other philosophical methods include hermeneutics, discursive analysis and phenomenology. Each of these has helpful applications in increasing our knowledge and understanding of values in mental health care.

- Hermeneutics: this is a technique for progressively revealing complex meanings hidden in a text or other sample of language.

The Dutch philosopher, Guy Widdershoven, has developed hermeneutic approaches to understanding the concerns and values of people with Alzheimer's disease who have difficulties with communication (Widdershoven & Widdershoven-Heerding, 2003).

- Discursive analysis: this approach is like hermeneutics in that it offers a method for revealing meanings hidden in language. However, it focuses on the way meanings are learned and sustained through inter-personal processes (i.e. discourse).

The American psychologist, Stephen Sabat, working with the Oxford philosopher Rom Harre, has applied discursive methods to the care of people with a variety of mental health problems. He has developed the approach into a detailed set of practical methods for working with people with Alzheimer's disease (Sabat, 2001).

- Phenomenology: as a philosophical method, phenomenology is the study of subjective experiences. It has been used in psychiatry for over 100 years as a method for mapping out and understanding different kinds of mental distress and disorder.

The Italian psychiatrist and phenomenologist, Giovanni Stanghellini, has applied phenomenological methods to the values of people with schizophrenia (Stanghellini, 2000).

The story of Tom – six ways of understanding mental distress

Activity 15 is based on a study carried out by the social scientist, Anthony Colombo, about 'models of disorder'. A 'model of disorder' is about how different people understand mental health – the overall values and beliefs about mental health that a person holds, and which define how they respond to mental distress and disorder. The study combined social scientific with philosophical methods (Colombo *et al.*, 2003, see also Readings 11 and 12 in Resource 5, Further Reading).

After Activity 15, which is broken down into a number of sections, we will be looking at what it tells us about knowledge of values.

Activity 15: Models of mental distress

Step One

Case summary of Tom

Tom Smith is a 30-year-old, white man who is married with two children. During the past three days Tom has stopped eating and has said very little. A psychiatrist has been called in and he has interviewed Tom, his wife and a close family friend who has known Tom since they were at school. These interviews revealed the following facts.

About one year ago Tom started to become increasingly withdrawn and preoccupied. According to his wife and friend it seemed as though he was in a world of his own. As time went by he became less interested in his work and his children. Most of the time Tom would sit upstairs on his own, though on occasion he would become excitable and leave the house, sometimes not returning for several hours. During the past month Tom has started to express ideas which his wife finds strange and difficult to understand.

During the interview Tom was initially reluctant to talk about his experiences but after a while he became more relaxed and said that he felt that a religious sect was putting thoughts into his mind, although he was unclear as to exactly what these thoughts were about. He had also heard members of the sect talking about him as a potential new member, though he had never seen them.

According to Tom's wife, he has had no previous psychiatric problems. Furthermore, he doesn't take street drugs, drinks very little and has had no major operations since having his tonsils removed when he was 12 years' old.

Tom has two brothers, one older and one younger. Neither has had psychiatric problems, and nor have any other members of his immediate family except Tom's grandmother, who received psychiatric treatment but no one can remember for what reason.

Tom did not go to school until he was seven as he was described as a 'delicate' child who was slow in learning to speak properly. When Tom was eight years' old his uncle of whom he was very fond, died unexpectedly. Tom was considered a very stubborn child who spent a lot of time on his own. As a teenager he lacked self confidence and considered himself to be ugly.

Until recently Tom was self-employed. His small business, however, was not doing well and as a result he had a few problems paying bills and the mortgage. Tom has been married for five years but according to his wife they have 'always argued with each other'.

The psychiatrist concluded the report by stating that this is all the information he has on Tom Smith.

(This case vignette was used by Tony Colombo and Bill Fulford in a study funded by the Nuffield Foundation on 'models of disorder' – see Colombo *et al.,* 2003.)

It is important that you **write down** your answers to the following questions. Please keep your sentences simple but clear. For example, "Tom is stressed due to things happening in his life", rather than just "Tom is stressed". Please write about five sentences for each of your answers. Below each main question there are further prompt questions to help you give your answer.

Question 1

What is the nature of Tom's mental distress?

The following prompt questions explore four areas: diagnosis/description of Tom's situation, interpretation of his behaviour, labels that might be applied to Tom and aetiology (the cause).

1. Judging from the information presented in the description, do you think that there is anything wrong with Tom?
2. What are your general thoughts about the way Tom is behaving? Would you say that Tom has mental health problems? How would you interpret or describe Tom's actual behaviour?
3. What are your views on mental health labels? How appropriate would you say labels are in Tom's case?
4. What would you say caused Tom to behave in this way?

Question 2

What should be done about it?

The following prompt questions explore four areas: suggested treatment, the function of the hospital, links between hospital and community care, and prognosis (the outcome).

5. Do you think that Tom needs some help with his behaviour? What sort of help? Who should be involved? How can they help? What are the good/bad points about the types of help you've suggested?
6. What do you understand by the term 'psychiatric hospital'? What function/purpose would you say they serve? What in your opinion are the advantages/disadvantages of psychiatric hospitals? For patients? For staff?
7. What do you understand by the term 'community care'? What are your views on the future relationship between hospital care and community care?
8. Do you think that Tom's circumstances are likely to improve? Why?

Question 3

How should the people involved behave towards each other?

The following prompt questions explore four areas: the rights of Tom, the rights of society, Tom's duties and the duties of society.

9. What rights, if any, does Tom have while he is getting help for his problems?
10. What rights, if any, do those involved in helping Tom have?
11. How should Tom behave towards those who are helping him? What would you say are Tom's main duties/obligations, if any?
12. How should those who are helping Tom behave towards him? What would you say are their main duties/obligations, if any?

Figure 18: Models Table

		A	B	C	D	E	F
		Medical (organic)	**Social (stresses)**	**Cognitive behavioural**	**Psycho-therapeutic**	**Family interactions**	**Conspiratorial**
	What is the nature of mental distress?						
1	**Diagnosis / description**	Physical health–illness continuum	Health/low stress–illness/high-stress continuum	Normal–abnormal continuum	Continuum of emotional distress/ difficulties	Whole family is sick, not just patient	Mental illness is a myth. A continuum of human difference
2	**Interpret-ation of behaviour**	Symptoms of illness are a rough guide to severity	Symptoms may indicate degrees of stress	Taken at face value, seen as acceptable/ not-acceptable	Decode/interpret symbolically to give it meaning	Look at behaviour of all family members	Result of way others expect person to behave
3	**Labels** [that might be applied]	Based on a patient's collection of symptoms	Person is seen as a victim of social forces and not as ill	Not important. Should focus on actual problem/ behaviour	Discussions about labels hide the individual	Externalise an illness which is inherent in the family itself	Create the mental illness myth. Cause stigma etc.
4	**Aetiology** [the cause]	Physiochemical changes in the brain. Genetic factors	Social and economic stress, cultural conflict, marginal status, etc.	Inappropriate learning, poor coping skills etc.	Unusual/traumatic early experiences	Patient acts in response to family pressures	Mental illness (so called), etc. is not something that is socially defined
	What should be done about it?						
5	**Treatment**	Medical and surgical procedures, drugs, etc.	Social change to reduce stress	Increase patient's responsibility for own behaviour	Long-term one-to-one therapy	Family therapy/help and support	None. Aim to empower people
6	**Function of the hospital**	To facilitate the care, treatment and cure of disease	A place of respite for those unable to cope	To provide training, OT, CBT	To maximise contact with psychotherapist	Not important. Whole family needs help	Controls those at risk to themselves but mainly to others
7	**Hospital and community**	Work towards developing a seamless service between hospital and community care	To provide flexible/ short-stay homes for respite/time out	To provide day hospitals offering training/therapy	To provide short-stay homes that provide therapy/counselling	Family training and support centres	Not relevant to the description of this model
8	**Prognosis** [the outcome]	Many symptoms can be controlled	Good if changes made at the social level	Partly depends on severity of learning problems	Depends on level of ego strength. Therapy may be long term	Good if services available for carers	Not relevant. Nothing considered to be wrong
	How should the people involved behave towards each other?						
9	**Rights of the patient**	To be in the sick role, i.e. to be given sympathy, not blamed for problem, etc.	To receive help and support as a victim of a stressful society	To leave hospital when behaviour acceptable	To be spared moral judgement for what is said or done	To expect whole family to see themselves as needing support	To privacy, personal freedom and same civil rights as anyone
10	**Rights of society**	To restrain those who are at risk of harming themselves or others	Limited rights, society should be proactive in preventing stress	To restrain/sanction those who break social rules	Not used in this description of this model	To help when families become dysfunctional	No right to politically define acceptable behaviour
11	**Duties of the patient**	To cooperate and take medication. Learn medical definition of problem	To co-operate with any social help offered	To take some responsibility for learning to cope with their problems	To co-operate with therapist; understand their interpretation of the problem	Whole family has a duty to participate in therapy process	To recognise their social obligations outside of being ill
12	**Duties of society**	To empathise and provide proper medical facilities for care	To acknowledge the problem and change so as to reduce social stress	To provide places for their training and therapy	To build therapeutic partnerships with people to listen and respect their views as individuals	To provide facilities for dysfunctional families. To give carers more direct support	To respect the rights of individuals and to tolerate difference

Figure 19: Blank Models Table

		A	B	C	D	E	F
		Medical (organic)	**Social (stresses)**	**Cognitive behavioural**	**Psycho-therapeutic**	**Family interactions**	**Conspiratorial**
	What is the nature of mental distress?						
1	**Diagnosis/ description**						
2	**Interpret-ation of behaviour**						
3	**Labels** [that might be applied]						
4	**Aetiology** [the cause]						
	What should be done about it?						
5	**Treatment**						
6	**Function of the hospital**						
7	**Hospital and community**						
8	**Prognosis** [the outcome]						
	How should the people involved behave towards each other?						
9	**Rights of the patient**						
10	**Rights of society**						
11	**Duties of the patient**						
12	**Duties of society**						

A: Medical – this model emphasises medication, diagnosis and bodily causes of mental distress.

B: Social – the social model, as its name suggests, emphasises social rather than bodily causes, including stress.

C: Cognitive behavioural – this includes any model which focuses on psychological ways of understanding and treating mental health problems.

D: Psychotherapeutic – includes a wide range of counselling and different forms of psychotherapy.

E: Family interactions – models focusing on whole families rather than individuals.

F: Conspiratorial – a broad term covering all those models that take mental disorder to be a myth created by society to control some of its members.

Activity 15: Models of mental distress (continued)

Step Two

- Figure 18* shows a table of six different models of mental distress, with questions relating to the questions asked in this activity. Read through the table and familiarise yourself with the content in each of the squares.
- Now complete the blank models table (Figure 19*) as follows: **first** read one of your answers to questions 1, 2 or 3. It is probably easiest if you start from the beginning of your answers and work down. **Then** decide which box in the models table your answer best fits. Once you have decided which box it fits in, place a tick in the corresponding box on the blank grid in Figure 19. For example:
  - If your answer to the first question was "Tom is probably reacting to the stresses in his life which is making him ill", then this would fit best with 'Health/low stress–illness/stress continuum' (box 1B). So you would place a tick in the corresponding box 1B in the blank grid.
- If you think your sentence fits in more than one box place a tick in both boxes. For example, "Tom is stressed and it is likely he has inherited an illness that means he has psychotic symptoms when stressed" would fit in box 4A '…Genetic factors' and Box 1B 'Health/low stress–illness/high stress'. So you would put a tick in both boxes.
- If you think your sentence does not fit in any box then leave it out and move on to the next sentence.

Step Three

Look at the spread of ticks you have made on the blank models grid.

Question

What do you notice?

Which column do you have most ticks in? Do you have an evenly distributed spread of ticks? Are there any columns that do not have any ticks in?

Which model does your set of answers most closely match?

Are you surprised by what you have discovered about your answers? Or is it what you expected?

You may find it useful to ask people you work with to complete the activity and compare their results with yours.

*You may find it helpful to photocopy Figures 18 and 19 for use in the following Activities.

What we say and what we do

The study on which Activity 15 is based looked at the different models of mental distress (or 'models of disorder') of five groups of stakeholders involved in the community care of people with a diagnosis of long-term schizophrenia – users themselves, informal carers, nurses, psychiatrists and social workers (Colombo *et al.,* 2003).

A 'model of disorder', as we noted earlier, represents the overall values and beliefs about mental health that a person holds, and which define how they respond to mental distress and disorder. The idea behind the 'models' study was that the models of mental distress that people say they have, may be different in some ways from the models that are *actually* driving their decisions and practice. This is not because people are trying to deceive each other. It is because our real models (about anything, not just mental health) are not always fully conscious.

In the case of mental health, the particular problem is that while all stakeholders claim to work with a holistic model, sometimes called a 'bio-psychosocial model', there is evidence that we use much narrower models in practice.

It was this problem that the 'models' study aimed to explore. The methods used were similar to those in Activity 15 – stakeholders from each of the groups were asked to read through Tom's story and then answer a series of questions. They had a more detailed list of questions than you have used, but covering the same areas.

The results of the interviews were then summarised and put on to tables, as shown in Figures 20 and 21. Each of these tables, as you will see, is laid out on exactly the same lines as Figures 18 and 19 that you worked with in the activity. Thus, each has six models across the top (marked A–F), and the numbers 1–12 down the side, representing the 12 questions on the more detailed list used in the study.

Figure 20: Two models of mental distress – showing reponses of psychiatrists (P) and social workers (S)

	MODELS (Psychiatrists)					
ELEMENTS OF MODELS	**A Medical (organic)**	**B Social (stresses)**	**C Cognitive behavioural**	**D Psycho-therapeutic**	**E Family interactions**	**F Conspira-torial**
1. Diagnosis/description	P					
2. Interpretation of behaviour	P					
3. Labels	P					
4. Aetiology [the cause]	P					
5. Treatment	P					
6. Function of the hospital	P	P				P
7. Hospital and community	P					
8. Prognosis [the outcome]	P					
9. Rights of the patient	P					
10. Rights of society	P					
11. Duties of the patient	P		P			
12. Duties of society	P					

P = Psychiatrists

	MODELS (Social workers)					
ELEMENTS OF MODELS	**A Medical (organic)**	**B Social (stresses)**	**C Cognitive behavioural**	**D Psycho-therapeutic**	**E Family interactions**	**F Conspira-torial**
1. Diagnosis/description				S		
2. Interpretation of behaviour				S		
3. Labels				S		
4. Aetiology [the cause]				S		
5. Treatment		S			S	
6. Function of the hospital	S	S				S
7. Hospital and community		S		S		
8. Prognosis [the outcome]				S		
9. Rights of the patient	S	S				S
10. Rights of society	S					
11. Duties of the patient			S			
12. Duties of society		S				

S = Social workers

In Figure 20, the letters P and S show which squares were most strongly emphasised respectively by psychiatrists (the table in the top half of the figure) and by social workers (the table in the bottom half). The psychiatrists strongly emphasised medical aspects of Tom's story (the 'P's are nearly all in column A, the 'medical' model), while the social workers focused much more on social (stress) and psychotherapeutic aspects (the 'S's are mainly in columns B and D). Again, this is very much along the lines of the exercise you carried out in Step Two of Activity 15.

The different emphases of psychiatrists and social workers were very much as the study predicted. Their unconscious models, as reflected in their responses to the story of Tom, were very different from the holistic or bio-psychosocial model both groups claim to follow. The details of these models (shown in Figure 18) provide us with very useful knowledge about the values and beliefs that are influencing decision

making in the context of community care. As the study predicted, therefore, what we actually do – the way we respond in practice – is likely to be different from what we say we would do.

Having better information about each other's values and beliefs, our different 'models of disorder', is a first step to more collaborative decision making between team members. Even more important, though, is how this relates to the values and beliefs of users of services.

Figure 21 shows the responses of two different groups of service users. The responses of one group, shown in the top half, with squares marked 'UP', are broadly like those of the psychiatrists in Figure 20. The responses of the other group, shown in the second part of the figure, with squares marked 'US', are broadly like the social workers' responses in Figure 20.

Figure 21: Two models of mental distress – showing responses from two groups of service users

	MODELS (User group responses like psychiatrists')					
ELEMENTS OF MODELS	**A Medical (organic)**	**B Social (stresses)**	**C Cognitive behavioural**	**D Psycho-therapeutic**	**E Family interactions**	**F Conspira-torial**
1. Diagnosis/description	UP					
2. Interpretation of behaviour			UP	UP		
3. Labels	UP					
4. Aetiology [the cause]	UP					
5. Treatment	UP					
6. Function of the hospital	UP	UP				UP
7. Hospital and community		UP		UP		
8. Prognosis [the outcome]	UP					
9. Rights of the patient	UP					UP
10. Rights of society		UP				
11. Duties of the patient		UP	UP			
12. Duties of society	UP		UP			UP

UP = Service users' responses similar to psychiatrists'

	MODELS (User group responses like social workers')					
ELEMENTS OF MODELS	**A Medical (organic)**	**B Social (stresses)**	**C Cognitive behavioural**	**D Psycho-therapeutic**	**E Family interactions**	**F Conspira-torial**
1. Diagnosis/description				US		
2. Interpretation of behaviour				US		
3. Labels			US	US		
4. Aetiology [the cause]				US		
5. Treatment		US		US		
6. Function of the hospital	US					US
7. Hospital and community		US		US		
8. Prognosis [the outcome]				US		
9. Rights of the patient	US	US				US
10. Rights of society		US				
11. Duties of the patient		US	US			
12. Duties of society			US		US	US

US = Service users' responses similar to social workers'

We are going to explore the differences and similarities between our own responses and those in Figures 20 and 21, in Activity 16. This will also help to connect your own responses to Tom's story with the findings from Colombo *et al.*'s 'models of disorder' study.

The variability of people's responses to the story of Tom means that your own table may look very different from any of those in Figures 20 and 21. Or you may find that your responses are similar to those of one of the groups in the study. Raising awareness of our own models is thus one useful outcome of activities of this kind. Often we find we are more biased towards one model or another than we expect.

Activity 16: Your models and other people's

Compare your models table (in Figure 19) with the ones in Figures 20 and 21.

Now consider the following questions:

Question 1

Which set of answers in Figures 20 and 21 (if any) most closely resembles your own?

Question 2

Are there differences? Are you surprised by the extent of any differences?

Question 3

In terms of values, what do you think is the significance of the fact that the responses from the user group were split into two sub-groups, one broadly like those of the psychiatrists, the other more like those of the social workers?

Differences of values, team functioning and user-centred practice

Activity 16 gives us a good deal of detailed information about the extent of the differences between team members. We may think we know where other team members are 'coming from', but in practice we often don't. Really knowing our colleagues' values and beliefs about mental disorder, rather than just relying on our assumptions, can help to improve communication and shared decision making. This was one of the key ideas behind the original study – that unacknowledged differences of values lay behind some of the frictions and difficulties in teamworking. Improved mutual understanding can help to improve communication and hence collaboration.

Even more important, though, is the fact that we (practitioners) think we know where our clients are 'coming from', but often we don't. Psychiatrists tend to assume their patients want medical treatments, social workers tend to assume they want counselling, etc. What this study showed is that users of services are just as variable in their values and beliefs about mental distress as providers.

The fact that the group of service users who took part in the study were partly 'medical' in their models, and partly 'social', connects this activity up with two of the other VBP Pointers:

VBP Pointer 5 User-centred practice

User-centred practice in VBP means starting from the values of each client as an individual. 'Users' are often lumped together as though they all had the same values, but of course everyone is different. In the study, some people in the user group showed a more medical approach (as reflected in their responses to Tom), while others showed an approach more like that of social workers. That our two service user groups in Figure 21 should show this degree of difference was a surprise, since all of those involved had very similar experiences of long-term care in the community and so might have been expected to have had rather similar value perspectives.

VBP Pointer 6 Multidisciplinary decision making

The importance of multidisciplinary decision making becomes clear when we compare the responses of two groups of users (Figure 21) with those of the group of psychiatrists and the group of social workers (Figure 20). We are all familiar with the idea that multidisciplinary teams are important in the management of mental health problems because they bring together a range of different skills. What this study showed is that the multidisciplinary team is also important in bringing a range of different value perspectives. If a team represents different value perspectives, this can make it effective in picking up and working with the equally different value perspectives of their clients.

In values-based practice, the different values perspectives represented by different disciplines, and indeed different individuals, in a multidisciplinary team, allow care plans to be adapted to the particular needs of individual service user and their families. This is why, in values-based practice, such differences of values, far from being a source of conflict and misunderstanding, become a positive resource for balanced and user-centred decision making.

Applying knowledge about values in practice

Activity 17: Models in your own practice

For the last activity in this section we are going to ask you to find a colleague who is willing to run through the Tom vignette with you. Ideally, this is an activity that a team should do together with some of their clients.

Question 1

Ask each participant to complete their own models table (Figure 19) based on Tom's story (summarised in Activity 15).

Then compare the tables: look together at any similarities, and any differences, and discuss the significance of these for your own care planning.

Question 2

Ask each participant to fill in Summary Table 3A based on Tom's story (summarised in Activity 15).

Ask the participants to think about what other VBP pointers are relevant to his story.

Summary Table 3A		
1. Awareness	☐	**Comments**
2. Reasoning	☐	
3. Knowledge	☐	
4. Communication	☐	
5. User-centred	☐	
6. Multidisciplinary	☐	
7. 'Two-Feet'	☐	
8. 'Squeaky Wheel'	☐	
9. Science and values	☐	
10. Partnership	☐	

If you do Activity 17 with a team you may be surprised by the differences it brings out. One of the authors used Question 1 of this activity with trainee psychiatrists. One group had just spent three hours looking at bio-psychosocial approaches to schizophrenia, yet they gave even more strongly medical model responses than the psychiatrists in the original study (Figure 20).

At first, the trainee psychiatrists in this group were surprised, but then began to recall situations where they seemed unaccountably at odds with other members of their teams. In discussion they came to see that these differences were caused by the different perspectives of the team members. Finally, when they were introduced to the very different emphases from the two groups of service users (Figure 21), they came to see the differences between them and their colleagues as a positive aspect of case management rather than a failure of collaborative care.

Summary Table 3B shows our suggested answers to Question 2 of Activity 17. As before, you may have picked up very different pointers. What is important about this activity is connecting a particular skill (knowledge, in this case) with the rest of the VBP approach.

Summary Table 3B		
1. Awareness	☐	**Comments**
2. Reasoning	☐	
3. Knowledge	☑	One 'tick' that most people fail to give enough thought to is the one for Pointer 7. This is the 'Two-Feet' principle, that all decisions rely on values as well as facts.
4. Communication	☐	
5. User-centred	☑	
6. Multidisciplinary	☐	What this shows is that the kind of assessment we make is, although partly a matter of facts, also a matter of values. This is particularly important for 'strengths-based' approaches, such as recovery practice (see Wallcraft, 2003 and Allott *et al.*, 2002 – papers 2 and 3 in the Reading Guide in Part 4, Resource 5). Assessment tends to be about deficits and problems, but in a balanced 'strengths-based' approach it is also about assets. VBP gives us the skills for looking at positive as well as negative values in a balanced approach to assessment. This is the first and key stage of a care-planning approach that is based on the real needs and wishes of individual service users and families.
7. 'Two-Feet'	☑	
8. 'Squeaky Wheel'	☐	
9. Science and values	☐	
10. Partnership	☐	

SECTION 6

Communication

Aim

The aim of this section is to raise some key aspects of communication and to bring them together in the context of values-based practice.

Learning outcomes

By completing this section you will have:

- identified ways to use communication in situations of conflicting values and perspectives;
- raised your awareness of barriers in language and in listening;
- learned ways to improve communication in relation to values-based practice.

Topics covered in this section

- Communication and values-based practice
- When communication breaks down
- Working with the challenges of different perspectives
- Improving your communication skills when there are conflicts
- Working with values at the individual level – language
- Building value language
- Listening and hearing
- What service users have said

Communication and values-based practice

What do we mean by communication? The following definition may be of help.

"Communication is generally considered to be a personal process which is an action that involves the transfer of information. There are several methods of communication including verbal, non-verbal, written, direct and indirect. Effective communication is dependent on the skills of the person sending the information and the understanding of the person receiving the information. Communication can be significantly influenced by the nature of the message and the relationship between the sender and receiver." (Ludlow & Panton, 1992)

Good communication skills are essential to values-based practice. Awareness, reasoning and knowledge are all achieved through the use of communication. It is central to achieving each of the Ten Key Pointers. In values-based practice we look at communication in two ways: the individual perspective, for example the importance of listening, empathy and other skills; and the multi-perspective, for example conflict resolution skills.

The area of communication is extensive and there are numerous books and articles written on the subject. It often forms part of basic training for those working in services and you may feel very experienced and knowledgeable in this area already. Completing this section is an opportunity to refresh your skills and to consider communication in relation to values-based practice. It is not intended as a comprehensive introduction to communication skills but relates aspects of communication skills to the process of values-based practice.

When communication breaks down

Good communication is often something we take for granted in our personal lives. We generally feel able to explain ourselves and believe that people understand us. However in our work experiences it can be far more challenging. If you are a service user the challenges can be even greater. Figure 22 is the account of a service user, Mila.

Figure 22: Mila's account

"Basically I've had a shit life. I had a hell of a childhood with abuse and foster care. I came into services when I was 11 years old. I think it must have been because I was harming myself pretty badly by then. Being part of child mental health services wasn't too bad – they pissed me off sometimes but I generally got the feeling they wanted to help me, it was just so difficult.

"But when I was 18 years' old they moved me into adult services and I had my first admission on an adult ward. My god, what a shock – they looked at me as if I was a criminal. I felt they hated me, saw me as a time waster stopping all the people who were really ill from getting help. I know I was difficult; I was just all over the place, my moods seemed so extreme. I felt wretched all the time and nobody seemed to understand. They kept telling me to stop being so attention-seeking and take some responsibility for myself. But I just felt like exploding all the time and the more they didn't like me and ignored me, the more I wanted to hurt myself and the more they said I was attention-seeking. No one told me I had been diagnosed as having a personality disorder – I don't know if they treated me the way they did because of how I behaved or because they had been told my diagnosis. I just know it was a shit time and no one seemed happy, me or them."

Now you have read through Mila's account, please complete Activity 18.

Activity 18: Reflecting on communication and Mila's account

Your answers to the following questions should be your own and not what you think would be a 'right' answer. It is important that you are honest with yourself.

Question 1

When you read the account by Mila how did you feel?

For example, angry, sympathetic.

Question 2

What thoughts immediately came to your mind?

For example, a previous experience you have had working with a service user whose behaviour was challenging.

Question 3

What message was Mila giving in her account?

Question 4

What message did Mila get from the staff?

Question 5

Do you think communication had broken down between the staff and Mila? If so, why?

What do you notice about your answers? It is possible that you may have felt uncomfortable answering them. This may have been because you were experiencing conflicting values, for example a conflict between respect for the service user and respect for the staff.

Figure 23 shows the Ten Key Pointers summary table. We have filled this in for Mila's case.

Figure 23: Ten Key Pointers table

1. Awareness	☑	**Comments**
2. Reasoning	☑	Besides Pointer 4 (communication), we have identified: 1 and 2 (because of the need to understand Mila's values, unusual as they may be); 5 (because Mila's extreme behaviour, which is very challenging, makes it even more important to retain a user-centred focus); and 10 (because no progress can be made here without building a therapeutic alliance).
3. Knowledge	☐	
4. Communication	☑	
5. User-centred	☑	
6. Multidisciplinary	☐	
7. 'Two-Feet'	☐	
8. 'Squeaky Wheel'	☐	
9. Science and values	☐	
10. Partnership	☑	

Just thinking of the relevant Pointers and what has happened in Mila's experience may give you ideas of how the situation could be improved and what could be done in a similar situation.

Working with the challenges of different perspectives

Another vital aspect of communication involves coming to a balance of values in situations of conflict and disagreement.

If you want to achieve good communication and to work with conflict, it is essential that you have listened to the other person's point of view. This does not mean you have 'given in' or agree with their perspective, it just means you are developing understanding. To be able to do this you will need tolerance and an ability to stand back from the situation and let go of your own strongly held beliefs and feelings.

You will also need the ability to give an account of the situation in another person's own words without adding your own comments. Once you have a good knowledge of where the person is and how they see the situation, you will be able to make more sense of how they hear and understand what you say to them. This sometimes takes real effort and skill:

> *"There are some situations where the team always gets into a heated discussion about what's happening and what should be done. When we are disagreeing it's hard not to take it personally and I have to remind myself that this is just my view, this just the way I see it, despite how strongly I feel I'm right. If I'm honest I really want them to stop talking, so I can say things that will get them to agree with me and see it my way. I really have to take a deep breath and make an effort to really listen and understand what they are saying to me."*
>
> (Support worker, community mental health team)

If you understand a situation you are more able to manage yourself and the situation. You will be less surprised by other people's reactions and hold a discussion which acknowledges all perspectives even if they differ widely. From this point it is easier to find some common ground and a place to start working together.

Improving your communication skills when there are conflicts

Figure 24 contains suggestions for improving communication. These are relevant for any situation but even more so when there are conflicts. The suggestions apply to communication with service users, carers and colleagues.

Figure 24: Improving communication when there are conflicts

First take time to think about:

- What is my attitude towards this person?
- What am I communicating to this person? What attitude am I expressing?
- To what degree is this person seeing me as willing to listen and understand?
- What are the core messages the person is sending?
- What is stopping me listening to this person?
- How aware am I of what is going on inside myself when I am listening to this person?

Then:

- Acknowledge that differences of view are normal and can be useful.
- Set aside judgements and biases for a moment and walk in the shoes of the person.
- Respond to the person's core messages.
- Employ the person in helping you understand.
- Accept the person and work with them.
- Check yourself for any reluctance or barriers to communication.
- Don't lose focus from trying to understand the person by trying to prove they are wrong.

(Adapted from Egan, 1994)

Working with values at the individual level – language

Communication skills necessary for VBP include not only working with disagreements and conflicts, but the ability to explore an individual's values and recognise the values messages in your own communications. An important starting point is the language used for communication between service users and mental health workers. However, the following information and activities are also relevant to carers and others with whom you are working.

One of the biggest problems with communication between mental health workers and service users is that they often use two different languages. The service user may describe a personal desire, problem or event in 'ordinary' language. This is then translated by the mental health worker into 'work' language such as 'symptom' or 'social functioning'. The mental health worker may use 'work' language to communicate with the service user, using terms such as 'assessment' and 'care plan', which the service user has to translate into 'ordinary' language. A substantial amount of meaning is lost in translation in both cases.

In VBP, where there is particular awareness of the values used in language, it is important that 'ordinary' language is used as much as possible to retain meaning and to prevent exclusion of service users and confusion.

Activity 19: Language

Mandy is a 47-year-old woman who lives on her own. Mandy's GP has concerns over her mental state, alcohol intake and lack of social support. He visits Mandy after her neighbours complain to the police about her behaviour. The neighbours say Mandy is verbally abusive, trespassing on their property at night and exhibiting odd behaviour.

Mandy tells her GP that the neighbours are stealing her things and that they laugh at her when she tries to get them back. She says the neighbours have also been trying to poison her because they are jealous of her. She says she does drink occasionally but it's not a problem. She doesn't go out much because she doesn't like leaving the house empty because she can't trust the neighbours. Mandy was diagnosed as having schizophrenia when she was 25 years' old but has not had much contact with services since.

Question 1

What do you think is the nature of the problem?

Question 2

What do you think should be done about it?

Question 3

What words in your answers can you identify as 'work' language?
Underline these words.
For example, risk assessment, referral, and assessment.

Question 4

If you have identified some 'work' words in your answers rewrite your answers without using them.
Try to say what you mean in 'ordinary' language.

Question 5

What do you notice about the two versions – one 'work' language, the other 'ordinary' language?

You may have found it quite hard to translate the 'work' language into 'ordinary' language even though you knew what you meant and wanted to say. It takes practice and time to become aware of the 'work' language we use in routine work conversation – terms such as keyworker and social care can seem like everyday terms.

The differences you noticed between the two versions are likely to show that the 'ordinary' language version is more personal, more unique to Mandy. This was only a brief exercise but if you were to apply the same process to care plans and case notes they could look very different.

Building value language

Another reason that values are lost in communication is that people may have little experience of a value vocabulary. Figure 25 shows values items identified by Schwartz (in press) from many different cultures – they are not specific to Western European society.

Figure 25: Examples of values statements

■ Social power	■ Authority	■ Wealth
■ Preserving my public image	■ Social recognition	■ Successful
■ Capable	■ Ambitious	■ Influential
■ Intelligent	■ Enjoying life	■ Pleasure
■ Self-indulgence	■ A varied life	■ Devout
■ Accepting my portion of life	■ Humble	■ Respect for tradition
■ Moderate	■ Detachment	■ Honouring of parents and elders
■ Obedient	■ Politeness	■ Self-discipline
■ Clean	■ National security	■ Social order
■ Family security	■ Healthy	■ An exciting life
■ Daring	■ Creativity	■ Curious
■ Freedom	■ Choosing own goals	■ Independent
■ Self respect	■ Privacy	■ Protecting the environment
■ Unity with nature	■ A world of beauty	■ Broadminded
■ Social justice	■ Equality	■ Wisdom
■ A world of peace	■ Inner harmony	■ Helpful
■ Honest	■ Forgiving	■ Loyal
■ Responsible	■ A spiritual life	■ True friendship
■ Mature love	■ Meaning in life	■ Reciprocation of favours
■ Sense of belonging		

(Schwartz, in press)

As you read through the list you may have thought more about what your own values are. Many people find it easier to discover their own values when they have a list such as the one in Figure 25. You may find the list useful to consider which of these values are important to the service users and others you work with and how they are respected. Further values statements are listed in Part 4.

Listening and hearing

An integral part of goodVBP is listening to service users, carers, colleagues and ourselves to be aware of and explore each individual's personal values. However, many factors, including familiarity, habit, custom and practice, may make us 'value blind' in our everyday discussions or writing.

To be able to unpack the work terms that are used every day we have to pay attention to the information we are exposed to during the many discussions we have during the day. Listening to and hearing what people are saying to us are a vital part of communication. Figure 26 suggests some barriers to hearing.

Figure 26: Challenges to hearing

It is easy to become distracted from what other people are saying, to become absorbed in your own thoughts as the other person is talking.

You may find yourself:

- making judgements about the merits of what the person is saying before they have finished the sentence or given you the whole message;
- filtering information and not actually hearing what the person is saying. The filter may be the result of a number of factors, such as cultural, gender or age differences;
- communicating with labels rather than people. Labels may come from a various sources, for example in the form of a diagnosis like 'schizophrenia', or professionally where all information is seen through a lens with the attributes of a 'social worker' or 'psychiatrist' rather than listening to the individual;
- communicating with general terms rather than actual things and events. For example, a person describes an experience such as 'wanting to go to the local shop' which may become translated into professional 'jargon' as a 'risk' or 'need';
- rehearsing or considering your own answers while the other person is talking.

What service users have said

Service users have also given their views on how communication can improve services:

> *"Service users feel they need to experience respect from staff. This is a complex concept involving valuing somebody's individuality and intelligence, listening to and being interested in somebody's point of view, and not being judgemental or dismissive. It also includes not talking in jargon, being interested in somebody beyond the fact of their difficulties, remembering them from meeting to meeting and calling them by their name. It was recognised that acceptance needs to be balanced by challenge, and the need to have collaborative discussions to reach compromises."*

This extract is taken from a service user's comment in *Personality Disorder: No longer a diagnosis of exclusion* (DoH, 2003)

PART 3

Putting skills into practice

Introduction

In Part 3 we look at putting skills into practice by bringing together what we have covered in the previous sections.

Section 7 explores how values-based practice and evidence-based practice can work together in partnership.

An excellent way to further develop values-based practice is to run a training session for your team. Section 8 provides a sample timetable and guidance on how to set this up. (An example of a one-day workshop schedule is given in Part 4.)

The final section of this part gives you the opportunity to reflect over the whole experience of completing this workbook, as well as helping you to make plans for your future values-based practice.

SECTION 7

Bringing together values-based practice and evidence-based practice

Aims

The aim of this section is to illustrate how values-based practice and evidence-based practice can come together to provide good and effective care.

Learning outcomes

On completing this section you will:

- understand how values-based practice can work in partnership with evidence-based practice;
- apply the partnership of VBP and EBP to your own practice.

Topics covered in this section

- Evidence-based practice
- Values-based practice
- Applying evidence-based practice in values-based practice

As we saw from Part 1, Section 2, the Ten Key Pointers to values-based practice work in partnership with evidence-based practice. This section will illustrate through an example and activities how this partnership can work.

Evidence-based practice

Sackett's definition of EBP (Sackett *et al.,* 2000) includes using research evidence, professional judgement and patient values. To explore the relationship between values-based practice and evidence-based practice we will start with the use of research evidence. One area that has been researched is family work in relation to a person who has a diagnosis of schizophrenia. More information on the use of research to develop guidelines for practice can be found on the National Institute for Clinical Excellence (NICE) website (see Part 4, Resource 6). Activity 20 will give you an opportunity to begin the process of applying EBP to a situation in practice.

Activity 20: Starting with evidence-based practice

John is an 18-year-old man who has recently been diagnosed as having schizophrenia by a local psychiatrist. John started experiencing psychotic symptoms from the age of 14 years and has been seen by a psychiatric service that works across child and adult care. His mother Maggie has been referred by her GP to the practice counsellor as he believes Maggie is depressed. John's father, Malcolm, has told his wife he wants to move out of the family home. John is an only child. John's community psychiatric nurse (CPN) has invited Maggie and Malcolm on two occasions to a group meeting for carers of people who have a diagnosis of schizophrenia. The meetings are intended to be both educational and supportive. John's parents have not attended on either occasion.

Question

Thinking of evidence-based practice, what would you recommend in this situation? What can we learn from the research evidence that can give some guidance here?

If you are not familiar with the research evidence in this area, you may use your knowledge and experience from your practice to answer the question.

If you are familiar with the research evidence, you have may have suggested that working with John's family is likely to improve the outcome of his illness. Also, that this family work is likely to be more successful if John is included in the sessions. Figure 27 shows further research information relevant to John's situation.

Figure 27: Extract from presentation of the research evidence underpinning the NICE guidelines for schizophrenia

- Overall, there is strong evidence that family interventions improve the outcomes for people with schizophrenia living with, or having close contact with, their family, most notably in reducing the relapse rate both during treatment and for up to 15 months after treatment has ended.
  - Family interventions are also effective in reducing relapse rates in those who have recently relapsed, and in those who remain symptomatic after resolution of an acute episode.
  - There is insufficient evidence to know if suicide rates are altered by family interventions.
  - The benefits are most marked if treatment is provided over a period of more than six months or for more than ten planned sessions, and if the service user is included in the family sessions.
  - Treatment with family interventions may be less acceptable when delivered as a multi-family group intervention.

(Kendall, 2003)

Visit www.nice.org.uk for a full copy of this guidance.

Values-based practice

We can now move on to consider the issues of values-based practice in this situation. Activity 21 includes an account of the situation a few months later in John's case.

Activity 21: Looking at values-based practice

It is a few months later and John has received a visit from his CPN.

John was a grade-A student and did well in his GCSEs. He was expecting to do well in his A Levels but over the last year has found it increasingly difficult to concentrate. He has found out that, after discussions between his teacher and his parents, he is to be moved to a college to study on a course with people who have special needs.

John hasn't been sleeping very well, and says he has intrusive images of torture and death during the night. He says no one is listening to him and he is desperate for help. His parents are distressed by his behaviour and feel helpless. John recently smashed a pane of glass in his bedroom door with his head during the night.

John's mother is tearful during the interview and she mentions that John's father is temporarily moving out of the house.

John's care plan includes: risk assessment; anti-psychotic medication with night sedation when necessary; and a referral for social skills training. John's CPN will visit again next week to monitor his progress. John's mother has been prescribed antidepressant medication.

Question 1

Does this care plan have meaning for John?

Question 2

What is being valued in the care plan?

Question 3

Whose values are most evident in the care plan?

Question 4

What values are missing from the care plan?

Although you may feel that you would never write a care plan like the one in the example, care plans very similar to it are written even now. Many care plans use 'work' language and abbreviations that exclude the service user or their carers from gaining any useful meaning from them. When others have completed this Activity they often say that the care plan does have meaning but it is all negative; for John, a risk assessment could give messages about people's expectations and views of him.

It would appear that what is being valued in John's case is, generally, a reduction in symptoms through medical intervention. Whose values are evident in the care and what values are missing? You may have noticed that the values of the community psychiatric nurse and the other professionals were present but John's were missing. For example, he was excluded from the decision to change his school. This was a major change in his life which was important to him; he may have found it distressing and quite an adjustment, and may have had many questions to discuss.

Applying evidence-based practice in values-based practice

In the first scenario (Activity 20), working with the family and including John, using the guidance and knowledge gained through research into working with families, are all likely to have improved the outcome of his case. In the second scenario (Activity 21), we can see how barren, anonymous and meaningless care plans can appear without considering the service user's values. It is clear from both scenarios that John's care would be vastly improved with the use of both evidence-based practice and values-based practice.

Now that you have completed Activities 20 and 21 it is useful to reflect on your own practice. Activity 22 is a simple but useful aid to reflection.

Activity 22: Thinking of your own practice

Think of your work over the last week, and of the decisions you have made about a person's care.

Question 1

What was the source of the knowledge that informed your decisions? Was there any relevant guidance or research evidence?

Question 2

What, and whose, values had the most influence on your decisions?

Question 3

Is there anything you would change?

The process used in Activity 22 can be used to reflect on any decision or activity, including: assessment; meetings; admission to and discharge from services; care planning; and when introducing change of any kind.

SECTION 8

Running a training session on values-based practice

Aim

The aim of this section is to help you to run a values-based practice training session for your team.

Learning outcomes

After completing this section you will be able to:

- decide whether running a session would be useful;
- evaluate whether you have the skills and confidence to run a session;
- know what you need to do to prepare to run a session;
- plan your session.

Topics covered in this section

- Why run a training session for your team?
- Preparing for a session
- Delivering a session
- Evaluation
- The benefits of running a workshop

Why run a training session for your team?

After completing the previous sections you may wish to share your experience of learning and using values-based practice with others. You may have ideas about how some of the activities would help with some problems or goals you have in your work and you may think about running a training session on values-based practice with your team or other colleagues.

The following comments were made by people who completed values-based practice workshops with the Sainsbury Centre for Mental Health.

> *"I had forgotten how essential values are to my practice – they are what make me do what I do in practice. This session has really made me think. We just never take time for this kind of discussion in practice but it is so important."*
>
> Taken from a workshop for team leaders

> *"The session was so helpful for understanding why conflicts arise between individuals in our team, other teams and service users. Just realising what's happening really takes the pressure off. It was good to realise it's OK to have different values and to see things differently, and that this is, in fact, a resource for the team."*
>
> Taken from a workshop with an assertive outreach team

Raising awareness of values in your team's practice, as long as the session is relaxed, comfortable and fun, can be beneficial to the individuals and the team by improving communication, understanding and team building.

A session on values-based practice may help your team with:

- reviewing the service user's journey through your service;
- improving the admissions or discharge experience of the service user;
- reviewing the Care Programme Approach (CPA) procedures and practices;
- recruitment and retention of staff;
- building staff morale;
- team building;
- reviewing communications with service users, for example, language used in posters, handouts and general paperwork;
- risk assessment paperwork and process.

Completing the activities from this workbook can also help your team to achieve these results. Helpful activities include those that: reveal what is being valued; show the values that are present in language; explain the values within the reasoning process; and improve the understanding and communication of the values of those involved with a decision or action.

Preparing for a session

To run a successful session it is important that you spend time and thought on planning and preparation. Pressures of work and competing demands can threaten to cut this short, but if your colleagues are giving up their time to attend, it is essential that you allow enough time for preparation.

If possible, co-train, as this will give you support and an opportunity to learn from each other and share constructive feedback. If you plan to do so, involve your co-trainer right from the start in the development of the session. Co-training with a service user will give access to a key perspective within values-based practice. If you would like a service user to be your co-trainer, approach them through your service's appropriate channels. You may have good links with local service-user organisations who can give advice on how to involve a service user in training. It is important that you are clear about what the role of your co-trainer is going to be and how they will be supported. It will also be important to consider how they will be paid for their work and to make sure there is money available to reimburse them immediately for any expenses they have incurred.

An example of a training session is given in Figure 28.

Figure 28: Example of a training session

Title of the session: Developing our team: starting with values

Who is it for: All team members including support staff

How many is it for: There are 12 of us

Facilitator: Gillian Bloggs (me) and Jane from the Service User Forum

Date and time of session: 9.30am Thursday (after team meeting)

Venue: West Team's group room

Aim of the session: To raise awareness of what is important to us in the team and review our operational policy

Learning outcomes:

At the end of the session we will:

- know what we mean by the term 'values';
- know what we value as a team member;
- know what values underpin our work as a team.

Time	Action	Comments
9.30am	**Start** Introduction (facilitator, participants, etc. if necessary), session aims, outcomes (if stated) and overview.	Overhead transparency with aims, outcomes and overview. You will need an overhead projector/screen.
9.45am	**Warm-up activity** "If you could have anybody, fact or fiction, to join your team, who would it be and why?" Each person to feed back their answers in the large group. Examples of answers: "Mary Poppins because she is so resourceful", "Lassie because she is always good when there is trouble".	
10.00am	**First activity** Split group into three (Group 1, Group 2, Group 3). "Please complete the values awareness activity."	See handout 1 in Figure 29.
10.30am	**Feedback** Group 1 gives their answer to Question 1, Group 2 gives their answer to Question 2 and Group 3 gives their answer to Question 3. The other groups comment and add to the answers of the group feeding back.	
11.00am	**Break**	
11.30am	**Second activity** "On your own, reflect on the last activity. Then share your reflections in pairs before feeding back to the large group."	See handout 2 in Figure 29.
11.50am	**Feedback to large group** Discuss, and agree next steps, looking at what has been generated by the morning's activity. Plan any action and record on flip chart paper. Flip chart to be typed up and disseminated to the group.	You will need flip chart paper and pens.
12.15pm	**Closing comments and evaluation**	Evaluation forms (Figure 30).
12.30pm	**Finish**	

Figure 29 shows the handouts for activities involved in the training session set out in Figure 28.

Figure 29: Example of handouts for training session

Handout 1

Please read the following questions and discuss in your group. Please note down your group's answers ready to feed back to the large group.

1. What are values?
2. What values do you bring to your work?
3. What values currently underpin your team and the service it provides?

Handout 2

Think through the activity you have just completed and the discussions you have had, and answer the following questions:

1. What did you learn about yourself, others, values, etc?
2. What was unexpected?
3. What had the most impact, and why?
4. How did you feel during the activity and discussion?

Think of your work over the last week. Consider the decisions that were made, and answer the following questions:

5. What values had the most influence on your work? Whose were they?
6. How does your team usually work with values, including conflicting values?

After the session:

7. Do you have any questions that you want to follow up after the session?
8. Have you anything you want to take back to your team or your practice from today? If yes, what is it and how will you use/do it?

Tips for preparing a session

- Make sure your session is not subject to interruptions. If possible find a venue away from your own team's work setting.
- Give people time to put it in their diaries, and keep reminding them.
- Tell people clearly what you plan to do and why.
- Make it part of a team decision that you agree to have the session.
- Make information about the session easily available, e.g., by using posters.

Delivering a session

Once you have planned your session, the necessary arrangements have been made and people are well informed, you are ready to deliver the session. The style of the session is very important. Values-based practice workshops are about raising awareness, deepening knowledge and giving opportunity for discovery and reflection. They are not about telling people what values they should have or judging people's values.

It is important to create an atmosphere that is relaxed and fun while maintaining a clear focus and purpose to the work. People will also need time to consider the tasks, so make sure the pace allows for sufficient opportunity for discussion and feedback.

Do not try to be an expert on values but gently guide the group through the activities, helping them to generate ideas and to keep on track. Make sure that you have completed for yourself the activities you are asking the group to complete and remember how you felt when you were completing them.

Completing the activities can be a challenge for some people – they may find it hard to 'think', or they may find the tasks very personal. It is important not to force people to participate but to enable them. You may find yourself using many of the skills that you have gained from clinical practice when running the session.

A response from some people may be that they have 'done' values or that they are already doing values-based practice. Our response to this is that much can be gained from sharing what you have done or are doing with the team as no one individual is the only person that a service user comes into contact with in the service. It is mutually beneficial to share good practice and we can all do with time for reflection, to review and update our skills and knowledge.

Tips for delivering a session

- Relax.
- Be well prepared.
- Complete the activities yourself before using them.
- Shadow a trainer before running your own session.
- Co-train.
- Stand back from people's comments and allow the group to explore. Do not give in to the temptation of giving your view of what the 'right' answer should be. Encourage the group to challenge the answers, considering the implications and the Ten Key Pointers to good practice.
- Do not be confrontational.
- Give people time.
- Be aware that some people may find the activities personally challenging.
- Don't try to be an expert.
- Have fun!

Evaluation

After completing your session it is useful to evaluate its impact on the group. This can be done by verbal feedback from your group or by noticing differences in practice subsequent to the session. You may also wish to construct a brief evaluation form. People often find completing forms quite tedious at the end of a session but if you keep them simple and easy to fill in, most people are happy to do this. Figure 30 is an example of an evaluation form.

Figure 30: Example of an evaluation form

Name of the session:

Date:

We should be grateful if you would complete the questions below. We are grateful for any ideas and suggestions for improving the session.

Question 1

What was most useful about the session?

Question 2

What will you use from the session in your practice?

Question 3

Do you have any suggestions for what would improve the session?

Please write any other comments here.

Thank you for your help and co-operation

Tips for evaluation

- Whatever evaluation you use, keep it simple.
- Remember what information you want and why you want it. Do not collect information you are not going to use.
- Give enough time at the end of the session for people to complete the evaluation form in the session time.

The benefits of running a workshop

Despite the hard work, running a values-based practice session can be really exciting. People can find the work inspirational and meaningful. The sessions can be very moving and great fun. The following comments are taken from session evaluations.

> *"Thank you for such a great day, I didn't know what to expect but it has been really worthwhile."*
>
> Taken from a workshop for a crisis team

> *"This has been a pivotal experience."*
>
> Taken from a workshop for managers

It is hard work but extremely rewarding and can be essential to the development of your team's 'capable practice'. A VBP training session can continue the process of building relationships, reduce the tensions of conflicting values and genuinely address issues of service-user centrality in the services provided.

If you are interested in running a whole-day workshop rather than just a session, an example is given in Figure 32 in Part 4 of this workbook.

SECTION 9

Review and action planning

Aim

The aim of this section is to give you an opportunity to reflect on your overall experience of completing the workbook and to identify any next steps you wish to take.

Learning outcomes

- to be aware of the overall learning experience of completing the workbook;
- to identify any future actions you wish to take.

Topics covered in this section

- Reviewing your experience of completing the workbook
- Action planning
- Your feedback

Reviewing your experience of completing the workbook

The aim of this workbook has been to help you to develop a way of working with values in your practice by providing the model, frameworks and skills of values-based practice for you to use in your everyday work. Now that you have completed the workbook we hope you feel more knowledgeable, confident and positive about working with values. We hope you have enjoyed the activities and that they have proved relevant and helpful.

Activity 23 is designed to help you to consolidate your learning and assist you in sustaining it in practice.

Activity 23: Reviewing your experience of completing the workbook

Think back over all the activities you have completed and the sections you have read and answer the following questions:

Question 1: Feelings

What were your feelings as you completed the workbook?

Question 2: Evaluation

What was good and bad about the experience?
What was unexpected? What had the most impact, and why?

Question 3: Analysis

What sense can you make of what you have read and the activities you have completed?

Question 4: Conclusion and planning for the future

What will you do differently in practice in the future?

How will you sustain your skills and energy over time? Do you have any questions that you want to follow up? Have you anything you want to share with your colleagues, service users/carers or team?

(Adapted from Gibbs, 1988)

After completing Activity 23 you may have some clearer ideas of what you want to do next. Keeping values fresh in your mind and using the skills and knowledge you have gained through completing this workbook will be an ongoing active process. You will need to identify ways that will help you to keep your ideas and learning alive in your day-to-day routines.

Completing the workbook may have given you ideas about how you would like to change practice where you are working. You may want to share the experience of completing the workbook by running a training session for your colleagues. Whatever your ideas, decide to act on them, make plans and discuss them with friends and colleagues. Don't forget that training sessions and workshops provide a really good opportunity to involve service users.

It will help if you use some of the activities contained in this workbook to structure your supervision sessions. If you do not currently receive supervision, arrange to start sessions in the future with someone who is qualified for the role and who is also interested in developing values-based practice.

There may also be times during care programme approach (CPA) meetings, team meetings or interest group meetings when you can raise some of the issues of values-based practice for discussion with others. It may also be helpful when setting standards or policies.

Action planning

Now that you have reflected on your learning and considered ideas for what you would like to do next to make it happen, complete the action plan (Figure 31) for each task you plan to do.

Figure 31: My action plan	
What do I want to achieve?	
How am I going to do it?	
When and where am I going to do it?	
What resources do I need? Who can help me?	
Date to review progress	
Date reviewed and comments	

It takes self discipline and commitment to fill in and use an action plan but it can be very useful for clarifying and detailing your intentions and also communicating them to others. Even if you lapse in achieving the tasks you have set yourself, always review your plan, reflect on any barriers or problems that have arisen and revise it accordingly. The purpose of completing the plan is to help you, and it should always be considered a 'work in progress'.

We hope that you continue to use values-based practice in the future and continue to find it meaningful and inspirational. We wish you well with your future work with values, and remember, it is about people and what is important to them.

Your feedback

We should be very interested to hear your response and thoughts about this workbook and should like to receive any feedback from you. If you would like to contact us please email or write to:

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PART 4

Resources

1. Information for running a values-based practice workshop
2. Additional value statements
3. Training development tools
4. Policy context of values-based practice
5. Further reading
6. References and useful websites

RESOURCE

I

Information for running a values-based practice workshop

Basic tips for developing and running workshops

- Know your stuff, teach only what you know.
- Have confidence in your material.
- Organisation and preparation are very important.
- Acknowledge there are some factors you have no control over.
- Identify priority points – rationales to get across.
- Identify the focus for the day – there are four sessions in a day, so you can cover four major areas. These areas should follow in a logical sequence.
- When pitching the level choose the middle.
- Use a variation of teaching methods e.g. videos, small group work.
- Good case study activities generally are a very successful method for addressing learning related to practice.
- Base role plays on real contexts and experiences such as CPA meetings.
- Use questions to develop discussion and sharing of thoughts and knowledge.
- Identify issues such as: relevant documentation, themes, user perspectives, students' responsibility.
- Look for audience feedback.
- Feedback during breaks helps to monitor progress and the groups' priorities.
- Be ready to make subtle changes.
- Agree to differ – be honest.
- Use a facilitative style.
- Be positive, confirming good practice.
- Always give handouts.
- Handouts may contain copies of many acetates; you may only use a few of them but it is a good way of giving more information than you can cover in the session. This takes the pressure off and enables a more relaxed day.
- Read through evaluations soon after to see if there is anything to be learnt.
- If one form contains comments not mentioned in any others don't let it have too much impact on the overall evaluation.
- Reflection is good but don't let negative or critical comments paralyse you.
- Remember that everyone has a beginning, and every trainer has workshop failures. Skills and knowledge develop with experience (sometimes painful).
- However, workshops can be great fun and very rewarding.

(Morgan, 2000)

A workshop example

A good way of implementing values-based practice is to use it to develop or revise your team's operational policy. This policy may include statements about the team's mission, philosophy and/or values. However, many do not include this, and some teams do not even have an operational policy.

One way to develop a policy and make it more representative and more likely to be understood and followed is for the team itself to contribute towards its development. Figure 32 provides a template for a one-day workshop on developing the team's operational policy by including statements on the team's values.

Figure 32: Example of a training workshop

Title of the session: Developing our team: starting with values

Who is it for: All team members including support staff

How many is it for: There are 12 of us

Facilitator: Gillian Bloggs (me) and Jane from the Service User Forum

Date and time of session: 9.30am Thursday (after team meeting)

Venue: West Team's group room

Aim of the session: To raise awareness of what is important to us in the team and review our operational policy

Learning outcomes:

At the end of the session we will:

- know what we mean by the term 'values';
- know what we value as a team member;
- know what values underpin our work as a team;
- have a clear plan of the changes we would like to make to our operational policy in relation to values-based practice.

Time	Action	Comments
9.30am	**Start** Introduction (facilitator, participants etc., if necessary). Session aims, outcomes and overview.	Overhead transparency with aims, outcomes and overview. You will need an overhead projector/screen.
9.45am	**Warm-up activity** "If you could have anybody, fact or fiction, to join your team, who would it be and why?" Each person to feed back their answers in the large group. Examples of answers: "Mary Poppins because she is so resourceful", "Lassie because she is always good when there is trouble".	

10.00am	**First activity** Split group into three (Group 1, Group 2, Group 3). "Please complete the values awareness activity."	See handout 1 in Figure 29.
10.30am	**Feedback** Group 1 gives their answer to Question 1, Group 2 gives their answer to Question 2 and Group 3 gives their answer to Question 3. The other groups comment and add to the answers of the group feeding back.	
11.00am	**Break**	
11.30am	**Second activity** "Complete this activity on your own, then share your reflections in pairs."	See handout 2 in Figure 33.
11.50am	**Feedback to large group and discussion**	
12.30pm	**Lunch**	
1.30pm	**Warm-up activity** "What is the most important thing that's ever happened to you at work?" For example, "the first time I felt I made a difference in some one's life".	The purpose of this activity is to help people regain their focus in a light-hearted way after lunch.
2.00pm	**Third activity** "Please complete this activity in your small groups. This activity aims to help you look at different perspectives in relation to services."	See handout 3 in Figure 33. You will need a flip chart paper and pens.
2.30pm	**Feedback and discussion in large group**	
3.00pm	**Break**	
3.30pm	**Whole group activity** "Thinking through the activities completed today, what values do you want to write into your operational policy?"	You will need a flip chart and pens.
4.00pm	**"Where next with the information?"** Whole group action planning.	
4.15pm	**Closing comments and evaluation**	Evaluation form (Figure 30)

Figure 33: Handouts for sample workshop

Handout 2

Please read through the following extract from the team's operational policy, then answer the following questions:

(Place extract of team's operational policy here.)

Questions

1. Underline any words that involve an evaluation or a value judgement, for example: severe, rapid, best, need, risk. For the words you have underlined, who would be making the evaluation?
2. Re-read the extract. What is being valued? What is seen as desired, important, a priority? For example, efficient record keeping, using evidence-based practice or speed.
3. With regard to the overall values you have identified, whose are they?
4. What are the implications of the values you have identified? What effect would they have on how staff behave?
5. Are there conflicting values?
6. Are there any values missing or that you would like to be more emphasised?

Handout 3

Group 1: How does your team fit into the overall service provision, including any voluntary or non-statutory service links?
With which service does it have the most contact, and with which the least? What happens at the interface? How does it differ from other parts of the service and how is it the same?

Group 2: What is the role and function of your team?
What are its main aims and goals? What staff make up the team? How would you briefly describe the team to others?

Group 3: If you were a service user and you were using the services of your team, what would you experience?
What would you want and need at each stage? What would be priorities for you? Would there be any challenges? What would you find most useful?

Please summarise your responses on the flip chart paper provided for feedback to the rest of the group

At the end of the workshop you may find that you have a flip chart with scattered ideas which you can refine for inclusion in your team's operational policy (see Figure 34).

Figure 34: Example of flip chart information refined for inclusion in the operational policy

Some values and beliefs remain constant, others change. Also there will be diverse values and beliefs within the team. However, some values and beliefs are core to all practice and to the service delivered by the team. The team have decided that although they realise values can change and that people in the team have different values, there are some values that do not change for the team. They have identified these as the team's core beliefs:

- **The centrality of the service user to their care.** This is demonstrated by:
  - sensitivity to language used and a commitment to use simple language;
  - the nature of the relationship – respectful and collaborative;
  - the availability of information to enable informed choice, where choices are possible;
  - open and honest care planning with service-user involvement. This is not just about obtaining the service user's signature at the end but a plan that is meaningful to the service user.
- **The valuing of team members.** Recognising the strength and resource that the diversity of staff within the team contributes to care. Recognising the importance of supporting team members individually and as a group.
- **The importance of relationships with other services.** Aiming to build relationships through sharing of information and experiences and the importance of seeking win–win (both services) and win–win–win (both services and the service user) outcomes.

It would be useful to be explicit about the models underpinning the team's 'operations'. It was suggested that using case studies to illustrate these models would be useful. (This process was used in a VBP workshop to illustrate VBP Pointers in practice.)

Models underpinning the team's operational policy:

- Evidence-based practice
- Values-based practice
- Practice-based evidence
- Recovery process.

It will be necessary to revisit the values within team meetings, clinical supervision and team planning. It will also be essential to have an ongoing process of reviewing the operational policy and the values it contains, both implicit and explicit.

RESOURCE
2

Additional value statements

When people are asked to think of their own values or the values of others, they can often struggle to recall them. We have found that providing people with examples of value statements can help them consider and communicate their own values. You may find the following examples of values helpful when thinking of your own or others' values. They are suggestions, and should not be viewed as definitive lists of facts. They are intended to reflect a broad range of perspectives and you may disagree with them or find some values in conflict with your own.

Values and traits, adapted from Rokeach (1973)

1. Self-controlled (thinks first, restrained, self-disciplined)
2. Honest (sincere, truthful, disclosing)
3. Loving (affectionate, tender, caring)
4. Ambitious (hard working, aspiring)
5. Cheerful (light-hearted, joyful)
6. Responsible (dependable, reliable)
7. Independent (self-reliant, sufficient)
8. Broad-minded (open-minded, able to see other viewpoints)
9. Polite (courteous, well-mannered)
10. Forgiving (willing to pardon others)
11. Intellectual (intelligent, reflective, knowledgeable)
12. Helpful (working for the welfare of others)
13. Obedient (dutiful, respectful)
14. Capable (competent, effective, skilful)
15. Logical (consistent, rational, aware of reality)
16. Courageous (standing up for your beliefs, strong)
17. Imaginative (daring, creative)
18. Clean (neat, tidy)

Ways of living, adapted from Morris (1973)

Way 1: Cautiously and intelligently preserve the best of our culture in order to develop an orderly, active, just world.

Way 2: Be self-sufficient, 'go it alone', avoid close social ties.

Way 3: Loving, sympathetic, concerned, respectful, and helpful with others, not greedy or controlling or aggressive.

Way 4: Have fun without getting too involved with others. You can't control the world so enjoy life, for tomorrow you may die. To fully enjoy life, think of 'number one' first; let yourself go!

Way 5: Get involved with others for fun and achieving common goals. Give of yourself to others to make this 'the good life', don't withdraw or be self-centred.

Way 6: Work hard to solve the problems we face. Don't follow the past or merely dream of the future, do something! Science can solve many of our problems.

Way 7: Accept all philosophies, not just one. Fun, action, and contemplation in equal proportions is the best way to live.

Way 8: Enjoy the simple, available, daily pleasures of home, relaxation, and friends.

Way 9: Stop seeking, be receptive, then wisdom and the good things of life will come freely.

Way 10: Constantly seek self control, firmly directed by reason and high ideals. Guard against seduction by comfort, selfish impulses, the urge to 'cop-out', etc.

Way 11: The internal world of ideas, dreams, sensitivity, and self knowledge is a better place to live than in the external world.

Way 12: Use all one's energy to build something, to overcome obstacles, to climb a mountain because it is there. Use all the power you have.

RESOURCE
3

Training development tools

Introduction

The Mental Health Workforce Strategy notes the central role of values-based practice in a document outlining its values and vision, key principles and main aims.

"In summary, our workforce strategy for staff working with people with mental health problems must be placed firmly in the context of social inclusion, placing the person with their individual values, beliefs and experiences, at the centre of the process and recognising that their perspective is of equal importance to that of the practitioner. The implications for the workforce are that we need to develop diversity within, across and in the staffing of services with competencies relevant to supporting personal goals in mainstream life and based on an understanding of individual and shared values."

Extract from Values and Vision Statement in the
Mental Health Workforce Strategy (DoH, forthcoming)

Training in values-based practice, using the materials and methods set out in this workbook, and within the policy framework of the National Institute for Mental Health in England (NIMHE) Values Framework (Figure 5), is supported by a number of curriculum support tools currently under development (Figure 6).

In this section we give: 1) more detailed guidance about how to use these curriculum support tools, 2) details of the Ten Essential Shared Capabilities for Mental Health Practice, and 3) information about the Skills for Health Functional Map, a further curriculum support tool currently under development which explicitly incorporates key elements of values-based practice.

Curriculum support tools

The following is an extract from a document being developed by the National Workforce Programme at NIMHE, explaining the links between four curriculum support tools for training in mental health: 1) The Essential Shared Capabilities (ESC); 2) The Capable Practitioner Framework (CPF); 3) The Mental Health National Occupational Standards (NOS); and 4) The Knowledge and Skills Framework (KSF) (as amended).

All of these pieces of guidance are important and need to be taken on board by staff and by those planning training in mental health care.

The place to start is …

1) **The Essential Shared Capabilities (ESC)**
   The aim of the ESC is to set out the shared or common capabilities that all staff working in mental health services should achieve as a minimum as part of their pre-qualifying training. Thus the ESC would form part of the basic building blocks for all mental health staff whether they be professionally qualified or not and whether they work in the NHS or social care field or the statutory and private and voluntary sector.

The next step or stage is to consider …

2) The Capable Practitioner Framework (CPF)

The CPF describes the inputs and underpinning knowledge, skills and attitudes necessary to become a Capable Practitioner. These capabilities should be developed both as part of pre- and post-qualifying training and Continuing Professional/Personal Development. The CPF sets out five domains from ethical practice; knowledge; process of care; interventions; and applications to specific service settings. This process starts from a base where the entire workforce must develop ethical practice, and progresses through five domains where there is increasing specialisation which will only apply to some staff.

Whilst the CPF is not designed to provide a measurement of output or performance nor is it designed to determine the level of capability at which a role is to be performed, it does provide the foundation upon which a national set of competencies can be developed.

These competencies can now be found in Stage 3 which is to consider …

3) The Mental Health National Occupational Standards (NOS)

Unlike the CPF, the NOS are designed to provide a measurement of output or performance by describing detailed descriptions of competence required in providing mental health services in three Key Areas. These are:

- Operating within an ethical framework – Standard A;
- Working with and supporting individuals, carers and families – Standards B to J; and
- Influencing and supporting communities, organisations, agencies and services – Standards K to O.

The expectation is that Standard A will apply to all staff; broadly speaking, Standards B to J will apply to individual members of staff and/or teams as appropriate i.e. not all of the Standards will apply to all staff – it depends on the function(s) each member of staff undertakes; and Standards K to O are more about management type functions. The knowledge and understanding set out in the NOS should be developed both as part of pre- and post-qualifying training and Continuing Professional/ Personal Development.

The fourth and final Stage is to consider and cross reference to …

4) The Knowledge and Skills Framework (KSF)

The KSF is made up of a number of dimensions, 6 of which have been defined as core to all those working in the NHS, and 16 of which may or may not relate to a person's job. The KSF is another form of competency framework which staff should take account of in mental health services where it applies. The concept behind the KSF is that as part of pay progression, a member of staff needs to move up a skills escalator so that as they gain more skills and knowledge, this may be reflected in a higher level of pay. Whilst the KSF dimension sets the framework or context for a particular function e.g. assessment of people's health and well being, the evidence for mental health care purposes that this function is being carried out effectively, comes from the National Occupational Standards. In other words, the NOS will provide the detail that a particular dimension in the KSF is being undertaken successfully.

Conclusion

For staff undertaking training, their focus should be on the Ten ESCs. For qualified staff particularly in the NHS, having the Ten ESCs under their belt, given the importance of the Agenda for Change initiative and the link to annual appraisal of performance, their immediate focus will be the dimensions of the KSF that they consider applies to their role and to measure their detailed progress up the skills escalator by way of the NOS.

(Allcock, 2004)

The Ten Essential Shared Capabilities for Mental Health Practice

The development of these Essential Capabilities is a joint NIMHE and Sainsbury Centre for Mental Health project. It builds on the work of the Sainsbury Centre's Capable Practitioner Framework, copies of which can be downloaded from www.scmh.org.uk.

The work lays out the capabilities that all staff working in mental health services should achieve as a minimum part of their basic qualifying training.

The 'roots' of the shared capabilities in VBP and EBP, and their connections with key curriculum support tools, are summarised in Figure 6.

The Ten 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 conflicts 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 oneself and colleagues through supervision, appraisal and reflective practice.

(NIMHE, The Sainsbury Centre for Mental Health & The NHSU, 2004)

The Skills for Health Functional Map

The Health Functional Map (HFM) has been developed by Skills for Health, the Sector Skills Council for Health, as a specific tool to guide the process of development of National Occupational Standards and other competency frameworks, including those for mental health (shown in Figure 6).

The Health Functional Map was developed by a working party made up of representatives from the main occupational groups involved in delivery of health services, and so represents a cross-cutting consensus as to the functions involved in health.

It is a living document, in that it is constantly being monitored, updated and improved as Skills for Health takes forward its development programme and as feedback comes in from applications that use the National Workforce Competence Frameworks, Workforce Competences and National Occupational Standards to meet different sector needs.

Because of its constantly evolving status, and its purpose in providing a very specific, internal resource for Skills for Health development projects, the Health Functional Map has not been made generally available. The products of its use within Skills for Health development projects, however, are widely available so that organisations and individuals can use them to address a variety of needs.

The HFM describes work activities that are underpinned by a number of principles of good practice. All individuals working within the health sector should adopt these principles and apply them in practice. They are to:

1 recognise each individual as a person with a variety of individual needs and a personal and cultural value perspective;
2 promote and support the rights of all individuals, groups and communities;
3 negotiate, establish and sustain informed consent from individuals receiving health care;
4 work within the law and adhere to ethical guidelines;
5 provide high-quality health care to all individuals;
6 maintain the confidentiality of information and disclose such information only to those who are entitled to it;
7 encourage individuals to be as independent as possible and to exercise informed choice, taking into account the risks involved;
8 respect individual choice, wishes and preferences in decision making processes and actions taken, whilst balancing the wider needs of the community and society;
9 communicate with the individual in a way that is most appropriate to the individual's needs and circumstances;
10 work in ways which are based on evidence of effectiveness and reflect the value perspectives of all those involved.

(Extract from the *Health Functional Map, Version 2* (February 2004), an unpublished document produced by Skills for Health)

Different aspects of values-based practice are relevant to each of these principles, e.g. principles 1, 5 and 9 focus on individual values (relevant to Pointer 5 of VBP, user-centred services), and principles 6, 7 and 8 involve balancing values (relevant to Pointer 6, multidisciplinary perspectives), and principle 10 directly parallels Pointer 7 (the 'Two-Feet' principle of VBP, that all decisions are based on values as well as evidence).

Further information on Skills for Health, National Workforce Competence Frameworks, Workforce Competences and National Occupational Standards can be seen on the Skills for Health website at www.skillsforhealth.org.uk

RESOURCE
4

Policy context of values-based practice

This section lists the policies in Figure 4, which shows the policy context of values-based practice.

Policy initiatives

Department of Health (1999) *National Service Framework for Mental Health – Modern Standards and Service Models*. London: Department of Health.

Department of Health (2000) *Improving Working Lives*. London: Department of Health.

Department of Health (2000) *The NHS Plan – A plan for investment, A plan for action.* London: Department of Health.

Department of Health (2002) *Improvement, Expansion and Reform: the next 3 years. Priorities and Planning Framework, 2003-06*. London: Department of Health.

Policy implementation guides

1) Department of Health (2001) *Mental health policy implementation guide*. London: Department of Health. This is the first policy implementation guide containing service specifications for all three functionalised community teams: assertive outreach, crisis resolution and early intervention.

2) Department of Health (2002) *Mental health policy implementation guide: Adult acute inpatient care provision.* London: Department of Health.

3) Department of Health (2002) *Mental health policy implementation guide: National minimum standards for general adult services in psychiatric intensive care units and low secure environments*. London: Department of Health.

4) Department of Health (2002) *Mental health policy implementation guide: Dual diagnosis good practice guidance*. London: Department of Health.

5) Department of Health (2002) *Mental health policy implementation guide: Community mental health teams*. London: Department of Health.

6) Department of Health (2002) *Mental health policy implementation guide: Support, time and recovery workers*. London: Department of Health.

Fast-forwarding primary care mental health

1) Department of Health (2002) *Fast-Forwarding Primary Care Mental Health: Gateway Workers*. London: Department of Health.

2) Department of Health (2002) *Fast-Forwarding Primary Care Mental Health: Graduate primary care mental health workers*. London: Department of Health.

Equalities publications

1) Department of Health (2002) *Women's mental health: Into the Mainstream.* London: Department of Health.

2) Department of Health (2003) *Mainstreaming gender and women's mental health: implementation guidance*. London: Department of Health.

3) Department of Health (2003) *Delivering Race Equality: A Framework for action, consultation document.* London: Department of Health.

4) Department of Health (2003) *Engaging and Changing: Developing effective policy for the care and treatment of Black and minority ethnic detained patients*. London: Department of Health.

5) Department of Health (2003) *Inside Outside: Improving Mental Health Services for Black and Minority Ethnic Communities in England.* London: Department of Health.

6) Office of the Deputy Prime Minister Social Exclusion Unit (2004) *Final report on Social Exclusion and Mental Health.* London: Office of the Deputy Prime Minister.

Other policies

1) **Mental health promotion**
Department of Health (2001) *Making it happen: a guide to delivering mental health promotion.* London: Department of Health.

2) **Suicide prevention**
Department of Health (2002) *National suicide prevention strategy for England.* London: Department of Health.
Department of Health (2003) *Preventing Suicide: A toolkit for mental health services*. London: Department of Health.

3) **Carers**
Department of Health (2002) *Developing services for carers and families of people with mental illness*. London: Department of Health.

4) **Prisons**
Department of Health/HM Prison Service/National Assembly for Wales (2001) *Changing the outlook: a strategy for developing and modernising mental health services in prisons*. London: Department of Health.

5) **Personality disorder**
Department of Health (2003) *Personality Disorder: No Longer a Diagnosis of Exclusion.* London: Department of Health.
Department of Health (2003) *Breaking the Cycle of Rejection: The Personality Disorder Capabilities Framework*. London: Department of Health.

RESOURCE 5

Further reading

1*) The National Framework of Values in Mental Health.
A one-page framework for VBP in mental health care developed for the National Institute for Mental Health in England. (Available at www.connects.org.uk/conferences). In NIMHE, The Sainsbury Centre for Mental Health & The NHSU (2004) *The Ten Essential Shared Capabilities: a Framework for the Whole of the Mental Health Workforce*. London: NIMHE, The Sainsbury Centre for Mental Health & The NHSU.

2*) Wallcraft, J. (2003) *Values in Mental Health – the Role of Experts by Experience*.
This is a detailed discussion paper exploring some of the key issues about values for the Experts by Experience programme, one of the work programmes of the NIMHE. (Available at www.connects.org.uk/conferences).

3*) Allott, P., Loganathan, L. & Fulford, K.W.M. (Bill) (2002) Discovering Hope for Recovery from a British Perspective. In Lurie, S., McCubbin, M. & Dallaire, B. (Eds) International innovations in community mental health [special issue]. *Canadian Journal of Community Mental Health,* **21** (2): 13–33.
A review article mainly about the 'recovery' approach to the management of mental disorder but connecting this with values-based practice.

4*) Fulford, K.W.M. (2004) Ten Principles of Values-Based Medicine. In Radden, J. (Ed) *The Philosophy of Psychiatry: A Companion.* New York: Oxford University Press.
A paper spelling out the principles of values-based practice as they apply to mental health. The paper includes a case history done as a series of 'boxes', each of which is an episode in the story of a particular person, Diane Abbot, illustrating how the ten principles work out in practice.

5*) Fulford, K.W.M., Williamson, T. & Woodbridge, K. (2002) Values-Added Practice (a Values-Awareness Workshop). *Mental Health Today,* October, pp 25–27.
This paper describes the first of the series of training workshops that Kim Woodbridge, Toby Williamson and Bill Fulford developed and on which this workbook is based.

6) Woodbridge, K. & Fulford, K.W.M. (2003) Good Practice? Values-based practice in mental health. *Mental Health Practice,* **7** (2): 30–34.
This paper covers similar material to reading 5 but in the form of an interactive workshop suitable for self-study.

7) Jackson, M. & Fulford, K.W.M. (1997) Spiritual Experience and Psychopathology. *Philosophy, Psychiatry, & Psychology,* **4:** 41–66. Commentaries by Littlewood, R., Lu, F.G. *et al.,* Sims, A. & Storr, A., and response by authors, pp 67–90.
A research paper drawing on a number of case histories to illustrate the central place of values in psychiatric diagnosis.

8) Fulford, K.W.M. & Williams, R. (2003) Values-based child and adolescent mental health services? *Current Opinion in Psychiatry,* **16:** 369–376.
A review article setting values-based practice in a policy context for the UK and illustrating each of the ten pointers to good process in values-based practice with examples from child and adolescent mental health.

9) Fulford, K.W.M. & Benington, J. (forthcoming) VBM²: A Collaborative Values-Based Model of Health Care Decision Making Combining Medical and Management Perspectives. In Williams, G. (Ed) *Medical and Management Perspectives in Child and Adolescent Psychiatry.* Oxford: Oxford University Press.
A book chapter illustrating the resources of VBP for bringing together medical (KWMF) and management (JB) perspectives. The VBM² of the title captures the idea that differences of values, which are a 'problem' to be solved in traditional quasi-legal ethics, become a positive resource for health care decision making in VBP.

10) Fulford, K.W.M. (2002) Human Values in Healthcare Ethics. Introduction. Many Voices: Human Values in Healthcare Ethics. In Fulford, K.W.M., Dickenson, D. & Murray, T.H. (Eds) *Healthcare Ethics and Human Values: An Introductory Text with Readings and Case Studies.* Malden, USA, and Oxford, UK: Blackwell Publishers.
This is an edited collection of classic papers and newly commissioned articles, literature and patient narrative, illustrating the diversity of human values in all areas of health care. The introductory chapter, 'Many Voices', spells out some of the key differences between VBP and traditional quasi-legal ethics.

11) Colombo, A., Bendelow, G., Fulford, K.W.M. & Williams, S. (2003a) Evaluating the influence of implicit models of mental disorder on processes of shared decision making within community-based multidisciplinary teams. *Social Science & Medicine,* **56:** 1557–1570.
This paper gives full details of work combining philosophical-analytic and empirical social science methods to elicit implicit models (values and beliefs) of mental disorder. The groups studied were psychiatrists, approved social workers, CPNs, people who use services and informal carers. This study is the basis for Activities 15 and 16 in Section 5.

12) Colombo, A., Bendelow, G., Fulford, K.W.M., & Williams, S. (2003b) Model behaviour. *Openmind,* **125:** 10–12.
This short paper gives the main findings from the study published in full in reading 10. It outlines the six models and describes the importance of this work for user-centred practice. Full details of the six models are given in a table.

13) West Midlands Mental Health Partnership (February 2003) *Values in Action: Developing a Values Based Practice in Mental Health.* (Unpublished).
This manual was developed by the West Midlands Mental Health Partnership to support training in values for mental health and to provide an informal audit tool to monitor their implementation.

14) Fulford, K.W.M. (1989, reprinted 1995 and 1999) *Moral Theory and Medical Practice.* Cambridge: Cambridge University Press.
This book provides the detailed philosophical theory behind values-based practice.

* NOTE: Items 1, 2, 3, 5, and a shortened version of 4 are all available at the Mental Health Foundation website: www.connects.org.uk/conferences, together with an extensive discussion by stakeholders. Registration with website is required in order to access these documents.

RESOURCE
6

References and useful websites

Below are references included in the main text and additional references for your further reading.

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New, B. (1999) *A Good Enough Service. Values, Trade-offs and the NHS.* London: Institute for Public Policy Research.

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Rokeach, M. (1973) *The Nature of Human Values.* New York: The Free Press.

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Sackett, D.L., Straus, S.E., Scott Richardson, W., Rosenberg, W. & Haynes, R.B. (2000) *Evidence-Based Medicine: How to Practice and Teach EBM* (2nd Edition). Edinburgh and London: Churchill Livingstone.

Sadler, J.Z. (1996) Epistemic Value Commitments in the Debate over Categorical vs. Dimensional Personality Diagnosis. *Philosophy, Psychiatry, & Psychology,* **3:** 203–222.

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Sharpe, C. (1997) *The origin and evolution of Human Values.* UK: DP Press Ltd.

Skills for Health (unpublished) *Health Functional Map,* Version 2 (February 2004) available at www.skillsforhealth.org.uk.

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Widdershoven, G. & Widdershoven-Heerding, I. (2003) Understanding Dementia: a Hermeneutic Perspective. Chapter 6 in Fulford, K.W.M., Morris, K.J., Sadler, J.Z., & Stanghellini, G. (Eds) *Nature and Narrative: An Introduction to the New Philosophy of Psychiatry.* Oxford: Oxford University Press.

Woodbridge, K. & Fulford, B. (2003) Good practice? Values-based practice in mental health. *Mental Health Practice.* **7** (2): 30–34.

Useful websites

http://www.basw.co.uk/articles.php?articleId=2 Values and principles of social work.

http://www.connects.org.uk/conferences Information on the National Institute for Mental Health in England's Values Framework. Requires registration to log in to website.

http://www.publications.doh.gov.uk/mentalhealth/implementationguide.htm For the extract on values underpinning the Mental Health National Service Framework.

http://www.nice.org.uk National Institute for Clinical Excellence (NICE). Schizophrenia guidelines and other information.

http://www.nimhe.org.uk National Institute for Mental Health England. For information regarding implementation guides and mental health policy.

http://www.nmc-uk.org Code of professional conduct for nursing and midwifery.

http://www.rcpsych.ac.uk/publications/cr/council/cr83.pdf The duties of a doctor registered with the General Medical Council.

http://www.scmh.org.uk For further useful information in general about practice and policy issues.

http://www.scie.org.uk Social Care Institute for Excellence. For information regarding social models of care and other general social care information.

http://www.skillsforhealth.org.uk The Health Functional Map and other curriculum support tools published by Skills for Health.

http://www.warwick.ac.uk The University of Warwick.

http://www2.warwick.ac.uk/fac/med Warwick Medical School.