Values and behaviours: using the Ten Essential Shared Capabilities to support policy reform in mental health practice

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Abstract
This paper will review aspects of current policy in mental health with specific reference to policy that has a values focus. In this context, values refers to the standards and expectations we hold and which we use to guide aspects of practice performance. Service users state that core values that support, respect choice, collaboration, and customer service are critical foundation stones of a trusting therapeutic relationship. Attending to these foundations for practice has merit in ensuring the quality of care delivery in mental health. This paper will analyse what this means for the mental health workforce in their engagement with service users and delivery of policy priorities. Finally, the paper will explore resources, such as the *Ten Essential Shared Capabilities* (see ***Appendix 1***), which support engagement and ongoing promotion of person-centred mental health care.

Key words
values-based practice; education; training; workforce; capability; capacity

Introduction

A review of general health policy literature will uncover continuing themes of personalisation and choice throughout. While these themes can be traced back to policy initiatives such as the National Service and *Community Care Act 1990* (HM Government, 1990), they are now central elements of the majority of statements emanating from Whitehall and other key stakeholders (Department of Health, 2000, 2006; Carr, 2008).

Recognition of the need to personalise services is not new, and reflects the idea that everyone has individual strengths and personal preferences concerning how they should be treated. At one end of the spectrum, personalisation may mean access to finances to manage practical aspects of personal care, while at the other it may refer to being treated with respect and dignity at all times, and being provided with meaningful choices over services, and the way these are provided. Consequently, issues of choice and personalisation will mean different things to different people, and will arise in a variety of ways in a variety of situations. What unites them conceptually is the values base on which these issues are addressed.

The need for the NHS to consider its response to the personalising of health care delivery has been fully explored in the national consultation programme that resulted in the Darzi (2008) review. This recent review in England has focused attention on the need for appropriate values in the workforce when seeking to deliver change for patients and service users. The importance of the workforce in this regard can be seen through the production of a dedicated practitioner report (Department of Health, 2008a), which makes it clear that the workforce has an integral role to play in facilitating the reform process in health and social care delivery.

A workforce response to policy

The National Institute of Mental Health in England National Workforce Programme (NIMHE NWP) from its inception in 2003 has recognised, and sought to respond to, the important role practitioners, service users and carers have in working collaboratively to support implementation of the new policy agenda. It is important to note that services are not operating at a low base. There is a consensus emerging

that, on a range of broad indicators, mental health services are progressing well and receive generally high degrees of satisfaction from service users and carers (Richards & Coulter, 2008). However, as the Darzi review indicates (Darzi, 2008), there is still a long way to go in achieving a health and social care policy that emphasises the centrality of service users and carers within a health care system that promotes choice in how health and social care is offered and delivered.

Emphasising choice has begun to redefine the relationship between providers and users of services, giving people a greater voice with which to drive up the quality of care (Care Services Improvement Partnership/National Institute of Mental Health in England, 2006). It affects a number of key decisions concerning how people manage their own care in order to maintain a normal life as far as possible. The importance of offering choice in how to contact mental health services, identified in both the New Ways of Working agenda (Department of Health, 2007) and the *National Service Framework for Mental Health* (Department of Health, 1999), has initiated a range of alternative service models and routes that seek to be more service user-centred, and, therefore, more acceptable and effective.

In a more formal sense, the issue of personalisation has influenced the way legislation is framed. The revised Code of Practice for the Mental Health Act 1983 (Department of Health, 2008b) opens with a statement of guiding principles covering issues of: purpose; least restriction; respect; participation and effectiveness, efficiency and equity. All of these five principles relate to the application of the Act and require a values-based approach to practice by those involved in utilising the powers of the Act. The correct application of legislation in the Act consequently relies on practitioners and other participants reflecting the values embedded in its guiding principles in their decision- making and subsequent statutory actions. Proponents of values-based practice (Woodbridge & Fulford, 2004) suggest that values-based practice skills are essential in the application of this legislation.

Values in practice, therefore, are of central importance and resonate through the recent swathe of policy, and the issue of workforce values in the application of policy requires detailed analysis. It can be argued that choice starts with identifying what service users and their carers really value, rather than what practitioners, managers and politicians think that they value. People express some very clear values when they talk about what they want from mental health services (Noble & Douglas, 2004; McSweeney & Smith, 1994; Diaz-Caneja & Johnson, 2004). The onus is on service providers to ask service users about their needs and preferences, and to respond positively to service users' requirements. Societal attitudes concerning the development of health care policy and the delivery of care have changed significantly over recent decades, and the policy drive over the past decade repeatedly tasks the workforce on how it is to respond to these changes. An example of this is reflected in the comments made from the Darzi review, which identified that a patient's time was equal in value to a clinician's time. A patient should not have to take a whole day off work in order to see a doctor or specialist (Darzi, 2008).

As noted earlier, the workforce plays a key role in the implementation of health policy, and the values that practitioners bring to the work setting are of considerable importance to the effective delivery of current policy objectives. *The High Quality Workforce* report (Department of Health 2008a) emphasises the need to reflect and deliver on values that underpin practice, to deliver a workforce that is:

- focused on quality
- patient-centred
- clinically-driven
- flexible
- values people
- promotes life-long learning.

However, if we are serious about system change it is essential that we identify the prerequisites on which a change is likely to succeed.

In the care of older people, the role of the workforce and their values and behaviours for delivering high quality healthcare has been explored in some detail (Department of Health, 2008c). A number of common themes emerge to form a shared perspective of what care for older people means, who is responsible for it, and how the care experience is linked to patient confidence. How individual staff members interact with service users and their families is clearly influenced by a dynamic set of factors, such as the clinical environment, culture and history of the ward and team, as well as the way staff behave and interact with each other. All of these aspects of care have an interdependency, and in order for reform to take hold and to drive forward high quality mental health provision, change must be embedded in the whole system – not just one part of it.

The *Confidence in Caring* report (Department of Health, 2008c) noted that although staff know what they should be doing, they don't always do it. Standards, policies and competencies only specify what people should do, not what they actually do in practice. The relationship between written policy, the behaviour and the values of the workforce, and the implementation of policy in clinical practice has been well articulated in the work of Lipsky (1983). Workers on the frontline have considerable influence on how (or if) policy is actually implemented. Therefore, engaging frontline practitioners in the policy-making process becomes critically important. In this regard, it is essential that the workforce in mental health becomes a real and continuing contributor to policy making. At the same time, attention must also be paid to engagement with policy implementation. Researchers such as Verplanken and Holland (2002) have repeatedly demonstrated how it is possible to espouse values, yet behave in ways that run contrary to these values and beliefs. It is proposed that a focus on developing and maintaining appropriate practitioner values, continually reinforcing their importance in everyday practice, will make it more likely that they guide practitioner behaviour. Without attention to values, marked divergence between values and practice can and will emerge. Therefore, for policy implementation to succeed, we may need to ensure that practitioners have the time and conceptual tools to examine and challenge the values that guide practice.

The Ten Essential Shared Capabilities (ESCs) (Department of Health, 2004) provided such a framework and have been written about extensively elsewhere (McGonagle *et al*, 2008; Brabban *et al*, 2006; Nicholls *et al*, 2008). The 10 ESCs were developed as an articulation of the core values and capabilities expected by service users and carers in their interactions with mental health practitioners and services. These value and behavioural statements arose out of a large-scale consultation exercise with service users and carers, mental health care practitioners and colleagues in higher education; a process led by the Sainsbury Centre for Mental Health on behalf of the NIMHE National Workforce Programme (Hope, 2008).

The 10 ESCs are important because both service users and carers strongly believe that they are essential components of a close, collaborative relationship built on mutual trust, respect and ethical practice. In essence, the 10 ESCs are a set of values with associated behaviours that mental health practitioners should hold and display in all interactions. These values can and should underpin not only interactions with service users and carers, but also interactions with colleagues in mental health and other services. They support policy implementation by providing practitioners, supervisors and service leaders with explicit criteria with which to examine and evaluate the various systems, processes and behaviours utilised in routine mental health practice. The framework provides a positive challenge to practitioners, to encourage them to review the flexibility of practice and to challenge long held assumptions about the way care is organised and delivered. This challenge includes the need for practitioners to move beyond any rhetoric of user and carer involvement towards a greater emphasis on improving the felt and actual experience of people using services and those who care for them.

In a helpful way, the ESCs require professionals to regularly and routinely examine the foundations of their practice to ensure that this practice is well supported and maintained. Without a framework such as the ESC, it is easy to assume that practice foundations are in fact stable and, therefore, require little attention. The societal and policy movements over the past 15 years would indicate that the ground has shifted and we collectively, as mental health professionals and workers for health, need to expose our assumptions and practices to some examination in order to reassure ourselves and others that the validity of our practice and the links between policy and practice are intact.

However, an initial and cursory reading of the 10 descriptors (see ***Appendix 1***) can be deceptive. There appears little to be debated or contested in these requirements for high quality mental health practice. All practitioners can subscribe to a written description of values such as the ESCs. This sense of the ESCs being self-evident creates a risk that practitioners and managers will assume conformity to ESC standards and fail to subject their practice to meaningful scrutiny. For example, it is possible to be a skilled technician, but without person-centred values and behaviours, technical skill and knowledge may have little positive impact on service users and carers. Only the routine use of the ESC framework to facilitate a searching and authentic appraisal of practice will enable such discrepancies between practice and values to be identified and remedied. The development of the ESC framework demonstrates that the role of the public in policy formation across health and social care is now significantly different. This democratisation of health and social care policy certainly causes consternation among some professional groups, since it requires practitioners from

all disciplines to attend to new priorities and perhaps make radical alterations to practice. The ESCs provide a method through which practitioners can positively (although not always comfortably) manage this process of change.

Our national work in promoting the ESCs has provided a unique insight to the complexity contained within a set of 10 simple statements for care delivery. We believe that the ESCs provide the practitioners, service users, carers and managers with a useful instrument for reviewing, confirming or refining practice. There is now considerable interest in the articulation of the ESCs and their potential utility in helping mental health workers describe and reflect meaningfully on their work (in all its complexity). The ESCs provide a foundation of practice expectation from a service user perspective and have utility when we think about the philosophical foundation for the development of education and training. In what way can a review of practice values have on the behaviour (and ultimately) on the delivery of health care policy? The ESCs are a tool to aid practitioners and teams scrutinise their practice in detailed way. They reflect the view of Argyris (1976) that an analysis that examines not only the practice, but the values behind the practice, is more likely to achieve sustainable and positive change.

Conclusion

The ESCs have the benefit of being created and articulated by representatives of all the key stakeholders in mental health care provision, including the users of care services. On first examination, they can appear unassuming and easily within everyone's value base. On closer examination, we have found the ESCs to positively challenge people, to recognise and understand the complexity in care planning, negotiation and solution implementation. Attending to the values we hold is a critical element in the delivery of high quality health and social care. The ESCs provide a helpful practical framework through which this aim can be achieved.

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Appendix 1.
The Ten Essential Shared Capabilities

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 one's self and colleagues through supervision, appraisal and reflective practice.

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