Vectors of Best Practice: An Introduction to Part III, Practice

15

Bill Fulford

Where Part II was about theory, Part III is about practice. It shows how a culturally enriched form of values-based practice supports best practice in the design and delivery of mental health services as defined by widely accepted norms of contemporary practice. Parts IV and V are about other aspects of best practice. Part IV, Science, is about best practice in linking science with people; Part V, Training, is about training for best practice. These three Parts together thus cover the elements of values-based practice set out in chapter 1, ‘Surprised by Values: An Introduction to Values-Based Practice and the Use of Personal Narratives in this Book’ (see Table 1.2).

Returning to this Part, then, contributing chapters illustrate the role of cultural values in relation to the elements of values-based practice most directly concerned with the design and delivery of services. As shown in Table 15.1, these include (1) person-centred care (‘person-values-centred care’, chapter 16, ‘Cross-Cultural Factors and Identity in Adolescence’), (2) multidisciplinary teamwork (the ‘*extended* multidisciplinary team’, chapters 17, ‘Multidisciplinary Teamwork and the Insanity Defence: A Case of Infanticide in Iraq’ and 18, ‘Colonial Values and Asylum Care in Brazil: Reclaiming the Streets through Carnival in Rio de Janeiro’), and (3) *shared decision-making* supported by *balanced dissensus* within *frameworks of shared values*, chapters 19, ‘Alcohol Use Disorder in a Culture that Normalizes the Consumption of Alcoholic Beverages: The Conflicts for Decision-Making’, 20, ‘Living at the Edge of Compromise: Balkan Pluralism as a Resource for Balanced Decision-Making’, and 21, “‘Thinking Too Much’: A Clash of Legitimate Values in Clinical Practice Calls for an Indaba Guided by African Values-Based Practice’). Part III concludes with two chapters on a service model of growing

Authors

The editors with input from the contributors to Part III.

B. Fulford (✉)
St Catherine’s College, University of Oxford, Oxford, UK

Table 15.1 Annotated table of contents for Part III, Practice

Part III: Practice
• Chapter 15 <i>'Vectors of Best Practice: An Introduction to Part III, Practice'</i>
Cultural values and the person-values-centred care of values-based practice
• Chapter 16 <i>'Cross-Cultural Factors and Identity in Adolescence'</i> —Vanya Matanova and Anna Hristova
Cultural values and the extended multidisciplinary team of values-based practice
• Chapter 17 <i>'Multidisciplinary Teamwork and the Insanity Defence: a Case of Infanticide in Iraq'</i> —Hasanen Al-Taïar
• Chapter 18 <i>'Colonial Values and Asylum Care in Brazil: Reclaiming the Streets Through Carnival in Rio de Janeiro'</i> —Julia Evangelista and William A Fulford
Shared Decision-making supported by balanced dissensual decision-making within frameworks of shared values
• Chapter 19 <i>'Alcohol Use Disorder in a Culture That Normalizes the Consumption of Alcoholic Beverages: The Conflicts for Decision-Making'</i> —Guilherme Messas and Maria Soares
• Chapter 20 <i>'Living at the Edge of Compromise: Balkan Pluralism as a Resource for Balanced Decision-Making'</i> —D.S. Stoyanov and K.W.M. (Bill) Fulford
• Chapter 21 <i>'"Thinking Too Much": A Clash of Legitimate Values in Clinical Practice Calls for an Indaba Guided by African Values-Based Practice'</i> —Werdie van Staden
Cultural values and recovery
• Chapter 22 <i>'Three Points in Time: How Values and Culture Affected My Life, Madness and the People Around Me'</i> —David Crepaz-Keay
• Chapter 23 <i>'Recovery and Cultural Values: On Our Own Terms (A Dialogue)'</i> —Justine Keen and Richard J Shaw

importance in mental health, *recovery practice* (chapters 22, 'Three Points in Time: How Values and Culture Affected My Life, Madness and the People Around Me' and 23, 'Recovery and Cultural Values: On Our Own Terms (A Dialogue)').

15.1 The Bottom Line

The bottom-line message of the Part as a whole is about the potential of cultural values to act as effective vectors for the delivery of best practice. This is well illustrated by the two topics with which this Part opens, person-centred care and multidisciplinary teamwork. Both are widely acknowledged in contemporary health care as aspects of best practice. Yet for both, experience on the ground is that all too often there is a yawning gap between aspiration and practical reality.

There are, no doubt, many reasons for this gap. But that unacknowledged cultural values—specifically, unacknowledged cultural values of service providers—have at least a role to play is evident from observations made in the early days of the development of values-based practice. What these observations showed was that, so long as they remained unacknowledged, and hence hidden, the cultural values of services could act as inadvertent barriers to best practice. Raising awareness of these same cultural values, however, and thus rendering them accessible to the processes of values-based practice, converted them from barriers into effective vectors of best practice.

15.2 Early Observations

We will look briefly at these observations from the early days of values-based practice before returning to how they are filled out by the contributions to this Part. The studies from which they came have been written up in detail elsewhere (see Guide to Further Information at the end of this chapter).

15.2.1 Early Observations Leading to Person-*Values*-Centred Care

We owe the key observations leading to the concept of person-values-centred care to Kim Woodbridge-Dodd (the first author of chapter 44, ‘Reflections on the Impact of Mental Health Ward Staff Training in Race Equality and Values-Based Practice’). In preparation for running an early training programme in values-based practice, Kim observed the priorities evinced by team members in one of their case review meetings. Her key finding was that although the service providers in question genuinely believed they were delivering *service user-centred* care, what they were *actually* delivering (as characterised by the topics on which the case review focused) was better characterised as *service provider-centred* care.

Importantly, as the full account of these observations makes clear, those concerned were wholly unaware of, and indeed much taken aback by, the gap thus demonstrated between their beliefs about the kind of service they were delivering and the reality of their practice. This had nothing to do with ‘bad faith’. The staff members concerned were genuinely unaware that their priorities in the way they ran their services (as evinced by what they focused on in their case review meeting) were so different from what they believed them to be.

These observations led naturally to the concept of ‘person-values-centred care’ as it is now used in values-based practice. Person-centred care, this concept spells out, means nothing if the values of the person concerned are left out of account. And the values of the person concerned will inevitably be left out of account if service providers are unaware of (as Kim’s group were unaware of) the extent to which their own values as service providers were leading them (all unawares) to make decisions based not on what was important to their service users but on what was important to them.

15.2.2 Early Observations Leading to the Extended Multidisciplinary Team

It was similar observations although in this instance made in the course of empirical social science research that led to the concept in values-based practice of the ‘extended multidisciplinary team’. The studies in question were led initially by the British Social Scientist, Anthony Colombo, and then, in a follow-up by a team based in the Mental Health Foundation in London and led by Colin King (the first author of chapter 46, ‘Beyond the Colour Bar: Sharing Narratives in Order to Promote a

Clearer Understanding of Mental Health Issues across Cultural and Racial Boundaries’).

Both these studies are described in detail in the sources given in the Guide to Further Information at the end of the chapter. The essence of what they showed is, again, as in Kim’s study, a failure of self-awareness among staff of their own cultural values. Here, however, the failure of self-awareness was of the extent of the *differences* of cultural values that as different team members with different professional backgrounds they brought to their work. As well-functioning teams, it was natural that they should assume they had shared values. They all believed they were approaching mental health issues with essentially the same biopsychosocial set of priorities. But the priorities revealed by their responses to the case vignette were markedly different. Psychiatrists, for example, focused on biological aspects of mental health (such as diagnosis and medication) while social workers focused on psychosocial aspects (such as stressors and risk management).

As in Kim Woodbridge-Dodds’ work, then, there was a gap between belief and reality for staff values. But what is important in this instance was not the gap between belief and reality in staff values as such. It was that the differences in staff values ran *closely parallel with similar differences subsequently demonstrated in the values of service users*. There was in other words a like-for-like matching between staff values within the multidisciplinary team and those of their service users.

It is this like-for-like matching that led to the concept in values-based practice of the ‘extended multidisciplinary team’. To that point, multidisciplinary teamwork had been recognised to be important for the range of knowledge and skills that team members from different professions bring to bear in meeting the diverse needs of service users. The like-for-like values matching shown by these studies extended the importance of the multidisciplinary team to include also the range of *different values* that team members bring to bear in meeting the diverse needs of service users.

15.3 With Hindsight: A Confession

With hindsight, the significance of the cultural values revealed by these early observations seems clear: in both cases, the cultural values of service providers were driving their practice; in both cases so long as these cultural values remained unacknowledged, they acted as a barrier to best practice in delivering person-centred care—services were unaware of the extent to which their decisions were being driven not by what was important to their service users but by what was important to them as service providers. In both cases, however, once these same cultural values were made explicit, they were converted into vectors of best practice in person-centred practice.

But it is here that a confession is called for. At the time, the significance of these studies had been understood in terms primarily *not of cultural but of individual values*. These studies, therefore, provide a further and somewhat (with hindsight) startling example of our failure within values-based practice itself, spelled out in chapter 1, ‘Surprised by Values: An Introduction to Values-Based Practice and the Use of Personal Narratives in this Book’, to attend to cultural values.

As we emphasised in chapter 1,¹ individual values, notably those of the individual patient or service user, are important clinically. For one thing, they are at the heart of contemporary models of shared decision-making. Individual values, furthermore, should not be somehow subordinated to cultural values (recall ‘the individual is an n of 1’ from chapter 1). But for all that, it was a clear failure of the early days of values-based practice that we failed to appreciate the full significance of these observations for our understanding of the role of cultural values in mental health.

15.4 Values-Based Practice in This Part

The first three chapters in this Part of the book together remedy this failure.

15.4.1 Person-Values-Centred Care

Chapter 16, ‘Cross-Cultural Factors and Identity in Adolescence’, by Vanya Matanova and Anna Hristova, both of Sophia University, Bulgaria, explores the complex relationships between cultural and individual values in person-centred care. It tells the story of a young woman with self-harming behaviour and the intra-personal and trans-generational conflicts of values that develop when she is brought from her native England to live with her father in Bulgaria. Similar themes are evident in other chapters (for example in chapter 11, ‘Madness, Mythopoeetry and Medicine’ on the African diaspora, see above, Part I). Chapter 16, ‘Cross-Cultural Factors and Identity in Adolescence’ also illustrates an aspect of the values tool kit: it draws on a culturally attuned form of family therapy to explicate the values issues and thereby develop a strategy for intervention.

15.4.2 The Extended Multidisciplinary Team

Moving now from person-centred care to multidisciplinary teamwork, chapters 17, ‘Multidisciplinary Teamwork and the Insanity Defence: A Case of Infanticide in Iraq’ and 18, ‘Colonial Values and Asylum Care in Brazil: Reclaiming the Streets through Carnival in Rio de Janeiro’ pick up similar themes about the extra levels of complexity added by cultural values. Through two very different narratives, these chapters add new dimensions to the significance of multidisciplinary teamwork in mental health. In chapter 17, the forensic psychiatrist, Hasanen Al-Taïar, provides a narrative from Iraq about the role of multidisciplinary teamwork in establishing criminal responsibility for infanticide. In Western countries, such assessments are generally assumed to be matters for expert medical opinion. This story thus extends the role of the multidisciplinary team to a wholly new level of importance. This is

¹ See the subheading subsection 4.1.

all the more significant given that in Iraq, in contrast to the legal norms of Western countries, infanticide remains a capital offence.

Chapter 18, ‘Colonial Values and Asylum Care in Brazil: Reclaiming the Streets through Carnival in Rio de Janeiro’, by Julia Evangelista and Will Fulford, describes a project with which they have been involved in Rio de Janeiro in Brazil, that has the aim of empowering people with mental health issues to, in the words of their title, ‘reclaim the streets’ through Carnival. Illustrated by the inspiring story of one of their participants, Elizama, they show how the Brazilian concept of Carnival, developed originally as a resistance movement during Brazil’s long period of colonisation, has become a potent cultural force in breaking down the stereotypes that drive post-colonial asylum care in that part of South America, thereby empowering people with mental health issues to re-establish their place in society.

15.4.3 Shared Clinical Decision-Making Supported by Dissensual Balancing Within Frameworks of Shared Values

With the next three chapters, we move to the role of cultural values as vectors of best practice in clinical decision-making. Here, the relevant paradigm of good practice is what is widely called ‘shared decision-making’: clinical decision-making that is shared between the clinician (contributing in particular knowledge and technical skills) and the patient (contributing in particular an understanding of his or her own values).

The story in chapter 1, ‘Surprised by Values: An Introduction to Values-Based Practice and the Use of Personal Narratives in this Book’ of Mrs Jones and her arthritic knee illustrates shared decision-making in surgery. In Mrs Jones’ story, the two sides (the knowledge side and the values side) of shared decision-making were supported respectively by evidence-based practice (represented in this instance by the surgeon, Mr Patel’s, knowledge and experience) and by values-based practice (represented in this instance by Mr Patel picking up on what really mattered to Mrs Jones).

But shared decision-making as we went on to indicate, although offering in many situations ‘win-win’ results for all concerned, and in consequence being widely mandated (see Guide to Further Information), faces many challenges in practice. The challenges moreover, particularly in mental health, often involve cultural values. One example is provided by involuntary psychiatric treatment: this frequently involves a direct conflict between the values of society (to avoid risk of harm) and the values of the individual concerned (to retain individual autonomy). This is where the dissensual decision-making of values-based practice comes into play. Dissensual decision-making allows a balance to be struck within a framework of shared values according to the circumstances presented by the situation in question. This approach has in point of fact been worked out in detail in relation to the conflicts of values presented by involuntary psychiatric treatment [1].

The conflicts between individual and cultural values in shared decision-making are illustrated in chapter 19, ‘Alcohol Use Disorder in a Culture that Normalizes the Consumption of Alcoholic Beverages: The Conflicts for Decision-Making’ of this Part, in which Brazilian psychiatrists, Guilherme Messas and Maria Soares, examine the challenges of managing alcohol use disorder in a society that normalises (even valorises) alcohol consumption. Messas and Soares’ narrative provides a vivid illustration of just how challenging the demands of dissensus may be when it comes to balancing conflicting cultural and individual values in the delivery of person-centred mental health care.

Cultural values, however, as our next two chapters illustrate, provide resources as well as challenges for shared decision-making. Chapter 20, ‘Living at the Edge of Compromise: Balkan Pluralism as a Resource for Balanced Decision-Making’, by Drozdtoj Stoyanov and Bill Fulford, illustrates through the story of Dr Petrov and his neighbour, the uniquely Balkan capacity for values pluralism. This capacity, gained through generations of having to ‘live at the edge of compromise’ in order to survive under successive colonising powers, shows that the ‘default to monism’ identified earlier (in chapter 1, ‘Surprised by Values: An Introduction to Values-Based Practice and the Use of Personal Narratives in this Book’) as perhaps the key challenge for the essentially pluralistic values-based practice may not after all be inevitable. Balkan pluralism, that is to say, suggests that the default to monism may be a learned rather than innate behaviour; it may be (as Stoyanov and Fulford put it) ‘more nurture than nature’.

Chapter 21, “‘Thinking Too Much’: A Clash of Legitimate Values in Clinical Practice Calls for an *Indaba* Guided by African Values-Based Practice’ illustrates the resources of African philosophy for dissensus. Decision-making in Western cultures relies mainly on consensus (as in evidence-based practice) and dissensus is in consequence a relatively unfamiliar (and hence problematic) concept. But dissensus, as Werdie van Staden shows in chapter 21, is entirely familiar in African cultures. We had intimations of the resources for values-based practice available from African philosophy in Part I, in Camillia Kong’s exploration of African Critical Sankofaism (chapter 10, ‘African Personhood, Humanism, and Critical Sankofaism: The Case of Male Suicide in Ghana’), and in Tutiette Thomas, Olusola Adebisi and Temitope Ademosu’s account of mythopoetry (chapter 11, ‘Madness, Mythopoetry and Medicine’). In chapter 21, van Staden shows how the *indaba*, a distinctively African form of meeting, supports balanced dissensual decision-making in the context of the clinical management of a young man with psychotic experiences. Van Staden and co-author, Samuel Ujewe, explore the use of *indaba* in administrative contexts in a later chapter (chapter 29, ‘Policy-Making *Indabas* to Prevent “Not Listening”: An Added Recommendation from the Life Esidimeni Tragedy’). Van Staden has elsewhere developed a general concept of *Batho Pele* as a distinctively African form of values-based practice [2].

15.5 Recovery Practice

Shared decision-making like any other model of care is of course empty if it fails the test of delivering for those with mental health problems. It is with this crucial test that the last two chapters of Part III are concerned. But just what does ‘delivering for those with mental health issues’ mean? The very concept of ‘recovery’ in mental health has indeed attracted much debate in recent decades, at least in Western countries.

Chapters 22, ‘Three Points in Time: How Values and Culture Affected My Life, Madness and the People Around Me’ and 23, ‘Recovery and Cultural Values: On Our Own Terms (A Dialogue)’, both by those with considerable personal experience of mental health issues, speak to the view of recovery adopted in values-based practice—*recovering a good quality of life as defined by the values of (by what is important to) the individual concerned* [3]. Cultural values as the narratives in these two chapters illustrate may have crucial roles to play in recovery so understood. Chapter 22, by David Crepaz-Keay, is autobiographical. David tells his own story of recovery and how this was influenced (positively or negatively) by the values of the cultures in which at different stages he found himself. Chapter 23, by Justine Keen and Richard Shaw, both members of a group in Bristol working on resources for co-production, is a transcript of an unscripted dialogue between its two authors. They compare notes on what has been important to them over the several years of their respective experiences of coping with mental health issues. The cultures in which they found themselves again emerge as being critically important.

A shared message of these two chapters is that what is important for people with mental health issues (and hence important for recovery), is what is important for any of us, namely the cultural values represented by having friends, a home, and a role in life. Recovery is often equated with recovering independence. But as David Crepaz-Kay has argued in a different context [4], recovery should not be understood as ending with independence if this is defined by individual values such as those of autonomy. Independence so defined is indeed important but only as a step towards achieving the culturally enriched values of *inter-dependence*. There could be no stronger statement of the importance of cultural values as vectors of best practice in mental health.

15.6 Conclusions

This chapter has outlined how the contributions to Part III illustrate the role of cultural values as vectors of best practice in a number of key areas of contemporary person-centred mental health care. So long as they remain implicit and unacknowledged, cultural values (notably the cultural values of service providers) may act as inadvertent barriers to best practice. Made explicit, however, within the framework of a culturally enriched form of values-based practice, cultural values play a number of key roles in delivering best practice:

- They extend the role of the multidisciplinary team in providing person-values-centred care
- They provide novel support resources for dissensus (such as Bulgarian pluralism and the African indaba) in the context of shared clinical decision-making
- They contribute substantively to the quality of life by which the very concept of recovery in contemporary mental health practice is defined

In Part II, we characterised the relationship between theory and practice in terms of a two-way partnership: just as theory informs practice, we said, so practice informs theory. Although not the focus of this Part, its constituent chapters nicely illustrate the many ways in which practice may inform theory. To take but one example from the philosophy of mind, the contributions to this Part, severally and together, provide a rich resource for philosophers interested in personal identity. The Oxford philosopher, Kathleen Wilkes, anticipated this in her seminal book ‘Real People: Personal Identity without Thought Experiments’ (Oxford, Clarendon Press, 1988). The resources for work on personal identity, moreover, represented by the contributions to this Part, point specifically towards a philosophically neglected but practically relevant aspect of the topic, namely the extent to which cultural values contribute to the formation and maintenance of personal identity over time.

In thus redirecting the focus of theory in this practically relevant way, cultural values show yet again their importance as vectors of best practice in mental health care.

15.7 Guide to Further Information

The observations from which the concept of person-values-centred care is derived are described in [5]. The research underpinning the role of the extended multidisciplinary team in delivering person-values-centred care is reported in [6, 7].

Shared decision-making based on evidence and values is mandated in the UK by professional regulators [8] and in evidence-based guidelines (see, for example, [9]). It has recently been further mandated by a decision of the UK Supreme Court (the Montgomery judgement, [10]).

References

1. Fulford KWM, Dewey S, King M. Values-based involuntary seclusion and treatment: value pluralism and the UK’s Mental Health Act 2007. Ch 60. In: Sadler JZ, van Staden W, Fulford KWM, editors. *The Oxford handbook of psychiatric ethics*. Oxford: Oxford University Press; 2015.
2. van Staden W, Fulford KWM. The Indaba in African values-based practice: respecting diversity of values without ethical relativism or individual liberalism. Ch 28. In: Sadler JZ, van Staden W, Fulford KWM, editors. *The Oxford handbook of psychiatric ethics*. Oxford: Oxford University Press; 2015.

3. Slade M, Amering M, Farkas M, Hamilton B, O'Hagan M, Panther G, Perkins R, Shepherd G, Tse S, Whitley R. Uses and abuses of recovery: implementing recovery-oriented practices in mental health systems. *World Psychiatry*. 2014;13:12–20.
4. Crepaz-Keay D, Fulford KWM, van Staden W. Putting both a person and people first: interdependence, values-based practice and African Batho Pele as resources for co-production in mental health. Ch 4. In: Sadler JZ, van Staden W, Fulford KWM, editors. *The Oxford handbook of psychiatric ethics*. Oxford: Oxford University Press; 2015.
5. Fulford KWM, Woodbridge K. Practicing ethically: values-based practice and ethics—working together to support person-centred and multidisciplinary mental health care. Chapter 5. In: Stickley T, Basset T, editors. *Learning about mental health practice*. London: Wiley; 2008. p. 79–103.
6. Colombo A, Bendelow G, Fulford KWM, Williams S. Evaluating the influence of implicit models of mental disorder on processes of shared decision making within community-based multi-disciplinary teams. *Soc Sci Med*. 2003;56:1557–70.
7. King C, Bhui K, Fulford KWM, Vasiliou-Theodore C, Williamson T. *Model values? Race, values and models in mental health*. London: The Mental Health Foundation; 2009.
8. General Medical Council. *Consent: patients and doctors making decisions together*. London: General Medical Council; 2008.
9. National Institute for Health and Care Excellence (2015/2017) Suspected cancer: recognition and referral: NICE guideline NG12 (published date: June 2015. Last updated: July 2017) See: <https://www.nice.org.uk/guidance/ng12> [and scroll down the page to the statement 'Your Responsibility'].
10. Herring J, Fulford KWM, Dunn D, Handa A. Elbow room for best practice? Montgomery, patients' values, and balanced decision-making in person-centred care. *Med Law Rev*. 2017;25(4):582–603. <https://doi.org/10.1093/medlaw/fwv029>. <https://academic.oup.com/medlaw/advance-articles>. Accessed 19 Jul 2017.

Open Access This chapter is licensed under the terms of the Creative Commons Attribution 4.0 International License (<http://creativecommons.org/licenses/by/4.0/>), which permits use, sharing, adaptation, distribution and reproduction in any medium or format, as long as you give appropriate credit to the original author(s) and the source, provide a link to the Creative Commons license and indicate if changes were made.

The images or other third party material in this chapter are included in the chapter's Creative Commons license, unless indicated otherwise in a credit line to the material. If material is not included in the chapter's Creative Commons license and your intended use is not permitted by statutory regulation or exceeds the permitted use, you will need to obtain permission directly from the copyright holder.