Social Work and Mental Health

The Value of Everything

Peter Gilbert

with Peter Bates, Sarah Carr, Michael Clark, Nick Gould and Greg Slay

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CHAPTER 2

Thinking About Professional Boundaries in an Inclusive Society

Peter Bates

Introduction

In this chapter, the terms 'person' and people' will generally be used in place of terms like 'client', 'patient' or 'service user'. Other people will be identified by their designation. Thus, the professional relationship exists between the 'person and the worker'. Mental health services exist at the confluence of many competing forces, values and ideologies. For social workers, one such junction occurs when attempts to 'fix the person' by offering talking therapies meet efforts to 'fix the community' by negotiating respectful, fair access to a job, a home and a social life. At the same crossroads, concerns about self-determination meet safeguarding obligations. Social workers who have trained in therapeutic interventions meet their colleagues who are drawing on the profession's community development roots to assist employers, educators and leisure providers to respond positively to people with mental health difficulties. The crossing-point is noisy with social work talk about recovery and the clamour that ensues when something goes wrong.

Elsewhere, I have set out some of the basic skills that social work staff need to promote recovery and inclusion (NSIP, 2007; Bates, 2008) and so this chapter considers safeguarding in the context of community life. All too often, the risk assessment process suggests a deterministic universe and an atomised society in which the behaviour of individuals is as predictable as that of snooker balls. Here we glimpse an altogether more complex and fascinating world. In particular, we explore the role of the professional and the implications for socially inclusive practice and our understanding of, and participation in, the wider community.

The chapter is divided into six sections, each of which explores a pair of competing priorities. These are set in opposition to one another to form the 12-point *Boundary Clock* (Figure 5). All metaphors have limited value and can carry unwanted freight. This clock has no hands, no power source, no machinery – it is simply a face with 12 observation points. The image of a 12-person jury might work just as well, although it suggests crime and punishment. Individual case studies can then be placed on the 'clockface' and the 12 vantage points used in turn to generate ideas for shaping practice in an individual situation. As each of the 12 is merely an entry point to the clockface area, the issues that arise inevitably overlap here and there, but the 12 points frame a systematic discussion. We begin with the 12 o'clock and 6 o'clock pair and then move clockwise.

Artificial and single versus natural and multiple

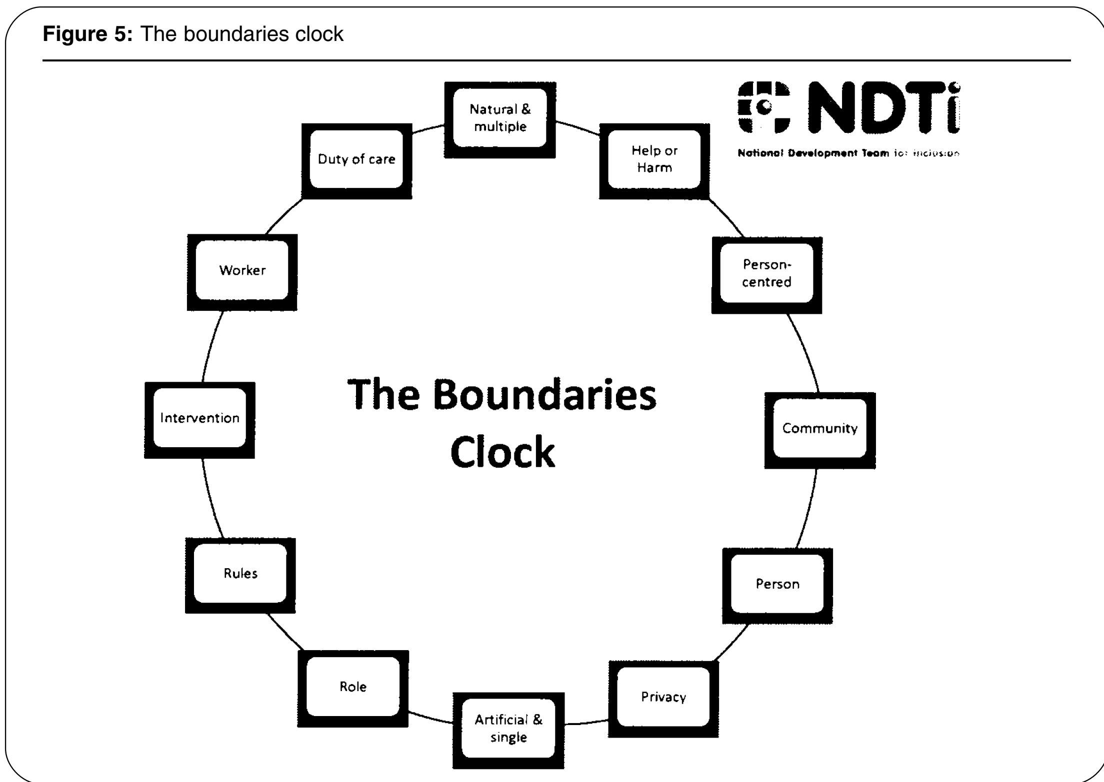
Maintaining professional distance is rather like bottling a vacuum

In recent decades, psychoanalytic traditions which assert that the worker has a responsibility to maintain 'professional distance' from the person have ballooned to encompass all professional groups in any kind of contact, including social work. As a result, some workers withhold information about their personal lives or home. This allows the social worker to enjoy off-duty time in a different social setting, keeps professional status untarnished by any awkward leakage of personal information, and improves safety for the worker and their family in the event that the person feels aggrieved. The single-strand relationship helps to keep transactions between the person and the worker free of distortion.

Q1: Is guidance available from your professional body or employer that directs you in how to respond to the potential of a dual relationship? If this guidance is not routinely followed in your service, how should you deal with this?

This type of relationship is deliberately unlike a natural friendship. It does not follow the usual

Figure 5: The boundaries clock



rules in which shared activity leads to gradual, mutual disclosure, but rather is an artificial, single-strand transaction.

Whilst the 'artificial and single' position is neat, it is often problematic:

- Social workers serving in isolated rural communities or working with minority groups are very likely to have a dual relationship through sharing a place of worship, neighbourhood or cultural centre.
- Forward-looking mental health services are deliberately employing substantial numbers of people who have used services themselves (Seebohm and Grove, 2006) and so professional-client relationships are jumbled up with co-worker relationships.
- The UK policy of Personalisation (HM Government, 2007) has increased the number of people who employ their own social care staff as personal assistants or brokers, blending the professional-client relationship with employer-employee relationships.
- Neighbours with shared concerns about their environment form community enterprises and projects to improve things, and these activities may throw together social workers and their clients as co-producers of a cohesive society.
- Since 2004, English mental health policy (ODPM, 2004) promotes socially inclusive lifestyles and so increases the chances that staff will introduce people to social environments that they themselves use when off-duty.

Several traditions within social work, mental health and elsewhere positively affirm the development of natural and multiple relationships, or what some authors (Galbreath, 2005) have called dual relationships. This term is sometimes used in a narrow way to refer to sexual relationships between staff and the people they support. Here it is used generically. Social work was born in the settlement movement where workers lived alongside those they helped, community development workers immerse themselves in their patch, anthropologists live in the communities they study; researchers with lived experience of mental health difficulties gather good data precisely because they disclose their shared history in the interview context; peer

support workers find that people with mental health issues make a better recovery because they meet staff who have made the same journey themselves. Indeed, several authors suggest that multistrand relationships may increase the efficacy of therapy (Lazarus and Zur, 2002; Gabriel, 2005). Rather than pessimistically expecting social workers to exploit the vulnerability of the people they are paid to support, such options thread safeguarding through these multi-layered relationships.

Social workers and the agencies that employ them need to position their practice on the *Boundaries Clock* between these two viewpoints.

Help or harm versus role

Josie wanted to volunteer and asked for someone to accompany her the first time. When her social worker mentioned it to the team manager, she was refused permission and told it was not her role.

Many people enter social work to help others. Three forces threaten this ambition: restructuring of services has left many social workers assessing (eligibility, risk, service quality, outcomes) rather than providing help; as the years go by, people sometimes forget why they came into the business in the first place as bureaucratic demands, pressure of work and career aspirations take over from compassion; and thirdly, working out what is helpful in the long run is both complex and ambiguous.

Take, for example, Josie's basic need for support. Was there anybody else in the team who could accompany her? Will Josie expect the worker to accompany her every week? Does the shared activity symbolise a change in the nature of the relationship with the worker? It is not always easy to know whether our help will turn out in the end to cause harm.

Defining harm can be difficult too. Mental health social workers deprive people of their liberty, curtail help in order to promote independence and refuse to help some in order to release scarce resources for others. Some people report that they only got started on their personal recovery journey when they gave up their reliance on helpers and took some personal responsibility. Withdrawing help may be the only way to persuade some people to reconnect with their community-based roles and relationships.

On the opposite side of the *Boundaries Clock* lie a number of issues that are related to the worker's role. Here we ask what is appropriate for someone in this job role to do. We are rightly concerned with power being abused, intentions being misinterpreted, with setting a precedent, with changing expectations, and with what others may think. Word may get out that workers are available in the evenings for social engagements, but Josie's worker may also worry whether going along the first time will help in the long run, or fear that others in her team will question her actions.

The literature on professional boundaries (Pope and Keith-Spiegel, 2008) refers to the 'slippery slope' by which staff unwittingly slide from informal acts of kindness into favouritism, over-disclosure, exclusive friendship and sexual relationships. The slope image suggests helpless inevitability rather than responsibility, and has led some agencies to ban trivial actions in an effort to prevent slippage. So, in Josie's case, going to the voluntary work site could lead in time to undue intimacy and abuse of power, and so it is safest to ban it – just in case.

Q2: Do your supervision sessions and staff meetings provide opportunities to discuss boundary crossings, admit mistakes, find creative solutions and celebrate success?

Whilst some staff find relief in receiving and obeying clear messages about the limits of their role, others include many hidden acts of kindness in their day to day work (Freud and Krug, 2002). In this complex arena, some clarity about the appropriate use of the social work role and the kind of help that a social worker can offer saves time and helps with the appropriate use of limited resources.

Person-centred versus rules

We got a memo round telling us not to kiss clients!

As the first decade of the 21st century draws to a close, English social work is in turbulent waters. The government's personalisation agenda has brought social care to the brink of its biggest change since the introduction of the Welfare State, and meanwhile, the twin concerns about safeguarding vulnerable people and holding staff to account for their productivity have substantially increased the rules. Whilst personalisation should open up more room for

creative responses that fit the individual, some workers are reporting that anything up to 90 per cent of their time is spent at the computer and in meetings, rather than face to face with people in need.

In mental health, the growing adoption of recovery as an organising concept for services has focused attention on personal meaning, self-directed support and advance directives, all of which reinforce the primacy of each person's idea of what 'wellness' or 'flourishing' means for them. Similarly, some services are exploring how well-being, social inclusion and community engagement could reshape their provision, and this has the potential to take services further into person-centred approaches. Government promotion of personal budgets is one aspect of this, as more and more people take up the offer of funding to arrange their own support and buy whatever will work for them.

Q3: How do your rules change if the person is in crisis, in 24 hour care, is especially vulnerable, poses additional risks or is discharged from your service? How do the rules apply to staff who are off-duty, to volunteers, students, or to colleagues who work in another team or in the administration department?

Opposing person-centred approaches – on the other side of the *Boundaries Clock* – lie rules. The Sexual Offences Act 2003 prohibits sexual relationships between people who are unable to give consent and the staff who support them, and a vast amount of the literature on professional boundaries has been devoted to preventing this abuse. Rules about confidentiality, gifts, handling money or medication have protected people from accident, exploitation or accusation. Indeed, the careful analysis of issues that is explained as well-made rules are introduced helps the individual social worker to apply rigour to their response to individual situations.

Sadly, not all actions labelled 'person-centred' are truly individualised, and not all rules are well-made. Custom and habit narrow the spectrum of options under consideration, and rules overreach their designated field until what works in one place is forced into others, where the fit is poor and staff feel straitjacketed. Did the regulator wish to ban erotic kissing or habitual greetings in the French community? Was one person's inappropriate conduct managed by producing a rule for all – a common but cowardly response that sidesteps the uncomfortable issue of challenging the individual.

The interaction between person-centred approaches and rules is perhaps at its sharpest as people move away from the control of the mental health system. Rules that are entirely appropriate within the secure forensic inpatient setting, for example, need to be gradually relaxed as people are supported to move out into community living and learn to cope with its demands. One such inpatient environment has a ban on access to the internet that prevents people with predatory sexual appetites from viewing unsuitable material. Unfortunately, this rule is inflexible and applies to everyone, and so rehabilitation staff fear that they will be punished if they assist people to visit an internet cafe, purchase a personal computer or attend the college library. For the people concerned, their inclusion in modern society and prospects for community living, and therefore the long-term safety of all, are compromised.

Community versus intervention

> *After 20 years using mental health services, they have employed me. The job is great, but, just because I now get to be called 'staff' and they are 'service users', I am expected to finish with all my old friends.*

At their best, communities have their own ways of keeping everyone safe and balancing individual freedom and corporate responsibility. Take, for example, the success of the Circles of Accountability pioneered by the Mennonite church in Canada. They offer friendship and informal support to notorious sex offenders after their discharge from prison. The Circle's uncompromising approach to information-sharing and zero tolerance of re-offending is maintained alongside the offer of companionship and community participation, so that ex-offenders do not have to hide their history or remain isolated and under-occupied. They have taken the general statement that bored, isolated, excluded and vulnerable people with few positive social roles are at most risk and most risky (DoH, 2008) – and turned the diagnosis into a prescription for informal, powerful community action.

In general, large, diverse and interlinked networks improve quality of life and protect people from abuse through well-meaning conversation, mutual support and advocacy (Pugh, 2007). For example, recent research on hate crimes against people with disabilities,

makes a very powerful plea for community empowerment to have a safeguarding focus integrated within it (Home Office, 2008).

But until recently, mental health services have paid insufficient attention to people's community roles and relationships. All too often, admission to inpatient psychiatric care wreaks havoc to role and relationship networks, as people lose their jobs, marriage and friends that could have been retained if the service just paid some more attention to these matters. The day to day ways in which mental health services are delivered increase the strain on community roles as people have to take time off work to attend outpatient appointments and are encouraged to join the mental health community at the expense of their other connections.

Along with the undoubted benefits of personalisation comes the risk that informal relationships will be colonised and disrupted, as people invite their friends to become their paid assistants. Both the person and their new assistant can forfeit forever the elusive benefit that comes from those people who freely choose to be in their lives rather than being there by contractual obligation. Or perhaps, after all, it is possible to maintain a friendship whilst also being paid. If this is so, then the traditional argument that social workers need to avoid any social contact with the people they support is also defeated and we need to move on to a new discourse about how to deliver safe and effective interventions to people with whom we share common citizenship.

Opposing this point on the *Boundaries Clock* sits the value of a deliberate social work intervention. Creating a respectful, confidential and empowering relationship with someone who has learnt to mistrust authority figures or who is experiencing high levels of suspicion or social anxiety demands a high level of skill and it can be vital to set aside complicating factors to make enough space for the work to be done.

Q4: How does the relationship between the social worker and the person change as they move away from the 'counselling room' intervention, into informal contacts in the corridor, casual greetings in the street and shared participation in community life?

The forces that oppose each other on this aspect of the clock face are to do with emphasis and priority. When someone is lonely and the social worker suggests that they join a group provided by the mental health service, they have selected an intervention option in contrast with the community alternative of assisting the person to find a friendship circle outside the mental health service. When someone needs support to attend the gym and the service considers a personal assistant rather than asking about current or potential friends, fitness instructors at the gym or fellow-members of the running club, they have chosen an intervention option rather than a community option.

Perhaps most importantly, whenever the mental health service writes a risk management protocol that applies to its own activities and staff but that offers no framework for how to negotiate that risk with the gym staff or with friends, they direct staff towards an intervention rather than a community solution.

Person versus worker

During a training course on safeguarding, staff were instructed how to behave when off duty, such as when in the pub with friends. If a person came in who used the mental health service, staff were told that they should leave the building immediately.

One of the distinguishing marks of a professional helping relationship is that it is generally one-way. The worker is there for the person's benefit, and not the other way round. For social workers, the focus is often on particular kinds of benefit, such as when the worker assesses mental illness or capacity. Social care workers often have a broader remit and find themselves assisting, not just with care and support, but social interaction, hobbies and interests. But the time is still for the person rather than for themselves. It has been suggested that workers who have a rich and satisfying personal life are less likely to bring their own needs forward in their encounters with the people they support.

Q5: Judgements about professional boundaries, safeguarding and a life in the community are smarter when the person's viewpoint is in the centre. What have you done to ensure that they take the lead in maintaining an appropriate relationship?

Workers have rights too. Staff should not find themselves excluded from their own leisure venues by Draconian regulations, as in the example above. Care workers often wonder if they have a right of veto should the person they are supporting wish to undertake activities that

they themselves would not select, whether it is assisting people to overeat or smoke, obtain pornography or join an extreme political party. The worker's rights are recognised on the Boundaries Clock.

Between the two extremes lie many subtleties:

- The social worker who occasionally discloses personal matters models the to and fro of ordinary conversation, slows the process by which continuous receiving of help can lead to unhealthy self-absorption and raises hope levels (Psychopathology Committee, 2001).
- The worker who invites people to social activities that they themselves are involved in may abuse their power to further their own personal, religious, political, business or social interests – but banning these connections closes off whole sections of community life to people who need support to participate.
- Whilst 'it is never appropriate to terminate a therapeutic relationship with the intention of pursuing a social or sexual relationship' (CHRE, 2008) staff may be quite willing to disclose information about their personal experiences or share off-duty leisure activities with the people they support – or they may prefer to maintain their personal privacy.

In deciding the right course of action for a service or with an individual, these competing needs should be acknowledged.

Duty of care versus privacy

When we arrive at work each day, we have to record every contact we had whilst we were off-duty with anyone who uses mental health services.

In order to keep everyone safe, it is sometimes necessary for social workers to use the Mental Health Act or the Mental Capacity Act to take action that over-rides the person's preferences. Mechanisms that restrict the opportunities available to certain offenders and the limits of the principle of confidentiality add to the duty of care that social workers must exercise in order to keep both the person and the community safe in the long term. In the example above, it is easy to imagine circumstances where a particular 'sighting' would quite properly be reported and action taken. Perhaps the person has a typical pattern of relapse in which a period of flamboyant disinhibition with strangers (seen by the worker on this occasion) is usually followed by taking irresponsible risks with traffic, and, in this circumstance, prompt action would clearly be indicated.

Duty of care is not always played out in consistent ways. In one circumstance, the hospital accident and emergency team provided assistance to someone who admitted to carrying a weapon, and who said that they would feel entirely justified in using it if anyone caused them any trouble. The hospital staff notified the person's GP that the person rarely visited, feeling a duty of care to their health colleagues, but did not speak to the college that the person attended five days a week.

Q6: How should information pass between the mental health service and community organisations – the university, an employer, the local darts team or faith-based group? Consider the potential for two-way flow of information.

In general, English information-sharing protocols for social care have been negotiated with the 'usual suspects' – police, schools, health, criminal justice – but do not address the ways in which information might be appropriately shared with the person's employer, family, friends or social club. It is certainly easier to strike a deal with large, monolithic organisations that have similar sanctions against staff who misuse information, but keeping people safe in an inclusive world demands meaningful connections with the plethora of formal and informal groups and organisations that make up society.

Across the clock face lies the range of human rights that we condense here to the single word 'privacy'. The Human Rights Act enshrines in law the person's right to run their own life, participate in the community and build a home free from surveillance or interference from the state. The person can refuse medical treatment and has a right to see any records kept about them, which should only be made if they are necessary and proportionate. The state can only get involved to 'assist in diagnosis and treatment or to protect health, morals or the safety and freedom of others', and this involvement needs to be individual, proportionate and the least intrusive option.

In the example given at the top of this section, the local policy to record every contact with everyone using the service was not individual, proportionate, least intrusive or necessary for diagnosis, treatment or safeguarding. If people are told that staff are routinely using all informal

and off-duty contacts as an added surveillance platform, or they read in their records that this has been taking place, then it is likely to influence their selection of social environment, and even communicate a message that the community 'belongs' to staff. Meanwhile, staff are never allowed to be off-duty. This is a very different situation from the off-duty worker who freely chooses to serve as a formal volunteer, who spontaneously assists a homeless person in the street, or who reports their concern about child abuse next door.

Conclusion

The *Boundaries Clock* reveals weaknesses in the policies of many social work employing organisations (Doel et al., 2009). It does not provide easy answers, but rather offers a framework for reviewing a wide range of issues that ultimately influence the shared citizenship of the worker and the person. Individual circumstances can be placed on the clock face and then – through discussion with the person, their family and friends, colleagues from social work and other disciplines, and reference to guidance from professional bodies and elsewhere – a judgement can be taken in the light of all 12 viewpoints. The outcome will influence the opportunities open to individuals to retain or recover their place in a diverse and cohesive community.

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and Mental Health

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Peter Gilbert
with Peter Bates, Sarah Carr,
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and Greg Slay

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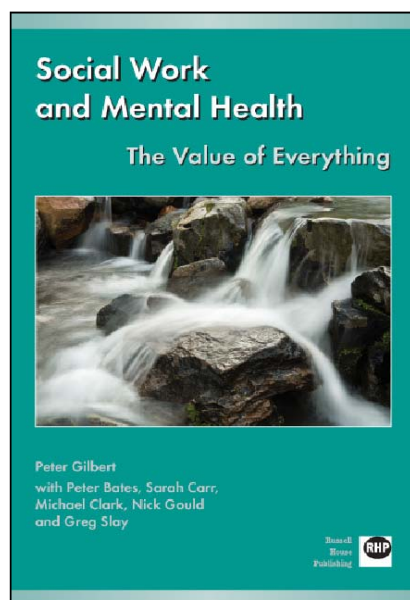

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Peter Gilbert is Professor of Social Work and Spirituality at Staffordshire University, and Visiting Professor with both Birmingham and Solihull NHS Foundation Trust and the University of Worcester. Peter was the NIMHE Project Lead on Spirituality from its inception to 31st March 2009, and now works for the National Spirituality and Mental Health Forum. He has recently been appointed Chair of the National Development Team for Inclusion. Peter is a member of the National Mental Health Development Unit's Equalities Programme Board. A former Director of Social Services for Worcestershire, Peter is a registered Social Worker with 13 years of direct practice. Between 2003 and 2006 he was NIMHE/SCIE Fellow in Social Care with Professor Nick Gould, and has also been Social Care Advisor to the Sainsbury Centre for Mental Health. Having experienced an episode of depression in 2000/1 Peter is very committed to a holistic and person-centred approach. He is author of *Leadership: Being Effective and Remaining Human* (RHP, 2005), and co-edited: *Spirituality, Values and Mental Health: Jewels for the Journey*, (JKP, 2007).

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