UNDERSTANDING MENTAL HEALTH CARE

CRITICAL ISSUES IN PRACTICE

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3 Church Street
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First published 2018

Editor: Alex Clabburn
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Marketing manager: Tamara Navaratnam
Cover design: Wendy Scott
Typeset by: C&M Digitals (P) Ltd, Chennai, India
Printed in the UK

Library of Congress Control Number: 2017957932

British Library Cataloguing in Publication data

A catalogue record for this book is available from the British Library

ISBN 978-1-5264-0447-3
ISBN 978-1-5264-0448-0 (pbk)

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INTRODUCTION

Contemporary mental health care is a complex and contested field of professional practice. What were once considered acceptable and productive ways of understanding and responding to mental distress are increasingly subject to critical examination. Such critical work is not only being conducted by the variety of professionals who practise within mental health services, but it is also being carried out by people who use those services. As a consequence, the authority of mental health professionals and the legitimacy of their interventions are the focus of ongoing critical consideration, and those who experience mental distress are increasingly calling for greater involvement in how their experiences are understood and addressed. Moreover, in response to the requirement to practise in an evidence-based, collaborative and recovery-focused way with those who use mental health services, practitioners are required as never before to appraise and justify the theory, research and evidence which informs the whole range of their work.

To provide informed, effective and responsive mental health care in this challenging and changing context, it is therefore necessary for mental health professionals to develop an understanding of, and engage actively with, the critical issues which characterise that context. Such engagement not only enables practitioners to consider critically the breadth of information which informs their work, but it is also necessary for the development of a critical awareness of how their own assumptions, values and beliefs may affect their practice in both productive and non-productive ways. Indeed, an engagement with critical issues in mental health care is essential for preventing potentially ineffective, dogmatic and paternalistic mental health care by questioning, challenging and seeking to change that which does not withstand critical examination, especially in response to contemporary research and evidence, the emergence of new theoretical perspectives and the innovative work of those who use mental health services.

The aim of this book is therefore to introduce, and facilitate an active engagement with, the critical issues that characterise contemporary mental health care. It is written primarily for mental health professionals and those who, in the course of their work, encounter people who experience mental distress. In addition, it will be of use to students undertaking a professional mental health qualification (or those pursuing a course of study that has a mental health care component) and for professionals who are returning to practice. Moreover, the practice-based character of the

book, and the numerous case studies and activities used throughout, means that it can be employed as a resource by lecturers and clinical mentors involved in mental health education. Finally, in so far as many of the critical issues examined are informed by the work of the service user/survivor movement, this book may also be of interest to those people who experience mental distress.

The purpose of Chapter 1, 'Critical Issues in Mental Health Care', is to examine the significance of critical issues in mental health care. In the context of the tendency for certain approaches to mental distress to become dominant, it will consider how an active engagement with those issues is central to becoming an informed, self-aware and proactive practitioner who is responsive to the needs of people who use mental health services. In addition, it will reflect upon the manner in which this engagement requires the development of a variety of intellectual skills including an ability to consider critical questions, to engage in analysis and to use the capacity to reason. Moreover, while an engagement with critical issues is commonly thought of as being a purely intellectual activity, this chapter will suggest that it also requires the possession of a number of emotional qualities such as an openness of mind, an emotional self-awareness and the possession of courage.

Chapter 2, 'Causes of Mental Distress', is concerned with what contributes to the emergence and maintenance of mental distress and how such distress is understood more generally. It will begin by examining what has variously been referred to as the biological, medical or biomedical model of mental distress, which has been, and continues to be, vigorously debated and disputed. This chapter will then consider the emerging psychological and, in particular, trauma-informed approach to mental distress in which such distress is understood as a meaningful response to a range of traumatic and adverse events that can occur at various stages of an individual's life. Finally, this chapter will examine how a multiplicity of social, economic and political factors can profoundly influence and determine the social and material conditions of people's lives and, in doing so, contribute to the emergence and maintenance of mental distress throughout the course of those lives.

The aim of Chapter 3, 'Psychiatric Diagnosis', is to reflect upon a variety of critical issues surrounding psychiatric diagnosis. It will begin by considering the legitimacy of existing diagnostic categories and the extent to which they accurately identify, and draw clear boundaries between, supposedly distinct biologically based 'mental disorders'. Set against the notion that psychiatric diagnosis is a value-free enterprise, this chapter will then examine the manner in which a variety of social, cultural and historical values and norms are implicated in the diagnostic categories used in mental health care. Moreover, it will conclude by considering an alternative to psychiatric diagnosis that is referred to as psychological formulation or simply formulation. In doing so, this chapter will examine the way in which the thoughts, feelings and behaviours that are associated with mental distress may be understood as meaningful once they are situated in the unique context of a person's life history and current circumstances.

Chapter 4, 'Psychiatric Drugs', is concerned with a variety of critical issues surrounding the use of psychiatric drugs and the manner in which they are thought

to work. It will begin by examining the widespread belief that psychiatric drugs work by targeting and correcting the biological dysfunctions or chemical imbalances that supposedly underlie the emergence and maintenance of mental distress. However, in contrast to the understanding of psychiatric drugs as precise medications or 'magic bullets' that target and correct chemical imbalances, this chapter will then discuss the notion that they are powerful psychoactive substances which produce a range of altered states and non-specific physiological and psychological effects. In doing so, it will consider the implications of these two ways of thinking about psychiatric drugs for how they are used in mental health care and for the character of the clinical and therapeutic relationship between practitioners and people who are prescribed psychiatric drugs.

The purpose of Chapter 5, 'Psychological Therapies', is to examine a variety of critical issues surrounding the use of psychological therapies. It will begin by considering the effectiveness of those interventions and the way in which the quality of the relationship that is established with people experiencing mental distress can influence this effectiveness. Moreover, despite the diverse range of available psychological therapies, many of them are said to possess an individualistic orientation in so far as they seek to facilitate change within the individual. This chapter will therefore move on to discuss the social and political implications of this individualistic orientation, as well as its potential limitations, for a productive understanding and response to mental distress. In contrast to the individualistic focus of various psychological therapies, this chapter will conclude by examining a variety of emerging initiatives that can be understood as being consistent with the field of practice that is known as community psychology.

Chapter 6, 'Service User/Survivor Involvement', is concerned with a variety of critical issues surrounding the involvement of mental health service users/survivors in the provision of those services. It will begin by reflecting upon the experiences of people who have used mental health services and the range of concerns that they have about the mental health system. In so far as the concerns of those who use mental health services have been influential in the formation of a service user/survivor movement, this chapter will then examine the varied objectives and activities of that movement. Moreover, while the requirement to involve service users/survivors in all aspects of mental health care is regarded as a significant achievement, this chapter will conclude by considering the extent to which it can be understood as meaningful, rather than being tokenistic, and the variety of barriers that may obstruct the inclusive, collaborative and transformative involvement of service users/survivors in the mental health system.

The aim of Chapter 7, 'Recovery', is to consider a variety of critical issues surrounding recovery in contemporary mental health care. While recovery has been understood in a variety of ways, this chapter will begin by reflecting upon how it is often formulated by those with personal experience of that process. It will then examine the manner in which recovery, through being adopted by the mental health

system, is said to have been co-opted by and assimilated into that system. In doing so, this chapter will consider how the recovery-focused reorientation of mental health services has entailed, among other things, the marginalisation of the way in which recovery is formulated by those with experience of that process. Finally, despite the suggested co-option of recovery, this chapter will conclude by examining how personal accounts of recovery can enable mental health professionals to consider the conditions which are conducive to recovery and what they can do in their practice to establish such conditions.

1

CRITICAL ISSUES IN MENTAL HEALTH CARE

CHAPTER AIMS

By the end of this chapter you will be able to:

- assess the importance of engaging with critical issues in mental health care;
- distinguish the intellectual skills associated with an engagement with critical issues in mental health care;
- distinguish the emotional qualities associated with an engagement with critical issues in mental health care.

INTRODUCTION

CASE STUDY

Nadia has recently returned to work as a mental health professional after a number of years and has been surprised by the variety of questions, debates and disputes that now characterise mental health care. Of course, she is aware that there have always been critical concerns about psychiatry but these were largely treated as historical disputes that characterised the 1960s and which were commonly presented as having been resolved by developments in biological and pharmacological approaches to mental distress. However, she is now discovering that the theory and practice of contemporary mental health care is subject to sustained critique from a variety of sources. In particular, Nadia has noticed that critical concerns about existing approaches to mental distress are not only being conducted by those who work within mental health services, but they are also being systematically raised by people who use those services. While she feels that such developments may add a degree of complexity to her professional practice, she is excited by the opportunities that they bring to question, challenge and potentially change mental health care in more productive and responsive ways.

As Nadia in the above case study has recently discovered, contemporary mental health care is an increasingly contested and dynamic field of professional practice. What were once considered acceptable and productive ways of understanding and responding to mental distress are being challenged, both by those who work within and those who use mental health services. The authority of mental health professionals, the legitimacy of their knowledge base and the effectiveness of their interventions are subject to ongoing critical examination, and those who use mental health services are increasingly calling for greater involvement in how their experiences are understood and addressed. Indeed, the basic presuppositions and the clinical interventions that characterise contemporary mental health practice are subject to question in a way not seen in any other area of health care. Of course, there are concerns and debates in other areas but these rarely concern the theoretical foundations, therapeutic practices or very existence of the field of practice under consideration. For example, while various issues of concern may be raised in other branches of medicine (such as the length of waiting lists, the quality of practitioners' training and the adequacy of available resources and equipment), few would oppose the general purpose or existence of those medical specialities. As Bracken and Thomas (2001) suggest, it is difficult to imagine an anti-paediatrics, post-cardiology or critical neurology movement. However, the existence of the so-called **anti-psychiatry movement** and, more recently, the **critical psychiatry movement** illustrates how a sustained engagement with a variety of critical concerns has been, and continues to be, a feature of psychiatry and mental health care.

The purpose of this chapter is therefore to introduce you to the significance of critical issues in mental health care for your professional practice. It will begin by considering how an awareness of, and active engagement with, those issues is fundamental to becoming an informed, self-aware and proactive mental health professional who is responsive to the needs of those who use mental health services. In particular, this chapter will suggest that the importance of such engagement can be understood in the context of the tendency for certain approaches to mental distress to become dominant and to be viewed as self-evident, unquestionable and even natural. We shall then consider how an engagement with the principles and practices that characterise mental health care requires the development of a variety of cognitive capabilities or intellectual skills. While various intellectual skills have been proposed, this chapter will examine three that are of particular significance: an ability to consider critical questions, to engage in analysis and to use the capacity to reason. While an engagement with critical issues in any area of human inquiry is commonly thought of as being a purely intellectual activity, this chapter will suggest that it also requires the possession of a number of affective capabilities or emotional qualities. While a variety of emotional qualities have been proposed, we shall examine three that can be understood as being of particular significance for an engagement with critical issues in mental health care: an intellectual receptivity or openness of mind, an emotional self-awareness and, finally, the possession of courage.

WHY CRITICAL ISSUES IN MENTAL HEALTH CARE?

CASE STUDY

Since qualifying as a mental health professional a little under two years ago, Sophie has become increasingly interested in the debates that characterise contemporary mental health care. At lunchtime earlier today she was discussing her recent reading around some of these critical issues with her colleague Callum and the significance that they may have for their mental health practice. While Callum acknowledged that these issues sounded interesting, he was unsure of their relevance for the clinical area. Contemporary mental health care, he maintained, is an increasingly complex, challenging and pressurised area in which the role of practitioners is to respond to the needs of those who use mental health services in a safe, effective and efficient manner. While an engagement with critical issues in mental health care may have some value in an academic context, he suggested that it has minimal relevance for their everyday practice. Rather than spending time reflecting on practice and thinking about critical issues, Callum concluded by proposing that they should simply be focused on 'getting things done'.

Although contemporary mental health care is characterised by a variety of critical issues, the importance of developing an awareness of these issues may not be immediately clear. In the context of challenging and pressurised mental health settings it is not uncommon to develop a sense that mental health care, as suggested by Callum in the above case study, should be exclusively concerned with 'getting things done'. Indeed, it has been suggested that in so far as modern health care environments are increasingly task-orientated, and characterised by an ongoing drive to maximise efficiency in order to meet a range of health care targets, a culture can arise in which the importance of 'thinking', and of critical thinking and reflection in particular, can be marginalised at the expense of 'doing' (Thompson & Thompson 2008; Roberts & Ion 2015). Influenced by a health care culture that is focused on getting things done, and continually seeking to do so in the most efficient manner possible, an engagement with critical issues in mental health care can therefore come to be seen as a distraction, annoyance or unaffordable luxury at best. Moreover, in so far as it requires a reconsideration of existing ways of thinking and doing things, it has also been suggested that such critically reflective activity can come to be seen as an unproductive, undesirable and even unacceptable challenge to the aims, objectives and efficient functioning of the organisations in which health care is provided (Schön 1983).

In contrast to such concerns and characterisations, an engagement with critical issues in mental health care can be understood as being fundamental to becoming a practitioner who is responsive to the needs of those who use mental health services. To begin to understand how, it is productive to recognise that a variety of frameworks, models and **paradigms** have been used to comprehend mental distress

and other societies, cultures and historical periods have understood and responded to such experiences in different and sometimes radically divergent ways (Foucault 2001; Scull 2016). Despite this diversity, there is an enduring tendency for certain approaches to mental distress to become favoured by individual practitioners, by the professional bodies and organisations with which they are associated and by the cultural and historical periods to which those individuals, professional bodies and organisations belong. However, the reasons why any one particular approach to mental distress becomes dominant is complex and contested. Such a dominance cannot, for example, simply be attributed to a supposed theoretical and therapeutic superiority over other ways of understanding and responding to mental distress. Rather, it has been argued that in any sphere of human inquiry a range of social, political and historical factors contribute to the establishment, maintenance and dominance of certain ways of understanding and responding to human experience while simultaneously marginalising, delegitimising and excluding alternative ways of understanding and responding to that experience (Foucault 1981).

CONCEPT SUMMARY: THE TECHNOLOGICAL MODEL OF MENTAL DISTRESS

It has been suggested that a particular approach to mental distress has come to dominate contemporary mental health care and, while it is the focus of critical consideration in some areas, is often uncritically maintained by many as being self-evident (Boyle 2011; Bracken *et al.* 2012). This dominant approach, or what has been referred to as the technological model of mental distress, is largely individualistic in so far as it understands that distress as primarily having its origin 'within' the individual, as a manifestation of some form of underlying biological dysfunction or psychological deficit. In doing so, it proposes that the most appropriate way to respond to that distress is through the expert application of various forms of technical intervention such as psychiatric medication or cognitive behavioural therapy.

It has been argued, however, that understanding and responding to mental distress by adopting this approach can have a variety of negative effects for those who use mental health services. By conceptualising mental distress as primarily having its origin within the individual, the technological model can obscure and even neglect how a variety of social and economic factors can contribute to the emergence and maintenance of that distress. Moreover, by prioritising professional understandings and responses to mental distress, the technological model not only minimises the personal meaning that such distress may have for a person, but it can also marginalise the expertise that the person may have obtained as a result of seeking to understand and respond to their particular experience of mental distress (Coles *et al.* 2015).

While the tendency for any one particular approach to mental distress to become dominant can have a range of negative effects, it can be understood as having a variety of productive consequences. For example, in so far as it is composed of relatively consistent assumptions, beliefs and concepts, a dominant approach can provide mental health professionals and those experiencing mental distress with

an accessible way to comprehend and organise the sometimes complex, unusual and disturbing experiences that can be associated with such distress. Moreover, the tendency for one particular way of approaching mental distress to become dominant provides a common vocabulary or language that can be shared, understood and used by many. It further enables practitioners to coherently and efficiently communicate their clinical understandings with others and to consider, negotiate and determine their interventions on the basis of those shared understandings. However, despite its potentially productive effects, the fundamental danger associated with dominant ways of thinking and doing things in any field of human inquiry is that they can come to be understood as self-evident (Foucault 2002; Darder *et al*. 2017). That is, rather than being understood as a productive and yet provisional approach to human experience in which a variety of social, political and historical factors have contributed to its dominance, a favoured way of understanding and responding to any aspect of human experience, including mental distress, can come to be seen as obvious, unquestionable and even natural.

Once any one particular approach to mental distress comes to be held by an individual practitioner, a professional body or even an entire organisation as self-evident, then the opportunities to consider alternative ways of thinking and doing things can become significantly reduced. Indeed, when a dominant approach to mental distress comes to be accepted as obvious then, rather than being understood as resting upon assumptions and beliefs that are open to question, discussion and revision, it can come to be held as indisputable and therefore something which 'everybody knows' (Deleuze 2001, p. 130). Moreover, in so far as any approach comes to be accepted as self-evident, then the need to think and reflect critically about the particular way of understanding and responding to mental distress that it provides can not only seem unnecessary but it can even come to be dismissed as unreasonable. As Morgan (2006) suggests, however, when this occurs in any area of human inquiry then those dominant approaches or 'ways of seeing' that enable people to make sense of human experience and to negotiate that experience in an orderly way can become 'ways of not seeing' (p. 209). In particular, those favoured ways of thinking and doing things that enable a productive understanding and response to a certain feature of human experience, such as the experience of mental distress, can become constraints that prevent the consideration of alternative and potentially more productive ways of understanding and responding to that experience.

CONCEPT SUMMARY: FORMS OF KNOWLEDGE

Contemporary mental health care is informed by a diverse body of research, evidence and theory that originates from a variety of academic and clinical sources. However, following the distinction introduced by the German philosopher Jürgen Habermas (1972), mental health practice can be understood as requiring three distinguishable, and yet interconnected, forms of knowledge: technical knowledge, practical knowledge and emancipatory knowledge.

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- **Technical knowledge** refers to the knowledge that is characteristic of the empirical sciences (such as biology, chemistry and physics) and is closely associated with evidence-based practice and technical health care interventions. In contemporary mental health care it can be understood as the knowledge that is required to decide, for example, the most effective psychotherapeutic techniques or psychiatric medication to use in response to a particular manifestation of mental distress.
- **Practical knowledge** refers to the knowledge that is associated with human interaction and which includes the skills necessary for effective interpersonal communication and mutual understanding to occur. In contemporary mental health care it can be understood as the knowledge that is required to develop therapeutic relationships with those experiencing mental distress as well as an awareness of the professional standards and values that characterise the development of those relationships.
- **Emancipatory knowledge** refers to the knowledge of those dominant ways of thinking and doing things in any sphere of human inquiry, and includes an awareness of how such dominance is maintained. In contemporary mental health care it can be understood as the knowledge that is required to engage critically with dominant approaches to mental distress and to participate in an exploration of potentially more productive ways of understanding and responding to that distress.

It is in the context of the tendency for certain ways of understanding and responding to mental distress to become dominant, and for those dominant approaches to come to be seen as obvious or natural, that we can understand the need for critical issues in mental health care. As you are probably already aware, rather than simply following instructions and getting things done without significant understanding and evaluation, as an autonomous and accountable mental health professional you are required to assess and justify the research, evidence and theory that informs the whole range of your clinical work. However, without an awareness of the critical issues raised by those who work within and those who use mental health services, your ability to assess your own practice, to examine how it may uncritically support supposedly self-evident ways of working, and to consider opportunities for practising in alternative and potentially more productive ways can be significantly diminished. For example, in highlighting the dangers that can accompany a failure to engage with alternative, critical perspectives in any area of human experience, and to reconsider the assumptions that underlie established approaches to that experience, Heath (2012) has suggested that 'If I only ever converse with people who agree with me, who share my assumptions and even my prejudices, I will not have access to the resources necessary to improve on my current levels of understanding' (p. 15).

Rather than having minimal significance for your practice, an engagement with critical issues in mental health care is therefore essential to becoming an informed, self-aware and proactive mental health professional. An awareness of these critical issues will not only provide you with the opportunity to begin to question approaches to mental distress that do not withstand critical examination, it will also enable a consideration of how to change those approaches as a result of

contemporary research and evidence, the emergence of new theoretical perspectives and the active involvement and innovative work of those people who use mental health services. Moreover, in contrast to what have been referred to as 'superficial transformations', or changes that do not challenge dominant approaches to mental distress, a critical engagement with the assumptions that inform those approaches can produce the transformations in thought that are necessary to bring about productive transformations in practice. For example, while not underestimating the considerable challenges that are associated with questioning and seeking to change supposedly self-evident ways of thinking and doing things in any sphere of human inquiry, Foucault (1990) makes it clear that 'A transformation that remains within the same mode of thought … can merely be a superficial transformation. On the other hand, as soon as one can no longer think things as one formerly thought them, transformation becomes both very urgent, very difficult, and quite possible' (p. 155).

ACTIVITY 1.1 CRITICAL THINKING

Rather than being marginal to your mental health practice and being of academic interest only, an engagement with critical issues in mental health care is central to transforming your practice in ways that will make it more humane and responsive to the needs of those in distress.

For this activity critically consider how mental distress might still be understood, and what practices might still be in existence, if people in the past had not questioned, challenged and sought to change dominant and supposedly obvious ways of understanding and responding to that distress.

An outline answer is provided at the end of the chapter.

CRITICAL ISSUES AND INTELLECTUAL SKILLS

CASE STUDY

Jonathan is currently at a two-day mental health conference and has just attended a presentation about the significance of critical issues for mental health professionals. In the presentation the speaker suggested that how practitioners understand and respond to mental distress is subject to ongoing critical examination, and those who use mental health services are demanding greater involvement in how their experiences are understood and addressed. Rather than simply accepting dominant and supposedly self-evident ways of working, the speaker argued that it is therefore becoming increasingly important for practitioners to 'engage actively' with

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these critical developments and to consider them in the context of their own work. Reflecting upon the presentation afterwards, Jonathan is beginning to appreciate the importance of critical issues in mental health care for his own practice and for mental health services more generally. However, while he understands that this involves accessing reading material about contemporary critical issues, he is unsure how he should go about 'engaging actively' with those issues and what skills, dispositions or qualities such engagement requires.

To become a mental health professional who is able to consider critically and, where necessary, seek to change dominant and supposedly unquestionable ways of working, you will be required to possess more than a knowledge or an awareness of the critical issues that characterise mental health care. Indeed, it has been suggested that one of the most enduring and yet mistaken assumptions about the process of learning is that by simply acquiring knowledge a person will become an 'independent' or 'autonomous' thinker (Mezirow 1997). That is, it is commonly thought that by learning about a particular area of human inquiry, or gaining proficiency in the practical competencies that are associated with that area, a person will somehow spontaneously begin to question, challenge and even change its dominant and seemingly self-evident ways of thinking and doing things. In contrast to this assumption, the ability to become an informed and proactive mental health professional who is responsive to the needs of those who use mental health services not only requires an awareness of the critical issues that characterise contemporary mental health care; rather, it also necessitates an active engagement with those issues and a consideration of their significance in the context of your own professional practice. Like Jonathan in the above case study, however, it may not be immediately clear how to go about engaging actively with those issues and what skills, dispositions or qualities such an engagement demands.

An active engagement with the critical issues that can characterise any area of human inquiry, and the ability to challenge dominant ways of thinking and doing things as a result, requires the development of certain intellectual skills (Brookfield 2001; Paul & Elder 2014). A variety of intellectual skills have been proposed and you may already possess many if not all of these skills and be able to transfer them from other areas of your professional practice. In the context of mental health care, one of the most fundamental intellectual skills that is required to engage actively with critical issues is a willingness to ask, and be receptive to, questions about established and supposedly self-evident approaches to mental distress. While seemingly straightforward, this intellectual skill is closely associated with a variety of other 'habits of mind' in so far as it necessitates the ability to maintain a curiosity or inquisitiveness about existing ways of understanding and responding to mental distress, and, at least periodically, consider why things are the way they are. Irrespective of how developed your intellectual skills are, the ability to maintain a curiosity about the principles and practices that characterise mental health care will be central to an active

engagement with critical issues because it is that which provides the disposition to ask and remain receptive to questions about dominant and supposedly obvious ways of working.

CONCEPT SUMMARY: INTELLECTUAL SKILLS

In order to acquire knowledge about any area of human inquiry, and to engage actively with the critical issues that can characterise that area, it is necessary to develop a variety of cognitive capabilities or intellectual skills (Bloom *et al*. 1956; Cottrell 2017). In the context of mental health care, a number of these intellectual skills can be understood as being of particular significance.

- **Comprehension** refers to the ability to understand the meaning or significance of the critical questions, debates and disputes that are a feature of contemporary mental health care. In particular, it requires an attempt to find ways of making sense of these issues even when they are experienced as being both personally and professionally challenging.
- **Application** is the ability to use our knowledge and understanding of a particular issue and employ it in a new situation. In doing so, it involves situating alternative approaches to mental distress in the context of our particular professional practice and considering the significance and relevance of those approaches in that unique context.
- **Synthesis** is the ability to bring seemingly separate elements together in order to form a new whole or create new meaning. It can involve making productive connections across the range of critical issues in mental health care in order to raise novel questions about, and consider alternatives to, existing approaches to mental distress.
- **Evaluation** refers to the ability to judge the quality of the evidence or arguments that are presented in support of a knowledge claim. In the process, it involves making an assessment about whether there are compelling reasons for understanding and responding to mental distress in a particular way or whether those reasons should be rejected.

As well as being challenging and contested, contemporary mental health care is also a complex area of professional practice. It has even been suggested that being a mental health professional 'inevitably involves us in some of the most important and perplexing questions that humans can face' (Kendler 2005, p. 439). While it can be tempting to simplify, disregard or even deny the complex character of the questions and debates that are a feature of mental health care, an active engagement with them will require you to confront and comprehend such complexity, and this, in turn, will require an ability to engage in analysis. As with many of the intellectual skills that can enable an active engagement with the principles and practices that characterise mental health care, analysis is a complex and multifaceted notion that has been defined in a variety of ways. However, to begin to understand what analysis means, it is instructive to recognise that its literal meaning is 'to loosen up' or 'to take things apart'. Therefore, in its most general sense,

analysis can be understood as that intellectual activity which involves examining something in order to determine its constituent parts or the manner in which it is put together. In particular, analysis is commonly employed to examine something complex (which can be any theoretical or therapeutic feature of mental health care) in order to break it down into smaller elements and thereby clarify and deepen our understanding of that which has been taken apart.

While analysis involves examining something in order to determine its parts, and thereby comprehend its complexity, it is sometimes not immediately apparent how something in mental health care is put together. This is not only because the theoretical principles and therapeutic practices that help us to understand and respond to mental distress can be complex, but also because they can be composed of elements that are often implicit or hidden. In so far as they are ideas or beliefs that are assumed to be the case, these implicit elements or **assumptions** can profoundly influence how we think about and respond to mental distress and they commonly do so without our explicit awareness. Moreover, we inherit a wide range of assumptions from a variety of sources and they can often be maintained without good reason and be questionable, misinformed or even simply wrong. To engage actively with the complexity that can characterise critical issues in mental health care, and to consider the significance of those issues in the context of your own professional practice, the use of analysis will therefore not be limited to identifying the parts of something in order to comprehend such complexity. Rather, it will also involve attempting to 'unearth' or make explicit the variety of assumptions that can underlie any theoretical or therapeutic feature of mental health care in order to reflect upon the implications and appropriateness of maintaining those assumptions and, where necessary, consider their revision or even replacement.

ACTIVITY 1.2 TEAM WORKING

Rather than simply describing the world in a neutral and value-free manner, the language that we use is informed by a variety of assumptions that can be profoundly influential in producing, maintaining and changing how we understand and respond to the world (Bourdieu 1992; Foucault 2005; Fairclough 2015).

For this activity analyse the following terms that are, or have been, used in mental health care. As you do so, consider the assumptions or implicit ideas and beliefs that are associated with each term, and, with your colleagues, discuss the appropriateness of using them in the context of your professional practice.

- Mental illness;
- Mental health difficulty;
- Mental distress;
- Madness.

An outline answer is provided at the end of the chapter.

In addition to considering questions and conducting analyses, an active engagement with the critical issues that are a feature of contemporary mental health care requires an ability to reason. While reasoning is a multifaceted intellectual skill that has been defined and characterised in various ways, in its broadest terms it can be understood as identifying and evaluating the reasons given for something – whether that involves the reasons given for understanding something in a particular way or for doing something in a particular way (Fisher 2011). In the context of the dominance and supposedly self-evident nature of certain approaches to mental distress, however, it can be a particular challenge to identify the reasons that may underlie the use of such approaches. It may be that the reasons for understanding and responding to mental distress in a particular way are assumed to be obvious or, in addition to those that are given, you may suspect that there are other influential reasons that have been omitted. Alternatively, there may be a variety of reasons presented for why you should adopt one particular approach to mental distress as opposed to others, and the line or chain of reasoning may be long and complicated. For example, the reasons given for practising in a particular way might include formal or logical arguments, established or new research and evidence, theoretical orientations or philosophies, financial pressures or resource limitations, clinical experience or intuition and even appeals to authority or claims that 'this is the way it's always been done'.

Reasoning is not only used to determine what specific reasons are being given for understanding and responding to mental distress in a particular way. Rather, one of the primary aims of using reason in order to engage actively with critical issues in any area of human inquiry is to judge, or critically evaluate, the worth of those reasons (Swatridge 2014; Hanscomb 2017) – to judge, for example, whether the arguments, evidence or appeals to tradition that may be presented as reasons for adopting a particular theoretical and therapeutic approach to mental distress are convincing or whether they should be rejected as inconsistent, inconclusive or simply irrelevant. However, while it commonly involves evaluating the reasons of other individuals, professional bodies or entire organisations, a significant feature of reasoning is the ability to develop, clarify and articulate your own reasons. If you conclude that the reasons that are given for understanding and responding to mental distress in a particular way are not justified then you will need to articulate the reasons why you think that is the case. Moreover, if you think that the existing reasons given for practising in a particular way do not withstand critical evaluation, and that different ways of thinking and doing things in mental health care ought to be adopted, you will be required to make your reasons for such changes robust enough to withstand the questioning, analysis and reasoning of others.

CONCEPT SUMMARY: CRITICAL EVALUATION

Throughout your career as a mental health professional you will be introduced to a large amount of information that will form the various reasons given for why you ought to adopt a particular approach to mental distress. This will range from informal opinions, beliefs and

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speculation to formal research, evidence and argument, and you will receive this information from a variety of sources, including lectures and tutorials, books and journal articles, presentations and conferences, professional guidance and peer discussions and, increasingly, through various forms of electronic media. Rather than simply accepting this information, it will be necessary to subject it to critical evaluation and to consider its value in the context of your professional practice. A variety of guidelines, methods and frameworks have been proposed to help you critically evaluate information and to critically appraise formal research in particular (Woolliams *et al*. 2011; Greenhalgh 2014). However, one of the most accessible and productive ways to critically evaluate the wide range of information that you will encounter as a mental health professional is to subject it to the following critically evaluative questions (Roberts 2015).

- **What does the information say?** This involves a consideration of the content of the information being presented and attempting to become clear about its meaning or position. While you may find that this is often a relatively straightforward process, on other occasions it can be more challenging and you may need to work hard, and use a variety of learning strategies, to clarify what is being said.
- **Where does the information come from?** This involves thinking about the source of the information and the extent to which it can be understood as credible. While it is possible to receive questionable information from reputable sources, and to obtain correct information from unreliable sources, finding out where it has come from can often provide you with a good indication of the quality of that information.
- **How has the information been produced?** The information that you will encounter as a mental health professional will have been produced through a variety of means, which can range from uninformed speculation to various sophisticated research methodologies. It can therefore be productive to assess the worth of those means and to consider if they are suitable for the particular area of mental health care being discussed.
- **Who has produced the information?** This involves an assessment of the experience and expertise of the individual or group that has produced the information. However, while it is important to respect the expertise of those who work within and use mental health services, it is necessary to focus upon the content of the information being presented without being overawed by, or dismissive of, those who have produced it.
- **Why has the information been produced?** This involves an attempt to determine the possible motives, interests and affiliations that may have influenced the production of a particular piece of information. In addition, it is necessary to consider if those motives, interests and affiliations have unduly influenced the production and presentation of the information in ways that are likely to misrepresent, mislead or even deceive others.
- **When was the information produced?** This involves thinking about whether the information is the best that is currently available and has not been superseded by more recent information. However, while discarding information on the basis of its age may be appropriate in relation to some areas of mental health care, doing so in other areas may unnecessarily restrict your discovery of potentially valuable information.

CRITICAL ISSUES AND EMOTIONAL QUALITIES

CASE STUDY

Amelia is a third-year student who is on her final clinical placement within a community mental health team before she qualifies as a mental health professional. She has quickly developed good relationships with the other practitioners and has discovered that many of them employ a cognitive behavioural approach to mental distress. Her mentor has told her that the team leader is a keen supporter of this approach and has worked hard to ensure almost all of the staff have attended some form of training course in cognitive behavioural therapy. Amelia is keen to develop her therapeutic skills in delivering this particular approach but has told her mentor that, as part of completing her practice assessment document, she is also required to display an understanding of a variety of approaches to mental distress. Her mentor has replied that while they can discuss these alternative approaches, they now have 'minimal relevance' in contemporary mental health care and, in thinking about her personal and professional development, she should focus upon developing her knowledge and skills surrounding cognitive behavioural therapy.

An active engagement with the questions and debates that can be a feature of any area of human inquiry is commonly characterised as an exclusively intellectual endeavour. As we highlighted at the beginning of this chapter, however, an engagement with critical issues in mental health care requires both the use of a variety of intellectual skills and the possession of a number of emotional qualities or dispositions. While you may already display many of these in the context of your professional practice, one of the most important emotional qualities for an awareness of and active engagement with critical issues in mental health care is an intellectual receptivity, or what is often referred to as an 'openness of mind'. While such a disposition is associated with a variety of other intellectual skills and emotional qualities (and, as in the case study above, can confront a number of obstacles) an openness of mind refers to a genuine and proactive willingness to consider new ideas, alternative perspectives and different ways of thinking and doing things (Hare 2007; Spiegel 2012). In the context of contemporary mental health care, open-mindedness requires us to become receptive to the critical issues that may challenge our favoured ways of understanding and responding to mental distress and, in the light of these challenges, to consider the possibility of thinking and working in alternative and potentially more productive ways.

CONCEPT SUMMARY: EMOTIONAL QUALITIES

While it is commonly characterised as a purely intellectual endeavour, there is a recognition that the emotions can assist us in gaining knowledge and actively engaging with the critical issues that can characterise any area of human inquiry (Hare 2011; Paul & Elder 2014). In the context

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of contemporary mental health care, a number of these affective capabilities or emotional qualities can be understood as being of particular significance.

- **Honesty** is the disposition to acknowledge the possibility of having inconsistencies, biases and errors in our current understanding of, and response to, mental distress. Such an outlook requires us to uncover the various reasons why we may favour one particular approach to mental distress over others and to critically consider the legitimacy of those reasons.
- **Perseverance** is the quality of being determined to engage actively with critical issues in mental health care even when those issues are experienced as complex and challenging. It requires a commitment to continue to work through such complexities and challenges despite their potential to create various forms of personal and professional resistance.
- **Integrity** refers to the ability to be consistent when actively engaging with the critical issues that are a feature of mental health care. It requires us to hold ourselves, and our favoured ways of understanding and responding to mental distress, to the same rigorous standards of evidence and critical thought to which we hold others.
- **Humility** refers to an awareness of the limitations of our current knowledge and understanding. It involves not claiming to know more than we actually do about a particular issue and being willing to reconsider, revise and even reject our knowledge claims when confronted with compelling reasons to do so.

While an openness of mind requires a receptivity to alternative approaches to mental distress, it does not suggest an uncritical acceptance of any perspective and neither does it require you to treat all perspectives as being equally legitimate. In characterising open-mindedness as a 'hospitality' to new perspectives, Dewey (1980) memorably proposes that 'open-mindedness is not the same as empty-mindedness', it is not a hospitality that beckons 'Come right in; there is nobody at home' (p. 183). Rather, an active and considered engagement with critical issues in mental health care will require you to be cautious about readily accepting the latest perspectives and the 'buzz words' that can often accompany them, as well as being sceptical of those who claim to have established a definitive approach to mental distress. While it will require a receptiveness to new perspectives from a variety of sources, an openness of mind will therefore require you to subject those perspectives to critical evaluation and to consider their significance in the context of your own professional practice. In doing so, this critical receptivity can help prevent your practice from becoming limited by, and even 'entrenched' within, a single perspective. That is, an openness of mind can not only enable you to gain a deeper appreciation of the complexity of mental distress but it can also help to develop an awareness that critically considering different perspectives, and using a plurality of therapeutic approaches, will enable you to productively respond to the distress experienced by different people at different times.

CONCEPT SUMMARY: EGOCENTRISM

The notion of egocentrism has been used in a variety of disciplines and, in the context of childhood cognitive development for example, refers to the manner in which young children have been characterised as being unable to distinguish their perspective from the perspective of others (Piaget 1959). However, egocentrism has been understood in broader terms as referring to the tendency of any person, irrespective of their age, to think and act exclusively from their own perspective without giving due consideration to alternative perspectives (Paul & Elder 2014). Moreover, while it can be a trait of an individual, it can also become manifest at the collective level, so that a group of people can embrace a particular perspective in such a way that the limitations of that perspective, and the strengths of other perspectives, are overlooked or even actively disregarded.

As one of the most common and yet profound obstacles to the development of our critical capabilities, egocentrism can be the result of a variety of powerful psychological processes. For example, rather than being justified by the available research, evidence and argument, we can support a particular way of understanding and responding to mental distress simply because it is the perspective we hold and thus we would like it to be true. In contrast, we can maintain a particular approach to mental distress because it is a perspective that we have uncritically adopted from others, such as the personal or professional group with which we associate. Alternatively, we can favour a particular way of working in mental health care, and actively disregard others, because it is in our vested interests to do so and it provides us with some form of personal, professional or financial reward.

In the context of the dominance and supposedly self-evident nature of certain ways of understanding and responding to mental distress, an openness of mind can be a particular challenge to develop and maintain. It is possible to form powerful and often biased attachments to particular approaches to mental distress and there can be a variety of personal, professional and organisational reasons, some of which might not be immediately apparent, why we may adhere to one particular approach without giving due consideration to others. An awareness of the ability to form emotional attachments to certain ways of thinking and doing things has led to the common suggestion that it is necessary to 'put aside' such attachments in order to somehow achieve a condition of 'pure rationality' and critical thought. However, rather than being a dispassionate and detached activity that is opposed to the influence of the emotions, the emotions can assist in learning about, and actively engaging with, critical issues in any area of human inquiry (Brookfield 2001; Reber 2016). Indeed, in the context of mental health care, an emotional engagement with the critical questions and debates which characterise that field of practice can be a powerful and productive force. It can not only motivate you to gain an awareness of those critical questions and debates, but it can also sustain your ongoing active consideration of them when confronted with a variety of obstacles, challenges and disincentives.

It is important to recognise, however, that simply possessing and displaying an emotional engagement with critical issues in mental health care is insufficient.

For example, an opposition to an existing way of understanding or responding to mental distress that is based solely on anger, no matter how intensely that emotion is felt, is unlikely to convince others of the merits of that opposition. Rather, in order to be considered a disciplined and fair-minded engagement with a critical issue, such emotional conviction will need to be accompanied by informed analysis, argument and reason. This does not mean that it is necessary to somehow achieve control or mastery over your emotions. Instead, an active engagement with critical issues in mental health care requires the development of an awareness of the power of the emotions both as a productive and non-productive influence on your thinking, along with a willingness to seek to harness the former influence while diminishing the latter. Such emotional self-awareness and management will therefore require a consideration of why you may favour certain approaches to mental distress over others, pursued with what may sometimes be experienced as an uncomfortable degree of honesty. You will be required to reflect, at least periodically, upon the reasons why you may be practising in certain ways and to think about whether doing so is justified by the available research, evidence and theory or whether it is a consequence of your emotional attachment to particular ways of working.

ACTIVITY 1.3 REFLECTION

Rather than being based upon the available research, evidence and theory, there may be a variety of alternative reasons why you favour one particular approach to mental distress over others. While it might not initially be clear to you what those reasons are, and while an investigation of them can produce varying degrees of personal resistance, for this activity reflect upon why you may support a certain approach to mental distress by considering the following questions.

- Do you maintain that approach as a result of 'intellectual complacency' and because that is the approach you have always adopted?
- Do you maintain that approach because it is shared by others, such as people in positions of authority or those whom you respect professionally?
- Do you maintain that approach because it is in your own self-interest to do so and because it provides you with some form of personal or professional advantage?

As this activity is based upon your own reflections, there is no outline answer at the end of the chapter.

In addition to open-mindedness and self-awareness, an emotional quality that is central to engaging actively with dominant and supposedly self-evident approaches to mental distress is courage. It may not be immediately clear why actively engaging with critical issues in mental health care requires courage until you remember that a fundamental feature of doing so is a willingness to raise and reflect upon a variety of questions about existing ways of understanding and

responding to mental distress. Such engagement variously requires us to question our favoured ways of working in mental health care, to consider critically the legitimacy of the assumptions that underlie those ways of working and to reflect honestly upon the reasons why we may adopt one particular approach to mental distress over others. However, this can be a profoundly challenging process, both personally and professionally, and we ought not to underestimate how attached we can become to our favoured ways of thinking and doing things in mental health care. Indeed, as Brookfield (2001) makes clear, 'Asking critical questions about our previously accepted values, ideas, and behaviours is anxiety-producing. We may well feel fearful of the consequences that might arise from contemplating alternatives to our current ways of thinking and living'; at any stage of this process of questioning, challenging and considering changes to our existing ways of thinking and doing things, 'resistance, resentment, and confusion' can be evident (p. 7).

An active engagement with critical issues in mental health care can not only involve raising and reflecting upon challenging questions about our own ways of working, but it can also involve asking challenging questions about how others understand and respond to mental distress. Similar to the variety of reasons why we may be unwilling to question our favoured ways of working, there may be multiple reasons why other individuals, professional bodies and even entire organisations are reluctant to consider critically their particular approach to mental distress. As highlighted above, in the context of a health care culture that is focused on getting things done, and continually seeking to do so in the most efficient manner possible, an engagement with critical issues in mental health care can be perceived as a distraction or annoyance at best. At worst, however, such critical activity can be understood as a dangerous and subversive challenge to the aims and efficient functioning of the organisations in which mental health care is provided. While there will almost certainly be others within and beyond your immediate working environment who welcome the critical consideration of existing ways of working, and with whom you should seek to make productive alliances, there will be others who do not. The ability to question, challenge and potentially seek to change dominant and supposedly self-evident approaches to mental distress will therefore require you to display courage when faced with the individual, and sometimes even collective, resistance of others.

CHAPTER SUMMARY

This chapter has introduced you to the importance of critical issues in mental health care for your professional practice. It has suggested that an awareness of, and active engagement with, those issues will be fundamental to becoming an informed, self-aware and proactive mental health professional who is responsive to the needs of those who use mental health services. In particular, this chapter has suggested that the importance of such engagement can be understood in the context

of the tendency for certain approaches to mental distress to become dominant and to be viewed as self-evident, unquestionable and even natural. Moreover, we have considered how an active engagement with the critical issues that characterise mental health care requires the development of a range of cognitive capabilities or intellectual skills. While various intellectual skills have been proposed, we have examined three that can be understood as being of particular significance: an ability to consider critical questions, to engage in analysis and to use the capacity to reason. While an engagement with critical issues in any area of human inquiry is commonly thought of as being a purely intellectual activity, this chapter has suggested that it also requires the possession of a number of affective capabilities or emotional qualities. While a variety of emotional qualities have been proposed, we have examined three that can be understood as being of particular significance for an engagement with critical issues in mental health care: an intellectual receptivity or openness of mind, an emotional self-awareness and management and, finally, the possession of courage.

ACTIVITIES: BRIEF OUTLINE ANSWERS

ACTIVITY 1.1 CRITICAL THINKING

There are a number of comprehensive, stimulating and controversial accounts of the history of mental distress and it will be productive to access and consider such accounts (Shorter 1997; Foucault 2001; Scull 2016). Importantly, when thinking about how mental distress has been understood in the past, and what practices were used to respond to such distress, you should be cautious about thinking of this history in terms of an unproblematic progression towards scientific and medical enlightenment. Multiple and competing histories have been written that illustrate how different approaches to mental distress sought to gain dominance at different times, with it being far from obvious which would prevail. However, you may have identified that in the past the experiences associated with mental distress were, for instance, understood in overtly religious terms. Viewed as being a consequence of the soul's possession by spirits and demons, or of God's vengeance for moral failings, a variety of spiritual means were used to respond to this perceived condition including prayer, pilgrimage or exorcism.

You may also have noted that while mental distress has been understood as possessing its own wisdom, during the 17th and 18th centuries it increasingly began to be thought of as a failure of reason and therefore to be understood in terms of 'irrationality'. In an attempt to 'shock' a person back to rationality a variety of interventions were used, such as whirling chairs and 'baths of surprise'. Moreover, you may have discussed with your colleagues the manner in which people who experienced mental distress in the past were confined in a variety of institutions, including private for-profit madhouses and public lunatic asylums. The quality of care provided in such institutions varied widely depending on a person's wealth, social status and family network, but, for the poor, life inside such institutions could be harsh. For example, you may have identified how a person inside such an institution

could be subject to various forms of physical restraint including the use of chains, belts and straightjackets and multiple invasive physical interventions such as purges, vomiting and blood-letting.

ACTIVITY 1.2 TEAM WORKING

In analysing a number of terms that are, or have been, used in mental health care, and the appropriateness of using them in the context of your professional practice, you may have had complex and stimulating discussions with your colleagues. By analysing the assumptions or implicit ideas and beliefs that are associated with each term, you may have reflected upon how the language that is used to account for the experiences of those who use mental health services can profoundly influence how we understand and respond to those experiences. For example, you may have noted that the term mental illness is closely associated with a biological, or what is often referred to as a medical or biomedical, understanding of a person's experience. In contrast, mental health difficulty or mental health problem are often used as alternative terms in order to reflect a less biomedical understanding.

You might also have discussed how the term mental distress is increasingly favoured to emphasise each person's unique lived experience and to recognise the person that exists prior to any diagnostic category (NSUN 2015). Finally, in considering the term madness you may have discussed how it has been used to stigmatise, discriminate against and exclude those who use mental health services. However, you may also have identified that there have been attempts to reclaim the term by service user/survivor movements such as Mad Pride (Curtis *et al.* 2000). Similarly, while identifying the need to be cautious about using the term madness in the context of your practice because of its past pejorative connotations, you may have discussed how it is increasingly being used in some areas, such as **Mad Studies**, to challenge the theoretical and clinical assumptions associated with psychiatry (LeFrançois *et al.* 2013).

FURTHER READING

- **Cromby J, Harper D & Reavey P** (eds) (2013) *Psychology, Mental Health and Distress*. Basingstoke: Palgrave Macmillan.

This book provides a stimulating and sustained critical engagement with a range of critical questions, debates and disputes in contemporary mental health care, and does so in the context of various forms of mental distress.

- **Hall W** (ed) *Outside Mental Health: Voices and Visions of Madness*. Northampton, MA: Madness Radio.

A highly accessible collection of interviews and essays that cover a diverse range of critical issues about existing approaches to mental distress, with contributions from service users/survivors, mental health practitioners and academics.

- **Paul R & Elder L** (2014) *Critical Thinking: Tools for Taking Charge of Your Professional and Personal Life*, 2nd edition. New Jersey: Pearson Education.

This is an accessible work that discusses critical thinking in a personal and professional context as well as providing a sustained exploration of egocentrism and the range of emotional qualities that are associated with critical thinking.

- **Rapley M, Moncrieff J & Dillon J** (eds) (2011) *De-Medicalising Misery: Psychiatry, Psychology and the Human Condition*. Basingstoke: Palgrave Macmillan.

A thought-provoking book that provides various critiques of the theoretical and therapeutic features of contemporary mental health care conducted by those who work within, and those who have experience of using, mental health services.

USEFUL WEBSITES

- www.criticalpsychiatry.co.uk

Here you will find the website for the Critical Psychiatry Network, which provides a range of resources and articles that are concerned with questioning, challenging and seeking to change existing approaches to mental distress.

- www.criticalthinking.org

This is the website for the Centre for Critical Thinking, which provides a variety of resources about critical thinking, including how its development can be facilitated in educational settings and throughout society.

- www.madinamerica.com

Here you will find the website for Mad in America which provides information and education that seeks to challenge and explore alternatives to the dominance of drug-based approaches to mental distress in America and around the world.

- www.nationalelfservice.net/mental-health/

This is the website for The Mental Elf, which seeks to make evidence-based research in mental health care readily available to health and social care professionals and does so by providing short, accessible summaries of this research.