

Trust and confidence: Making the moral case for social work

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Abstract: *Social work is often seen as a technical activity based on systems of specialist knowledge and evidence of 'what works', particular role expectations, regulatory frameworks and law. Although systems have no moral agency, individual encounters between social workers and service users are morally charged insofar as they impact directly on service users' wellbeing. This paper argues that the 'modernisation' agenda in social care privileges confidence in systems over trust in moral agents. Relying on confidence neglects the role of trust and moral competence in human affairs and has significant consequences for service users and the nature of social work.*

Key words: *trust, moral motivation, confidence, regulation, uncertainty*

The moral nature of social work

My discussion is based on the premise that social work, and more broadly social care, are morally charged activities insofar as they are centrally concerned with the personal and social wellbeing of service users. I am not concerned here with contested issues regarding the relationship between an occupational group's core purpose, its ethical code and its professional 'status' (see Banks 2004, Chapter 2, for a helpful discussion of these issues). However, I am concerned with differentiating social workers from other occupational groups on the basis of their motivation and the consequences of their interventions.

Social work intervention has a direct impact on the lives of people who are vulnerable and who need help for various reasons. Motivation that guides a worker towards morally good outcomes is necessary under conditions where much of what goes on between social workers and service users is hidden from direct surveillance and is free from immediate external control. This is also the case where such interaction is characterised, in at least some important respects, by ambiguity and uncertainty (Parton, 1998; White 1997; Stancombe and White, 1998). Similarly,

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the consequences of social work intervention are morally loaded insofar as they can directly benefit or harm the wellbeing of service users in a whole range of ways. Other occupational groups, for example plumbers, electricians, architects, bank employees are not *centrally* concerned with the moral wellbeing of their clients, although intentional malpractice, a lack of care or negligence may have *secondary* consequences in terms of clients' self-esteem, independence, and emotional, social and physical wellbeing.

In emphasising *moral* motivation and consequences, it is not my intention to minimise the importance of systems such as technical knowledge, role expectations, regulations, procedures and law, as all contribute to the relationship between intervention and outcomes that enhances service users' wellbeing. However, as Giddens (1990) points out, moral considerations are extrinsic to abstract systems. In modernity, such structured ways of knowing, thinking and acting are 'disembedded' from local contexts and personal relations, hence their durability across time and space. Importantly, systems cannot act and have no moral agency. Systems are designed to be functional and to achieve identified ends - their *internal* effectiveness depends neither on the moral motivation of those who operate them, nor on the moral nature of their outcomes. Of course, moral agents may misuse systems or neglect system imperatives but these 'faults' cannot be attributed to the system. If a system fails to produce the ends for which it is designed, it can be modified or extended to achieve greater effectiveness. This may happen, for example, through the development of more reliable knowledge to guide intervention, the introduction of procedural detail to direct action, the elaboration of rules to cover newly identified contingencies and the extension of law to incorporate moral rights into a legal framework (Smith, 2002). While systems that inform or govern social work intervention are devoid of moral qualities, the engagement between social workers and service users that encourages emotional openness, invites trust, identifies need and provides help and reassurance, is shot through with moral possibilities.

It is my contention that New Labour's 'modernisation' policy in health (see Harrison and Smith, 2003; 2004) and social care (Smith 2001) has privileged the development of systems for providing safe, reliable, standardised services and predictable outcomes. This approach to service provision neglects issues associated with moral motivation and moral consequences which are central to service users' experience of intervention and the expression of care. A reliance on system effectiveness readily accommodates the identification of performance indicators, the measurement of performance against targets, audit and inspection arrangements and a range of prescriptive guidance about 'what works', based on a particular epistemological understanding of 'scientific evidence'. Systems aim to introduce certainty and predictability into the management of human affairs and are designed to circumvent or overcome uncertainty and ambiguity. Hence the establishment of new institutions in the form of the Social Care Institute for Excellence, the Commission for Social Care Inspection (which will assume the National Care Standards Commission's

regulatory and enforcement functions) and the General Social Care Councils. Between them, they will instruct, inspect, monitor and regulate the social care workforce and its activities. Additionally, systems have been introduced to measure performance against targets, including National Standards, annually published Social Services Performance Framework Indicators and summary star ratings that identify the best and worst performers.

Social workers are familiar with the legal framework that allows or requires intervention under prescribed circumstances and procedures that govern child protection (Department of Health, 1999). However, their work with service users has become increasingly regulated through official instructions about what they should do, what information they should collect, how information should be recorded, what targets they should achieve and what time-scales they should meet (see for example, Department of Health, 1995; 2000; 2001). The drive towards greater transparency, accountability and cost-effectiveness in public services, which reflect some characteristics of new public management (Pollitt, 1990), began to gather momentum in the 1980s. Under New Labour, however, it has assumed a focused momentum and a policy identity through the Government's 'determination' to modernise health and social care (Department of Health 1998; para. 5). These developments have led some commentators to refer (somewhat loosely) to the 'bureaucratisation' of health and social care (Howe 1992; 1994; Blaugh 1995; Clarke 1996; Salter 2001). Here, they follow Max Weber's (1947; 1970) characterisation of bureaucracy as incorporating hierarchically organised roles, disciplined and impartial application of rules and the focus of formal rationality on quantitative calculation and accounting. Modernisation is designed to establish confidence that major decisions affecting human wellbeing can be 'deliberate, systematic, calculable, impersonal, instrumental, exact, quantitative, rule-governed, predictable, methodical, sober, scrupulous, efficacious, intelligible and consistent' (Brubaker, 1984, p.2).

Morality and the role of trust

Moral motivation and moral consequences necessarily escape the capacity of abstract systems to identify their content, to require their performance or to calculate their effectiveness (see below for a consideration of ethical codes in this context). While confidence characterises our attitude to abstract systems, trust characterises our attitude to social exchanges that rely on moral motivation and that have moral consequences. This requires an explanation of the conditions under which trust becomes a relevant concern and which enable it to flourish. Hollis (1998, p.1) says of trust that 'although trust is an obvious fact of life, it is an exasperating one. Like the flight of the bumblebee or a cure for hiccoughs, it works in practice but not in theory'. In other words, we have an unproblematic (unreflective) grasp of

trust as it influences our everyday decisions and relationships, although it becomes more problematic to define the difference between trust and related attitudes such as hope, belief, confidence and faith. However, an investigation of trust indicates coherent features, which enable an understanding of the nature of trust and its role in mediating social affairs.

First, It is generally agreed that trust becomes relevant when social interaction is based on uncertain knowledge about the likely action of another and one depends on their response for a beneficial outcome. This generates a 'moral hazard' that untrustworthy agents will act in such a way as to harm rather than to benefit a trusting counterpart (Coleman, 1990; Lyons and Mehta, 1996; Williamson, 1993). Debates about trust frequently refer to Gambetta's (1988, p.218) view that, in spite of complex definitional debates, we may identify convergence on a central characteristic of trust. This indicates that 'the condition of ignorance or uncertainty about other people's behaviour is central to the notion of trust' such that an attitude of trust or distrust arises from an assessment about the likely consequences of engaging with others. Insofar as responses to our engagement become calculable or amenable to probabilistic outcomes (risk analysis) or are governed by abstract systems (regulatory frameworks, knowledge claims, role expectations and law), we come to depend less on trust and more on confidence in functioning systems. Arrangements for accounting, audit and ensuring compliance reduce uncertainty and increase predictability. System effectiveness makes trust at best invisible and at worst redundant (Rose 1993; Power 1994a, 1994b; Parton 1998). Fukuyama (1995, p.27) suggests that people who do not trust each other can only co-operate 'under a system of formal rules and regulations, which have to be negotiated, agreed to, litigated and enforced, sometimes by coercive means' and which serve as a '*substitute for trust*'.

Second, because trust operates outside formal regulatory frameworks, it must depend upon moral motivation. Thus, Baier suggests we cannot single-handedly safeguard things that are valuable to us, such as our health, emotional wellbeing, reputation, our dependants' welfare and our significant relationships. We therefore require help from others and in enlisting their help we make ourselves vulnerable to their opportunistic or careless behaviour in relation to the things we value. Thus, trusting constitutes a 'reliance on others' competence and willingness to look after, rather than harm, things one cares about which are entrusted to their care' (Baier 1986, p.259). Trusting also allows others to use their discretion to respond beneficially to our expectations and to care adequately for things we entrust to them. Jones develops Baier's account by arguing that trusting behaviour requires:

An attitude of optimism that the goodwill and competence of another will extend to cover the domain of our interaction with her, together with the expectation that the one trusted will be directly and favourably moved by the thought that we are counting on her (1996, p.4).

Importantly, Jones emphasises ‘moral competence’ as opposed to technical competence, where to trust anticipates kindness, care, generosity, compassion and sensitivity on the part of another. Optimism relates specifically to another’s actions and depends on ‘an affectively loaded way of seeing the one trusted’. Govier takes a similar view, suggesting that trusting incorporates an expectation of a beneficial or neutral response even though it gives another the power to do us harm. In trusting another ‘we confidently expect that he or she will do what is right for us - being competent to do so and being motivated in the right way’ (1993, p.157). These accounts emphasise affective and moral attitudes between those who act on trust and those who respond in a trustworthy way. This translates into a moral concern about the wellbeing of another and a morally motivated response to their trusting behaviour.

Although empirical research is limited, studies identify such variables as perceived openness, competence, fairness and care or altruism as influencing trusting attitudes to institutions/organisations (Petts, 1998; Johnson, 1999). Mechanic and Meyer’s (2000) research with patients having ongoing treatment or health monitoring, reports that they articulated trust in terms of ‘honesty, openness, responsiveness, having one’s best interests at heart, and willingness to be vulnerable without fear of being harmed’. They refer to Thom and Campbell’s (1997) study where participants identified the kind of physician behaviour that promoted trust. Of seven categories, five included interpersonal behaviour expressed as ‘understanding patients’ individual experiences, caring, communicating clearly and completely, building partnerships and honesty with respect for the patient’. Such studies suggest that when people reflect on trust, they tend to identify qualitative interpersonal factors that point to the importance of moral and affective concerns. There is also evidence that social care users value attributes in social workers such as openness, warmth, honesty, sensitivity and a willingness and ability to offer caring relationships (Maluccio, 1981; Thoburn et al, 1995; Bleach and Ryan, 1995; Smith et al, 1995; White, 1998).

Third, trust involves personal responsibility for making decisions under conditions of uncertainty. Luhmann (1988) reflects this situation when he argues that ‘internal attribution’ is the response to trusting outcomes. When systems go wrong - the operation of law, the organisation of public transport, the delivery of social and health care - we can blame *external* others and events. However, when we decide that trust is warranted there is nobody but ourselves to blame if others let us down. This is why a violation of trust is thought to engender feelings of betrayal. That is, the trusting agent who is disappointed does not simply feel annoyed or irritated by untrustworthy behaviour. The elements of personal judgement, vulnerability and dependence on another’s actions, which are built into trust, indicate its moral nature and suggest that a sense of betrayal is appropriate to disappointed expectations. This is even more understandable if one relies on another’s goodwill and ‘moral competence’ in trusting relations.

Fourth, expressions of confident or trusting attitudes tend to depend on distinctive

sources of information and to reflect different assessments. Deciding on confidence relies on evidence that systems are well designed for their purpose, that they cover known eventualities, that they incorporate operational checks and that their outcomes are monitored and evaluated against their purpose. Deciding on trust, however, is a much more uncertain business. We tend to look for affective clues about potential trustworthiness including gestures, 'body language', facial expression, tone of voice and all those qualitative features of interaction that provide a sense of someone's interest in us and concern about our wellbeing. Sometimes, there is little more to go on than 'gut feeling'. Experience suggests that these distinctions are made in everyday life. For example, the system that ensures doctors or social workers are competent to practise (a regulated and quality assured programme of training, registration and periodic re-registration with a regulating body and arrangements for disciplinary action and de-registration) may promote confidence. However, confidence in a practitioner's technical competence may be accompanied by a lack of trust in their moral competence, that is in their willingness and ability to practise with care, sensitivity, honesty and attentiveness to our particular needs.

Trust and confidence: Distinctions and paradigms

Some commentators have begun to recognise a distinction between trust and confidence, although this tends to be underdeveloped. For example, Lyons and Mehta (1996) suggest that technical and managerial abilities of trading partners do not constitute the 'moral hazards' of economic engagement. It is the behaviour (including motivation) of trading partners that must be factored into the equation of net gains resulting from a transaction. They therefore distinguish between 'having *confidence* in the *abilities* of a partner and having *trust* in their *behaviour*' [original emphasis]. Luhmann (1988) argues that trust depends on action, which is chosen in the knowledge that a trusting agent must accept responsibility for disappointment. Confidence refers to living with everyday dangers, where individuals routinely 'bracket' life's contingencies so that they can go about their business without a permanent sense of uncertainty. Here, confidence must rely on 'expert knowledge' and social systems that control, predict or keep contingent events at bay. Tonkiss and Passey (1999) distinguish between social exchanges that depend on trust and moral commitment and those that require confidence in 'contract or other regulatory forms' to secure co-operation.

Distinguishing trust and confidence enables us to make sense of situations where we are unwilling to trust someone with apparently impeccable credentials. It points to an assessment that while someone is perfectly capable of doing a competent job, they may not be motivated to do it with care. They may instead be motivated by morally bad intentions or they may simply be careless about looking after things

that we value. This distinction also explains the contradiction to which O'Neill refers (2002, p.11) when noting the apparent decline of trust:

In short, reported public trust in science and even in medicine has faltered *despite* successes, *despite* increased efforts to respect persons and their rights, *despite* stronger regulation to protect the environment and *despite* the fact that environmental concerns are taken far more seriously than they were a few years ago. [Original emphasis]

O'Neill's comments are unsurprising if we understand these developments as designed to improve confidence rather than trust. It seems to me that two paradigms are in order here – one (trust) that centralises uncertainty, motivation and moral agency and the other (confidence) that refers to predictability (risk), instrumentality and performance.

Improving the visibility of trust

I have argued that modernisation imperatives in health and social care emphasise the central role of systems for ensuring the competent performance of organisations and practitioners. This promotes confidence. However, the moral nature of providing care, the significance of motivation and uncertainty and the reported perceptions of service users suggest that confidence is necessary, but not sufficient, to meet service users' needs. Additionally, trusting relationships may benefit service users and constitute a moral good irrespective of any demonstrable association between intervention and outcomes. 'What works' does not necessarily constitute everything that service users and practitioners need and value. Encouraging the role of trust in social affairs requires action on several fronts.

First, Government must recognise that it cannot cure all the problems in the delivery of social care through policy imperatives that privilege confidence over trust. Policy must be designed to promote an organisational and professional culture where trust can flourish

Second, recruitment to programmes of social work education and training should not ignore or devalue candidates' moral capacities. For example, Fox (1995, p.112) points to the kind of instrumental expectations that influence the recruitment of nursing candidates:

When a candidate at interview is asked why she chose nursing, the correct answer is no longer 'I want to help people'. If that is what she actually feels it would be more prudent to talk about social obligations, nursing being a profession that involved relating to others, career mobility, academic and emotional gratification . . . A nurse no longer has a vocation: she has a profession. She is no longer dedicated; she is a professional. She is no longer moral; she is accountable.

Third, teaching and learning about social work must include attention to trust and its moral implications and this should be part of practitioners' ongoing development. It might be argued that this area is already covered by Department of Health/GSCC and subject benchmark requirements for learning outcomes in ethics, the BASW (2002) Code of Ethics and the GSCC (2002) Codes of Practice. However, apart from observations that codes cannot include all contingencies, that they absolve individuals from personal responsibility and that they stunt moral reflection and development (see for example: Dawson, 1994; Bauman, 1993, 1995; Banks, 2004, Ch. 4), I think they are properly understood as supporting confidence rather than trust. Insofar as codes of ethics, particularly when they are transmuted into codes of practice or conduct, identify rules or ethical principles for guiding action, they do not refer to the kinds of motivation, uncertainty and moral capacity that characterise trust. Indeed, they are singularly unconcerned about motivation and they seek to achieve certainty in interpersonal encounters. Blum (1991) also argues that ethical principles are ineffective without reference to prior questions. These concern how individuals perceive the morally salient features of a situation, how they recognise the moral actions that such features require of them and how they understand the relevance of moral principles (ethical codes) in guiding their responses. Furthermore, principles or rules governing ethical conduct exclude the significance of morally good qualities such as compassion, respect, kindness and sensitivity, which are valued by those who need health and social care.

There is a fourth reason why social work students, practitioners and employers should concern themselves with the relationship between moral motivation and trust, rather than concentrating only on adherence to codes of ethics and conduct. Stone (2002, p.63) suggests that 'ethics, one might say, is what practitioners do when no one else is looking'. On the contrary, it seems more likely that ethics is what practitioners do when everyone else is looking. This mode of surveillance may be likened to the Panopticon - 'permanent in its effects, even if it is discontinuous in its action' (Foucault 1977, p.201). Codes of ethics and conduct provide the standards against which practice may be found wanting and constitute the basis for complaints, disciplinary action and possible litigation. Moral motivation and trust, by their very nature, cannot be codified or regulated but are centrally implicated in the wellbeing of service users.

Finally, as Mechanic and Meyer (2000) note, it is possible to teach and learn about qualities, such as sensitive listening, responsiveness and a demeanour that conveys care and understanding, which are fundamental to acting on trust.

Conclusion: Giving trust a necessary role

I am often asked to elaborate on the disadvantages of ‘returning’ to a dependence on trust, rather than continuing to improve confidence in the delivery of health and social care. Critics of trust argue that modernisation imperatives are, after all, designed to improve on a well-known history of poor performance, scandals, ‘adverse events’, delay and organisational malaise, which are damaging for service users. This, however, is not the appropriate question. Trust and confidence refer to distinctive aspects of experience and service provision. They represent two paradigms, which by their nature are incommensurable. Service users appreciate having confidence in reliable service delivery, in systems that ensure safe and effective care and in the technical competence of a regulated and accountable workforce. However, service users also value practitioners who can be trusted to respect them and to respond morally well to their vulnerability and who will be motivated to work with care, sensitivity and kindness. Both trust and confidence are necessary to recognise and respond to the needs of service users for effective performance and for moral competence. The danger to our willingness and ability to achieve morally competent social work practice lies in either thinking that measures to improve confidence will also support trust or in concluding that trust has no role to play at all.

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