



Shared Decision Making in Mental Health Practice

Anne Felton & Gemma Stacey

(Theo Stickley, Bob Diamond, Bev Johnson, Alastair Morgan, Phil Houghton, Martin Willis, John Dumenya, James Shutt: Members of the Values Based Practice Managed Innovation Network)

What is Values Based Practice?



- “Values based practice is the theory and skills base for effective health care decision making where different (and hence potentially conflicting) values are in play.”
- Advocates a democratic decision making process whereby the service users views are central to the outcome.

(Woodbridge & Fullford 2005)

Shared Decision Making



SDM is defined as a “...process by which clinicians and patients work together to clarify treatment, management or self-management, support goals ...with the aim of reaching mutual agreement on the best course of action”

(Coulter and Collins 2011:2)

Our Critique



- Does not account for hierarchy, power or perceived accountability.
- Remains uncritical of the structural and cultural constraints which might influence the decision making process.
- (Houghton & Diamond 2010)

Theories of Power



- Marx - ideologies function by covering up essential inequalities of power, through the creation of necessary illusions, that enable the system to function as though it were democratic (Eagleton, 1991).
- Discourses provide and constrain subject positions, which locate people within the discourse which affects which social actions are possible (Davies & Harré, 1990). Particular subject positions allow the speaker the “right to be taken seriously or to be granted superiority” (Gergen, 1989, p. 74).
- The subject position gives the speaker a ‘warranting voice’: the right to say certain things because they either have specialist knowledge or are granted particular powers.

Research Aim



To explore professionals, service users and carer's views and experiences of the process of multi-disciplinary decision making in mental health care.



Objectives



- To investigate the levels of inclusion of the various parties involved within the decision making process
- To explore the extent to which participants feel their views are listened to, considered and contributed to the final outcome.
- Consider future developments to promote real inclusion based on respect, dignity and equality

Method



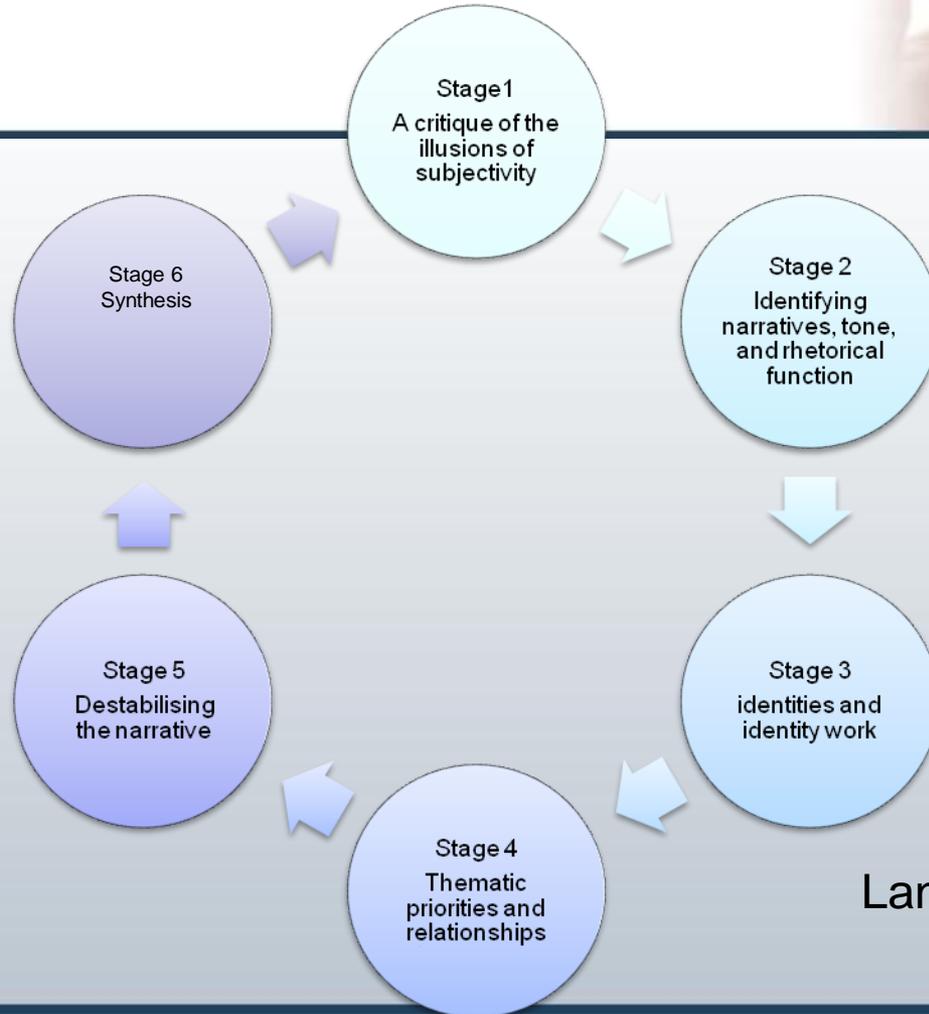
- Ethical approval granted by NRES and Nottinghamshire Healthcare Trust
- Focus groups conducted with service users, carers, mental health nurses, social workers, occupational therapists, peer support workers and psychiatrists (n = 42).
- Facilitated by two members of the VBP MIN who adopted a non-directive, semi-structured approach.
- A small number of pre-devised general open-ended prompts were used to guide the focus group session, address the research problem and ensure comparability between sessions.

The Question of Analysis ?????



- A commitment to a collaborative process whereby people with varied experience of qualitative research could contribute
- A desire to explore issues of power, hierarchy and influence
- A loyalty to ensure findings were relevant and meaningful to practice development

Critical Narrative Analysis



Langdridge 2007

Findings – CNA



- A worked example – Social workers
- Stage 2 – narratives, tone and rhetorical function
- *“When I go on a ward round, there’s no, an agenda isn’t discussed, I’m not asked what’s on my agenda, no one tells me what’s on their agenda. Things come up and at the end, you can be trying to get a word in edgeways, what I’m trying to bring to the meeting and talk about and get a decision on, and they’re throwing me out the door. [laughs] Because it wasn’t on their agenda, so, it’s just a completely different world”.*

Findings – CNA



- A worked example – Social workers
- Stage 3 – Identities and Identity Work
- *“you may be a social worker but you have to be aware of medication issues, you have to be aware of the medical side and that some of the comments you’re making are valid on those, because that is your role as a care co-ordinator, you’re looking at the whole person, not just their social world. And I think, sometimes, in a hospital setting, they’re used to a much more defined dominion. [agreement] And so maybe that’s why people don’t necessarily hear what you’re saying”.*

Findings – CNA



- A worked example – Social workers
- Stage 4 – Thematic Priorities and Relationships
 - Knowledge and experience
 - Relationships
 - “It’s also, being known, being around for a while, or making the alliances and the networks that you need to actually strategically get your way, basically”.*
 - Structural barriers

Group	Summary of how groups positioned themselves within shared decision making	Who knows best for the service user? (the warranting voice)	Impact of power on narratives (destabilisation)
Service Users	Coerced but at times need to be 'looked after'	Sometimes it is us , sometimes we don't know what is best	Might be times that decisions need to be made for service users.
Carers	Felt no place in decision making Professionals/systems purposefully excluding	We would know best because we are closest to the person	There is a conflict between parental role and autonomy of service user.
Peer Support	No voice in decision making Tension no right/power to be part of decision Shared helplessness	Claim for particular knowledge based on our expertise by experience. The service user themselves knows best, we don't have a right to make decisions for them.	They are positioned within a network of power but disclaiming any rights to contribute they will never have influence. However, they are at the bottom of the professional power hierarchy.
Social Workers	AMP provides vehicle for being respected in shared decisions Not part of the ward process coming from outside	Law and experience legitimises our role in decision making	Distancing themselves from ward environment enables disclaiming of responsibility
Psychiatrists	Expected to make decisions Held accountability & responsibility	We know best due to our role, status education and expectations. We feel that they were the leaders for better or worse.	Paternalistic tone represents position of power
Nurses	Enforcers of decisions Functionary, Facilitator, Collective voice	We spend more time with service users than anybody else.	Collective pronoun function to distance responsibility
Occupational Therapists	Aligned with service user limits power in decisions Clear about expertise but outnumbered and side-lined Built alliances to promote influence	We know best how to assess people and help them recover.	Imply no power as aligned to service users but this disclaims responsibility

Key Findings



- The goal of shared decision making in acute settings is a long way from being met. All focus groups felt that decisions were not shared and that the voice of the service user was marginalised.
- The ward round is the main forum for SDM in inpatient settings and it is not fit for purpose.
- The discourse of VBP and SDM need to take account of how differentials of power, interests and the positioning of speakers affect the context in which decisions take place.

What Next?



- Conducting literature review on alternative approaches to ward round
- Attending practice development forums to disseminate findings and work alongside change agents
- Scoping workshops to generate ideas for decision making structures
- Conduct small scale pilot study incorporating alternative approaches to decision making
- Collaborating with Values Based Practice developments nationally

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