Mental Health Practice

Informed, Involved and Influential: The 3 I's model of Shared Decision Making in Mental Health Care

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Corresponding Author:	Gemma Stacey, MN,RMN,PhD University of Nottingham, School of Health Sciences Derby, UNITED KINGDOM
Other Authors:	Anne Felton
	Philip Houghton
	Ada Hui
	Alastair Morgan
	James Shutt
	Bob Diamond
	Martin Willis
	Theo Stickley
Abstract:	Collaboration between service users and mental health professionals is at the heart of values based practice and shared decision making. However, there has been limited analysis of the implications of these approaches within a healthcare context that involves depriving service users of their freedom. This article proposes a framework that aims to promote shared decision making which acknowledges, all participants must be Informed, Involved and Influential in the decision-making process. However, these are fluid; they refer to a sliding scale of influence that moves between these different positions depending on context, capacity and desire to influence.
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Abstract

Collaboration between service users and mental health professionals is at the heart of values based practice and shared decision making. However, there has been limited analysis of the implications of these approaches within a healthcare context that involves depriving service users of their freedom. This article proposes a framework that aims to promote shared decision making which acknowledges, all participants must be Informed, Involved and Influential in the decision-making process. However, these are fluid; they refer to a sliding scale of influence that moves between these different positions depending on context, capacity and desire to influence.

Introduction

The service user movement and consumerist models of healthcare have significantly changed the perception of the role of the 'patient' in their own care. This shift has culminated in a policy framework that seeks to enshrine patients' choices at the heart of healthcare (Department of Health 2012). Indeed the guiding principles of the Mental Health Act 1983: Code of Practice (Department of Health 2015) states that 'patients should be fully involved in decisions about care, support and treatment', and that the 'views of families, carers and others, should be fully considered when taking decisions' (p 22). Values Based Practice recognises that decisions taken in mental health care are based on personal and professional values as well as the research evidence (Woodbridge and Fulford 2005). Decision-making therefore involves incorporating the differing, and sometimes conflicting, values of those involved in planning and delivering services, service users and carers (Cleary, 2003). However, these agendas are limited by a lack of recognition of the implications of power implicit within the mental health system. Therefore despite the rhetoric surrounding shared decision making within a mental health setting, service users remain on the periphery of decision making processes.

This paper summarises the findings of a research study which explicitly focused on the barriers to shared decision making which central to in-patient mental health settings. These challenges specifically relate to the impact of compulsory treatment and heightened levels of psychological distress which influence relationships and hierarchies in the decision making process.   The discussion offers an alternative framework to promote shared decision making whilst acknowledging that these constraints present very real and active barriers.

Background

The role of mental health services in containing and controlling service users is endorsed by legislation (Szmukler and Holloway 2001). This function of mental health services questions the values on which shared decision making is based. It is apparent that an individual's liberty is frequently affected by using mental health services, not only in the sense of being held in hospital and potentially treated against their will but also in the experience of coercion. Service users have consistently described how, for example, being admitted to hospital is not perceived as a voluntary decision, even when legally it is (Laurence 2003; Vassilev and Pilgrim 2007; Katsakou, Bowers, Amos et al 2010). This means that professionals have the power to override a person's preferences and people with mental health problems are using services with this awareness. It would be naïve to assume that such a gulf in power would not impact on the dynamic of negotiation and mutual agreement at the heart of shared decisions. Much of the literature discussing shared decision making and mental health lacks an analysis of this influence (Houghton & Diamond 2010).

Yet shared decision making is an approach within mental health practice that can promote recovery. It involves valuing and responding to an individuals' values, social context and preferences recognising their expertise which promotes person centred care. This is in line with established models of participation (eg Arnstein 1969) which promote the premise that those who are most effected by the outcome of a decision should be most influential in the decision making process. Caution needs to be exercised in adopting an uncritical acceptance of shared decision making. Therefore, an awareness of the complexities in implementing it within mental health settings is an important step towards enabling more equal power relationships in making shared decisions.

The Research Study

A research study was conducted exploring the concept of shared decision making (SDM) in mental health acute in-patient settings. This was achieved through the facilitation of focus groups with service users, carers, OTs, social workers, peer support workers, psychiatrists and nurses (n=48). The focus groups aimed to gain insight into the experiences of each party within the decision making process, including the degree to which they felt involved in the process and influential in the outcome. Groups were made up of people with the same professional or personal background. The data arising from the focus groups was analysed using critical narrative analysis (Landridge 2007). This framework facilitates an analytical process which focuses on issues of power and how people position themselves within decision making. Interpretation of the data highlighted the following key themes from each group of participants of decision making.

Summary of findings

Service Users- were highly critical of their lack of involvement in decision making forums. They discussed the changing level of inclusion that they preferred at different phases of their contact with mental health services. They also recognised the need to appear to conform to the outcomes of decisions that they did not agree with, in order to achieve the end result they desired.

Carers positioned themselves as outside of the decision making process and felt that their knowledge of their family member was often disregarded. Professional standards or structures, such as confidentiality, were seen to be used by professionals to exclude them from decision making forums and from being informed about the outcome of those decisions.

Occupational Therapists strongly aligned themselves with the service user which they felt gave other professionals the permission to side line them and reduce their level of influence within the decision making process. Whilst they were clear about their unique area of expertise being focused on occupational assessment and promoting recovery, they did not feel this was valued by others.

Social Workers viewed their role as Approved Mental Health Practitioners as giving them a legitimised and outwardly respected position within the decision making processes. In routine decision making within the ward setting, they viewed themselves as outsiders who were, at best, informed about the outcomes of decision but were rarely consulted in the process.

Peer Support Workers described having no voice within decision making forums and dealing with the often conflicting role of being employed by the organisation whilst also attempting to advocate for service users. They were clear that their expertise lies with sharing the experience of mental distress. However, they did not feel that the structures were in place to utilise or respect this within the decision making process.

Psychiatrists positioned themselves as attempting to involve other professionals in the decision making process, but were continuously relied upon to make the definitive decision. They recognised that their education and social position influenced this and acknowledged that their salary was often regarded as the justification by other professional for their lack of willingness to take responsibility for the outcome of decisions.

Nurses viewed themselves as the enforcers of the decisions which were made by other professional groups, most significantly psychiatrists. They reiterated the expertise they held as a result of being the professional group who spent the most time with the service user. They also discussed their lack

of willingness to make decisions which were perceived to be the responsibility of the psychiatrists, due to the level of accountability they associated with the psychiatrists' role.

There was recognition amongst all parties that the system does not facilitate decision making that is genuinely shared. Each group has their own respective values but they each position themselves as being relatively powerless in changing the system to make shared decision making authentic. It was evident that very real power hierarchies exist and have significant effects on people within the organisational structure. The "No decision about me without me" framework (DH, 2012) requires the acknowledgement of power when service users are not involved in shared decision making and a fair rationale given. The question remains, however, how forces of power can be made explicit? In this study, none of the groups were able to offer an alternative model that would underpin shared decision making. This suggests that the current structures may blind those participating within them to see new ways of working.

An Alternative Model for Shared Decision Making

In light of these findings we would like to consider what a shared decision making model might need to look like if it were able to acknowledge hierarchies and the effects of power in order to promote a radical level of transparency within the decision making process. Whilst it is important for professional groups to maintain their professional identities in healthcare settings, they might also need to consider the importance of talking about these identities within multidisciplinary groups and acknowledge uncertainties of role and identity when the power to decide is shared amongst professional groups, service users and carers.

It is suggested that the concept of shared decision making should be broken down into its component parts. Borrowing a phrase from communication theory, we need to specify the "core conditions" for a shared decision to take place (Rogers 1957). We suggest that in order for this, to occur, all participants must be Informed, Involved and Influential (the three I's) in the decision-making process (See Figure 1.0). However, the three "I"s of shared decision making are fluid, they refer to a sliding scale of influence that moves between these different positions depending on context, capacity and desire to influence. This model draws upon established theories of participation which recognises how the distribution of power results in a ladder of participation ranging from non-participation, which is viewed as manipulation, to involvement which can encompass consultancy but is also regarded as tokenism. Full participation is achieved when a partnership is genuinely present and results in shared power (Arnstein 1969)

Informed

Informed refers to the practice of ensuring that service users, carers and professionals know what is available for consideration. This does not mean that the professional is viewed as holding the knowledge of all options but rather that all have valid information to bring to the decision making process. Therefore this is different to a service user just being told the outcome of a decision. The person who is experiencing a mental health problem will have insight into the distress that this may bring, the impact on their identity, relationships and the way other people view them. They have insight into the stigma that is associated with their condition and what it feels like to live with their specific diagnosis. Much of this expertise will be lacking within the healthcare professional, unless they have their own experience of mental distress. Healthcare professionals will also have expertise that may not be available to the service user which would include understanding different treatment options, services and resources available, insight into the structure and organisational culture of health services. Being informed entails genuinely valuing the significance of all information and having an understanding of the rationale for the final outcome. These principles are in line with those promoted when gaining informed consent.

Involved

Being involved entails being willing to adapt outcomes in light of sharing information. All parties are therefore responding to the expertise of others in order to reach a decision. Traditionally involvement has entailed service users and carers being consulted on their views. Research shows that this does not translate into power sharing within decision making and the professionals' views often prevail (Schauer, Everett, del Vecchio, Hamann, Mendel, Buhner et al 2011).

Recovery and shared decision making values the expertise of service users and carers (Deegan and Drake 2006). This is grounded within notions of the person as an active participant in their own care. The problem with traditional views on involvement is that power remains with professionals regarding when and how service users are involved. This might be valid in some situations where people feel unable to take control in decision making. However, decision making capabilities can be fluid. Too often the assumption that a person is permanently irrational, incompetent and therefore cannot be trusted act as barriers to people being involved in decision making (Olsen 2003). Health care professionals can question the abilities of service users to be involved in decision making highlighting issues such as cognitive abilities, insight and paranoia as barriers to service users being able to communicate their views to providers (Chong et al 2013). Yet studies have shown that people with serious mental health problems want to and feel able to be involved in decision making (Mathias et al 2012).

An alternative conceptualisation of involvement would be one that offers the option to consider how service users involve professionals rather than the default position of the other way around. A good example of this might be direct payments, based on assessment of needs but choice about who provides the services required to meet these needs. This acknowledges that in the majority of situations that a person is capable and in a position to make their own decisions. In the context of decision making forums this would involve the service user setting the agenda, deciding whose expertise they wish to consult and, where it is preferred, having a sense of collaboration within the decision making process.

From the perspective of professional groups, involved refers to the opportunity to contribute their viewpoint and to feel that they are included within the collaborative process. It requires those who hold an alternative view to feel confident to offer their perspective and encourage those who perceive themselves on the outside of decision making to come in. This would involve those viewed as in control of the outcome of decisions, seeking and being open to the views of others.

Influential

Being influential in decision making entails listening to other people's views, giving these consideration but also having the right to follow a particular option respected even when it is not in-line with the majority view. Influence provides a challenge to both involvement and shared decision making rhetoric. For service users to have influence this means them genuinely holding power and accountability for decisions. This position may present a challenge for healthcare professionals to have the conviction to support a person's choices, particularly if these options are perceived as risky or a 'bad choice'.

An emphasis on risk within mental health services in many respects undermines the notion of individual choice. Service users are presented as needing protection from succumbing to their 'irrational urges' constructed as a threat to the public (Adams and Drake 2006) yet without the label of mental illness we have greater autonomy to make choices including bad ones. The reality of compulsory care restricts opportunities for service users to exert full influence in decision making. As the findings of our study suggest there may be times when service users perceive this as the preferred option due to the acknowledgment of how their distress may impact on their perception. In these circumstances service users should feel confident that their opinions are respected and they remain informed and involved where ever possible which could be archived through the involvement of an advocate. The service users participants in our study articulated this and

identified this meant that compulsory treatment was carried out in a compassionate and ethical manner.

In the study, psychiatrists viewed themselves and were viewed by other professional groups as the most influential. However, working within the 3Is model supports the notion that all parties contributing to the decision making process can and should be influential. This does not necessarily mean there is equality of power in the process. Where there is dissensus (Fulford 1998) being influential would mean that all have had the opportunity to impact on the decision outcome. The person(s) who decides the outcome should be defined by their relationship with the service user as opposed to their position within the hierarchy. The proceeding phases of the 3 I's model (informed & involved) suggest that the service user is best placed to decide who this is in situations when this isn't them.

Implementing the Code of Practice through the 3Is

It is proposed that the 3Is model may go some way towards supporting the implementation of the recently revised Mental Health Act 1983: Code of Practice (Department of Health, 2015). In particular, the Code of Practice advocates that 'patients should be engaged in the processes of reaching decisions which affect their care and treatment' and that 'carers, [nearest relatives and advocates] are key partners with health and care services and local authorities' (Department of Health, 2015: 37 & 43). The five overarching principles of the Code of Practice are:

1) *Least restrictive option and maximising independence*

2) *Empowerment and involvement*

3) *Respect and dignity*

4) *Purpose and effectiveness*

5) *Efficiency and equity* (Department of Health, 2015: 22).

The 3Is model considered the 'least restrictive option and maximising independence' as involving patients in their care in such a way that they can influence their care and treatment towards greater independence. Through implementing the 3Is, patients can be empowered through improved communication, information sharing and genuine involvement and influence surrounding their care and treatment. Through being kept informed and involved, service users will be treated with greater dignity and respect. Through being influential in the decisions being made, service users are more

likely to feel empowered. Through being informed, involved and influential, steps can be made towards a more equitable approach for all involved during the decision making processes.

While each of these principles have been outlined under each of the Is for ease of representation, it is important to note that there are parallels in the fluidity of implementing each of these principles between each of the three Is, just as there is fluidity in the prominence of each of the 3Is at any given time during the shared decision-making process.

Conclusion

In this paper we have acknowledged how decision making forums in mental health in-patient settings sit within the very high walls of mental health legislation and the professional's role as enforcers of control. Within such constrains it becomes more relevant to think about the specific decision being made. If this decision does not threaten the constraints of mental health legislation then there is a much greater scope for higher levels of involvement and influence. This suggests that whilst within the walls of the mental health act we simply can't have shared decision making, more powerful forces mean that this is not possible. Therefore the question becomes one of trying to acknowledge the constraints through the implementation of the 3 I's model and do all that we can to increase the level of shared decision making when the more powerful constraints around us allow this.

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Figure 1.0 The 3 I's Scale of Influence

INFORMED   INVOLVED   INFLUENTIAL