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Implementing shared decision making in routine mental health care

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Shared decision making (SDM) in mental health care involves clinicians and patients working together to make decisions. The key elements of SDM have been identified, decision support tools have been developed, and SDM has been recommended in mental health at policy level. Yet implementation remains limited. Two justifications are typically advanced in support of SDM. The clinical justification is that SDM leads to improved outcome, yet the available empirical evidence base is inconclusive. The ethical justification is that SDM is a right, but clinicians need to balance the biomedical ethical principles of autonomy and justice with beneficence and non-maleficence. It is argued that SDM is "polyvalent", a sociological concept which describes an idea commanding superficial but not deep agreement between disparate stakeholders. Implementing SDM in routine mental health services is as much a cultural as a technical problem. Three challenges are identified: creating widespread access to high-quality decision support tools; integrating SDM with other recovery-supporting interventions; and responding to cultural changes as patients develop the normal expectations of citizenship. Two approaches which may inform responses in the mental health system to these cultural changes – social marketing and the hospitality industry – are identified.

Decision making is a complex and dynamic social interaction[1]. The balance of involvement between clinician and patient can be conceptualized as lying on a continuum from clinician-led/passive/paternalistic, through shared, to patient-led/informed/active[2]. Clinician-led decision making occurs when the clinician makes the decision for the patient, possibly after consulting with him/her. Patient-led decision making occurs when the patient makes the decision, possibly having received information from the clinician. The intermediate position of shared decision making (SDM) involves collaboration.

A widely used definition of SDM is that it is "a process in which clinicians and patients work together to select tests, treatments, management or support packages, based on clinical evidence and the patient's informed preferences; it involves the provision of evidence-based information about options, outcomes and uncertainties, together with decision support counselling and a system for recording and implementing patients' informed preferences"[3]. This definition focuses, as does the present paper, on interactions between clinicians and patients, but SDM also has relevance to decision making between clinicians and family members, and perhaps also to clinical discussion between different professional groups.

What is a decision? In physical health care, decisions might include whether to complete a diagnostic test, undergo a medical procedure, receive a particular pharmacological or psychological treatment, or attempt a lifestyle change. In mental health, decisions relating to inpatient care are broadly similar. When asked to name recent clinical decisions, inpatients with a diagnosis of schizophrenia (N=60) and their psychiatrists (N=30) consistently mentioned categories such as "medication", "leave from ward/hospital", "non-pharmacological therapies" and "changes in treatment setting"[4]. By contrast, decision making in community mental health settings is more wide-ranging; a principal component analysis of topics discussed in routine consultations between community patients (N=418) and their clinicians found a three-factor solution comprising treatment, social (family, friends, leisure) and financial (work, benefits)[5].

The essential elements of SDM have been identified. A systematic review synthesized 161 conceptual models of SDM to identify eight characteristics of clinician behaviour: define/explain the health care problem, present options, discuss benefits/risks/costs, clarify patient values/preferences, discuss patient ability/self-efficacy, present what is known and make recommendations, clarify the patient's understanding, and make or explicitly defer a decision[6]. This framework underpinned a

systematic review of implementation of SDM across different health care settings, identifying five randomized controlled trials of interventions to improve clinicians' adoption of SDM[7]. Training of clinicians and use of decision aids (structured approaches to facilitate SDM) were tentatively recommended, though none of the studies related to mental health populations.

Patients want SDM[8]. A systematic review of 199 analyses from 115 studies of decision-making style preference concluded that patients prefer shared to clinician-led decision making, with the preference proportion higher in studies carried out in patients with cancer or undergoing invasive procedures, compared to those conducted in non-disease specific study populations or patients with other chronic conditions[9].

Overall, there is international consensus across medicine about the importance of SDM[10], and it is widely supported[11]. It is argued that SDM leads to better outcomes, including help-seeking behaviour[12], increased compliance with decisions[13], reduction in errors[14], reduced stigma and increased involvement[15]. In 2010, a gathering of 58 experts from 18 countries produced the Salzburg Statement on Shared Decision Making[16]. This included a call for clinicians to recognize SDM as an ethical imperative, stimulate two-way flow of accurate and tailored information, and give patients and their families resources and help to reach decisions. The statement also exhorted action by researchers, editors, journalists, patients (to speak up, to expect to be an equal partner, to seek and use high-quality information) and policy makers.

SHARED DECISION MAKING IS RECOMMENDED IN MENTAL HEALTH

SDM is promoted in mental health systems[17]. It is advocated as an important approach in the mental health policy of many countries internationally[10]. For example, in England it is recommended that "a shared decision making approach should be facilitated" across all adult mental health services[18].

Why is SDM in mental health so widely recommended? The standard argument made to support SDM is that clinicians have expertise in diagnosis, etiology, prognosis, treatment options and outcome probabilities, whereas patients have expertise in illness experience, social circumstances, attitudes to risk, values and preferences[3]. Bringing these two types of expertise together can, when informed by research evidence,

produce better decisions. However, this standard argument conflates two overlapping but separate justifications: clinical and ethical.

The clinical justification

The clinical justification put forward for SDM is that patients who are active participants in managing their care have better outcomes. Increased involvement will lead to better engagement, higher-quality decision making, and increased treatment adherence – all of which will improve outcome. There is some evidence supporting this justification. For example, a trial in the Netherlands involving 220 psychiatric inpatients showed that SDM led to reduced substance use and improved quality of life[19]. A follow-up study found that SDM was also associated with increases in patient autonomy[20].

However, critical appraisal of all available evidence is less positive. A Cochrane review of SDM in mental health[21] identified only two randomized controlled trials. Both studies took place in Germany, one involving 107 patients with a schizophrenia diagnosis[22] and the other 405 patients with depression[23]. The Cochrane review concluded that there was no evidence for harm, but the weak evidence base meant that no firm conclusions could be drawn. Since that review, one randomized controlled trial involving 80 community patients[24], also showing advantages for decision aids, has been published.

Other reviews have reached similar conclusions. A systematic review[25] identified eleven randomized controlled trials, including two in mental health, one focussing on schizophrenia[26] and the other on depression[27]. Five trials, including the two mental health trials, showed positive outcomes associated with SDM, but the reviewers concluded that the overall evidence is encouraging but inconclusive.

It should be noted that this conclusion is not unique to mental health. The most recent systematic review of trials (N=22) testing the impact of SDM on outcome in physical health concluded: "The trials performed to date to address the effect of SDM on patient-relevant, disease-related endpoints are insufficient in both quantity and quality. Although just under half of the trials reviewed here indicated a positive effect, no final conclusion can be drawn"[28]. But available evidence does suggest that SDM in mental health is particularly challenging. For example, SDM leads to a greater increase in treatment adherence in general medicine than in mental health[29].

Overall, the totality of evidence is inconclusive about the impact of SDM on patient outcomes in mental health.

The ethical justification

The ethical justification put forward for SDM is that it is a human right. Sometimes expressed as "No decision about me without me"[3], the right to self-determination implies full involvement in decisions affecting the person. This seems to be a view increasingly taken by patients: the above-mentioned 2012 systematic review of 115 studies investigating decision-making preferences[9] identified a patient preference for SDM in 63% of studies, but a time trend was evident, with 50% of studies before 2000 and 71% after 2000 showing this preference.

Reviews of SDM in persons with schizophrenia[30] and depression[31] showed that patients and clinicians found SDM acceptable and did in fact engage in SDM, which resulted in improvements in patients' knowledge about their illness and a higher level of perceived involvement in decision making.

The ethical justification is often positioned as a solution to the suggested problem of an assumption that the clinician is the only competent decision maker, who will make decisions *for* rather than *with* the patient. Ethical justifications emphasize that "clinicians and patients bring different but equally important forms of expertise to the decision-making process"[3]. Arguments made from this perspective often focus on values and power relationships, for example by linking SDM with values-based practice[32]. SDM is understood primarily as a process involving the expert-by-training (the clinician) and the expert-by-experience (the patient) both contributing their expertise, committing to decision-making responsibility, and being respectful of the other's perspective. This transactional focus contrasts with the clinical justification emphasis on producing better outcomes.

Shared decision making is a polyvalent concept

SDM is thus supported both by those who prioritize clinical expertise and expertise-by-experience. In this sense, the term is what sociologists call a polyvalent concept[33] – one which commands superficial agreement and apparent consensus between disparate stakeholders, but which conceals incompatible assumptions and expectations. Put

concretely, does the clinician still support SDM if it leads to empowered patients who are less adherent to treatment recommendations? Does the patient still support SDM if apparently involving conversations that seem somehow always to end up with the clinician's view prevailing[34]?

There are particular challenges in mental health care[35]. Is SDM still the best approach to decision making with non-capacitous adults, such as those with advanced dementia or acute psychosis[36]? Is it appropriate in a forensic context, where the decisions that the person makes may fall slightly or greatly outside social norms?

These tensions between different justifications for shared decision making also occur in other initiatives in mental health. The same features of apparent universal agreement occur in relation to the service agenda and rights agenda which both provide support for anti-stigma initiatives[37]. Other polyvalent constructs include self-management, advance directives and social inclusion.

For example, recovery has emerged as a guiding vision for mental health systems[38]. Like the ethical justification for SDM, a recovery orientation involves a re-focussing on subjectively-defined process rather than clinician-defined outcome. The relevance of recovery to dementia[39], forensic[40] and mental health inpatient services[41], however, has been questioned. A focus on recovery creates challenges for clinicians and patients. Clinicians have the uncomfortable experience of competing priorities[42] leading to role tensions[43], yet advocates raise concerns that recovery is being "commandeered"[44] to individualize social problems, to de-politicize individual experience and to remain focussed on deficit amelioration[45]. The recommendation that sociological research is needed to understand the socio-cultural meaning and implications of recovery[46] is probably equally applicable to SDM.

HOW IS SHARED DECISION MAKING IMPLEMENTED IN MENTAL HEALTH?

SDM is not yet widely implemented across mental health systems. For example, in the National Health Service (NHS) Community Mental Health Survey 2015 in England[47], only 42% – a reduction on 2014[48] – fully agreed with the statement "Have you agreed with someone from NHS mental health services what care you will receive?" (N=12,695). Only 50% fully agreed with the statement "Were you involved as much as you wanted to be in decisions about which medicines you receive?" (N=9,775), and among patients

who received non-pharmacological treatments, only 55% fully agreed with "Were you involved as much as you wanted to be in deciding what treatments or therapies to use?".

Is there a difference between SDM in mental versus physical health? A study in the Canary Islands compared experience of decision making between patients attending psychiatric outpatient clinics and primary care (N=1,477)[49]. It found no difference in overall score, but differences at the item level. Participants using psychiatric outpatient services said that they were helped to understand the information, but were more likely to say that they were not asked about which treatment option they preferred, that there was no negotiation, and that the selection of treatment was not a consensus decision. There may be challenges specific to SDM in mental health.

A qualitative investigation of the views of experienced psychiatrists (N=26) identified barriers to its use in relation to prescribing[50]. The most frequently identified barrier was beliefs about the insight of the patient, which in some cases was seen as an absolute barrier. Other challenges were societal expectations about mental disorder (so statutory powers are held by the psychiatrist), beliefs about the primacy and the tranquillizing effects of antipsychotic medication, and financial pressures limiting options.

These barriers may lead to SDM conversations in mental health being more factual than values-based. An exploration using factor analysis of decision making in psychiatric visits in the U.S. (N=191) found that discussions about the science (pros and cons, clinical issues and uncertainties, consumers' goals and understanding) were more common than about preferences (the consumer's role in decision making, discussion of alternatives, exploration of preferences)[51].

Other implementation challenges have been identified in physical health[10] and mental health[52] settings, such as hierarchical doctor-patient relationships[53], differing understandings of, and low commitment to, SDM[54], lack of a "rights discourse" in the culture[55], and challenges of avoiding inequities when access to support tools is through insurance-funded health systems[56].

RESEARCH IN ROUTINE CLINICAL SETTINGS

Given these implementation challenges, research in routine mental health services is needed. The European Union-funded "Clinical decision making and outcome in routine care for people with severe mental illness" (CEDAR) study took place in six European

countries (Denmark, Germany, Hungary, Italy, Switzerland and UK) from 2009 until 2014[57]. The study had two aims.

The first aim was to establish a methodology to assess clinical decision making in people with severe mental illness. This aim was met by the development and cross-cultural validation of three new measures. All of them comprised parallel clinician and patient versions, and were developed in English followed by rigorous translation and cultural adaptation using good practice guidelines[58] into Danish, German, Hungarian and Italian. The Clinical Decision Making in Routine Care (CDRC) measure assesses the content and implementation of decisions[59]. The Clinical Decision Making Style (CDMS) measure assesses preference for different styles of decision making[60]. The Clinical Decision-making Involvement and Satisfaction (CDIS) measure assesses involvement and satisfaction in a specific decision. All measures are available at www.cedar-net.eu/instruments.html.

The second aim was to investigate decision making in routine adult community-based mental health services, using a six-country prospective observational design. A total of 588 patients met inclusion criteria, primarily comprising age 18-60 with mental disorder present (established using research diagnosis[61]), severe[62] and enduring for two years. After giving consent, patients identified a clinician, and these clinician-patient dyads were then asked to complete bimonthly assessments for one year.

The main study investigated the relationship between decision making style and outcome[63]. A preference for shared, rather than patient-led or clinician-led, decision making was reported by both patients (χ^2=135.08, p<0.001) and clinicians (χ^2=368.17, p<0.001). SDM was also the dominant experience, with a 10% increase in the proportion of both groups reporting SDM over the one-year study period. Hierarchical linear modelling found that the decision-making style of clinicians significantly affected patient-rated unmet needs over time, with unmet needs decreasing more in patients whose clinicians preferred patient-led to clinician-led (−0.406 unmet needs per two months, p=0.007) or shared (−0.303 unmet needs per two months, p=0.015) decision making. In other words, outcomes were best when clinicians supported patient-led decision making.

A second study investigated the relationship between decision-making involvement and satisfaction[64]. Patients (N=445) were partitioned based on involvement preferences (assessed using CDMS) and experiences (assessed using CDIS). The preference hypothesis was that satisfaction with a specific decision will be higher if it is made using the patient's preferred decision-making style (patient-led, shared, clinician-led). This was

not confirmed. Overall, 90 patients (20%) had less involvement than preferred ("disempowered"), 190 (43%) were "matched" and 162 (37%) were "empowered". Empowered patients, who experienced more involvement in decision making than they desired, rated highest satisfaction (OR=2.47, p=0.005, 95% CI: 1.32-4.63). The agreement hypothesis was that satisfaction will be higher when decisions are made with a clinician with the same preferred decision-making style. This was also not confirmed, with ordinal logistic regression modelling showed that decisions made with clinicians whose decision-making style preference was for more active involvement than the patient preference were rated with highest satisfaction (OR=3.17, p=0.003, 95% CI: 1.48-6.82). So, higher satisfaction was experienced following more active involvement in decision making than the patient stated as desired, and with a clinical orientation towards empowering, rather than shared, decision making. This is consistent with findings from other health sectors. For example, a primary care study (N=1,913) in Germany found that high experienced involvement predicted higher patient satisfaction[65].

The CEDAR study has two implications for routine practice. First, if the intention is to reduce patient-rated unmet needs and to maximize satisfaction, then the empirical findings indicate that long-term efforts should be oriented towards developing patient-led rather than shared decision making. This is challenging to the current culture of health services. Patient-led decision making is not always valued by the system; a patient preference for involvement has been found to be negatively associated with experienced involvement[65]. Socio-political debate would be needed about the purpose of the mental health system – to what extent is the "core business" of the system keeping people (patients and others) safe, which may necessarily involve some clinician-led decision making, versus supporting them to live as well as possible? Can and should we socialize clinicians into a professional role which gives primacy to patient-led decision making? Clinical practice would need to be oriented towards supporting this type of patient empowerment, with a recovery-oriented culture in mental health systems which promotes the normal entitlements of citizenship[66]. We know that the desire to participate in decision making is higher in some groups of patients, e.g. inpatients with experiences of involuntary treatment, with negative attitudes toward medication, with a higher level of education, with lower treatment satisfaction, with better perceived decision-making skills, in patients of female gender and in younger patients[30]. Should efforts to support patient-led decision making be targeted at these patient subgroups, or at all patients?

Also, patients may bring expectations about being looked after whilst unwell. When is this expectation helpful, and when is it ultimately harmful? Recovery is far more common than often understood in mental health systems[67,68], and access to peer workers can powerfully transform these role expectations[69]. How do we minimize harm, balancing the reality that being allowed to disengage from services leads to the best outcome for some people[70] and to avoidable tragedies for others?

The second implication is that an orientation towards SDM is an empirically defensible goal in mental health systems which have traditionally used clinician-led decision making. An SDM orientation will improve both patient experiences and outcomes, indicating an alignment between the clinical and ethical justifications for SDM as a more beneficial style than clinician-led decision making. If it is accepted that SDM is a necessary component of a modern mental health system, then three challenges can be identified: the technical problems of access to appropriate tools and integration with other innovations, and addressing the implications of changing culture.

DECISION SUPPORT TOOLS

Changing practice often involves the use of formal decision support tools, and resources exist to support SDM. For example, online decisions support systems are available which are both generic (e.g., optiongrid.org) and condition-specific (e.g., sdm.rightcare.nhs.uk/pda and thedecisionaidcollection.nl for depression).

These tools may target behaviour change in either clinicians or patients. Clinician-focussed approaches typically involve training and support for practice change. These approaches have been evaluated in depression, and (when augmented with patient information leaflets giving information and encouragement towards involvement) they lead to improved patient participation and satisfaction without adding to consultation time[23].

A good example of a patient-focussed approach is the CommonGround system, which is an online peer-delivered decision support system to support patient involvement and empowerment in psychopharmacology consultations[71].

Widespread access to generic and condition-specific decision support tools is needed. Tools need to be of a high quality: a systematic review of decision aids across medicine found a tendency to under-specify the procedure, to emphasize benefits more

than harms, and to focus more on false positives than on false negatives in screening tools[72]. Development of reporting guidelines for decision aid studies would be one approach to improving quality[73].

Decision support tools also need to be small in number: the same systematic review identified 68 tools relating to treatment and 30 relating to screening. This variation makes benchmarking and comparison between services and systems more difficult[28]. Finally, there needs to be a focus on tailoring and testing tools in different clinical groups and geographical locations. The extent to which patients expect to be actively involved in treatment decisions varies according to the prevailing culture[74]. In paternalistic cultures, both clinicians and patients are likely to assume that decisions are the responsibility of the clinician only, whereas in more egalitarian cultures a partnership or SDM approach may be jointly preferred[75]. Translation processes therefore need to address these cultural factors in ensuring both linguistic and conceptual equivalence[58].

INTEGRATION WITH OTHER RECOVERY-SUPPORTING INNOVATIONS

Implementation of SDM will involve the integration of the relevant technologies with wider innovations, and the application of improvement science to support evaluation and sustainable implementation. A number of measures of SDM now exist: a structured review identified 19 measures, and a move towards measuring processes from both patient and clinician perspectives[76]. These provide standardized approaches to evaluate complex interventions which integrate SDM with other established innovations.

Advanced directives and joint crisis plans are examples of established innovations[77]. Advance directives involve the patients pre-specifying their preferences for what should occur if they lose capacity due to mental illness. An emergent problem with this patient-led approach was that the clinician might not be involved in, or even aware of, the directive in advance, leading to low implementation[78]. A variant involving SDM has emerged, called joint crisis plans. These are developed through facilitated meetings between the patient and involved clinicians[79]. A randomized controlled trial involving 569 patients in 64 community mental health teams in England found that implementation by clinicians was the main challenge, with no significant treatment effect for the primary outcome of compulsory admissions, or any secondary outcome with the exception of improved therapeutic relationships[80]. Qualitative investigation identified four barriers to

clinician engagement: ambivalence about care planning; perceptions that they were "already doing SDM"; concerns regarding the clinical "appropriateness of service users' choices"; and limited "availability of service users' choices"[81].

Another example of integration is with the emergent field of routine outcome monitoring[82], which involves the longitudinal collection of patient-level outcome information to inform individualized care. There is strong evidence of short-term benefit and moderate evidence of longer-term benefit from routine outcome monitoring[83]. A study is now underway which integrates SDM and that monitoring[84]. Routinely collected outcome data are fed into the SDM process, with the intervention supported by a quality improvement collaborative programme involving a national and local implementation strategy.

ETHICAL AND CULTURAL CHALLENGES OF IMPLEMENTATION

Although most clinicians believe that they are using the SDM approach, there is evidence to the contrary[85]. Perceptions about level of involvement differ, with patients identifying more clinician-led and clinicians identifying more shared approaches[86]. Patients report inhibiting factors including the patient-clinician relationship, fear of being judged, perceived inadequacy, and a history of substance abuse[87]. The use of clinician-led decision making is most pronounced in treatment-related decisions[5].

One reason for low implementation is represented by ethical tensions. A widely-used biomedical ethical framework identifies four principles: respect for autonomy, justice, beneficence and non-maleficence[88]. Skilled clinicians attempt to integrate these principles, for example supporting patient participation not just for reasons of autonomy but also justified by beneficence (as well as other influences, such as avoiding legal liability)[89]. However, engagement remains challenging[90]. The potential conflict between these principles has been characterized in relation to antipsychotic prescribing for a patient who lacks insight; the psychiatrist may think: "If I leave it up to the patient, he would certainly choose not to initiate treatment. Symptoms would persist or even worsen, and thus I would harm the patient. If I apply pressure and he accepts antipsychotics, he may respond to treatment and likely gain insight. Then he will later be thankful that I proceeded in the way I did"[91]. This reflects the tension between

deontological (duty-based) ethical frameworks emphasized in the training of many professional groups and teleological (rights-based) frameworks emphasized by citizens.

A second reason for low implementation is cultural. An asylum-based system creates a micro-culture (a "total institution"[92]) which can be out of step with wider cultural values. Institutional structures can powerfully socialize a patient into a moral duty to be treatment-adherent (a "good" patient) and respectful of the clinician's sapiential expertise and professional authority. When the dominant discourse is clinician-led, a primary flow of information from clinician to patient means that the patient's values and treatment preferences are given less importance[93]. Overall, it is difficult to avoid clinician-led decision making being the default choice in institution-based mental health services, because SDM involves a shift in power arrangements[94].

TRANSFORMATION IN THE MENTAL HEALTH SYSTEMS

The world is changing. Mental health systems internationally are transitioning towards community-based services[95-101], which involve interactions with patients who are more influenced by citizenship expectations relating to consumerism, self-determination and empowerment[102]. Patients increasingly expect as a right to be active participants in decisions about their lives, with a greater emphasis on the biomedical ethical principles of autonomy and justice.

The implications of this shift for mental health systems are profound, and extend well beyond discussion of approaches to decision making. Disruptive organizational transformation may be needed if the mental health systems are to survive this transition to engaging with patients holding citizenship expectations. A readiness to draw in insights and use language and constructs from other sectors will be needed to inform this transformation. This can be illustrated by two examples, both of which are potentially relevant but currently almost unused in planning and developing mental health systems.

The first example is given by the academic discipline of social marketing[103], which could be used as an approach to fostering culture change in mental health systems. Social marketing involves the application of marketing principles and practices to advance social good, in this case participation in decision making. It takes a citizen-centred approach in which insights developed with citizens and stakeholders inform the process[104]. An orientation towards mutuality, exchange and reciprocity differentiates

social marketing from other social intervention approaches, particularly in traditional expert-driven, top-down public health approaches. So, social marketing provides an approach to developing citizen-centred mental health systems oriented around the preferences of participants (patients), and in which partnership working (shown for example by SDM) is the foundation rather than a feature to be added on.

Participatory approaches to service development already exist in mental health services. Peer support theories such as intentional mutuality emphasize relationships in which both people have value and reciprocity is possible[105]. Recovery Colleges are based on principles of collaboration, co-production, inclusiveness and a community focus[106]. Similarly, "a majority of participants in user-run programmes value role equity, the mutuality and reciprocity of relationships and the non-hierarchical organization"[107].

Market segmentation is a well-established business technique used to identify and manage diverse customer needs and to target marketing resources[108]. Positioning similar groups of people into market segments, and then focusing marketing efforts at these different segments as appropriate can manage heterogeneity in preferences. By developing marketing strategies and behaviour change strategies for distinct groups of patients who have specific needs or values, it becomes possible to influence culture and create demand for SDM in clinicians working with, and patients coming from, different clinical populations.

The second example is given by the expertise held by the hospitality industry in working with disparate customers: "Key values, such as the importance of welcome, the customer always being right and the job being to provide help to meet the customer's needs, underpin the best interactions in this service industry. Hospitality workers are skilled in recognising how customers like to be engaged with – from face-to-face to elbow-to-elbow. Workers are not doing their job if customer care is poor"[109]. If patients achieve similar levels of emancipation and agency as other citizens, then patient choices and preferences become central. If clinicians don't work in partnership with patients to ensure they have a positive experience, then patients will – and should – choose to go elsewhere for support.

CONCLUSION

In this paper, the case has been made that SDM is part of a broader movement of change in the mental health system[110]. There are implementation challenges, but these are ethical and cultural as well as technical.

It is worth addressing these complex issues relating to power, control, expertise and valued knowledge, because SDM has the potential to contribute to supporting people to live as well as possible in communities of their own choosing.

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