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Shared Decision Making in Psychiatric Medication Management.

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Why is Shared Decision Making important?

- In mental health, SDM sits within the larger move towards **recovery based practice** in mental health, which along with 'patient centred care' are now considered to be core components of the UK mental health system (NIMHE, 2005; 2008; DoH, 2009; 2011; 2012)
- Taking a recovery perspective requires greater emphasis on the collaborative nature of care between providers, consumers and their families. Valuing the individuals right to autonomy and self determination is fundamental to this.
- SDM is also seen as a recovery tool for medication management in mental health, allowing for the revaluing of psychiatric medication in the recovery journey.
- Especially relevant for psychiatric medication management, yet still less researched than other areas of medicine.

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In Summary

- Increase service users' control over major decisions about their lives
- Take seriously service users' knowledge and experience of psychiatric medication
- Create a more equal and genuine partnership between service users and prescribers
- Incorporate alternatives to medication and coming off medication as options worthy of consideration

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A Grounded and Exploratory Study:

- To explore current medication management practice in mental health services
- To investigate views to collaborative working and shared decision making in psychiatric medication management
- To identify barriers and facilitators to collaborative working in psychiatric medication management
- AND finally, to provide a theoretical basis for change in medication management practice in mental health

Two data collection phases

Qualitative interviews (n=30)

- Service users
- Practitioners (CPNs & Psychiatrists)
- Thematic analysis

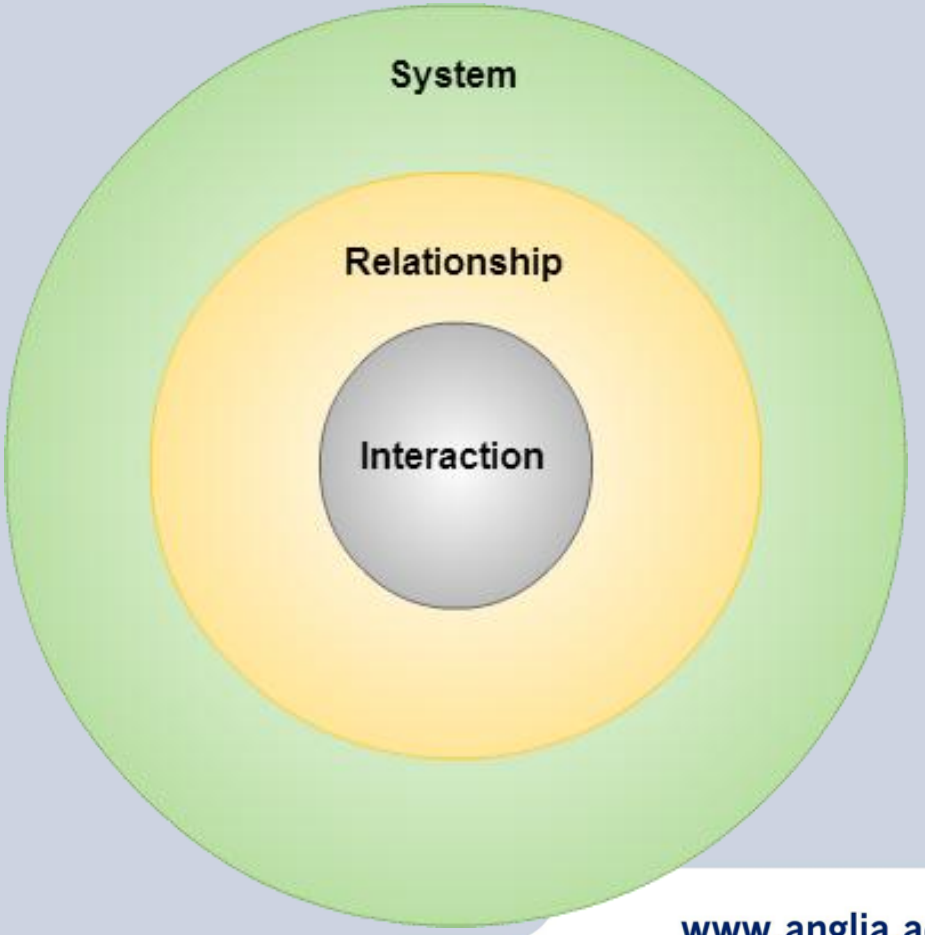
Recorded meetings (n=4)

- Between Service users and Psychiatrists
- Applied conversation analysis

Methodology

- Social constructivist position
- Participatory methodology
  - Mixed practitioner and service user advisory group in place since June 2010.
  - Service user / carer co researchers
    - As interviewers, facilitating discussion groups, research dissemination and leading subsequent change phases
  - Expert service user trainers (SE SURG) for training and support
  - Co researcher involvement in data analysis
- Took place in one care pathway (intake & treatment) in Cambridgeshire and Peterborough Foundation trust.

Findings at three levels



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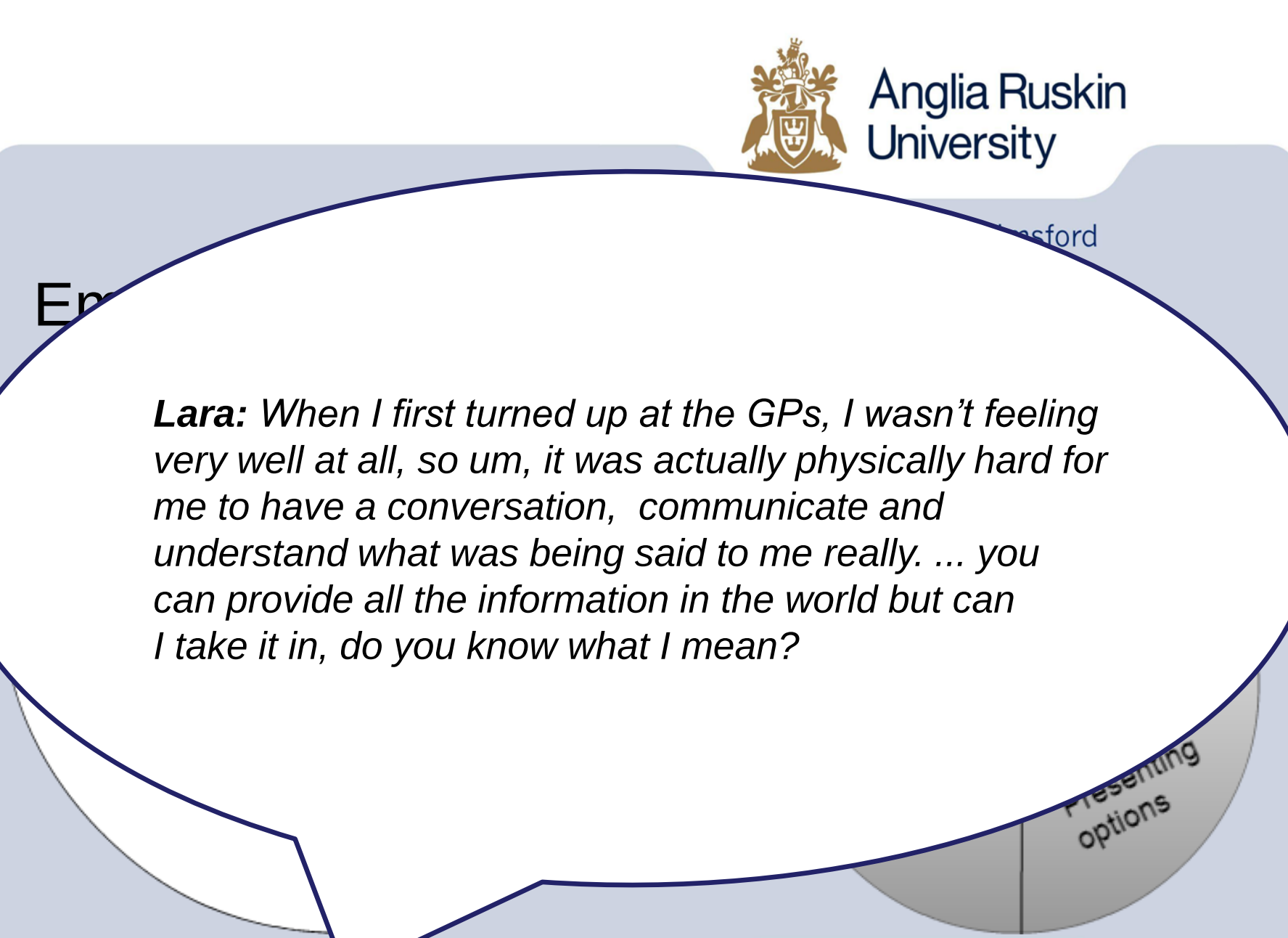
Lara: *When I first turned up at the GPs, I wasn't feeling very well at all, so um, it was actually physically hard for me to have a conversation, communicate and understand what was being said to me really. ... you can provide all the information in the world but can I take it in, do you know what I mean?*



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Lara...*when I got to the point of saying, you know, I don't know what to do next, um, she said****,*** OK, we'll sort this together... ..and it was that phrase actually that kind of made me feel, Ok, I can deal with this *person because she wasn't offering to take over and she wasn't making me do the whole thing myself she was saying, you know I'm there to support you, we'll be a team and well overcome this and I sort of felt, OK, so this is good...*

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Dr Black:*.... they are in charge of it completely. They come to me as an expert of medication. My job is to put for them my best opinion and to give them the tools to make a cost benefit analysis on that and to be able to choose to do it or not to do*

CPN 2:*... So there's a kind of walking the journey together, and sometimes he's pulling back a bit and I'm pushing forward ... but actually the success is about two people building up a mutual respect and real affection for each other and thinking I really care about you..... I know that's a very didactic approach but its a kind of push pull*

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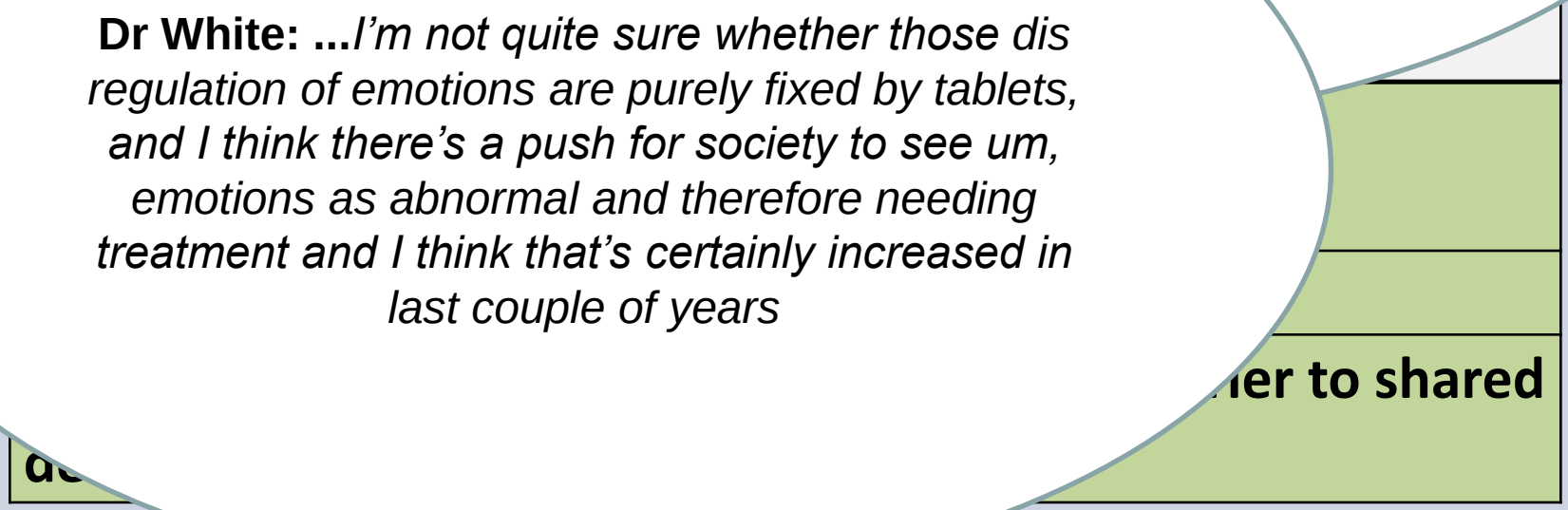
Terry: ..*try and be as honest as you can, but hold back a little bit because you don't want to sort of end up in h when you look different t*

Ziggy: *...and there are some assemblances of listening, but it's not lly going in because in their mind, e already put a label on me*

Holly: *like, obviously he's the expert,.. but yeah, it felt really nice to be able to have a conversation with a psychiatrist, rather than just 'OK, yes sir!'*

Dr White: ...*the sort of decision making power that she puts with you and tell me what to do, tell me what to take to fix it, that a sort of pressure.. there's something about the pressure that put on you to fix it that really ve that conversation*

Dr White: ...*I'm not quite sure whether those dis regulation of emotions are purely fixed by tablets, and I think there's a push for society to see um, emotions as abnormal and therefore needing treatment and I think that's certainly increased in last couple of years*



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Recorded meetings data – striking findings

- SDM not fully adhered to
  - Psychiatrist does not give ‘full’ list of options
  - Side effect information ‘brushed over’ ..BUT
- Some evidence for ‘meeting of experts’
- Rapport and service user input valued
- Asymmetry present but not often applied by psychiatrist....BUT
- Wide spectrum on service user involvement between 4 meetings

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Refractured Passivity

- Here two scenarios. In one offshoot of this typology, service user overtly passive in conversation and refuses opportunities to direct topics or assert preferences towards goals or problems to be discussed. A sense of helplessness emerges. Prescriber uncomfortable and unsure how to progress conversation
- Other scenario is when a service user is deemed by the prescriber to lack insight into being ill. Practitioner is unlikely to explore range of options and embarks in tactful manipulation below. Service user may adopt passive resistance strategies and 'false compliance' possible outcome.

Tactful manipulation

- Psychiatrist steers patient towards new medication, possibly avoiding concerns raised about side effects. Service user, whilst participating in conversation and at times direct topics in conversation, happy to be led by psychiatrist expertise on final decision. No objections raised and mutual consensus.

Meeting of experts

- Discussion and dialogue over possible options and pros and cons of a new medication or coming off medication. Psychiatrist presents opinion on best course of action, but in consideration with service user. Service user brings experiential expertise to the meeting and this is reflected upon in the encounter. There remains a conversational style with little asymmetry.

Self Management

- Service user adopts active power claiming strategies in conversation, asserting opinions and preferences and asking questions .Prescriber assists process and provides information on pros and cons, being led by service user preferences.
- Final decision deferred to service user, who asserts preference then and there or following full review of relevant information

Facilitating SDM in community care

- CPN often in role of go-between
- The value of traditional long-standing relationships between SUs and health professionals
- MHA means SDM is not always possible in acute illness

Sharing the shared decision-making

- All members of the MDT need to be engaged to promote collaborative working and SDM
- Meaningful care planning is central
- Bands 3-5 the new “shop floor”?

Barriers to future SDM

- Cuts in mental health budgets impacting on provision of standard services and skill mix
- Implications of changes to professional roles and responsibilities
- More demands upon secondary care services to discharge to GP; time limited access to secondary care
- AQP to fill the gap - implications for SDM?
- **More choice but less continuity?**

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Final thoughts:

- SDM is more than just a list of requirements or competencies.
- It is a journey over time and sits at the centre of the recovery model in mental health services
- It represents agency hope and opportunity within medication management practice, yet structural constraints remain
- Increasing consumerisation of mental health services offers opportunities but also threats towards achieving greater SDM in practice. **More choice but less continuity?**

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Thank you