Editorial

Shared Decision Making in mental health: Special Issue of the Mental Health Review Journal, 2017

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This special issue reflects our wish to take into account the recent developments in the research and practice of shared decision making (SDM) in the field of mental health, and share this knowledge with service users, practitioners, researchers, and policymakers interested in SDM in this issue. We view SDM as the process in which decisions related to mental health treatment and interventions are reached as a co-production through sharing different types of knowledge: professional or evidence based versus more experiential knowledge of people with the lived experience of mental ill health (Deegan et al, 2010; Morant et al, 2015).

SDM occupies the middle position of the range, which begins with decisions made only by clinicians on behalf of people, and ends with decisions made only by people who use mental health services (Charles et al., 1997; 1999). It has the potential to foster good collaboration between service users and providers based on trust, mutual respect, and readiness to share concerns, hope, and knowledge. For some, the desired outcomes would be the greater honesty in the relationships, increased motivation for change, and empowerment. For others, the focus would be on agreeing to follow a specific treatment regime, or a joint decision to try out a new intervention (see article by James & Quirk, this issue).

For many years, the research and practice of SDM in mental health has lagged behind general medicine. Explanation for that might be related to the primary care origins of the SDM model (Charles et al., 1997; 1999; Elwyn et al, 1999; O'connor et al, 2006) and to prevalent assumptions related to lack of decision capacity among people experiencing mental ill health (Lincoln, Lullmann and Rief, 2007). Hamann and colleague's (2003) review of SDM in mental health represents one of the first attempts to focus attention emphasize the need and potential for SDM in mental health. However, their focus was on medications decision making. With the introduction of the new meaning of personal recovery to mental health (Anthony, 1993, Davidson, 2003; Slade 2009), and the acknowledgement that people with the lived experience of mental ill health have strengths and not only deficits (Rapp, 2006), an increased interest emerged into the potential role and promise of SDM for personal recovery in mental health (Drake et al., 2010). Now, seven years after the important special issue on the promise of SDM to mental health (Drake et al., 2010), in this special issue we would like to describe the efforts that have been done regarding SDM in mental health and the future steps still needed.

Methodologically, most articles in the special issue include an updated systematic literature search in the English language, albeit in a variety of forms, for the last decade or more, followed by a thematic analysis or a narrative synthesis. The authors of the commissioned review articles come from Germany, Spain, UK and the US, and include researchers, service users and providers, from the disciplines of counselling, nursing, psychiatry, psychology, sociology and social work.

The articles in this special issue cover different topics: the rationale of SDM (James and Quirk, this issue), the perspectives on mental health SDM by service users, family members and service providers (Kaminskiy et al.,), the range of SDM interventions and their underlying components (Zisman-Ilani et al., 2017), SDM from the perspective of recovery-oriented person centred care

(Davidson et al, this issue), SDM measures and outcomes (Perestelo-Perez et al, 2017), and the implementation of SDM in everyday practice (Ramon et al, 2017), of which relatively little has been published up to now.

Although a number of the articles focus on SDM in the context of psychiatric medication management, some also include the wider area of psychosocial care in mental health. The review of SDM interventions in mental health (Zisman-Ilani et al., 2007) points to the unrealistic expectations from clinicians and patients in mental health organizations and primary care settings to discuss treatment or rehabilitation options with limited time and training to build sufficient rapport, trust, and partnership. This is linked to the finding of the review on implementation of SDM in mental health (Ramon et al., 2017) which highlights the inclusion of the Normalisation Process Theory as a conceptual innovation in the context of SDM in mental health. It focuses on the routinisation of change in organisational systems from the perspectives of coherence, cognitive participation, collective action and reflexive monitoring. The review of service users' perception of SDM highlights the impact of the power differentials in existence in mental health (Kaminskiy et al., 2017). This issue is exemplified not only in the drastic impact of compulsory admission, but in most routine decisions and ways of relating to service users (See Castillo and Ramon's paper in this review). Reflection on SDM training for service users, care-coordinators and psychiatrists given by O'sullivan and Rae in the paper on implementation of SDM helps to understand better what each group looks for in SDM and in training for it. Evaluation of both SDM measures in mental health is essential to enable SDM to meet the promise of improving communication and mutual learning (Perestelo-Perez et al, 2017)

Key issues that require clarification in the context of SDM include what are effective processes of sharing such different types of knowledge between service users and providers who have unequal power positions in our respective societies? What are the necessary and sufficient conditions for a trusting and respectful relationships between these key stakeholders and relevant others (such as family members)? (Zisman Ilani et al 2017);How do attitudes to SDM differ between practitioners and service users? (Kaminskiy et al., 2017); and what are effective information sharing processes which take into account likely challenges in accessing and understanding reliable information about different interventions as well as the benefits and adverse effects of mental health interventions, and which enable user friendly and collaborative process of reaching decisions which include the right to disagree. Above all, SDM requires a value framework centred on recovery-oriented personal care, one that values the knowledge provided by people with the lived experience of mental ill health (Davidson et al 2017).

We hope that this special issue will stimulate further the interest in the place of SDM in mental health, and will inform the next stage of debate and development of this important aspect.

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