A critical narrative analysis of shared decision-making in acute inpatient mental health care

Gemma Stacey, Anne Felton, Alastair Morgan, Theo Stickley, Martin Willis, Bob Diamond, Philip Houghton, Beverley Johnson & John Dumenya

Published online: 01 Feb 2016.

Submit your article to this journal ⏎

View related articles ⏎

View Crossmark data ⏎

Taylor & Francis
Taylor & Francis Group

ORIGINAL ARTICLE

A critical narrative analysis of shared decision-making in acute inpatient mental health care

Gemma Stacey[a], Anne Felton[a], Alastair Morgan[b], Theo Stickley[a], Martin Willis[c], Bob Diamond[d], Philip Houghton[e], Beverley Johnson[e], and John Dumenya[e]

[a]School of Health Sciences, Univeristy of Nottingham, Nottingham, UK; [b]Centre for Health and Social Care Research, Sheffield Hallam University, Sheffield, UK; [c]School of Psychology, Loughborough University, Loughborough, UK; [d]Adult Mental Health, University of Sheffield, Sheffield, UK; [e]Adult Mental Health, Nottinghamshire Healthcare Trust, Nottingham, UK

ABSTRACT

Shared decision-making (SDM) is a high priority in healthcare policy and is complementary to the recovery philosophy in mental health care. This agenda has been operationalised within the Values-Based Practice (VBP) framework, which offers a theoretical and practical model to promote democratic interprofessional approaches to decision-making. However, these are limited by a lack of recognition of the implications of power implicit within the mental health system. This study considers issues of power within the context of decision-making and examines to what extent decisions about patients' care on acute in-patient wards are perceived to be shared. Focus groups were conducted with 46 mental health professionals, service users, and carers. The data were analysed using the framework of critical narrative analysis (CNA). The findings of the study suggested each group constructed different identity positions, which placed them as inside or outside of the decision-making process. This reflected their view of themselves as best placed to influence a decision on behalf of the service user. In conclusion, the discourse of VBP and SDM needs to take account of how differentials of power and the positioning of speakers affect the context in which decisions take place.

Introduction

There is a growing awareness of the need for shared decision-making (SDM) in mental health care in the UK. Values-Based Practice (VBP) (Woodbridge and Fullford, 2005) offers a model for SDM in mental health care and recognises that decisions taken are based on personal and professional values as well as the research evidence. 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; Colombo, 2003; Fagermoen, 1997). Within an interprofessional team, professionals, service users, and carers bring a range of values. However with increasing specialisation within the professions there is a danger that these essential values become progressively disparate (Hall, 2005). The acquisition and control of specialist or expert knowledge enable professions to construct an identity that separates them from competing occupational groups. This is often achieved through control over access to education, formalisation of knowledge through accreditation, and prescription of available career paths. Freidson (2001) argues that these strategies enable the power/knowledge nexus from which the profession draws its legitimacy, which in turn shapes their behaviour, action, and the identity of the individual within the profession.

Woodbridge and Fullford (2005) highlight the range of values and their influence on SDM, advocating a 'democratic' approach to interprofessional decision-making whereby the values of all involved are respected. Their notion of decision-making in mental health services as a democracy in which all values are considered is, however, not without its problems. It has been criticised as it does not adequately address issues of power and interest (Houghton and Diamond, 2010). These challenges are acknowledged within the literature (Pilgrim & Rodgers, 2009; Smail, 2005), although genuine SDM remains a goal.

Shared decision-making

The mental health service user movement and consumerist models of healthcare have significantly changed the perception of the role of the 'patient' in their own care (Chong, Aslani, & Chen, 2013). This shift has culminated in a policy framework that seeks to enshrine patients' choices to become the heart of future healthcare (DH, 2012). The framework promotes SDM as a practice that will help ensure people receive care that is centred on individual circumstances and choices. 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). Emphasis is placed on processes of understanding the person's own values and attitudes, identifying their own goals. Achieving SDM entails the recognition of the person's expertise developed through the experience of health problems.

CONTACT Gemma Stacey ✉ gemma.stacey@nottingham.ac.uk 🖥 School of Health Sciences, Royal Derby Hospital, Derby, DE22 3NE, UK.
Alastair Morgan is now affiliated with the School of Nursing, Midwifery and Social Work at the University of Manchester.

Adopting this approach to making decisions represents a departure from traditional, paternalistic models of healthcare. Within such approaches, the role of a healthcare professional is to inform the person of the options and persuade them to accept the option that the professional perceives is best for that person; however, SDM involves sharing information, identifying the person's preferences, and jointly agreeing on an option (Schauer et al., 2007, Hamann et al., 2011; The Health Foundation, 2012). Making such choices about their own lives acknowledges individuals' rights, self-determination, autonomy, and empowerment (Deegan and Drake, 2006).

Power

One important tradition for understanding the concept of power is derived from the work of Karl Marx (1818–1883) and writers working in the Marxist tradition. Marx, writing with his collaborator Friedrich Engels, argues that supposedly neutral and value-free terms such as the 'free market', 'democracy', and 'justice' are not as neutral as they first appear.

For Marx, ideologies function by covering up essential inequalities of power, through the creation of necessary illusions, that enable an underlying unequal set of power relationships to function as though they were equal (Eagleton, 1991). This critique of ideology demonstrates the main flaw in the VBP discourse, which presumes that differing values can be debated as though each participant has an equal place at the table, and fails to acknowledge the key part that differences of power and positioning play in whose voice counts (Houghton & Diamond, 2010; Smail, 2005).

We must not forget that mutually respectful and egalitarian decision-making can take place. There is a distinct tradition that understands the concept of power as one of communicative reason (Arendt, 1970), whereby we think about power as a mutual process of involving a range of stakeholders in taking decisions. Scott (2001, p6) has termed this a 'second stream of power research' that focuses on involvement and empowerment. This has been vitally important in mental health work and particularly when thinking about involvement and collaborative models of practice in mental health (Slay & Stephens, 2013). Uhm et al. (2012) have written about the importance of creating 'patient panels' of different levels of expertise to increase knowledge from different stakeholders in medicine. Nevertheless, this increased focus on involvement and co-production still exists within a context where service users often feel unconsulted and marginalised in decisions about their lives (NICE, 2011).

Whilst we believe that the critique of power is a central component of any analysis of shared decision-making, following Foucault (2002), we view power as not just about a 'conflict of unequals' but as a plural concept, which both enables and constrains. Bracken and Thomas (2005) have written about how psychiatric power should no longer be viewed as simply repressive, but that it also produces subject positions and new formations of identity. Who we are as individuals and the values we espouse are formed by networks of power that enable us to take up particular identities at the same time as they restrict other possibilities (Rose, 2006). Therefore, whilst it is important to be aware of hierarchies and disparities of power in any decision-making process, it is also necessary to consider how identities are produced through the productive operations of power, which is why there is an emphasis in this study on professional identities and 'subject positions'.

Davies and Harré (1990) drew attention to dynamic aspects of interaction through the concept of 'positioning'. 'Positioning' is largely a conversational phenomenon. During the course of a conversation the participants 'make (or attempt to make) their own and each other's actions socially determinate' (Davies & Harré, 1990, p. 45). Multiple speech-acts may be accomplished by any single utterance. 'Positioning' is one of those speech-acts and occurs constantly in the flow of social interactions, including research focus groups.

Using discourse and talk, speakers rhetorically construct themselves and others in specific ways (Billig, 1987). Here, 'a discourse is to be understood as an institutionalised use of language' (Davies & Harré, 1990, p. 45). Discourses are forceful because they provide (and constrain) subject positions, which locate people (and their rights and responsibilities) within the discourse and affect 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). That is, the subject position gives the speaker a 'warranting voice', meaning the right to say certain things because they either have specialist knowledge or are granted particular powers. Specialist knowledge might be to do with empirical matters or with specialist training.

Methods

This research study examined to what extent decisions about patients' care are perceived to be shared on adult acute mental health wards. Focus groups were conducted and the data were subject to a critical narrative analysis (CNA) using a framework developed by Langdridge (2007).

Data collection

The research team consisted of individuals with professional backgrounds in nursing, social work, and psychology. Seven focus groups were conducted with occupational therapists, nurses, service users, carers, psychiatrists, peer-support workers, and social workers. A separate focus group was conducted for each group of people; therefore, groups fully consisted of people from the same personal or professional group. Focus groups were selected as the most appropriate means of data collection in accordance with the belief that the process of understanding social phenomena is not undertaken by individuals in isolation from each other (Blumer, 1969). Rather, it occurs in interaction with others and therefore focus groups offer the opportunity to explore the production of knowledge through dialogue and debate (Bryman, 2001). An interview schedule was used as a guide for each of the focus groups. Each group was facilitated by the same two members of the research team who were mental health professionals within the fields of nursing and psychology (see Table 1). The focus groups were

Table 1. Focus group participants.

Group	No. of participants
1. Service users	5
2. Carers	6
3. Occupational therapists	8
4. Psychiatrist	6
5. Nurses	7
6. Peer-support workers	5
7. Social workers	9

audio recorded and lasted between 45 and 90 minutes and transcribed verbatim by an external transcriber. Transcripts were checked for accuracy by the focus group facilitators.

A theoretical sampling strategy was adopted in order to recruit information-rich participants with the required experience to meet the objectives of the study (Denzin & Lincoln, 2000). The primary criteria for recruiting participants were that attendees should have experience of inpatient care in their respective capacity or role within the last 2 years. Professionals were recruited through pre-established meeting forums within a Mental Health Trust in the UK and service users and carers were recruited through a voluntary service user organisation. Groups were initially approached to provide information about the study and offer the opportunity for potential participants to ask questions.

Data analysis

A CNA was conducted on the data guided by the framework devised by Langdridge (2007). This form of CNA combines phenomenologically informed narrative methods with a critical theory (Langdridge, 2007). As a phenomenological method, it respects individual subjectivity and takes seriously what people say (narratives) about their experiences. As a critical method, it uses political critique to question people's narratives, taking the position that people always speak from somewhere, from some tradition, and some ideological position. Rather than seeing these positions as incompatible or mutually exclusive, CNA sees phenomenology and critical theory as mutually informing. Thus, adopting this form of analysis allowed us to explore both how our participants experience decision-making processes and how issues of power and interest are at play in those processes. The analysis involved six stages, including:

(1) A critique of the illusions of subjectivity – Researchers reflected on their value position in relation to the focus of the study and their expectations.
(2) Narrative tone and function – Transcripts were reviewed to identify distinct 'narratives' within the text relating to the research aim. These were examined in detail to identify the character of these narratives and the manner in which they were communicated to identify the narrative tone.
(3) Identities and identity work – Narratives were explored to identify how participants constructed and presented their professional identity.
(4) Thematic priorities and relationships – Significant patterns within groups were noted to identify major themes. These analytical processes were initially captured for each focus group. This was followed by a comparison of these themes across groups to consider the relationship between themes.
(5) Destabilising the narrative – This involved using a political/critical theory to interrogate the data. In this study we adopted the framework of power and applied this as a critical lens with which to review the data.
(6) Synthesis – This entailed researchers developing an analytical summary for each focus group based upon the analysis carried out in the proceeding stages. Through a discursive process researchers collaboratively identified salient commonalties, engaging debate during this process to challenge, question, and justify interpretations.

Ethical considerations

Ethical approval was acquired through the National Health Service, National Research Ethics Service. If discussions arose involving questionable practice, prevision was made for participants to be directed towards the NHS Trust complaints procedures if they wish to make a formal grievance. All participants gave full written consent following a thorough information-sharing process.

Results

This article will focus on stages 5 and 6. A summary of the key subject positions, the warranting voices, and implications of power are presented in Table 2 and discussed in the following section. Extracts from the focus groups are given in this section to demonstrate how findings were expressed within the data.

An element of CNA entails examining the way that subjects position themselves in their talk. Participants in all focus groups, except psychiatrists, consistently positioned themselves as being outside the decision-making systems. This position reflects the way in which they used language to demonstrate their perception of influence over the decision-making process. Consequently people who could be present in the discussion (e.g. ward round) however remain outside the sphere of influence relating to the overall outcome. For example, occupational therapists positioned themselves as being outside this system due to their alignment with service users or a lack of perceived professional status. This created an 'us' versus 'them' scenario, with occupational therapists and service users on one side and all other professions on the other. This was a way of saying that they are on the side of the service users and, by implication, they too, have no power:

'We fit with the patient, don't we? Because we're usually fighting for the patient. We're fighting for what their wants and needs are in terms of recovery, in terms of how they want to spend their life. So often, we come a bit left of center really' (Occupational Therapists – Group 7).

Table 2. Summary of findings.

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 sidelined 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

Peer support workers also linguistically located themselves as outside the decision-making process. There was a tension between the identity of peer support worker and that of 'patient'. Having experienced being a 'patient' they strongly identified with the service users they support, distancing themselves from the machinery of the institution. But, as paid peer support workers they were aware that there was an expectation to be part of the ward team and therefore undoubtedly are part of the mental healthcare organisation:

'Yes, we'll advocate for a patient, we'll be a peer support worker, but as potential participants in a review, we're putting ourselves at a sort of a risk, I don't mean at a personal risk but I mean, is it possible that a patient, oh a service user, would then begin to think actually, are they a part of the system?' (Peer Support Worker – Group 4).

Additionally one carer spoke of themselves as being an outsider due to being 'in the way':

'I was considered to be a nuisance. When they opened the doors for me to go into the ward where my son was, I was in the way, literally and figuratively, I was a bit of a nuisance so I was pushed up into one corner, and I would be told when I could go through and see my son.' (Carer – Group 4).

This can be seen as the carer positioning themselves as outsiders to rhetorically elicit sympathy or to point the finger of blame. But, equally this can be taken to be evidence that it is the mental health system that positions carers as outsiders. The choice is not either/or, rather both situations are simultaneously plausibly valid. That is, the decision-making structures and organisation of mental healthcare may well position carers outside of its processes and carers subsequently take up the subject position of powerless to influence the outcome.

Social workers, too, positioned themselves as outsiders, distancing themselves from the ward environment and from ideologies and processes that they do not agree with. This positioning gives social workers a way of disclaiming responsibility for the difficult decisions of inpatient settings. Social workers spoke of feeling like they only had influence when occupying the professional position of Approved Mental Health Practitioner (AMHP). They said they were clear about their responsibilities and status as AMHPs and that the medical system is dependent on them within that role:

'I think it's much easier being in an (AMHP) role. It feels as if there's more equality between people that are making that decision, really. I feel that that's the best part of me being a social worker, in terms of that level of equality with the medics. And, really, feeling that I've got a voice and the authority to say what I feel about a situation.' (Social Worker- Group 1).

This suggests that the AMHP's role is a liminal position as it brings outsiders inside. In this way, the role of AMHP provides social workers a warranting voice in the decision-making process. However, since it is explicitly written as a non-medical role, social workers are also given permission to criticise the medical system.

Service users however position themselves as lacking influence in decision-making. The grand narrative that was presented was one of disempowerment. This was poignantly illustrated by all participants in this focus group relating their experiences of having their freedom, choices, and rights removed against their will. What was apparent though was that it was not necessarily having their freedoms curtailed that disempowered them, but the manner in which they were treated. Participants were aware that at times they needed to be 'looked after'; they recognised that at times they were unable to take full control and responsibility for themselves:

'I think the structure (ward review) is ridiculous and frightening. Because all the people on that end, and there's one chair where we sit, like, you're out in a space on your own… You're not in that circle. You're the odd one out in other words.' (Service User – Group 3).

In this critical moment when decisions are being made, the service users felt 'outsiders' as well as being at the bottom of the hierarchy.

Psychiatrists talked about having most responsibility for decisions. For them, responsibly meant making the decision as opposed to facilitating shared decision-making. This suggests that in this context 'responsibility' may be just another word for power. When it came to the process of shared decision-making, the psychiatrists spoke of their position with an air of resigned paternalism, suggesting that their perceived accountability left them feeling reluctant to share the responsibility of making decisions, which was an unavoidable professional strain:

'…because of the risks involved, the decision then gets escalated upwards to the person who they think is responsible.' (Psychiatrists – Group 5)

'….I still feel responsible if I hadn't overseen it, but then, you haven't the ability to oversee everything so you have to give them responsibility and the accountability but at the same time, something goes wrong, you still know you're going to get it in the neck at the end of the day, but I think you just have to accept that, and I think it's a matter of trust really. If you can trust the people you work with to do a good job, you know, or a reasonable job, then, I think you're kind of half way there really.' (Psychiatrists – Group 5).

There was a consistent view of the need to guide others and to ensure that decisions were implemented. Members of this group spoke of how they attempted to include others, but revealed that they were sceptical of other professional's willingness to take responsibility.

It was apparent that, within decision-making, psychiatrists are perceived by all other groups as being at the top of the hierarchy, holding most power, rights, and responsibilities. Supporting this, the nurses presented an image of their role as a functionary. This position of the nurse entails the facilitation of processes, ensuring that the ward operates smoothly and decisions made by doctors are carried out and followed through:

'….you facilitate what has been decided and you are co-ordinating as well, because very often, a lot of those decisions are going to involve community services or other agencies, so you're going to take that away from your MDT and that is your responsibility and the team's responsibility to put into practice.' (Nurses – Group 6).

Nurses spoke in terms of waiting for decisions to be made by physicians before implementing them. They not only appeared to accept this position, but also were reluctant to lead or influence decisions more significantly, insisting that the accountability of the decision made should lie with the psychiatrist. In many cases this means that nurses are enforcers of surveillance, restraint, isolation, and medication of service users. What was notable amongst the nurses' focus group was that more than other groups, they identified as a collective. This group spoke of enforcement as horrible but necessary, coming at some personal cost to the nurse. When specifically talking about coercion, nurses often used the collective pronoun 'we' as opposed to 'I'. This can be interpreted in at least two ways. First, it expresses a strong identity of being part of a team and an acceptance of collective responsibility. Second, though, the use of 'we' depersonalises the coercive practice, distancing the individual nurse from the activity.

Discussion

A strong discourse of influence and interest was evidently present in the data. All groups, while nominally talking about the interests of service users, also spoke about their own interests. This often involved the linguistic construction of boundaries or identities for their group in terms of their role in mental healthcare, including what rights and responsibilities they have or do not have. The 'who knows best?' argument is a device used to gain influence and maintain interests (Gergen, 1989). Whoever successfully positions themselves as having superior knowledge becomes the group with the most influence (Freidson, 2001). Research suggests that at present, psychiatrists successfully use their medical training and social status to position themselves as the most knowledgeable group and thus have most influence in acute mental healthcare. Furthermore their reluctance to engage in shared decision-making practice might be underpinned by their anxiety relating to disclosing any professional uncertainty to service users and other professionals, which may act to challenge this positioning (Politi & Légaré, 2010). Therefore the goal of shared decision-making in acute settings is a long way from being met because this study demonstrates that there is limited evidence that others' voices are heard or have influence. All focus groups felt that decisions were not shared and that the voice of the service user was marginalised. This supports the notion that models that promote shared decision-making such as VBP are unlikely to achieve their aim (Chong et al., 2013).

Questioning this further however reveals how the findings of this study indicate how each group involved in decision-making absolved themselves of the capacity to take on the responsibility of making decisions. This functioned to enable participants to maintain a safe place in terms of professional accountability. Whilst they were critical of the hierarchical nature of decision-making processes, this functioned to maintain the current power relationships. Decisions made in mental healthcare can involve the restriction of liberty and enforced treatment. It was evident that most groups would rather distance themselves from decisions that meant personal freedom was revoked to avoid being viewed as at blame. This was revealed when groups, who had identified themselves as on the outside of decision-making, discussed their discomfort and rejection of opportunities to come in. This highlights the ambivalence amongst some when equity and influence are actually offered. These findings resonate with a wider theoretical analysis of shared decision-making models that have been criticised for neglecting to account for the dynamics of interprofessional collaboration within their approach (Stacey, Légaré, Pouliotc, Kryworuchkoa, & Dunna, 2010).

The discourse of VBP and SDM needs to take account of how differentials of power, interests, and the positioning of

speakers affect the process of how decisions take place. The power critique that conceptualises SDM as an illusion (Eagleton, 1991) has been challenged by the findings of this study as all groups agreed that there is a decision-making hierarchy. The literature discussing SDM in a range of contexts focuses on placing the service user at the centre of decision-making processes; however, our findings show that this is currently political rhetoric as warned by The Health Foundation (2012). Furthermore findings support the premise that there are some emergency circumstances where shared decision-making is neither appropriate nor desired by service users (Müller-Engelmann et al., 2011).

Whilst it is important for professional groups to maintain their professional identities in healthcare settings, they might also need to consider the need to talk about their identities in groups and with other groups to acknowledge uncertainties of role, implications of accountability, and wider social forces influencing their perceived decision-making capabilities. Without this critical dialogue surrounding SDM practice, there is a danger that the agenda may promote the extension of power across a broader range of professional groups. In doing so, Fox and Reeves (2015) warn that professional roles and hierarchies are reinforced and the service users' influence and contribution is further marginalised.

This research supports the need for critical dialogue amongst those involved within the decision-making processes (Roberts, 2000). This dialogue should enable individuals to be open about these influential factors and pay attention to the implications of hierarchy and accountability. It is suggested that a model of interprofessional clinical supervision would facilitate this process as professionals are supported in a non-threatening forum to explore their personal and professional motivations impacting their willingness to share power and influence (Clouder & Sellars, 2004).

The findings of this study are congruent with theoretically and empirically underpinned discussion relating to the criticisms of shared decision-making within the literature (e.g., Fox & Reeves, 2015; Stacey et al., 2010). However, they should be considered in light of their arising from the potential limitations of the method adopted in this study. This relates to the complex relation of focus group talk to everyday talk. Focus groups can be viewed as performances in which the participants jointly produce accounts about the proposed topics in a socially organised situation (Myers, 1998). However, Goffman (1981) maintains 'natural' discussion is also a performance and there is not a 'simple opposition of the institutional and the everyday, the artificial and the real' (Myers, 1998: 107). Silverman (1993) argues that neither kind of data (artificial and naturally occurring) is intrinsically better than the other (Silverman, 1993). The data arising from this study therefore has not been interpreted as if they are naturally occurring discussions, but as discussions occurring in a specific, controlled setting, which provides insight into how professionally homogenous groups collectively position themselves in relation to shared decision-making. Furthermore, a theoretical sampling strategy was adopted underpinned by the desire to identify information-rich participants. Therefore generalisations are made on an analytical basis as opposed to the extrapolation of findings to the wider population.

In summary, this study has presented a CNA of multiple perspectives of how decisions are made about patient care. There is recognition amongst all parties that the system does not facilitate decision-making that is genuinely inclusive. Each of the groups have their respective values, but they each position themselves relatively powerless to change the system to make shared decision-making authentic. Very real power hierarchies exist and have powerful effects on actors within the hierarchy. This suggests that the current structures may at best obscure and at worst actively obstruct new ways of working. Until the role and identity of the professional groups are understood in the context of power, a practical implementation of shared decision-making, as advocated in policy and literature, will be illusory. By creating space for open debate, there could be potential for the service user to be valued in terms of their expertise.

Declaration of interest

Funding

References

Arendt, H. (1970). *On violence*. London, UK: Harcourt Publishers.

Billig, M. (1987). *Arguing and thinking: A rhetorical approach to social psychology*. Cambridge, UK: Cambridge University Press.

Blumer, H. (1969). *Symbolic interactionism: Perspectives and method*. Berkeley and Los Angeles: University of California.

Bracken, P., & Thomas, P. (2005). *Postpsychiatry: Mental health in a postmodern world*. Oxford, UK: Oxford University Press.

Bryman, A. (2001). *Social Research Methods*. Oxford, UK: Oxford University Press.

Chong, W. W., Aslani, P., & Chen, T. F. (2013). Multiple perspectives on shared decision-making and interprofessional collaboration in mental healthcare. *Journal of Inter-Professional Care*, 27(3), 223–30.

Cleary, M. (2003). The challenges of mental health care reform for contemporary mental health nursing practice: Relationships, power and control. *International Journal of Mental Health Nursing*, 12, 139–147.

Clouder, L., & Sellars, J. (2004). Reflective practice and clinical supervision: An interprofessional perspective. *Journal of Advanced Nursing*, 46(3), 262–269.

Colombo, A. (2003). Evaluating the influence of implicit models of mental disorder on the process of shared decision-making within community-based multi-disciplinary teams. *Social Science and Medicine*, 56(7), 1557–1570.

Coulter, A., & Collins, A. (2011). *Making Shared decision making a reality*, no decision about me, without me. London, UK: Kings Fund.

Davies, B., & Harré, R. (1990). Positioning: The discursive production of selves. *Journal for the Theory of Social Behaviour*, 20(1), 43–63.

Deegan, P., & Drake, R. (2006). Shared decision making and medication management in the recovery process. *Psychiatric Services*, 57(11), 1636–1639.

Denzin, N. K., & Lincoln, Y. S. (2000). *Handbook of qualitative research*. London, UK: Sage.

Department of Health. (2012). *No decision about me without me: Liberating the NHS*. London, UK: HMSO.

Eagleton, T. (1991). *Ideology: An introduction*. London, UK: Verso.

Fagermoen, M. S. (1997). Professional identity: Values embedded in meaningful nursing practice. *Journal of Advanced Nursing, 25,* 434–441.

Foucault, M. (2002). *Archaeology of knowledge.* New York, NY: Routledge.

Fox, A., & Reeves, S. (2015). Interprofessional collaborative patient-centred care: A critical exploration of two related discourses. *Journal of Interprofessional Care, 29*(2): 113–118.

Freidson. (2001). *Professionalism, the third logic.* Cambridge, UK: Polity.

Gergen, K. J. (1989). Warranting voice and the elaboration of the self. In J. Shotter & K. G. Gergen (Eds.), *Texts of identity* (pp. 70–81). London, UK: SAGE.

Goffman, E. (1981). *Forms of talk.* Oxford, UK: Blackwell.

Hall, P. (2005). Interprofessional teamwork: Professional cultures as barriers. *Journal of Interprofessional Healthcare, 19*(1), 188–196.

Hamann, J., Mendel, R., Buhner, M., Kissling, W., Cohen, R., Knipfer, E., & Eckstein, H. H. (2011). How should patients behave to facilitate shared decision making-the doctors' view. *Health Expectations, 15,* 360–366.

The Health Foundation. (2012). *Helping people share decision making: A review of evidence considering whether shared decision making is worthwhile.* London, UK: Author.

Houghton, P., & Diamond, R. (2010). 'Values-based practice: A critique'. *Clinical Psychology Forum, 205,* 24–7.

Langdridge, D. (2007). *Phenomenological psychology: Theory, research and method.* Harlow, Canada: Pearson Education.

Müller-Engelmann, M., Keller, H., Donner-Banzhoff, N., & Krones, T. (2011). Shared decision making in medicine: The influence of situational treatment factors. *Patient Education and Counseling, 82,* 240–246.

Myers, G. (1998) Displaying opinions: Topics and disagreement in focus groups. *Language in Society, 27,* 85–111.

National Institute for health and Care excellence. (2011). *Service user experience in adult mental health: improving the experience of care for people using adult NHS mental health services: NICE clinical guideline 136,* NHS Evidence.

Politi, M. C., & Légaré, F. (2010). Physicians' reactions to uncertainty in the context of shared decision making. *Patient Education and Counseling, 80,* 155–157.

Roberts, S. J. (2000). Development of a positive professional identity: Liberating oneself from the oppressor within. *Advances in Nursing Science, 22,* 71–82.

Rogers, A., & Pilgrim, D. (2009). *A sociology of mental health and illness* (4th ed.). Buckingham, UK: Open University Press.

Rose, N. (2006). *The Politics of life Itself: Biomedicine, power and subjectivity in the 21st century.* Princeton, NJ: Princeton University Press.

Schauer, C., Everett, A., del Vecchio, P., & Anderson, L. (2007). Promoting the value and practice of shared decision-making in mental health care. *Psychiatric Rehabilitation Journal, 31*(1), 54–61.

Scott, J. (2001). *Power.* Cambridge, UK: Polity.

Silverman, D. (1993). *Interpreting qualitative data: Methods for analysing talk, text and interaction.* London, UK: Sage.

Slay, J., & Stephens, L. (2013). *Co-production in mental health: A literature review.* London, UK: new economics foundation.

Smail, D. (2005). *Power, Interest & Psychology.* Ross-on-Wye, UK: PCCS Books.

Stacey, D., Légaré, F., Pouliotc, S., Kryworuchkoa, J., & Dunna, S. (2010). Shared decision making models to inform an interprofessional perspective on decision making: A theory analysis. *Patient Education and Counseling, 80*(2), 164–172.

Uhm, S., Liabo, K., Stewart, R., Rees, R., Oliver, S. (2012). Patient and public perspectives shaping scientific and medical research: Panels for data, discussions and decisions. *Patient Intelligence, 4,* 1–10.

Woodbridge, K., & Fullford, B. (2005). *Whose Values? A workbook for values-based practice in mental health care.* London, UK: SCMH.