The Meaning of
Shared Decision-Making in Mental Care
– A Hermeneutical Study

by

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Acknowledgements

Summary

Background: Shared decision-making is understood to be a process where the patients and the mental healthcare professionals are engaged in a dialogue of information in order to understand each other's preferences and values regarding care and to agree on a plan of action. This understanding is mainly derived from a medical context. It is important that the scientific knowledge of shared decision-making is linked to the practice where it is to be carried out. The understanding of shared decision-making and its meaning in mental care needs to be developed, based on a caring science perspective.

Aims: The overall aim of this study was to develop a deeper understanding of the meaning of shared decision-making in mental care. The specific aims of the three sub-studies were: I) To describe patient participation in shared decision-making in the context of indoor mental care. II) To explore how mental healthcare professionals describe shared decision-making in a therapeutic milieu as expressed through clinical supervision. III) To interpret the meaning of shared decision-making in mental care as perceived by patients and mental healthcare professionals.

Methods: This thesis has a hermeneutical approach with an explorative design. Data were collected by means of three empirical sub-studies (Papers I, II and III), which contain in-depth interviews with 16 patients and multistage focus group interviews with eight mental healthcare professionals. Data analysis methods include qualitative content analysis (Papers I and II) and thematic interpretive analysis (Paper III). A deeper understanding of the meaning of shared decision-making was developed based on the empirical inductive findings, through deductive interpretation and finally an abductive interpretation.

Findings: The first sub-study revealed the main theme *thriving in relation to participating actively in a complementary ensemble of care,* and the two themes *having mental space to discover my way forward* and

being in a position to express my case. In the second sub-study, the theme was *practising shared decision-making when balancing between power and responsibility to form safe care,* comprising the three categories *internalizing the mental healthcare professionals' attributes, facilitating patient participation* and *creating a culture of trust.* The third sub-study revealed the overall theme *being in a space of sharing decision-making for dignified mental care,* comprising the three themes *engaging in a mental room of values and knowledge, relating in a process of awareness and comprehension* and *responding anchored in acknowledgement.* The three sub-studies represented parts of a larger whole of the investigated phenomenon and a synthesis of them was developed. Through a deductive interpretation the understanding *Shared decision-making - a healing process and an integral part of mental care* as well as *Shared decision-making - a process of understanding* emerged. The final abductive stage illuminated the comprehensive understanding: *The meaning of shared decision-making in mental care is being partners with an existential responsibility.*

Conclusion: The meaning of shared decision-making in mental care is being partners with an existential responsibility. The relationship between a person in need of care and the carer constitutes the existential responsibility, which acknowledges the being in human beings and is essential for mental growth. The mental healthcare professionals should be the patients' partner and supporter throughout care. This understanding conveys that shared decision-making requires great attention to emotional and relational qualities, scoping the existential dimensions in mental care.

Key words: Content analysis, existential responsibility, focus group interviews, hermeneutics, in-depth interviews, interpretive thematic analysis, mental care, mental healthcare professionals, patients, shared decision-making, qualitative method.

List of original publications

This thesis is based on the following papers, referred to in the text by their Roman numerals.

I Beyene, L. S., Severinsson, E., Hansen, B. S., & Rørtveit, K. (2018b). Patients' experiences of participating actively in shared decision- making in mental care. *Journal of Patient Experience*, 1–7.

II Beyene, L. S., Severinsson, E., Hansen, B. S., & Rørtveit, K. (2018a). Shared decision-making— balancing between power and responsibility as mental healthcare professionals in a therapeutic milieu. *SAGE Open Nursing*, 4, 1–10.

III Beyene, L. S., Severinsson, E., Hansen, B. S., & Rørtveit, K. (2019). Being in a space of sharing decision-making for dignified mental care. *Journal of Psychiatric and Mental Health Nursing*, 26:368–376.

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Part I

1   Introduction

In this thesis the phenomenon of shared decision-making (SDM) in mental care was explored, employing qualitative methods in order to develop a deeper understanding of this phenomenon. As a nurse, my research domain is caring science anchored in the human science perspective, looking beyond the instrumental factors related to the researched phenomenon by focusing on ethics, relations and humanity based on an entity of body, soul, and spirit (Eriksson, 2002). Caring science seeks an understanding of human beings in relation to existential conditions such as emotional and relational desires, as well as trying to illuminate the true and the good in care (Martinsen & Eriksson, 2009). By the use of a hermeneutic approach, the perspectives of patients' and mental healthcare professionals' (MHCPs') experiences in mental care were explored. Knowledge of their reality was illuminated, leading us to a deeper understanding of the meaning of SDM (Gadamer, 2013).

Decision-making in mental care is a dynamic social interaction which involves both the patients and the healthcare professionals to a greater or lesser extent (Charles, Gafni, & Whelan, 1999). SDM is a type of user participation, including the patients together with the carers in decision-making (Thompson, 2007). How mental care is understood will affect the patients' and the MHCPs' roles in decision-making (Gulbrandsen et al., 2016; Hummelvoll, 2006; Thompson, 2007).

The first definition of the phenomenon SDM was published in the report Making Health Care Decisions in 1982, by the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research. This definition focused on informed consent and explained SDM as a process based on partnership and mutual respect between the patients and the healthcare professionals (Makoul & Clayman, 2006). SDM had a relatively small focus until the interest escalated in the late 1990s. The definitions of SDM have been varied and

vague throughout the years, diverging in how they describe the patients' and healthcare professionals' responsibilities and roles (Charles, Whelan, Gafni, Willan, & Farrell, 2003). This gave rise to Makolul & Clayman's (2006) literature review to determine the variety of conceptual definitions. The authors identified essential elements of SDM required to be present for patients and healthcare professionals to participate in the SDM process: The patients and healthcare professionals define and/or explain the problem together. They present various options, they discuss the pros and cons of the options raised, including the patient's ability to follow up. They regularly check for further clarifications needed, decisions are made or deferred, and they arrange continuation to evaluate the result of decisions that have been made (Makoul & Clayman, 2006). This understanding of SDM is derived from the context of physician–patient encounters, mainly focusing on sharing information and decision-making, together with the patients' right to be self-determinant (Gulbrandsen et al., 2016).

Understanding derived from the perspective of caring science describes SDM to be based on an interdependent relationship between the healthcare professionals and the patients as they influence each other and cooperate in making decisions about the patients' well-being (McCance, Slater, & McCormack, 2009). SDM is argued to bear an existential dimension, which includes both physical needs and capacities, social belonging, psychological self-understanding and spiritual meaning (Gulbrandsen et al., 2016). The intention of SDM is to increase patients´ knowledge and control over treatment decisions that affect their well-being (Storm & Edwards, 2013). Bringing the expertise from both MHCPs and patients together is supposed to give rise to better decisions (Farrelly et al., 2016; Slade, 2017). However, the meaning of SDM in mental care remains unclear.

There is international consensus about the importance of SDM. It has been greeted by policymakers worldwide and is accepted as a guiding principle in mental care (Elwyn, Frosch, & Kobrin, 2016; Slade, 2017).

WHO (2006) states that improved quality of care depends on the active participation of patients. The patients have a responsibility and play an important role in identifying their own needs, preferences and ways of dealing with their own health with proper support from healthcare professionals. While the healthcare professionals possess professional expertise, the patients possess personal expertise, experiences and knowledge of social circumstances, values and preferences. Combining these types of expertise, together with research evidence, is supposed to be an optimal basis for making the best possible decisions (Slade, 2017). The ethical justification asserts patients participating in SDM as a basic human right. Ethical justifications highlight that patients and healthcare professionals contribute with diverse but equally important forms of expertise (Coulter & Collins, 2011).

Various interventions for practising SDM have been investigated (Légaré et al., 2018), yet SDM and its implementation into mental care practice is still at an early phase (Morant, Kaminskiy, & Ramon, 2016; Stovell, Morrison, Panayiotou, & Hutton, 2016). Tailoring the implementation of SDM to contextual conditions is important in order to increase the chances of successful implementation (Damschroder et al., 2009). SDM in mental care requires MHCPs to be able to recognize that different clinical situations need differing approaches, as well as accepting it as a core element of good practice (Elwyn & Fisher, 2014). There is a need for enhancing knowledge on how to translate the evidence on SDM into mental care practice and to develop an implementation strategy for SDM in mental care (Scholl & Barr, 2017; Schön, Grim, Wallin, Rosenberg, & Svedberg, 2018). Implementation challenges should be the main concern in the effort to push SDM practice forward in mental care (Slade, 2017).

It is necessary to distinguish on what kind of knowledge the understanding of SDM is based and in which context the knowledge derives so that the scientific knowledge of SDM is linked to the practice to be carried out (Martinsen & Eriksson, 2009). The existing knowledge

of SDM is mainly derived from a medical context (Gulbrandsen et al., 2016), which involves a risk that important knowledge derived from a caring science perspective will be ignored. Developing the understanding of this phenomenon, it is important to explore the meaning of SDM from a caring science perspective, including experiences from both the patients' and MHCPs' perspectives.

1.1 Aims and research questions

The overall aim of this study was to develop a deeper understanding of the meaning of SDM in mental care.

Three sub-studies (Papers I-III) were carried out, each of them presented in separate papers, all representing parts of the whole of this thesis. The overall aim was translated into the following specific aims:

1) To describe patient participation in SDM in the context of indoor mental care (Paper I).
2) To explore how MHCPs describe SDM in a therapeutic milieu as expressed through clinical supervision (Paper II).
3) To interpret the meaning of SDM in mental care as perceived by patients and MHCPs (Paper III).

The research questions (RQ) were:

RQ 1) What are patients´ experiences of participating in SDM? (Paper I)

RQ 2) What are prerequisites for MHCPs to practise SDM in a therapeutic milieu? (Paper II)

RQ 3) What is the meaning of SDM in mental care? (Paper III)

1.2 Context

The context of this thesis is mental care in three wards in a community mental health centre in Norway. The community mental health centres

in Norway have the responsibility for serving a geographically defined area, each with an estimated responsibility for 30,000 to 75,000 inhabitants. The core tasks of the community mental health centres are to offer acute and emergency services, both in- and out-patient services, short-term treatment as well as long-term. The referred patients should be checked, diagnosed and offered differentiated treatment. People with severe mental disorders should be offered rehabilitation (Malt, 2019).

There is an ongoing process of reducing places for in-patients at the community mental health centres, as in psychiatric institutions in general, but alternative services are not developed in line with this reduction. Patients are often discharged before they feel restored enough to cope with life outside the hospital and before alternative services are offered (Norwegian Health Directorate, 2015). This situation affects both patients and MHCPs in mental care. The patients are often in very poor mental health when being hospitalized in the community mental health centres, and the time available to work towards restored mental health is often too short. This challenges the relational and holistic focus in care, which involves encountering the patients with their physical, mental, social and spiritual needs (Eriksson, 2002).

Increasing demands of effectiveness and lack of research-based knowledge of mental care have contributed to unclear professional content and a lack of shared professional practice (Borge & Hummelvoll, 2019). The traditional biomedical care system has been dominant in mental care wards in Norway (Martinsen & Eriksson, 2009) which, in contrast to SDM, has placed MHCPs in a position of power and authority with the patients playing a passive role in their care. The MHCPs have instructed their patients about what to do and the patients have usually followed their advice (Lyttle & Ryan, 2010). National authorities have required a focus on user participation, which has been derived with the purpose of increasing the patients' coping ability and influence over their own lives. This means that MHCPs now have to consider the patient as an equal partner, and it challenges the care to be more flexible and

person-oriented (Norwegian Ministry of Health & Care Services, 2015–2016).

The purpose of mental care is to empower patients to take control and to be self-determinant (Davidson, Tondora, Pavlo, & Stanhope, 2017). Peplau (1991) describes the hospital ward as a social context where the patients will be helped to mature towards improved health. Indoor mental care is based on relational treatment, the main focus being to use relationships to alleviate relational harm. Indoor mental care is intended to be based on a therapeutic milieu, which is more than an environment in the ordinary sense of the word. It is supposed to be a healing culture, rich in therapeutic interpersonal relationships and co-operative attentiveness to patients. Its physical features should soothe patients and provide optimum safety. The purpose of the therapeutic milieu is two-fold: to foster patients' optimal healing by being protective, calming and restful, and to provide a practice conducive to their health (Skårderud & Sommerfeldt, 2013). Important factors in a therapeutic milieu are treatment programming, interpersonal relationships, patient empowerment, patient safety and hope for the future (Long, Knight, Bradley, & Thomas, 2012). The optimal therapeutic milieu supports patient-centered care, safety and continuous healing (Mahoney, Palyo, Napier, & Giordano, 2009).

MHCPs are the frontline workers on the ward. MHCPs working in the mental health wards possess various professions, mostly bachelor degrees in nursing or as a social educator, some with a specialized education in mental care (Malt, 2019). Because of the lack of MHCPs, unskilled assistants also work in this clinical context. Psychologists and psychiatrists are linked to the ward as individual therapists. Assistants, psychologists and psychiatrists, as well as the managers are not focused on in this thesis.

The patients hospitalized at community mental health centres, represented in this thesis, struggle with various mental health problems,

suffering from different mental illnesses, which makes them in need of being an in-patient for a period of time, short or long term.

1.3   Research design

This study was based on an explorative design (Holm, 2009; Polit & Beck, 2010) in order to illuminate stakeholders' experiences, and the meaning of SDM. The design is visualised in Figure I. The interpretative paradigm with a hermeneutic approach was adopted (Gadamer, 2013) to develop a deeper understanding of the meaning of SDM in mental care. Three stages of interpretations were developed; inductive, deductive and abductive (Graneheim, Lindgren, & Lundman, 2017; Råholm, 2014).

The first stage of this study was conducted inductively (Polit & Beck, 2010) arranging for new insights to occur (Hsieh & Shannon, 2005). The empirical part consisted of dialogues with the MHCP participants (N=8) in multistage focus groups (Papers II and III) and with the patient participants (N=16) in individual dialogues (Papers I and III), illuminating a variety of aspects of the researched phenomena (Malterud, Siersma, & Guassora, 2016). Three sub-studies (Papers I-III) were carried out and constituted independent papers that formed the foundation on which the hermeneutic circle was constructed (Gadamer, 2013). Qualitative content analysis (Papers I and II) and thematic interpretive analysis (Paper III) were conducted on the empirical data (Braun & Clarke, 2006; Graneheim et al., 2017; Graneheim & Lundman, 2004). The findings from the empirical sub-studies (Papers I-III) were synthesised in order to grasp a sense of the whole.

The second stage was conducted deductively (Polit & Beck, 2010) in order to develop a deeper understanding of the meaning of SDM (Hsieh & Shannon, 2005). Interpretations from the previous inductive stage were formed in the light of existing knowledge. A systematic review of the research evidence of SDM in mental care was conducted (Smith, Devane, Begley, & Clarke, 2011) and constituted the theoretical

background, providing a basis for the deductive interpretation together with theories linked to the focused topic.

In the abductive stage a fusion of horizons created a comprehensive understanding (Gadamer, 2013; Råholm, 2014). Dialogues with the empirical patient perspective, the empirical MHCP perspective, existing knowledge and existential philosophy (Frankl, 2014; Levinas, 2003; Sartre, 2007) as well as and me as researcher, illuminated new insights, contributing to a deeper understanding of the meaning of SDM in mental care.
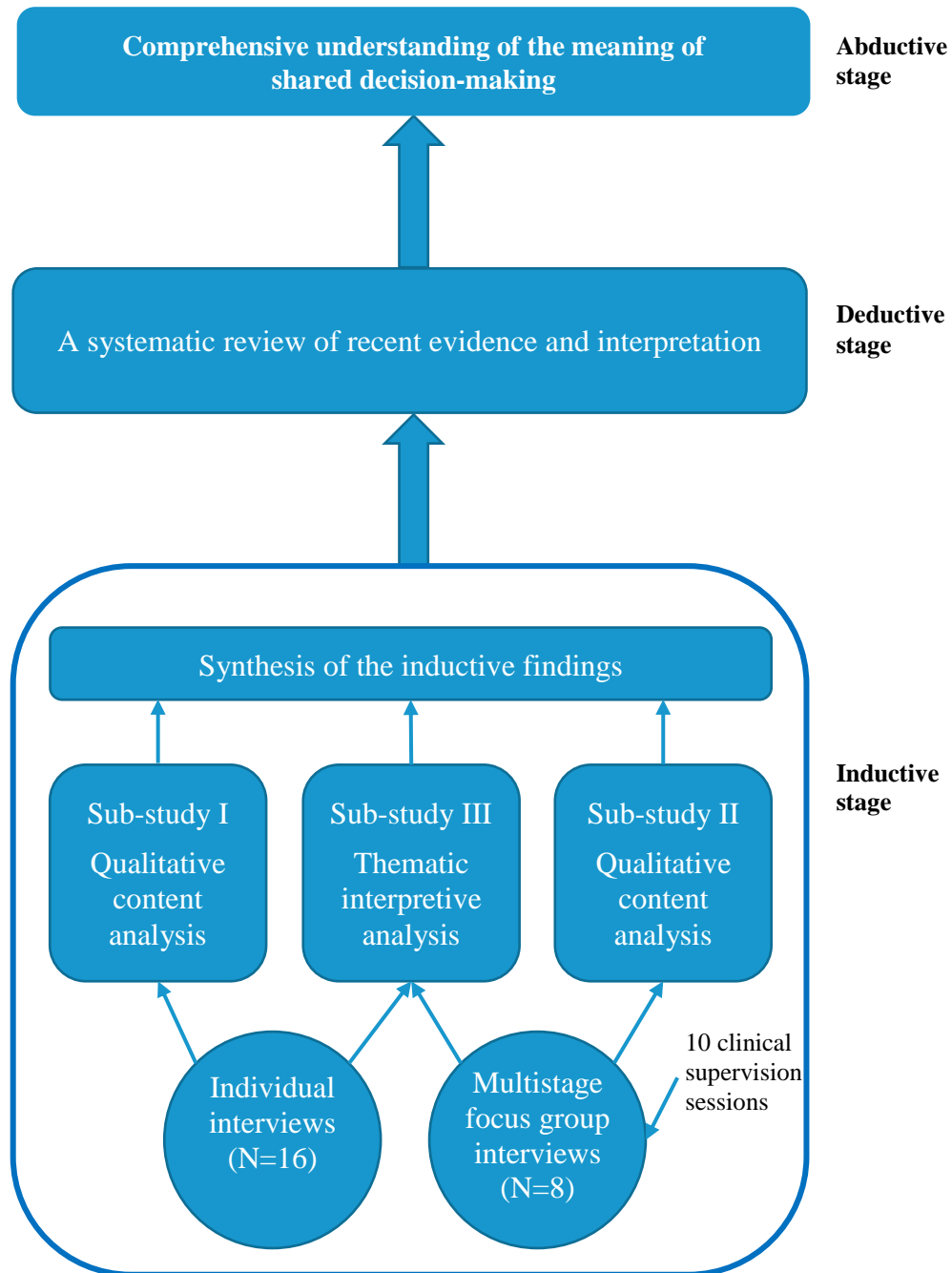
Figure 1 – Research design

1.4   Structure of the thesis

This thesis is built on three original research papers (Papers I-III) and comprises two parts.

Part I is devided into seven sections. First, in the introduction (Section 1), the research area and the study context are described. The aims, research questions and the research design are presented together with the structure of the thesis. The theoretical background (Section 2) is a presentation of a systematic review of review articles focusing on SDM in mental care. The methodological framework (Section 3) of the thesis presents the hermeneutical approach and methods, as well as methodological and ethical considerations. An overview of the findings (Section 4) derived from the three sub-studies is followed by an interpretation and discussion (Section 5). Finally, a conclusion (Section 6) is developed, followed by the implications (Section 7) for clinical practice and suggestions for further research.

Part II contains the three original research papers and the appendices.

2   Theoretical background

Theory is understood as basic perceptions of the nature of a research area (Fredriksson, 2014). This section presents a systematic review of research evidence of SDM in mental care (Smith et al., 2011). It forms the basis for the theoretical background of this thesis. The synthesis of the scientific knowledge is aimed at obtaining the existing understanding of findings in this research field. The review question was "what is the scientific knowledge of SDM in the context of mental care?".

An electronic search was carried out, assisted by a librarian. The objective was to identify review articles about SDM in mental care in the English language, published between 2015 and 2019 including SDM in the title in the data bases Embase, PsycINFO, Medline, Cinahl (via Ebsco) and Web of Science. An overview of the search strategy is attached (Appendix 1). A total of 321 reviews were identified and screened for relevance. The first stage of screening involved exclusion of duplicates. Articles lacking relevance for the review question were excluded as well. Exclusion criteria were articles focusing on children, youths and medical treatment. A total of 16 reviews were examined during the second screening phase, which involved reading article abstracts to ensure the relevance to the scope of this review. Eight reviews were selected for inclusion in this review (Table 1), reflecting evidence of SDM from 426 different original articles. In order to sum up the evidence, the findings synthesised in this section present the recent status of research of SDM: *SDM- an approach in mental care,* and *Changing attitudes towards the theory and practice of shared decision - making.*

Table 1 – Review articles for the research synthesis

AUTHORS	TYPE OF REVIEW
Alguera-Lara, Dowsey, Ride, Kinder & Castle (2017) (Australia)	Narrative review (N=18)
Castillo & Ramon (2017) (UK)	Systematic review using narrative synthesis of relevant data bases (N=17)
Davidson, Tondora, Pavlo & Standhope (2017) (USA)	General review (N=27)
James & Quirk (2017) (UK)	Systematic review (N=175)
Kaminsky, Senner & Hamann (2017) (UK, Germany)	Qualitative synthesis (including studies adopting qualitative, quantitative and mixed methods design) (N=43)
Legare, Adekpedjo, Stacey, Turcotte, Krywo-ruchko, Graham, Lyddiatt, Politi, Thomson, Elwyn &, Donner-Banzhoff (2018) (Canada, USA, UK, Germany)	Systematic review of randomized and non-randomized trials, controlled before-after studies and interrupted time series studies evaluating interventions for increasing the use of SDM in which the primary outcomes were evaluated using observer-based or patient-reported measures (N= 87)
Ramon, Brooks, Rae & O'Sullivan (2017) (UK)	Review (N=28)
Zisman-Ilani, Barnett, Harik, Pavlo & O'Connell (2017) (USA)	Systematic search and scoping review of interventions (N=31)

2.1 Shared decision-making - an approach in mental care

SDM is an approach for planning and carrying out care which focuses on the process of decision-making in the setting of the relationship between patients, MHCPs, and sometimes also the patients' next of kin (Davidson et al., 2017). SDM values the patients' experiential knowledge together with the professional and scientific knowledge, and by integrating these perspectives it is expected to lead to better decisions in mental care (James & Quirk, 2017; Ramon, Brooks, Rae, & O'Sullivan, 2017).

Decisions in mental care are not only about rehabilitation and treatment. The patients' process of restoring their mental health is a dynamic, relational journey which takes place over time and varies according to circumstances (Castillo & Ramon, 2017). Therefore the focus in SDM should be on the process, rather than the final decision (James & Quirk, 2017).

Mental care is about helping patients deal with mental ill-health in the context of their lives and involves the patients' personal decisions and life decisions. The patients are the main characters of the care process and the key decision-makers. The MHCPs can provide the patients with their professional knowledge, but the patients have to participate by sharing their knowledge and experiences of what they think is required to attain the life they desire. The patients' role in SDM is therefore essential and cannot be ignored or assumed. However, the patients' mental challenges often require a level of support, experience and expertise which is hard to find in a traditional mental care system (Davidson et al., 2017). Assisting the patients in these decisions pushes the MHCPs beyond the scope of traditional mental care and requires relationships between patients and MHCPs which stimulate the patients' ability for self-determination. MHCPs have to find out how to apply their own professional skills and knowledge for the patients' to use in search

of his or her own goals (Davidson et al., 2017). Core aspects for SDM are respect and open dialogue, in addition to MHCPs being committed to empathetic partnering (Castillo & Ramon, 2017; Davidson et al., 2017).

SDM is an important approach to uphold patient-centered mental care. MHCPs should place emphasis on being their patients' partners by supporting, encouraging and guiding them to voice their own care needs and help their life to move forward in their own process of restoring their mental health (Davidson et al., 2017). The SDM approach improves patients' well-being more than just focusing on a particular intervention (Ramon et al., 2017).

The purpose of mental care has moved beyond the maintenance of clinical stability and the emphasis is now on empowering patients to take control and live self-determined lives regardless of severe mental ill-health. Traditional mental care is in itself not sufficient to achieve this purpose. The patients need to take an active role, learning about taking responsibility and dealing with all the challenges a life with mental ill-health entails (Davidson et al., 2017). SDM is a useful approach in this regard (James & Quirk, 2017; Kaminskiy, Senner, & Hamann, 2017).

James & Quirk (2017) report that SDM strengthens the therapeutic relationship between patients and MHCPs, with qualities such as trust and mutual understanding, genuineness and empathy. It adjusts power imbalances and upholds communication and partnership. SDM activates patients to take control in their lives. It enables them to express their experiences and desires and allows them to influence their care and find their own way of restoring their mental health. This is supposed to give rise to improved self-esteem, self-confidence and self-efficacy and is assessed to be therapeutic in itself. SDM is viewed as a way for patients to take back control, which protects them against coercion (James & Quirk, 2017; Kaminskiy et al., 2017). In addition, Alguera-Lara, Dowsey, Ride, Kinder, and Castle (2017) report that patients

participating in SDM have reduced symptoms, increased care satisfaction and improved adherence to care, as well as enhanced knowledge and increased engagement. SDM also strengthens other mental care interventions (Castillo & Ramon, 2017; James & Quirk, 2017; Ramon et al., 2017). Patients with schizophrenia were observed to attain decreased rates of hospitalisation when participating in SDM (Alguera-Lara et al., 2017). James & Quirk (2017) describe SDM in mental care to be cost effective.

2.2 Changing attitudes towards the theory and practice of shared decision-making

There is an existing gap between the theoretical model of SDM and the practical implementation of SDM in mental care (Ramon et al., 2017; Zisman-Ilani, Barnett, Harik, Pavlo, & O'Connell, 2017). To better understand this gap between SDM knowledge and practice it is useful to understand patients' and MHCPs' attitudes towards it.

Studies demonstrate that patients and MHCPs prefer and support SDM (Ramon et al., 2017). The SDM approach is considered "best practice" in mental care and is essential to the "modernisation" of mental care services (James & Quirk, 2017). However, some MHCPs still have ambivalent attitudes towards SDM and view it as distant from the traditional psychiatric approach. Some also have concerns that SDM will threaten their professional responsibility. There is a medical dominance in mental care, probably as a consequence of occupational control over many other conflicting interest groups, and attitudes concerning SDM may be determined by the MHCPs' speciality (Kaminskiy, Senner, & Hamann, 2017).

Patients' preferences for SDM may vary according to education levels, employment status, ethnicity and diagnosis (Ramon et al., 2017). However, patients in mental care want, and are able, to be involved in decisions about their care, though the degree of involvement varies.

Currently, they often do not experience access to the participation they prefer (Alguera-Lara et al., 2017; James & Quirk, 2017). In practice, they experience a lack of information from their MHCPs and the type of information offered by their MHCPs is lacking in choice. MHCPs sometimes hold back information and do not acknowledge that sharing the responsibility and risk with the patients in their care is a part of SDM (Ramon et al., 2017). Davidson et al. (2017) report the consideration of patients being incompetent to make their own decisions and take responsibility, to be based on the stigma linked to patients with mental ill-health more than to the nature of the condition itself.

Castillo & Ramon (2017) report that MHCPs consider respect to be fully integrated in their practice, while patients do not find that apparent. Their understanding of dialogue differs.

The patients acknowledge a need for increased assistance during phases of mental health crisis. However, they highlight the importance of a therapeutic relationship with the MHCPs; being listened to, building trust and having autonomy returned to them over time (Castillo & Ramon, 2017). MHCPs emphasise the need to modify the decision-making style to the individual patients and the specific situation (Kaminskiy et al., 2017). SDM is associated with basic human dignity (Castillo & Ramon, 2017).

Building relationships between the stakeholders, as well as individual commitment is required for promoting SDM (Ramon et al., 2017). Implementation of SDM requires all stakeholders to know what SDM is and to be able to distinguish it from their current practices (Ramon et al., 2017). This demands that MHCPs change the traditional scope of mental care and emphasizes supporting their patients in their entire lives (Davidson et al., 2017). A de-implementation of existing practices is necessary when implementing SDM (Ramon et al., 2017).

Focus on promoting SDM should be guided by facilitators for SDM, which will be described in the following section.

2.2.1 Facilitating and obstructing a trusting, shared decision-making relationship

Alguera-Lara et al. (2017) found openness, patience, trust and respect to be essential in SDM to support relational attitudes. A prerequisite to practising SDM is a trusting relationship between patients and the MHCPs, which is built on empathy, mutual understanding, compromise and partnership. A non-judgemental and supportive environment, holding up the patient to be an active and deciding agent, is essential for SDM to be beneficial. A respectful culture acknowledging the patients' expertise, communicating belief in the individual patients' potential, as well as recognising power issues in the helping relationships are elements which enhance patients' participation in SDM. This requires MHCPs to possess relational competencies to foster an open, genuine dialogue with their patients (Castillo & Ramon, 2017; Davidson et al., 2017; Kaminskiy et al., 2017).

MHCPs encouraging their patients to participate actively is supposed to reveal an attitude of being open to new understanding. Possessing an active role in SDM, the patients must be provided with information about the options for treatment and the advantages and disadvantages thereof. Behaviours to support SDM are MHCPs educating their patients about available choices, information sharing and giving feedback. Active participation and engagement in the encounters is needed, in addition to collecting information and preparing for the encounters as well as applying the decision (Alguera-Lara et al., 2017; Davidson et al., 2017; Ramon et al., 2017).

Some patients may fear negative consequences if they assert themselves, they may feel powerless, they may not feel safe enough in their relationships with MHCPs and they may lack trust in their MHCPs, in addition to having different expectations about the roles of MHCPs and patients. For that reason, patients need to know that they have a right to participate in their own care and they need to experience the MHCPs as

open to new understanding (Alguera-Lara et al., 2017; Davidson et al., 2017).

Being open to new understanding, MHCPs view collaboration with the patients' families and other caregivers as promoting SDM. Another facilitator for SDM may be interprofessional collaboration by providing more occasions for patients to talk about their concerns regarding care and addressing time barriers (Kaminskiy et al., 2017).

A barrier for several patients to participate in SDM is the inability to process information efficiently and to express themselves clearly when in poor mental health. Patients may see their historical passivity, past trauma, their own competence and fragile hope as challenging for participating in SDM, as they are afraid of being incompetent (Castillo & Ramon, 2017; Kaminskiy et al., 2017). The standard mental care approach is that the MHCPs make the decisions. The patients may feel they have to please their MHCPs by just following their decisions, as they often experience being informed rather than involved in choices (Castillo & Ramon, 2017; Davidson et al., 2017). Kaminsky et al. (2017) report that the patients' opinions are seen as less important or less valued than the MHCPs'. Many patients inform that they are struggling to be seen or heard as competent and equal in encounters with their MHCPs.

A barrier for MHCPs practising SDM is that they are not open to new understandings. Their own attitudes and lack of willingness, motivation and empathy keeps them from being able to involve their patients in their own care. Some MHCPs determine certain patients and situations as generally inappropriate for SDM (Alguera-Lara et al., 2017; Kaminskiy et al., 2017; Ramon et al., 2017). Some MHCPs state that patients' adherence, cognitive capacity and insight is essential in order to participate in SDM (Ramon et al., 2017). Patients' lack of insight into their illness is a key barrier to SDM, as MHCPs consider their obligation is to prevent the patients from the risk of harm to self or to others (Castillo & Ramon, 2017; Kaminskiy et al., 2017). A concern is that an

incorporation of the patients' preference may not always reflect the best clinical choice. Being open to new understanding requires a shift in roles from a traditional, paternalistic decision-making style towards SDM, which is necessary to practise SDM (Castillo & Ramon, 2017; Ramon et al., 2017).

Coercive and legislative frameworks included in the mental care context may be an aspect which can erode trust between patients and MHCPs, thus making the SDM relationships difficult to initiate and sustain. Prevalent norms about control and surveillance in mental care are a direct barrier for SDM, but are seldom confessed by MHCPs. Informal norms within mental care and pressures from the clinical context are likely to impede an openness to new understanding and SDM (Castillo & Ramon, 2017; Ramon et al., 2017).

Practising SDM requires MHCPs to see a difference between current practice and SDM and an understanding of SDM as a continuing process which cannot be fully completed (Castillo & Ramon, 2017; Ramon et al., 2017). Facilitating a practice of openness to new understanding needs broader contextual support, including support from the organisation and upper level administration (Ramon et al., 2017). Kaminskiy et al. (2017) report that SDM interventions, like decision aids which support patients' involvement in SDM, are necessary for practising SDM.

2.2.2   The evidence of shared decision-making interventions

At present, a proven method of practising SDM in routine care is lacking. A range of interventions have been developed in order to facilitate the practice of SDM (Légaré et al., 2018). Some of the interventions targeting patients are patient activation, decision tools, rapid question lists and training for patients. Examples of interventions targeting MHCPs are aides-mémoires, educational material, educational meetings and educational outreach. Interventions combining patient and MHCP

interventions have also been established. Légaré et al. (2018) report the evidence to be very low and therefore cannot designate which interventions for practising SDM are the most effective. However, comparing to no intervention at all, interventions for MHCPs were considered to slightly improve quality of life regarding mental health.

Training to support SDM should be advocated continually and should not only be a one-off decision (Ramon et al., 2017). Both patients and MHCPs need SDM training. The training of MHCPs might only demonstrate scarce improvements in the long-term, but combining the training of MHCPs with the training of patients has been found to improve results (Castillo & Ramon, 2017; Ramon et al., 2017). However, patients and MHCPs need to have separate SDM interventions (Kaminskiy et al., 2017; Zisman-Ilani et al., 2017).

Documented interventions to implement SDM should not be assumed to work generally. It is necessary to adapt them, together with procedures, to the patients' individual needs (Ramon et al., 2017). By the education and support of patients they can become empowered and gain self-confidence regarding their own decision-making (Castillo & Ramon, 2017). Zisman-Ilani et al. (2017) highlight parts of SDM interventions in mental care beyond decision support tools and information exchange, and encourage broader SDM intervention strategies. Important aspects are to bring forth patients' values and preferences, to facilitate patients' motivation, to provide for patients' communication skills training and to elicit patient participation in care planning and goal setting.

Providing training for MHCPs at a team level could equip them to give each other support in challenging existing practices and to develop SDM. Clinical supervision sessions are suggested to facilitate practising SDM. However, how to operationalize clinical supervision sessions needs further investigation (Ramon et al., 2017).

2.3   Summary

Decisions in the context of mental care involve the patients' personal decisions and life decisions, in addition to concerns about rehabilitation and treatment (Castillo & Ramon, 2017). Assisting the patients in these decisions requires trusting relationships between patients and MHCPs which stimulate the patients' ability for self-determination. Respect and open dialogue are core aspects for SDM, as well as MHCPs being dedicated to empathetic partnering by supporting, encouraging and guiding their patients to move forward in their own process of restoring their mental health (Castillo & Ramon, 2017; Davidson et al., 2017).

SDM is assessed to be healing for patients in mental care and is viewed as a way for patients to take back control, which protects against coercion (Alguera-Lara et al., 2017; James & Quirk, 2017). SDM is considered "best practice" in mental care and is significant for the "modernisation" of services (James & Quirk, 2017). Both patients and MHCPs prefer and support SDM. However, some MHCPs are hesitant about SDM and view it as distant from traditional mental care and patients often do not experience being involved as much as they would prefer (Alguera-Lara et al., 2017; James & Quirk, 2017).

Promoting SDM requires all stakeholders to understand what SDM is and to distinguish it from existing practices (Davidson et al., 2017; Ramon et al., 2017). De-implementation of current practices is required, as well as establishing individual commitment and relationships between the stakeholders in the implementation of SDM (Ramon et al., 2017).

Being open to new understanding facilitates SDM, which requires a respectful culture acknowledging the patients' expertise and the communication of belief in the individual patients' potential as well as recognition of power issues in the helping relationships (Alguera-Lara et al., 2017; Castillo & Ramon, 2017; Davidson et al., 2017; Kaminskiy et al., 2017; Zisman-Ilani et al., 2017). The patients must receive all the necessary information about the options for care. Furthermore, it is

necessary that the MHCPs possess relational competencies for practising SDM (Alguera-Lara et al., 2017; Davidson et al., 2017). Inter-professional collaboration and support from the organisation and upper level administration are facilitators for the implementation of SDM (Kaminskiy et al., 2017; Ramon et al., 2017).

Factors related to the patients' ill-health in addition to their feeling of powerlessness, fear of negative consequences if they assert themselves and insecurity in their relationships with their MHCPs are all barriers for patients to practise SDM (Alguera-Lara et al., 2017; Davidson et al., 2017). Other barriers for MHCPs to practise SDM are their own attitudes, willingness, motivation, empathy and ability to involve their patients, together with concerns that an incorporation of the patients' preference may not always reflect the best clinical choice. Prevalent norms about control and surveillance, as well as informal norms within mental care and pressures from the clinical context are likely to impede the implementation of SDM (Alguera-Lara et al., 2017; Kaminskiy et al., 2017; Ramon et al., 2017).

A proven intervention for practising SDM in mental care is currently lacking. Interventions for MHCPs were considered to slightly improve SDM in mental care (Légaré et al., 2018). Combining interventions for MHCPs with training for patients is also found to improve results (Castillo & Ramon, 2017; Ramon et al., 2017). Providing interventions for MHCPs, at a team level, is supposed to prepare them for supporting each other in challenging situations and improving SDM. Clinical supervision sessions are found to facilitate the implementation of SDM. However, how to operationalize these interventions needs further investigation (Ramon et al., 2017).

3   Methodological framework

The following section describes the methodological framework applied in this thesis. The hermeneutical approach is defined as well as methods, with a description of participants, data collection methods and methods for analyses. Methodological considerations are discussed and ethical considerations are outlined.

3.1   Hermeneutic approach

A deeper understanding of the meaning of SDM in mental care was sought after in this thesis, applying a hermeneutic approach. The hermeneutic research paradigm for this thesis is based on Gadamer (2013) who describes understanding of the world and provides an explanation of human understanding as limited, shaped by our being, such as our values, interests, language, traditions and time in history. In order to experience the world, we must interpret what is around us and through our interpretations we achieve an understanding, which is more complex than an explanation. Achieving an understanding is a starting point for new experiences of being open to new perspectives and being open to encounter the unknown (Gadamer, 2013).

Understanding is described as a multifaceted experience explained as the hermeneutic circle; a dialectic movement between proximity and distance, part and whole, self and others, present and past. Attaining the overall aim of this study, I considered various aspects of SDM as a part, continuously having new aspects in sight and gaining more insight by seeing more clearly. A fusion of horizons, Gadamers description of understanding, was developed as the dialogue, the written text and me as a researcher, entered the hermeneutic circle, dialectically moving between the empirical findings and theory, as well as between the various parts and the whole (Gadamer, 2013). The new expanded understanding, derived from my pre-understanding, was influenced by patients and

MHCPs (Holm, 2009), as well as the co-researchers. A hermeneutical movement back and forth between the findings of the sub-studies (Papers I-III), pre-understanding, the theoretical background employed, other relevant theories, as well as philosophy led to a comprehensive understanding of the researched phenomenon.

3.1.1 The researcher's pre-understanding and role

Who we are and the experiences we have had earlier in life will colour the understanding we achieve in new situations. Gadamer (2013) conveys that our pre-understandings derive from the tradition in which we take part, and an intentional organizing is activated when we consider something. Tradition does not stand over in contradiction of our thinking. It is the horizon within that conducts our understanding. Pre-understandings can prevent us from grasping the meaning of a phenomenon in the way that it is impossible to see further and to understand in a new way if the researcher does not know his or her pre-understanding or is aware of his or her prejudices (Gadamer, 2013).

My pre-understanding consists of the human science perspective, ethical understanding, caring and medical knowledge, prejudices, and values in addition to several years of experiences of being a registered mental health nurse. I value every human being as a unique creature, everyone carrying some hidden treasures waiting to be unfolded. I believe all human beings have both resources and vulnerabilities that need to be balanced in order for them to feel valued. I find mental care challenging because so many situations occur without having a clear answer for best practice. Maybe that is why I trained to be a clinical supervisor, helping other MHCPs to reflect on their everyday practices. I think clinical supervision is essential for MHCPs' practice of quality in care. My intention with this thesis was to explore the practice in order to get a deeper understanding of how it can be formed to facilitate the patients' and MHCPs' cooperation for the patients' benefit.

The research team in this study consisted of me as manager of the project, my main supervisor, Associate Professor Kristine Rørtveit and my two co-supervisors Professor Elisabeth Severinsson and Professor Britt Sætre Hansen. Three of us are registered psychiatric nurses (LSB, KR and ES) and one is a registered intensive care nurse (BSH), all possessing many years of clinical experience.

My role in this project was to administer as well as conduct all parts of this study along with the supervisors, who were actively engaged. Firstly, we (LSB, KR and ES) designed the supervision program (Appendix 8), which served as a basis for the multistage focus group interviews. I was responsible for applying to the Regional Ethics Committee for approval to carry out this study and for recruiting the participants. I conducted the individual interviews, transcribed all the recorded interviews and performed the systematization and categorization part of the analysis before the supervisors were engaged in the interpretation and validation of the findings.

I was involved as a researcher and as a participating observer in the clinical supervision sessions in the multistage focus group interviews with the MHCPs and transcribed the recorded data after each session. I was involved in listening to the participants' dialogues and reflections, and I asked questions in order to get deeper into the core of their reflections. The main academic supervisor in this study (KR) had the role of clinical supervisor, guiding the participants through the clinical supervision sessions in the multistage focus group interviews. The role of the co-supervisors, who were not closely involved in the data collection in the clinical supervision group, was to challenge the involved's pre-understanding, as well as validating the analysis process from their "outsider" perspectives (Graneheim et al., 2017).

3.1.2 Establishing trustworthiness

To establish confidence in the research it was necessary to have a thoughtful, conscious self-awareness and critical reflection of pre-understanding during all parts of the study (Polit & Beck, 2010). To achieve a horizon means to look beyond what is near – not with the intention of looking away from it but to grasp it better, within a larger whole and in truer proportion (Gadamer, 2013). If we want to expand the horizon of meaning and our understanding we should look beyond what is nearby and overcome our pure subjectivity with its preunderstanding and existing prejudices (Launsø, Olsen, & Rieper, 2011).

Own awareness and self-understanding

Gadamer (2013) emphasizes that the phenomenon we want to understand, must appear on its own terms as far as possible. My intuition, insight, awareness of prejudice and knowledge facilitated this. The dialogue between the participants and me as a researcher formed a communion. A circular motion was created between my expectations and the meaning that the participants conveyed as I was deeply tuned-in to the experiences and meanings of the participants (Dwyer & Buckle, 2009). In order to uncover the meaning, I had to be aware that I did not understand and I had to take part in the dialogue that took place (Gadamer, 2013). I searched for something that provoked my pre-understanding in order to find what the participants were telling me and it was important for me to critically reflect when something appeared that was not in line with my pre-understanding, as well as discussing the issues with the research team. This gave me a better position to search for new aspects of the researched phenomenon and it was necessary for promoting a deeper understanding of the meaning of SDM (Launsø et al., 2011).

Being aware of one's own subjectivity and pre-understanding is challenging. It was important that the research team, the reference group

as well as research groups, were actively involved in the research process in order to optimize the study's trustworthiness.

The research team's, reference group's and research groups' contribution

In addition to me, three supervisors participated as co-researchers, cross-checked and discussed the content throughout the analysis process, focusing on how to understand and discover a deeper meaning of the content of the data (Graneheim et al., 2017).

A reference group was established in order to secure that this study mirrored the practice field and to keep an outsider-view on the project. In addition to me as the project leader and the main supervisor in the project, the reference group was comprised of a service user representative, a representative from the hospital managerial group and the MHCPs, as well as a psychologist representing the interdisciplinary team. The reference group met at least once every 6 months, and its members were consulted whenever needed. Their role was to evaluate the various activities and elements in the research process from their point of view, including the interview guide, recruitment of participants and the findings derived from the data analysis.

I have been connected to three different research groups throughout this study: The research group Life Phenomena and Care at the University of Stavanger which involves mostly qualitative nursing researchers. The research group Nursing and Healthcare Research Group at Stavanger University Hospital which involves interdisciplinary health researchers representing all departments of the hospital. The research group FAST, Research Group for Anxiety and mood disorders at Stavanger University Hospital departments of mental health care, which involves health researchers, psychiatrists and psychologists. Various parts of this study have been presented several times in these research groups who have

provided useful feedback and discussions, contributing to the study's trustworthiness.

3.1.3 The hermeneutical interpretation process

Three empirical sub-studies and a review of review articles were conducted in order to achieve the overall aim and to answer the research questions of this thesis. The sub-studies (Papers I-III) were interpreted inductively. The starting point was the empirical data material, and by the use of my pre-understanding the data was organized according to similarities and differences, which created patterns, presented as themes and categories (Braun & Clarke, 2006; Graneheim et al., 2017; Graneheim & Lundman, 2004). Each sub-study (Papers I-III) was interpreted and published sequentially, allowing each part to be understood separately. I was constantly aware that each sub-study was an independent unit representing distinctive findings, as well as simultaneously being part of the whole. The three sub-studies were positioned in the hermeneutic circle (as described in 3.1), now dependent on each other, as together they created a synthesis of the inductive findings from the empirical sub-studies (Papers I-III) in order to grasp a sense of the whole.

The hermeneutic circle continued by making a dialogue between the already inductively interpreted empirical findings and theory (the review presented in the theoretical background in Section 2), and other applicable theories. A deductive interpretation was conducted, trying to understand the inductive findings in the light of theory (Graneheim et al., 2017) in order to grasp a new sense of the whole (Gadamer, 2013) and developing new dimensions of SDM in mental care (Graneheim et al., 2017; Hsieh & Shannon, 2005).

An abductive interpretation was based on the already inductively and deductively interpreted knowledge, moving beyond the already known understanding. A deeper understanding of the meaning of SDM was

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developed through dialogues with the various empirical aspects of SDM and the existing knowledge, by means of the researchers' pre-understanding as an impetus (Graneheim et al., 2017; Råholm, 2014). Through the inductive and deductive interpretations, a new consciousness emerged. During the process of intertwining existential philosophy to the various parts, a pattern of meaning emerged. The fusion of horizons created a comprehensive understanding of the meaning of SDM in mental care (cf.Gadamer, 2013).

3.2 Methods

This study consists of three sub-studies. The methods conducted in these sub-studies will be outlined in this section. Table 2 provides a brief overview of the sub-studies (Papers I-III).

Table 2 – Overview of the sub-studies

Sub-studies Title/Journal	Participants	Data collection method	Analysis method
Paper I: Patients' experiences of participating actively in shared decision-making in mental care. *Journal of Patient Experience*, 2018; 1-7.	Patients (N=16)	Individual in-depth interviews	Qualitative content analysis
Paper II: Shared decision-making—balancing between power and responsibility as mental healthcare professionals in a therapeutic milieu. *SAGE Open Nursing*, 2018; 4:1-10.	Mental healthcare professionals (N= 8)	Multistage focus group interviews	Qualitative content analysis
Paper III: Being in a space of sharing decision-making for dignified mental care. *Journal of Psychiatric and Mental Health Nursing,* 2019; 26:368–376.	Mental healthcare professionals (N= 8) and patients (N=16)	Multistage focus group interviews and individual in-depth interviews	Thematic interpretative analysis

3.2.1 Participants

In the three empirical sub-studies the participants were patients (Papers I and III) and MHCPs (Papers II and III). In order to illuminate various perspectives of the researched phenomenon it was important to explore the patients' experiences (Paper I), the MHCPs' experiences (Paper II) as well as interpreting their experiences combined with each other (Paper III). Paper III involved the same participants as in Papers I and II.

In January 2016 I contacted clinical nurse managers at a community mental health centre in Norway and informed them face-to-face about the study, after which the clinical nurse managers invited MHCPs from three different wards to participate in a clinical supervision group, informed to serve as a multistage focus group in this study. We recruited nine MHCP participants after which one withdrew following the introduction session due to prioritization of time regarding workload on the ward. Eight MHCPs participated throughout the ten clinical supervision sessions, however not everyone was able to participate in each session. Four to twelve participants in a focus group are a sufficient number to generate adequate data (Jayasekara, 2012).

Snowball sampling, which means that previous participants recruit new participants (Polit & Beck, 2010), was performed as the MHCP participants were asked to recruit two patients each who were willing to participate from the ward where they worked. Snowball sampling would enable the MHCPs to identify patients with mental health in-patient experience for the individual research interviews with specific experiences that matched our study aims (Polit & Beck, 2010). In line with a patient participation approach, the participation of these patients would be of great value for the study. A sample size of 16 was considered to ensure data with high information richness (Malterud et al., 2016; Polit & Beck, 2010).

Patient participants in Papers I and III

16 patients, aged from 30 to 77 years, were included in this study. There were nine females and seven males with experience from one to 38 hospitalizations. The patient participants described the reason for their hospitalization as anxiety, depression, life crisis, obsessive- compulsive disorder, personality disorder, posttraumatic stress disorder, psychoses and suicidal attempt.

The inclusion criteria for the patients' participation were experience of being an in-patient at a mental health ward for at least one month, aged >20 years and the ability to speak Norwegian in order to be a source of rich data. There were no exclusion criteria.

The 16 patient participants were unknown to the researchers.

MHCP participants in Papers II and III

The eight MHCPs in this study, were aged from 38 to 60 years and included one male and seven females. Six of them were registered mental health nurses, one was a nurse and one was a social educator. They had from one to 27 years of experience in mental care in-patient settings.

The inclusion criteria were at least one year of work experience in in-patient settings and a Bachelor degree in nursing or related social sciences. MHCPs with at least one year's experience of mental health in-patient work were expected to yield rich data (Malterud et al., 2016; Polit & Beck, 2010). The exclusion criteria were part time MHCPs who worked for less than 28 hours per week, those who exclusively worked night shifts and clinical nurse managers. This ensured that the participants were engaged in clinical practice and could engage with experiences with SDM from their daily work.

The eight included MHCP participants were unknown to the researchers.

3.2.2 Data collection methods

There were two steps in the data collection, including two different data collection methods in the three sub-studies; multistage focus groups and individual interviews. All of the focus group sessions and individual interviews were audio recorded and transcribed. These methods and the data collection processes are described in the following.

Multistage focus group interviews (Papers II and III)

Multistage focus group interviews are a method for collecting data based on the same group exploring a certain phenomenon through dialogues focused on predefined themes over several sessions (Hummelvoll, 2008; D. L. Morgan, 1997). As I was searching for a deeper understanding of the MHCPs' various experiences, concerns and beliefs, in addition to a more comprehensive understanding of the meaning of SDM, multistage focus group interviews with MHCPs were considered to be a suitable method for creating rich data (Hummelvoll, 2008).

When searching for a deeper understanding of the meaning of SDM the researchers have to be involved in the data collection (Polit & Beck, 2010) in order to be deeply tuned-in to the experiences and meaning systems of the researched to provide rich data (Colucci, 2007; Dwyer & Buckle, 2009). Flyvbjerg (2006) claims that the most advanced form of understanding can be achieved when the researchers are highly involved and put themselves right into in the context under study. When the researchers have proximity to situations in real life and create a substantial involvement with those researched, a rich data set around a series of aspects of the theme researched will be provided (M. S. Morgan, 2015). Based on this, clinical supervision sessions were chosen for data collection, serving as multistage focus groups. Clinical supervision is defined as a support tool for professionals where they can share clinical, emotional, developmental and organizational experiences with each other in a confidential and secure setting in order to improve knowledge

and skills. This process will be the basis for an increased attentiveness of other perceptions comprising accountability and reflective practice (Lyth, 2000).

The core phenomena in clinical supervision can be summarized in three dimensions; value-based phenomena, supportive and nurturing relationships and the clinical supervision space. The first dimension is value-based phenomena (guilt, shame and inadequacy, forgiveness and reconciliation, suffering and relief, power and responsibility and courage). These value-based phenomena formed the pre-designed supervision programme, serving as topics for the dialogues in the sessions, relating each topic to patient participation and the patient–MHCPs relationship. The second dimension of clinical supervision is based on supportive and nurturing relationships (confirmation, understanding and empathy, presence, creating trust and security), and formed the basis of all the clinical supervision sessions. The third dimension related to the clinical supervision space (storytelling, sharing and reflection, playing and challenges) and was adhered to throughout all the supervision sessions (Holm Wiebe, Johansson, Lindquist, & Severinsson, 2011) (Appendix 2).

The ten sessions took place every second week and each session had a duration of 1.5 hours. The structure of the clinical supervision sessions was comprised of five phases. The first phase was bridging from the last session, where the question "what have we brought with us from the last session?". In the second phase this session's topic was introduced (Holm Wiebe et al., 2011). The third phase consisted of an individual creative exercise where the participants got their own sheets and pencils and drew while they reflected individually on this session's topic (Colucci, 2007). The fourth phase was plenum sharing and reflection based on questions related to this session's theme. The participants shared their thoughts and feelings in a dialogical process. The last phase involved an evaluation of the day's session, content and structure based on the question "how have

you experienced the clinical supervision today?" and "what will you bring with you from the today's clinical supervision session?".

The ten focus group interview sessions took place at the community mental health centre where the MHCPs were employed, from February to June 2016, in a room where there were no interruptions. The purpose of the focus group interview sessions was to facilitate wondering in-depth dialogues that addressed the research question. The pre-designed supervision programme, based on value-based topics related to patient participation, was the starting point for all the sessions (Appendix 2). The main supervisor (KR) in this study, who is a registered mental health nurse and clinical supervisor, performed the role of moderator and clinical supervisor, being involved in the dialogues by commenting and leading the reflections by asking follow-up questions. I was present in the group as a researcher, asking for more in-depth information when needed. Possessing a more distant role in the group made it easier for me to be aware of the group dynamics and to attain an overall picture of the participants' reflections.

A number of three to five sessions is suggested to be suitable for multistage focus groups (Liamputtong, 2011). In this study the number of sessions was directed by the clinical supervision program, involving ten themes covered over ten sessions. The participants became familiar with each other and the supervisors throughout the sessions, which made them more confident and comfortable. In addition, they had an internal agreement not to share the information given in the group with others, which was also important in order to create confidence in the group. When the participants are confident, they will feel freer to share their thoughts and feelings about the topics being reflected on, which is important for providing rich data material. A space for sharing breadth and depth of experiences was created. This improved the reflective process, which was also important for attaining rich data (Hummelvoll, 2008).

Individual in-depth interviews (Papers I and III)

Individual face-to-face interviews facilitated a close dialogue between me and the patient participants which offered them the opportunity to share their experiences and opinions (D. L. Morgan, 1997) and provided insight into their personal feelings, thoughts and world views (Guest, Namey, & McKenna, 2017). This was considered to create rich data for this study (Malterud et al., 2016). A pre-designed semi-structured interview guide (Appendix 3) validated by the reference group guided the interviews. A pilot interview was carried out with one patient in order to test the interview guide, who after the interview asked to be included as participant in the study because she wanted her voice to be heard and she hoped her contribution could provide for change in clinical practice.

The in-depth individual interviews (Polit & Beck, 2010) with the 16 patients took place at the community mental health centre where the patients had their present connection. All the interviews were conducted by me between March and August 2016. Based on the open-ended pre-set questions from the interview guide, I involved the patients in a dialogue about their experiences of participating in SDM while being hospitalized. This dialogue took place in accordance with Gadamer (2013). As I searched for a deeper understanding of the meaning of SDM through dialogue, I engaged in the conversation with the patients in order to grasp what they conveyed. The flexible and fluid nature of individual interviews made it possible for me to follow up understandings, interpretations and subjective experiences, which is of special importance in the data collection from vulnerable groups, as mental in-patients are defined (Liamputtong, 2007).

3.2.3 Data analysis methods

Two different analysis methods were performed in the sub-studies; qualitative content analysis (Graneheim et al., 2017; Graneheim & Lundman, 2004) and thematic interpretive analysis (Braun & Clarke,

2006). Both the qualitative content analysis and the thematic interpretive analysis were conducted inductively, strongly driven by the data themselves without a specific theoretical interest (Braun & Clarke, 2006; Graneheim et al., 2017).

Qualitative content analysis (Papers I and II)

A qualitative content analysis was conducted for organizing the data in the two first sub-studies (Papers I and II) by following the steps of Graneheim and Lundman (2004).

Qualitative content analysis is a method of describing the meaning of qualitative data material systematically. It focuses on context and the phenomena, and emphasizes the identification of similarities and differences within and between codes and categories. This method allows for analysis on different levels of abstraction and interpretation by dealing with manifested as well as latent content in a text. What the text says, the manifest content, is often presented in categories, while the expressions of the latent content is presented in themes (Graneheim et al., 2017; Graneheim & Lundman, 2004).

This analysis method is systematic in that all data related to the research question were taken into account, certain steps were followed throughout the analysis process and the coding was checked for consistency. The coding was modified to fit the data material in order to secure trustworthiness. Through classifying distinct information into a category, it was considered under a more general concept. The qualitative content analysis contributed to developing a deeper understanding of the researched phenomena (Schreier, 2012).

Thematic interpretive analysis (Paper III)

The analysis of the third sub-study was performed using thematic interpretive analysis, guided by Braun & Clark's (2006) phases of analysis.

A thematic analysis is suitable for almost all kinds of qualitative data and does not require linking to a certain theoretical framework. Being transparent, Braun and Clarke (2006) point to the importance of clarifying the researcher's theoretical position. Applying a hermeneutic study, I make explicit that I conducted a thematic interpretive analysis.

Thematic interpretive analysis is a method of recognizing and interpreting various aspects of the researched phenomena within the data, labelling themes and reporting these. It is a method for reflecting on the experiences, meanings and reality of participants, as well as illuminating the surface of reality. This analysis involves a recursive process of six phases, with a movement back and forth throughout the phases. The research question drove the analysis of the data and involved searching across the entire data set to discover patterns of meaning related to it. The analysis needed interpretation, which required me to be grounded in, and simultaneously go beyond the surface of the data (Braun & Clarke, 2006). Thematic interpretive analysis helped me to reflect on the understandings which were taken for granted and to unravel the surface of these realities in order to gain a deeper understanding of the meaning of SDM (Ho, Chiang, & Leung, 2017).

3.3   Methodological considerations

A hermeneutic approach was assessed to be the most appropriate method of answering this study's research questions. However, this study represents one angle of understanding of the meaning of SDM in mental care. Though the findings in this study are adequate, other understandings are possible (Gadamer, 2013).

Quality in qualitative research is described to be both descriptively precise and clear, and interpretively creative and rich (Polit & Beck, 2010). Various initiatives were taken throughout the study in order to ensure trustworthiness. Important aspects regarding the research are reported according to the COREQ checklist (Tong, Sainsbury, & Craig,

2007) in order to ensure high quality (Appendix 4). However, methodological strengths and limitations exist and must be taken into consideration when assessing quality. This section will critically reflect on methodological issues which are of significance for the quality of this study.

There should be a red thread between the study's research questions, the context, the participants and the methods for data collection and analysis securing that the results as a whole reflect what each part in the study intends to convey. All parts should be reflexive, letting the readers assess the information provided. Trustworthiness in research is crucial and concerns credibility, transferability, dependability, confirmability and authenticity. These terms are chosen to discuss the trustworthiness of this study in the following sections (Polit & Beck, 2010).

3.3.1 Credibility

Credibility refers to the consistency of the data and the interpretations thereof. The study must be performed in a way that improves the believability of the results, which should clearly mirror the data, and be carried out in a way that validates external credibility (Polit & Beck, 2010).

A purposive sampling was conducted in order to find participants possessing a wide range of in-depth experiences (Malterud et al., 2016), able to mirror the various facets of SDM in mental care. The included MHCP participants represented three different wards with different ward cultures, practices and considerations, and their reflections gave rise to a deeper understanding of issues related to SDM in the context of mental care. However, the participants represented only one community mental health centre in Norway. It is possible that the results would have been different had participants been recruited from various hospitals, other parts of Norway or from other countries.

Purposive sampling was conducted in the recruitment of patient participants as well. The MHCPs participants were asked to identify key participants with mental health in-patient experience who would be appropriate for this study. The use of snowball sampling enabled us to find patients with specific experience matching our study targets, who wanted to attend individual research interviews (Polit & Beck, 2010). However, the MHCP participants used their power to select which patients to invite to participate. They may have avoided inviting some patients to participate in order to protect them against harm rather than safeguarding their opportunity to participate in research (Carlsson, Blomqvist, & Jormfeldt, 2017). The results could have been different if other patients had received an invitation to participate.

Everything the participants said during the interviews was transcribed and included in the analysis process. Quotations were used in order to give the reader the opportunity to assess the credibility of the interpretations. I read the text a number of times in order to grasp its meaning and the interpretations were reflected upon and compared by my supervisors. Preliminary results were given to the reference group, as well as presented in various research groups in order for them to assess the quality and give feedback. In this way the results were validated internally and externally.

3.3.2 Transferability

Transferability refers to whether or not the results of the study can be transferred to other similar contexts or are applicable to other groups (Polit & Beck, 2010). I have made considerable effort to provide enough descriptive data in order to facilitate the readers' assessment of the applicability of this study's results to other settings. Yet, it is out of my control how the reader interprets the results and judges the applicability to their own practice.

3.3.3 Dependability

Dependability refers to the constancy of the data over time and in various situations (Polit & Beck, 2010). Ensuring both that all topics in the interview guides were covered, and that the data collection with the MHCP participants was carried out over ten sessions, gave constancy of the data. Yet, the fact that the data collection took the form of dialogues and that the follow-up questions were ad-hoc, meant that the data will be difficult to duplicate. However, I have administered as well as conducted all parts throughout this study, in collaboration with my supervisors. This stability made it possible to safeguard constancy in all parts of the study. The consistency between the parts and the whole throughout the interpretations was found to facilitate dependability in this study (Gadamer, 2013).

3.3.4 Authenticity

Authenticity refers to the researchers' faithfulness in showing various realities. In this study I have made determined effort to capture the nuances in the data material, describing the participants' various experiences and reality, which facilitate the readers' improved understanding of the lives being represented (Polit & Beck, 2010).

Securing authenticity, I was involved in the multistage focus group interviews with clinical supervision sessions as a researcher. I chose not to have the role of clinical supervisor so that I could more easily take the meta-perspective of what was spoken in the focus group interviews with clinical supervision sessions. The main academic supervisor and co-researcher in this study (KR) had the role of clinical supervisor, guiding the participants through the clinical supervision sessions in the multistage focus group interviews. Together with the clinical supervisor (KR) we critically reflected upon our roles and the content of the group reflections before and after each focus group interview with clinical supervision session. This was important in order to maintain the

conciseness and focus of our roles, whether in any way we affected the participants, the quality of the multistage focus group interviews with clinical supervision sessions, and the research. It was important that we had the necessary skills required (Aase & Fossåskaret, 2014) to lead the clinical supervision group. We are both educated clinical supervisors and have broad experience as clinical supervisors. It was therefore not a contrived experiment, but a natural clinical supervision situation where the studied phenomenon became activated in real life.

Possessing different roles in the multistage focus group interviews with clinical supervision sessions, the participants had to be and were all well-informed about our roles and our intentions when conducting the clinical supervision sessions. It was important to be aware of the role expectations the participants had of us, as well as of their own role and the setting in which they were positioned. The participants were supposed to respond as clinical supervisees and reflect upon the chosen theme in another way than if they were seen as research participants sharing information about the focused theme (Aase & Fossåskaret, 2014; Fangen, 2010). The participants were well-informed about the clinical supervisors' and my role in the multistage focus group interviews with clinical supervision sessions, as well as their own role. This data collection led us close to the practice field, securing authenticity in the research.

This study is limited to include patients and MHCPs. If the patients' next of kin, psychiatrists, psychologists or unskilled employees had participated, other important nuances could have been included.

3.3.5 Confirmability

Confirmability refers to the findings' derived from the text without being controlled by the researchers' pre-understanding, allowing congruence of the meaning between two or more autonomous people (Polit & Beck, 2010). Being aware of own pre-understanding and being self-reflective

and reflexive during all parts of the study has been crucial. Doing so, it was necessary to cooperate with the co-researchers, the reference group and research groups which were not closely involved. Balancing between proximity and distance was necessary to safeguard a deep insight into practice, simultaneously as the research was not based on subjective constructions. Doing so, the participants' voices were hopefully grasped and reflected in the findings and expectantly the interpretations have been conducted in accordance with the participants' original meaning.

Possessing different roles in the multistage focus group interviews/clinical supervision sessions challenged the data collection not to be controlled by the researchers' pre-understanding. We constantly had to be conscious of how our own involvement in the data collection may have had an impact on the research process (Aase & Fossåskaret, 2014; Fangen, 2010).

3.4   Ethical considerations

Research ethics refer to standards and values that are complex and support the regulation and constitution of scientific activity. Ethical guidelines serve as a tool to help researchers take relevant factors into account and weigh important issues against each other in order to protect both human and scientific interests in the research work (World Medical Association, 2008). This study has been carried out in accordance with guidelines for research ethics (World Medical Association, 2008) and has been approved by the Regional Ethics Committee of Western Norway (2015/1721) (Appendix 5). In the following section, the ethical considerations concerning this study will be outlined.

Considering that mental health in-patients consented to participate in this study, their ability to accurately understand the benefits and risks of participation and their ability to make informed decisions required great care (Polit & Beck, 2010). This project safeguarded the participants by defining in the inclusion criteria for patients´ participation that they must

be limited to using only Norwegian language and that they must have an age of over 20 years. In addition, the MHCPs from the patients' ward, who knew them well, informed and invited patients whom they assessed as able to understand the benefits and risks of participation and to have the ability to give informed consent to participate.

Both the patients and the MHCPs who consented to participate in this study were contacted by the researcher, who gave thorough information about the study. The researcher also provided practical information about participation and the study in general. The information was given verbally and in writing. The written information they received is attached in Appendix 6 and 7. Feedback from both the patients and the MHCPs made it clear that they had understood the information. There was no compensation or payment offered for participating in this research project in order to prevent them from feeling any obligation or pressure to participate (World Medical Association, 2008).

If the participants voluntarily agreed to participate, they were asked to sign a consent form. They were informed that at any time and without giving any reason they could withdraw their consent to participate in the study without any negative consequences (World Medical Association, 2008).

Mentally ill in-patients are defined as particularly vulnerable participants (Liamputtong, 2007; Polit & Beck, 2010). Excluding vulnerable patients because they are mentally ill will hinder SDM and this research could not have been completed without including these patients in the study. Vulnerable participants can be sensitive in different ways and some issues can serve as triggers to their vulnerability. As a professional and experienced MHCP, I could address these risks and meet the patient participants in a professional and safe manner. The participants were asked to share their experiences that felt comfortable and right to them. At the end of the individual interviews all the patient participants were asked how they experienced the interview. Their feedback was positive.

They said that it was a pleasure for them to share their experiences and they were glad they had been given the opportunity to participate as informants in this research project. The information about the further work with the taped interview was repeated in order to give the patient participants the opportunity to withdraw if they were not comfortable with it (World Medical Association, 2008). No participants withdrew after the interview.

Patient participants were given the opportunity to take part in a follow-up conversation with their therapists if necessary, in order to safeguard access to professional help with thoughts or difficult memories that may have been trigged after the interview. In this way we ensured that the vulnerable patient participants were not left with any harm linked to the interview (Liamputtong, 2007).

The MHCP participants were engaged in the data collection as clinical supervisees. This made them involved in the research in another way than if they were engaged only as informants answering a set of questions. Their role as clinical supervisees made them exposed in the way that they also engaged themselves emotionally by sharing personal experiences in the group. In order to safeguard the MHCP participants, a guarantee was given by the researcher that their responses would remain anonymous. They also had an internal agreement not to share the information given in the group with any other person. In addition, the MHCP participants were informed that they could withdraw their consent at any time without any negative consequences. The researcher did not ask for sensitive information during the focus group interviews (World Medical Association, 2008). These ethical principles protected and respected the MHCP participants' right to self-determination and autonomy, as well as their integrity and dignity (Polit & Beck, 2010).

All data, both recorded interviews and written documents, were treated confidentially, kept securely locked away and only used for research

purposes. A guarantee was given to all participants that their responses would remain anonymous (World Medical Association, 2008).

4 Findings

This section presents the main findings (Table 3) from the three sub-studies related to the aims and research questions (Papers I - III). These findings create a basis for further interpretation and discussion.

4.1 Patients' experiences of participating actively in shared decision-making in mental care (Paper I)

The aim of this sub-study (Paper I) was to describe patient participation in SDM in the context of indoor mental care. The research question was w*hat are patients´ experiences of participating in SDM?*

The analysis revealed the main theme *thriving in relation to participating actively in a complementary ensemble of care.* A complementary ensemble of care means that all those involved in the patients' care work together in companionship. The patients experienced being important and included when participating in SDM, regardless of mental ill-health, and the process of participation contributed to growth and restored mental health. The patients felt safe when the MHCPs were their companions and were complementary to their own participation in SDM, which was a support for them when working to improve their mental health. In situations where the patients were not able to make rational choices, they felt safe knowing that the MHCPs would take care of them by treating them according to their best interests and safeguarding their values. When the participants were able to make rational choices, they wanted to participate actively in order to collaborate with their MHCPs to find good solutions and to make appropriate decisions. They experienced that their contribution of participating actively was necessary for making a complementary ensemble of their care.

The first theme *having mental space to discover my way forward* reflected the patients' wish to find out what worked or not in their process of restoring their mental health. They wanted to *learn from life experiences* without the MHCPs deciding for them. On their way to discovering a new way forward, they desired to *feel encouraged by supportive MHCPs*. *To discover the way forward* the patients needed to *make use of flexible frames* in order to find a solution suitable for them and their situation.

The theme *being in a position to express my case* described the patients' desire to express what was important to them. They wanted to influence the decision-making, to be listened and responded to when *participating by using their own current resources*, which could vary throughout their care. *Feeling trustingly included* was essential for participating actively, which required that the MHCPs were present and took the initiative to include them in their care. *Sensing an empowering ward atmosphere where* patients' autonomy and value were appreciated, was an important issue for the patients to participate actively in SDM.

4.2 Shared decision-making - Balancing between power and responsibility as mental health-care professionals in a therapeutic milieu (Paper II)

The aim of this sub-study (Paper II) was to explore how MHCPs describe SDM in a therapeutic milieu as expressed through clinical supervision. The research question was *what are prerequisites for MHCPs to practise SDM in a therapeutic milieu*?

The theme *practising SDM when balancing between power and responsibility to form safe care* described the MHCPs' experiences of being in a dynamic process together with their patients. They should safeguard patients' participation and sense of control at the same time as ensuring good recovery conditions for their patients. In order to share the

power they possessed with their patients in a way that improved their patients' mental health, they continuously had to assess their patients' ability to take responsibility for their own choices and balance it with their responsibility for promoting safe care. The balance between power and responsibility should always be in the patients' best interests.

The category *internalizing the MHCPs' attributes* explained the importance of possessing a high level of professional skills and being attentive to patients. *Making use of professional skills* was important in order to practise a balance between power and responsibility in SDM. It implied possessing professional knowledge, in addition to interpersonal competence, which involved attitudes, values and ways of being. The interpersonal competence was experienced as challenging to improve because it was considered as mostly based on unconscious features. By *being attentive to the patient,* the MHCPs experienced that they should encounter their patients with a dialogue in order to understand the patients, thus intervene in accordance with the patients' benefit. The MHCPs conveyed that reflecting together on challenging situations was necessary in order to understand various aspects of a specific situation, the patients and oneself. They experienced that a well-reflected situation would lead to improving professional skills, which in turn would facilitate practising SDM.

The category *facilitating patient participation* described that the MHCPs considered it their responsibility to take the initiative to facilitate patient participation. Yet, they found it challenging to assess in what ways and to what extent each patient was able to participate in their own care. The MHCPs experienced trustworthiness, honesty, and always showing respect for the patients' feelings as essential for *stimulating patient involvement*. Being aware of their own emotions, thoughts and processing was found to be necessary in order to uphold a trusting relationship with the patients throughout mental care. The MHCPs experienced that patient participation varied and it was important to *acknowledge the patients' process of participation* in order to balance

between power and responsibility. *Facilitating patient participation* required MHCPs to possess insight and a high level of expertise to be capable of meeting their patients' personal needs.

The category *creating a culture of trust* was described as essential in order to uphold a balance between power and responsibility to form safe care. Applying guidelines, procedures and a structure of the ward in a person-centered way was described as challenging because they experienced that the procedures and structure of the ward could hinder SDM. The MHCPs wanted to use procedures and checklists as guidelines, but safeguarding a person-centered practice they needed flexible frames to do it differently if they found it beneficial for the patients. Doing so, they had to be confident in their own assessment, and needed supporting and trusting expectations from their colleagues.

4.3 Being in a space of sharing decision-making for dignified mental care (Paper III)

The aim of this sub-study (Paper III) was to interpret the meaning of SDM in mental care as perceived by patients and MHCPs. The research question was *what is the meaning of SDM in mental care?*

The overall theme *being in a space of sharing decision-making for dignified mental care* expressed the patients' and the MHCPs' continued search for an expansion of the patients' room for action and dignity. The patients' autonomy needed to be balanced in line with their mental health and capacity for taking responsibility in decision-making in order to form dignified care. The MHCPs' respectful and caring relationship with their patients affected dignified care.

The first theme *engaging in a mental room of values and knowledge* reflected the moments when the patients and the MHCPs were relating with engagement. The patients *moved between involvement and being cared for* throughout their care and the MCHP's felt responsible for

taking care of their patients at all times. They wanted to *cooperate and contribute with their own professionality* for the individual patients' benefit. The moments when the patients neither understood nor chose in their own best interests were especially challenging for the MHCPs in order to safeguard dignified care.

The theme *relating in a process of awareness and comprehension* described how the patients and MHCPs continually should search for awareness and comprehension. The patients *longed for information and to be understood* at the same time as the MCHPs *desired to understand and appreciated their patients' engagement*. If the MHCPs succeeded in relating to their patients like partners, showing them that they wanted to understand more, the patients were more likely to show them trust. Being too occupied with finding the "right" practice, following guidelines, and even the MHCPs' own pre-understanding could hinder *the process of awareness and comprehension* in care. Putting their own opinions and guidelines at stake and being willing to open up to new perspectives were found necessary when *relating in a process of awareness and comprehension.*

The theme *responding anchored in acknowledgement* explained the patients' *search for confirmation and for being affirmed*. The patients felt acknowledged and valued when the MHCPs responded to their message. It sometimes took courage for the MHCPs to respond because they were afraid of not being perceived as professionals when the patients' wishes did not match the guidelines or their colleagues' opinions of best practice. The MHCPs experienced that they sometimes had to act against the patients' will in order to provide safe care in a dignified manner. When the MHCPs responded to their patients in order to support their worth they felt affirmed, and compulsion sometimes seemed to be necessary for providing dignified care. Responses anchored in acknowledgement appeared to form dignified care.

Table 3 – Overview of findings (Papers I, II and III)

Paper I	Paper II	Paper III
Main theme Thriving in relation to participating actively in a complementary ensemble of care	**Theme** Practising SDM when balancing between power and responsibility to provide safe care	**Overall theme** Being in a space of sharing decision-making for dignified mental care
Theme 1 Having mental space to discover my way forward	**Category 1** Internalizing the mental healthcare professionals' attributes	**Theme 1** Engaging in a mental room of values and knowledge
Theme 2 Being in a position to express my case	**Category 2** Facilitating patient participation	**Theme 2** Relating in a process of awareness and comprehension
	Category 3 Creating a culture of trust	**Theme 3** Responding anchored in acknowledgement

5   Interpretation and discussion towards a comprehensive understanding

The overall aim of this study was to develop a deeper understanding of the meaning of SDM in mental care. This section contains interpretations and discussions towards a comprehensive understanding of the explored phenomenon. The findings from the three inductive empirical sub-studies describe different perspectives of SDM. In this section they will be synthesised, deductively interpreted and discussed as a whole, and eventually an abductive interpretation of the new whole will be conducted towards a comprehensive understanding (Gadamer, 2013). An overview over the three stages in the interpretational process is presented in Table 4.

Table 4 – Overview over the three stages in the interpretational process towards a comprehensive understanding of SDM in mental care

I: Inductive stage	SDM contributes to patients' thriving and requires the MHCPs balancing between power and responsibility for dignified mental care.
II: Deductive stage	SDM - a healing process and an integral part of mental care. SDM - a process of understanding.
III: Abductive stage	The meaning of SDM is being partners with an existential responsibility.

5.1 Shared decision-making contributes to patients' thriving and requires the MHCPs balancing between power and responsibility for dignified mental care

The inductive stage consists of a synthesis of the findings from the different perspectives in the empirical sub-studies (Papers I-III) in order to grasp a sense of the whole.

Findings from the inductive stage showed that the patients experienced being important and included when participating in SDM, and the process contributed to thriving in relation to participating actively in a complementary ensemble of care. They felt safe when the MHCPs were companions and were complementary to their own participation in SDM. SDM gave them the opportunity to find out what worked or not in the process of restoring their mental health. They could learn from their own life experiences, feel encouraged by supportive MHCPs and make use of flexible frames. SDM also gave the patients the opportunity of being in a position to express their case. They could participate by using their own current resources, whilst feeling trustingly included and having the sense of an empowering ward atmosphere (Paper I).

The patients move between involvement and being cared for throughout their care, and the MCHP's are responsible for taking care of their patients at all times. They should cooperate and contribute with their own professionality for the individual patients' benefit. SDM implies the MHCPs' being in a dynamic process together with their patients. They have to balance between power and responsibility as they safeguard patients' participation and sense of control, at the same time as they ensure good conditions for their patients to restore their mental health. Practising SDM the MHCPs should internalize their attributes by possessing professional knowledge, in addition to interpersonal competence, involving attitudes, values and ways of being, and they should be attentive to their patients (Papers II and III).

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Both patients and MHCPs embrace SDM but find it challenging to practise (Papers I and II). MHCPs should take the initiative to facilitate patient participation in SDM. Yet, they find it challenging to assess in what way and to what extent each patient is able to participate in their own care. Facilitating patient participation requires MHCPs to possess insight and a high level of expertise to be capable of meeting their patients' personal needs (Papers II and III).

A trusting relationship between the patients and the MHCPs is necessary in order to practise SDM. A basis for a trusting relationship is the MHCPs being aware of their own emotions and thoughts and processing these. If the MHCPs succeed in relating to their patients like partners, showing them that they want to understand more, the patients are more likely to show them trust. A culture of trust is essential in order to uphold a balance between power and responsibility, thus practising SDM in mental care (Papers II and III).

Practising SDM the MHCPs should acknowledge their patients' process of participation. The patients feel acknowledged and valued when the MHCPs respond to their message. Responses anchored in acknowledgement appear to form dignified care. It sometimes takes courage for the MHCPs to respond because they may be afraid of not being perceived as professionals when the patients' wishes do not match the guidelines or their colleagues' opinions of best practice (Papers I-III).

Applying guidelines, procedures and structure of the ward in a person-centered way may be challenging as the MHCPs experience that the procedures and structure of the ward could hinder SDM. In order to safeguard a person-centered practice, the MHCPs need flexible frames to act differently if they find it beneficial for the patients. Doing so, they must be confident in their own assessment and receive support and trust from their colleagues. Being too occupied with finding the "right" practice, following guidelines, and even the MHCPs' own pre-

understanding could hinder the process of awareness and comprehension in care. Putting their own opinions and guidelines at stake and being willing to open up to new perspectives is necessary for practising SDM (Paper III).

A well-reflected situation would improve MHCPs' professional skills, which in turn would facilitate practising SDM (Papers II and III).

Both the patients and the MHCPs experienced SDM as being in a space of sharing decision-making for dignified mental care. The patients' autonomy needed to be balanced in line with their mental health and their capacity for taking responsibility in decision-making in order to form dignified care. The MHCPs' respectful and caring relationship with their patients affected dignified care (Paper III).

5.2   *Shared decision-making - a healing process and an integral part of mental care*

In the deductive stage (Sections 5.2 and 5.3), findings from the inductive interpreted sub-studies will be interpreted and discussed in light of the theoretical background (Section 2) and theories linked to the focused area. The deductive interpretation will assess this study's findings together with existing knowledge of SDM in mental care, mainly based on the headings in the theoretical background; *Shared decision-making - an approach in mental care* and *Changing attitudes towards the theory and practice of shared decision-making.* The aim is to develop a deeper understanding of the meaning of SDM in mental care (Graneheim et al., 2017).

The heading in the theoretical background *SDM - an approach in mental care* is the theoretical basis for this section, together with theory of interpersonal relations in nursing (Peplau, 1991) and self-determination theory (Deci & Ryan, 2008).

Davidson et al. (2017) claim that the purpose of mental care is to empower patients to take control and live self-determined lives regardless of severe mental ill-health. Autonomy and self-determination is a human need and expanding these competencies is supposed to give rise to restored mental health (Deci & Ryan, 2008). The current study investigated SDM as a phenomenon in mental care and from the patients' perspective it illuminated that SDM is experienced as thriving in relation to participating actively in a complementary ensemble of care. In such a process a mental space to discover ones' way forward and being in a position to express ones' case is essential (Paper I). This points to SDM being understood as an interpersonal healing process. Peplau (1991) describes a human relationship between a person who needs health services and a MHCP to be caring. SDM is described to be an approach for planning and carrying out care (Davidson et al., 2017). Mental care is concerned with ways for facilitating people to stay healthy, and technical procedures alone cannot help the patients to mature (Peplau, 1991). Mental care is first of all a process, which means that its ongoing and goal-directed character demands certain steps and actions to take place between the patients and the MHCPs. Participation between these parts is necessary, and the interaction between them should be focused towards understanding the patients' difficulties and identifying their needs (Peplau, 1991). This is in line with Castillo and Ramon (2017) who describe the patients' process of restoring their mental health to be a relational and dynamic journey. Due to the patients' mental challenges they often call for a level of support, but no others can ever possess the same comprehensive understanding of their individual and personal needs and desires as they do (Paper I). The patients' active participation in SDM is therefore essential (Davidson et al., 2017) in mental care. Deci and Ryan (2008) describe the type of a patient's motivation as essential for growth. Making decisions based on their own inner values and ideals promotes autonomous motivation, and will encourage a volition for action. In contrast, if a decision is guided or regulated by MHCPs, a controlled motivation will be promoted and the person will feel obligated

to think, feel or behave in certain ways. An autonomous motivation is important to improve mental health and maintain change towards beneficial choices of action. A controlled motivation is more likely to promote rigid functioning and decreased well-being (Deci & Ryan, 2008). The MHCPs' role in SDM should be to assist their patients in growing and becoming more skilled in coping with their difficulties (Papers II and III). The quality of SDM and the patients' process of growth and restored mental health depend on how well the MHCPs can facilitate their patients' active participation in SDM (Peplau, 1991).

Patients experience SDM as having the mental space to discover their way forward (Paper I). Mental care is about facilitating patients to deal with mental ill-health in the context of their life (Davidson et al., 2017). Patients cannot be helped to experience health without their own real-life situations (Paper I). The MHCPs should assist their patients in expanding their understanding of their actual mental health challenge (Paper II). Deci and Ryan (2008) point to the importance of facilitating the person's autonomy by providing them with competence in order to understand and be conscious of the consequences and the values an autonomous decision may have. SDM may contribute to new experiences (Paper I) which will promote the patients' maturing processes. When the patients learn how to cope with their mental ill-health through experimenting with various possibilities to find a way through their life, the experience will take them another step towards greater maturity in dealing with their mental challenges (Peplau, 1991).

SDM integrates the patients' experiential knowledge and the professional knowledge for conducting better decisions in mental care (James & Quirk, 2017; Ramon et al., 2017). This provides the patients with a position from which to express their case (Paper I). The patients are central and the key decision-makers in their process of mental growth. Therefore, they need to take an active role in their unique position, learning about taking responsibility and dealing with all the challenges that a life with mental ill-health entails (Davidson et al.,

2017). MHCPs should be their patients' partners by supporting, encouraging and guiding them to take their position to express their case (Papers I and II; Davidson et al., 2017). Deci and Ryan (2008) argue that feeling involved will facilitate the patients becoming autonomous and participating actively based on their own values and ideals. A MHCP patient-relationship should be developed to provide concrete experiences of reducing feelings of helplessness in patients and to displace feelings of powerlessness and helplessness with feelings of autonomy and dignity (Paper III). This facilitates growth of the patients' personality, which is supposed to be healing (Peplau, 1991).

The patients thrive when participating actively in a complementary ensemble of care (Paper I). A complementary ensemble of care involves a personal relationship where the patients and the MHCPs get to know each other well enough to identify the patients' problem in a co-operative way and to work together to find out what each is seeking in the relationship. The process of SDM is supposed to be healing when the patients and the MHCPs get to know and respect each other as different but equals who share the decision-making in the patients' life (Peplau, 1991).

Up to now, research has described SDM to be an approach for planning and carrying out care (Davidson et al., 2017) and for making better decisions (James & Quirk, 2017; Ramon et al., 2017). Findings in this study illuminate that the SDM process contributes to growth and restored mental health (Papers I and III) which is understood to be a healing process in mental care. This study's findings viewed in the light of theory develop a deeper understanding of the researched phenomenon: SDM is understood to be a healing process and an integral part of mental care where the patients' autonomy and support towards self-determination is central.

5.3   Shared decision-making - a process of understanding

The deductive stage continues in this section. The theoretical basis is the heading in the theoretical background *Changing attitudes towards the theory and practice of shared decision-making,* mainly together with the theory of Lassenius (2014) and Martinsen and Eriksson (2009).

Alguera-Lara et al. (2017) found that shared understanding, empathy, compromise and partnership were fundamental to practising SDM. This requires that the MHCPs are in a process of understanding their patients' personal requests, difficulties and opportunities (Peplau, 1991). This study finds that MHCPs practise SDM when balancing between power and responsibility to form safe care (Paper II), which requires them to possess a high level of expertise and insight in order to meet their patients' personal needs (Papers II and III). Providing a position in which the patients can express their case and participate actively in SDM (Paper I) depends on the MHCPs' ability to listen and be open to new understanding. Every patient is unique and deserves the focus in the encounter with the MHCPs. It is necessary to understand the patients' life world in order to help them in their process of restoring their mental health. It is the MHCPs' task to illuminate what is hidden, to grasp the essence of each patient's life world in order to move towards a shared understanding (Lassenius, 2014).

If the MHCPs show their patients that they want to understand more, SDM is more likely to succeed (Paper II). The theory describes that MHCPs often do not try to understand their patients and refuse to consider the patients' preference because it is not in line with the best clinical choice (Castillo & Ramon, 2017; Ramon et al., 2017). MHCPs sometimes hold back information (Ramon et al., 2017) and some MHCPs consider their patients incompetent to make their own decisions (Davidson et al., 2017). Some MHCPs are also concerned that SDM will threaten their professional responsibility (Kaminskiy et al., 2017). It is

likely that this may be why the patients experience their opinions to be less valued than the MHCPs' and that they are struggling to be seen or heard as competent and equal in the encounters with their MHCPs (Kaminskiy et al., 2017). Martinsen and Eriksson (2009) describe such an understanding to be in line with a medical paradigm, which is based on medical knowledge, derived from statistics and randomised controlled trials. The theory describes a medical dominance in mental care, which seems to be in conflict with SDM (Kaminskiy et al., 2017). The patients feel controlled by their MHCPs as they often experience being informed rather than involved about choices and the MHCPs prefer to make the decisions themselves (Castillo & Ramon, 2017; Davidson et al., 2017). The apparent emphasis on generalizations regarding effective treatment, which is best known by the professionals, usually the physicians, gives rise to procedures and rules that are to be followed by all patients (Martinsen & Eriksson, 2009). MHCPs find it challenging to respond to their patients when the patients' wishes do not match the guidelines (Papers I-III) because they may be afraid of not being perceived as professionals (Paper II). A paternalistic decision-making style based solely on the MHCPs' professional competence and attitudes will hinder SDM (Castillo & Ramon, 2017). Letting the medical paradigm guide the understanding of mental care may be destructive for the individual patients' care (Martinsen & Eriksson, 2009).

Practising SDM requires that the MHCPs know what SDM is and that they are able to distinguish it from their existing practices (Ramon et al., 2017). The traditional mental care should be questioned continually (Davidson et al., 2017) in order to be open to the understanding of each patient to support them in restoring their mental health (Lassenius, 2014). To understand more, it is necessary to open up to a new and different way of seeing and understanding (Martinsen & Eriksson, 2009). The patients expressed a wish for mental space to discover their way forward (Paper I). They need to learn to deal with the challenges that their life with mental ill-health entails (Davidson et al., 2017), which involves

forming new understanding. The discovery of their way forward is a personal development and therefore the focus in SDM should be on the process, rather than a compromise on a final decision (James & Quirk, 2017). Mental care may fail if the MHCPs believe that they can understand and explain their patients solely based on their own professional competence and they try to transfer this understanding to their patients, expecting their patients to implement it into their own lives. It is not possible to understand anything from just one dimension (Frankl, 2014). Both the patients and the MHCPs need each other to make a new and shared understanding (Lassenius, 2014). The patients need their MHCPs to understand their life-world in order to support them in the process of making new and more mature understandings.

All understanding is guided by pre-understanding. The MHCPs' understanding in the encounter with known or unknown patients, in new or well-known situations will always be a result of the existing pre-understanding (Gadamer, 2013). If the patients are understood out of the pre-understanding of for instance a medical diagnosis, the essence in the patients' situation will be lost and an understanding of the patients' life-world will probably fail (Lassenius, 2014). MHCPs putting their own opinions and guidelines on hold and being willing to open up to new perspectives is necessary for practising SDM (Lassenius, 2014; Paper III). The quality of mental care depends on the MHCPs' ability to understand, which means that they have to step out of their own pre-understanding, question it and open up to what is different and unknown (Martinsen & Eriksson, 2009). This will not only provide for a greater understanding, but a transformed understanding. A new understanding of each unique patient may emerge in a new way (Lassenius, 2014).

SDM requires interventions beyond the traditional decision support tools and information exchange (Zisman-Ilani et al., 2017) and such a method is still lacking (Légaré et al., 2018). However, clinical supervision sessions are suggested to facilitate practising SDM (Ramon et al., 2017). Papers II and III report that a well-reflected situation is supposed to

facilitate practising SDM. Through dialogue and reflection, the MHCPs come together in wonder of how to understand each unique patient and situation in which they are involved. Wonder is about staying by an experience and exploring the uncertainty and diversity in it. The basic premise of wonder is to be open, inquiring and receptive to the core of the situation. It is in the moment of being and occurrence of creation that the phenomenon can become illuminated. The MHCPs should allow themselves to be touched, lift themselves above their own personal feelings and opinions through listening to the wonder. By allowing the focused phenomena to reveal itself in wonder, a new understanding will occur and a new meaning will emerge (Hansen, 2014).

Ramon et al. (2017) claim that training to support SDM should be advocated continually, which implies that the MHCPs constantly should seek to reach a shared understanding with their patients. There is no understanding that would constitute absolute knowledge. With every new understanding, a new question is raised (Gadamer, 1996). SDM requires attitudes and culture in mental care to reach out for being in a process of understanding. This study's findings viewed in the light of theory develop a deeper understanding of the researched phenomenon: SDM is understood to be a process of understanding.

5.4   *The meaning of shared decision-making is being partners with an existential responsibility*

The abductive stage of the interpretation was performed from the inductive stage through the deductive stage, guided by my pre-understanding, which was developing throughout the interpretation process. As caring science seeks an understanding of human beings in relation to existential conditions (Martinsen & Eriksson, 2009), existential philosophy (Frankl, 2014; Levinas, 2003; Sartre, 2007) was included as a new part of the whole in order to deepen the understanding

of the researched phenomenon. A fusion of horizons occurred by the development of a pattern connecting the previous interpretations into a comprehensive understanding of the meaning of SDM in mental care (Gadamer, 2013; Råholm, 2014).

To date, the interpretation process has developed my pre-understanding of the meaning of SDM to being in a space of sharing decision-making for dignified mental care. I understand this space to be a community where the one in need of care and the carer are connected with a joint focus on the one in need of care's mental health. The one in need of care's urge to be understood and the carer's desire to understand, draw them towards each other into a unity. Including philosophy in this understanding, this unity can be understood to constitute their existential responsibility in SDM (Frankl, 2014; Levinas, 2003; Sartre, 2007).

Responsibility in care may be understood out of the formal principles and professional guidelines to be followed or by the expectations created in a personal encounter (Sjögren, 2012). Sartre (2007) claims that human beings are characterised by an existence that goes before essence, with subjectivity as a starting point. Existential responsibility involves relating with the other and placing oneself at the disposal of the other (Sjögren, 2012). When a person in need of care and a carer meet, they both meet someone other than themselves. Levinas (2003) claims that it is in this meeting the responsibility appears: The face of the other expresses an appeal to the other, which calls the other to be good, which is where the existential responsibility occurs. SDM involves a social interaction between the person in need of care and the carer and brings an existential responsibility.

Levinas (2003) describes relating as a meeting with someone that is totally different from ourselves. The other is the one I can never understand, in the sense of understanding by general terms. The face of the other cannot be generalized as a representative of my fellow human beings. The other is always a unique and determined individual person,

totally different from me. This view offers a special meaning to the social interaction between the person in need of care and the carer. The existential responsibility arising in the meeting is primarily a response to the appeal with which the individual person meets the other, allowing oneself to be touched by the other. Being conscious of the existential responsibility in SDM, the carer will continually search to understand the one in need of care. The needs of the one in care should always be at the centre, not one's own needs. It is the carer's existential responsibility when engaging with the other person to accept the appeal from the other's face and respond by making a difference in the other's life, for the other's good.

Frankl (2014) claims that a human being's life means taking the existential responsibility to find a true answer to its difficulties and to search for the meaning of life. As human beings we are responsible for what we are, and we all need to take our responsibility in order to be defined as human beings. Sartre (2007) states that we all have a duty to bear the responsibility of own actions and we must take the consequences of own choices and we all choose our own selves. This may be the core of why it is so important to participate actively when being in need of mental care. If others make the decisions without the other being able to participate, they simultaneously hinder them from taking some of their existential responsibility and some of the other's own being will become lost. Participating actively in one's own care means taking the responsibility for living one own's life meaningfully. Being responsible is essential for the ability to change and move forward. Frankl (2014) claims that human beings must take responsibility for what has been done, use the opportunities offered and act upon them in order to realize one's own chances and values, even in a despairing situation. SDM provides for this when the carer stands together with the one in need of care as a partner, supporting him/her in taking the existential responsibility.

Frankl (2014) asserts that the meaning of each persons' life must be discovered in the encounter with others rather than within each individual. We are all dependent on others to attain truth about ourselves. Others are indispensable to our existence and the awareness we have of ourselves. Together with others, we can discover what we are and what others are. Therefore, it is so important that the carers take their role as partners in SDM, exploring together with the one in need of care the basis on which the decisions are to be made and together finding and choosing a decision. Sartre (2007) states that besides being responsible for ourselves, we are also responsible for choosing others. The carers must take their existential responsibility by choosing the one in need of care, being their partners and helping them attain the truth about themselves. Frankl (2014) argues that everybody has a healthy core and internal resources and the carers should enlighten the one in need of care's healthy parts and provide for them in their search for meaning and mental growth.

Frankl (2014) advises that taking an existential responsibility when caring for others, the carers should not transfer their own values to the one in need of care. They should be tolerant and recognize the other's right to trust and obey their own beliefs without agreeing with them. The one in need of care should be given the opportunity to refer to his/her own convictions. However, if the conviction is deceptive or harmful to themselves or others the carers must intervene, take responsibility for the other's responsibility and try to lead him/her to a more beneficial choice. Sartre (2007) claims that the helpers' existential responsibility is to guide the one in need of care towards comprehending themselves and recovering. Taking an existential responsibility for a person in need of care requires the carer to possess insight and wisdom in order for the one in need of care to experience thriving.

Carers possess both a formal, professional responsibility and an existential responsibility. Their professional responsibility requires them to follow certain regulations, laws, guidelines and rules, which do not

always involve a deeper personal attitude and conviction (Sjögren, 2012). A hinder for SDM is that the carers may be more concerned with the procedures and guidelines to be followed, rather than the subjectivity of the one in need of care. Principles concerning the professional responsibility will dominate and the one in need of care's values and wishes may be ignored if they are not in line with the professional principles. Sartre (2007) claims that carers doing what they are supposed to do by law and guidelines safeguards the system more than protecting the dignity of those in need of care. Levinas (2003) states that this makes the ones in need of care become all the same, like an anonymous. "faceless" group of people. Taking the existential responsibility, we need to challenge what we believe in order to know about the one in need of care and unbind ourselves from general guidelines. A face-to-face relationship can modify unwanted interference and rigid generalizations and principles (Levinas, 2003). For SDM to succeed the carers have to relate and cooperate as partners together with the one in need of care. A co-operating relationship between the one in need of care and the carer will promote dignity, growth and maturation of mental health (Sartre, 2007).

Possessing an existential responsibility for the other, the carer is called to be good to the one in need of care. An unanswered question is the relationship between the carer's professional knowledge and the one in need of care's experiential knowledge of their own lives. How does the carer balance their own convictions with the one in need of care's convictions if they differ, in order to be good? According to Levinas (2003) we find ourselves standing in an insoluble dilemma in the gap between the unique individual and the common general.

This abductive stage of interpretation has illuminated the meaning of SDM in mental care to being partners with an existential responsibility. The existential responsibility constitutes the relationship between the one in need of care and the carer, and requires a response to the other, always for the other's good. Possessing the existential responsibility and

acknowledging the human being is essential for the ability to change and move forward. The carer should be a partner to the one in need of care, helping them enlighten their healthy parts and providing for them in their search for meaning and mental growth.

6 Conclusion

A deeper understanding of the meaning of SDM in mental care was illuminated through the perspective of caring science in this thesis. From that view this thesis concludes that the meaning of shared decision-making in mental care is being partners with an existential responsibility. The relationship between a person in need of care and the carer constitutes the existential responsibility, which acknowledges the being in human beings and is essential for mental growth. The MHCPs should be the patients' partner and supporter throughout care.

The SDM process contributes to growth and restored mental health. It is is a healing process and an integral part of mental care, where the patients' autonomy and support towards self-determination is essential. SDM is also considered to be a process of understanding. MHCPs should constantly seek to reach a shared understanding with their patients. No understanding is final. With every new understanding, a new question is raised. SDM requires attitudes and cultures in mental care to reach out to being in a process of understanding. SDM contributes to patients' thriving and emphasises the MHCPs balance between power and responsibility for dignified mental care.

This understanding conveys that SDM is much greater than just sharing information and making decisions. SDM requires close attention to emotional and relational qualities, encompassing the existential dimensions in mental care.

7   Implications

Considering the findings of this study, I suggest the following in order to facilitate practising SDM in mental care and for further research.

7.1   Implications for clinical practice

Improving SDM practice requires the MHCPs to acknowledge and respond to the existential dimensions of mental care. Mental care must be understood as a process, with the patient relationship at the core. The MHCPs should follow their patients towards restored mental health by being their partners, acknowledging the patients' subjectivity in care and placing them at the core of the care. In this process it is important not to push the patients to understand what the MHCPs think is the best answer to cure their mental ill-health, but to be humble and listen to their patients as well as responding to their desires. SDM should be implemented as an integral part of mental care. This may require a cultural change in mental health wards and high-level professional skills are crucial.

Development of the MHCPs' professional skills should be given great attention. MHCPs need to be able to respond individually to each patient according to the patient's needs and expressions. Professional skills include MHCPs being able to understand their patients experience and emotions and enhance their patients' autonomous capacity while safeguarding dignified care. It is necessary that the professional skills essential for practising SDM are trained throughout the education of MHCPs.   In order to safeguard the development of the MHCPs' professional skills in practice, all MHCPs should be taught and should attend clinical supervision continuously. The clinical supervision must emphasise reflections on attitudes and relational competencies, and provide space for wonder and new understanding.

The hospital managers and the managers of the wards are essential in the implementation process of SDM. It is crucial that they value SDM and

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understand its importance. They should take responsibility for facilitating teaching and clinical supervision for their MHCPs and that such initiatives are funded, prioritized in the time schedule and highlighted as important for the MHCPs to attend. Facilitating continuity of care is also an important issue. SDM is dependent on MHCPs knowing and following the same patients over time and the managers should organize the ward in such a way that the same MHCPs and their patients can be partners throughout the patients' hospitalization. Furthermore, it is important that the managers set a standard that values the existential responsibility as much as the formal responsibility. The MHCPs should be encouraged to safeguard their existential responsibility by being allowed to set aside formal principles and guidelines if they are not the most beneficial for the patients.

SDM challenges the clinical mental care practice to change attitudes as well as culture. This may be difficult to achieve without forcing it forward by political expectations and regulations in the law to facilitate SDM.

7.2   Implications for further research

This study has illuminated the meaning of SDM in a caring science perspective. This is a contribution to the research field, yet further research is needed. I suggest further research to focus on the following:

The MHCPs dilemma of possessing both an existential and a formal, professional responsibility for practising SDM should be explored.

The implementation of SDM is needed to be investigated in an action research model, involving patients even more, together with next of kins, managers and interdisciplinary professionals, expanding the various perspectives of the understanding of SDM.

An understanding of leadership involvement in SDM should be developed, as well as the impact of the ward atmosphere on SDM.

Studies regarding clinical supervision's impact on MHCPs' attitudes to SDM should be performed.

I suggest an effect study investigating the clinical benefits of SDM, by doing a pre- and post-intervention survey.

Patient safety is a major concern in mental care and the role of SDM in patient safety in this context should be a focus in future research.

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Part II

Paper I

Patients' Experiences of Participating Actively in Shared Decision-Making in Mental Care

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Abstract

Background: Patients in mental care express a wish for more active participation. Shared decision-making is a way of increasing patient participation. There is lack of research into what the shared decision-making process means and how the patients can participate in and experience it in the context of mental care. **Objective:** To describe patient participation in shared decision-making in the context of indoor mental care. **Method:** A qualitative content analysis of data from in-depth interviews with 16 patients was performed. **Results:** One main theme was revealed: *thriving in relation to participating actively in a complementary ensemble of care*, which represented the red thread between 2 themes: *having mental space to discover my way forward* and *being in a position to express my case*. **Conclusion:** Patients can participate actively in shared decision-making when the patients' and the mental health-care professionals' joint expertise is applied throughout their mental care. The patients experience thriving when participating actively in a complementary ensemble of care.

Keywords

mental care, patient experiences, patient participation, qualitative research, shared decision-making

Introduction

Patient participation relates to the patients' role and involvement in decision-making regarding their treatment and care (1) with the intention of increasing patients' influence on safeguarding that the care is in accordance with their requests (2). When hospitalized in a mental health ward, the patients' daily life and activities are lived in close contact with the mental health-care professionals (MHCPs) in a therapeutic interpersonal relationship (3,4). In Norway, MHCPs are the frontline workers on the ward. Most of them have a bachelor degree in nursing or are social educators, some have a specialized education in mental care, and some are high school educated health-care workers or unskilled assistants. The MHCPs working on the wards where this study took place are aged between 20 and 65. They have various professional backgrounds and experience of mental care—ranging from more than 20 years' experience to none. This context of mental care provides a setting for the patients to work through their mental problems, contributing to restored mental health (5,6). During mental ill-health, some patients may lack insight and may not always choose what is in their best interests. They may sometimes have difficulty in

describing what they want, which influences their ability to participate (7). Participating in care also means that patients sometimes can make inexpedient and unpredictable decisions (8), and in severe mental ill-health, they may not always be able to take responsibility for their own choices and actions (7). In order to empower the patients in their process of restoring their mental health, they should work together with the MHCPs to explore their experiences of health and ill-health (9). In spite of much attention on patient

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Table 1. Description of the Participants.

Pseudonym	Age	Gender	Length of This Hospitalization	Number of Hospitalizations	Patient's Own Description of Hospitalization Cause
Anna	57	F	3 months	38	Emotional unstable personality disorder
Ben	33	M	4 months	3	Psychoses
Christian	59	M	2 months	10	Depression
Daniela	39	F	5 weeks	3	Depression
Eric	66	M	2 months	2	Depression
Febe	53	F	3 months	3	Obsessive-compulsive disorder
Gabriella	68	F	2 months	28	Depression
Harriet	37	F	1 month	2	Suicidal attempt and trauma
Ina	68	F	5 months	1	Anxiety and depression
John	63	M	5 days	30	Relief stay
Ken	30	M	3 months	15	Depression
Laura	48	F	4 months	2	Posttraumatic stress disorder
Mary	54	F	24 days	2	Suicidal
Ned	55	M	4 months	1	Depression
Oscar	48	M	6 weeks	1	Life crisis
Paula	77	F	2 months	2	Life crisis, panic attacks

participation, patients express a wish for more active participation and the tension between patients' and MHCPs' perspectives on care remains a challenge in mental health wards (2,10,11).

A strategy for patient participation is to implement shared decision-making (SDM), which considers both the patients and the MHCPs as experts who should share information, and to cooperate and agree on a choice of intervention (2,12,13). Shared decision-making focuses on the process of decisions, with the intention of increasing the patients' knowledge and control over decisions that affect their mental health (1). Shared decision-making highlights the balancing of power and responsibility, which is a dynamic process requiring a continuous assessment of the patient's resources, limitations, and necessity for assistance. Both the MHCPs and patients have power and responsibility for SDM which should be balanced in a way that secures the patients' best interests throughout the process of their mental care (14). Therefore, there is a need to consider the patients' ability to participate actively and to define their role in SDM (8). In order to achieve active patient participation, we should also consider how the patients can participate in SDM throughout the process of their care (7,8).The objective of this study was to describe patient participation in SDM in the context of indoor mental care. The research question was "What are patients' experiences of participating in SDM?"

Methods

Design

A qualitative inductive design was used in order to illuminate the patients' lived experiences (15).

Participants

The 16 participants had differing reasons for their hospitalization and various magnitudes of experience from different mental health institutions and differing lengths and numbers of hospital stays (Table 1). They were recruited from 3 different wards in a community mental health center in the western part of Norway. The MHCPs on the wards, who knew the patients well, were asked to recruit patients willing to participate. The inclusion criteria were experience of being an in-patient for at least one month, aged >20 years, and having the ability to speak Norwegian.

Data Collection

Individual interviews were conducted between March and August 2016 by the first author (L.S.B.), all at the community mental health center where the participants had their current connection. In order to achieve an in-depth understanding of patient participation in SDM, it was necessary that the participants shed light on various elements and aspects of their experiences (15,16). The participants were asked to share only the experiences that felt comfortable and right for them to share. A social interaction with a trusting communication between the interviewer and the participants was important in order to make them feel free to share their experiences for providing rich data (17). The flexible nature of the qualitative interview made it possible to follow up understandings, interpretations, and subjective experiences (18). The interviews took the form of a dialogue from open-ended questions about the participants' experiences of being involved in SDM during indoor mental care (15). They responded with their experiences of participation in SDM while being hospitalized in a mental health ward.

Table 2. Description of the Qualitative Content Analysis According to Graneheim and Lundman. (19, 20).

1 The audio-recorded data material was transcribed verbatim by the first author (L.S.B.), and the transcribed text was further repetitively read in order to grasp a sense of the whole.

2 The inductive analytic approach involved dividing the content into meaning units that were condensed and labeled with a code, which formed the basis of the categorization.

3 The codes were compared and sorted into subthemes, which all comprised a manifest content.

4 The subthemes were organized and abstracted into 2 themes by the first (L.S.B.) and last (K.R.) authors.

5 The 4 authors discussed the meaning of the 2 themes. Further analysis of the themes and subthemes were discovered and integrated in one main theme.

6 The data were compared across points in time and the themes and main theme validated through reflections and conversations by the 4 authors and qualitative research group.

Analysis

A qualitative content analysis (19,20) was performed to systematically unveil a deeper understanding in the collected data (Table 2). The authors' preunderstanding was related to their experience as researchers and clinical nurses. Three of the authors (L.S.B., K.R., and E.S.) are authorized mental health nurses and have several years of clinical experience from mental care.

Ethical Considerations

This study was carried out in accordance with the Declaration of Helsinki (21) and has been approved by the regional ethics committee of Western Norway (2015/1721). The invited patients were informed verbally and in writing about the study and a guarantee of anonymity and confidentiality was given. Confirmation of the fact that participation was voluntary and that the participants could withdraw at any time with no consequences for their further treatment at the hospital was provided prior to the start of the study. The patients who agreed to participate in this study were able to give their informed consent and signed the consent form. The participants are referred to by pseudonyms (21,22).

Results

One main theme was revealed: thriving in relation to participating actively in a complementary ensemble of care, which represented the red thread between 2 themes: having mental space to discover my way forward and being in a position to express my case. The first of the 2 themes was based on the 3 subthemes: learning from life experiences, feeling encouraged by supportive MHCPs, and making use of flexible frames. The second theme was based on the 3 subthemes: participating by using own current resources, feeling trustingly included, and sensing an empowering ward atmosphere (Table 3).

Thriving in Relation to Participating Actively in a Complementary Ensemble of Care

This main theme described patients' experiences of SDM relating to their care. The participants in this study described that they wanted all those involved in their care to work together in companionship, which was interpreted as the complementary ensemble of care. Patient participation in SDM was associated with feeling important and included, regardless of mental ill-health. The participants conveyed that the process of restoring their mental health depended on their possibility to participate and to what extent they were respected. Participating actively was considered to give them the motivation, willpower, and courage to move forward.

The participants highlighted that they felt safe when the MHCPs were companions and were complementary to their own participation in SDM. Their feeling of safety was described as necessary for thriving. It helped them try new interventions and work with themselves. In situations where the participants had reduced insight and rationality, they communicated that they felt safe knowing that the MHCPs would take care of them by safeguarding their values and treating them according to their best interests without feeling violated. When the participants were in better mental health, they wanted to participate by sharing their experiences, knowledge, and observations with the MHCPs in order to collaborate to find suitable solutions and to make appropriate decisions. They experienced that their contribution of participating actively was necessary for making a complementary ensemble of their care.

Some participants described the lack of opportunity to participate as being held back, controlled, and restricted, which resulted in feelings of irritation, humiliation, and violation. Not being allowed to participate was experienced as destructive. In contrast, the participants experienced thriving through positive development, growth, and restored mental health when they participated actively, which reflects a maturation in the process of care.

Having mental space to discover my way forward. This theme referred to the participants' wish to discover what worked or not in their process of restoring their mental health, the meaning of feeling encouraged by supportive MHCPs, and the use of flexible frames in this process.

Some participants highlighted the importance of *learning from life experiences* without the MHCPs controlling them in order to find something on which to build their own processes of restoring mental health. Several participants highlighted that they had experienced through their life what was necessary for restoring their mental health. They conveyed that support for practicing what they already knew was important, and if the MHCPs told them that they could not do it in that way without any further reflection, they found it destructive.

Table 3. Main Theme, Themes, Subthemes, and Condensed Meaning Units.

Main theme	Thriving in relation to participating actively in a complementary ensemble of care					
Theme	Having mental space to discover my way forward			Being in a position to express my case		
Subtheme	Learning from life experiences	Feeling encouraged by supportive mental health-care professionals	Making use of flexible frames	Participating by using own current resources	Feeling trustingly included	Sensing an empowering ward atmosphere
Condensed meaning unit	My self-esteem is very low and I'm very unsecure concerned how to live my life and how to take care of myself...I think I'm in the "trial and error-phase." I know that there should be a balance in life, but where is my balance? I'm struggling with that.	When I arrived I talked to T who told me about experiences with quitting addictive medicine and how well another person succeeded and that I could succeed as well. I didn't believe in it, but now I've managed to quit completely.	I asked for a talk at night and she refused me like I was a little kid by saying: "It's not allowed to talk at night. Take this magazine and go to your room!" I felt bad and dishonoured. I just needed to talk a little...	When I'm very ill I have to trust them. They always ask me and they give me advice. Then it's up to me if I want to listen to them or not. I am treated with respect.	He never gave me up. He included me and was always there for me. He did everything to help me (...) he listened to me and gave me advise.	They say I need to do it in that way but I don't know why...It's like kindergarten; I don't need to sleep but I must go to bed anyway...It makes me very annoyed, grudging and reluctant. I try to avoid having contact with them.

Feeling encouraged by supportive MHCPs was emphasized both for the participants trying to discover a new way forward and for the participants who already knew what was necessary for moving forward. The participants described that they felt encouraged when MHCPs were supportive by listening to them and reflecting together with them. They experienced the MHCPs having faith in and responding to their wishes, cooperating, and kindly pushing them as supportive. *Feeling encouraged by supportive MHCPs* was enhancing for *having mental space to discover the way forward*. Some participants described that the poorer they felt, the more they wanted their supporters to be engaged, closer, and more compassionate. In better phases, the participants still wanted their supporters, but less engaged and with greater distance.

Making use of flexible frames was described by the participants to be essential in order to achieve the *mental space to discover the way forward*. Some of them had experiences of being cared for by MHCPs saying "that's the way it is," which gave no space for finding a solution more suitable for them. The participants experienced that *making use of flexible frames* created more creativity, courage, and enthusiasm for care, which made them feel that their participation in decision-making was important.

Being in a position to express my case. This theme described the participants' experiences of wanting the opportunity to express what was important to them, their wishes, and how they found their situation in circumstances where decisions were to be taken. The participants required that the MHCPs listened to them and responded to what they expressed in order to influence the decision-making.

The participants conveyed that their capacity for participating in decision-making when being hospitalized varied according to their mental health. They wanted *to participate by using their own current resources*. Sometimes, when they were in poor mental health, they found it hard to know what was for their own best and to be responsible for their own decisions. They imparted that during such circumstances, they found it supportive when the MHCPs helped them by sharing experiences, giving advice, or conducting the decision-making. If the MHCPs deemed it necessary to take charge in a situation, the participants wanted to participate by getting information and being invited to a dialogue about their thoughts and opinions in order to feel present in their care.

The participants revealed that *feeling trustingly included* was important for participating actively. They desired to experience that the MHCPs listened to them, respected them, and that they were taken seriously. Some of the participants had experience of MHCPs who signalized that they already knew the situation from their own perceptions, which gave little or no opening for the patients' voice and patient participation became difficult. The participants wanted the MHCPs to be present and to take the initiative to include them in their care. They conveyed that they felt *trustingly included* when they experienced the MHCPs to be supportive with positive attitudes.

Some participants believed that an exchange of information, thoughts, and views were important to make them feel trustingly included and in a position to express their case.

They shared that when they were in poor health, it was easier to participate if the MHCPs informed them of what they thought was for the best, simultaneously asking them for feedback on the issues that had been raised.

Sensing an empowering ward atmosphere was highlighted as an important issue when *being in a position to express one's case*. Some participants had experienced that routines on the ward were a hindrance for them to participate in decision-making and it gave them a sense of powerlessness. They wanted a ward atmosphere which could serve them in achieving autonomy and value.

Discussion

This study aimed to describe patient participation in SDM in the context of indoor mental care. Patients' experiences of participating in SDM revealed the main theme *thriving in relation to participating actively in a complementary ensemble of care*. This represented the red thread between 2 themes: *having mental space to discover my way forward* and *being in a position to express my case*.

The first theme describes the importance of patients *having mental space to discover their way forward*. The MHCPs can give patients mental space by accepting unpredictability and letting them make decisions with uncertain outcomes as long as they are not put in danger. The patients might have wishes which do not seem to be for their best, but they want space to find their way (8). In line with this study, Barker and Buchanan-Barker (9) highlight that patients *learning from life experiences* without MHCPs controlling them is of great importance in their process of discovering their way forward. No one is fully able to understand the experiences of others. We can only know our own experiences and only by learning from life experiences can the patients become wiser about the events in life. By discovering what is suitable for themselves, the patients can develop confidence, independence, and become able to make decisions on their own and take responsibility (2,13), which is important for thriving in the process of restoring their mental health (9).

This study reveals the importance of *feeling encouraged by supportive MHCPs* to discover their way forward. Sufficient support is necessary for being able to work on restoring their mental health (9), but how much support and what kind of support the individual patient requires varies with their mental ill-health, which must be continually assessed (14). The supporters should focus on empowering the patients by exploring with them how they understand their problems and by helping them to recognize how to increase their control of their lives. The best supporters are those who let the patients "own" their experience without trying to control the situation completely. In this way, the supporters should guide the patients toward making appropriate choices by intervening, not interfering (9). Patients want to work in companionship with the MHCPs to explore together their experiences of health and ill-health. This is considered to empower the patients in their process of restoring their mental health (9,10) and promoting thriving.

In order to have mental space to discover the way forward, it is necessary to *make use of flexible frames* which are designed on the basis of the patients' prerequisites. Routines of the ward are frames in which many patients feel safe and secure in times of mental ill-health. These frames may at the next turn serve as a hindrance in letting the patients learn from life experiences because they protect them too much from real life (9).

This study reveals the importance of patients *being in a position to express their case*. In mental care, it is the MHCPs' duty to determine whether the patients have insight or not. The assessment of patients' insight builds on the MHCPs' understanding of rationality, and if patients lack insight, their views are seen as invalid (7). As the patients do not always define and prioritize the dimensions of their care in the same way as MHCPs (23), the MHCPs may take a dominating position in order to practice their understanding of safe care (7). In order to participate in SDM, the patients must *be in a position to express their case* throughout their mental care. The onus should be on the patients, their experience of ill-health, and their appreciation of what they want in order to handle the current problems (9). Montori et al (24) claim that the MHCPs should empower their patients by informing about their own preferences and state the reason for these so that the patients can judge for themselves whether this view makes sense for them in this situation or not. The MHCPs should also listen to their patients' point of view. An equal dialogue between the patients and the MHCPs is of importance in order to put the patients in a position where they can participate actively (8).

This study finds that the patients must *feel trustingly included* by experiencing that the MHCPs are interested in them as people and available for them. Without feeling trustingly included, the patients will be on their own (3). The MHCPs should be close to their patients in order to get the companionship required for SDM when exchanging information, cooperating, and for finding the optimal choice together (9,12).

Sensing an empowering ward atmosphere is of great importance for the patients in order to be in a position to express their case. The MHCPs who are strongly committed to general guidelines seem to be less involved with the patients as individuals (23,25). This can form a ward atmosphere of powerlessness where the patients' *position to express their case* is reduced (14).

Limitations

The data in this study had high information richness which gave a deep insight into patients' experiences of participating in SDM (17). However, the results might have been different if we had selected participants who were discharged from hospital or who had a specific diagnosis.

One limitation may be with regard to the selection procedure of participants. Carlson et al (26) argue that trustworthiness regarding sampling procedures in qualitative studies involving persons with severe mental health issues needs to be thoroughly discussed as these procedures may influence the results. In our study, MHCPs selected the participants and thereby were given power to decide who should be given a voice and who should not (27). Such a procedure may be influenced by stigmas about mental illness as people with severe mental illness may be considered unable to participate in research studies. Therefore, we considered that the thorough ethical procedure, the description of recruitment procedures, and the fact that the data analysis was carried out by more than one author were important in order to attain trustworthiness in the reported findings of our study (26).

The findings are not to be generalized but hopefully the knowledge presented will be transferable to similar contexts (15). Further research might investigate how the patients' lack of opportunity to participate actively in their care can be improved.

Conclusion

Patients can participate actively in SDM when the patients' and the MHCPs' joint expertise is applied throughout their mental care. How the patients participate and how much support they desire vary according to their mental illhealth and should be continually assessed. The patients experience thriving when participating actively in a complementary ensemble of care in a ward which is conducive to allowing them the mental space to find their way forward and to be in a position to express their case in order to restore their mental health.

Authors' Note

The study was designed by L.S.B., K.R., and E.S. L.S.B. coordinated the research. The data were collected and transcribed by L.S.B. L.S.B. made the categorization in the analyses of the data, while L.S.B. and K.R. discussed the underlying meaning of the findings. The themes and main theme were validated through reflections and conversations by the 4 authors (L.S.B., K.R., E.S., and B.S.H.). The report was written by L.S.B. with supervision from K.R., E.S., and B.S.H. All authors provided feedback on the draft manuscript and approved the final version. They all adhered to the criteria pertaining to roles and responsibilities in the research process recommended by the ICMJE (http://www.icmje.org/recommendations).

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Paper II

Shared Decision-Making—Balancing Between Power and Responsibility as Mental Health-Care Professionals in a Therapeutic Milieu

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Abstract

Background: Shared decision-making (SDM) is supposed to position patient and expert knowledge more equal, in which will have an impact on how mental health-care professionals relate to their patients. As SDM has not yet been widely adopted in therapeutic milieus, a deeper understanding of its use and more knowledge of interventions to foster its implementation in clinical practice are required.

Aim: To explore how mental health-care professionals describe SDM in a therapeutic milieu as expressed through clinical supervision. The research question was "What are prerequisites for mental health-care professionals to practice SDM in a therapeutic milieu?"

Methods: A qualitative content analysis of data from focus groups dialogues in 10 clinical supervision sessions where eight mental health-care professionals participated was performed.

Findings: The theme, *practicing SDM when balancing between power and responsibility to form safe care*, was based on three categories: *internalizing the mental health-care professionals' attributes, facilitating patient participation*, and *creating a culture of trust*.

Conclusion: SDM is a complex and arduous process requiring appropriate interventions. Clinical supervision is necessary for reflection on SDM and for improving practice in a therapeutic milieu.

Keywords

clinical supervision, focus groups, mental health-care professionals, shared decision-making, therapeutic milieu

Introduction

High-quality care should be a common goal for all mental health-care professionals, and patient participation is argued to be an important element in high-quality services (Rise, Westerlund, Bjorgen, & Steinsbekk, 2014). A recommendation in Norwegian White Papers (Norwegian Ministry of Health & Care Services, 2008–2009; Norwegian Ministry of Health & Care Services, 2012–2013) is that the patient perspective should be taken into account in the planning and implementation of treatment. The therapeutic milieu in mental health wards is based on relational treatment, the main focus of which is the use of relationships to alleviate relational harm. Daily life and activities are lived in a healing culture, rich in therapeutic interpersonal relationships and cooperative attentiveness to patients (Long, Knight, Bradley, & Thomas, 2012; Mahoney, Palyo, Napier, & Giordano, 2009).

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Shared decision-making (SDM) is a care model facilitating patient involvement (Dierckx, Deveugele, Roosen, & Devisch, 2013) by adjusting the asymmetrical power balance between patients and mental health-care professionals. As SDM has not yet been widely adopted in therapeutic milieus, a deeper understanding of its use and more knowledge of interventions to foster its implementation in clinical practice are required (Gravel, Légaré, & Graham, 2006; Perestelo-Perez, Gonzalez-Lorenzo, Perez-Ramos, Rivero-Santana, & Serrano-Aguilar, 2011). A prerequisite for implementing SDM in care settings is that mental health-care professionals have the ability and are willing to include the patient in decisions (Grim, Rosenberg, Svedberg, & Schön, 2016).

This quality improvement study contributes to new knowledge of prerequisites for mental health-care professionals to practice SDM in a therapeutic milieu as expressed through clinical supervision. Clinical supervision is a way of creating a culture where a process of sharing, learning about, and reflecting on clinical experiences of patient mental health-care professionals interaction enhances the professional development of mental health-care professionals (Berggren & Severinsson, 2011). The purpose of clinical supervision is to improve practice (Brunero & Stein-Parbury, 2008) by means of a forum where questions about how to perform high-quality work are raised and safe work practices studied in order to learn from everyday situations (Brunero & Lamont, 2012). Mental health-care professionals attending clinical supervision are supposed to improve SDM (Berggren & Severinsson, 2011; Brunero & Stein-Parbury, 2008). Clinical supervision outcomes are shown to include "changing organization of care, confirmation of nursing interventions, problem solving, and improving and confirming practice" (Brunero & Stein-Parbury, 2008, p. 93), in which the approach of clinical supervision turns to be a suitable tool for strengthening SDM in a therapeutic milieu.

Review of Literature

In Norway, the health and care service legislation strongly supports patient participation (Norwegian Ministry of Health & Care Services, 2012 2013) which means to acknowledge the patients' experience and knowledge of their right to participate in their health, and to position patient and expert knowledge more equal (Solbjør, Rise, Westerlund, & Steinsbekk, 2011). However, the power balance between patients and mental health-care professionals needs to be adjusted, which will have an impact on how mental health-care professionals relate to their patients. SDM consists of five elements: active participation between patients and mental health-care professionals, information sharing, problem definition, deliberation about treatment

options, and finally, a decision or deferment (Charles, Gafni, & Whelan, 1997). The interaction between the patient and mental health-care professionals should be characterized by an equal division of power between the parties, a negotiated agenda, and exploration of the patient's values, with mental health-care professionals playing an advisory role regarding the patient's goals and decisions (Elwyn et al., 2009). Practices with standardized procedures and guidelines are dominated by the expert power, and become challenged by this equal power relationship on which SDM builds on (Grim et al., 2016).

In mental health-care, some patients are considered incapable to act in their best interest. Both health-care professionals and patients have characterized SDM as challenging during episodes of mental illness, as the patients may have phases with lack of insight, difficulties in communication and cooperating disabilities. Solbjør et al. (2011) reports that this requires mental health-care professionals having the sensitivity and the insight to facilitate SDM in ways that safeguard patients in all phases of illness. Despite the fact that there has been a great deal of focus on SDM in mental health care, many patients continue to express a desire for more active involvement in their treatment (Angell, Matthews, Stanhope, & Rowe, 2015). This means that mental health-care professionals need to improve their work of facilitating SDM, in which involves an ongoing reflection on and assessment of the patient's resources, limitations, and need for assistance (Kontio et al., 2010).

The aim of this study was to explore how mental health-care professionals describe SDM in at therapeutic milieu as expressed through clinical supervision.

Methods

Study Context

The context of this study was the therapeutic milieu in three different wards in a community mental health center in Norway, possessing a total of 30 beds. This is an autonomous professional unit responsible for general mental health services in a distinct geographic region. Mental health-care professionals working in the therapeutic milieu possess various professions, mostly bachelor degree in nursing or as a social educator, some with a specialized education in mental health care. Because of lack of mental health-care professionals, unskilled assistants are working in this clinical context. A total of 105 employees are connected to the 30 inpatients in the three wards in permanent positions or as stand-in, covering 24 hours a day, 7 days a week. The patients have various mental health problems, suffering from different mental illnesses which makes them in need of being inpatient in a period of time, short or long term.

Study Design and Supervision Program

A qualitative study with an explorative and descriptive design was chosen (Polit & Beck, 2010) in order to gain a deeper understanding of SDM as described by mental health-care professionals working in therapeutic milieu. The researchers designed a 10-session supervision program based on knowledge of core phenomena in clinical supervision (Holm Wiebe, Lindquist, & Severinsson, 2011). This formed the basis for the data collection by facilitating in-depth dialogues that addressed the research question. The principles of a supportive and nurturing relationship (confirmation, understanding, empathy, presence, creating trust, and security) presented by Holm Wiebe et al. (2011) formed the basis of the 10 sessions, and their principles related to the supervision space (storytelling, sharing and reflection, acting, and challenges) were adhered to at all times. These elements were equally important for collecting in-depth data by means of dialogues (Polit & Beck, 2010). The main topics addressed in the clinical supervision were the mental health-care professionals patient relationship and SDM in the therapeutic milieu. The mental health-care professionals reflected on what SDM means in various situations, using examples from their everyday practice. Knowledge development took place when mental health-care professionals who were attending clinical supervision shared their experiences and viewpoints, in addition to being open to the various perspectives of their fellow supervisees.

The research question was: "What are prerequisites for mental health-care professionals to practice SDM in a therapeutic milieu?"

Participants

Inclusion criteria for participating in the clinical supervision were a bachelor degree in nursing or as a social educator and at least 1 year of work experience in mental health inpatient settings, as such mental health-care professionals were expected to provide rich data (Polit & Beck, 2010). The exclusion criteria were working for less than 28 hr per week, working only night shifts, and clinical nurse managers. The researchers contacted clinical nurse managers at a community mental health center and informed them about the study, after which the clinical nurse managers invited eight mental health-care professionals from three different wards to participate in the clinical supervision program. The eight included participants were unknown to the authors. The participants are presented in Table 1.

Data Collection

Focus group discussion in clinical supervision was employed to collect the qualitative data (Colucci, 2007; D. L. Morgan, 1996). The topics were determined by the researchers ahead of the sessions. This technique used the group interaction on the specified topic focusing on the research interest (D. L. Morgan, 1996). In this way, we formed the focus group in a way that adhered to the aim of the study. According to D. L. Morgan (1996), more creative uses and formats for focus groups remain to be discovered.

D. L. Morgan (1996) argues that focus groups as a data-collection tool are influenced by participants' reliance on the researcher and the interaction, and that this has a direct impact on the project's strength or weakness. In the current study, the participants and researchers became familiar with each other as a consequence of several meetings. No conflicts between the participants and the researchers were determined, and the dialogues that took place in the sessions were characterized by an open, engaged, and curious atmosphere. This attitude seemed to enhance the participants' will to share experiences from their clinical field (cf. D. L. Morgan, 1996).

Table 1. Description of Participants.

Name (anonymous)	Age	Years of experience in mental health inpatient settings	Gender	Profession
Tina	57	11	Female	Social educator
Janet	43	8	Female	Mental health nurse
Ester	47	1	Female	Nurse
Rachel	45	27	Female	Mental health nurse
Kaia	54	21	Female	Mental health nurse
Anna	60	14	Female	Mental health nurse
Hanna	43	22	Female	Mental health nurse
Dan	38	13	Male	Mental health nurse

The first (LB) and last author (KR) acted as moderators. We always started the sessions with some evaluation from last time, an introduction of todays' topic, and thereafter the reflection in the group. The sessions always ended with an evaluation of today's session. By holding this routine, the form of the sessions became predictable and was a way for the moderators to find an appropriate way of approaching the participants. We tried to use the activity-oriented questions to encourage the discussion; "Activity-oriented questions can also be appropriate to talk about sensitive topics, which may look less threatening when discussed through practical and enjoyable tasks" (Colucci, 2007, p. 319).

The sessions, each of which lasted for 1.5 hr, were performed every second week between February and June 2016. All sessions were audio-taped and transcribed verbatim, and the dialogues were used as data for the study. Two of the four authors were involved in the clinical supervision group, which provided proximity to real-life situations. By having proximity to real-life situations, the researchers can understand the participants' views and become involved with them, thus creating a trusting relationship that enables the participants to feel safe enough to share their experiences and provide a rich data set (M. S. Morgan, 2015). To ensure that the data were as genuine and trustworthy as possible, the researchers were aware of and reflected on their own preunderstandings and how they could affect the participants, while at the same time remaining open to other possibilities of understanding (Graneheim, Lindgren, & Lundman, 2017).

Qualitative Content Analysis

The qualitative content analysis was performed at a descriptive manifest level (Graneheim et al., 2017). An inductive approach, with a search for patterns in the text, was employed in order to illuminate the mental health-care professionals' views as a whole (Graneheim et al., 2017; Lincoln & Guba, 1985). The authors searched for variations in the data material by identifying similarities and differences in the text, which were presented in the form of theme, categories, and subcategories on various levels of abstraction and interpretation. The analysis was conducted in three steps after the conclusion of the 10 supervision sessions: In Step 1, the transcribed text was read and listened to several times in order to gain a sense of the whole, after which the content was divided into meaning units that were then condensed and labeled with a code. In Step 2, the various codes were compared and sorted into categories, which constituted the manifest content. In Step 3, the codes and categories were compared and organized into three categories, each of which was based on two subcategories. The categories were abstractions of the linked subcategories. The data

became clearer and a new understanding emerged as a result of the process of temporal distance, when feelings and experiences from the data collection grew more distant. The categories were validated and the abstractions of the data were reflected on and discussed by the four authors with focus on how to discover and understand their meaning. As a final point, the content in the three categories were interpreted and integrated in one theme (Graneheim et al., 2017).

The authors' preunderstandings were related to their experience as clinical nurses, clinical supervisors, and researchers, while three of the authors (LB, KR, and ES) are registered mental health nurses and have several years of clinical experience caring for mentally ill people.

Ethical Considerations

This study was carried out in accordance with the Declaration of Helsinki (World Medical Association, 2013) and has been approved by the Regional Ethics Committee of Western Norway (2015/1721). A guarantee of anonymity and confidentiality was given to all participants and their written consent was obtained. The participants' role as clinical supervisees exposed them in the sense that they became emotionally involved by sharing personal experiences in the group. All data were treated confidentially, kept securely locked away, and only used for research purposes.

In addition, the participants were informed about the aim of the study and that they could withdraw their consent at any time without any negative consequences. The researcher did not ask for sensitive information during the interviews (International Committee of Medical Journal Editors, 2017; World Medical Association, 2013). The mental health-care professionals were closely monitored in the supervision group by being asked how they experienced participating in the clinical supervision sessions.

Findings

The findings revealed prerequisites for practicing SDM in a therapeutic milieu. The interpretation of the findings identified one theme, *practicing SDM when balancing between power and responsibility to form safe care,* which represented the internal link between the three categories, each of which was based on two subcategories (Table 2). The first, *internalizing the mental health-care professionals' attributes,* is based on *making use of professional skills* and *being attentive to the patient.* The second, *facilitating patient participation,* is described by *stimulating patient involvement* and *acknowledging the patient's process of participation.* The third category, *creating a culture of trust,* is based on *applying guidelines in a person-centered way* and *standing together as a team.*

Table 2. Theme, Categories, Subcategories, and Condensed Meaning Units.

Theme	Practicing SDM when balancing between power and responsibility to form safe care				
Categories	Internalizing the mental health-care professionals' attributes		Facilitating patient participation		Creating a culture of trust	
Subcategories	Making use of professional skills	Being attentive to the patient	Stimulating patient involvement	Acknowledging the patient's process of participation	Applying guidelines in a person-centered way	Standing together as a team
Condensed meaning units	Our attitudes to the patient have an impact on their behavior	If you are attentive to the patient, you understand what you can do to help that person to alleviate their anxiety	At the end of the shift, we usually ask the patient if everything was OK. I think the patient feels more involved when we do so	A patient thanked us for what we did by preventing her from taking her own life	It is not good for the patient to be discharged from the ward as a consequence of not following the treatment plan	Being able to trust colleagues is important. Trust is created by the experience that the other is reliable. We have a dialogue about what we think and understand in a situation and how to proceed

Practicing SDM When Balancing Between Power and Responsibility to Form Safe Care

The theme reflected the participants' experiences of being in a dynamic process together with their patients. Mental health-care professionals should safeguard patients' participation and sense of control at the same time as they ensure good recovery conditions. Both mental health-care professionals and patients have power and responsibility for SDM, where the power and responsibility should be balanced in a way that forms patient recovery and safety. The participants experienced that SDM was a dynamic process where they continuously should assess the patient's insight and ability to take responsibility for own choices, securing that the patient was of no danger for oneself or others. In such phases, the participants saw it as their mission to compensate for the power and responsibility the patient is unable to maintain. The participants took charge by providing information, encouraging their patients, and reducing choices, as they safeguarded the patient by showing dignity and respect. Some of the participants described that when the patient recovers and is no longer in danger for oneself or others, the power and responsibility is given back to the patient. They stated that the balance between power and responsibility should be perceived to be the patient's best interest at all times. *Practicing SDM when balancing between power and responsibility to form safe care* seemed to be a red thread throughout the data and the subcategories represent different aspects of the prerequisites for SDM in a therapeutic milieu.

Internalizing the Mental Health-Care Professionals' Attributes

The first category describes the importance of mental health-care professionals possessing a high level of professional skills and being attentive to patients in order to achieve a balance between power and responsibility in SDM, thus forming safe care.

The participants reflected on how *making use of professional skills* implied professional knowledge on the part of mental health-care professionals:

> "If we haven't enough knowledge about the problems the patient is struggling with he will not get the help he needs and it could threaten patient participation" (Anna, Session 5).

Mental health-care professionals' attitudes, values, and way of being influenced the patients. The interpersonal competence is an important part of the professional skills and was experienced as challenging to improve because it is mostly grounded in automated and unconscious features.

By *being attentive to the patient*, the mental health-care professionals experienced that they should invite the patients to participate in a dialogue in order to become more aware of what is beneficial for them, in which implied that mental health-care professionals understand the patients and can intervene in accordance with their understanding:

> I didn't know the patient well and a violent situation occurred. In retrospect we can understand what led to

the patient's violent reactions. When we have built a relationship we notice signs of violent reactions earlier and can intervene to avoid them (Rachel, Session 2).

The participants expressed that they needed to reflect together on challenging situations in order to get the view of the diverse aspects of the specific situation, put them together and get a better understanding of the patient, the situation, and oneself. They experienced that a well-reflected situation will arrange for professional skills and make them better suited to handle similar situations in the future, which more successfully will facilitate SDM.

Facilitating Patient Participation

The participants reflected on a variety of experiences when *facilitating patient participation*. They described how some patients want mental health-care professionals to know what is best for them and make them healthy without becoming involved themselves. The participants described that they found this problematic because they could not find themselves able to know what was the best for each patient without getting the patient's point of view. They considered it their responsibility to take the initiative to facilitate patient participation, however, they found it challenging to assess how much and in what way each patient is capable to participate in different situations and with differing levels of engagement. Facilitating patient participation comprises *stimulating patient involvement* and *acknowledging the patients' process of participation*.

The theme *stimulating patient involvement* concerned being trustworthy, honest, and always showing respect for the patient's feelings. Maintain a trusting relationship with the patient through challenging situations requires mental health-care professionals being aware of their own emotions and thoughts and processing these so that they are able to balance between supporting the patients and encouraging them to cope with challenges in a way that facilitate patient participation. The participants stated that in their experience, confirming patients is very important for stimulating involvement in their own treatment. One participant commented:

"Acknowledging patients' knowledge of their own lives helps to create a good relationship. You show that you care about what they need for recovery" (Ester, Session 2).

Predictability was highlighted as important for stimulating patient involvement. Unexpected interventions without their involvement can make patients lose faith in SDM. How predictability is ensured was described as follows:

The patient is involved in making a plan for how to deal with similar crises at a later stage. In that way, she knows

what will happen next. The plan will be evaluated together with the patient on a regular basis, which means that the patient has ownership of her treatment plan (Janet, Session 3).

Acknowledging the patient's process of participation was emphasized as important for encountering the patients at their current stage in the recovery process. The participants had experienced that not demanding too much or too little from patients is important for *balancing between power and responsibility to form safe care*. They reported that acknowledging the fact that patients can have a different understanding of their situation at various times and that their involvement varies according to where they are in the recovery process is a part of facilitating patient participation. The participants experienced that patients' understanding of a situation often changes as they recover and reported that patients frequently express their thanks for the help they received by coercion when they are well again:

"Sometimes we must help and protect patients against their will. In retrospect, they feel ashamed and thank us for taking over" (Dan, Session 5).

The participants described that patient involvement can vary over time; sometimes the patients have the strength to participate, while on other occasions they need the mental health-care professionals to take over. Acknowledging this process was considered important for balancing between power and responsibility.

Mental health-care professionals being able to encounter the patients where they stand was experienced as crucial when facilitating patient participation, and this insight needs high expertise to convey.

Creating a Culture of Trust

When reflecting on the fact that many mental health-care professionals work in the therapeutic milieu at different times with the same patients, the participants reported that creating a culture of trust is essential in order to maintain the balance between power and responsibility to form safe care. According to the participants, the prerequisites for creating a culture of trust are *applying guidelines in a person-centered way* and *standing together as a team*.

Applying guidelines in a person-centered way was reported as challenging. The participants experienced that SDM is hindered by the procedures and structure of the ward. If mental health-care professionals adhere to checklists and procedures for their own sake without taking account of the patients' recovery process, the participants believed that a culture of trust would fail to emerge. Checklists do not help when mental health-care professionals know that something is not right.

In such situations, they have to act on their intuition in a way that enhances patient well-being. One participant shared the following experience:

> The doctor said the patient was fine, but we were very familiar with the patient and knew that he was not well. To protect the patient, we acted against the doctor's orders and ran to the patient to secure him. It led to a long hospitalization but prevented the patient from taking his own life (Janet, Session 9).

Applying guidelines in a person-centered way is about being confident in own assessment. The mental health-care professionals will use procedures and checklists as guidelines, but they are free to do it differently if they find it beneficial for the patient.

The participants discussed their concern about situations in which there is a failure to create a culture of trust and where the conditions for SDM are difficult. They experienced that colleagues' expectations of mental health-care professionals professionalism can hinder patient participation:

> "Therapists may be hesitant to let patients find the solution themselves because it can challenge the professionalism expected of a good therapist" (Kaia, Session 1).

Having a dialogue with the colleagues about expectations was experienced to promote a culture of trust, which was seen as prerequisites for SDM.

Sometimes, mental health-care professionals are forced to employ coercion as a part of the treatment. The participants expressed that the way they employ coercion is crucial for balancing power and responsibility when facilitating SDM to form safe care:

> The decisions are beyond the power of both the patient and myself. I must do my job while showing respect for her as a human being … We made it (administering medication by coercion) by taking time, and she decided who was to give her the medicine and how she should lie. I offered to hold her hand. She refused to talk to me. When it was over, I offered her a slice of bread with honey and a cup of tea, and she smiled at me (Kaia, Session 8).

Being able to employ coercion in a way that makes the patient experience some control in the situation, dignity, and respect requires that the mental health-care professionals have insight and awareness, simultaneously as the culture on the ward supports person-centeredness as common practice.

Standing together as a team was deemed necessary to make it possible for the therapeutic milieu as a whole to balance power and responsibility to form safe care. The participants described that standing together as a team entails good teamwork, shared knowledge, familiarity with, and a supportive attitude toward the patient. They experienced that good teamwork implies that colleagues know and trust each other, feel safe when working together, cooperate and are honest with each other, are not afraid to express disagreement, and stand together on the decisions made. They described good teamwork as shaping the atmosphere in the therapeutic milieu and having an impact on patients' impression of receiving safe care:

> If the team members are uncertain about each other, there is a lot of anxiety on the ward, but when they are well coordinated, it becomes calm (Janet, Session 4).

The participants highlighted the importance of sharing knowledge of the patients in order to obtain a more holistic understanding of them. If the mental health-care professionals working together know the patient and each other, the therapeutic milieu was expected to be more cooperating and understanding, which was seen as important for SDM.

The participants experienced that a supportive attitude toward the patient is important for creating a culture of trust. In the words of one participant,

> 11 persons stood in the staff room and expected that the next shift would be difficult because of one patient, but I considered it differently and had to tell them because I didn't think it was right. It took courage for me to say that we must encounter the patient with a better attitude (Janet, Session 5).

Sharing the same supportive attitudes is necessary for creating a culture of trust, which was experienced as prerequisites for SDM in a therapeutic milieu.

Discussion

SDM is supposed to facilitate patients achieving real involvement in a therapeutic milieu (Dierckx et al., 2013). This study reveals that practicing SDM when balancing between power and responsibility to form safe care is a continuous, dynamic, and arduous process that requires each mental health-care professionals to internalize their attributes, facilitate patient participation, and create a culture of trust in the therapeutic milieu. According to the literature, such balance requires ongoing reflection on and assessment of the patient's resources, limitations, and need for assistance in order to give them the power and responsibility they are capable of managing during various phases of illness with various needs (Kontio et al., 2010). The patient's functioning can change over time, thus to ensure safe care mental health-care professionals should always compensate for the power and responsibility that

the patient is unable to maintain (Rise et al., 2014). Kontio et al. (2010) describe that achieving this balance is a challenge for mental health-care professionals in the therapeutic milieu, as it sometimes creates difficulty because of the question "who knows what is best for the patient?" In a literature review by Sutton, Eborall, and Martin (2015), it is reported that patients can become specialists in their own conditions and that they want to ensure the best outcome. This is an important basis for SDM. However, mental health-care professionals experience that patients are often unable to maintain good recovery conditions for themselves (Kontio et al., 2010; Solbjør et al., 2011). For instance, when a patient is determined to take their own life, mental health-care professionals are obliged to assume responsibility and use the necessary power to intervene and prevent them from committing suicide. When mental health-care professionals use power against the patient's will, they must simultaneously bear professional responsibility for protecting them. As the patient recovers and is no longer in danger, the power and responsibility should be gradually transferred back to them (Rise et al., 2014).

Prerequisites for practicing SDM include mental health-care professionals who are able to recognize that different clinical situations require differing approaches, as well as acceptance of SDM as a core element of good practice (Elwyn & Fisher, 2014; Grim et al., 2016). The process of reflection in clinical supervision improves mental health-care professionals' understanding of their relationship with their patients (Holm Wiebe et al., 2011), which is essential for achieving a balance between power and responsibility to form safe care.

Participation in a clinical supervision program focusing on SDM, as in this study, is a way to develop knowledge of practice and make implicit knowledge explicit (Neher, 2016). In line with Neher (2016), this study promotes learning by allowing the members of the group receiving clinical supervision to critically reflect on implicit assumptions about themselves, the patient and others, as well as thoughts, motives, and behavior patterns associated with their experiences of SDM. Automatic and habitual actions can be transformed into more conscious and targeted ones (Neher, 2016). In this way, clinical supervision can help mental health-care professionals to *make use of their professional skills* and *be attentive to the patient*.

As described in this study, mental health-care professionals experience that *facilitating patient participation* is important as many patients either do not want or are unable to participate in their recovery process. Rise et al. (2014) state that patients need flexible services in order to regulate to their changing needs. When the patients have strong symptoms, they have a need to be taken care of and less responsibility, and when they have less symptoms, the need for empowerment, active participation, and more responsibility in decision-making is

increased. Making it possible for patients to be listened to and have their views considered meaningful and acted upon in differing phases of illness requires active intervention (Sutton et al., 2015). By participating in clinical supervision, mental health-care professionals will gain a space where they can reflect on their practice, their experiences, and how they can develop better interactions with patients in different situations and with differing levels of engagement (Brunero & Lamont, 2012). The awareness and knowledge gained by reflection should enable mental health-care professionals to increase their capacity to apply the principles of SDM (Charles et al., 1997). By *acknowledging the patients' process of participation*, mental health-care professionals show that they care about what is needed to help and that patient participation is important throughout the recovery process. Confirming that patients are important in their own recovery process should provide them with an impression of being autonomous and equal, conveying respect and dignity, which is essential in the balance between power and responsibility (Florin, 2007; Solbjør et al., 2011). When mental health-care professionals are aware of *stimulating their patients' involvement* and *acknowledging their patients' process of participation*, they are more likely to involve their patients in care by asking for feedback on treatment, encouraging them to speak up about risks, and plan for new interventions (Sutton et al., 2015).

Creating a culture of trust as outlined in this study is necessary in order to enable the therapeutic milieu as a whole to balance between power and responsibility to form safe care. "The way we do things here" is based on the mental health-care professionals' norms, attitudes, beliefs, and values. As the culture is local, the work of creating a culture of trust should occur at unit level (Pronovost et al., 2009). Gathering mental health-care professionals who work together in the therapeutic milieu for clinical supervision provides them with a forum where they can share individual knowledge related to experiences of patient dialogue. A creative dialogue within the team enables mental health-care professionals to actively reflect on their experiences, attitudes, and alternatives for action. This learning process may promote collective SDM practice in the therapeutic milieu (Swart & Pye, 2002), and is also important for *applying guidelines in a person-centered way* (Elwyn & Fisher, 2014). The learning process may promote collective understanding and shared attitudes, which are important for *standing together as a team*.

Limitations

A limitation of this study is that the data were collected from dialogues in only one clinical supervision group. However, a strength is that the group took part in 10

meetings over a period of 4 months, thus providing insight into various aspects of the participants' experiences (Polit & Beck, 2010). As the analysis and data interpretation process were influenced by the authors' preunderstandings, the findings are therefore not objective facts but a reconstruction of the participants' experiences, perceptions of reality, and understandings (Polit & Beck, 2010).

Implications for Practice

Ensuring SDM in a therapeutic milieu concerns balancing between power and responsibility. This is a complex and arduous process that does not take place by itself. Clinical supervision is necessary for enabling reflection on and promoting the practice of SDM in a therapeutic milieu. There is need for more research focusing on the patient perspective related to patients' role in SDM.

Summary

SDM in a therapeutic milieu is supposed to facilitate patients achieving real involvement in a therapeutic milieu, in which concerns mental health-care professionals balancing between power and responsibility to form safe care. The clinical supervision program presented here is considered a useful tool in the effort to implement SDM practice in a therapeutic milieu. The findings revealed that clinical supervision facilitates the mental health-care professionals in the process of internalizing their attributes, stimulates them to promote patient participation, and serves as a forum for creating a culture of trust, which may enhance patient safety in the therapeutic milieu (Brunero & Stein-Parbury, 2008).

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Author Contributions

The study and the clinical supervision program were designed by L. B., K. R., and E. S. L. B. coordinated the research. L. B. and K. R. participated in the data collection: K. R. as clinical supervisor and LB as facilitator and moderator. L. B. analyzed the first two steps of the data interpretation, while L. B., K. R., E. S., and B. S. H. participated in the third step. The report was written by L. B. with supervision from K. R., E. S., and B. S. H. All authors provided feedback on the draft manuscript and approved the final version. They all adhered to the criteria pertaining to roles and responsibilities in the research process recommended by the ICMJE (http://www.icmje.org/recommendations).

Declaration of Conflicting Interests

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Paper III

ORIGINAL ARTICLE

WILEY

Being in a space of sharing decision-making for dignified mental care

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Accessible summary

What is known on the subject?
- Several studies describe barriers and facilitators for implementing shared decision-making in mental care, yet a deeper understanding of the meaning of shared decision-making in this context is lacking.
- Shared decision-making is aimed at facilitating patients' active participation in their care.
- Mental care is intended to empower the patients by increasing their responsibility and self-awareness and helping them to use their own resources.
- Too much focus on the patients' independence, responsibility and choice may hinder the patients getting the help they need.

What this paper adds to existing knowledge?
- The meaning of SDM can be understood as a continuous relational process between the patients and MHCPs in search of dignified care.
- Practising shared decision-making is a challenging process which requires the MHCPs to possess high professional competence.

What are the implications for practice?
- Mental healthcare professionals should be conscious of their own role in the asymmetrical power relationship in decision-making and use their professional competence for their patients' benefit.
- Clinical supervision can be a tool for developing professional competence and is considered important when assisting mental healthcare professionals practising shared decision-making for dignified care.

Abstract

Introduction: Several studies describe barriers and facilitators for implementing shared decision-making in mental care. However, a deeper understanding of the meaning of shared decision-making in this context is lacking. Shared decision-making is aimed at facilitating patients' active participation in their care by placing them at the centre of care. Too much focus on the patients' autonomy may hinder them getting the help they need. A comprehensive understanding of shared decision-making is needed for its implementation.

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Aim/research question: To interpret the meaning of shared decision-making in mental care as perceived by patients and mental healthcare professionals. The research question was: What is the meaning of shared decision-making in mental care?

Method: A hermeneutic inductive design with a thematic interpretative analysis of data was performed from in-depth interviews with 16 patients and multistage focus group interviews with eight mental healthcare professionals.

Results: The overall theme *being in a space of sharing decision-making for dignified mental care* was described by the three themes *engaging in a mental room of values and knowledge, relating in a process of awareness and comprehension* and *responding anchored in acknowledgement.*

Discussion: Balancing the patients' need for assistance with autonomy, while safeguarding their dignity, is a challenging process requiring mental healthcare professionals to possess professional competence.

Implications for practice: Organized professional development of the carers' professional competence is important to facilitate shared decision-making.

KEYWORDS

dignified care, hermeneutics, in-depth interviews, mental care, qualitative research, shared decision-making

1 | INTRODUCTION

Shared decision-making (SDM) is a process where the carers and the patients in care are engaged in a dialogue of information, aimed at understanding each other's values and preferences regarding care and agreeing on a plan of action (Makoul & Clayman, 2006). The context of this study is mental care. Shared decision-making in mental care facilitates patients' active participation both by placing the patients at the centre of care and by equalizing the asymmetrical power relationship between the patients and the mental healthcare professionals (MHCPs) (Beyene, Severinsson, Hansen and Rørtveit, 2018a; Dierckx, Deveugele, Roosen, & Devisch, 2013).

Mental ill-health is associated with emotional pain which may cause patients to withdraw temporarily and have difficulty in expressing their feelings in words (Holm, 2009). Throughout mental ill-health, some patients may have difficulty in expressing what they need and sometimes they make unpredictable and inappropriate choices (Delmar, 2012; Solbjør, Rise, Westerlund, & Steinsbekk, 2011). People with mental ill-health become patients because they need help to master their life and they are dependent on their MHCPs (Delmar, 2012; Grimen, 2009). Historically, people with mental ill-health have been encountered with a paternalistic approach, being restricted from making decisions for themselves with the purpose of protecting them and society from harm. In 2008, the Convention of the Rights of Persons with Disabilities came into force, declaring that people with mental ill-health should have the same rights to make decisions for themselves as other citizens (Drake, Deegan, & Rapp, 2010; Pahtare & Sheilds, 2012). MHCPs have been criticized for playing a dominant role in care which may cause unwanted

consequences. This critique stresses the importance of being aware of the patients' own understandings of health and ill-health, which are significant for the healthcare process (Ocloo & Fulop, 2011). A change of the premises in mental care is required, moving away from a substitute decision-making model to a supported decision-making model (Pahtare & Sheilds, 2012). Mental care is intended to empower the patients by increasing their responsibility and self-awareness and helping them to use their own resources (Akerjordet & Severinsson, 2004). Expanding the patients' room for action upholds the patients' respect and dignity. However, too much focus on the patients' independence, responsibility and own choice may cause a feeling of devaluation and hinder the patients getting the help needed (Delmar, 2012). Shared decision-making is possible when the patients' and the MHCPs' shared expertise is applied throughout the mental care (Beyene, Severinsson, Hansen and Rørtveit, 2018b).

There is international consensus about the importance of SDM, and it has been welcomed by policymakers worldwide (Slade, 2017). Despite the growing focus, SDM and its implementation in mental care practice are still at an early phase (Elwyn, Frosch, & Kobrin, 2016). Tailoring the implementation of SDM to contextual conditions is important in order to increase the chances of successful implementation (Damschroder et al., 2009). A comprehensive understanding of what occurs at the individual relational level (Elwyn et al., 2012) during the SDM process in mental care should be acknowledged as a basis for implementation strategies (Morse, Penrod, & Hupcey, 2000). Several studies describe barriers and facilitators for implementing SDM in mental care. However, a deeper understanding of the meaning of SDM in this context is lacking (Elwyn et al., 2016; Gravel, Lègarè, & Graham, 2006).

2 | AIM AND RESEARCH QUESTION

The aim was to interpret the meaning of SDM in mental care as perceived by patients and MHCPs. The research question was: What is the meaning of SDM in mental care?

3 | METHOD

3.1 | Design

An inductive hermeneutic design was performed (Polit & Beck, 2010) according to Gadamer (2013) to develop a deeper understanding of SDM. Using focus groups with MHCPs, individual interviews with patients and thematic interpretative analyses, the data were interpreted and the concept of SDM was illuminated by the data material, the available research on the topic in question and the researchers' pre-understanding. The dialogue between all these elements entered the hermeneutic circle, dialectically moving between the empirical findings, pre-understanding and theory, as well as between the parts and the whole (Gadamer, 2013).

3.2 | Context and participants

The context of this study was three wards at a community mental health centre in Norway from where twenty-four people participated, both patients and MHCPs. A community mental health centre in Norway is an autonomous professional unit responsible for a significant part of the general mental health services within a defined geographic area. The service offered at the community mental health centre consists of voluntary admissions of varying length, from a few days to several weeks, some planned and other acute. Most of the MHCPs at the community mental health centre are social educators or have a bachelor degree in nursing, some are registered mental health nurses and some are high school educated care workers or unskilled assistants. The MHCPs are responsible for the therapeutic milieu at the ward.

The three inclusion criteria for patients were experience of being an inpatient for at least 1 month, aged >20 years and the ability to speak Norwegian. The three inclusion criteria for the MHCPs were a bachelor degree in nursing or related social sciences, at least 1 year of work experience in inpatient settings and experience of working for more than 28 hr per week directly in contact with patients during the day and/or evening.

Clinical nurse managers at the wards were informed about this study, after which they invited face-to-face two/three MHCPs each to participate. The included MHCPs (n = 8) were aged from 38 to 60 years. They consisted of one male and seven females who had from one to 27 years of experience in mental care inpatient settings. Six of them were registered mental health nurses, one was a nurse, and one was a social educator. The eight MHCPs were asked to recruit face-to-face two patients, each of whom they knew well, willing to participate in this study. The included patients (n = 16) aged from 30 to 77 years, of which there were nine females and seven

males who had experience from one to 38 hospitalizations. They described the reason for their hospitalization as personality disorder, psychoses, obsessive-compulsive disorder, suicidal attempt, trauma, anxiety, depression, post-traumatic stress disorder and life crisis. They were all voluntarily admitted when the interview took place. All the included participants were unknown to the authors.

3.3 | Data collection

The data collection was carried out in two stages. The first stage with the MHCPs was conducted by means of ten multistage focus groups (Morgan, 1996) from February to June 2016 by the first (LSB) and the last (KR) authors. The sessions were conducted at the community mental health centre where the MHCP participants were employed, in a room separated from the wards where they worked. Each session lasted for 90 min. The main topic addressed in the focus groups was the meaning of SDM in various situations in indoor mental care, reflecting on settings from their everyday practice related to value-based phenomena such as trust, fear, guilt and shame, suffering and relief, power and responsibility and courage. The second stage was conducted by means of in-depth individual interviews (Polit & Beck, 2010) with the patients by the first author (LSB) between March and August 2016. The interviews were arranged at the community mental health centre where the patient participants were admitted. All patient participants decided where they wanted the interview to take place. All the interviews took place in the author's office except one, which was arranged in the patient's room. Through a dialogue from open-ended pre-set questions, the patient participants shared their experiences of participating in SDM while being hospitalized in a mental health ward. They illuminated various aspects of their experiences which substantiated the meaning of SDM (Polit & Beck, 2010). All interviews were audio-recorded, treated confidentially and kept securely locked away (World Medical Association, 2008).

3.4 | Thematic interpretative analysis

A thematic interpretative analysis of the qualitative data was conducted based on Braun and Clarke (2006) to systematically discover a deeper understanding from the data material. According to a hermeneutical approach, the analyses were performed in phases which overlapped in moves back and forth, considering the parts and the whole as a process with reference to the hermeneutical circle (Gadamer, 2013). The first author (LSB) performed the analysis in phases 1–4 where the text was systematized and categorized. The interpretation in phases 5–6 was performed and validated by all four authors (LSB, KR, ES and BSH).

The datasets from patients and MHCPs were analysed separately from phases 1–4 and interpreted together in phases 5–6. In phase one, the audio-taped interviews were transcribed verbatim and read several times in order to become familiarized with the data. The second phase involved generating initial codes related to the research question inductively and then organizing them into groups across

TABLE 1 Overview of the interpretations of the patients' and MHCPs' understanding of SDM in the context of mental care

Overall theme:Being in a space of sharing decision-making for dignified mental care			
Theme	Engaging in a mental room of values and knowledge	Relating in a process of awareness and comprehension	Responding anchored in acknowledgement
Sub-theme patients	Moving between involvement and being cared for	Longing for information and being understood	Searching for confirmation and being affirmed
Sub-theme MHCPs	Cooperating and contributing with own professionality	Desiring to understand and appreciating patients' engagement	Supporting the patients' worth and having courage to respond

each of the datasets. An example of a code from patients' reflections was *life experience*. In the third phase, empirical patterns were identified in the MHCPs' data as well as the patients' data, which explained the meaning of the different parts of the data (Gadamer, 2013). Similarities and differences between the codes within each data set were searched for and compared, which gave direction for the codes to be sorted into pertinent groups labelled by sub-themes, for example patients' sub-theme *Moving between involvement and being cared for* and the MHCPs' sub-theme *Cooperating and contributing with own professionality*. During the fourth phase, a validation of the interpretation was conducted by reading the text as a whole to examine if the sub-themes fitted in a coherent pattern and if they reflected the meanings evident in the text. The fifth phase consisted of an interpretation of the patterns displayed by the two explored perspectives and the themes were defined, refined and named. Each perspective is a necessary part but alone is not sufficient to understand the meaning of SDM as a whole. In order to answer the research question, both the patients' and MHCPs' perspectives had to be combined and interpreted together (Gadamer, 2013). A deeper understanding of the meaning of SDM was developed as the various horizons of understanding merged together; the two datasets entered the hermeneutic circle, dialectically moving between the empirical findings and pre-understandings, as well as between the parts and the whole. This process involved a more analytical interpretation distant from the direct quotes but still embracing the participants' lived experiences, for example *Engaging in a mental room of values and knowledge* (Gadamer, 2013). In the sixth phase, the authors went beyond the original content by interpreting the analytical pattern of the themes and the overall theme was identified (Braun & Clarke, 2006).

3.5 | Ethical considerations

This study has been conducted in accordance with the Declaration of Helsinki (World Medical Association, 2008) with approval by the Regional Ethics Committee (2015/1721). All participants were informed in writing and verbally about the study and that they could withdraw at any time. A guarantee of anonymity and confidentiality was given. Those who agreed to participate gave their informed consent and signed the consent form (World Medical Association, 2008). The participants were all able to give their informed consent.

Mental health inpatients are defined as particularly vulnerable participants who can be sensitive in different ways, and some issues can serve as triggers to their vulnerability (Liamputtong, 2007;

Polit & Beck, 2010). As a professional and experienced MHCP, the interviewer (LSB) addressed these risks and met the participants in a professional and safeguarding manner.

4 | RESULTS

The meaning of SDM was elaborated by the overall theme *being in a space of sharing decision-making for dignified mental care*. This overall theme was categorized by three themes and six sub-themes. The themes illuminated values, knowledge, awareness, comprehension, response and acknowledgement. Each theme was defined from the patients' and the MHCPs' view (Table 1).

4.1 | Being in a space of sharing decision-making for dignified mental care

This overall theme focused on the space of sharing decision-making as it was formed by bringing various perspectives together. In such a space, the patients and the MHCPs were continually searching for an expansion of the patients' room for action and dignified care. In this space and within these relationships, there was cognitive, emotional and sometimes existential sharing, from verbal and non-verbal communication which gave rise to the decision-making. The patients were in a position where they needed help and the MHCPs' power-position gave them the opportunity to make decisions for their patients. In situations where the patients were able to actively participate in the decision-making they felt dignified when they experienced being taken seriously, but if their autonomy was rejected they felt devalued. In situations where the patients needed the MHCPs to assist them in decision-making, but the MHCPs provided them the responsibility to decide for themselves and act independently, the patient felt rather helpless and insignificant. Such situations required the MHCPs' insight to understand how to respond in order to safeguard the patients' dignity by making decisions with care and respect for the patients.

In the space of sharing decision-making, the MHCPs did not always assess the patients' autonomy to be in the patients' best interest. When they understood that their patients' choices threatened their dignity, the MHCPs took their responsibility and made decisions against the patients' will. In situations where the patients experienced restrictions of their autonomy, they could feel offended. Both too much and too little autonomy could threaten the patients' dignity, depending on the patients' mental health. Dignified care was

affected by the MHCPs' respectful and caring relationship with their patients.

Being in a space of sharing decision-making for dignified mental care was the red thread throughout the data and the themes represented various facets of the meaning of SDM.

4.1.1 | Engaging in a mental room of values and knowledge

Those times when both the patients and the MHCPs were actively relating, involved and engaged in the decision-making process, were interpreted as them both being in a mental room of values and knowledge. This mental room takes into consideration the patients' vulnerability and dependency on the MHCPs while being hospitalized. Some patients reported that they were familiar with their needs for care and they expressed frustration and feelings of devaluation if their knowledge and values were ignored when decisions were to be made. They wanted *to be involved* while they also needed *to be cared for*. Some patients conveyed that they did not always know what was best for them. A woman in her sixties with many years' experience of mental ill-health shared this experience:

> When I'm very ill I don't always know what's best for
> me, but it means a lot to be heard.
>
> (Patient, no. 9)

They expressed relief if the MHCPs were there to assist them in making decisions and when they experienced being taken seriously it gave them a feeling of safety and being cared for.

Regarding the mental room of values and knowledge, the MCHPs revealed their feeling of responsibility for taking care of their patients and they wanted to *cooperate and contribute with their own professionality* in order to benefit the individual patient. The MHCPs reported experiences of lacking knowledge where they felt unsure of the best possible care and conveyed that they needed to interact with their patients in order to deepen their understanding of the situation they faced. A registered mental health nurse with 8 years of experience in mental health inpatient settings conveyed this:

> We don't have a ready-made solution for every situ-
> ation (…) but the patients often divulge the solutions
> themselves.
>
> (MHCP, no. 2)

They reported that the situations were challenging where their patients neither understood nor chose for their own best interests.

4.1.2 | Relating in a process of awareness and comprehension

This theme reflected how the patients and MHCPs continually should search for awareness and comprehension. The patients illuminated the importance of being understood. This was revealed as

one patient, a woman in her fifties during her 38th hospitalization, described a situation of being misunderstood:

> I have trouble with eating when I'm home. They (the
> MHCPs) talked together without asking me and de-
> cided to ship me food instead of asking me how to
> solve my trouble of eating. I told them that I have food
> in my fridge and I can go shopping, my problem is that
> I don't have appetite. They should listen more to the
> patient before they come up with solutions to things
> they don't know!
>
> (Patient, no. 1)

They *longed for information and to be understood.* Some patients uttered their frustration with the MHCPs definite opinions about what was required for them to restore their health with little room for alternative suggestions. They expressed powerlessness and some described their feelings of being devalued in such situations which was considered unhelpful for restoring their mental health. They also had a wish to receive feedback on thoughts about their situation and plans for their care. Some patients reported that the information they received from the MHCPs gave them the opportunity to search for and assure themselves of the appropriateness of their care, which was understood as important for their dignity. Some patients conveyed that they did not dare to inform the MHCPs about their condition because they were afraid of being misunderstood or disliked. The impression of MHCPs being rigid, unavailable or distant seemed to hinder the patients from speaking up.

The MHCPs' reflections revealed that they *desired to understand and appreciate their patients' engagement.* They experienced that how they related to their patients was essential for their patients' reactions; if they rigidly followed guidelines or procedures trying to explain the right thing to do, their patients tended to react with rejection or resistance. If they related to their patients like partners, showing them that they wanted to understand more, the patients were more likely to show them trust.

The MHCPs reported that they found it challenging assessing the practice of safe care between practising their own conviction versus general guidelines containing procedures and standard rules. Being too occupied with finding the "right" practice seemed to hinder them in listening to their patients' desires and trying to understand more from the patients' perspectives. The MHCPs' own pre-understanding could also hinder the *process of awareness and comprehension.* A nurse shared how she attempted to understand her patients:

> Some of the dilemmas of everyday life may be that I
> might be so well intentioned at trying to understand
> what the patient would say and I can become too
> eager and think that I have understood…. I use con-
> cepts and speak professionally, and then, of course, I
> understand what the patient means. But I often forget
> to check if I have really understood.
>
> (MHCP, no. 3)

Understanding the patients and the situation in an extensive way implied that the MHCPs put their own opinions and guidelines at stake to become open to the patient's point of view. Knowing that there is always more to understand and being willing to open up to new perspectives were found essential when *relating in a process of awareness and comprehension*.

4.1.3 | Responding anchored in acknowledgement

This theme focused on the patients' *search for confirmation and for being affirmed*. Some patients described that the MHCPs could go on with their habitual practice despite new information, even when it did not benefit the patients. They believed that the MHCPs trivialized the new information or had so much to focus on that they lost sight of the perspective that appeared. This made them feel unimportant and ignored. Nevertheless, most patients wanted to collaborate and tried to follow their MHCPs' programme, even if they usually failed over time. These patients experienced that they did not get the help they needed, they felt unsuccessful and they conveyed that the time of admission could become prolonged or that re-admission was likely to occur in such situations. However, when the MHCPs responded to their patients' message, the patients felt acknowledged and valued.

The MHCPs stated that it sometimes took *courage to respond*. They found it difficult to reply to responses from the patients that did not match the guidelines or their colleagues' opinions of best practice because they were afraid of not being perceived as professionals. A registered mental health nurse shared her thoughts about being a professional:

> I think many MHCPs are afraid to find the key with the patient. (...) They want to be a good therapist by fixing and organizing and then we may forget the most important thing: involving the patient. Perhaps the patient is the most important therapist in his own life.
>
> (MHCP, no. 5)

This study revealed that MHCPs, who responded to care without putting the onus on their patients and acknowledging them, were likely to give an inappropriate response and even harm their patients.

The MHCPs shared their experiences of sometimes being bound to act against the patient's will in order to provide safe care in a dignified manner. One registered mental health nurse shared how she found it challenging when she and her colleague had to respond by taking control in a situation where the patient was not able to take control on her own:

> Our patient was very psychotic and needed protection. We first tried to help her voluntarily but it failed. (..) She became really threatening and disgraced herself outside. She had the opportunity to run away but she came by herself and set into the ambulance. She was so scared. (...) It was painful to see her like that. There is no doubt that we did the right thing but it's

hard to respond like this to another person. I hadn't slept well tonight if I knew about this but hadn't done anything.

(MHCP, no. 4)

Some of the patients shared their experiences from similar situations where MHCPs took action without their consent. In retrospect they realized that it was their ill-health that led to their lack of insight in the situation and then they appreciated that the MHCPs had taken action to safeguard dignified care. The patients stated that they felt safe when the MHCPs responded prior to unpleasant events. They wanted the MHCPs to respond and take over when they lost grip and could not take care of themselves. A woman in her thirties who struggled with self-harm and suicidal problems shared her desire for care:

> Actually, in a way I want them to stop me. I really don't wish to self-harm but I would never have asked them to stop me. It's a way of safeguarding me if someone takes control (...)I get annoyed when being compelled because I want to take care of myself, but another part of me will be very pleased if someone shows interest and cares about me. Compulsion is a kind of care.
>
> (Patient, no. 8)

The patients felt affirmed when the MHCPs responded to them in order to support their worth, and compulsion sometimes seemed to be necessary for providing dignified care. *Responses anchored in acknowledgement* appeared to form dignified care.

5 | DISCUSSION

This study aimed at interpreting the meaning of SDM in mental care as perceived by patients and MHCPs and the research question was what is the meaning of SDM in mental care? Patients' and MHCPs' joint perspectives revealed the overall theme *being in a space of sharing decision-making for dignified mental care*.

The current study illuminates *values* and *awareness* in understanding SDM. Patients understand treatment and care from a different angle to MHCPs. The personal knowledge the patients possess is an important part of evidence-based practice and should be acknowledged to the same degree as the MHCPs' clinical experience, expertise and scientific knowledge (Rycroft-Malone & Bucknall, 2010; Sackett, Rosenberg, Gray, Haynes, & Richardson, 1996; Slade, 2017). Patients and MHCPs should *relate in a process of awareness and comprehension* as they share information, which will deepen their shared understanding of the situation they face (Beyene et al., 2018b; Ocloo & Fulop, 2011). When MHCPs adjust their perspectives and respond to the understanding that emerges from the shared information, safe care is expected to increase (Langer & Moloveanu, 2000; Sutcliffe, 2011). Expanding the patients' room for action is fundamental for patients experiencing dignity (Delmar, 2013) and as demonstrated in this study, a sharing of decision-making will support dignified care.

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The overall theme in this study demonstrates that dignified care requires MHCPs and patients to be connected to one another regarding sharing decisions through *values and knowledge, awareness and comprehension*, and *acknowledgement*. Dignity means to be respected and valued in relation to others (Edlund, Lindwall, Post, & Lindström, 2013). The patients' experience of being an important person by contributing to decisions about their own care is essential for dignified care (Rasmussen & Delmar, 2014). Patients who feel important and experience that they are taken seriously can experience relief in their emotional pain (Holm, 2009). Participating actively in SDM is reported to make patients thrive thus restoring their mental health (Beyene et al., 2018b). However, there are significant differences in the power relationship between patients and MHCPs regarding knowledge, opportunities of control and their mandate for decisions and MHCPs are in a position where they are expected to have superior knowledge and responsibility regarding care (Grimen, 2009). It is important for the MHCPs to serve the patients, interact and care for them in a way that will help them restore their mental health. MHCPs should use their power in a way that demonstrates their equal worth, expands their patients' room for action and safeguards their patients' human rights (Pahtare & Sheilds, 2012). Sensitive *awareness* is needed in order to be conscious of their own role in the asymmetrical power relationship in decision-making (Delmar, 2012). If the MHCPs are not conscious about how dependent the patients are on them (Grimen, 2009) and how to use their power for their patients' benefit, the patients' dignity may become offended (Lindwall, Boussaid, Kulzer, & Wigerblad, 2012).

The patients' *moving between involvement and being cared for* highlights that patients sometimes cannot take care of themselves hence the need for MHCPs to support them in their decision-making in order to protect their dignity (Pahtare & Sheilds, 2012). MHCPs *cooperate with the patients and contribute their own professionality*; they may have more knowledge and insight in a situation when the patients are not capable of taking responsibility because their mental symptoms are too overwhelming and they lose grip of the comprehensive understanding (Solbjør et al., 2011). Too much focus on patients' autonomy in such situations may lead to a violation of patients' dignity (Delmar, 2013). Being independent and autonomous is a central value in Western societies, and MHCPs have a duty to safeguard the patients' right to self-determination. It is essential in mental care that the patients are not patronized by MHCPs making decisions for them, taking their responsibilities and hindering them deal with their life on their own (Delmar, 2013). At the same time, there is a risk that MHCPs leave too much responsibility in the hands of their patients and the patients may be expected to be active and autonomous in situations where they actually need help (Delmar, Alenius-Karlsson, & Mikkelsen, 2011). A neglect of patients' need for help may lead the patients to feel powerless and undignified (Lindwall et al., 2012). Patients and situations in mental care may be inconsistent and changeable; however, they need *affirmation* throughout care. How MHCPs *respond* may be experienced as healing in one situation and invading in another and balancing between assistance and autonomy is necessary in order to protect the patients' dignity (Delmar et al., 2011; Lindwall et al., 2012). MHCPs should be sensitively *aware* of their patients, their own emotions and the

dynamics in the relationship (Delmar, 2012; Akerjordet & Severinsson, 2004). Constantly being able to empathically *support the patients' worth*, safeguarding human rights and expanding the patients' room for action, the MHCPs need to interpret and communicate emotional information, combining emotions with intelligence when sharing decision-making (Akerjordet & Severinsson, 2004). The manner in which the MHCPs respond to what they sense is essential for patients' experience of dignified care (Lindwall et al., 2012). This is a challenge for the MHCPs (Slade, 2017) who need a lot of experience and personal training to manage (McCormack & McCance, 2010). Clinical supervision with creative dialogues and reflections of clinical situations can strengthen the understanding of self, others, relationships and actions (Beyene et. al. 2018a; Holm Wiebe, Lindquist & Severinsson, 2011) and can develop the MHCPs' professional competence (Akerjordet & Severinsson, 2004; Mangubat, 2017). Consequently, participating in clinical supervision is considered important for MHCPs' *being in a space of sharing decision-making for dignified care*.

5.1 | Study limitations and strengths

Important aspects regarding qualitative research are reported in this article according to the COREQ checklist in order to ensure high quality (Tong, Sainsbury, & Craig, 2007, Appendix S1). However, methodological limitations and strengths need to be considered.

The design of this study made it possible to shed light on various facets of the explored topic. The ten sessions of multistage focus groups with the MHCPs provided for proximity to the participants. The MHCP participants became trustful, open and shared valuable information with the researchers. The dialogues with the patient participants who had diverse experience from being hospitalized in a magnitude of mental health wards and differing causes for their hospitalization elaborated a great diversity of information. A deep insight from the involved stakeholders' perspectives about the meaning of SDM (Gadamer, 2013) is provided due to information richness in the data (Malterud, Siersma & Guassora, 2016). This provides valuable contextual knowledge important for the development of professional expertise, though it is limited regarding the development of facts, rules and general guidelines (Flyvbjerg, 2006).

The recruitment of patient participants may have influenced the trustworthiness of the results in this study. The MHCP participants recruited patients whom they knew were willing to participate. They had the power to decide who should and should not take part in this research and patients with important information for this study may have been excluded (Carlson, Blomqvist & Jormfeldt, 2017). A strength is that the patient participants convey a magnitude of experiences with SDM in mental care.

The interpretation of the data was derived from the authors' pre-understanding and thus affected the results (Gadamer, 2013; Polit & Beck, 2010). The authors' pre-understandings were generated from their experience as clinical nurses and researchers. Three of the authors (LB, KR and ES) are registered mental health nurses and have extended clinical experience of caring for mentally ill people. The validity of the interpretation was strengthened by being aware of

pre-understandings and by all the authors validating the interpretation separately (Gadamer, 2013).

6 | CONCLUSION

The meaning of SDM can be understood as a continual relational process between the patients and MHCPs in search of dignified care. The patients want to be autonomous simultaneously as their limitations and need for help is acknowledged. Practising SDM is a multifaceted process which involves engaging with values and knowledge, being aware, comprehending, responding and acknowledging in various circumstances, which require the MHCPs to possess high professional competence.

7 | IMPLICATION FOR PRACTICE

Patients and MHCPs should search for a common understanding of SDM. The MHCPs should use their professional competence to balance between assistance and autonomy for their patients in order to protect the patients' dignity. Implementing SDM through patient participation guidelines and procedures is unlikely to succeed without acknowledging the importance of personal development of the MHCPs' professional competence as a basis for the implementation. Clinical supervision can be a tool for developing professional competence and is considered important to assist MHCPs in practising SDM for dignified care.

There is need for further research towards successful implementation of SDM into mental care. The quality of personal development for practising SDM in mental care should be investigated through intervention studies with pre- and post-analyses, as well as action research studies actively involving patients and managers in an exploration of the organizational and cultural aspects of SDM.

8 | RELEVANCE STATEMENT

There is international consensus about the importance of shared decision-making, and it has been welcomed by policymakers worldwide. Despite the growing focus, shared decision-making and its implementation in mental care practice are still at an early phase. This paper contributes an in-depth understanding of shared decision-making and what occurs at the individual relational level during the shared decision-making process in the context of mental care, which is essential for furthering the process of implementation of shared decision-making.

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SUPPORTING INFORMATION

Additional supporting information may be found online in the Supporting Information section at the end of the article.

Appendices

Appendix 1 – Search strategy of the electronic search of review articles

Search strategy of the electronic search of review articles

Embase (via Ovid) (104 treff)

(shared decision making/ or shared decision*.ti,ab,kw.) and (Exp Mental health/ or psychiatry/ or social psychiatry/ or mental health care/ or mental health service/ or exp mental hospital/ or exp psychiatric nursing/ or psychiatric department/ or (psychiatr* or ((mental) adj3 (health* or ward* or care or unit* or department* or hospital* or service*))).ti,ab,kw.) and (meta-analys*.mp. or review.pt. or ((systematic* or literature) adj2 (overview or review* or search*)).ti,ab.)

limit 1 to ((embase or medline) and (danish or english or norwegian or swedish) and yr="2009 -Current")

PsycINFO (via Ovid) (28 treff)

((decision making/ and client participation/) or shared decision*.ti,ab,id.) and (psychiatry/ or social psychiatry/ or Mental health/ or Community Psychiatry/ or exp Mental Health Services/ or Mental Health Programs/ or Psychiatric Units/ or Psychiatric Hospitals/ or (psychiatr* or ((mental) adj3 (health* or ward* or care or unit* or department* or hospital* or service*))).ti,ab,id.) and (Literature Review/ or meta-analys*.mp. or ((systematic* or literature) adj2 (overview or review* or search*)).ti,ab.)

Medline (via Ovid) (85 treff)

((Decision Making/ and Patient Participation/) or shared decision*.ti,ab,kw.) and (psychiatry/ or community psychiatry/ or mental health/ or mental health services/ or emergency services, psychiatric/ or Psychiatric Department, Hospital/ or Hospitals, Psychiatric/ or (psychiatr* or ((mental) adj3 (health* or ward* or care or unit* or department* or hospital* or service*))).ti,ab,kw.) and (meta-analys*.mp. or review.pt. or ((systematic* or literature) adj2 (overview or review* or search*)).ti,ab.)

limit 1 to ((danish or english or norwegian or swedish) and yr="2009 - Current")

Cinahl (via Ebsco) (53 treff) DOCUMENT TYPES: (Review)

((MH "Decision Making, Shared") or "shared decision*") and ((MH "Psychiatry") or (MH "Community Mental Health Services") OR (MH "Mental Health Services") OR (MH "Emergency Services, Psychiatric") or (psychiatr* or ((mental) N2 (health* or ward* or care or unit* or department* or hospital* or service*)))) and (meta-analys* or review or ((systematic* or literature) N1 (overview or review* or search*)))

Web of Science (51 treff)

TS=("shared decision*") AND TS=(psychiatr* OR (mental PRE/2 (health* OR ward* OR care OR unit* OR department* OR hospital* OR service*)))

Appendix 2 – Supervision program used as interview guide (mental healthcare professionals)

Supervision program used as interview guide (mental healthcare professionals)

Supervision programme for mental healthcare professionals (MHCPs) in a therapeutic milieu (TM) - focusing on the patient-MHCP relationship (PMR), patient safety (PS) and shared decision-making (SDM).			
Structure and content of a 10 session programme by RPN Lise Beyene, RPN/PhD Kristine Rørtveit and Professor Elisabeth Severinsson			
	Clinical supervision session focus	**MHCPs leverage and resources**	**Topics for reflection**	**Focus, aims and session exercises**
1	Introduction	Eight MHS with a minimum of three years of experience. Presentation.	Think about one of the patients you worked with. Focus on safe care in the therapeutic milieu.	Becoming familiar with each other's work and with the programme (Use a pencil to sketch figures you can colour in with positive colours)
2	Resources	What are your resources as a MHCP in the therapeutic milieu? What are your thoughts on the PMR? What do you consider safe ward therapy?	Describe the patient's resources. How can she/he actively participate in SDM? What factors are important for a good PMR? How do these contribute to SDM?	Becoming familiar with and able to describe resources (Sketch various symbols with your left hand for colouring in)

3	Trust	How can you build trust in the PMR in a therapeutic milieu context?	What does your patient need in order to feel safe and be able to trust her/his surroundings? How do feelings of trust influence SDM?	Exploring the importance of trust and patient safety (Draw a tree with your left hand.)
4	Fear	How do you deal with anxiety in the therapeutic milieu?	How did the patient affect you? How does fear of the patient influence SDM?	Exploring how fear influences SDM and patient safety (Imagine a tree that is alone and vulnerable- do a drawing).
5	Guilt, shame and inadequacy	What are feelings of guilt, shame and inadequacy and how are they expressed by MHCPs in the therapeutic milieu?	How did the patient influence you and your feelings of guilt, shame and inadequacy? How do these feelings influence SDM?	Exploring how guilt, shame and feelings of inadequacy can influence the patient-MHCP relationship and patient safety (Imagine a mask that appears to feel guilty and draw it)
6	Forgiveness and reconciliation	What are forgiveness and reconciliation and how are they promoted in the therapeutic milieu?	How did the patient influence you and your feelings and thoughts of forgiveness and reconciliation? How do feelings of forgiveness influence SDM?	Exploring the relationship between feelings of reconciliation and patient safety (Make a sketch and colour it in. Draw various circles)

7	Suffering and relief	What are suffering and relief and how do they function in the therapeutic milieu?	How did the patient influence you and your thoughts on suffering and relief?	Illuminating how suffering and relief influence SDM (Draw lines in different directions)
8	Power and responsibility	What are power and responsibility and how do they function in the therapeutic milieu?	How did the patient influence you and your ideas of power? How does power influence SDM?	Exploring how power and responsibility influence SDM (Imagine and draw a butterfly).
9	Courage	What is courage and how does it function in the therapeutic milieu?	How did the patient influence you and your feelings of inadequacy? How does inadequacy influence SDM?	Illuminating the importance of trust when working with SDM and patient safety (Imagine and draw a mountain).
10	Closure and evaluation.	What is the best way of ending a therapeutic relationship?	How do you end your relationship with patients? How does SDM influence achieving closure?	Illuminating the importance of being ready to leave the group (Imagine and draw a tree)

Appendix 3 – Interview guide (patients)

Interview guide (patients)

No = Norwegian text   Eng = English text

No. Individuelle dybdeintervju

Eng. Individual in depth interviews

1.

No: Hva er brukermedvirkning for deg?

Eng: What is user involvement for you?

2.

No: Kan du fortelle om konkrete situasjoner der du har deltatt i beslutningsprosesser vedrørende din behandling når du har vært innlagt i psykiatrisk avdeling? Hvordan opplevde du det?

Eng: Tell about specific situations in which you have participated in decisions about your treatment when you have been hospitalized in a psychiatric ward? How did you experience it?

3.

No: Hvordan har du opplevd å ikke bli tatt med i beslutninger vedrørende din behandling når du har vært innlagt i psykiatrisk avdeling?

Eng: How have you experienced not being included in decisions about your treatment when you have been hospitalized in a psychiatric ward?

4.

No:Hva betyr det for deg å delta i beslutning om din egen behandling når du er innlagt i psykiatrisk avdeling?

Eng: What does it mean for you to participate in decision-making concerning your own treatment when you are hospitalized in a psychiatric ward?

5.

No: Hvordan tenker du at brukermedvirkning kan forbedres når du er innlagt i psykiatrisk avdeling?

Eng: How do you think user involvement can be improved when you are hospitalized in a psychiatric ward?

6.

No: Hva er pasientsikkerhet for deg?

Eng: What is patient safety to you?

7.

No: Hvordan tenker du at brukermedvirkning kan innvirke på sikkerheten din som pasient?

Eng: How do you think user involvement can affect your safety as a patient?

8.

No: Hva skal til for at du skal være aktivt med i beslutningsprosesser som omhandler din behandling?

Eng: What will it take for you to be actively involved in decision making concerning your treatment?

9.

No: Hva vil du som pasient anbefale at behandlingen i den psykiatriske avdelingen fokuserer på for å få enda bedre pasientsikkerhet?

Eng: What would you as a patient recommend that treatment in the psychiatric ward focuses on for even better patient safety?

Appendix 4 – COREQ Checklist

COREQ (COnsolidated criteria for REporting Qualitative research) Checklist

Topic	Item No.	Guide Questions/Description	Reported on Page No.
Domain 1: Research team and reflexivity			
Personal characteristics			
Interviewer/facilitator	1	Which author/s conducted the interview or focus group?	25, 35, 36
Credentials	2	What were the researcher's credentials? E.g. PhD, MD	25
Occupation	3	What was their occupation at the time of the study?	25, 35
Gender	4	Was the researcher male or female?	N/A
Experience and training	5	What experience or training did the researcher have?	25, 35, 42
Relationship with Participants			
Relationship established	6	Was a relationship established prior to study commencement?	31, 44
Participant knowledge of the interviewer	7	What did the participants know about the researcher? e.g. personal goals, reasons for doing the research	42, 44
Interviewer characteristics	8	What characteristics were reported about the inter viewer/facilitator? e.g. Bias, assumptions, reasons and interests in the research topic	44
Domain 2: Study design			
Theoretical framework			
Methodological orientation and theory	9	What methodological orientation was stated to underpin the study? e.g. grounded theory, discourse analysis, ethnography, phenomenology, content analysis	1, 7, 23-38
Participant selection			

Sampling	10	How were participants selected? e.g. purposive, convenience, consecutive, snowball	31
Method of approach	11	How were participants approached? e.g. face-to-face, telephone, mail, email	31, 44
Sample size	12	How many participants were in the study?	32
Non-participation	13	How many people refused to participate or dropped out? Reasons?	31, 45
Setting			
Setting of data collection	14	Where was the data collected? e.g. home, clinic, workplace	35-36
Presence of non-participants	15	Was anyone else present besides the participants and researchers?	N/A
Description of sample	16	What are the important characteristics of the sample? e.g. demographic data, date	32
Data collection			
Interview guide	17	Were questions, prompts, guides provided by the authors? Was it pilot tested?	25, 35, 36
Repeat interviews	18	Were repeat inter views carried out? If yes, how many?	33-36
Audio/visual recording	19	Did the research use audio or visual recording to collect the data?	33
Field notes	20	Were field notes made during and/or after the interview or focus group?	N/A
Duration	21	What was the duration of the inter views or focus group?	N/A
Data saturation	22	Was data saturation discussed?	31, 33, 36
Transcripts returned	23	Were transcripts returned to participants for comment and/or correction?	N/A

Domain 3: analysis and findings			
Data analysis			
Number of data coders	24	How many data coders coded the data?	25, 27
Description of the coding tree	25	Did authors provide a description of the coding tree?	Papers I-III
Derivation of themes	26	Were themes identified in advance or derived from the data?	7-9, 28,29, 37, 53, 54, 56, 60, 63
Software	27	What software, if applicable, was used to manage the data?	N/A
Participant checking	28	Did participants provide feedback on the findings?	N/A
Reporting			
Quotations presented	29	Were participant quotations presented to illustrate the themes/findings? Was each quotation identified? e.g. participant number	Papers I-III
Data and findings consistent	30	Was there consistency between the data presented and the findings?	Papers I-III
Clarity of major themes	31	Were major themes clearly presented in the findings?	Papers I-III 47-68
Clarity of minor themes	32	Is there a description of diverse cases or discussion of minor themes?	Papers I-III

Developed from: Tong A, Sainsbury P, Craig J. (2007). Consolidated criteria for reporting qualitative research (COREQ): a 32-item checklist for interviews and focus groups. *International Journal for Quality in Health Care*. Volume 19, Number 6: pp. 349 – 357.

Appendix 5 – Ethical approval

REK
REGIONALE KOMITEER FOR MEDISINSK OG HELSEFAGLIG FORSKNINGSETIKK

Region:	Saksbehandler:	Telefon:		Vår dato:	Vår referanse:
REK vest	Camilla Gjerstad	55978499		05.11.2015	2015/1721/REK vest
				Deres dato:	
				22.09.2015	

Vår referanse må oppgis ved alle henvendelser

Lise Beyene
Helse Stavanger HF

2015/1721 Felles beslutningsprosesser - Implementering og evaluering av veiledning for å bedre pasientsikkerheten i miljøterapi

Forskningsansvarlig: Helse Stavanger HF
Prosjektleder: Lise Beyene

Vi viser til søknad om forhåndsgodkjenning av ovennevnte forskningsprosjekt. Søknaden ble behandlet av Regional komité for medisinsk og helsefaglig forskningsetikk (REK vest) i møtet 22.10.2015. Vurderingen er gjort med hjemmel i helseforskningsloven (hfl.) § 10, jf. forskningsetikkloven § 4.

Prosjektomtale
Studien har som mål å bidra til kunnskap om klinisk veiledning når det gjelder felles beslutningsprosesser og pasientsikkerhet i miljøterapi. Forskningsspørsmål: Hvordan forbedrer psykisk helsearbeidere felles beslutningsprosesser og pasientsikkerhet etter å delta i veiledningsprogrammet? Hva er pasienters erfaringer med verdien av å være involvert i, og hva er meningen med felles beslutningsprosesser? Det vil bli gjennomført fokusgrupper med 8 helsearbeidere og dybdeintervju med 16 pasienter.

Vurdering
Fremleggingsvurdering
Helseforskningsloven gjelder for medisinsk og helsefaglig forskning på mennesker, humant biologisk materiale eller helseopplysninger, jf. § 2. Medisinsk og helsefaglig forskning defineres som *«virksomhet som utføres med vitenskapelig metodikk for å skaffe til veie ny kunnskap om helse og sykdom»*, jf. § 4 bokstav a. Slike prosjekter må søke REK.

Formålet med studien er å søke ny kunnskap om beslutningsprosesser og pasientsikkerhet i miljøterapi ved å studere implementering og evaluering av klinisk veiledning. Forskningsformålet er således i grenseland for hva som er fremleggingspliktig for REK. Ved slik tvil om fremleggingsplikten, kan REK legge vekt på at studien inkluderer en sårbar gruppe, som i dette tilfellet. Komiteen konkluderte etter en kort diskusjon med at studien er omfattet av helseforskningsloven og at søknaden skal vurderes av REK.

Søknad
REK forutsetter at intervjuguiden til helsearbeiderne oversettes fra engelsk til norsk.

Informasjonsskriv
REK har følgende merknader til informasjonsskrivet:

- Forespørselen til deltakerne må inkludere informasjon om prosjektslutt og at opplysningene vil bli

slettet innen 31.12.18.
- Overtalende eller appellerende språk må tones ned, jf. *«Dette prosjektet kan ikke gjennomføres uten informasjon fra pasienter. Det at du er med å bidra vil gi ny kunnskap som er viktig for pasienter, psykisk helsearbeidere, ledelse i helseforetaket og for samfunnet».*

Prosjektslutt
Søknaden legger opp til at opplysningene slettes ved prosjektslutt 31.12.18. REK vest har ingen merknader til dette.

Vilkår
Informasjonsskrivet må revideres.

Vedtak
REK vest godkjenner prosjektet på betingelse av at ovennevnte vilkår tas til følge.

Sluttmelding og søknad om prosjektendring
Prosjektleder skal sende sluttmelding til REK vest på eget skjema senest 30.06.2019, jf. hfl. §
12. Prosjektleder skal sende søknad om prosjektendring til REK vest dersom det skal gjøres vesentlige endringer i forhold til de opplysninger som er gitt i søknaden, jf. hfl. § 11.

Klageadgang
Du kan klage på komiteens vedtak, jf. forvaltningsloven § 28 flg. Klagen sendes til REK vest. Klagefristen er tre uker fra du mottar dette brevet. Dersom vedtaket opprettholdes av REK vest, sendes klagen videre til Den nasjonale forskningsetiske komité for medisin og helsefag for endelig vurdering.

Med vennlig hilsen

Ansgar Berg
Prof. Dr.med
Komitéleder

Camilla Gjerstad
Rådgiver

Kopi til: forskning@sus.no

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REK
REGIONALE KOMITEER FOR MEDISINSK OG HELSEFAGLIG FORSKNINGSETIKK

Region:	Saksbehandler:	Telefon:	Vår dato:	Vår referanse:
REK vest	Arne Salbu	55978498	07.12.2015	2015/1721/REK vest
			Deres dato:	Deres referanse:
			02.12.2015	

Vår referanse må oppgis ved alle henvendelser

Lise Beyene
Forsknings- og Undervisningsenheten
Stavanger universitetssykehus

2015/1721 Felles beslutningsprosesser - Implementering og evaluering av veiledning for å bedre pasientsikkerheten i miljøterapi

Forskningsansvarlig: Helse Stavanger HF
Prosjektleder: Lise Beyene

Vi viser til søknad om prosjektendring datert 02.12.2015 for ovennevnte forskningsprosjekt. Søknaden er behandlet av leder for REK vest på fullmakt, med hjemmel i helseforskningsloven § 11.

Vurdering
Man ønsker å utvide prosjektperioden til 31.12.2021. dette er begrunnet med at gjennomføring skal skje i 50% stilling og ikke 100%.

Videre ønsker man å oppbevare prosjektdatas i fem år etter prosjektslutt, noe REK kan bestemme, jfr helseforskningslovens § 38.

Forespørsel er justert for å informere om de ønskede endringene.

REK vest har ingen merknader.

Ny dato for prosjektslutt: 31.12.2021.

Vedtak
REK vest godkjenner prosjektendring i samsvar med søknad.

Prosjektdata skal oppbevares i fem år etter prosjektslutt, for mulig etterkontroll.

Klageadgang
Du kan klage på komiteens vedtak, jf. forvaltningsloven § 28 flg. Klagen sendes til REK vest. Klagefristen er tre uker fra du mottar dette brevet. Dersom vedtaket opprettholdes av REK vest,

sendes klagen videre til Den nasjonale forskningsetiske komité for medisin og helsefag for endelig vurdering.

Med vennlig hilsen

Ansgar Berg
Prof. Dr.med
Komitéleder

Arne Salbu
rådgiver

Kopi til: *forskning@sus.no*

Appendix 6 – Information letter to patient participants

«Felles beslutningsprosesser - Implementering og evaluering av veiledning for å bedre pasientsikkerheten i miljøterapi». Del II 17.08.2015

Forespørsel om deltakelse i forskningsprosjekt (pasient)

«Felles beslutningsprosesser - Implementering og evaluering av veiledning for å bedre pasientsikkerheten i miljøterapi»

Bakgrunn og hensikt
Dette er et spørsmål til deg om å delta i en forskningsstudie som har til hensikt å få ny kunnskap om felles beslutningsprosesser knyttet til pasientsikkerhet i miljøterapi, dels ved å utforske psykisk helsearbeideres erfaringer og refleksjoner gjennom klinisk veiledning, og dels ved å beskrive pasientenes erfaringer med felles beslutningsprosesser og pasientsikkerhet i forbindelse med miljøterapi, og utforske og beskrive pasienters erfaringer med felles beslutningsprosesser med et spesielt fokus på pasientsikkerhet. Det viktig for dette forskningsprosjektet at pasienter vil være med å bidra med erfaringer om felles beslutningsprosesser og pasientsikkerhet.
Felles beslutningsprosesser har fem kjennetegn; aktiv deltakelse fra pasienten og helsepersonell, informasjonsdeling, problemdefinisjon, diskusjoner om behandlingstilbud og en avgjørelse eller utsettelse. Intensjonen med felles beslutningsprosesser er å øke pasienters kunnskap og kontroll over behandlingsbeslutninger som kan påvirke deres trivsel og bedringsprosess.

Hva innebærer studien?
Du vil bli innkalt til intervju med leder for forskningsprosjeketet. Intervjuet vil følge en på forhånd oppsatt intervjuguide med spørsmål som omhandler dine erfaringer med felles beslutningsprosesser og pasientsikkerhet når du har vært innlagt i psykiatrisk avdeling. Du vil ikke på noen måte bli presset til å snakke om noe du ikke selv ønsker å snakke om. Intervjuet vil ta ca en time.
For at alt som blir sagt i intervjuet skal bli registrert vil intervjuet bli tatt opp på lydbånd. Lydopptaket vil til enhver tid være innelåst i arkiv i Psykiatrisk divisjon (SUS). Det er bare forskere som er aktivt med i forskningsprosjektet (som alle har taushetsplikt) som har tilgang til å høre lydopptaket. Etter intervjuet blir alt som er sagt bli skrevet ned før det blir analysert og videre presentert i forskningsartikkel.

Mulige fordeler og ulemper
Informasjon fra pasienter er viktig i gjennomføringen av dette prosjektet. Det vil kunne bidra til å gi ny kunnskap som er viktig for pasienter, psykisk helsearbeidere, ledelse i helseforetaket og for samfunnet.

Hva skjer med informasjonen om deg?
Informasjonen som registreres om deltagerne i denne studien er navn, adresse, tlf. nr. og navn på din primærkontakt under sykehusinnleggelsen. Deltagerne er anonyme for alle andre enn de som leder forskningsprosjektet. Navnet på deltagerne vil bli kodet, og kodenøkkelen vil være innelåst i arkiv i Psykiatrisk divisjon (SUS).

Det vil ikke bli spurt etter sensitive opplysninger i intervjuet, men om slike opplysninger likevel kommer fram vil disse anonymiseres og behandles slik at det ikke kan identifiseres av noen. Sitater eller andre karakteristika som kan avsløre deltageres identitet vil ikke bli gjengitt. Det vil ikke være mulig å identifisere deg i resultatene av studien når disse publiseres.

Det er kun autorisert personell knyttet til prosjektet som har adgang til navnelisten og som kan finne tilbake til deg. Alle opplysningene vil bli behandlet uten direkte gjenkjennende opplysninger. Informasjonen du gir skal brukes som beskrevet i hensikten med studien, og alle opplysningene vil bli behandlet uten direkte gjenkjennende opplysninger. Prosjektet antas ferdig innen 2021. Datamaterialet blir ikke analysert etter dette, men lagres for etterkontroll i 5 år etter prosjektslutt. Alle data vil bli slettet innen utgangen av 2026.

«Felles beslutningsprosesser - Implementering og evaluering av veiledning for å bedre pasientsikkerheten i miljøterapi». Del II 17.08.2015

Frivillig deltakelse
Det er frivillig å delta i studien. Du kan når som helst og uten å oppgi noen grunn trekke ditt samtykke til å delta i studien. Dette vil ikke få konsekvenser for din videre behandling. Dersom du ønsker å delta, undertegner du samtykkeerklæringen på siste side. Om du nå sier ja til å delta, kan du senere trekke tilbake ditt samtykke uten at det påvirker din øvrige behandling. Dersom du senere ønsker å trekke deg eller har spørsmål til studien, kan du kontakte Lise S. Beyene på tlf.402 31 972

Ytterligere informasjon om studien finnes i kapittel *A – utdypende forklaring av hva studien innebærer.*
Ytterligere informasjon om biobank, personvern og forsikring finnes i kapittel B *– Personvern, biobank, økonomi og forsikring.*

Samtykkeerklæring følger etter kapittel B.

«Felles beslutningsprosesser - Implementering og evaluering av veiledning for å bedre pasientsikkerheten i miljøterapi». Kapittel A og B – 17.08.2015

Kapittel A- utdypende forklaring av hva studien innebærer

- Kriterier for deltakelse i denne forskningsstudien er at du har vært innlagt i psykiatrisk avdeling minst 1 uke og at du er mer enn 20 år gammel. Du må kunne snakke norsk og ikke være psykotisk eller ruset under intervjuet.
- Høy kvalitet er et overordnet mål i all pasientbehandling. Til tross for dette representerer pasientsikkerhet bemerkelsesverdige utfordringer. Felles beslutningsprosesser vil kunne øke pasienters kunnskap og kontroll over beslutninger, som kan påvirke deres trivsel og kvalitet på pasientbehandlingen. Denne forskningsstudien har til hensikt å få ny kunnskap om felles beslutningsprosesser knyttet til pasientsikkerhet i miljøterapi, dels ved å utforske psykisk helsearbeideres erfaringer og refleksjoner gjennom klinisk veiledning, og dels ved å beskrive pasienters erfaringer med felles beslutningsprosesser og pasientsikkerhet i forbindelse med miljøterapi, og utforske og beskrive pasienters erfaringer med felles beslutningsprosesser med et spesielt fokus på pasientsikkerhet.
- Du vil bli kontaktet en gang i april - september 2016 for avtale om tidspunkt for intervju.
- At pasienter bidrar med dine erfaringer vil gi ny kunnskap som er viktig for psykisk helsearbeidere, ledelse i helseforetaket og for samfunnet.
- Det er ikke noen ulemper for deg å delta i denne studien.
- Du som pasient er ansvarlig for å gi korrekt informasjon i forhold til det du blir spurt om under intervjuet. Du er også ansvarlig for å møte til avtalt intervjutidspunkt.

Kapittel B - Personvern

Personvern
Opplysninger som registreres om deg er navn, adresse og telefonnummer. Det er bare forskningsprosjektleder (som har taushetsplikt) som har tilgang til disse opplysningene.

Andre forskere som er med i dette prosjektet vil ha tilgang til datamaterialet som består av transkribert intervju.

Lise S Beyene som er ansvarlig for forskningsprosjektet er databehandlingsansvarlig.

Rett til innsyn og sletting av opplysninger om deg og sletting av prøver
Hvis du sier ja til å delta i studien, har du rett til å få innsyn i hvilke opplysninger som er registrert om deg. Du har videre rett til å få korrigert eventuelle feil i de opplysningene vi har registrert. Dersom du trekker deg fra studien, kan du kreve å få slettet de opplysningene du har gitt, med mindre opplysningene allerede er inngått i analyser eller brukt i vitenskapelige publikasjoner.

Økonomi
Studien er søkt finansiert gjennom forskningsmidler fra Helse Vest. Det er ikke noen interessekonflikter mellom forsker og potensiell finansierende instans.

Informasjon om utfallet av studien
Resultat av studien vil bli publisert i internasjonale tidsskrifter.

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«Felles beslutningsprosesser - Implementering og evaluering av veiledning for å bedre pasientsikkerheten i miljøterapi». Kapittel A og B – 17.08.2015

Samtykke til deltakelse i studien

Jeg er villig til å delta i studien

(Signert av prosjektdeltaker, dato)

Jeg bekrefter å ha gitt informasjon om studien

(Signert, rolle i studien, dato)

Appendix 7 – Information letter to mental healthcare professional participants

Forespørsel om deltakelse i forskningsprosjekt (personell)

«Felles beslutningsprosesser - Implementering og evaluering av veiledning for å bedre pasientsikkerheten i miljøterapi»

Bakgrunn og hensikt

Dette er et spørsmål til deg om å delta i en forskningsstudie som har til hensikt å få ny kunnskap om felles beslutningsprosesser knyttet til pasientsikkerhet i miljøterapi, dels ved å utforske psykisk helsearbeideres erfaringer og refleksjoner gjennom klinisk veiledning, og dels ved å beskrive pasientenes erfaringer med felles beslutningsprosesser og pasientsikkerhet i forbindelse med miljøterapi, og utforske og beskrive pasienters erfaringer med felles beslutningsprosesser med et spesielt fokus på pasientsikkerhet.

Felles beslutningsprosesser har fem kjennetegn; aktiv deltakelse fra pasienten og helsepersonell, informasjonsdeling, problemdefinisjon, diskusjoner om behandlingstilbud og en avgjørelse eller utsettelse. Intensjonen med felles beslutningsprosesser er å øke pasienters kunnskap og kontroll over behandlingsbeslutninger som kan påvirke deres trivsel og bedringsprosess.

Hva innebærer studien?

Første del av studien innebærer å implementere klinisk veiledning for psykisk helsearbeidere med minimum 1 års relevant arbeidserfaring som nå jobber i en miljøterapeutisk setting. Veiledningen består av et designet program med 10 sesjoner på 90 minutter hver 2. uke med fokus på tema som er knyttet til felles beslutningsprosesser og pasientsikkerhet. Veiledningssesjonene vil brukes som fokusgrupper. De vil bli tatt opp på lydbånd og brukt som data for denne studien. Lydopptaket vil til enhver tid være innelåst i arkiv i Psykiatrisk divisjon (SUS). Det er bare forskere som er aktivt med i forskningsprosjektet (som alle har taushetsplikt) som har tilgang til å høre lydopptaket. Etter intervjuet blir alt som er sagt skrevet ned før det blir analysert og videre presentert i forskningsartikkel. Psykisk helsearbeidere som blir med i veiledningsgruppen vil i løpet av veiledningsperioden bli bedt om å rekruttere 2 pasienter hver til del II i studien, som er en evaluering av forbedringer i felles beslutningsprosesser og pasientsikkerhet i miljøterapi. Brukerinvolvering er hovedfokus i denne studien og det blir derfor viktig å innhente kunnskap fra pasientene selv gjennom individuelle dybdeintervju.

Mulige fordeler og ulemper

Dette prosjektet implementerer et veiledningsprogram som har til hensikt å forbedre felles beslutningsprosesser og pasientsikkerhet i miljøterapi. Ved å bli med i denne studien vil du få veiledning som kan bidra til å øke din bevissthet og profesjonelle fagutøvelse, som igjen kan gi økt pasientsikkerhet. Det at du er med å bidra vil gi ny kunnskap som er viktig for pasienter, veiledere, psykisk helsearbeidere, ledelse i helseforetaket og for samfunnet.

Hva skjer med informasjonen om deg?

Informasjonen som registreres om deltagerne i denne studien er navn, mailadresse, arbeidssted og tlf. nr. Deltagerne er anonyme for alle andre enn de som leder forskningsprosjektet. Navnet på deltagerne vil bli kodet, og kodenøkkelen vil være innelåst i arkiv i Psykiatrisk divisjon (SUS).

Det vil ikke bli spurt etter sensitive opplysninger under veiledningen, men om slike opplysninger likevel kommer fram vil disse anonymiseres og behandles slik at det ikke kan identifiseres av noen. Sitater eller andre karakteristika som kan avsløre deltageres identitet vil ikke bli gjengitt. Det vil ikke være mulig å identifisere deg i resultatene av studien når disse publiseres.

Det er kun autorisert personell knyttet til prosjektet som har adgang til navnelisten og som kan finne tilbake til deg. Informasjonen du gir skal brukes som beskrevet i hensikten med studien, og alle opplysningene vil bli behandlet uten direkte gjenkjennende opplysninger. Prosjektet antas ferdig innen

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2021. Datamaterialet blir ikke analysert etter dette, men lagres for etterkontroll i 5 år etter prosjektslutt. Alle data vil bli slettet innen utgangen av 2026.

Frivillig deltakelse
Det er frivillig å delta i studien. Du kan når som helst og uten å oppgi noen grunn trekke ditt samtykke til å delta i studien. Dette vil ikke få negative konsekvenser for deg. Dersom du ønsker å delta, undertegner du samtykkeerklæringen på siste side. Dersom du har spørsmål til studien, eller senere ønsker å trekke deg, kan du kontakte Lise S. Beyene på tlf. 402 31 972.

Ytterligere informasjon om studien finnes i kapittel A – *utdypende forklaring av hva studien innebærer.*
Ytterligere informasjon om personvern finnes i kapittel B – *Personvern og økonomi.*

Samtykkeerklæring følger etter kapittel B.

Kapittel A- utdypende forklaring av hva studien innebærer

- Kriterier for deltakelse i denne forskningsstudien er at du har minimum 1 år med relevant klinisk erfaring og at du har en bachelorutdanning innen helse – og sosialfag. Du må jobbe minimum 75% på dag/kveldstid i klinisk stilling.
- Høy kvalitet er et overordnet mål i all pasientbehandling. Til tross for dette representerer pasientsikkerhet bemerkelsesverdige utfordringer. Felles beslutningsprosesser vil kunne øke pasienters kunnskap og kontroll over beslutninger, som kan påvirke deres trivsel og kvalitet på pasientbehandlingen. Denne forskningsstudien har til hensikt å få ny kunnskap om felles beslutningsprosesser knyttet til pasientsikkerhet i miljøterapi, dels ved å utforske psykisk helsearbeideres erfaringer og refleksjoner gjennom klinisk veiledning, og dels ved å beskrive pasienters erfaringer med felles beslutningsprosesser og pasientsikkerhet i forbindelse med miljøterapi, og utforske og beskrive pasienters erfaringer med felles beslutningsprosesser med et spesielt fokus på pasientsikkerhet.
- Du vil bli kontaktet i løpet av desember 2015/ januar 2016 for avtale om tidspunkt og sted for veiledningsgruppe.
- Det at du er med å bidra med dine erfaringer vil gi ny kunnskap som er viktig for pasienter, veiledere, psykisk helsearbeidere, ledelse i helseforetaket og for samfunnet.
- Det er ikke noen ulemper for deg å delta i denne studien.
- Du er ansvarlig for å gi korrekt informasjon i veiledningsgruppen. Du er også ansvarlig for å møte til avtalt intervjutidspunkt og følge opp alle 10 veiledningssesjonene.

Kapittel B – Personvern og økonomi

Personvern
Opplysninger som registreres om deg er navn, mailadresse, arbeidssted og telefonnummer. Det er bare forskningsprosjektleder (som har taushetsplikt) som har tilgang til disse opplysningene.

Andre forskere som er med i dette prosjektet vil ha tilgang til datamaterialet som består av transkribert intervju.

Lise S. Beyene som er ansvarlig for forskningsprosjektet er databehandlingsansvarlig.

Rett til innsyn og sletting av opplysninger om deg og sletting av prøver
Hvis du sier ja til å delta i studien, har du rett til å få innsyn i hvilke opplysninger som er registrert om deg. Du har videre rett til å få korrigert eventuelle feil i de opplysningene vi har registrert. Dersom du trekker deg fra studien, kan du kreve å få slettet de opplysningene du har gitt, med mindre opplysningene allerede er inngått i analyser eller brukt i vitenskapelige publikasjoner.

Økonomi
Studien er søkt finansiert gjennom forskningsmidler fra Helse Vest. Det er ikke noen interessekonflikter mellom forsker og potensiell finansierende instans.

Informasjon om utfallet av studien
Resultat av studien vil bli publisert i internasjonale tidsskrifter.

Samtykke til deltakelse i studien

Jeg er villig til å delta i studien

(Signert av prosjektdeltaker, dato)

Jeg bekrefter å ha gitt informasjon om studien

(Signert, rolle i studien, dato)