



Towards the Implementation of SDM in everyday practice

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Background

- This presentation utilises three sets of information outlined in:
 - 1. A review article on key issues in implementation of SDM in mental health (Ramon, Brooks, O'Sullivan and Rae, 2017)
 - 2. A piloted evaluated training programme on the SDM process in mental health delivered in parallel to service users, care co-ordinators and psychiatrists (Stead, Morant & Ramon, 2017)
 - 3. Follow up of SDM implementation in the same mental health unit during 2014-2017 (ongoing).
- Definition of implementation: applying SDM systematically as part of everyday practice of a service beyond the introductory, experimental, phase



Why implement SDM in mental health:

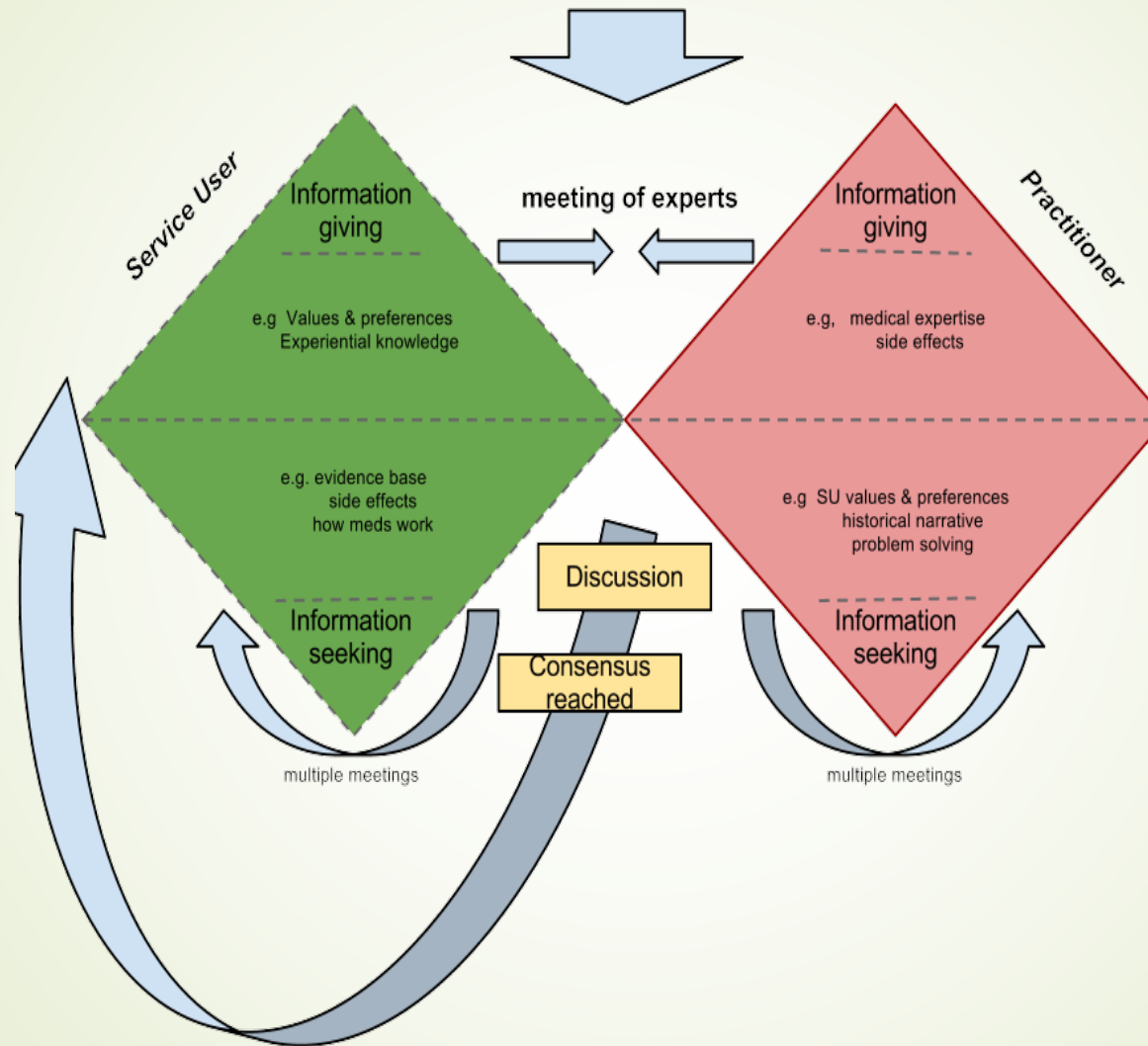
To:

- ▶ Facilitate sharing of two different kinds of knowledge (scientific and experiential) which are central to decision making in mental health, a contested area of knowledge and beliefs.
- ▶ Enable service users to be active in decisions about their lives
- ▶ Enable clinicians to benefit from the subjective, in-depth, experiential knowledge that service users have
- ▶ Enable a more genuine partnership
- ▶ Adds a more in-depth component to the consideration of an intervention, reducing conflict and increasing certainty re decisions
- ▶ The process of SDM is relatively simple and feasible
- ▶ The cost is minimal, and it can save time once it becomes part of everyday practice
- ▶ See NICE guidance 2016 (SDM Collaborative- an Action Plan)
<https://www.nice.org.uk/about/what-we-do/our-programmes/nice-guidance/nice-guidelines/shared-decision-making>




Centrality of SDM concerning psychiatric medication

- ▶ SDM in Psychiatric Medication Management is a problematic issue given that:
- ▶ Research evidence highlights that 50% of mental health service users do not take the medication prescribed for them on a regular basis
- ▶ often do not inform their prescriber of this decision (Nose, Barbui and Tansella, 2003)
- ▶ Why do people stop taking medication, given the evidence as to its effectiveness? (Roe et al, 2009)
- ▶ The growing doubts as to the efficacy of antipsychotic medication (Morrison et al, 2012)
- ▶ The introduction of NIHR funded project on antipsychotic discontinuation and reduction led by Dr. Joanna Moncrieff
- ▶ <https://joannamoncrieff.com/2016/03/02/new-research-into-antipsychotic-discontinuation-and-reduction-the-radar-programme/>





Existing research evidence

- ▶ An increasing number of studies on SDM, though less in mental health than in physical health
 - ▶ Experimental studies: acute admission; primary care; community mental health centres
 - ▶ Attitudinal studies
 - ▶ Outcomes findings
 - ▶ Process findings
 - ▶ A slow pace of implementation of SDM in everyday practice
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Key studies

- ▶ Two RCT completed studies, both taking place in Germany:
- ▶ A.Loh et al (2007) with people experiencing depression in general practice
- ▶ B.Hamman et (2006, 2011) in an acute admission unit
- ▶ Ongoing large scale SDM RCT study in Cadiz, Spain – a replication of the Hamman’s study (Perez-Revulta et al, 2014).
- ▶ Priebe, McCabe et al (2007) have demonstrated the effectiveness of following the patient’s agenda in clinical consultations in six European countries.
- ▶ The CommonGround approach (Deegan, 2005 , Deegan and Drake, 2006, Deegan et al, 2008, Deegan et al, 2010, MacDonald-Wilson, 2016) focus on well being, including medication management, but not only medication management



Barriers to implementing SDM in everyday practice

- "We already do it"
- "We have no time"
- Fear that it will increase the risk of relapse
- Fear that it will encourage service users to stop taking medication
- We are tired of having to introduce one more change to our practice
- It means that what we have done until now was not good enough
- Service users lack insight
- Service users do not have the necessary information
- The doctor knows best




Facilitators

- Respect of SU by professionals
- Good and understandable information
- “Insight” – whose insight?
- A good process of collaboration
- Real choice to be made
- Within person-centred approach
- Engagement of providers who work closely with the person:
- (e.g. PSWs, nurses, Ots, not only psychiatrists)



The role of SDM policy of government and local trusts

- ▶ Policies can encourage providers to develop new ways of working, as they provide a message from above of a preferred direction.
- ▶ The UK relevant ministry and NICE (national institute of clinical excellence) have issued statements on the desirability of SDM in the past (NICE 2009, DH 2011). These statements were not followed on by specific actions.
- ▶ However, in 2016 a collaborative network focused on an action plan for DSM has been established by NICE (2017) which includes also service users, evidence, aids, and case studies (<https://www.nice.org.uk/about/what-we-do/our-programmes/nice-guidance/nice-guidelines/shared-decision-making>) (file:///C:/Users/schqsr/Desktop/nicesdm2017bmj.j1744.full.pdf.).
- ▶ As we know this is not going to be enough to ensure that every UK trust will adopt SDM. In the example I will give you the local trust adopted SDM as its preferred policy for all pathways as a result of the findings of the project.



Piloting a participatory action research on SDM in the UK

- ▶ The SHIMME project
- ▶ Funder: RfPB, NIHR, 2011-2014 disclaimer
- ▶ Location: a large mental health UK trust, ethical approval
- ▶ Its uniqueness: involving mental health service users from the bid stage as members of the management group, as co-trainers and as co-researchers, training all three key stakeholders (service users, care co-ordinators and psychiatrists), but in parallel groups
- ▶ Focus on psychiatric medication management
- ▶ Basic assumptions: SDM as an opportunity for a genuine dialogue between experts in experience and experts in scientific knowledge
- ▶ Multi-disciplinary project: service users, researchers from social work and psychology, practising care co-ordinators and psychiatrists



What was offered to participants?

- ▶ Who were the service users; sample, and sample selection (47)
- ▶ Who were the providers (psychiatrists, care-coordinators (47), and later also PSWs two cohorts, 20)
- ▶ They were offered interactive training programmes in parallel small groups, focused on the process of SDM in the context of psychiatric medication management
- ▶ All deliveries of the training programmes were co-led by a professional and a service user trainer
- ▶ Training programmes content and format were based on an international literature review and local consultations with each of the three groups



Evaluation

- ▶ The importance of evaluation of a pilot
- ▶ Use of mixed qualitative and quantitative methods led by qualitative methodology
- ▶ Before and after the intervention, follow up at 12 months from the end of the training
- ▶ Evaluation tools included:
- ▶ Standardised measures: Decisional conflict scale; CPS (control preference scale, Denger 1997), a version of the Option tool; Recovery Star, Attitudes to Drug Taking, Client Sociodemographic Inventory – Cost Effectiveness
- ▶ Qualitative measures: anonymised comments at the immediate end of the training, interviewing 10% of the sample (SU by SU researchers) at the follow up phase



Key findings

- Overall significant reduction in DCS
- Increase of SDM (Option)
- Significant outcomes in the CPS
- Positive cost effectiveness for 40% clinical, social and economic outcomes
- 57.5% positive clinical outcomes with slight economic cost increase
- Highly positive comments from service users
- Positive comments from care co-ordinators: reduction of fear of managing medication
- Reserved comments from psychiatrists; some positive ones and accusation of being “anti-psychiatry”
- Study limitations: small samples (47 SU, 35 Care co-ordinators, 12 Psychiatrists); non-randomised sample, few of the professionals participated in the follow up stage.



Implementation: 2014-2018

- Adoption of SDM as trust policy across all pathways
- No mandatory endorsement of the SHIMME forms
- Development of personalised letters
- Training of Peer Support Workers
- Training of Non-Medical Prescribers
- Training of junior doctors
- Mandatory training of all new staff, as part of the training on risk management
- Alternatives to medication: Developing the Hearing Voices Network
- Working group on Creative Family Interventions
- Personalised letters project
- Presentations, Publications, enacted video scenarios, three forms, PhD



Coherence

The 'making sense' work that people do when putting something into practice.

Cognitive Participation

The work on relationships that people do to sustain the practice of a new intervention.

Collective Action

The work that people do to act out a set of practices related to novel/ complex intervention.

Reflexive monitoring

The appraisal work that people do to assess and understand the ways in which a new set of practices affect them and others around them.



Analysis of Implementation Work

- ▶ The unending scope of implementation
- ▶ Successes and failures
- ▶ The application of NPT (normalisation process theory) to the analysis of the implementation work:
 - ▶ Coherence, Cognitive Participation, Collective Action, Reflexive Monitoring
- ▶ Training on SDM in Israel vs training in the UK
- ▶ The meaning of SHARED vs. "AUTONOMOUS" decision making within mental health person centred care
- ▶ The need to move more in the direction of social psychiatry, beyond medication.
- ▶ My conclusion: implementation of SDM depends much more on professionals staff's attitudes than on SU; the majority of SU are ready to embrace SDM.
- ▶ Vindication of the parallel training and of having service users as co-trainers



Relevant publications



- ▶ Kaminskiy, E., Ramon, S. Morant, N. (2013) Exploring shared decision making for psychiatric medication management. In: Walker, S. (ed) Modern Mental Health Practice - Critical Voices. London: Critical Publishing, 39-55.
- ▶ Staley, C. (2013) SDM in Psychiatric Medication Management. In: A series of case studies illustrating the impact of service user and carer involvement on research. London: National Institute of Mental Health, 6-14.
- ▶ O'Sullivan, M.J., Rae, S. (2014) Shared Decision Making in Psychiatric Medication management. *Mental Health Practice*, 17, 8, 16-22.
- ▶ Morant, N., Ramon, S. Kaminskiy, E (2015) Shared Decision Making in Psychiatric Medication Management: Beyond the Micro-Social. *Health Expectations*, 19(5) 1002-1014. DOI:1111/hex12392 1-13.
- ▶ Stead, U., Morant, N., Ramon, S. (2017) Shared decision Making in Medication management: Development of a Training Intervention. *British Journal Psychiatric Bulletin*, 1-7, Doi: 10.1192/pb.bp.116.053819.



Our publications II

- ▶ Ramon, S., Brooks, H., O'Sullivan, M.J., Rae, S. (2017) Key Issues in the Process of Implementing Shared Decision Making in Mental Health Practice. In: Ramon, S. Zisman-Ilani, Y., Kaminskiy, E. (ed) Mental Health Review Journal Special Issue on Mental Health Shared Decision Making , 22,3, 257-274.
- ▶ Ramon, S., Morant, N., Stead, U., Perry, B. (2017) Shared decision making for psychiatric medication: A mixed-methods evaluation of a UK training programme for service users and clinicians. International Journal of Social Psychiatry, 63,8, 763-772.



Forthcoming publications

- ▶ Ramon, S., Brooks, H., O'Sullivan, M.J., Rae, S. (2017) Ramon, S. Brooks, H. O'Sullivan, M.J., Rae, S (2017) The implementation of shared decision-making (SDM) in mental health practice. In: Ramon, S., Zisman-Ilani, Y., Kaminskiy, E. (ed) Mental Health Shared Decision Making, special issue of the Mental Health Review Journal
- ▶ Ramon, S.(2017) Shared Decision Making As An Integral Component of Recovery In Mental Health: Focus on training service users and providers.
- ▶ In: Lachman, M., Hadas-Lidor, N. (ed) Against the Odds: From Rehabilitation and Recovery in Mental health to Community Integration. Kiryat Ono: Ono Academic Press (Hebrew)