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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.

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) were 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 situation (…) 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 decided 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 concepts 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.

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.

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