The Elephant in the Room: A Theoretical Examination of Power for Shared Decision Making in Psychiatric Medication Management

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Abstract

Shared decision making (SDM) is an important tool for recovery-oriented practice in mental health services. It has been defined using narrow and broad conceptualizations. One overarching theme that merges the differing models is the emphasis on a rebalancing of power, with experiential knowledge holding equal weight in the encounter, alongside more traditional "medical" forms of knowledge. Nevertheless, the concept of power and how it is enacted and shared has received relatively little attention in the wider SDM literature. Yet, it is fundamental both to the principles and models of SDM more generally and to the recovery model within mental health services more specifically. This article explores the theoretical concept of power in the context of SDM for psychiatric medication management practice. It highlights the diverse structural components of the U.K. contemporary mental health system, their intersections, and the resultant opportunities for persons to take back control and enact their agency.

Keywords: collaboration, SDM, power, mental health, mental illness

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This article focuses on exploring shared decision making (SDM) in the context of decisions concerning psychiatric medication. This context is chosen as psychotropic medication is the key component of many mental health treatment plans (Healy, 2009). In fact, according to some, people's interactions within mental health services often revolve around medication (Moncrieff, 2009). Medication can be an important tool for an individual's personal recovery, but decisions pertaining to medication are complex and involve a process of trial and error, where potential benefits are weighed against the adverse impacts medication may have for a person's functioning, quality of life, and identity (Deegan, 2005, 2007; Kartalova-O'Doherty & Doherty, 2011).

In short, the relationship between people with a mental health condition and psychiatric medication is often complicated. For example, although many service users see psychiatric medication as helpful, a dilemma often emerges. Many people report that the adverse effects of psychiatric medication are, in fact, worse than the mental illness itself. There is growing awareness of the serious and enduring nature of the adverse affects associated with long-term use of certain types of psychotropic medication (notably anti-psychotics; see Healy et al., 2012; Moritz et al., 2009; The

Schizophrenia Commission, 2012; Whitaker, 2004, 2010). Of particular concern is multiple prescribing, or what is known as poly-pharmacy. For example, up to a third of service users are being prescribed a total dose of anti-psychotic medication above that deemed acceptable by the British National Formulary (Harrington et al., 2002; Howes et al., 2012; Ito, Koyama, & Higuchi, 2005). This is compounded by the trend that prescription of new medication and increased doses of psychiatric medication are often given during periods of crisis, yet are less frequently reduced once the crisis is resolved. While policy guidelines have been issued to counteract such issues (e.g. Department of Health [DH], 2013; National Institute for Health and Care Excellence [NICE], 2009), there nevertheless seems a disconnect between what the lay person would expect from mental health services (emphasis on psycho-social interventions and support) and actual service offerings (dominated by diagnosis and prescription of psychiatric medication).

People may often choose not to take medication because of the stigma associated with it, rejecting medication as a symbol of their illness. Many also choose not to take medications as prescribed because it does not appear to be effective. As part of this, it often takes significant time to ascertain any benefits of psychiatric medication, which are incremental and slow. In addition, for some people descriptions of their symptoms are seen as an integral part of who they are and not something they would like to eliminate via medication.

Consequently, often people who are prescribed psychiatric medication do not take it systematically and do not share this information with their doctor. Strategies such as only taking medication at certain times or non-adherence may, for some, act as a positive attempt at self-management (Britten, Riley, & Morgan, 2010; Roe, Goldblatt, Baloush-Klienman, Swarbrick, & Davidson, 2009). Yet previous research suggests that often service users do not inform or consult practitioners in the serious decision to come off psychiatric medication (Read, 2005). This highlights lack of trust between mental health service users and their clinicians, and difficulties in sharing knowledge, both scientific and experiential.

It is proposed that SDM offers opportunities for service users' knowledge and experience of taking and using psychiatric medication to move to the fore, thereby enabling greater empowerment, enhanced control, and formation of a partnership with practitioners, in their personalized treatment plan (Baker et al., 2013; Deegan & Drake, 2006; Drake, Deegan, & Rapp, 2010). Service users may grow in expertise and refine medication strategies over time finding the *right balance between what they do to be well and what they take to be well* (MacDonald-Wilson, Deegan, Hutchison, Parrotta, & Schuster, 2013, p. 263). SDM's value lies in the need for service users and practitioners to recognize each other as experts and work together to exchange information and clarify values; this is seen as crucial for a recovery-oriented approach to psychiatric medication decision making (Baker et al., 2013). Here the service providers' and prescribers' role is to assist in the process of individual-led recovery and the change in the service users' re-evaluation of identity, with a corresponding move away from clinically defined care (Shepherd, Boardman, & Slade, 2008).

The model of SDM has been growing in support and is now ingrained into policy and professional discourse for psychiatric medication management (NICE, 2009). SDM sits within the larger move toward recovery-based practice in mental health, which, along with person-centred care, are now considered to be a core component of the U.K. mental health system (National Institute for Mental Health in England, 2005; DH, 2011, 2012). However, there is an apparent and large gap between stated policy ideals and actual practice. This article explores this complexity further. Power is a concept central yet often ignored by SDM models, as highlighted by an article in a recent edition of the *British Medical Journal* (Joseph-Williams, Edwards, & Elwyn, 2014). This article presents a theoretical analysis of the concept of power for SDM in psychiatric medication management practice, highlighting how the intersections between different structural components of contemporary mental health services influence opportunities toward achieving meaningful shared dialogue in practice.

Before the theoretical analysis is considered in more depth, a brief examination of the defining features of SDM, and its historical origin, is offered.

SDM—A More Detailed Examination

For many,… SDM is a philosophy as well as a way of doing things. Central to it is the belief that patients have a vital role in the decision-making process; that their values and self-determination need to be considered equally alongside scientific knowledge. (Da Silva, 2012, p. i)

While SDM offers opportunities for psychiatric medication management practice, it emerges from other health care arenas. In the U.K., SDM sits alongside the rhetoric of "no decision about me without me" (DH, 2012), promoting increased obligations to increase involvement of patients in decisions about treatment, occupying the middle ground between paternalism and informed choice (Makoul & Clayman, 2006, p. 301). It is important to note that SDM also reflects broader trends toward the neo-liberalization of health and social care over recent decades, linked to the growth in agendas such as personalization, choice, and competition in service delivery (Glasby, 2012).

There is a considerable overlap between SDM and constructs with similar connotations, such as mutual participation, evidence-based patient choice, enhanced autonomy, and concordance (Makoul & Clayman, 2006; Wirtz, Cribb, & Barber, 2008); and these concepts have been proposed to sit within the wider SDM model (Coulter & Collins, 2011).

SDM was first defined by the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research (1982), with an emphasis on a process based on the values of mutual respect and partnership. Since then, there has been a growing amount of literature exploring SDM and its defining features (Makoul & Clayman, 2006). A popular definition commonly cited in the literature is that of Charles, Gafni, & Whelan (1997, 1999). This definition focuses on the interactional components, with the prerequisite that there are legitimate treatment choices. In this definition, each person has to be willing and actively engage in the process of exchanging information and sharing preferences before an

agreement is reached. However, some disagreement exists as to whether this process in of itself is enough in order to view the interaction as SDM. There is a lack of support for the model's premise that shared consensus has to be achieved in order for it to be seen as SDM. According to these authors, if consensus on the decision does not occur, even if the process itself is collaborative, it cannot be considered SDM. However, this article argues that one of the key limitations of Charles et al.'s (1997, 1999) definition (along with others) is that it does little to explain the process of acting as equal partners in reality, or the subjective experience of feeling informed, or having a say. In short, models do not acknowledge or offer solutions to the inherent power imbalance in the relationship between the doctor and the service user. Indeed there has been a growing body of research that has emphasized a broader conceptualization of SDM, as something that involves more than just actions and requirements from the health care provider and instead is a complex process, which has multiple components, developing over time (e.g., Entwistle & Watt, 2006; Moreau et al., 2012).

The hallmark, but often implicit, feature apparent across the models is that both parties have an equally valuable contribution to the decision-making process. As such, the term a "meeting between experts" is especially relevant. Therefore, the differing, intersecting, but often conflicting cultural components of the broader system need to be made more open in the decision-making process (Wirtz et al., 2008). More generally, models of SDM need to make more explicit what barriers exist (and therefore may need to be overcome) in order to uphold respect and recognition for different forms of knowledge in the decision-making process. At the forefront of these is the inherent power imbalance present between service user and doctor or prescriber in the health care encounter. In such a complex process, it is easy to see how resource or resource constraints (such as time) influence the ability to truly engage in such a process and why such models are not being taken up in practice (Stevenson, Barry, Britten, Barber, & Bradley, 2000). In the context of making decisions about psychiatric medication, many barriers specific to psychiatry are highly relevant to consider.

The remainder of this article will explore these important cultural features of the contemporary mental health system, linking these to different forms of power applicable in this context. By doing so, a more meaningful and grounded conceptualization of shared decisions may emerge, making more explicit the barriers and challenges that need to be acknowledged in order for the ideal "meeting of experts" to emerge in the psychiatric medication management encounter.

The Concept of Power and Its Relevance to SDM in Psychiatric Medication Management

This article does not offer the reader a critical evaluation or thorough examination of the power literature. It does not even offer a whistle-stop tour. Rather, it reveals the different forms of power that may be applicable to consider when exploring SDM, as well as presenting useful theoretical representations of this construct in order to provide a sense of structure and meaning relevant for considering SDM in psychiatric medication management.

Weber (1864–1920) conceptualized power as "power over"—as something that can be done unto someone, with person A having power over person B. In the context of mental health services, it has been suggested that those individuals who possess power (i.e., the professionals and particularly the prescribers or psychiatrists) would need to relinquish some of their own power if SDM is to take place, and consequently this is "a reason to resist genuine service user empowerment" (Masterson & Owen, 2006, p. 21). As such there is an overt conflict, but domination, of the powerful (mental health professionals) over the powerless (service users), with ideas such as compliance to medication regimes being particularly relevant. This form of power is often recognized as overly negative, and as having associations with terms such as *coercion* (Veneklasen & Miller, 2002). Studies of the asymmetrical psychiatric encounter and the role of status and authority on decisions about psychiatric medication fit with these conceptualizations of power, focusing on adherence or compliance to medication routines and on their enforcement by prescribers. Such challenges are not unique to mental health encounters. Prevalent paternalistic cultural norms such as the "doctor knows best" and "patients do as they are told" mean that power relations will continue to shape the experience and outcome of most health care encounter contexts (Murtagh, 2009). However, unlike in other areas of medicine, mental health services operate in a specific legal context. A person's previous experiences of coercive practice and of being treated against their will under Mental Health Act legislation, in addition to acting as power-over at this level of analysis, also has a particularly damaging impact on the formation of a collaborative relationship with practitioners, instead encouraging greater passivity, "false compliance," and a lack of engagement with mental health services (Chamberlin, 2005; Haglund, von Knorring, & von Essen, 2003).

While pertinent, many modern theorists, however, look beyond this simplistic picture of how power imbalances are enacted. The influential work of Lukes (2005) is widely regarded and has received some attention for its applicability in considering the mental health services context (Brosnan, 2012; Masterson & Owen, 2006).

Lukes (2005) proposed that the Weberian or "behaviourist" models of power are inadequate because "although A may exercise power over B by getting him to do what he does not want to do he may also exercise power by determining his very wants" (p. 107).

Instead Lukes proposed a three-dimensional view of power. The first dimension is comparable to the Weberian form described above as that of *power over*, associated with overt conflict, where one party has power over another. However, in the second and third faces of power, more covert forms of power are described. The second face, also described as "non decision making," is power that is exercised by the powerful (the professionals or prescribers), but by controlling what is on the agenda for discussion, or more specifically, by controlling which particular options are open for discussion. In the case of psychiatric medication management, this may involve which types of medication are described by professionals as options, or whether non-medication alternatives are in fact considered at all. The central issue of adverse effects of medication is important to consider at this level of power. The adverse effects and risk–benefit profile of different psychotropic

medications are central to the balanced weighing of the pros and cons in a shared decision concerning psychiatric medication. The presentation of the side effects is, however, in the hands of the psychiatrist, whose competing interests and limited time available pose a challenge for the full disclosure of information needed for a fully shared dialogue. While the internet and other open-access forms of knowledge may assist the full disclosure of information to mental health service users at this level, this remains inconsistent, potentially misleading, and influenced by structural factors such as education levels, class and age (Preston, 2013). Other factors are also important to consider at this level of power, such as expense of medication and direct marketing incentives, influencing which options are presented in the psychiatric medication encounter.

However, this second dimension of power still maintains the idea that the exercise of power involves conflict between the powerful (prescribers) and powerless (mental health service users), over recognized areas of dispute. Lukes' defining contribution to the literature was to explore a third dimension of power, which challenges this, instead suggesting the most insidious form of power is that which prevents conflict from emerging in the first place. This conceptually overlaps with other philosophers and researchers of the 20th century. For example, Foucault (1926– 1984, see below) or Freire (1921–1997), who explored power via broader repressive cultures and internalized- or self-stigma. At this dimension of power, identities and roles are manipulated so that certain groups do not question, but instead accept certain situations without conflict. This is highly pertinent to much of the critical psychiatry literature, which it has argued that this form of power is present in the dominating bio-medical model of psychiatry. In particular, for psychiatric medication management a dominating bio-medical model may distance the value of service users' experiential knowledge, thus hindering the recovery ideals of the service user taking back control and empowerment (Masterson & Owen, 2006).

There are strong links with Lukes' third dimension of power and Foucauldian approaches to power, which, additionally, emphasize the positive aspects of power in social relations. Foucault's widely quoted phrase "knowledge is power," is often misinterpreted as meaning how knowledge can be used as a form of power. However, this actually refers to how power is constructed, and subsequently maintained, through discourses and institutional practices, which frame action by governing what is seen as possible (Foucault, 1977, 1980). However, for Foucault there wasn't a distinction between knowledge and power, both being inherent upon social relations, affecting every person in every role, both the service user and professional alike. Thus, while linked to Lukes' third face of power, it also refers to positive aspects of power, emphasizing that within institutions, such as psychiatry, hierarchies of knowledge are created that place certain people in certain roles (i.e., psychiatrists and/or prescribers) as having more control over decisions concerning psychiatric medication. For Foucault, power is exercised by actions, as opposed to being exercised by a person in a certain position of authority (Couzens-Hoy, 1986). Applying this notion of power in the context of psychiatric medication management, the meeting itself is of importance to consider, with power being exercised through use of strategies employed by all participants as part of the wider social relations of

the meeting. Doctor–patient asymmetry and patterns of social relations may be important to consider at this level, then. Indeed, Foucault's work has been used extensively in areas of health and medicine, exploring both the caring profession and traditional doctor–patient studies, focusing on how medicalized forms of knowledge impact on identity and behaviour in medical encounters, toward avoiding conflict and encouraging consensus (Petersen, 2012). In the context of mental health services, Boyle (1992) suggests that mental health legislation acts as specific form of disciplinary power "in constructing and producing and in using language for subtle forms of self and social regulation" (p. 71). Mental health legislation relies on scientific expertise from mental health practitioners, practitioners, general practitioners (GPs), and the approved mental health practitioners (AHMPs), and this furthers more insidious forms of disciplinary power.

In addition, while in other areas of health, decision-making capacity may be limited by service users' knowledge of medical conditions and treatments, their ability to reason is not in dispute. In mental health, the capacity to reason and make effective decisions resides with others rather than with the service users themselves. Part of this is defined in legislation and part through the social construction of professional practice unique to mental health (Morant, 2006). For example, in a study by Chong, Aslani, & Chen (2013), only mental health practitioners prioritized "service user lack of competence" as a particular challenge for SDM, a factor not considered by practitioners in other medical contexts. A key challenge for SDM in psychiatric medication management is that practitioners (at times, at least) do not place equal value on service user expertise and knowledge.[1] Yet, for SDM to become a reality, experiential understanding as well as an acknowledgement that conceptions of mental illness and treatment are contested and complex, need to be at the forefront of conversations. According to Baker et al. (2013) there needs to be a

> rebalancing of the traditional focus on diagnosis and treatment with prioritisation on personal and self determined perspectives. A key component of this shift would be the value and status that is ascribed to different forms of knowledge. (p. 3)

As such, medicalized discourse and diagnosis are important hierarchies of knowledge at this level, played out through the pattern of social interaction in the psychiatric medication encounters. A contemporary example is illustrated by the recent controversy following the release of the new *Diagnostic and Statistical Manual of Mental Disorders* (5th ed.; *DSM–5*; American Psychiatric Association, 2013). Its release was associated with much public debate and discussion. In particular, new diagnostic categories incorporated into the *DSM–5* have highlighted the increasing medicalization and further pathologizing of emotions and behaviours (Division of Clinical Psychology, 2013; The Guardian, 2013; Zisman-Iliani, Roe, Flanagan, Rudnick, & Davidson, 2013). This pathologization and creation of arbitrary distinctions between what is seen as normal and abnormal is proposed to be a form of power and control, through the mechanism of voluntary compliance. As a

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[1] Either "raw" individual experiential knowledge or "collective" forms of knowledge (see Borkman, 1999)

result, societal expectations and the dominance of medicalized perspectives of emotions, behaviour, and distress may be an important structural factor in the psychiatric medication management encounter, resulting in the less powerful enforcing the aims of the powerful, through self-surveillance.

> There is no need for arms, physical violence, material constraints. Just a gaze. An inspecting gaze, which each individual under its weight will end by interiorising to the point that he is his own overseer, each individual thus exercising this surveillance over and against himself. (Foucault, 1980, p. 155)

However, an important aspect of power relevant to psychiatric medication management encounters then, but somewhat overlooked by Foucault is the lack of attention paid to the influences of industry in shaping discourse. Petersen (2012) argues

> neo-liberalism is a manifestation of late, free-market capitalism and we need to better understand how the particular forms of governance associated with contemporary health and medicine and healthcare reflect and are shaped by the dynamics of the political economy. (p. 17)

For psychiatric medication management, it is suggested by critics that there is a strong co-production of knowledge between the medication and the roots of the disorder, via the marketing strategies of large pharmaceuticals and other organizations with vested interests. Rose (2003) eloquently emphasized this possible link, making it clear that the dominance of psychiatric medication has also impacted how both professionals and the lay person speak and understand mental illness: "So the debate cannot be only one of efficacy, as if illness, treatment and cure were independent of one another" (p. 58).

Having said this, a body of criticism of psychiatric medication has been growing over the last 15 years also. Criticism of the role of the pharmaceutical industry in prescribing behaviours and marketing has become increasingly popular. Indeed, one of the main criticisms to the Foucauldian approach to power is, while seen as a form of critical theory, it does not construct a new systematic set of principles of power, but instead reconciles to criticizing other assumptions of social theory and philosophy. His work has been criticized as overly fatalistic, not encompassing the idea of universal progress. However, Foucault maintained his position that emancipation of the powerless was still possible, if taken at the local level, in terms of pockets of resistance to exercises of power.

Lukes' three faces of power has also received criticism. For some, it ignores other types of power such as *power with*, *power to,* and *power within,* associated with empowerment and transformational change. *Power with* is achievable through working together in groups, for advocacy and change. *Power to* act is related to this, but linked to ideas of agency and autonomy (or *power within*). These other forms of power are largely ignored by Lukes, but it is suggested, remain highly relevant within the psychiatric encounter (Veneklasen & Miller, 2002).

Linked to this, there is also a body of research that has explored the importance of acknowledging the resistance and strategies employed by the less powerful in the

encounter. The importance of exploring *active non-compliance* to medication regimes is particularly pertinent to the medication management encounter in mental health. Scott (1990) explored the importance of the "hidden transcript of the subordinate" as a way of explaining the phenomenon of passive resistance. Here, the main premise is that the discourse of a subordinate group is vastly different when in the presence of a dominant group as compared to when in the company of peers. This is highly relevant to considering psychiatric medication management practice. That is, the idea of "acting" or presenting a false picture of compliance in order to avoid confrontation and conflict in the medication management encounter. However, active non-compliance strategies are not seen as the only subversive form of power.

> The conflict will (also) accordingly take a dialogic form in which the language of the dialogue will invariably borrow heavily from the terms of the dominant ideology prevailing in the public transcript.… We may consider the dominant discourse as a plastic idiom or dialect that is capable of carrying an enormous variety of meanings, including those that are subversive of their use as intended by the dominant. (Scott, 1990, p. 102)

Thus, not only are there covert or passive forms of power associated with subversive actions, such as not taking a prescribed medication and non-compliance, but also within dialogue itself, and through the use of the dominant discourse by redefining the parameters of the dominant discourse itself. In this context, language and norms associated, for example, with the dominant medical model in psychiatry, thereby influence how mental illness is conceptualized and what are deemed the social norms of mental health prescribing practice.

On another level, it is important to recognize movement, change, and resistance at a wider cultural and system level of understanding. Whereas the medical model has been labelled as oppressive and an insidious form of power in the modern mental health system over the last half a century, so to have movements of resistance emerged over the same time period. For example, Crossley (2005), in a sociological examination of the mental health field from 1950–2000, explored five distinct but interrelated social movements over this period:

1) Mental hygiene movement

2) Civil rights movement

3) Anti-psychiatry movement

4) User/survivor movement

5) Has no label but comprises a movement in which families and carers are critical of items 2, 3, and 4 and support diagnosis and treatment.

Having considered some of these additional complexities and avenues that are relevant to exploring power in medication management practice, we can now return to Lukes' three-dimensional model of power. One of the seen benefits of this model is its simplicity and presentation of the ideas surrounding power. Gaventa (2006) and Gaventa and Cornwall (2008) expanded on Lukes' work to make it more applicable to ideas of encouraging empowerment and change in a development context. Here,

Gaventa's aim was to make more explicit where power can be acted upon (or, as Gaventa called them, "engagement spaces") within a participatory framework to encourage change in organizations. By making these spaces more explicit, challenges to these barriers may emerge, such as being able to prevent certain issues from arising, as well as the increased mobilization of less powerful or excluded voices and knowledge. Gaventa (2006) represented these ideas using a power cube which he defined as a "framework for analysing spaces, places and forms of power and their inter relationship" (p. 26).

Brosnan (2012) has adopted this framework to explore user involvement in mental health services in Ireland, suggesting it is both applicable to the mental health context and useful for making more explicit the role of power as an obstacle to user involvement in mental health. Lukes' representation of both overt and more hidden forms of power are presented as layers to the cube, occurring on different planes: the strategic, operational, and individual levels. Ideas of creating new spaces within these planes are also explored: closed, invited, and created spaces to emphasize how change may happen on the different planes. Finally, by presenting the layers and spaces as a Rubik's cube, complexity is emphasized, involving numerous combinations of forms, levels, and spaces.

While useful, this representation does present a rather static picture of power. Although it enables the appreciation of how and where strategies can be employed to tackle power in the context of psychiatric services, it does not really talk about the changing or dynamic context of power or of the strategies already employed by the less powerful in the context of dynamic changing social relationships, as alluded to in the below quote:

> Power can be defined as the degree of control over material, human intellectual and financial resources by different sections of society. The control of these resources becomes a source of individual and social power. Power is dynamic and in relationships, rather than absolute…, but neither power, ideology, not the state are static or monolithic. There is a continuous process of resistance and challenge by the less powerful and marginalized sections of society, resulting in various degrees of change in the structure of power. When these challenges become strong and extensive enough, they can result in the total transformation of a power structure. (Veneklasen & Miller, 2002, p. 41)

In Veneklasen's quote, the dynamic nature of power is emphasized with the idea of continual change and review being important to the concept of power. This idea of power and its impact on systems and change has been explored in depth by Clegg (1989) who discussed circuits of power, thereby moving the concepts of power toward a more dynamic idea of power than those presented by Lukes or Gaventa.

Intersectionality of Structure and Agency in Medication Management and Practice

At this point, it is also useful to consider the concepts of structure and agency in psychiatric medication management practice. The definitions of structure and agency

are contested and depend on school of thought. The characteristics of structures vary in (Sewell, 1992):

- Character (for example, they have different purposes, organization, strong or weak informal networks, and may have a subculture)

- Scope (local to global)

- Dynamism (stable to less stable)

- Durability (long to short duration)

Overall, there is an appreciation of the overlapping, diverse, and intersecting aspects of structure, which is particularly relevant for SDM in psychiatric medication management. Adopting this perspective, differing, overlapping, and potentially conflicting structures are acknowledged. Historical and contextual factors have been briefly explored above. For instance, diagnosis, pathologizing, and the medicalization of mental illness are dominating structures, often associated with concerns over a depersonalization of experience and creating stigma. This has the potential to be a significant challenge to achieving the ideals of SDM and is therefore an important structural factor to consider for psychiatric medication management. However, this is intersected by the recovery model, which is mainstream in modern mental health policy, as well as by the broader historical movements linked to this (e.g., the survivor movement and growth of neo-liberalism in health care provision). These structural components are associated with increased personal control and empowerment of mental health service users, bringing service user perspectives to the fore and encouraging increased personalization of care and a move away from a deficits-based perspective. Linked to this, positive psychology has also emerged as an important knowledge base in the recent couple of decades, emphasizing the importance of well-being in delivery of mental health services, as opposed to treating illness (Slade, 2010). In addition, the hugely influential social model of disability has had a significant impact on culture and societal attitudes toward social inclusion, representing a cornerstone for user movements in this period. In short, the social model of disability has changed the focus from impairments of the individual and policy emphasis on charity and medical care, to an appreciation of society's failure to accommodate diverse needs and policies focused on rights, equality, and citizenship (Beresford, 2002). For example, Slade (2010) went on to suggest that mental health professionals will need

> to focus on improving social inclusion, becoming social activists who challenge stigma and discrimination, and promoting societal wellbeing [and this] may need to become the norm rather than the exception for mental health professionals in the 21st Century. (p. 2)

These structural components and their intersection in modern mental health system is highly relevant to consider for SDM in psychiatric medication management. This intersection of structures is discussed in Archer's (1995, 2003, 2012) seminal work and the theory of morphogenetic cycles. In this work, Archer explores the variety and dynamic societies of late modernism:

> Structure and culture have each become morphogenetic and are coming to stand in a relationship of positive reinforcement towards one another. The new generative mechanism entailed by this is for variety to produce still more variety because, in pure form, nothing restrains it (such as defensive attachment to previous quasi traditional interests and ideas or adherence to prior forms of routine action). Even more importantly, in pure form, it can develop because the very novelty of new variety means that no group has commandeered it an acquired vested interests in it. Indeed the rapidity of change means that the very notion of vested interests will become outdated if and when morphogenesis becomes truly unbound. (Archer, 2012, p. 31)

This offers a dynamic perspective on structure, but one that reflects the diversity, as well as representing the uncertainty, change, and movement of structures in the mental health system. Although power or social capital may remain, the links are less direct and according to Archer (2012) are often via indirect routes such as the transmission of confidence in being able to pursue opportunities. Applying this to psychiatric medication management, this suggests that while vested interests and power remain, there are a multiplicity of structures that potentially enable greater flexibility in how people (individually or as groups) move forward and take action (agency).

There is a lot of debate in the literature as to how agency and structure interact. On the one side, theorists propose a fatalistic stance of agency, such as Bourdieu's *habitus*, where structure is all encompassing and mutually reproducing. For example, in an exploration of Bourdieu's habitus for decision making in health care:

> Choices may be rendered meaningless to those who lack the resources to make a meaningful choice. This has particular resonance if one considers the changes to the national health service … In the field of health, habitus has been characterized as one of passivity and compliance. The power structure of the field within which health habitus is enacted is one in which medical and allied professionals take the position of power and control the interactions. Thus the passivity is structural. (Scambler, 2012, pp. 75–76)

While the issues of passivity are highly relevant to mental health medication management, as suggested, this stance potentially ignores the dynamic and intersecting aspects of structure and the potential for agency to be brought further to the fore. This position therefore "assumes a far too rigid causal determination in social life" (Sewell, 1992, p. 2) where agency has little influence and therefore sit at odds with the dynamic picture of structure presented above.

At the other end of the spectrum, theorists propose agency only is viewed in relation to an individual's decision-making process. This, again, is less relevant to psychiatric medication management practice, where the historical, economic, and social context are all highly pertinent and strongly influence wider psychiatric medication management practice.

Instead, in the middling position endorsed by theorists such as Giddens (1984) and Archer (1995), structure and agency are seen as interacting in determining psychiatric medication management practice. In other words, "agency is necessarily

structured but not structurally determined" (Scambler, 2012, p. 131). This is a useful approach for considering psychiatric medication management practice.

According to this perspective,

> to be an agent means to be capable of exerting some degree of control over the social relations in which one is enmeshed, which in turn implies the ability to transform those social relations to some degree. (Sewell, 1992, p. 20)

Archer (2012) proposes that there are four modes of agency possible. These are: communicative reflexivity (internal conversations need to be confirmed and completed by others); autonomous reflexivity (internal conversations are self contained, leading to action); meta reflexivity (internal conversations critically evaluate previous inner dialogues and are critical about effective action in society); and finally, fractured reflexivity (internal conversation cannot lead to purposeful action, but intensify distress and disorientation. In Archer's (1995) model, the interaction and change between structure and agency is a process through time as a cycle (called the morphogenetic cycle), consisting of societal interactions and structural elaborations (where conflict and negotiation between societal groups further impacts structural change).

Archer's model is useful to consider as it allows for an increased appreciation of a flexibility toward structural components of the mental health system, and for the diverse combination of different vested interests to be more explicit in understanding how people enact their agency. While dominating structures are present (e.g., fear of coercion, diagnostic categories, labelling, and medicalization) and pose a challenge to SDM in psychiatric medication management, there is also opportunity and acknowledgement of a continual and changing environment. In the intersections between diverse structural components of the system, the individual has the opportunity to process this dynamic environment and reflect upon it, thereby encouraging further change, as illustrated in the quote below.

> As individuals and groups are acting in situations to defend their vested interests and to realize their projects, they reproduce or transform the structural and cultural conditions that impinge on them, but in this process they are themselves being transformed from involuntarily placed agents into social actors and individual persons. (Archer, 2012, p. 31)

In summary, unlike the overly fatalistic stance of people's actions being a consequence of the dominating structural components of the system, Archer offers a positive and dynamic perspective on agency. However, within a multi-faceted structure, there is continual flux with different modes of agency being drawn upon. This does also present a worrying perspective: the suggestion that the proportion of fractured reflexives may increase.

On a related point, this uncertainty and opportunity associated with late modernity in sociology have also been proposed to be related to a growth in health inequalities, suggestive again that this high-uncertainty, but dynamic, structural setting of mental health may not suit all (Scambler, 2012). This may be a significant

challenge for SDM in medication management. Yet, this structural complexity and uncertainty also offer increased opportunity for service users[2] to enact their agency and further impact structural and cultural components of the system.

Summary

Bringing these concepts together, I have illustrated the idea of power in the medication management context, using a diagram (Figure 1). This has the aim of making more explicit the notion of power as a core concept for SDM, while bringing to the fore the dynamic nature of the decision-making process. While it is highly useful to consider different dimensions of power as well as different levels of analysis, as shown by Gaventa's power cube, this diagram also aims to emphasize movement and resistance and to present a dynamic representation of medication management decision making, changing and moulding the relationship between structure and agency (Kaminskiy, 2014).

Figure 1. Framework of Power for Collaborative Psychiatric Medication Management Practice

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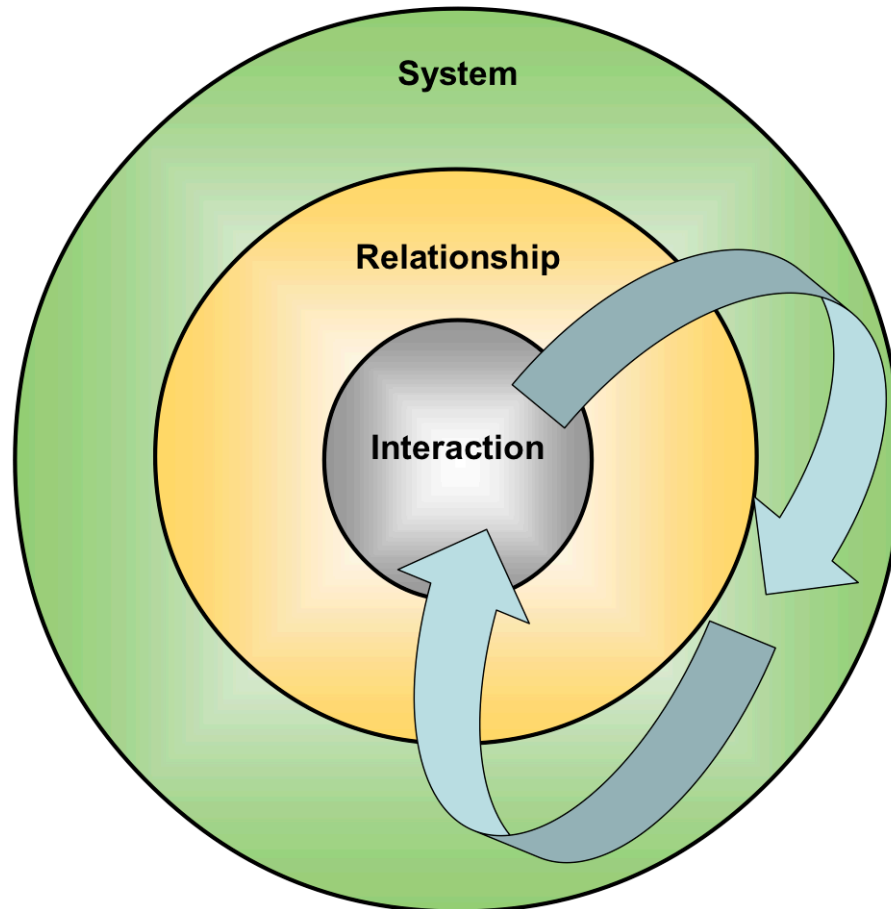
[2] Collectively and individually

In Figure 1 different levels of analysis are presented in an onion diagram to emphasize that power exists on different planes, at the system (or macro) level, the relationship level, and the interaction (or micro) level. The diagram illustrates that power is embedded within each of these levels. For example, at the system level the dominant ideology of the medical model is present, as are other forms of established norms, such as Aescuplian power (or the power to heal) applicable in all medical encounters. However, other structural components are also embedded at this level, including among others: the personal recovery model, with its roots in the survivor movement; contemporary shifts toward neo-liberalism and the rhetoric of choice and personalization; changes in expectations toward increased service user participation and involvement in decision making; and the management of risk and the legal framework within which mental health services operate. These embedded, intersecting structures directly influence the other levels. In fact, the relationship and interaction levels are seen to sit within the wider system-level circle in the onion-based diagram, meaning to represent ideas from Foucault and Lukes, i.e., that power is always present and sits within wider structures, impacting covertly what is possible at the interaction level, where decisions about psychiatric medication occur. At the interaction level, SDM may be impeded not only overtly through authority and power-over in decisions about psychiatric medication, but also through deciding which options are discussed in the first place (the second face of power) and by considering what is deemed socially acceptable as relevant knowledge for the decision in the first place (the third face of power).

Taken together in the context of psychiatric medication management, power—as an obstacle to the defining aspects of SDM, i.e., equality of knowledge, a full considered weighing of options, and experienced control by the service user—is an important theoretical construct in psychiatric medication management. However, the feedback arrows represent how both active resistance strategies and the discourse itself are important for also shaping the outer layers. The interaction and reflection at this level shapes the dominant discourse at the system level, both directly and indirectly via developing (or not developing) relationships (Kaminskiy, 2014). This is represented as being a continual process adapting over time, with movement and change occurring at each level of understanding.

In conclusion, this article does not aim to contribute to our conceptual understanding of power, and would perhaps not stand up to high-level academic debate. However, the presentation of the framework, shown in Figure 1, serves to structure thinking about how to explore the complex nature of SDM for psychiatric medication management, making more explicit how power is relevant to consider for SDM models. SDM and its emphasis on equality of knowledge and meaningful dialogue remain fundamental to the recovery model within mental health services, yet often the structural components and dynamic nature of the process are ignored both by research and by policy development in the field. By exploring the intersection of diverse structures present in contemporary mental health services, opportunities for increased agency and taking back control are highlighted.

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