

INSIGHTS

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Supported decision making

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Key points

- Supported decision making aims to protect a person's 'legal capacity', or their right to have their will and preferences upheld in relation to all aspects of their life, regardless of disability or mental health status.
- Supported decision making is central to the reform of mental health and capacity legislation nationally and internationally, but the research evidence is limited and it is likely that forms of substitute decision making will need to be retained.
- Supported decision making refers to a wide range of models and practices, including informal supports from friends and family, assistance from advocates and legally mandated supporters, advance directives, and communication tools, among others, which will vary depending on the particular needs and circumstances of the person.
- Building effective relationships is a foundational element of supported decision making.
- Training and education initiatives are required to ensure social workers and health care professionals develop appropriate knowledge and skills for supported decision making.

Introduction

Consider the last 'big' decision you made. Not the type of decision you make every day such as what to wear or what to eat for lunch, but the type that you had to think over carefully before finalising. Maybe it was moving to a new home, making a large purchase, accepting treatment for a health issue, or entering into a new relationship. When it came to making this decision, did you know what to do instantly without any additional information, or did you seek to understand the possible repercussions of your decision and discuss it over with people you trust? Chances are you, like most people, gathered information about your options and spoke to someone else before deciding.

This process of decision making is very normal. It's unusual to make big (or even small) decisions without some basic research and consideration, but as a society we tend to take it for granted that people can make decisions this way. For persons

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with certain limitations, such as an intellectual impairment, severe mental illness, or dementia, making decisions may not be so straightforward, yet they often have significant and wide-ranging implications for their lives, including the types of services they receive, who provides them and others that involve limitations on their freedoms.

When people are not able to seek out, understand, weigh-up, and/or retain information fully, their decision making ability, often referred to as their 'capacity' to make a decision, is affected. Historically for people with limited capacity, someone else has either informally assumed or been granted the authority to make decisions for them. This is referred to as 'substitute decision making'. In Scotland, there are several types

of formal substitute decision making, including Power of Attorney, where an attorney or attorneys are appointed by the individual before they lose capacity, and Guardianship, where a guardian or guardians are appointed by the Court when the individual already lacks capacity.

Both are provisions of the Adults with Incapacity (Scotland) Act 2000. In addition, the Mental Health (Care and Treatment) (Scotland) Act 2003 provides for substitute decision making in relation to care and treatment for mental health where a person's ability to do so is deemed to be significantly impaired.

Legislation which facilitates substitute decision making is common around the world, and most countries have 'safeguards' within these laws to protect people from abuse. However, in recent years there has been a push to promote the rights of Disabled people, including their right to make decisions about themselves. This is largely due to the introduction of the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD), which was adopted in 2006. The UNCRPD also reflects increasing evidence that legal 'safeguards' are not sufficiently understood or applied by professionals, often leading to significant infringements of peoples' human rights. For example, a recent Mental Welfare Commission for Scotland report (2021a) found a lack of understanding among professionals about the legal framework for moving adults who lacked capacity from hospital to care homes during the Covid-19 pandemic, and that some of these moves were illegal.

Relatedly, there are concerns about inadequacies with 'capacity assessments' and the degree of subjectivity they afford professional assessors. In response to the UNCRPD and related rights-based activism and advocacy, academics, lawmakers, and practitioners are exploring how supported decision making can enable people to exercise their legal capacity on an equal basis with others by overcoming decision making challenges, moving away from substitute decision making and seeking to ensure their human rights, will and preferences are upheld.

What is supported decision making?

Supported decision making (hereafter SDM) is exactly what it sounds like; it is relying on support from others to make and enact informed decisions. As has been noted above, most people already utilise some degree of support to make decisions, but people with certain limitations require more specific and tailored support to achieve this.

In addition to human rights imperatives, the drive to formalise SDM is informed by the social model of disability and the feminist critique of

individualism (Dixon and colleagues, 2022). The social model of disability is the simple idea that a person's individual impairment is not what disables them, rather it is structures within society which present barriers to their differences (Oliver, 2013). When viewing issues through the lens of the social model rather than the medical/individual model, the focus shifts away from the individual's impairments and on to adapting the social environment as a means of promoting equality. Framed in this way, in SDM, the primary focus of state and professional activity is enabling the person to exercise their rights, will and preferences. This requires a wholesale shift from the current focus on assessing levels of impairment or incapacity and 'looking beyond human rights simply in terms of limiting unwarranted interventions to the proactive removal of obstacles to full rights enjoyment and the creation of environments that respect and support such enjoyment' (Stavert, 2021, p1).

SDM can look different in different contexts, but the general guiding principles are the same. The aim of SDM is to 'help [the person] understand the situations and choices they face so they may make their own informed decisions' (Blanck and Martinis, 2015, p26). This ultimately helps to promote the person's autonomy and upholds their right to self-determination. In contrast,

substitute decision making has been criticised for cancelling rights and enforcing paternalistic control, particularly when it is 'plenary', which means without any limitations (Arstein-Kerslake, 2016; Shogren, 2017). Additionally, SDM is distinct from 'shared decision making' in helping contexts because of its emphasis on shifting power from professionals to service users (Kokanović and colleagues, 2018).

In jurisdictions that endorse human rights, such as the countries of the UK, it may seem obvious that upholding a person's rights is preferable to cancelling them. So why, then, is SDM being discussed at all, rather than having already been implemented as the norm? Despite general agreement about the merits of SDM, the questions of if/when/how to implement it in practice remain contentious (Davidson and colleagues, 2015).

This *Insight* will provide an overview of the policy and legislative background to SDM as well as the changing landscape in Scotland and globally. It will then provide a brief summary of research evidence looking at how SDM may be approached within three key areas of intellectual impairment, mental health, and older age/dementia. Finally, implications for current and future social work practice are explored.

The policy and legal context

While SDM is a relatively new concept, it is already reshaping policy and legislation around the world. SDM is a tool which gives effect to a person's 'legal capacity', or the right to hold and exercise legal agency. This is an important concept that is often confused with 'mental capacity', which refers specifically to someone's 'functional decision-making ability' (Harding and Taşcıoğlu, 2018, p2). SDM in policy and legislation is aimed at protecting a person's legal capacity, even where there are limitations on their mental capacity.

Much of the recent legislation in this area is informed by two international treaties which uphold the rights of Disabled people – the European Convention on Human Rights (ECHR) and, particularly, the United Nations Convention on the Rights of Persons with Disabilities (UNCRPD).

The ECHR dates back to 1953 and has helped shape policy and law formation in Europe since that time. In

Scotland, the law states that the rights protected by ECHR must be reflected in any devolved legislation. This includes Article 5 (the right to liberty) and Article 8 (the right to private and family life), among others. While the ECHR does not explicitly protect a person's legal capacity, the principles of rights and equality provided many of the building blocks for subsequent legislation for Disabled people.

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Following on from the ECHR, the UNCRPD, is an international human rights treaty which aims to protect the rights for all Disabled people. Since it was first adopted in 2006, it has gained 186 ratifications, representing broad agreement from the vast majority of

UN member states. Unlike the ECHR, Article 12 of the UNCRPD (2006) explicitly recognises the right of all Disabled people to hold and exercise legal capacity on an equal basis with others, ie, regardless of the type or extent of disability or impairment, which is the first time this right has been made unequivocal. Further to this, General Comment No. 1

of the UN Committee on the Rights of Persons with Disabilities calls for the revocation of all substitute-decision making and the implementation of SDM alternatives. This 'paradigm shift' is influencing policy around the world, however no countries have fully eliminated the practice of substitute decision making and commentators argue that this is unlikely to be achieved (Kokanović and colleagues, 2018).

While the UK is party to the UNCRPD, legislation related to capacity, mental health treatment, and safeguarding does not yet align fully with the requirements as outlined by the UNCRPD Committee. Despite this, most of the laws in the UK rest on similar principles to those endorsed by the international treaties mentioned, although the specific approach taken and degree of alignment varies. In England and Wales, the Mental Capacity Act (2005) and the Mental Health Act (2007) dictate the parameters of professional intervention for those with mental impairment. The Mental Capacity Act (2005) provides the basis for assessing mental capacity and is built on five key principles, including the presumption of capacity and the need to support people to make their own decisions. And while this would appear to endorse SDM in all contexts, there is evidence that practitioners still default to the 'best

interest' principle and substitute decision making for large and complex decisions (Harding and Tascioglu, 2018). The Mental Health Act (2007) provides mechanisms for, and is still most often used for, providing compulsory treatment in hospital and the community (Davidson and colleagues, 2016).

Unlike England, Wales and Scotland, the recently implemented Mental Capacity Act (Northern Ireland) 2016 combines capacity law and mental health law using a 'fusion approach' (Campbell and colleagues, 2018). And while this Act still includes mechanisms for the deprivation of liberty and some other restrictive processes, it provides explicit instruction to offer all support necessary before utilising any substitute measures.

In Scotland, both the Adults with Incapacity (Scotland) Act 2000 and the Mental Health (Care and Treatment) (Scotland) Act 2003 were written and introduced prior to the UNCRPD; they do not provide an explicit presumption of legal capacity, but the underlying principles provide a great deal of recognition and protection for people to make their own choices regarding their lives. Similarly, there is no explicit requirement to utilise SDM before resorting to

substitute measures, although the in-built principles provide a clear opportunity for this and there is an evident direction in practice guidance toward SDM (Mental Welfare Commission for Scotland, 2021b). The impact of the UNCRPD and the need for change can be seen in the recent review of mental health legislation in Scotland, whose proposals place SDM at the centre of a human rights approach and recognise the necessity of embedding it in professional health and social care practice (Scottish Mental Health Law Review, 2022).

Further afield, some countries have already reformed their laws to align more fully with the UNCRPD. While legislation exists that endorses SDM as an alternative to substitute measures in Canada (Browning and colleagues, 2020), Ireland (Donnelly, 2019), and Australia (Campbell and colleagues, 2018), many point out that further reform and evaluation is badly needed (Arstein-Kerslake, 2016; Callus, 2018).

Supported decision making: intellectual impairment

There are many ways that SDM can be utilised for all Disabled people, including those with intellectual impairment. This demographic is wide ranging and

therefore has a variety of support needs, however there are some common themes which help to guide practice.

Shogren and colleagues (2017) completed a review of literature on SDM and included a thorough synopsis of some of the themes identified for working with Disabled persons with intellectual impairment. Their review identified that for this population, the relationship with the support provider was especially critical as it was shown to influence decisions. This was particularly noted where families of these individuals placed a greater emphasis on risk and protection, rather than on opportunities to take risks (Shogren and colleagues, 2017). Additionally, the authors discovered that Disabled persons with intellectual impairments were given more support for decision making when in community-based settings, as opposed to institutional care settings. Finally, the review evidenced that utilising a specific decision making aide helped significantly to increase their participation and engagement.

In Webb and colleagues' (2020) study with 41 Disabled adults with intellectual impairment and/or mental health problems, participants identified the positive impact of being able to make decisions

for their sense of self and agency. Without support, however, the decision making experience could feel abstract and difficult, provoking fear related to not knowing 'how' to make a decision or of making the wrong one, and confusion when a quick decision was called for. The study underlined the requirement for tailored approaches to SDM to suit different needs but identified the main factors found to support decision making as: ensuring there is enough time; practical help, including having matters explained sufficiently and offered in accessible formats; emotional support; and having a range of options provided.

Because the support needs of Disabled people with intellectual impairment may be more static than those with poor mental health or dementia, there is a particular emphasis here on developing practical tools and theoretical models for implementation. One tangible decision making aide, Talking Mats, originated in Scotland but is now used around the globe. Talking Mats is a tool that utilises specially designed visual images to gain a better understanding of a person's views. Talking Mats has been shown to improve the quantity and quality of information communicated when used effectively with those with intellectual impairment (Murphy and Cameron, 2008).

Another example of a common SDM practice model is a 'support circle', which sees family, friends, or other close relations working to support individuals to make their own decisions (Devi, 2013). A support circle should ideally know the individual well and have a sense of their history, their communication style, and their general desires; they can help the person to understand information, communicate their wishes, and enact their decisions (Devi, 2013). In addition, the past decade has seen a growth internationally in the development of legally mandated and informal roles to support decision makers, with research highlighting the importance of providing education to facilitate effective and culturally sensitive SDM (Kileen, 2016). In their study with Disabled adults and their nominated supporters, Then and colleagues, (2022) found increased confidence and autonomy in the adults' decision making over time, together with a greater willingness for supporters to step-back from decision making and to seek more opportunities for the adult to participate. Alongside these formally nominated supported roles are found important contributions by independent advocacy workers. This includes 'non-instructed advocacy', where the advocate seeks to uphold the person's rights and wishes when they are unable to give a clear indication of their views (The Scottish Independent Advocacy Alliance, 2009).

Despite the apparent push to create and implement models and tools of SDM for Disabled persons with intellectual impairment, it has been noted that there remains a dearth of empirical research in this area (Webb and colleagues, 2020) which creates a risk that strategies employed could result in unintended harm (Kohn and Blumenthal, 2014). Areas for further exploration include SDM with people with ‘severe or profound’ intellectual impairment, with recent research highlighting the importance of relational approaches when planning life transitions for people in this demographic (Jacobs, 2021). In addition, Laurens and colleagues (2021) point to other intersectional factors, such as gender and cultural diversity, that need to be considered in order to address power differentials in how people are enabled to express autonomy over their lives.

Supported decision making: mental health

The challenges of achieving effective SDM in mental health contexts may be particularly marked, when considering the impact mental health symptoms can have on people’s insight related to care and medical treatment, and how this may fluctuate

in response to levels of mental distress/illness. Penzenstadler and colleagues (2020) cite the example of eating disorders, where skewed views about weight together with cognitive impairment caused by lack of nutrition directly impact decision making capacity. The experience of fluctuating capacity can also be exacerbated by factors such as substance use, potentially making SDM more difficult. In addition, concerns about risk to the person or others often necessitate making quick decisions, a process that does not lend itself to SDM. Like other care groups, however, the critical factor appears to be building trusting relationships. In their study with 90 mental health service users, family members and professionals, Kokanović and colleagues (2018) found that communication skills, empathy and attitudes among clinicians were key. Likewise, Knight and colleagues (2018, p2002) saw SDM as dependent upon ‘sharing information and working toward consensus about treatment and life decisions’. In their study with 29 individuals diagnosed with a mental illness, they note that best practice in SDM doesn’t guarantee service user engagement, which may be disrupted by histories of mistrust, but that a fundamental starting point is to understand the individual’s unique perspective

or ‘narrative position’ about SDM. They identified a range of narrative positions adopted by participants, ie, how they expect to be interacted with and supported by professionals. From one position, self-reliance and the degree to which clinicians showed respect to them as ‘experts by experience’ was key. In contrast, from another position, medical expertise and attention were seen as crucial and likened to ‘being rescued’, and fear was associated with this being taken away. A third position saw personal autonomy and support from others as equally valid, whereas a fourth placed emphasis on the social dimensions of illness and was more likely to accept interventions that promoted social inclusion and citizenship. The study found that people’s narrative positions weren’t fixed and changed in line with factors such as degree of illness/wellness. The authors conclude that effective SDM is predicated on the professional getting to know the individual’s standpoint and adapting their approach to communication and support accordingly.

Effective SDM is predicated on the professional getting to know the individual’s standpoint and adapting their approach accordingly

Theoretically, SDM is aligned with concepts of ‘recovery’ and ‘citizenship’ in mental health, in which helping efforts are directed at facilitating the person’s engagement in support of their rights, will and preferences (Minkowitz, 2006). Key approaches include planning tools such as Wellness Recovery Action Plans (WRAPs) which enable the individual to explore and record in detail how they wish to

live, and the kind of supports they wish to have in place (Knight and colleague, 2018). Relatedly, ‘advance directives’ (ADs), such as an ‘advance statement’ under the Mental Health (Care and Treatment) (Scotland) Act 2003, provide means of stipulating the types of treatments given during periods of illness. Criticisms of

ADs relate to the degree to which medical opinion may override the person’s views. While this is recognised as a difficult balancing act, there is a discernible trend towards strengthening the effects of ADs in the reform of mental health legislation in recognition of their importance for SDM (Department of Health, Victoria State Government, 2021; Mental Welfare Commission

for Scotland, 2019; Kokanović and colleagues, 2018) by including both treatment related options and personal support choices (Lenagh-Glue and colleagues, 2022). Lenagh-Glue and colleagues' (2022) project developed a new AD called a 'Mental-health Advance Preferences Statement' highlighting the importance of the right support, prominently flagging it to clinicians and overcoming apathy among users and clinicians by identifying champions to promote it.

Nominated persons arrangements, including power of attorney, as well as advocacy schemes, including peer advocacy (Penzenstadler and colleagues, 2020) feature increasingly in mental health legislation as ways of supporting decision-making. Advocacy schemes show potential to avoid 'risk aversion' and 'best interests' recommendations by professionals and families (Simmons and Gooding, 2017). Penzenstadler and colleagues (2020), however, note the potential for 'undue coercive influence' to shape any support for decision making. There has also been growing interest in more collaborative approaches to SDM, including Family Group Decision-Making (FGDM) (also known as Family Group Conferencing) which shares features with the above-mentioned circles of support and in which the 'resources' of the individual's family

and social network are marshalled to give effect to the person's will and preferences. While the research evidence for FGDM in adult mental health context is small, it does illustrate its ability to equalise power differentials and to arrive at decisions and outcomes that support adults' autonomy (de Jong, Schout and Abma, 2018; de Jong and Schout, 2011). Relatedly, there is a growing body of research on 'Open Dialogue' in mental health, which originated in Finland and is described as 'a consistent family and social network approach where all treatment is carried out via a whole system / network meeting, which always include the patient' (NELFT NHS Foundation Trust, 2022 [online]). There is good research evidence for its effectiveness, with a recent NHS study concluding, 'participants experienced unique therapeutic benefits when engaging with the open dialogue service', which was facilitated by qualities of 'openness, inclusivity and mutuality' (Hendy and Person, 2020, p101).

Supported decision making: older age and dementia

Providing support for decision making is challenging in every context, but it may be especially complex when it comes to supporting those in later life.

The global population is ageing at a rapid pace (WHO, 2022), and societies around the world are scrambling as they attempt to adjust to the complex needs of this shifting demographic. Older age presents a number of challenges to services, including a higher prevalence of multi-morbidity and dementia.

Dementia is an umbrella term to describe a group of symptoms including memory loss, confusion, and changes to understanding and behaviour (Alzheimer's Scotland, 2022). Dementia is not a normal part of the ageing process, but it is more prevalent for people over the age of 65 (Alzheimer's Scotland, 2022); albeit it can also affect people in younger age groups. Dementia can be a devastating disorder for individuals and families; among many other things, it impairs someone's capacity to make their own decisions in areas where they previously had full autonomy. In these cases, many jurisdictions, including Scotland, rely on pre-appointed substitute decision making in the form of Power of Attorney, or where this is not in place prior to losing capacity to make specific decisions, a Guardianship Order.

Given the prevalence of substitute decision making for people with dementia, there is growing interest

in developing SDM practice frameworks. However, this area is not well researched (Sinclair and colleagues, 2018) and the challenges of SDM with this demographic are different than in other areas. One of the unique challenges of supporting those with dementia is that prior to the onset of the condition they will have formed set views informed by their moral, political, and social perspectives (Donnelly, 2019). And while these previous views can and should be taken into consideration (Dixon and colleagues, 2022), they may be at odds with the person's expressed wishes following the onset of dementia. When this occurs, it becomes difficult to navigate which views to honour, particularly as the UNCRPD Committee seems to emphasise 'the prioritisation at all points of a person's immediately identifiable wishes and feelings' (Ruck Keene and colleagues., 2017, p 138). Dixon and colleagues (2022) point out this is especially problematic where such decisions are placing the individual at risk and safeguarding is necessary. Szmulker (2017) offers the concept of 'subjective best interests', as a way through, based on the premise that a person's will and preferences that have been established over a long period of time are a more reliable guide than those seen to be more transient.

So, what does the limited research base say about how SDM may be provided to those with dementia? Wied and colleagues (2019) conducted a systematic review of existing literature and identified only 11 studies which looked specifically at this question. The review indicated that modifying information to increase understanding and the application of support tools could be successful strategies (Wied and colleagues, 2019). One tool, DecideGuide, was specifically designed to support those with dementia and their wider networks with decision making in the Netherlands and has been received favourably so far by users (Span and colleagues, 2015). Scotland's Talking Mats, as described above, has also been evidenced as an effective tool for supporting those with dementia (Murphy and colleagues, 2010).

As an alternative to practical tools for simplifying information or collecting a person's views, some have proposed a 'spectrum approach' for people living with dementia, which aims to maintain the individual's involvement wherever possible, but allows for an increasing amount of support and eventual representation as cognitive impairment progresses (Sinclair and colleagues, 2018). This flexible model was devised after those living with dementia and their

families described the relational nature of decision making in the context of a progressive illness, rather than viewing it as a solely individual responsibility (Sinclair and colleagues, 2018). Writing in the context of safeguarding adults with dementia, Dixon and colleagues (2022) propose an holistic approach to SDM, which includes a focus on providing clear and accessible communication, being flexible with timescales and building effective relationships. These themes are echoed in Donnelly and colleagues' (2021) study with health and social care professionals in acute hospital, which identified enablers and barriers to SDM with older people with dementia, including: building meaningful engagement with the person and their family, including ensuring the older person's attendance at family/professional meetings; effective interprofessional collaboration, which require culture shifts in knowledge about SDM; and addressing the ward environment, in particular, providing quiet and private spaces to facilitate communication.

Looking ahead

The view expressed by people living with dementia that decision making is a relational and shared process brings us full circle to the original point

about decision making – it is very rarely an isolated process for most of us. This highlights one of the many debates around SDM and its implementation. While there is broad agreement that the ‘traditional’ approach to substitute decision making should be challenged and that legal capacity should be presumed, there is concern about the practicalities and ethical implications involved in prioritising an individual’s will and preferences above all else. Many have raised that this could place vulnerable individuals at risk of harm, and others have noted that there will inevitably be situations where it is not possible to ascertain someone’s desires at all. Nonetheless, SDM holds the potential to make the paradigm shift sought by the UNCRPD happen; a shift from achieving ‘protection’ by restricting a person’s autonomy to make decisions, towards the protection of their human rights, which necessitates a more enabling approach.

When it comes to working out these ethical and practical dilemmas, social workers have a critical voice. Social workers are faced with complex and difficult decisions regularly; it is part of their values and skillset to manage competing demands, assess risks, and uphold the law, all while promoting the rights of individuals. As practitioners, they will be

familiar with the tensions presented ‘in the real world’ and can offer valuable ideas for navigating such dilemmas. They are also orientated as a professional group to the social model of disability, on which SDM is founded. Social workers, therefore, should not shy away from engaging with these critical debates, particularly as so many laws and policies involving SDM are currently being formulated and therefore may be shaped by social work perspectives. As indicated, this includes the recommendations of the Scottish Mental Health Law Review, which place SDM at the centre of transforming current legislation relating to mental health, capacity and adult safeguarding so that they become human rights compliant (Scottish Mental Health Law Review, 2022). However, the Scottish Mental Health Law Review and the broader literature recognise that as well as additional empirical research, social workers and health professionals need dedicated training on SDM. This is required to enable them to deepen knowledge of its nuances, such as how it differs from shared decision making, and to adopt approaches that are congruent with principles of respect for autonomy and can stand up to the competing resource and time constraints of frontline practice (Knight and colleagues, 2018).

Conclusion

SDM has become a core organising concept for the objective of upholding people's legal capacity and honouring their will and preferences. It is key to large-scale reform of national and international law on mental health and capacity, driven by recognition that current statutes and policies are too deficit-based and aligned with substitute decision making principles and frameworks. SDM comprises a series of models, tools and practices designed to maximise a person's understanding about the decisions they need to make, and to give effect to their views and wishes. These include communication aids and approaches (eg support circles, 'open dialogue', family group decision making, Talking Mats, etc) advance directives, informal and legally mandated supporters, among others. SDM should be tailored to a person's specific needs and circumstances, including factors that affect their health and development. This *Insight* has provided an overview of legal and policy developments, and research in SDM in relation to people with intellectual impairment, mental health problems and dementia. It has identified that SDM is complex and necessitates navigating ethical, professional

knowledge and skills, and resourcing barriers. It has, however, established that building effective relationships is at the heart of SDM and that decision making is an inherently relational process; it therefore takes time and is built on trust. This summary finds that SDM aligns with the social work profession's social model perspective and social workers are ideally placed in terms of values, knowledge and skills to lead in the development of progressive SDM initiatives, in line with recommendations regarding law reform (Scottish Mental Health Law Review, 2022). It also concludes that significantly more empirical research is needed into what effective SDM looks like, as well as educational and training schemes to embed SDM in professional social work and interprofessional practice.

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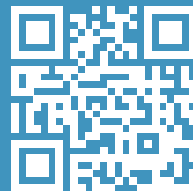
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Lauren Gillespie is a registered social worker and PhD student at the University of Edinburgh. Lauren practised in adult care and justice settings before starting her PhD, which is exploring supported decision making in care transitions with older adults who lack capacity and is funded by the University's Advanced Care and Research Centre. This study aims to add to the research evidence on SDM and provide insight into how it might be facilitated in the context of practice challenges.

Dr Pearse McCusker is a registered social worker and Senior Lecturer in Social Work at the University of Edinburgh. His teaching and research focuses on mental health, including the ethical use of mental health, capacity and safeguarding legislation, and ways of improving mental health and wellbeing, such as mindfulness. He also explores initiatives to improve opportunities for practitioner-based research and develop participatory methodologies to increase involvement in research and education for people with lived experience.



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