PROFESSIONS & PROFESSIONALISM

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Patient Centered Professionalism? Patient Participation in Dutch Mental Health Professional Frameworks

Abstract: Patient participation is an important development in Dutch mental health care. Notwithstanding a generally positive attitude towards patient participation, mental health professionals show ambivalent responses to it due to tensions that may occur between professional values and societal values like (more) patient participation. Professionals vary in their degree of professionalization which is translated to their formal professional frameworks like professional profiles and codes of conduct. To explore how formal professional frameworks of mental health professionals mirror how and to what degree they accommodate patient participation the professional frameworks of four types of mental health care professionals were studied: psychiatrists, psychologists, nurses, and social workers. We hypothesized that the higher professionalized professions were less open to patient participation. The results partly support this hypothesis. Professional frameworks of social workers and nurses indeed show more openness to patient participation, but the picture for psychiatrists and psychologists is ambiguous—more professionalized psychiatrists being more inclined to incorporate patient participation than less professionalized psychologists.

Keywords: Mental health care, professionalization, occupational attitude, patient participation, Netherlands

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Professions are sometimes seen as beacons of stability who will adhere to their professional values no matter the circumstances. Crime may rise and fall, but defense lawyers will take an oath to defend their clients to the best of their abilities. Health care costs may rise to an all-time high, but doctors will devote themselves to their patients' health no matter what. Nevertheless, authors also sometimes argue that professions should become more flexible, acknowledge the contradictory values in their surrounding environment and adapt their professional habitus to accommodate them. They should, for example, help the government fight crime or cut health care costs. Such contradictory values, however, can cause tensions for professions, having to accommodate societal demands and to balance these with their professional norms and values. In the beautiful words of the oncologist Lucien Israel (1982, pp. 99-100):

> As a private citizen, I am aware of the pressing economic issues connected to finite resources.… Apparently, contradictory values do exist, and balancing them is the art of governing. As a citizen, I use my vote to express my choice, and as a witness to history, I deplore human society's orientation toward the welfare state.

> As a doctor, however, I am lock, stock, and barrel behind those who want a longer life.… In the future, some politicians or administrators may have the power to reduce my clinical budget. But they will never get me to do it for them. I hope that all physicians will do the same, to preserve what is essential, their status as a human resource against sickness, the avatar of fate.

In this article, we will look at the way different health care professions balance societal demands with their professional values. We have chosen one specific and important societal development in health care—enhanced patient participation, which will be introduced in the next section. Our research was done in the Netherlands, and we have chosen four professions in the field of mental health varying from strongly professionalized psychiatry to far less professionalized social work to answer the following research question: How do professions in mental health care with different degrees of professionalization accommodate patient participation?

We introduce existing theory about professions and professionalism and discuss what is known about the way in which different professions respond to societal demands. Following that, we introduce patient participation and professionalism in our chosen case—mental health care in the Netherlands. In the next two sections we explain our chosen methodology and present our findings. In the final section we answer our research question and discuss the merits and limitations of our research.

Patient participation

As in most Western countries, patient participation and user involvement have become very fashionable in Dutch health care (Dedding & Slager, 2013; Lang, Gühne, Riedel-Heller & Becker, 2015; Raad voor de Volksgezondheid en Zorg [RVZ], 2013; Vennik, Van de Bovenkamp, Grit & Putters, 2015; Vollaard, Van de Bovenkamp & Vrangbaek, 2013). Patient participation is sought at various levels in the health care domain. Patients (or patient representatives) are asked to co-design policy at the macro level (Van de Bovenkamp, Vollaard, Trappenburg & Grit, 2013), to co-create medical guidelines and hospital policy at the meso level of organizations (Van de Bovenkamp & Trappenburg, 2009; Van de Bovenkamp & Zuiderent-Jerak, 2015; Vennik et al., 2015) and to engage in shared decision making at the micro level of doctor-patient contacts. Patient participation is taken to improve the quality of care and to be just from a democratic perspective.

Research has shown that patient participation in practice is far from ideal and continues to be a subject of debate. Participation requires time and energy both of which are scarce for people with serious health problems (Trappenburg, 2008; Van Staa, 2012). Including patients' preferences based on anecdotes and personal impressions in medical guidelines sits uneasily with evidence-based medicine (Van de Bovenkamp & Trappenburg, 2009; Van de Bovenkamp & Zuiderent-Jerak, 2015). Patient-representatives experience a marked tension between being taken seriously by other stakeholders and resembling ordinary patients. Following courses in research or "expert participation" contributes to the first aspect while diminishing the latter (Trappenburg, 2008). In addition, authors sometimes find that patients are being used by policy makers, health insurers or pharmaceutical companies who "play the user card," announcing that their chosen course of action is right because it has been approved by patients. Professionals sometimes argue that putting the patient's interest first has always been a guiding principle in their work (Trappenburg, 2008). Thus, while there are good reasons to strive for patient participation, there are also valid reasons to be much more reluctant to accommodate this trend. In this article we take a neutral position towards the enhanced demand for patient participation,

considering it a given phenomenon in health care, and we focus on the way professions handle it.

Professions and societal pressures

Defining professionalism

Professions are generally assumed to possess three defining characteristics: specialized knowledge, a service ideal, and professional autonomy (Evetts, 2003; Freidson, 2001; Wilensky, 1964). The work of professionals is based on highly specialized knowledge, achieved after years of higher education and vocational training. The goal of the profession is always a (public) service ideal—educating young people, providing fair justice, curing the sick. There is a set of professional institutions such as a professional association with its "esprit de corps," professional profile, professional code, and disciplinary board. Access to the profession is legally protected and regulated through formal registration and membership of the professional association. There is, in other words, professional control, including both content and institutional control (Noordegraaf, 2007). Finally, in daily practice, professionals have considerable discretion in the execution of their jobs. This discretionary authority implies a moral responsibility, hence the importance of professional codes of conduct.

Changes in health care professionalism

These defining characteristics of professions may be challenged due to social developments like increasing managerialism in public services, growing bureaucracy, new technologies, distribution of knowledge, and democratization (Evetts, 2003; Noordegraaf & Steijn, 2013). Dwarswaard, Hilhorst and Trappenburg (2009) studied the way general practitioners and surgeons respond to changing patient demands as a result of patients' higher education and better access to information. They conclude that, in the Netherlands, general practitioners adapted much more quickly to patients' demands than surgeons.

Rogowski (2011), Younghusband (1973) and Spierts (2014) studied social work as a profession. All of them argue that social work is much less professionalized than medicine, first and foremost because it lacks a specialized body of knowledge. Hence social work is more inclined to accommodate societal demands. Social workers in the nineteen fifties tried to help clients adjust to societal norms whereas their colleagues in the late sixties and seventies climbed the barricades to change society rather than their clients. The new public management era thereafter forced social workers to register their every move and find business models for their tasks. Social workers adjusted to each of these new demands.

From these studies we may carefully conclude that the more professionalized a profession is—surgery is generally seen as a profession *par excellence* whilst general practitioners struggled for years to find their own niche once more medical specialties developed—the more it will be inclined to adhere to its traditional professional autonomy and moral code.

Adapting to societal demands

Scientists differ in their opinions on how and to what degree professions should accommodate societal demands. Researchers studied the effects of a market ideology on professions, arguing that having to face market competition might make profes-

sionals give up their service ideal (e.g. patient's health) trading it for consumer preferences. Krizova (2008) theorizes about a decline of professional autonomy due to marketization. Professional autonomy used to be in the patient's best interest; hence a decline might cause "a decrease in altruistic or service-oriented attitudes toward patients" (Groenewoud & Dwarswaard, 2007; Krizova, 2008, p. 111). Inspired by the late Elliott Freidson, these authors feel that professions should be careful to adapt to political or societal demands for fear that supreme professional values might get lost in the process.

On the other hand, there are also authors who argue that professions and professionals should not see themselves as isolated from society and its ever changing and developing values and demands (Allsop et al., 2009; Evetts, 2011; Noordegraaf, 2007; Noordegraaf & Steijn, 2013; Trommel, 2006). They state that professions should develop their professional skills and standards in ways that maintain certain occupational autonomies and values but at the same time adapt to societal expectations and changing values (Noordegraaf & Steijn, 2013). Subsequently, these authors observe that there are many societal changes: People are becoming more highly educated, society is more individualized, computer technology is expanding, women's participation in the labor market is growing, state authorities are in transition from government to governance. New societal demands cannot be ignored, so the best way forward is to adjust. Professional services need to be "reconfigured" and "reshaped" (Noordegraaf & Steijn, 2013, p. 235).

The above-mentioned studies and discussions demonstrate that accommodation to societal demands may cause tensions and dilemmas for professions because it may force them to handle competing or conflicting values. In this article, we focus on the tensions that may rise from accommodating patient participation, for example, the tension between patient autonomy and professional autonomy. We present a comparative study of four professions in mental health care varying from psychiatry (highly professionalized medical doctors) to psychology, to mental health nursing and social work (semi-professionalized). Following up on the findings of Dwarswaard et al. (2009), Rogowski (2011), Younghusband (1973) and Spiers (2014), we hypothesize that the more professionalized of these professions will be more adherent to classic professional values like professional autonomy than the less professionalized ones, and thus give less room to patient participation.

We studied formal professional frameworks[1] of four mental health care professions. These frameworks mirror the professional norms and values of a given profession and therefore can be used as an indication how these different professional groups respond to patient participation.

Patient participation and mental health professionals

Patient participation in (Dutch) mental health care

Patient involvement in mental health care is rooted in the widespread anti-psychiatry movement in the nineteen seventies (Hunt & Resnick, 2015; Oosterhuis & Gijswijt-Hofstra, 2008; Van Dijkum & Henkelman, 2010). The influence of this movement is still visible in patient organizations nowadays, especially in the plea for patient empowerment, recovery-oriented care, and the direct use of patient experience in mental health care. Many Dutch mental health care organizations have an explicit policy to involve "experience experts" in treatment and care, a booming

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[1] Formal documents, drafted by professional associations that describe and prescribe goals, responsibilities, values, and rules of conduct of professions such as professional profiles and codes of conduct.

development during the last 20 years (Boertien & Van Bakel, 2012; Karbouniaris & Brettschneider, 2008; Storm & Edwards, 2013; Van Haaster, Hidajatoellah, Knooren & Wilken, 2009). (Ex)patients are actively involved in the development of care programs, in the practical execution of care and in training mental health professionals. Patient organizations are involved in developing and evaluating health care policy and research (Dedding & Slager, 2013; RVZ, 2013; Van Dijkum & Henkelman, 2010). At the organizational level, legally based patient councils have advisory rights on issues that relate to patient care and patients increasingly have an active role in measuring and evaluating the quality of care.

By contrast, at the level of individual treatment relationships patient participation is not widely practiced in mental health care (Angell & Bolden, 2015; De las Cuevas & Peñate, 2014). Shared Decision Making[2] in psychiatric care has led to discussions, specifically considering the decisional capacity of patients in view of their mental disease (Angell & Bolden, 2015; Haman et al., 2009; Zijlstra & Goossensen, 2007).

Responses of mental health professionals

Professionals in mental health care have ambivalent responses toward patient participation. Oosterhuis and Gijswijt-Hofstra (2008, p. 754) point out that the Dutch professional association of psychiatrists (Nederlandse Vereniging voor Psychiatrie [NVvP]) in the nineteen sixties and seventies, when psychiatrists were confronted with assertiveness and even resistance of patients, did not take a clear stance towards the issue because of different opinions among its members. Angell and Bolden (2015) found that psychiatrists in the US find it difficult to combine their professional considerations and patients' wishes in decisions on medication. Storm and Edwards (2013) collected empirical research on patient-centered care in the US, the UK, and Scandinavian countries and conclude that notwithstanding the general enthusiasm for user involvement, there are concerns regarding the implementation, sometimes directly related to the capacities or attitudes of professionals:

> What evidence there is indicates tensions between patients' and providers' perspectives on treatment and care.… Lack of competence and awareness among providers are further issues … difficulties when patients' views are different and challenge staff judgments of proper aims. (Storm & Edwards, 2013, pp. 313, 322)

They refer to Larsen (2009) who suggests that mental health professionals face an ambiguous role; while policies call for more user involvement, their daily work seems to be influenced by the understanding that professionals have the expertise and know what patients' best interests are (Storm & Edwards, 2013, p. 322).

Four types of mental health professionals

Mental health care professionals come in varieties, with different levels of education and different degrees of professionalization. We try to link openness to the development of patient participation to the degree of professionalization of four professions in mental health care as mentioned above.

Based on the criteria discussed before *psychiatrists* can be ranked as having the highest degree of professionalization, being medical doctors and therefore belonging to one of the classical professions. It takes more than ten years of academic education and vocational training to become a psychiatrist. To exercise the profession one has

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[2] A methodical approach that enables patient and professional to decide jointly on the applied treatment and care.

to be registered in the Dutch BIG-register[3]. The professional association—the Nederlandse Vereniging voor Psychiatrie [NVvP]—plays an influential role in development and policy in mental health care. It has its own disciplinary board and sets professional standards through a variety of activities assessing the quality of care, accreditation of professionals and postgraduate training.

Like psychiatrists, *psychologists* working in health care need to register in the BIG-register. Professional titles vary: general psychologist, psychotherapist, health care psychologist or clinical psychologist. There are several professional organizations for psychologists of which the Nederlands Instituut van Psychologen [NIP] is the most important. This organization represents all types of psychologists, not just the ones working in (mental) health care. In this study, we focus on health care psychologists and (more specialized) clinical psychologists, who received respectively two and six years of academic education and vocational training after finishing their master degree in psychology. These are the two most important professional groups of psychologists working in mental health care. Considering these characteristics the degree of professionalization of psychologists is quite high, albeit lower than that of psychiatrists.

The degree of professionalization of specialized *mental health nurses* is lower but still considerable—at least four years of training and education at bachelor level. Because nurses are qualified to perform medical procedures, they have to meet certain regulatory requirements and are also obliged to be BIG-registered. Nurses form a strongly organized but at the same time strongly differentiated profession. In the Netherlands, nursing studies range from a four-year program in secondary vocational education to master programs at universities of applied sciences. Professional titles, specializations, and qualifications vary similarly. Consequently, there are many different professional organizations each with their own specific professional profile and other professional frameworks. Recently steps have been made towards less fragmentation: A code of conduct for nurses, endorsed by all Dutch nursing associations, has been published in January 2015 (CGMV et al., 2015).

Finally, *social workers* in mental health care can be classified as having the lowest degree of professionalization. They are educated at universities of applied sciences in a four-year bachelor program. Specialization and further education is possible but not compulsory by following a master's in social work. Social workers are not BIG-registered. There used to be a professional organization for social workers in mental health care called Phorza founded in 2005 (Phorza, Beroepsvereniging voor sociaal-agogische professionals [Phorza], 2009). In 2011, due to insufficient members, it merged into the general professional association for social workers, the Nederlandse Vereniging voor Maatschappelijk Werk [NVMW]. The NVMW has a professional register and disciplinary system, a professional profile for social workers in general (Nederlandse Vereniging voor Maatschappelijk Werk [NVMW], 2011) and several professional codes tailored to specific types of social workers (e.g. working with youth or with mental health patients). The register and disciplinary code are, however, initiatives taken by the NVMW itself and not legally prescribed. In 2009 Phorza drew up a specific professional code for social workers in mental health care (Phorza, 2009) which was adopted by the NVMW and is still applicable.

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[3] Register Beroepen in de Gezondheidszorg: the BIG-register administers the registration of health care professionals in the Netherlands on behalf of the Ministry of Health, Welfare and Sport.

Methodology

As mentioned above, the objects of our study are professional frameworks for psychiatrists, psychologists, (mental health) nurses and social workers, in which guidelines on the patient-professional relationship are a central theme. The selected documents for our study are professional frameworks drafted and published by the various professional associations, which ensures their authenticity, credibility and representativeness (Scott, 1990; Platt, 1981a). For each profession, the most recent versions of two basic professional frameworks were selected: the professional profile and the code of conduct. This choice was made because these are generally the most determining and important documents used as a basis for professional practice, education and disciplinary procedures. According to Payne and Payne (2004) documents like these can be seen as concrete objects which indirectly mirror the social world of their composers. Therefore they can be considered an indirect but reliable display of applicable values and norms of each profession (although they do not mirror professional practices in their daily reality). From this perspective analyzing these documents can be seen as a valid method contributing to answering our research question. Some adjustments in our selection had to be made:

– There is no code of conduct specifically for health care psychologists; the code of conduct for psychologists, in general, is equally applicable to health care psychologists.
– A specific profile for health care psychologists was not found. Instead, we analyzed a document presenting required competencies for the profession.
– For nurses, we chose to focus on the frameworks developed by the Dutch nursing association that is most influential as to the contents of the profession, Verpleegkundigen en Verzorgenden Nederland [V&VN].
– Since there is no separate profile for social workers in mental health care, we used the general profile for social workers as drafted by the NVMW.
– The analyzed documents are presented in Table 1 as shown below.

Table 1
Selection of formal professional frameworks used in this study

Profession	Type of document
Psychiatrists	Professional profile for psychiatrists (Nederlandse Vereniging voor Psychiatrie [NVvP], 2005)
	Professional code of conduct for psychiatrists (NVvP, 2010)
Psychologists	Professional profile for clinical psychologists (Werkgroep Klinisch psycholoog/klinisch neuropsycholoog, 2013)
	Competence profile for health care psychologists (Werkgroep Modernisering opleiding GZ-psycholoog, 2012)
	Professional code of conduct for psychologists (Nederlands Instituut van Psychologen [NIP], 2015)
Mental health nurses	Professional profile for nurses (Verpleegkundigen & Verzorgenden Nederland [V&VN], 2012a)
	Professional profile for nurses specialized in mental health (V&VN, 2012b)
	New code of conduct for nurses and carers (CGMV et al., 2015)
Social workers	Professional profile for the overall professional group of social workers (NVMW, 2011)
	Professional code of conduct for social workers in mental health (Phorza, 2009)

We conducted a qualitative content analysis using a directed approach (Hsieh & Shannon, 2005). The documents were analyzed by extensively reading the full text, using selective coding based on our theoretical framework.

First, we searched for phrases explicitly referring to patient participation as a significant development in mental health care or to the changing attitude of patients ("the self-assertive patient"). As professional frameworks mainly focus on individual professional practice, most references relate to the micro level of patient participation, although we also searched for references to participation on meso and macro level.

Next, the frameworks were analyzed for their references to a set of sensitizing concepts linked to our hypothesis. During this process, an open eye was kept for emerging concepts that were not identified up front. The first concept was *patient autonomy[4],* operationalized by searching in the documents for these exact words and terms and sentences related to this concept such as "self-determination," "patient rights" or "(in)dependency of the patient." Following that, references to *professional autonomy* were found by screening the documents for these words and terms and sentences related to professionalism, like "responsibility of the professional" or "professional attitude." This way, we determined how professions envision possible tensions between patient participation/patient autonomy on the one hand and professional responsibility/professional autonomy on the other.

Finally, we focused on statements considering *patient influence on decisions* about treatment and care, as well as the balance between the application of professional guidelines and the input of patients. For example, "involving patient actively in the composing treatment plan" or "informing patients sufficiently to be able to give consent." By doing this, we obtained a picture of the extent to which the frameworks stimulate or leave room for patient involvement. Delineations of the different aspects of the professional-patient relationship were also traced.

This approach ensured that possible tensions as described above were made visible. A disadvantage may be the researcher's possible bias limiting reliability; it may be a matter of interpretation whether a certain word or phrase is indeed referring to the selected concepts. We strived to avoid this pitfall by adding citations to provide evidence for our findings (Platt, 1981b).

Results

In Table 2 we present an overview of our findings. Besides our initial concepts of *patient autonomy, professional autonomy* and *patient influence on decisions*, a set of other concepts is included. *Professional responsibility* turned out to be a key concept in all professional frameworks. All profiles describe and prescribe the *relationship* between patient and a professional and pay attention to the *power balance* and the patient's dependent position. Despite these similarities the specific terms and sentences used in the frameworks to describe these issues show interesting differences.

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[4] In several documents, e.g. the frameworks of social workers, the usual term is "client" instead of "patient." For reasons of consistency and readability, we here use "patient" as in the rest of the article, except in quotations.

Table 2
Characteristics of four professions regarding the concepts of analysis

	References to patient participation as development in health care	Patient autonomy and self-determination	Professional autonomy	Professional responsibility	Patient-professional relationship	Patient influence on treatment decisions	Power balance in patient-professional
Psychiatrists	No	Patient autonomy is starting point. Several references. Can be limited due to patient's illness	Outweighs other (e.g. organizational) norms or demands, because of the primacy of the patient-professional relationship.	A highly important theme, considered of even higher importance if patient's illness limits his autonomy.	*Central theme*: described extensively and in detail. Explicitly connected with professional responsibility.	Informed consent regarding the decision on treatment. Limited patient influence on the content of treatment.	An explicit and repeated point of attention; professional should be aware of patient's dependent position.
Psychologists	No	One of the four basic principles in the code of conduct. Scarce references. Can be limited due to conflicting professional responsibilities or patient's illness.	Referred to as "characteristic for the profession."	*Central theme*: One of the four basic principles in the code of conduct and referred to as "the basic principle" for the profession. Frequent references in the text.	Explicit references frequent in the code of conduct ("professional relationship"), scarce or implicit in other documents.	Informed consent regarding start or termination of treatment. Limited patient influence on the content of treatment.	Patient's dependent position is mentioned as point of attention in preamble code of conduct.
Mental health nurses	Explicitly described in the professional profile. Positive and negative aspects are mentioned.	The important principle, to be enhanced by the professional "if possible." Several references. Can be restricted by patient's limited capacities, or other professional responsibilities.	Scarce references, "professional responsibility" is predominant as a concept.	*Central theme*: Described extensively and in detail. Explicitly connected with patient-professional partnership.	Professional works in partnership with the patient.	Patient involved in conducting plan, shared decision making if possible. Patient's perspective is important in decisions.	Several references to equivalence between patient and professional. Patient's dependent position is mentioned once.
Mental health social workers	Shortly described in professional profile. Negative consequences for "vulnerable" patients are mentioned.	*Central theme*: Starting point and goal of the profession is to enhance patient autonomy and self-determination.	Is referred to in negative sense: "Professional autonomy is not always fulfilled."	Scarce explicit references. Professional responsibility is regarding patient and society.	Cooperative and dialogic relationship between patient and professional is central.	Patient and professional have to agree on goals and content of relationship and treatment.	Equivalence between patient and professional is central. Professional dominance or paternalism is sometimes justified.

A first and marked difference comes forward regarding references to "the assertive patient" or the changing role of patients in (mental) health care. The professional frameworks of psychiatrists and psychologists do not refer to the increasing participation of patients in health care whereas the profiles for nurses and social workers do pay explicit attention to this development. This attention is focused on patient participation at the micro level, the relationship between individual patient and professional. Patient participation at meso or macro level is not discussed at all.

We describe our further findings per profession in order to give a clear picture of each professional group.

Psychiatrists

The professional profile for psychiatrists is elaborate on the patient-professional relationship. It discusses in detail the nature of this relationship, dissecting it in three layers: a contract (the patient as a customer), a counseling relationship (the patient as a client), and a relationship focused on the illness (where the word patient fits) (NVvP, 2005, pp. 12-13). It is concluded that the word patient is to be preferred, giving most weight to this aspect of the relationship: "the relationship between patient and psychiatrist is the starting point of the psychiatric treatment" (NVvP, 2010).

Considerable attention is paid to the dependency of the patient and the fact that patients can suffer reduced ability to make judgments:

> Here it is relevant to state that illness in itself can limit the freedom of the patient in his relationship with the doctor.… This aspect puts extra pressure on the doctor's responsibility. First, it implies that duties stemming from the treatment contract and the counseling relationship become even more pressing. Second, it can mean that the doctor sometimes has to act without the patient being able to explicitly voice his will. (NVvP, 2005, p. 13)

The code of conduct initially states that "respect for the autonomy of the patient" should be a guiding principle for psychiatrists. However, this is immediately followed by a comment pointing out that in many cases patients have limited autonomy due to their psychiatric condition. This tension is a recurring issue. It leads to dilemmas of conflicting duties: The psychiatrist should inform the patient about his condition and the proposed treatment, thereby paying attention to the patient's autonomy. However, psychiatrists should also fulfill their duty to cure patients or reduce their suffering, and this might entail measures or activities which are undertaken without the patient's consent. However, even in cases of limited patient autonomy, this should still be a guiding principle that psychiatrists should respect.

A power disbalance in the patient-professional relationship comes forward. In effect, it is the psychiatrist who assesses the degree of patient autonomy. The professional frameworks reflect on the complicated aspects of control and power brought into the relationship:

> Because … the patient's own input can be diminished, simultaneously increasing the doctor's power, the word "patient" is sometimes associated with this kind of power difference as an unwanted aspect of the doctor-patient relationship. However, it is often misunderstood that circumstances following from illness, even more, oblige the doctor to fulfill his duties. (NVvP, 2005, p. 13)

Here the power disbalance is connected directly with enlarged professional responsibility, a principle that is strongly emphasized in the frameworks, much more than professional autonomy. Both principles are connected by stating that the special responsibility of the psychiatrist for the patient should be secured in professional autonomy, which implies that "the physician lets his method of operation and its quality be determined by professional norms as applicable within his profession" (NVvP,

2005, p. 13).

Patient autonomy may be a guiding principle for psychiatrists, but this is not unequivocally translated into clear statements about involving the patient in decisions. Psychiatrists can only start the treatment if the patient, being informed sufficiently, has given consent, as regulated by law (NVvP, 2010, p. 7). However, the code of conduct and the profile do not prescribe to involve the patient actively in the process of drawing up a treatment plan. Overall the patient's role in decision-making is rather confined. The code states: "The psychiatrist informs the patient … about the care that the psychiatrist proposes" (NVvP, 2010, p. 7).

This, in fact, shows the psychiatrists stronger influence in decision making: The professional drafts a plan and presents it to the patient, which leaves the patient a "following" position instead of a position of conducting the plan of care together. Involving the patient in the process of drawing up a treatment plan is mentioned only once in the profile when more treatment options are available the psychiatrist should not rely exclusively on professional expertise, but also on the patient's preferences (NVvP, 2005, p. 26). Strikingly, the profile recommends the involvement of the patient's family: "If possible, the patient's environment, with his consent, is involved in the process of drawing and executing the treatment plan" (NVvP, 2005, p. 18).

Psychologists

In the professional frameworks of psychologists, the emphasis is clearly on professional responsibility and professional autonomy. The foreword to the code of conduct states that 'the basic principle of responsibility is the general starting point' and that "professional autonomy and making independent decisions" are characteristic for the psychological profession. References to patient autonomy and self-determination are scarce and if they are made they are sometimes attenuated:

> [Psychologists] respect and improve his (the client's) self-determination and autonomy, as far as this is compatible with other professional obligations of the psychologist and with the law. (NIP, 2015, p. 12)

The code of conduct shows one other reference to patient autonomy and one article that specifically prescribes to recognize "the patient's knowledge, insights, and experience."

References to professional responsibility, on the other hand, are abundant. There are many detailed descriptions of psychologists' responsibility regarding several elements of their work: informing the client, saving client records, cooperating with other professionals, and many more. Indeed, professional responsibility is the central theme for the profession of psychologists.

It should be noted that the code of conduct is drafted for psychologists in general and not specifically for psychologists in (mental) health care. However, looking at professional frameworks that are tailored to health care psychologists there is hardly more attention for patient autonomy. In the professional profile for clinical psychologists, this concept is not mentioned in any way. The formal text of the document is alternated with interviews with psychologists and only in a few sections some references to patient autonomy are found. The same goes for the competence profile for health care psychologists. The document focuses on the psychologist's tasks and responsibilities and the competencies and attitude required to accomplish them.

The psychologists' code of conduct includes several sections on informing and consulting the client, in particular with regard to entering or terminating the relationship. Seen from this perspective, the patient-professional relationship is an important theme. There is, however, no extensive description of the nature and aspects of this relationship, as in psychiatrists' frameworks.

Influence of patients is clear when it comes to entering or terminating the relationship: here the patient's consent is explicitly required. In addition, there is a clause on the informed consent of the patient concerning the psychologists' actions. Nevertheless, patient's influence on the precise content of treatments is limited:

> The psychologist offers the opportunity to the client to discuss his wishes and opinions considering the content of the professional relationship unless this hinders a good progression of the professional relationship. (NIP, 2015, p. 18)

The profile for clinical psychologists contains two sentences referring to input from the client. The most far-reaching is: "[the psychologist] determines the plan of treatment in consultation with the patient" (Werkgroep Klinisch Psycholoog/klinisch neuropsycholoog, 2013, p. 18)

In the other reference, it is stated that the psychologist "evaluates the plan of treatment with the patient and adjusts it if necessary." Other references to patient influence are only found in the interviews that are included in the document. Just once the competence profile for health care psychologists mentions that the psychologist should ensure that there is shared decision making, but this is not elaborated or explicitly translated to competencies, or recurring in assessments.

The power disbalance between patient and professional is not a frequently mentioned issue. The code shows a separate article stating that patient self-determination can be limited because of (among other things) his mental condition. Moreover, in the preamble the patient's dependent position is mentioned: "In professional practice, many relationships are unequal by nature and therefore can easily lead to dependence of the persons involved" (NIP, 2015, p. 8).

Nurses

In the professional profiles for nurses (V&VN, 2012a; V&VN, 2012b) the patient's perspective and self-direction are presented as the guiding principles for nursing practice. However, patient self-direction is often attenuated by adding words like "if possible": "The nurse supports the patient in maintaining or regaining control over his own life, as far as possible" (V&VN, 2012a, p. 8).

The code of conduct for nurses (CGMV, 2015) shows the same attenuation: "This means I know … the patient has the right not to contract the care relationship or to end it, and I respect that decision, as far as this is responsible" (CGMV, 2015, p. 9). Nuances like "as far as possible" imply ambiguity; patient autonomy is in fact placed *within* the professional norms and frameworks and thus subordinated to professional autonomy.

Furthermore, the attention for patient autonomy and self-determination is nearly always connected with the dominant issue of professional responsibility. Much more than patient autonomy, professional responsibility is the central theme in the professional frameworks for nurses. This resounds in several sections and phrases, for example:

> The nurse has a professional responsibility in the execution of her profession.…
> Taking responsibility for nursing care means being open to the needs and experienced problems of the patient, and examine together what in his or her case is "good care." (V&VN, 2012a, p. 20)

In line with this, an expanded definition of "professional responsibility" is presented, consisting of three elements: functional (referring to the organizational role), professional (referring to the profession), and personal (referring to the individual) responsibility. Professional autonomy is scarcely mentioned and if so, it is in the context of nurses' position in health care organizations: "nurses have professional autonomy

and responsibility in connection with the organization" (V&VN, 2012a, p. 30).

Contrary to psychologists, nurses' professional responsibility is linked explicitly to the nature of the patient-professional relationship. Nurses are supposed to function as partners of their patients; several sections of the profile describe how this relationship should take shape (V&VN, 2012a). Core element here is the nurse's role to support the patient in (re)gaining autonomy and strengthening self-management.

The commitment to partnership and the principle to work "in partnership with patients and others" imply equality in the relationship with patients. A possible power disbalance is addressed only once, in the code of conduct: it is stated that respecting professional boundaries means that the nurse should not abuse the patient's dependent position (CGMV et. al., 2015, p. 9).

As to active patient involvement in decisions on treatment, the code of conduct (CGMV et. al., 2015, p. 10) clearly states that the professional should co-operate with the patient, implying that the nurse conducts, executes and evaluates the nursing or care plan together with the patient. The nurse is obliged to give understandable information and to inform the patient about his or her rights. Comparable statements are found in the professional profiles. On the other hand, these principles about patient involvement again are weakened by regularly adding sentences like "if the patient is willing and able."

Social workers

The professional profile of social workers emphasizes patient autonomy as central to the profession. Indeed the *goal* of the profession is "to stimulate participation, autonomy and the ability to manage oneself" (NVMW, 2011, p. 10). Patient autonomy is a main theme in the document, and the incorporation of this principle comes to the fore:

> Autonomy is an important value in people's lives, especially in health care, where people become dependent on professionals, due to problems in their ability to manage for themselves. The social worker will never let this dependency diminish the client's own responsibility. (Phorza, 2009, p. 11)

It is considered an important responsibility for the practitioner to guard this value of patient autonomy since in care relationships there is an inherent dependency of the patient (Phorza, 2009, p. 11). Here professional responsibility and the issue of power disbalance come forth.

The frameworks show some ambiguity on the latter issue. On the one hand aversion of the professional to paternalism is seen as connected to the core value of patient autonomy (NVMW, 2011, p. 18). On the other hand, it is observed that "In recent years, there is a quest for 'well-considered paternalism' for people who have lost control over their life" (NVMW, 2011, p. 18).

However, the issue of power (dis)balance gets much less emphasis here than in the psychiatrists' frameworks. Power and dependency are mentioned, but only briefly, and in terms of restriction of the professional, who should refrain from abuse of power towards the patient (Phorza, 2009, p. 12). References to this possible tension in executing the profession of the social worker are followed by statements that even in the case of limited patient autonomy the professional should keep striving to restore and enhance it.

Compared to the other professions, the frameworks of social workers put much less emphasis to professional autonomy and responsibility. References to both principles are scarce. Professional autonomy is noted to be "not always fulfilled" (NVMW, 2011, p. 28), but this remark is not further explained. Professional responsibility is mainly implicit and is not just related to the individual patient, but also to society as a whole. Improving patient autonomy can imply interventions directed at

the individual, but also directed at societal circumstances.

Overall there is a strong emphasis on cooperation, reciprocity, and equality in the patient-professional relationship. This comes forward in prescriptions about patient involvement. The professional code states that patients are supposed to consent to the plan for treatment or service (Phorza, 2009, p. 11). Patients have to be informed by the professional and can refuse the offered service. Additionally, patients are potentially given a contributive role in the drafting of the plan: "As a social worker I consult with my client when composing a treatment, service or activity plan, and ask for consent" (Phorza, 2009, p. 11).

To achieve this it is required that professional and patient agree about the definition of the patient's problem(s) and the goals pursued (NVMW, 2011, pp. 13, 15, 18). The profile prescribes that social workers should use their knowledge, but also the experience, knowledge, and strengths of the patient. It even states: "In turn, the client is not just a 'receiver' of service but a co-producer" (NVMW, 2011, p. 29).

Discussion and conclusion

In Table 3, the essential guiding principles per profession are presented as we see them come forward from our analysis.

Table 3
Central starting point for professional practice

Profession	Central starting point
Psychiatrists	The relationship between patient and professional prevails over all other relationships
Psychologists	Professional responsibility is the basic principle for professional practice
Mental health nurses	Professional responsibility and partnership with the patient are central
Mental health social workers	Patient autonomy and equivalence between patient and professional are central

We expected highly professionalized mental health professions to leave less room for patient participation and to adhere more strongly to professional autonomy than less professionalized ones. This assumption turns out to be partly true. The studied professions indeed differ in the way their professional frameworks pay attention to this issue in the emphasis they put on professional autonomy or patient self-determination and in the degree they explicitly prescribe or promote active patient involvement, but this can only partly be linked to their degree of professionalization.

Social workers, being the least professionalized group, are clearly most far-reaching in allowing patient involvement in decisions about treatment and care. This supports our hypothesis.

Looking at nurses, being next in line regarding the degree of professionalization, our argument still holds. Being more professionalized than social workers, nurses give more weight to their professional responsibility and autonomy, but their openness to patient participation is still considerable, because of the character of the patient-professional relationship ("partners") and because of the emphasis on patient influence in decision making.

The picture gets ambiguous when we turn to psychologists and psychiatrists. Both professions are highly professionalized, and psychiatrists the most so.

Nevertheless, psychologists put more emphasis on professional autonomy and responsibility than psychiatrists who take ample space to accommodate patient's preferences and autonomy. For psychologists, as for nurses, professional responsibility is the central theme in their professional frameworks, but they do not connect this extensively to the patient-professional relationship (as do nurses). Furthermore, substantial patient involvement in decision making is restricted in the frameworks of both psychologists and psychiatrists. In the latter, the patient-professional relationship trumps all other principles, thus putting more focus and giving more attention to the role and position of the patient than a psychologist.

Explanations for these differences between professions may be found in their different goals and orientations: Psychiatrists strive to cure their patients or lessen their suffering, psychologists are more broadly oriented and can also be assigned to diagnose, test or give advice. Nurses strive to support people in improving their health and prevent illness, while social workers strive to empower their patients.

The remarkable difference between psychologists and psychiatrists may also be related to a struggle over professional domains. Illustrative in this respect is a phrase in the competence profile for psychologists which explicitly refers to "the emancipation of the health care psychologist" (Werkgroep Modernisering GZ-psycholoog, 2012, p. 8).

Our study focuses on a Dutch context; this might limit the value of our findings for other more international contexts. However, since both changes in professionalism and patient participation are not specifically Dutch developments, as our theoretical frame points out, some insights offered here might also have some relevance for mental health care in other Western countries.

Finally, these conclusions about the different professions and their openness to patient participation are only based on document analysis. Professional frameworks, on the one hand, represent professional norms and orientations in a compact way, which makes studying them worthwhile. On the other hand, professional daily practice is not done "by the book." So empirical research is required to complete insights on responses of mental health care professionals to patient participation.

The fact remains that in mental health care practice all four professional groups can be involved with the same patients. This implies that people with mental health problems, receiving treatment and care, might be confronted with a variety of professionals that act from considerably different perspectives on patient autonomy and participation. Ignoring these differences may complicate or impede the further implementation and development of patient participation in mental health care.

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