DECISION-MAKING

Shared decision-making: benefits, barriers and current opportunities for application

Magenta Simmons, Sarah Hetrick and Anthony Jorm

Objective: *Patient preference and involvement are two important aspects for many psychiatric treatment decisions. Shared decision-making (SDM) has been proposed as the optimal model to include patient preferences and involve patients in such decisions. Decision-making tools called decision aids (DA) are the most common application of SDM. DAs have been demonstrated to increase patients' knowledge, reduce decisional conflict, and reduce the proportion of patients who are passive in the decision-making process or remain undecided. Unfortunately, there are few DAs available for treatment decisions for psychiatric disorders and implementing SDM can be a challenge for mental health professionals. There are also issues unique to psychiatry related to the development and implementation of DAs that need consideration. Despite this, mental health professionals can and do still employ SDM techniques. This article offers an overview of the skills required to implement a SDM model and the resources currently available.*

Conclusions: *The core features of SDM are advocated for in clinical guidelines, but more resources are needed to ensure these recommendations are implemented in practice. In particular, the benefits of freely available DAs developed according to international standards need to be assessed for suitability and effectiveness.*

Key words: *evidence-based practice, mental health, patient-centred care, patient participation, shared decision-making.*

The importance of patient preference and involvement in decision-making as core features of health care is increasingly recognized. The need to provide current, evidence-based information to patients and to consider patient preferences when making decisions about treatment options are two key features apparent in all NICE guidelines for psychiatric disorders (http://www.nice.org.uk/guidance/index.jsp). Ultimately, it is patients who decide whether or not to follow through with treatment options, and considering their preferences from the outset is one way to encourage adherence to the treatment decision. Shared decision-making (SDM) has been proposed internationally as an optimal way in which to involve patients and to incorporate patient preferences and values.[1,2] Despite the growing interest in SDM for psychiatric disorders and the recent increase in studies reported,[3] little work has been done overall in this area. In order to assist mental health professionals in the meantime, this article describes the process of SDM and the use of decision-making tools, provides an overview of the evidence to support such models, and discusses the main challenges and barriers.

WHAT IS SHARED DECISION-MAKING?

SDM is a model of medical decision-making that lies between a paternalistic model (whereby the doctor makes the decision for the patient) and an autonomous model (whereby the patient makes the decision for themselves,

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consulting the doctor only to obtain information or treatment). SDM combines tenets from evidence-based medicine and patient-centred care, and comprises three main stages: (i) the doctor and patient act in a partnership, sharing information about evidence and preferences, with or without the use of a decision aid; (ii) both parties talk through this information and discuss the relevant issues; and (iii) a decision is reached that is informed by evidence, matches the patient's preferences and values, and that ideally both parties agree upon.[4] The emphasis should not be on who actually makes the decision, but that the process involves the sharing of relevant information.[5] Box 1 describes the process of SDM, using the example of a young adult experiencing moderate depression.

USE OF DECISION AIDS

The most common way that SDM has been implemented is with the use of decision-making tools called decision aids (DAs). DAs should include information from the following three categories: (i) a general description of the disorder and treatment options, (ii) a clear presentation of the evidence concerning the potential risks and benefits of each treatment option, and (iii) a section that encourages the patient to work through their individual characteristics (e.g. risk factors, available resources for support), values and preferences around these potential options. DAs are not designed to exclude the input of the doctor. Ideally, both parties should use the DA together (with the inclusion of carers as necessary), and the DA should act to facilitate discussion between the doctor and patient about the evidence. The opinions and experiences of both the doctor and patient are included in this process. Very few decision aids exist for treatment decisions about psychiatric disorders, meaning that the current opportunities for SDM in such contexts rely on healthcare professionals employing the techniques of SDM.

Box 1. **An example of the processes involved in shared decision-making (adapted from[4,6])**

The following is an example of what steps might be taken if employing a SDM model to treatment decision-making about the treatment for an 18-year-old female presenting with moderate depression:

- Discuss what depression is.
- State that there is more than one suitable treatment option (i.e. psychotherapy, prescription of different types of antidepressant medication).
- Ask the patient about her preferred level of involvement and desire for carer involvement.
- Discuss preferred information format (fact sheets or decision aids if available, verbal, websites etc.).
- Discuss the potential risks and benefits of each treatment option (including other available resources and treatment options from other professionals, e.g. psychological therapies).
- Explore ideas, fears and expectations of the problem and possible treatments.
- Check with the patient about her understanding of the information and reactions to this.
- Make, discuss or defer the decision/s.
- Arrange follow up.

WHAT ARE THE BENEFITS?

The majority of studies investigating SDM to date have tested the effectiveness of DAs as a means of facilitating SDM. Evidence for the benefits of DAs varies according to the type of decision under consideration, the quality of the DA and the way in which the DA is evaluated. A recent Cochrane review concluded that DAs increased patients' knowledge, reduced decisional conflict (both in terms of feeling uninformed or feeling unclear about personal values), reduced the proportion of patients who were passive in the decision-making process and reduced the proportion of patients who remained undecided.[7] More work is needed to provide evidence about the effect of DAs on treatment adherence and healthcare outcomes, and several large studies are underway in the USA and Europe. In terms of psychiatric disorders, initial studies testing the feasibility and effectiveness of SDM programs for depression and schizophrenia have been promising.[3] No studies to date have investigated SDM for young people with psychiatric disorders, and the suitability of this approach needs further consideration.

DO PATIENTS WANT TO BE INVOLVED?

The main principle to support the rationale of a SDM approach is the desire of patients to be informed and involved. Three types of involvement have been proposed: active, collaborative and passive.[8] Desire for involvement varies from person to person, and can be related to different factors (e.g. demographic characteristics of patients, type of decision being made and so forth).[9,10] However, the majority of patients, across general medical disorders and including psychiatric disorders, want at least some involvement in the decision-making process.[11,12] Because of this variation, an important step in the SDM model is to ask the person explicitly if they want to be involved in the decision-making process; they might not be aware that involvement is possible, or they may feel uncomfortable initiating involvement. The difference between the desire to make a decision and the desire to receive more information has also been emphasized.[5,13] However, information can support all three types of involvement. That is, information is required in order to be involved in the process, to make the decision, and may be required to reassure a patient who prefers a

passive role about why a doctor has chosen a certain option.

WHAT ARE THE BARRIERS?

Given the relatively low levels of patient involvement in existing practice,[14,15] and the highly variable nature of patient information available,[16] there appear to be real barriers to implementing a SDM approach. Legare and colleagues[17] reported that the three main perceived barriers to implementing SDM were time constraints (although not all applications of SDM increase consultation time, for examples see[15,18]), feeling that SDM was not relevant to patients with certain individual characteristics, and feeling that SDM was not relevant to particular clinical situations. Stevenson and colleagues[19] describe further barriers, including patients feeling uncertain about their ability to be involved, that medications are not referred to by name (making it difficult for patients to seek further information outside of the consultation and possibly resulting in confusion between doctor and patient), and the variability of consultation content according to the profession of the healthcare provider (e.g. SDM may be difficult to implement with pharmacists because they do not typically offer counselling about medication and patients prefer not to receive such counselling from pharmacists). Furthermore, discrepancies between doctor and patient perceptions of what constitutes true involvement can make it difficult for a collaborative approach to occur.

WHAT ARE THE CURRENT OPTIONS FOR IMPLEMENTING SDM?

DAs are available for a range of non-psychiatric disorders and a small number of psychiatric disorders, and are usually made available free of charge. Previously, the development processes and content of DAs have been variable, making it difficult for doctors and other healthcare professionals to assess the quality of available DAs. This is set to change, with the recent development of the International Patient Decision Aid Standards (IPDAS)[20] and a valid and reliable tool that can assess the quality of decision aids (the IPDAS instrument, or IPDASi).[21] An international database of DAs for all health areas is publicly available online (http://decisionaid.ohri.ca/cochinvent.php), and a small number of DAs are now available for some psychiatric disorders (e.g. schizophrenia) from the National Prescribing Centre in the UK (http://www.npci.org.uk/lift/lift.php). While the framework exists for the future development of DAs for psychiatric disorders, in the meantime other resources may need to be employed. The Ottawa Health Decision Centre provides practical resources for SDM in general, which may be of particular use when there is no DA available for a given decision. These include a generic DA (available at http://decisionaid.ohri.ca/decguide.html as both a document and Facebook application) and an implementation toolkit for SDM that includes free, online training for healthcare professionals to increase their skills in providing support to patients facing a treatment or screening decision.

DAs IN PSYCHIATRY

While the principles of SDM are readily argued for on ethical and pragmatic grounds, there are several caveats with regard to the translation of DAs from general medicine to psychiatry. DAs stem from 'evidence-based psychiatry' (EBP, based on evidence-based medicine), a paradigm that relies upon the use of a diagnostic framework and emphasizes the importance of evidence in the decision-making process. The issues of poor validity, reliability and utility of the psychiatric diagnostic system[22,23] have led to criticisms of the core assumptions of EBP.[24] In terms of thinking about the usefulness and validity of DAs for psychiatry, these problems can be considered in terms of the nature of both psychiatric decision-making and psychiatric research. The successful implementation of DAs will therefore rely upon careful consideration of the following issues.

PSYCHIATRIC TREATMENT DECISION-MAKING

Treatment decision-making in psychiatry is often likely to be complex, with additional issues such as comorbidity and chronicity meaning that symptoms and decisions are more likely to fluctuate and change over time and be influenced by a broad range of factors. DAs have been developed within a medical framework that relies on diagnosis rather than formulation-based interventions, which may not account for this complexity. For these reasons, DAs may be more suited to decisions that have a more medical leaning (e.g. whether or not to take an antidepressant medication, or which type of antipsychotic medication to take). However, it should be noted that DAs can accommodate some complexity by allowing the decision to be made over several sessions, and they can be used multiple times (e.g. where there are more than two treatment options, as in the example of choosing which type of antipsychotic medication to take).

PSYCHIATRIC RESEARCH

Another factor for consideration is the availability and quality of evidence in psychiatric research. There is a general paucity of research about treatment for many psychiatric disorders. Also, any discrepancies between the characteristics of the trial participants and the individual patient will attenuate the relevance of information drawn from such studies. This is an issue for general medicine as well. However, it is more exaggerated in psychiatry due to the complexity of presentations and

breadth of influencing factors. For DAs to be truly useful, good evidence about the potential risks and benefits of relevant treatment options needs to be available. Having said that, DAs can also serve to highlight the lack of evidence about particular treatment options, and make it clear to the patient that the outcomes of choosing such a treatment are difficult to predict.

CONCLUSION

SDM is a rapidly growing field and is increasingly being advocated for in clinical guidelines. Furthermore, a substantial proportion of patients want either more information or to be involved in the decision-making process. Many psychiatric treatment decisions are preference-sensitive, and the involvement of patients in the decision-making process can result in benefits for both the doctor and patient. The use of DAs may assist in this process and has demonstrated benefits across decision types. However, few exist for psychiatric treatment decisions. The development of DAs for psychiatric treatment decisions pose some unique challenges, and these need to be considered if DAs are to be truly useful in this area. Several barriers to SDM are also evident. However, resources are available to assist healthcare professionals for those situations where SDM is relevant and potentially beneficial. The mode of implementation for SDM in the field of psychiatric decision-making needs to account for the inherent complexity, but ultimately the investigation of SDM for psychiatric decision-making is warranted for both ethical and pragmatic reasons.

DISCLOSURE

The authors report no conflicts of interest. The authors alone are responsible for the content and writing of the paper.

REFERENCES

1. Mistler L, Drake R. Shared decision making in antipsychotic management. *Journal of Psychiatric Practice* 2008; **14**: 333–344.
2. Schauer C, Everett A, del Vecchio P, Anderson L. Promoting the value and practice of shared decision-making in mental health care. *Psychiatric Rehabilitation Journal* 2007; **31**: 54–61.
3. Patel SR, Bakken S, Ruland C. Recent advances in shared decision making for mental health. *Current Opinion in Psychiatry* 2008; **21**: 606–612.
4. Charles C, Gafni A, Whelan T. Shared decision-making in the medical encounter: what does it mean? (or it takes at least two to tango). *Social Science & Medicine* 1997; **44**: 681–692.
5. Edwards A, Elwyn G. Inside the black box of shared decision making: distinguishing between the process of involvement and who makes the decision. *Health Expectations* 2006; **9**: 307–320.
6. Elwyn G, Edwards A, Kinnersley P, Grol R. Shared decision making and the concept of equipoise: the competences of involving patients in healthcare choices. *British Journal of General Practice* 2000; **50**: 892–899.
7. O'Connor AM, Bennett CL, Stacey D *et al*. Decision aids for people facing health treatment or screening decisions. Cochrane Database of Systematic Reviews 2006, Issue 3. Art. No.: CD001431. DOI: 10.1002/14651858.CD001431.pub2
8. Barratt A, Ragg M, Cockburn J, Irwig L, Swinburne L, Chapman S. How to prepare and present evidence-based information for consumers of health services: A literature review (1999). National Health and Medical Research Council 1999. Available from URL: http://www.nhmrc.gov.au/publications/synopses/cp66syn.htm.
9. Say R, Murtagh M, Thomson R. Patients' preferences for involvement in medical decision making: A narrative review. *Patient Education & Counseling* 2006; **60**: 102–114.
10. Kiesler D, Auerbach S. Optimal matches of patient preferences for information, decision-making and interpersonal behavior: Evidence, models and interventions. *Patient Education & Counselling* 2006; **61**: 319–341.
11. Guadagnoli E, Ward P. Patient participation in decision-making. *Social Science & Medicine* 1998; **47**: 329–339.
12. Hamann J, Cohen R, Leucht S, Busch R, Kissling W. Do patients with schizophrenia wish to be involved in decisions about their medical treatment? *American Journal of Psychiatry* 2005; **162**: 2382–2384.
13. Wilkinson C, Khanji M, Cotter PE, Dunne O, O'Keeffe ST. Preferences of acutely ill patients for participation in medical decision-making. *Quality & Safety in Health Care* 2008; **17**: 97–100.
14. Goss C, Moretti F, Mazzi MA, Del Piccolo L, Rimondini M, Zimmermann C. Involving patients in decisions during psychiatric consultations. *British Journal of Psychiatry* 2008; **193**: 416–421.
15. Loh A, Simon D, Hennig K, Hennig B, Harter M, Elwyn G. The assessment of depressive patients' involvement in decision making in audio-taped primary care consultations. *Patient Education & Counselling* 2006; **63**: 314–318.
16. Young HN, Bell RA, Epstein RM, Feldman MD, Kravitz RL. Types of information physicians provide when prescribing antidepressants. *Journal of General Internal Medicine* 2006; **21**: 1172–1177.
17. Legare F, Ratte S, Gravel K, Graham ID. Barriers and facilitators to implementing shared decision-making in clinical practice: update of a systematic review of health professionals' perceptions. *Patient Education & Counselling* 2008; **73**: 526–535.
18. Cruz M, Pincus HA. Research on the influence that communication in psychiatric encounters has on treatment. *Psychiatric Services* 2002; **53**: 1253–1265.
19. Stevenson FA, Cox K, Britten N, Dundar Y. A systematic review of the research on communication between patients and health care professionals about medicines: the consequences for concordance. *Health Expectations* 2004; **7**: 235–245.
20. Elwyn G, O'Connor A, Stacy D *et al*. Developing a quality criteria framework for patient decision aids: online international Delphi consensus process. *British Medical Journal* 2006; **333**: 417–422.
21. Elwyn G, O'Connor AM, Bennett C *et al*. Assessing the quality of decision support technologies using the International Patient Decision Aid Standards instrument (IPDASi). *Public Library of Science ONE* 2009; **4**: e4705.
22. Bentall R. *Madness Explained: Psychosis and Human Nature*. London: Penguin, 2003.
23. Parker G. Through a glass darkly: the disutility of the DSM nosology of depressive disorders. *Canadian Journal of Psychiatry (Revue Canadienne de Psychiatrie)* 2006; **51**: 879–886.
24. Maier T. Evidence-based psychiatry: understanding the limitations of a method. *Journal of Evaluation in Clinical Practice* 2006; **12**: 325–329.