Shared decision-making in mental health treatment: What clinicians need to know

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Key learning objectives for today's webinar

- Identify the key rationale for and components of shared decision-making (SDM) in clinical practice
- Articulate the potential benefits of SDM for mental health populations, incl. people with co-occurring alcohol/other drug use conditions
- Understand ways of facilitating SDM in practice, including via the use of decision-aids.

What is SDM?

- *A process whereby clinicians and their patients/clients (and others, e.g., family/peer-worker)* ***work together*** *to make a* ***mutually agreed-upon healthcare decision*** *based the* ***best available evidence*** *and* ***informed preferences****.*

Both clinicians & patients are active participants

Final decisions integrate both clinician & patient preferences

Involves a two-way exchange of knowledge & expertise

How does SDM differ from other decision-making approaches?

Decision-making stage	Models	Paternalistic/ Clinician-led	Shared	Autonomous/ Client-led
Information exchange ***'Sharing information'***	Flow Direction Type Amount	One way (largely) Clinician → Client Clinical Min. legally required	Two way Clinician ⇄ Client Clinical and personal All relevant for decision	One way (largely) Clinician → Client Clinical and personal All relevant for decision
Deliberation ***'Considering options'***		Clinician alone or with other clinicians	Clinician and client (plus potentially others)	Client (plus potentially others)
Deciding on option to implement ***'Making a choice'***		Clinician	Clinician and client	Client

Adapted from Charles et al., 1997; 1999

SDM vs supported decision-making[1]

SIMILARITIES

- Both emphasise self-determination and importance of making decisions about one's own life
- Both recognise inherent power imbalances in psychiatric and other mental health services
- Both premised on the view that mental health servicer providers should involve clients and support people in all relevant decisions

DIFFERENCES

- SDM emerged from healthcare provision, more targeted to decision-making about treatment
- Supported decision-making emerged from disability and human rights, encompasses broader range of decisions (eg health, financial, housing etc.)
- SDM focusses on clinicians and clients arriving at a decision together; supported decision-making holds that people have right to make own decisions regardless of others' perceptions/judgments of choice (eg refusing treatment)

[1.] Simmons & Gooding, 2017

Essential elements of SDM[1]

- Define/explain problem (i.e., condition, symptoms, diagnosis)
- Discuss available options (incl. status quo/no change)
- Discuss pros/cons of options (i.e., benefits/risks/costs)
- Discuss/elicit client values and preferences for options
- Discuss patient ability/self-efficacy to enact options*
- Provide clinician-based knowledge and recommendations
- Check/clarify client's understanding
- Make or explicitly defer decision
- Arrange follow-up
- Provide unbiased information
- Define roles (client's desire for involvement)
- Present evidence for options and outcomes
- Reach mutual agreement in making decision

Ideal elements (last four items)

1. Makoul & Clayman, 2006

* Not defined in previous models of SDM

Putting steps of SDM into practice[1]…

Introduce an awareness of a choice between the available (viable) options

Initial preferences

Informed preferences

Choice talk

Option talk

Preference/ Decision talk

Decision

Deliberation

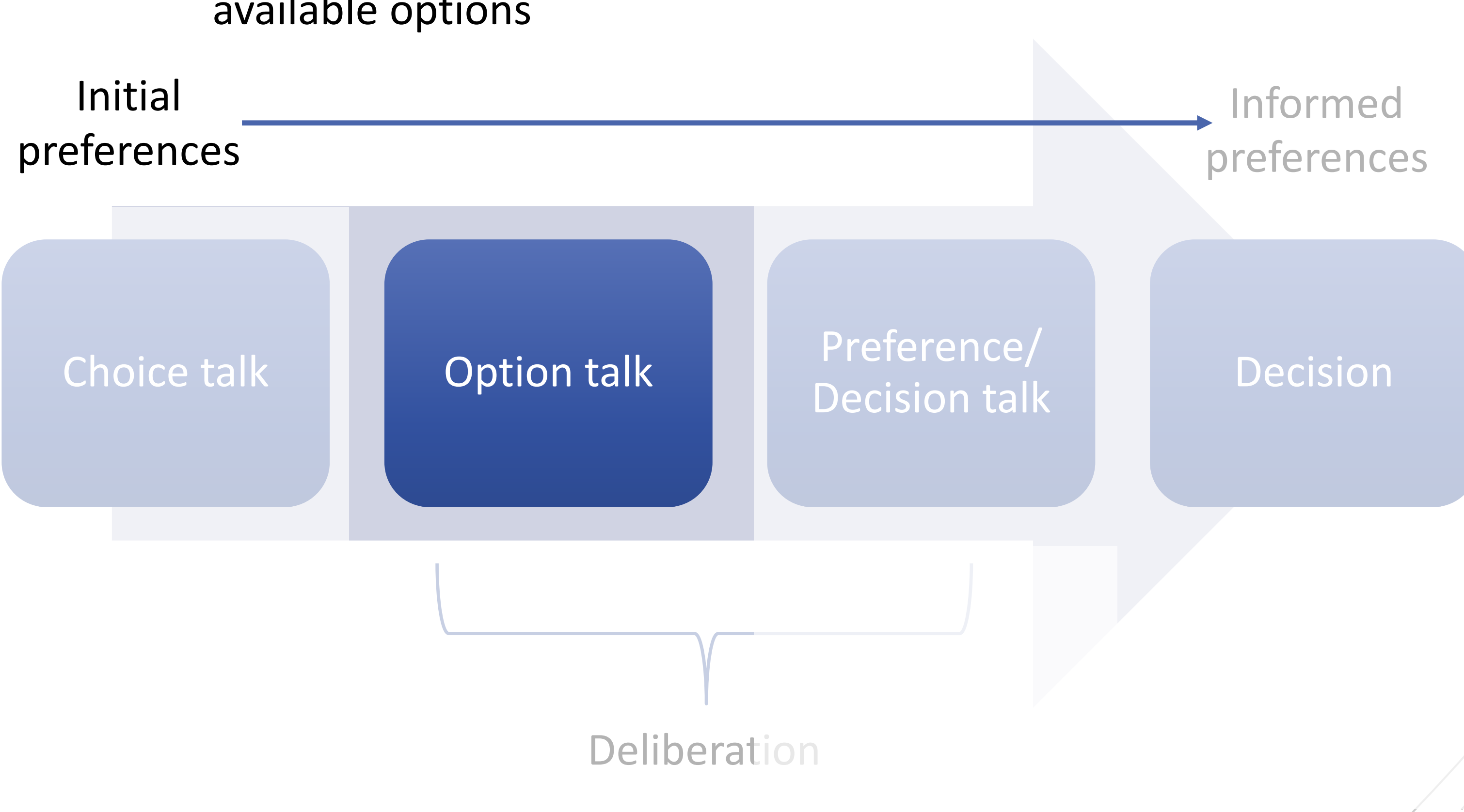
1. Based on Elwyn et al., 2012

Choice talk examples for clinicians[1]

- *”Now that we’ve identified the issue at hand, it’s time to think about what to do next”*
- *”There’s good information about how these treatments differ that I’d like to discuss with you.”*
- *”Treatments have different advantages and disadvantages, and some will matter more to you than other people…”*
- *“Treatments aren’t always effective and the chances of experiencing side-effects vary…”*
- *”Shall I tell you about the options available…?”*
- *“I’m happy to share my views and help you get to a good decision. But first, may I describe the options in more detail so that you can understand what the decision involves?”*

1. Elwyn et al., 2012

Putting steps of SDM into practice[1]…



1. Based on Elwyn et al., 2012

Option talk examples for clinicians

- *"Have you heard or read about the options for treating/managing…?"*
- *"Let me list the options before going into more detail"*
- *"These options are similar in that…. These options differ in that…"*
- *"With these options there will be some other things we need to consider compared to other people, so I want to describe…"*
- *"Can you tell me what you understand about the options we've discussed…?"*

Putting steps of SDM into practice[1]…

Consider the ‘pros’ & ‘cons’ (i.e., benefits & costs) of available options and consider ‘what matters most’ to the client

Initial preferences → Informed preferences

Choice talk → Option talk → Preference/ Decision talk → Decision

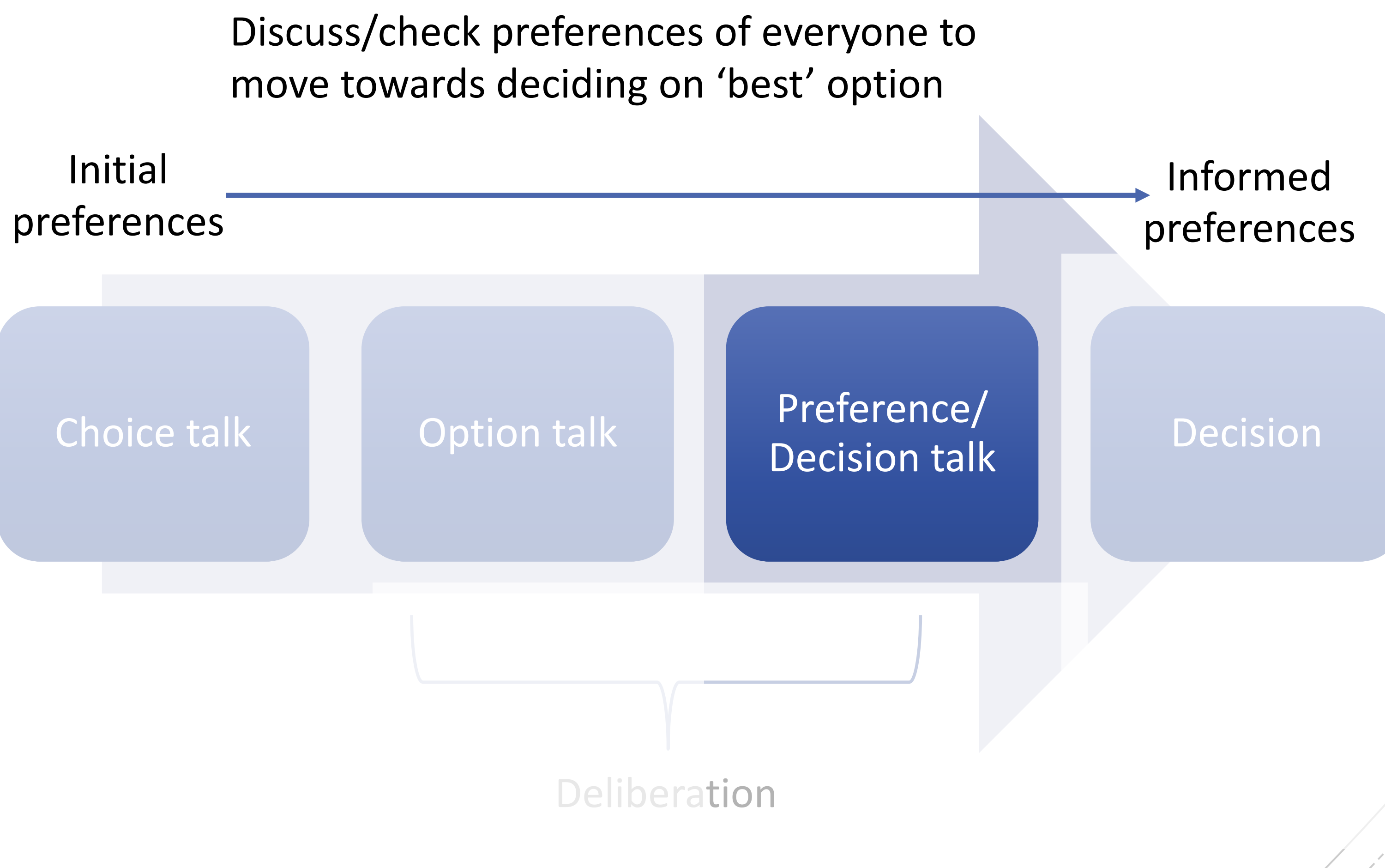
Deliberation

1. Based on Elwyn et al., 2012

Deliberation/ introducing decision-support

- *“These tools have been designed to help you understand your options in more detail. Use them and come back so that I can answer your questions.”*

Putting steps of SDM into practice[1]…



1. Based on Elwyn et al., 2012

Preference/ decision talk examples for clinicians

- *“What, from your point of view, matters to you?”*
- *“Are there any concerns you have at this stage?”*
- *“Are you ready to decide?”*
- *”Do you want more time?”*
- *“Do you have any more questions?”*
- *“Are there things you think we should discuss?”*
- *“It’s possible we can come back and review things again, if you like.”*

Putting steps of SDM into practice[1]...

Make a decision that clinician/patient both agree on or can support

Initial preferences → Informed preferences

Choice talk → Option talk → Preference/ Decision talk → Decision*

Deliberation

*NB: Decision may be to:

i) maintain status-quo (i.e., do nothing/no change/ watch & wait) or

ii) delay implementing a choice/revisit decision later

iii) Trial one option and review at a later set date

1. Based on Elwyn et al., 2012

Putting steps of SDM into practice[1]…

- Throughout discussions, support clients making decisions by:
  - Presenting information in manageable chunks, via **chunk and check**
  - Check clients understand the information (for example, using **teach back technique**)
  - discussing what matters to clients in light of the information provided and checking that their choice is consistent with this

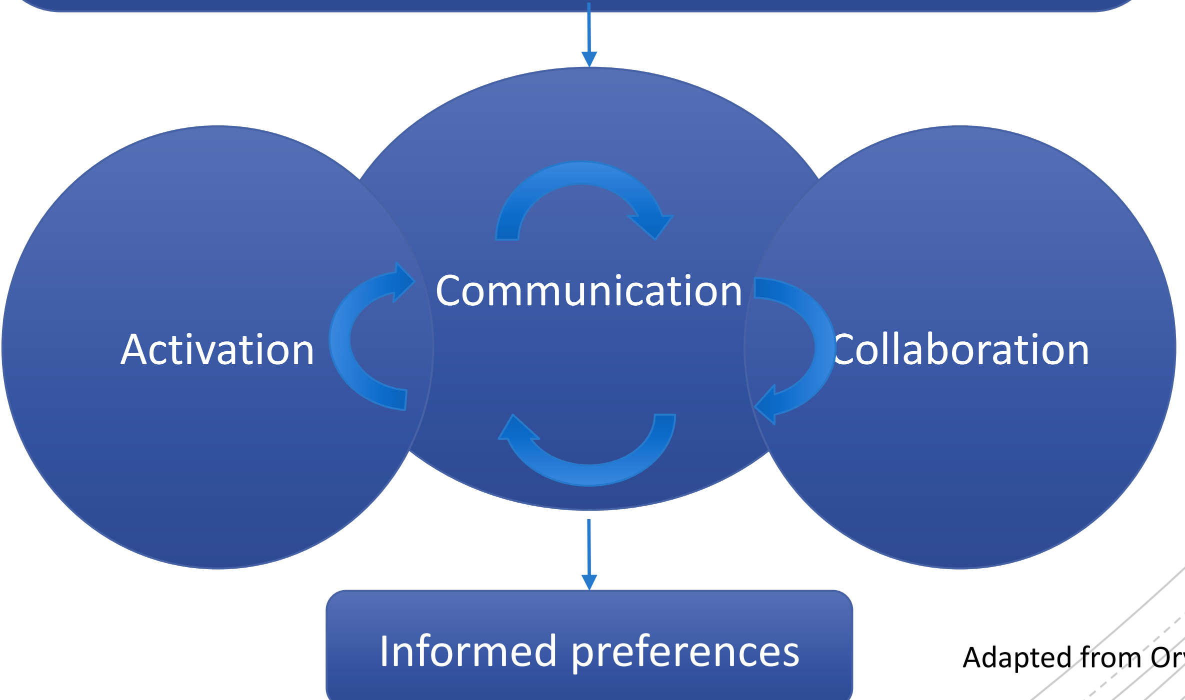
1. SDM NICE Guidelines, 2021

Requirements for effective SDM

Clinician contribution
- Evidence/risk communication
– Knowledge & skills

Client contribution
- Individual characteristics & needs
– Personal preferences & values

Both need
- Belief in the benefit of SDM
- Willingness to participate
- Acknowledgement that a choice exists; that current preferences may be at least partially uninformed



Adapted from Orygen, 2016.

Some other considerations for SDM in mental health

Expanded concept of SDM for enhancing client engagement:

- emphasise additional components beyond information exchange e.g., rapport building and mutual trust[1]
- fluctuating mental health symptoms and insight may impact on decisional capacity/self-efficacy and motivation[1]
- more salient role of multiple stakeholders (incl. family caregivers) and social networks[2]
- adjunctive motivational interviewing for severe and acute populations (*SDM-PLUS*)[3]

1. Zisman-Ilani et al., 2017; 2. Morant et al., 2016; 3. Hamann et al., 2020

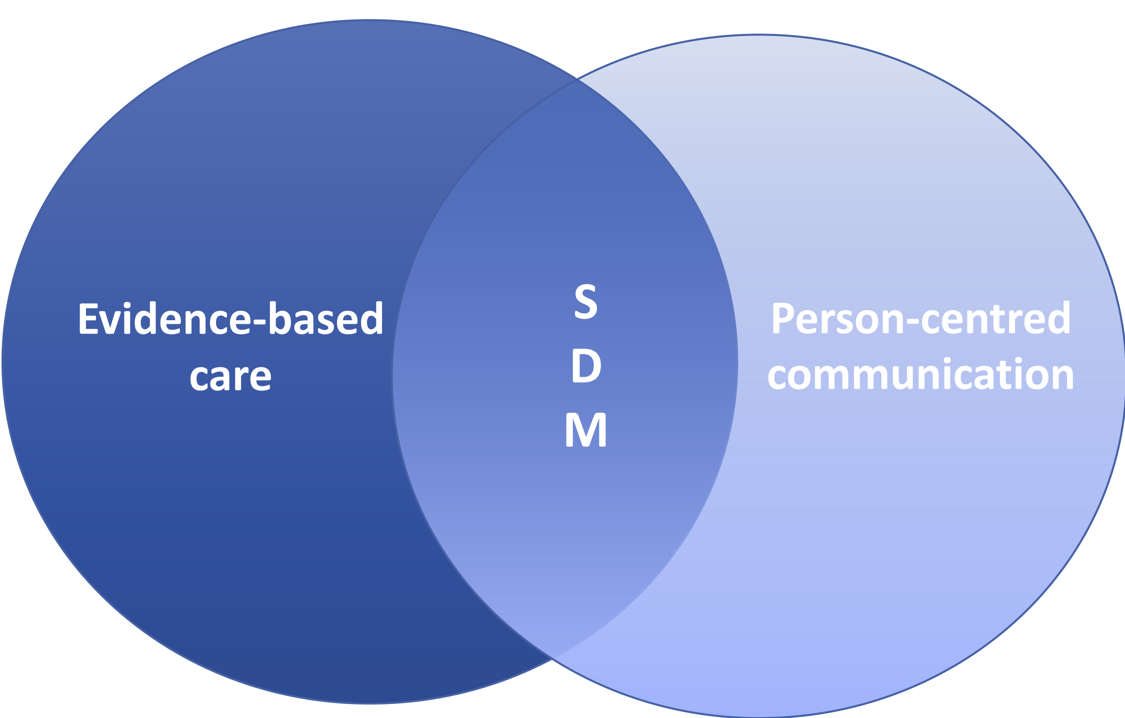
So why SDM? Clinical and ethical imperatives

- Many healthcare decisions **lack a single ‘best course of action**’; at least two viable options with similar evidence of efficacy and safety etc.
- **Limited or mixed evidence** to support the superiority of one healthcare option over others
- Different options carry different benefits, costs, probabilities, and uncertainties = **different clients may value these differently**

So why SDM? Clinical and ethical imperatives

- An effective healthcare option has **known adverse effects** = likely impacts on a client's quality-of-life and/or adherence to treatment.
- Clinicians have an **ethical imperative** to ensure that their clients are informed about healthcare options and have the opportunity be involved in decision-making to the extent possible.
- Most clients **want to be actively involved** in making decisions about their healthcare, esp. so in mental health

- SDM enables evidence-based, person-centred choices that optimise their care[1]



1. Hoffman et al., 2014

Benefits of SDM in mental health

- Based on studies of adult populations, SDM associated with improvements in:
  - ✓ How involved people feel in treatment decisions
  - ✓ Decisional conflict and decisional delay
  - ✓ Clinician’s awareness of preferences of people in their care
  - ✓ Satisfaction with treatment decisions, among both patients and treating clinicians
  - ✓ Individual’s understanding of their own values
  - ✓ Attitudes towards recovery (mental health)

Benefits of SDM in mental health

- Based on studies of adult populations, SDM associated with improvements in (cont'd):
  - ✓ Knowledge about conditions and treatment
  - ✓ Concern about taking medications
  - ✓ Adherence to medications in the short-term (long-term evidence lacking)
  - ✓ Severity of AOD use and psychiatric problems in people with AOD use disorders
  - ✓ Uptake of psychoeducational and psychosocial interventions
  - ✓ Uptake of guideline-consistent treatment
  - ✓ (Self-)stigma and help-seeking

Patient decision-aids for SDM

Effective SDM requires numerous complex skills, e.g.:

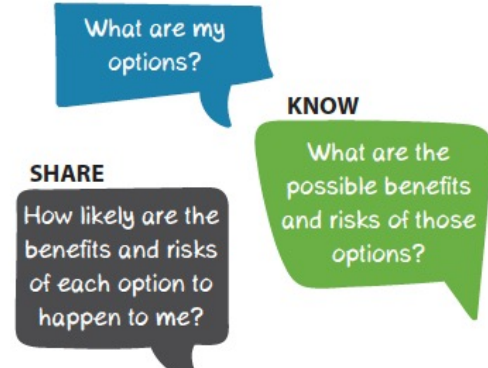
- **Clinician's ability to communicate knowledge** about treatment benefits/risks in a way the patient can understand & use.
- **Client's ability to recognise and communicate their needs**, values and preferences regarding treatment

Patient decision-aids are one part of a "tool-kit" to facilitate SDM:

- **Evidence-based, unbiased information** about available options and outcomes
- Clear, **easy-to-understand format** with text and graphics
- **Values-clarification exercises** to help clients to weigh-up the 'pros'/ 'cons' of options against personal values
- Can be used **before, during, after** speaking with clinician
- **Supporting NOT replacing discussions** with clinicians (e.g., information exchange and deliberation)
- Developed in line with consensus-based international standards (IPDAS criteria) to ensure rigor

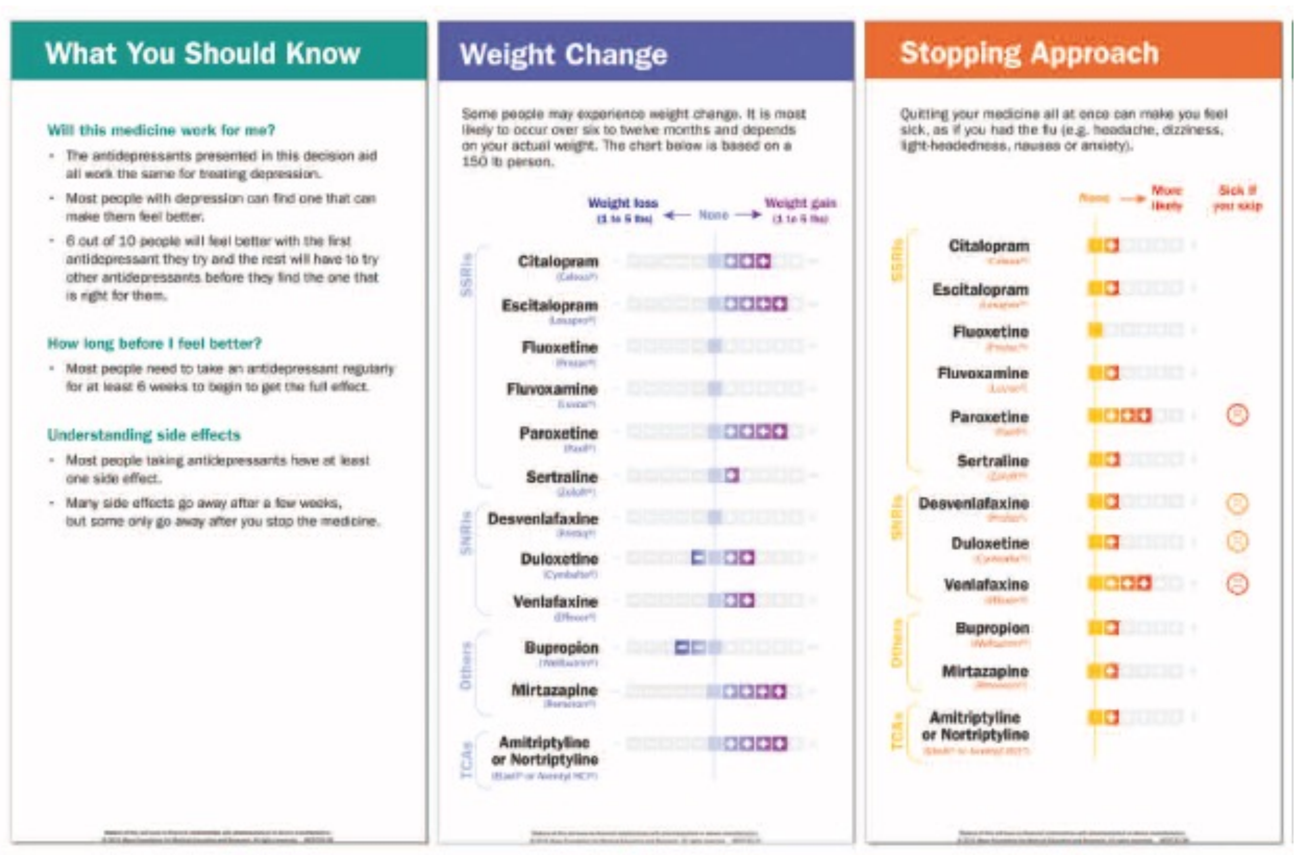
Patient decision-aids for SDM

- Only use a decision-aid[1] if:
  - It is up-to-date and reflects evidence-based practice
  - Relevant to that discussion and the decision that needs to be made
  - Relevant to that clinical setting
  - You (as the clinician) have first familiarised yourself with the content
- If a relevant decision-aid is not available (see https://decisionaid.ohri.ca/AZlist.html) then use the SDM elements and steps outlined before, “Choice Talk”, ”Option Talk”, ”Preference/Decision Talk”
- Clients may also be encouraged to ask questions to promote SDM[2]:



1. SDM NICE Guideline (2021)
2. askshareknow.com.au

Examples of patient decision-aids for mental health



Le Blanc et al. (2015). Shared decision-making for antidepressants in primary care: A cluster randomised trial.

Examples of patient decision-aids for mental health

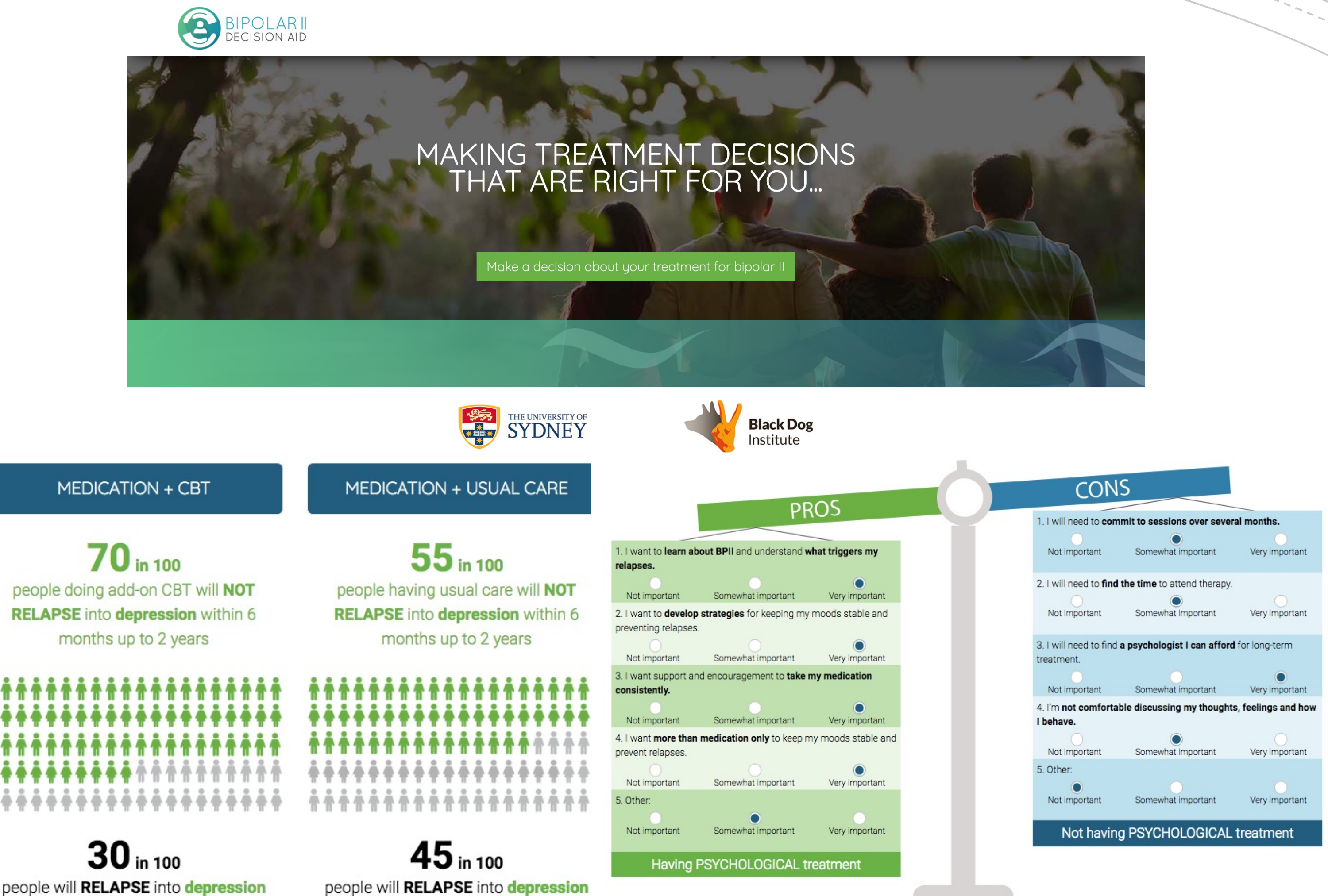
My preferences

What importance does it have for you ...	Nothing important										Extremely important
... relieve the **symptoms** of depression?	0	1	2	3	4	5	6	7	8	9	10
... be able to perform the activities you did regularly before you had depression?	0	1	2	3	4	5	6	7	8	9	10
... avoid the **side / adverse effects** of antidepressant medications?	0	1	2	3	4	5	6	7	8	9	10
..learn **coping strategies** to change your negative thoughts and inappropriate behaviors?	0	1	2	3	4	5	6	7	8	9	10

Deciding the Treatment

Perestelo-Perez et al. (2017). Effectiveness of a decision-aid for patients with depression: A randomised controlled trial.

Examples of patient decision-aids for mental health



Fisher et al. (2020). Improving treatment decision-making in bipolar II disorder: a phase II randomised controlled trial of an online patient decision-aid.
www.bipolardecisionaid.com.au

Benefits of using a patient decision-aid

- Most comprehensive systematic review[1] of RCTs of patient decision-aids across health conditions found that compared to usual care, decision-aids:
  - ⬆ Increase clients' **knowledge** of treatment options
  - ⬆ Give clients more **realistic expectations** about potential risks and benefits of these treatment options
  - ⬆ Help clients make a decision that is more in line with with their **personal values**
  - ⬆ Help clients to be **more involved** in the decision-making process
  - ⬆ Increase clients' **satisfaction** with their decision, and decision-making process
  - ⬆ Help clients to feel **better prepared** to make a decision
  - ⬇ Decrease clients' **decisional conflict** related to feeling uninformed and unclear about personal values
  - ⬇ Decrease the proportion of clients who are **undecided, delay** making a choice

1. Stacey et al., 2017

Scope for SDM for clients with co-occurring conditions

Guidelines on the management of

Co-occurring alcohol and other drug and mental health conditions in alcohol and other drug treatment settings

SECOND EDITION

Christina Marel
Katherine L Mills
Rosemary Kingston
Kevin Gournay
Mark Deady
Frances Kay-Lambkin
Amanda Baker
Maree Teesson

Scope for SDM for clients with co-occurring conditions

"… several…approaches for treatment promising… further research is required to establish which… are particularly effective…

"…clinical efforts should be focused on the provision of client-centred, evidence-based treatment, taking into account the client's needs and preferences, in a collaborative partnership"

(Depression & AOD use disorders, p.138[1])

Scope for SDM for clients with co-occurring conditions

"… treatment and care should reflect an individual's needs and preferences, whilst taking into account the evidence base…

"…there is no clear evidence supporting the use of one treatment over another." (Psychosis & AOD use disorders p. 118[1])

"As with all decisions to treat, this should be informed by the relevant evidence-base, and decisions made in partnership with the client"

- (OCD & AOD use disorders p. 180[1]).

Scope for SDM for clients with co-occurring conditions

Drug and Alcohol Review (2020)
DOI: 10.1111/dar.13149

COMPREHENSIVE REVIEW

Shared decision-making among people with problematic alcohol/other drug use and co-occurring mental health conditions: A systematic review

ALANA FISHER[1,2], KATHERINE MILLS[1], MAREE TEESSON[1] & CHRISTINA MAREL[1]

[1]*The Matilda Centre for Research in Mental Health and Substance Use, Faculty of Medicine and Health, The University of Sydney, Sydney, Australia, and* [2]*The School of Psychology, The University of Sydney, Sydney, Australia*

Abstract
Introduction and Aims. *Over half of people presenting to alcohol/other drug (AOD) treatment services also have a mental health condition. Guidelines support numerous viable treatment options, meaning that treatment decisions need to be evidence based and patients' preferences need to be considered. Shared decision-making (SDM) facilitates evidence- and preference-based decisions and is well researched in other health-care areas. Little is known, however, about people's attitudes towards and experience of SDM in co-occurring AOD and mental health conditions.* ***Design and Methods.*** *Systematic literature review via key database searches MEDLINE, EMBASE, PsycINFO, Scopus, the Cochrane Central Register of Controlled Trials and Database of Systematic Reviews (January 2000–July 2019). Two independent reviewers assessed study eligibility, extracted data and rated study quality using a validated tool.* ***Results.*** *Of 2393 articles identified, 10 studies were retained for final inclusion. The reviewed studies suggested that SDM is a well-accepted and preferred approach to treatment decision-making. SDM-based interventions are viewed as feasible, acceptable and useful; are associated with improvements in the quality of the decision-making process and the decision made; and have accrued less consistent evidence to support improvements in patient-related outcomes (e.g. symptoms, treatment adherence/engagement).* ***Discussion and Conclusions.*** *This is the first rigorous synthesis of the empirical literature on SDM in co-occurring AOD and mental health conditions. SDM remains a nascent area of research in comorbidity treatment. Preliminary evidence supports SDM's acceptability, feasibility and utility in managing mental health and AOD comorbidities. Further research is needed to build the evidence base, especially with regard to the efficacy of SDM at improving patient-related outcomes.* [Fisher A, Mills K, Teesson M, Marel C. Shared decision-making among people with problematic alcohol/other drug use and co-occurring mental health conditions: A systematic review. *Drug Alcohol Rev* 2020]

Key words: substance-related disorders, mental disorders, patient participation, decision-making, systematic review.

Systematic review findings

- Key findings from the 13 included articles:
  - Most clients prefer to be actively involved in decision-making re treatment, incl. via SDM (89.7%, n = 1)
  - Interventions to support SDM viewed as acceptable, feasible, and useful by both clinicians and clients (n = 3)

Authors/Year	Decision-making quality outcomes	Client treatment outcomes	Client symptom outcomes
Bradley 2018	--	✗ =	✓
Joosten 2009	--	✓ ✓ =	--
Joosten 2011	=	--	--
Joosten 2008	✓ ✓ =	--	--
Woltmann 2011	✓ = =	--	--

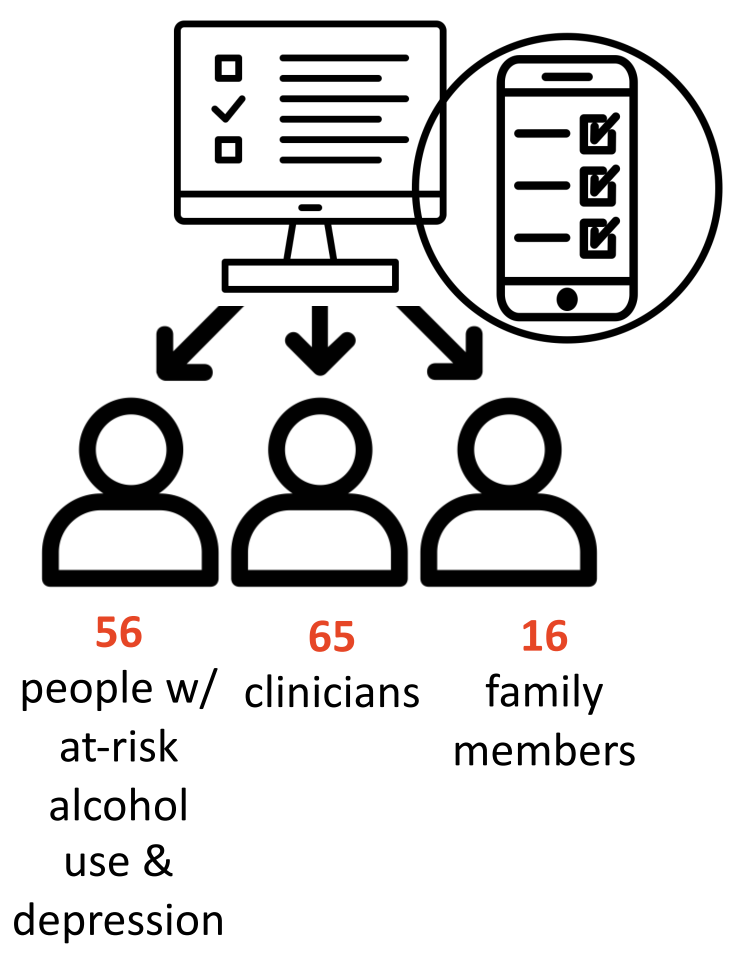
Scope for SDM for clients with co-occurring conditions

Assessing patient information and decision-support needs in problematic alcohol use and co-occurring depression to inform shared decision-making interventions

Alana Fisher, PhD
Christina Marel, PhD
Maree Teesson, PhD
Katherine Mills, PhD

The authors assessed the informational and decision-support needs of patients, families, and clinicians when deciding on treatment for problematic alcohol use and depression. Patients (n = 56), family members (n = 16), and clinicians (n = 65) with experience deciding on treatment for problematic alcohol use and depression were eligible. Participants completed an online decisional needs assessment survey. Stakeholder groups identified numerous difficult patient-level treatment decisions and elevated decisional conflict. Participants preferred patient-led or shared treatment decision-making (75%–95.4%). Patients (32.6%) reported not being as involved in treatment decision-making as preferred, a higher proportion than reported by clinicians (16.4%; p = .056). More patients (19.6%) than clinicians (3.6%) reported clinician-led treatment decision-making, with little or no patient involvement (p = .022). Stakeholder preferences for future decision-support resources included online information for use outside consultations. (Bulletin of the Menninger Clinic, 85[2], 143–176)

Decisional needs assessment survey

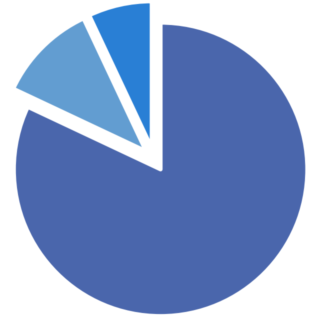


Unmet decision-making support needs

Top-rated difficult decisions:
- Focus on depression, alcohol use, or both?
- Start psychotherapy?
- Start add-on medication for depression?
- Reduce or abstain from drinking?

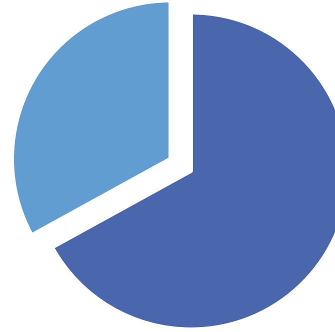
Elevated decisional conflict, i.e. feeling:
- Uninformed
- Uncertain
- Unsupported
- Unable to make a choice
- Likely to delay choice

Preferences for decision-making



Patient-led · Shared · Clinician-led

Match preferences vs experienced



Experienced preferred · Did not experience preferred

Client-rated preferences for decision-support tools

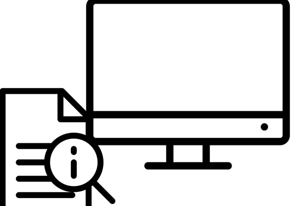
Modality

78% 1:1 counselling
63% Information materials

Guidance using resources

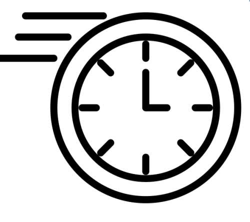
63% health professional
44% no-one (client alone)*

Format



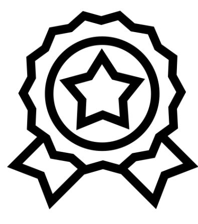
81% website
66% downloadable factsheets

Delivery (timing)



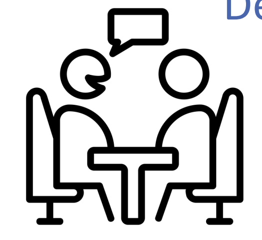
71% in prep. for/ btw consultations
24% within consultations*

Source/ Developers



71% professional societies
66% healthcare specialists
59% not-for-profits

Delivery (where/who)



78% GP appointment
66% Counsellor/ Psychologist

*Deviation from clinician and family member groups

Scope for SDM for clients with co-occurring conditions

- ✓ Based on the best available evidence for single- and dual-focussed psychological treatments
- ✓ Responds to decision-support preferences and needs of clients
- ✓ Content and format developed in consultation with people with lived experience and experienced clinicians
- ✓ Designed according to international standards and recommendations for decision-aids
- ✓ Copy-edited for low health literacy levels to enhance readability and usability of information

Making decisions that are right for you

THE UNIVERSITY OF SYDNEY

Matilda Centre

ADDAPT tool to facilitate SDM

Who is this decision aid for?

This decision aid has been developed to support people who are seeking professional help for depression and risky alcohol use.

This decision aid is meant for people who:

- are 16 years or older
- have mild or moderate symptoms of depression
- are drinking alcohol to risky or hazardous levels, and
- are thinking about whether to address their depression and/or drinking with psychosocial treatments.

This decision aid is not meant for people who:

- are under 16 years
- have severe or acute symptoms of depression
- are dependent on, or abuse, alcohol, or
- are mainly thinking about using medication to address their depression and/ or drinking.

ADDAPT key features

‘Choice talk’

There is currently no ‘single best’ approach to treating depression and at-risk alcohol use. Because of this, it is important to consider the evidence for the options together with what is important and what matters to you.

PSYCHOSOCIAL TREATMENT OPTIONS

- **‘WAIT AND SEE’** (Information only)
- **SINGLE-FOCUSSED TREATMENT** (Depression only or alcohol use)
- **DUAL-FOCUSSED TREATMENT** (Depression and alcohol use)

ADDAPT key features

‘Option talk’

Overview of the main approaches to treatment

What does it involve?		
’WAIT AND SEE’ ACCESS TO INFORMATION ONLY	SINGLE-FOCUSSED TREATMENT[1]	DUAL-FOCUSSED TREATMENT[1]
You do not receive any formal treatment. You may be assessed for your current symptoms of depression and/or alcohol use. You may be assessed over time to ‘wait and see’/check for any changes to symptoms. You may be given some information and other educational resources on depression and/or alcohol use.	You receive treatment for one condition only, either alcohol use or depression. Treatment may contain elements which address the other condition, but the focus is on one condition only.	You receive treatment for both conditions at the same time, either together (integrated system) or separately (parallel system).

ADDAPT key features

'Option talk'

What are the possible advantages of each option?[1,6]

What are the possible disadvantages of each option?[1,4-7]

ADDAPT key features

'Option talk'

ADDAPT

Summary of treatment effectiveness for depression

Does most of the research show that this treatment helps with...

...reducing symptoms of depression?

Single-focussed treatment[1]
Most evidence has shown that single-focussed treatment (for depression or alcohol use only) is not as good as dual-focussed treatment.

Dual-focussed treatments[1]
Most evidence has shown dual-focussed treatments are better than single-focussed treatments (for alcohol use or depression only).
BETTER

How long did effects last? LONG TERM
Studies have shown that these effects last over the longer term (up to six months after treatment ends).

Quality of the research EXCELLENT
Based on several high-quality studies.

Click here to find out more about the effectiveness of these treatment types for depression.

Alcohol and Depression Decision Aid

ADDAPT

Summary of treatment effectiveness for risky alcohol use

Does most of the research show that this treatment helps with...

...reducing how much and how often you drink alcohol?

Single-focussed treatment[1]
Most evidence has shown that single-focussed treatment (for depression or alcohol use only) is as good as dual-focussed treatment.
SIMILAR

Dual-focussed treatments[1]
Most evidence has shown that dual-focussed treatments is the same as (i.e. no better than) single-focussed treatment (for depression or alcohol use only).
SIMILAR

How long did effects last? LONG TERM
Studies have shown that these effects last over the longer-term (up to 6-18 months after treatment ends).

Quality of the research EXCELLENT
Based on evidence from several high-quality studies.

Click here to find out more about the effectiveness of these types of treatment for at-risk alcohol use

Alcohol and Depression Decision Aid

ADDAPT key features

‘Preference/ decision talk’

Option 2: Single-focussed treatment

PROS	CONS
Only one of my conditions (depression or alcohol use) is concerning me right now.	By treating only one condition, symptoms of the other condition may persist and increase my risk of relapse.
Not Important / Important	Not Important / Important
I do not need to make appointments with different treatment providers/services at the same time.	If I reduce my alcohol use with treatment, my untreated depression might get worse (or vice versa).
Not Important / Important	Not Important / Important
I can start treatment for one condition, even if I am not ready to start treatment for the other.	Untreated alcohol use might make it more difficult to stick to depression treatment (or vice versa).
Not Important / Important	Not Important / Important
I want to see if treatment of one condition is enough to improve the other condition also.	I am concerned that treatment of one condition will not be enough to improve my other condition.
Not Important / Important	Not Important / Important
Other:	Other:
Not Important / Important	Not Important / Important
Doing single-focussed treatment	**NOT doing single-focussed treatment**

Alcohol and Depression Decision Aid

Provide feedback on the ADDAPT tool

- Aged 18 years +
- In Australia
- Internet access
- Experienced depression and risky alcohol use *at the same time*
- Currently considering or recently considered options for psychological treatment
- Asked to review e-booklet and complete 20 min survey

https://bit.ly/ADDAPT

Are you thinking about options for treatment for your depression and alcohol use? Give us your feedback on our new resource designed to help make better treatment decisions.

HTTPS://BIT.LY/ADDAPT

Have your say in our survey now!

LEARN MORE

Key take homes

SDM:

- Involves a **two-way exchange** of information/knowledge/expertise, **shared deliberation** of options, and **mutually-agreed upon decision**
- Is the **union of evidence-based and person-centred care**; permits decisions which consider the evidence-base and the client's values, preferences, life circumstances
- Is best suited to decisions with **at least two viable options** and/or **options carry different benefits and costs** which different clients may view differently
- Leads to **improvements in quality of decision-making** and **quality of the decision made**
- May carry **additional considerations in mental health**, e.g., rapport building, involvement of broader networks
- May be facilitated by use of **decision-aids**

Thank you!

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Are you thinking about options for treatment for your depression and alcohol use? Give us your feedback on our new resource designed to help make better treatment decisions.

HTTPS://BIT.LY/ADDAPT

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