Recommendations on Increasing the Uptake of Shared Decision-Making in Integrated Behavioral Health Care

INTRODUCTION

As part of the Increasing Uptake of Shared Decision-Making in Behavioral Health project of the Primary Care Collaborative (PCC), funded by a Eugene Washington PCORI Engagement Award for Community Convening, PCC reviewed existing literature on shared decision-making (SDM) in integrated care. The final results of this review are provided in this document. This review pays particular attention to SDM in an interprofessional context and SDM that considers orienting/training the patient and the clinician. After sharing an initial list of literature with the project’s planning committee, PCC expanded the literature review in order to gain a deeper understanding of the current research available on this topic.

While there is an abundance of research on the subject that suggest benefits to the patient, SDM has not been widely implemented in clinical practice. Therefore, there is little concrete evidence that supports the use of SDM to improve clinical outcomes. The reading list provided in this document includes a selection of publications that speak to the potential of SDM from a clinician and patient perspective, almost all recommending that additional research is required to document concrete clinical outcomes.

The organization* of the review is described below:

Overview/uncategorized
General shared decision-making publications as well as publications conceptualizing and translating shared decision-making into a mental and behavioral health context.

Identification of barriers and enablers to implementation
Publications that explore various barriers and enablers to implementing shared decision-making in behavioral health care.

Reported outcomes
Publications that include results for how shared decision-making impacts clinical outcomes and patient satisfaction.

Clinician perspectives; interprofessional collaboration
Publications that focus on clinician perspectives on implementing shared decision-making in mental and behavioral health as well as how interprofessional collaboration can support this implementation.

Patient perspectives, experiences, and needs
Publications that focus on the perspective of patients, their needs, and wants in shared decision-making and reasons they may feel empowered or disempowered in their care plans.

Training and education
Publications that look at training and educational programs that support the implementation of shared decision-making into behavioral health care.

Assessment of a decision aid
Publications assess the efficacy of specific decision aids or interventions that promote shared decision-making in behavioral health care.

* This organizational system serves the purpose of a general guide. Several of these articles contain elements that could fall into multiple categories. Publications were categorized by the way the main findings and conclusions were framed.

Keywords:
- Patients are also referred to as consumers, service users, and clients
- Clinicians are also referred to as providers and mental health professionals
- SDM elements are referred to as shared decision-making, recovery-oriented approach, therapeutic alliance, patient activation, and person-centered planning
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69. Does Shared Decision Making Improve Care at Community Mental Health Clinics?

70. Shared decision-making in medication management: development of a training intervention.

71. Effectiveness of Shared Decision-Making Training Program in People with Schizophrenia in South Korea.

72. Shared decision-making for psychiatric medication: A mixed-methods evaluation of a UK training programme for service users and clinicians.

## Assessment of a decision aid or intervention

73. Use of a Web-Based Shared Decision-Making Program: Impact on Ongoing Treatment Engagement and Antipsychotic Adherence.

74. Effectiveness of a multi-faceted blended eHealth intervention during intake supporting patients and clinicians in Shared Decision Making: A cluster randomised controlled trial in a specialist mental health outpatient setting.

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OVERVIEW OF THE EVIDENCE

Overview/Uncategorized
Overviewing evidence shows that there is a definite need for more research on shared decision-making (SDM), especially in mental health. More specifically, there is a need for more population- and context-specific research in order to tailor SDM to consumers' varying needs. Available evidence shows one key facet: a strong patient-provider relationship and clear communication are fundamental for making shared decisions. Some preliminary findings showed that SDM is viewed by consumers and clinicians as feasible, acceptable, and useful. Additionally, survey data has shown that both patients and clinicians value client-centered priorities when making decisions about treatment plans. Some “shared decisions” are made with much more pressure than others, and this does not seem to be correlated with patient risk factors. Shared decision-making has the potential to help overcome traditional power imbalances between providers and service users. Structured interventions such as peer instruction, case manager guidance, and condition-specific decision aids can help consumers take initiative in conversations with their providers. Providing training for both consumers and clinicians can help to facilitate mutual understanding and create a space in which consumers can feel comfortable being honest with their clinicians. Findings have shown that SDM is most effective and more frequently used when staff members have support, training, and education. To inform these interventions, it is important to first effectively translate conceptual descriptions of SDM to guide clinician skill development.

Identification of barriers and enablers to implementation
Studies exploring barriers and enablers to SDM implementation found that, while clinicians find SDM difficult to implement, they still view it as an ethical ideal for motivating a therapeutic alliance. Findings emphasize the need for organized professional development including direct training in SDM communication with clear resources to guide implementation. There is a strong need for a cultural shift among mental and behavioral health professionals to effectively balance consumer needs for assistance with autonomy. One study found that for medication consultations, SDM needs to be contextualized within longer-term patient-provider relationships. According to providers, some of the main barriers to implementation included lack of systematic support, time constraints, cultural challenges, and integration with other recovery-oriented systems. For consumers, main barriers included confidence in their own competency, literacy and language barriers, and fear and trauma caused by past experiences in the mental health system. One difficulty found was that clinicians and consumers had very different concerns and perspectives about treatment options, and stakeholder groups had a tendency to blame one another for implementation failure. For patients with involuntary hospitalizations, it was found that SDM needs to initiated very early in the care process in order to establish trust in the providers. Overall, the evidence shows that implementation efforts should be flexible and adaptable so that SDM can be individualized for cultural differences among patients.

Reported outcomes
Though there are few available studies on clinical outcomes of SDM, preliminary findings are positive. One such study found that even a brief SDM intervention was associated with greater patient initiation and improved adherence to psychotherapy. A similar study showed that SDM intervention with substance use disorder (SUD) patients resulted in significantly better improvements than standard decision-making procedures. A correlational analysis indicated that SDM lowered decisional conflict for patients, which is associated with a higher quality of life. Despite clinician concerns, one study found that involvement in decision-making did not increase visit times and depended mostly on the preferences of individual psychiatrists. It has also been shown that the use of an Electronic Decision Support System (EDSS) resulted in higher patient satisfaction in care planning. While more research is needed, these initial results show that implementation of SDM in mental health can improve patient experiences and outcomes.

Clinician perspectives; interprofessional collaboration
One significant barrier to implementing SDM into practice is the differences in clinician versus patient perspectives and preferences. Several studies have been conducted to assess clinician perspectives and the effects of interprofessional collaboration on implementing SDM into behavioral health. Some major findings in the literature indicate certain hesitations providers have in utilizing SDM with their patients. One prominent barrier was a perceived lack of consumer competence when it came to understanding insights in to their mental disorders. Many clinicians also expressed the feeling that SDM should be condition-dependent due to the added complexities of certain conditions. In studies focusing on interprofessional collaboration, limitations included provider preferences, systemic factors, and the need to improve mental health expertise among primary care providers (PCPs). Interprofessional roles need to be better understood and strengthened to increase efficacy of SDM in an integrated primary care-behavioral health space. In a study focusing on PCPs treating mental health concerns of their patients, providers seemed to communicate with patients in a manner falling between a paternalistic and
shared approach to decision making. In the same study, it was also found that stigma was a significant barrier to making shared decisions with African American and Latinx patients. The literature finds that clinicians can improve SDM by targeting stigma, demonstrating positive affect, and tailoring communication to specific patients’ needs. Another study of clinician perspectives focused on using specific tools to support SDM. It was found that staff found the tools useful and would be receptive to implementing concrete supports that work within organizational contexts.

**Consumer perspectives, experiences, and needs**

Encouraging consumers to take an active role in conversations with providers about their treatment options is an important way to increase SDM. This can help strengthen the patient-provider relationship, which has been described as the bedrock of SDM. While it is understood that both internal and external factors impact consumer participation in decision making, new findings suggest that mental health consumers may have a different view of decision-making than standard literature on SDM would suggest. In mental and behavioral health, it is more common for service users to initially prioritize autonomy but defer to care managers when decisional conflict arises. It is therefore important to engage patients and support their active role in decision-making. One study found that 85 percent of patients preferred being provided options and being asked their opinions about their own mental health treatment. Increasing SDM in mental and behavioral health can improve patients’ experiences and treatment outcomes, as shown in one study that found SDM implementation led to more positive attitudes about medication. While more research is needed, one preliminary study of substance-use disorder patients found that matching patient preferences resulted in an overall reduction of substance use. In a study of alcohol-dependent patients, 90 percent preferred an active or shared role in decision-making regarding their care. In studies focused on minority populations, especially with White providers, it was found that patients were more hesitant about taking the initiative to have an active role in decision-making. Service users who had experienced healthcare discrimination in the past were found to have more difficulty in forming trusted relationships with their providers and thus in engaging in SDM. Self-stigma and feelings of shame around mental illness led to consumers being less participatory in care decisions. Paternalistic decision-making can reinforce these feeling in patients, so it is critical for providers, particularly White providers dealing with patients of color, to be trained in cultural sensitivity and interventions to reduce self-stigma in order to promote SDM.

**Training and education**

External systemic factors and implementation challenges have been found to be the most prevalent barriers to SDM efficacy. Structured clinician training has been shown to significantly increase SDM, and more coaching sessions were associated with more effective SDM and greater patient-reported quality of care. Overall, most of the preliminary literature on this topic shows that SDM is most prevalent and effective when all parties, including service users, care coordinators, psychotherapists, and psychiatrists, receive training or structured support. Training service users and care coordinators specifically was associated with increased confidence to explore medication options. Additionally, patient training was positively correlated with improved self-esteem, problem-solving abilities, and quality of life in a study of patients with schizophrenia. The significant effects that self-esteem and stigma have on patient participation in decision-making warrant further investigation.

**Assessment of a decision aid or intervention**

Implementing structured tools into decision-making and/or training can greatly improve implementation and efficacy of SDM in mental health. In a study of one eHealth intervention, it was found that when it was applied correctly, patient reported less decisional conflict, which allows for more confidence in decision-making capabilities. When using the CommonGround digital decision support tool, patients were able to access the most up-to-date information about side effects, which has been found to be one of patients' main concerns when making decisions about medication. Use of a web-based safety-planning tool allowed suicidal patients to build their own plan while receiving feedback from clinicians when they needed it. This resulted in significantly lower intensity of suicidal thoughts and an increased ability to cope with suicidal thoughts. For patients with alcohol dependence, the use of a mobile app showed significant reductions in alcohol consumption. Additionally, the use of a web-based SDM tool was shown to increase antipsychotic medication adherence. In one study, focusing on the Right Question Project – Mental Health (RQP-MH) for Latinx patients, findings suggested that there are layers cultural and contextual factors influencing Latinx participation in healthcare interactions. Patients with linguistic differences from their providers were at higher risk of having difficult or negative interactions within the healthcare system, even after they were exposed to training. This study reinforces the need for additional research in this space as well as the need for all providers to receive culturally competent trainings developed with inputs from diverse minority communities.
ARTICLE ABSTRACTS

Overview/Uncategorized

1. **Shared Decision-Making in Mental Health Care: Practice, Research, and Future Directions.**

   Shared decision-making (SDM) is a practice and concept with the potential to advance wellness and recovery in mental health care. By making the consumer an indispensable partner in the process of recovery, SDM advances many of the goals of mental health care transformation, previously identified by the President's New Freedom Commission on Mental Health, the Institute of Medicine, and others. As A. Kathryn Power, Director of the Center for Mental Health Services (CMHS), Substance Abuse and Mental Health Services Administration (SAMHSA), said: “SDM is an opportunity to make recovery real. By developing and promoting SDM in mental health care, we can advance consumer-centered care and recovery” (Power, 2007). In July 2007, a meeting of approximately 50 experts and stakeholders in SDM and mental health was convened in Washington, DC by CMHS. Participants included researchers and SDM providers in general and mental health care, policymakers, and mental health consumers. The meeting provided an opportunity for participants to exchange perspectives on SDM, inform one another of the state of the science and practice of SDM in general and mental health care, and develop recommendations for advancing SDM within the U.S. mental health care field. Participants shared their experiences as consumers and providers of mental health care and offered insights and perspectives on a variety of aspects of SDM. This report is intended to provide a general overview of SDM and the available research on its effects in both general and mental health care. It includes recommendations from the participants of the SDM meeting. Participant perspectives are included throughout the report, as well as in a section specifically devoted to learnings from the meeting. A resource list, to assist those seeking further information about the concept and practice of SDM, is included in Appendix A.

2. **Shared decision-making: a model for clinical practice.**

   The principles of shared decision-making are well documented but there is a lack of guidance about how to accomplish the approach in routine clinical practice. Our aim here is to translate existing conceptual descriptions into a three-step model that is practical, easy to remember, and can act as a guide to skill development. Achieving shared decision-making depends on building a good relationship in the clinical encounter so that information is shared, and patients are supported to deliberate and express their preferences and views during the decision-making process. To accomplish these tasks, we propose a model of how to do shared decision-making that is based on choice, option and decision talk. The model has three steps: a) introducing choice, b) describing options, often by integrating the use of patient decision support, and c) helping patients explore preferences and make decisions. This model rests on supporting a process of deliberation, and on understanding that decisions should be influenced by exploring and respecting “what matters most” to patients as individuals, and that this exploration in turn depends on them developing informed preferences.

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

   **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.

4. **Decision making in recovery-oriented mental health care.**

**Objective:** Patient-centered communication has been linked to patient satisfaction, treatment adherence and outcomes. Shared decision making (SDM) has been advocated as an important and ethically essential aspect of patient-centered care, but SDM has received relatively little attention in mental health care, despite studies indicating that consumers want to be involved in making decisions. This is particularly important in a recovery-oriented system, where consumers are active participants in their treatment and rehabilitation. Because medication management is a key component of recovery from severe mental illnesses, this study explores how consumers and providers make decisions in medication management consultations.

**Methods:** Four providers (3 psychiatrists, 1 nurse practitioner) and 40 consumers with severe mental illness (10 consumers per provider) were recruited from a community mental health center with a recovery-oriented focus. We directly observed 40 medication management appointments. Observations were audio recorded and transcribed. We used emergent thematic analysis to characterize decision making processes.

**Results:** Providers initiated most decisions, although they often invited consumers to participate in decision making. Decisions initiated by consumers elicited a greater degree of discussion and disagreement, but also frequently resulted in consumers' preferences prevailing. Consultations generally exhibited more characteristics of person-centeredness than SDM.

**Conclusions and implications for practice:** While we observed a high degree of person-centeredness, SDM was not prevalent. Interventions helping consumers to take greater initiative when working with service providers may be helpful. For example, programs using tools such as peer instruction, Internet-based software, and individual case-manager instruction all have shown promise for enhancing SDM in mental health treatment. Further research is needed to determine the degree of SDM in other settings (e.g., with case managers) and the impact of SDM on consumers' recovery.

5. **Pushing the envelope: shared decision making in mental health.**

**Topic:** This article reviews the literature on shared decision making in health and mental health and discusses tools in general health that are proposed for adaptation and use in mental health.

**Purpose:** To offer findings from literature and a product development process to help inform/guide those who wish to create or implement materials for shared decision making in mental health.

**Sources used:** Published literature and research on issues related to shared decision making in health and mental health, focus groups, and product testing.

**Conclusions:** Structured shared decision making in mental health shows promise in supporting service user involvement in critical decision making and provides a process to open all treatment and service decisions to informed and respectful dialogue.

6. **Shared decision making for adults with severe mental illness: A concept analysis.**

**Aim:** Shared decision making for adults with severe mental illness has increasingly attracted attention. However, this concept has not been comprehensively clarified. This review aimed to clarify a concept of shared decision making for adults with severe mental illness such as schizophrenia, depression, and bipolar disorder, and propose an adequate definition.

**Methods:** Rodgers' evolutionary concept analysis was used. MEDLINE, PsychINFO, and CINAHL were searched for articles written in English and published between 2010 and November 2019. The search terms were "psychiatr*" or "mental" or "schizophren*" or "depression" or "bipolar disorder", combined with "shared decision making". In total, 70 articles met the inclusion criteria. An inductive approach was used to identify themes and sub-themes related to shared decision making for adults with severe mental illness. Surrogate terms and a definition of the concept were also described.
**Results:** Four key attributes were identified: user-professional relationship, communication process, user-friendly visualization, and broader stakeholder approach. Communication process was the densest attribute, which consisted of five phases: goal sharing, information sharing, deliberation, mutual agreement, and follow-up. The antecedents as prominent predisposing factors were long-term complex illness, power imbalance, global trend, users' desire, concerns, and stigma. The consequences included decision-related outcomes, users' changes, professionals' changes, and enhanced relationship.

**Conclusions:** Shared decision making for adults with severe mental illness is a communication process, involving both user-friendly visualization techniques and broader stakeholders. The process may overcome traditional power imbalance and encourage changes among both users and professionals that could enhance the dyadic relationship.

7. **Involved, inputting or informing: "Shared" decision making in adult mental health care.**

**Background:** A diagnosis of serious mental illness can impact on the whole family. Families informally provide significant amounts of care but are disproportionately at risk of carer burden when compared to those supporting people with other long-term conditions. Shared decision making (SDM) is an ethical model of health communication associated with positive health outcomes; however, there has been little research to evaluate how routinely family is invited to participate in SDM, or what this looks like in practice.

**Objective:** This UK study aimed to better understand how the family caregivers of those diagnosed with SMI are currently involved in decision making, particularly decisions about treatment options including prescribed medication. Objectives were to explore the extent to which family members wish to be involved in decisions about prescribed medication. Determine how and when professionals engage family in these decisions. Identify barriers and facilitators associated with the engagement of family in decisions about treatment.

**Participants:** Open-ended questions were sent to professionals and family members to elicit written responses. Qualitative responses were analysed thematically.

**Results:** Themes included the definition of involvement and "rules of engagement." Staff members are gatekeepers for family involvement, and the process is not democratic. Family and staff ascribe practical, rather than recovery-oriented roles to family, with preoccupation around notions of adherence.

**Conclusions:** Staff members need support, training, and education to apply SDM. Time to exchange information is vital but practically difficult. Negotiated teams, comprising of staff, service users, family, peers as applicable, with ascribed roles and responsibilities could support SDM.

8. **Integrating Client and Clinician Perspectives on Psychotropic Medication Decisions: Developing a Communication-Centered Epistemic Model of Shared Decision Making for Mental Health Contexts.**

Shared decision making (SDM) interventions aim to improve client autonomy, information sharing, and collaborative decision making, yet implementation of these interventions has been variably perceived. Using interviews and focus groups with clients and clinicians from mental health clinics, we explored experiences with and perceptions about decision support strategies aimed to promote SDM around psychotropic medication treatment. Using thematic analysis, we identified themes regarding beliefs about participant involvement, information management, and participants' broader understanding of their epistemic expertise. Clients and clinicians highly valued client-centered priorities such as autonomy and empowerment when making decisions. However, two frequently discussed themes revealed complex beliefs about what that involvement should look like in practice: (a) the role of communication and information exchange and (b) the value and stability of clinician and client epistemic expertise. Complex beliefs regarding these two themes suggested a dynamic and reflexive approach to information management. Situating these findings within the Theory of Motivated Information Management, we discuss implications for conceptualizing SDM in mental health services and adapt Siminoff and Step's Communication Model of Shared Decision Making (CMSDM) to propose a Communication-centered Epistemic Model of Shared Decision Making (CEM-SDM).

9. **How pressure is applied in shared decisions about antipsychotic medication: a conversation analytic study of psychiatric outpatient consultations.**

The professional identity of psychiatry depends on it being regarded as one amongst many medical specialties and sharing ideals of good practice with other specialties, an important marker of which is the achievement of shared decision-making and avoiding a reputation for being purely agents of social control. Yet the interactions
involved in trying to achieve shared decision-making are relatively unexplored in psychiatry. This study analyses audiotapes of 92 outpatient consultations involving nine consultant psychiatrists focusing on how pressure is applied in shared decisions about antipsychotic medication. Detailed conversation analysis reveals that some shared decisions are considerably more pressured than others. At one end of a spectrum of pressure are pressured shared decisions, characterised by an escalating cycle of pressure and resistance from which it is difficult to exit without someone losing face. In the middle are directed decisions, where the patient cooperates with being diplomatically steered by the psychiatrist. At the other extreme are open decisions where the patient is allowed to decide, with the psychiatrist exerting little or no pressure. Directed and open decisions occurred most frequently; pressured decisions were rarer. Patient risk did not appear to influence the degree of pressure applied in these outpatient consultations.

10. **Conceptualizing patient-centered care for substance use disorder treatment: findings from a systematic scoping review.**

**Background:** Despite ongoing efforts aimed to improve treatment engagement for people with substance-related disorders, evidence shows modest rates of utilization as well as client-perceived barriers to care. Patient-centered care (PCC) is one widely recognized approach that has been recommended as an evidence-based practice to improve the quality of substance use disorder treatment. PCC includes four core principles: a holistic and individualized focus to care, shared decision-making and enhanced therapeutic alliance.

**Aims:** This scoping review aimed to explore which PCC principles have been described and how they have defined and measured among people with substance-related disorders.

**Methods:** Following the iterative stages of the Arksey and O'Malley scoping review methodology, empirical (from Medline, Embase, PsycINFO, CINAHL and ISI Web of Science) and grey literature references were eligible if they focused on people accessing treatment for substance-related disorders and described PCC. Two reviewers independently screened the title/abstract and full texts of references. Descriptive analyses and a directed content analysis were performed on extracted data.

**Findings:** One-hundred and forty-nine references met inclusion from the 2951 de-duplicated references screened. Therapeutic alliance was the most frequent principle of PCC described by references (72%); this was consistently defined by characteristics of empathy and non-judgment. Shared decision-making was identified in 36% of references and was primarily defined by client and provider strategies of negotiation in the treatment planning process. Individualized care was described by 30% of references and included individualized assessment and treatment delivery efforts. Holistic care was identified in 23% of references; it included an integrated delivery of substance use, health and psychosocial services via comprehensive care settings or coordination. Substance use and treatment engagement outcomes were most frequently described, regardless of PCC principle.

**Conclusions:** This review represents a necessary first step to explore how PCC has been defined and measured for people accessing substance use disorder treatment. The directed content analysis revealed population and context-specific evidence regarding the defining characteristics of PCC-principles that can be used to further support the implementation of PCC.

11. **U.S. Survey of Shared Decision-Making Use for Treating Pregnant Women Presenting with Opioid Use Disorder.**

**Background:** The incidence of pregnant women with an opioid use disorder (PWOUD) at delivery has quadrupled since 1999. State-specific statutes regarding PWOUD often pose punitive measures to the mother-infant dyad, involving the child welfare and criminal justice systems. Shared decision making (SDM) assists individuals through complex health and recovery processes.

**Objectives:** To determine use of SDM in treating PWOUD and associated factors and to quantify physicians' review and discussion of child welfare statutes.

**Methods:** The American College of Obstetricians and Gynecologists (ACOG) e-mailed the survey to a random sample of members, with 568 responding. Bivariate analyses to identify factors associated with each outcome were performed using Wilcoxon Rank Sum tests or Fisher's Exact tests. Variables yielding p values < .20 were included in initial logistic regression models; the final model included only significant (<.05) variables.

**Results:** Sixty-one percent used SDM most of the time. Logistic regression indicated that those using SDM were more likely to have had training in substance use disorder and felt prepared for caring for PWOUD; 39% reviewed statutes, and 54% discussed them with PWOUDs.

**Conclusion:** Survey results provide evidence for patient-centered care approaches that support PWOUD involvement in treatment decision making. The SDM model provides an empowerment framework for women
to be involved in the process during their pregnancies and opioid use disorder treatments. Future studies might assess the effectiveness of SDM dialogs with PWOU and evaluate CME training and medical curricula regarding the SDM model.

12. **Caring for the suicidal person: A Delphi study of what characterizes a recovery-oriented caring approach**

More research is needed for supporting mental health nurses in their caring for suicidal individuals. This study aimed to describe what characterizes a recovery-oriented caring approach, and how this can be expressed through caring acts involving suicidal patients and their relatives. Delphi methodology was used, and research participants were recruited as experts by experience to explore a recovery-oriented caring approach in a dialogical process between the experts and the researchers. The results highlight that it is important to acknowledge the view of the uniqueness of each person and reflected understanding of each individual person and experience. The results also reveal that a recovery-oriented caring approach is characterized by a 'communicative togetherness'. This communicative togetherness is associated with enabling a nurturing and caring space for suicidal patients to really express themselves and to reach for their own resources. The recovery-oriented caring approach has thereby potential to facilitate a mutual understanding of the complexities of the patient's situation and supports patients in influencing their care and regaining authority over their own lives. Accordingly, mental health nurses need to listen sensitively to what suicidal patients really say by acknowledging their lifeworlds and being open to individual variations of their recovery processes. This includes recognizing available and supportive relatives as capable of contributing to the patient's life project to continue living.

13. **Centering the Voice of the Client: On Becoming a Collaborative Practitioner with Low-Income Individuals and Families.**

Despite current interest in collaborative practices, few investigations document the ways practitioners can facilitate collaboration during in-session interactions. This investigation explores verbatim psychotherapy transcripts to describe and illustrate therapist's communications that facilitate or hinder centering client's voice in work with socioeconomically disadvantaged populations. Four exemplar cases were selected from a large intervention trial aimed at improving shared decision making (SDM) skills of psychotherapists working with low-income clients. The exemplar cases were selected because they showed therapist's different degrees of success in facilitating SDM. Therapist's verbalizations were grouped into five distinct communicative practices that centered or de-centered the voice of clients. Communication practices were examined through the lens of collaborative approaches in family therapy. The analysis suggests that cross-fertilization between SDM and family-oriented collaborative and critical approaches shows promise to illuminate and enhance the challenging road from clinician-led to client-led interactions. This paper also stresses the importance of incorporating relational intersectionality with individuals and families who may not feel entitled to express their expectations or raise questions when interacting with authority figures.

**Identification of barriers and enablers to implementation**

14. **Shared decision making in mental health treatment: qualitative findings from stakeholder focus groups.**

**Purpose:** This article reports on findings from seven stakeholder focus groups conducted in exploring shared decision making (SDM) between provider and consumer in mental health (MH) treatment in public MH.

**Basic procedures:** Seven focus groups were conducted with stakeholders-consumers, family members, prescribers, MH clinicians, and rural providers. Each of the focus groups was recorded digitally, transcribed into text, and analyzed qualitatively for recurring themes.

**Main findings:** Provider barriers to SDM include history of the medical model, MH crises, lack of system support, and time. Consumer-related barriers included consumer competency, fears, insight, literacy, and trauma from past experiences. Information-exchange issues include consumer passivity, whether consumers could be viewed as experts, and importance of adequate history information. New skills needed to practice SDM included provider's knowledge about alternative treatments, mastery of person-first language, and listening skills; consumer's ability to articulate their expert information; and computer skills for both providers and consumers. Outcomes expected from practice of SDM include greater sharing of power between provider and
consumer, greater follow-through with treatment plans, greater self-management on the part of consumers, and improved therapeutic alliances.

**Principal conclusions:** Implementing SDM in public MH will impact consumers and their families, providers, prescribers, and administrators. More SDM trials in public MH are needed to answer some of the many questions that remain.

15. **Being in a space of sharing decision-making for dignified mental care.**

**Introduction:** Several studies describe barriers and facilitators for implementing shared decision-making in mental care. However, a deeper understanding of the meaning of shared decision-making in this context is lacking. Shared decision-making is aimed at facilitating patients' active participation in their care by placing them at the centre of care. Too much focus on the patients' autonomy may hinder them getting the help they need. A comprehensive understanding of shared decision-making is needed for its implementation.

**Aim/research question:** To interpret the meaning of shared decision-making in mental care as perceived by patients and mental healthcare professionals. The research question was: What is the meaning of shared decision-making in mental care?

**Method:** A hermeneutic inductive design with a thematic interpretative analysis of data was performed from in-depth interviews with 16 patients and multistage focus group interviews with eight mental healthcare professionals.

**Results:** The overall theme being in a space of sharing decision-making for dignified mental care was described by the three themes engaging in a mental room of values and knowledge, relating in a process of awareness and comprehension and responding anchored in acknowledgement.

**Discussion:** Balancing the patients' need for assistance with autonomy, while safeguarding their dignity, is a challenging process requiring mental healthcare professionals to possess professional competence.

**Implications for practice:** Organized professional development of the carers' professional competence is important to facilitate shared decision-making.

16. **Implementing shared decision making in routine mental health care.**

Shared decision making (SDM) in mental health care involves clinicians and patients working together to make decisions. The key elements of SDM have been identified, decision support tools have been developed, and SDM has been recommended in mental health at policy level. Yet implementation remains limited. Two justifications are typically advanced in support of SDM. The clinical justification is that SDM leads to improved outcome, yet the available empirical evidence base is inconclusive. The ethical justification is that SDM is a right, but clinicians need to balance the biomedical ethical principles of autonomy and justice with beneficence and non-maleficence. It is argued that SDM is "polyvalent", a sociological concept which describes an idea commanding superficial but not deep agreement between disparate stakeholders. Implementing SDM in routine mental health services is as much a cultural as a technical problem. Three challenges are identified: creating widespread access to high-quality decision support tools; integrating SDM with other recovery-supporting interventions; and responding to cultural changes as patients develop the normal expectations of citizenship. Two approaches which may inform responses in the mental health system to these cultural changes - social marketing and the hospitality industry - are identified.

17. **Antipsychotic choice: understanding shared decision-making among doctors and patients.**

**Background:** In deciding pharmacotherapy treatment, doctors have to balance the risks and benefits of treatment, and their preferences may not always align with patient preferences. Aim: A pilot study to explore decision-making regarding treatment with antipsychotic medications among doctors and patients.

**Methods:** A discrete choice experiment (DCE), comprised of systematically structured choice tasks, in which doctors and patients were asked to tradeoff between attributes of antipsychotic medications, each described in terms of mode of administration, effectiveness (on positive and negative symptoms) and side effect profiles. Participants also ranked different factors that they consider important when choosing an antipsychotic medication.

**Results:** 52 doctors and 49 patients completed the survey. Doctors accepted a higher risk of side effects than patients if it achieved better efficacy. Patients perceived long acting injectables (LAIs) to be easier than taking tablets every day. Issues of embarrassment, pain and fear of needles were not rated as highly by patients, as
anticipated by doctors. **Conclusions:** Doctors and patients demonstrated differences in decision-making about treatment with antipsychotic medications. Addressing these issues could facilitate shared decision-making, with the goal of improving patient adherence to antipsychotic medications, and thereby improve patient outcomes.

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

**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.

19. **Exploring the potential implementation of a tool to enhance shared decision making (SDM) in mental health services in the United Kingdom: a qualitative exploration of the views of service users, carers and professionals.**

**Background:** As a response to evidence that mental health service users and carers expect greater involvement in decisions about antipsychotic medication choice and prescribing, shared decision-making (SDM) has increasingly come to be viewed as an essential element of person-centred care and practice. However, this aspiration has yet to be realised in practice, as service users and carers continue to feel alienated from healthcare services. Existing understanding of the factors affecting the use of tools to support SDM is limited to inter-individual influences and wider factors affecting potential implementation are underexplored.

**Aim:** To explore the potential use of a tool designed to enhance collaborative antipsychotic prescribing from the perspectives of secondary care mental health service users, carers and professionals.

**Methods:** We conducted a qualitative study (semi-structured interviews and focus groups) using a convenience sample of 33 participants (10 mental health service users, 10 carers and 13 professionals) involved in antipsychotic prescribing in one Trust in the North of England. Participants were asked about the potential implementation of a tool to support SDM within secondary mental health services. Framework analysis incorporating the use of constant comparative method was used to analyse the data.

**Results:** The study identified a divergence in the views of service users and professionals, including a previously undocumented tendency for stakeholder groups to blame each other for potential implementation failure. This dissonance was shaped by meso and macro level influences relating to paternalism, legislative frameworks, accountability and lack of resources. Participants did not identify any macro level (policy or structural) facilitators to the use of the tool highlighting the negative impact of mental health contexts. Our study indicated that inter-individual factors are likely to be most important to implementation, given their potential to transcend meso and macro level barriers.

**Conclusions:** Consideration of the meso and macro level influences identified areas for potential intervention, including challenging professionals' and service users' perceptions of each other, rebalancing the notion of accountability within services and introducing new means for service user feedback on the quality of SDM. Multi-level strategies for facilitating the implementation of tools to support SDM are also presented.

20. **Patients’ and clinicians’ perspectives on shared decision-making regarding treatment decisions for depression, anxiety disorders, and obsessive-compulsive disorder in specialized psychiatric care.**

**Rationale, aims, and objectives:** People worldwide are affected by psychiatric disorders that lack a "best" treatment option. The role of shared decision-making (SDM) in psychiatric care seems evident yet remains limited. Research on SDM in specialized mental health is scarce, concentrating on patients with depressive disorder or psychiatric disorders in general and less on patients with anxiety and obsessive-compulsive disorder (OCD). Furthermore, recent research concentrates on the evaluation of interventions to promote and measure
SDM rather than on the feasibility of SDM in routine practice. This study investigated patients’ and clinicians’ perspectives on SDM to treat depression, anxiety disorders, and OCD as to better understand SDM in specialized psychiatric care and its challenges in clinical practice.

**Methods:** Transcripts of eight focus groups with 17 outpatients and 33 clinicians were coded, and SDM-related codes were analysed using thematic analyses.

**Results:** Motivators, responsibilities, and preconditions regarding SDM were defined. Patients thought SDM should be common practice given the autonomy they have over their own bodies and felt responsible for their treatments. Clinicians value SDM for obtaining patients’ consent, promoting treatment adherence, and establishing a good patient-clinician relationship. Patients and clinicians thought clinicians assumed the most responsibility regarding the initiation and achievement of SDM in clinical practice. According to clinicians, preconditions were often not met, were influenced by illness severity, and formed important barriers (e.g., patient’s decision-making capacity, treatment availability, and clinicians’ preferences), leading to paternalistic decision-making. Patients recognized these difficulties but felt none of these preclude the implementation of SDM. Personalized information and more consultation time could facilitate SDM.

**Conclusions:** Patients and clinicians in specialized psychiatric care value SDM but adapting it to daily practice remains challenging. Clinicians are vital to the implementation of SDM and should become versed in how to involve patients in the decision-making process, even when this is difficult.

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21. **Barriers to shared decision making in mental health care: qualitative study of the Joint Crisis Plan for psychosis.**

**Background:** Despite increasing calls for shared decision making (SDM), the precise mechanisms for its attainment are unclear. Sharing decisions in mental health care may be especially complex. Fluctuations in service user capacity and significant power differences are particular barriers.

**Objective and design:** We trialled a form of facilitated SDM that aimed to generate patients’ treatment preferences in advance of a possible relapse. The ‘Joint Crisis Plan’ (JCP) intervention was trialled in four mental health trusts in England between 2008 and 2011. This qualitative study used grounded theory methods to analyse focus group and interview data to understand how stakeholders perceived the intervention and the barriers to SDM in the form of a JCP.

**Results:** Fifty service users with psychotic disorders and 45 clinicians participated in focus groups or interviews between February 2010 and November 2011. Results suggested four barriers to clinician engagement in the JCP: (i) ambivalence about care planning; (ii) perceptions that they were ‘already doing SDM’; (iii) concerns regarding the clinical ‘appropriateness of service users’ choices’; and (iv) limited ‘availability of service users’ choices’. Service users reported barriers to SDM in routine practice, most of which were addressed by the JCP process. Barriers identified by clinicians led to their lack of constructive engagement in the process, undermining the service users’ experience.

**Conclusions:** Future work requires interventions targeted at the engagement of clinicians addressing their concerns about SDM. Particular strategies include organizational investment in implementation of service users’ choices and directly training clinicians in SDM communication processes.

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22. **Models of user involvement in the mental health context: intentions and implementation challenges.**

Patient-centered care, shared decision-making, patient participation and the recovery model are models of care which incorporate user involvement and patients’ perspectives on their treatment and care. The aims of this paper are to examine these different care models and their association with user involvement in the mental health context and discuss some of the challenges associated with their implementation. The sources used are health policy documents and published literature and research on patient-centered care, shared decision-making, patient participation and recovery. The policy documents advocate that mental health services should be oriented towards patients’ or users’ needs, participation and involvement. These policies also emphasize recovery and integration of people with mental disorders in the community. However, these collaborative care models have generally been subject to limited empirical research about effectiveness. There are also challenges to implementation of the models in inpatient care. What evidence there is indicates tensions between patients’ and providers’ perspectives on treatment and care. There are issues related to risk and the person’s capacity for user involvement, and concerns about what role patients themselves wish to play in decision-making. Lack of competence and awareness among providers are further issues. Further work on training, evaluation and implementation is needed to ensure that inpatient mental health services are adapting user-oriented care models at all levels of services.
23. **Overcoming Obstacles to Shared Mental Health Decision Making.**

Shared decision making (SDM) is difficult to implement in mental health practice, but it remains an ethical ideal for motivating therapeutic capacity in patient-clinician relationships, this discrepancy warrants attention from clinical and ethical perspectives. This article explores what some clinicians see as obstacles to even attempting SDM with patients with psychiatric disabilities. In particular, this article identifies 4 such obstacles: a patient's lack of decision-making capacity, a patient's poor insight, a health care professional's therapeutic pessimism or personal dislike, and a patient's or health care professional's conflicting recovery orientations or goals of care. This article argues that each obstacle could be overcome in many cases and that health care professionals, patients, and their caregivers should remain dedicated to attempting SDM in mental health practice.


Shared decision making (SDM) is a model of interaction between doctors and patients in which both actors contribute to the medical decision-making process. There is an international consensus across medicine about the importance of SDM interventions, which have raised great interest in mental healthcare over the last decade. Yet SDM is not widely adopted, particularly in the field of psychiatry. The purpose of the present article is to examine, from a patient and physician perspective, the importance of SDM in the management of healthcare with a focus on mental health; it reviews the enablers and barriers (and how to overcome them) to implementing a SDM process in psychiatric practice. SDM models have been developed recently for involving patients with depression in the decision-making process, which could result in augmenting the proportion of patients who adhere to their antidepressant or other treatments for a duration that complies with the current recommendations. To implement this approach, more physicians need training in the SDM approach and access to appropriate tools that help engage in collaborative deliberation, and practice generally needs to be reorganized around the principles of patient engagement.

25. **Competing priorities in treatment decision-making: a US national survey of individuals with depression and clinicians who treat depression.**

**Objective:** To identify information priorities for consumers and clinicians making depression treatment decisions and assess shared decision-making (SDM) in routine depression care.

**Design:** 20 questions related to common features of depression treatments were provided. Participants were initially asked to select which features were important, and in a second stage they were asked to rank their top 5 ‘important features’ in order of importance. Clinicians were asked to provide rankings according to both consumer and clinician perspectives. Consumers completed CollaboRATE, a measure of SDM. Multiple logistic regression analysis identified consumer characteristics associated with CollaboRATE scores.

**Setting:** Online cross-sectional surveys fielded in September to December 2014.

**Participants:** We administered surveys to convenience samples of US adults with depression and clinicians who treat depression. Consumer sampling was targeted to reflect age, gender and educational attainment of adults with depression in the USA.

**Primary outcome measures:** Information priority rankings; CollaboRATE, a 3-item consumer-reported measure of SDM.

**Results:** 972 consumers and 244 clinicians completed the surveys. The highest ranked question for both consumers and clinicians was ‘Will the treatment work?’ Clinicians were aware of consumers’ priorities, yet did not always prioritise that information themselves, particularly insurance coverage and cost of treatment. Only 18% of consumers reported high levels of SDM. Working with a psychiatrist (OR 1.87; 95% CI 1.07 to 3.26) and female gender (OR 2.04; 95% CI 1.25 to 3.34) were associated with top CollaboRATE scores.

**Conclusions:** While clinicians know what information is important to consumers making depression treatment decisions, they do not always address these concerns. This mismatch, coupled with low SDM, adversely affects the quality of depression care. Development of a decision support intervention based on our findings can improve levels of SDM and provide clinicians and consumers with a tool to address the existing misalignment in information priorities.

26. **Predictors of shared decision making and level of agreement between consumers and providers in psychiatric care.**
The purpose of this study was to quantitatively examine elements of shared decision making (SDM), and to establish empirical evidence for factors correlated with SDM and the level of agreement between consumer and provider in psychiatric care. Transcripts containing 128 audio-recorded medication check-up visits with eight providers at three community mental health centers were rated using the Shared Decision-Making scale, adapted from Braddock's Informed Decision-Making Scale (Braddock et al. 1997, 1999, 2008). Multilevel regression analyses revealed that greater consumer activity in the session and greater decision complexity significantly predicted the SDM score. The best predictor of agreement between consumer and provider was "exploration of consumer preference," with a four-fold increase in full agreement when consumer preferences were discussed more completely. Enhancing active consumer participation, particularly by incorporating consumer preferences in the decision-making process appears to be an important factor in SDM.

27. From providing a service to being of service: advances in person-centred care in mental health.

**Purpose of review:** This review explores the concept of person-centred care, giving particular attention to its application in mental health and its relationship to recovery. It then outlines a framework for understanding the variety of approaches that have been used to operationalize person-centred care, focusing particularly on shared decision-making and self-directed care, two practices that have significant implications for mental health internationally.

**Recent findings:** Despite growing recognition of person-centred care as an essential component of recovery-orientated practice, the levels of uptake of shared decision-making and self-directed care in mental health remain low. The most significant barrier appears to be the challenge presented to service providers by one of the key principles of person-centred care, namely empowerment.

**Summary:** Shared decision-making and self-directed support, two practices based upon the principles of person-centred care, have the potential for being effective tools for recovery. Full engagement of clinicians is crucial for their successful uptake into practice. More research is needed to address both outcomes and implementation.

28. Shared decision-making across the specialties: Much potential but many challenges.

Shared decision-making (SDM) is a collaborative process through which patients and clinicians work together to arrive at a mutually agreed-upon treatment plan. The use of SDM has gathered momentum, with it being legally mandated in some areas; however, despite being a ubiquitously applicable intervention, its maturity in use varies across the specialties and requires an appreciation of the nuanced and different challenges they each present. It is therefore our aim in this paper to review the current and potential use of SDM across a wide variety of specialties in order to understand its value and the challenges in its implementation. The specialties we consider are Primary Care, Mental Health, Paediatrics, Palliative Care, Medicine, and Surgery. SDM has been demonstrated to improve decision quality in many scenarios across all of these specialties. There are, however, many challenges to its successful implementation, including the need for high-quality decision aids, cultural shift, and adequate training. SDM represents a paradigm shift towards more patient-centred care but must be implemented with continued people centrity in order to realize its full potential.

29. Shared decision-making with involuntary hospital patients: a qualitative study of barriers and facilitators.

**Background:** Last year, there were more than 63,622 involuntary admissions to psychiatric hospitals in England. One of the core principles stipulated in the code of practice for care under the Mental Health Act is involving involuntary patients in care decisions.

**Aims:** Identifying barriers and facilitators to shared decision-making with involuntary patients.

**Method:** Focus groups and individual interviews with patients and clinicians who have experience with involuntary hospital treatment were carried out. Data were subjected to thematic analysis.

**Results:** Twenty-two patients and 16 clinicians participated. Barriers identified included challenges in communication, and noisy and busy wards making one-to-one meetings difficult. Patient involvement was identified as easier if initiated early after admission and if the whole clinical team was on board. Carers' presence helped decision-making through providing additional information and comfort.

**Conclusions:** The barriers and facilitators identified can inform changes in the practice of involuntary care to increase patient involvement.
30. Feasibility and acceptability of shared decision-making to promote alcohol behavior change among women Veterans: Results from focus groups.

**Background:** Although rates of unhealthy drinking are high among women Veterans with mental health comorbidities, most women Veterans with mental comorbidities who present to primary care with unhealthy drinking do not receive alcohol-related care. Barriers to alcohol-related treatment could be reduced through patient-centered approaches to care, such as shared decision-making.

**Aims:** We assessed the feasibility and acceptability of a telephone-delivered shared decision-making intervention for promoting alcohol behavior change in women Veterans with unhealthy drinking and co-morbid depression and/or probable post-traumatic stress disorder.

**Methods:** We used 3, 2-hour focus group discussions with 19 women Veterans to identify barriers and solicit recommendations for using the intervention with women Veterans who present to primary care with unhealthy drinking and mental health comorbidities. Transcripts from the focus groups were qualitatively analyzed using template analysis.

**Results:** Although participants perceived that the intervention was feasible and acceptable for the targeted patient population, they identified the treatment delivery modality, length of telephone sessions, and some of the option grid content as potential barriers. Facilitators included strategies for enhancing the telephone-delivered shared decision-making sessions and diversifying the treatment options contained in the option grids. Focus group feedback resulted in preliminary adaptations to the intervention that are mindful of women Veterans' individual preferences for care and realistic in the everyday context of their busy lives.

31. Barriers to Implementing Person-Centered Recovery Planning in Public Mental Health Organizations in Texas: Results from Nine Focus Groups.

Despite being an established practice in the disabilities service systems, person-centered planning is a relatively new practice in the behavioral health system. As a result, little is known about the barriers that mental health organizations face in implementing person-centered recovery planning (PCRP). To fill this gap, results are presented from a qualitative analysis of nine focus groups at three public mental health organizations in Texas that have been implementing PCRP for at least 2 years. Findings suggest that organizations experienced 12 distinct barriers to PCRP implementation which were categorized into the Consolidated Framework for Implementation Research domains of intervention characteristics, the outer setting, the inner setting, characteristics of individuals, and the implementation process. Half of these 12 barriers fell within the inner setting domain, suggesting that implementation efforts should be flexible and adaptable to organizational culture and context. One-quarter of the barriers fell into the domain of characteristics of individuals involved in the intervention, which further suggests implementation efforts should assess the impact that both staff and consumers have on implementation success.

32. A clinical trial of peer-based culturally responsive person-centered care for psychosis for African Americans and Latinos.

**Background:** Providing culturally competent and person-centered care is at the forefront of changing practices in behavioral health. Significant health disparities remain between people of color and whites in terms of care received in the mental health system. Peer services, or support provided by others who have experience in the behavioral health system, is a promising new avenue for helping those with behavioral health concerns move forward in their lives.

**Purpose:** We describe a model of peer-based culturally competent person-centered care and treatment planning, informed by longstanding research on recovery from serious mental illness used in a randomized clinical trial conducted at two community mental health centers.

**Methods:** Participants all were Latino or African American with a current or past diagnosis within the psychotic disorders spectrum as this population is often underserved with limited access to culturally responsive, person-centered services. Study interventions were carried out in both an English-speaking and a Spanish-speaking outpatient program at each study center. Interventions included connecting individuals to their communities of choice and providing assistance in preparing for treatment planning meetings, all delivered by peer-service providers. Three points of evaluation, at baseline, 6 and 18 months, explored the impact of the interventions on areas such as community engagement, satisfaction with treatment, symptom distress, ethnic identity, personal empowerment, and quality of life.
Conclusions: Lessons learned from implementation include making cultural modifications, the need for a longer engagement period with participants, and the tension between maintaining strict interventions while addressing the individual needs of participants in line with person-centered principles. The study is one of the first to rigorously test peer-supported interventions in implementing person-centered care within the context of public mental health systems.

33. Shared decision making for psychiatric medication management: beyond the micro-social.

Background: Mental health care has lagged behind other health-care domains in developing and applying shared decision making (SDM) for treatment decisions. This is despite compatibilities with ideals of modern mental health care such as self-management and recovery-oriented practice, and growing policy-level interest. Psychiatric medication is a mainstay of mental health treatment, but there are known problems with prescribing practices, and service users report feeling uninvolved in medication decisions and concerned about adverse effects. SDM has potential to produce better tailoring of psychiatric medication to individuals' needs.

Objectives: This conceptual review argues that several aspects of mental health care that differ from other health-care contexts (e.g., forms of coercion, questions about service users' insight and disempowerment) may impact on processes and possibilities for SDM. It is therefore problematic to uncritically import models of SDM developed in other health-care contexts. We argue that decision making for psychiatric medication is better understood in a broader way that moves beyond the micro-social focus of a medical consultation. Contextualizing specific medication-related consultations within longer term relationships, and broader service systems enables recognition of the multiple processes, actors and agendas that shape how psychiatric medication is prescribed, managed and used, and which may facilitate or impede SDM.

Conclusion: A broad conceptualization of decision making for psychiatric medication that moves beyond the micro-social can account for why SDM in this domain remains a rarity. It has both conceptual and practical utility for evaluating research evidence, identifying future research priorities and highlighting fruitful ways of developing and implementing SDM in mental health care.

34. Considering the care of the suicidal client and the case for 'engagement and inspiring hope' or 'observations.'

Psychiatric/mental health (P/MH) nursing has rightly been described as a 'broad church', and one that contains many contested matters and areas of differing opinion. One such contested matter is that of the appropriate care for the person who is at risk of suicide. Recent, albeit limited, debate of this issue has taken place, and the literature, such as it is, indicates two principal (though linked) positions. These can be summarized as the 'engagement and hope inspiration' position and the 'observations' position. Given the P/MH nurse's unique position in providing 24-hour, day-to-day care to suicidal clients and the growing problem of suicide within people who suffer from mental health problems, it is both necessary and perhaps timely to consider this debate in more detail. Accordingly, this paper considers the debate regarding care for suicidal mental health care clients. First, the paper briefly describes the historical policy context of care for the suicidal client. Next, it focuses on 'observations' and concludes that there is a range of well-established, empirically based problems or drawbacks to this approach. Following this, it focuses on 'engagement, inspiring hope' and points out the key processes of engagement: forming a relationship, a human-human connection, conveying acceptance and tolerance, and hearing and understanding. The value and importance of these most fundamental of interpersonal processes is described and alluded to throughout the limited research into care of the suicidal client. The paper then describes the range of criticisms that have been levelled at the engagement-inspiring hope approach and considers these criticisms in more detail. As a result of this detailed examination, the paper then reiterates the need to replace 'observations' with 'engagement-hope inspiration' as the principal approach to caring for suicidal mental health clients.

Reported outcomes

35. Effectiveness of Shared Decision-Making for Elderly Depressed Minority Primary Care Patients.

Objective: The authors assessed the impact of a shared decision-making (SDM) intervention among elderly depressed minority primary care patients not currently receiving treatment.
Methods: A total of 202 English and Spanish-speaking primary care participants aged 65 and older who scored positive on the Patient Health Questionnaire-9 (≥10) were randomized at the physician level to receive a brief SDM intervention or usual care (UC). Primary analyses focused on patient adherence to either psychotherapy or antidepressant medication, and reduction in depression severity (Hamilton Depression Rating Scale) over 12 weeks.

Results: Patients randomized to physicians in the SDM condition were significantly more likely than patients of physicians randomized to UC to receive a mental health evaluation or initiate some form of treatment (39% versus 21%), and to adhere to psychotherapy visits over 12 weeks. There were no differences between groups in adherence to antidepressant medication or in reduction of depressive symptoms.

Conclusion: Among untreated elderly depressed minority patients from an inner-city municipal hospital, a brief SDM intervention was associated with greater initiation and adherence to psychotherapy. However, low treatment adherence rates across both groups and the intervention's lack of impact on clinical outcomes highlight the need to provide focused and accessible mental health services to patients choosing active treatments.

36. Quality of life, recovery and decision-making: a mixed methods study of mental health recovery in social care.

Purpose: Mental health care is a complex system that includes social care organisations providing support for people with continuing needs. The relationship over time between decisional conflict, social support, quality of life and recovery outcomes across two time periods for people experiencing mental health problems in receipt of social care was investigated.

Methods: This is a mixed methods study comprised of a quantitative survey at two time points using measures of decisional conflict, social support, recovery and quality of life in a random sample (n = 122) using social care services in Wales, UK. In addition, 16 qualitative case studies were developed from data collected from individuals, a supportive other and a care worker (n = 41) to investigate trajectories of care. Survey responses were statistically analysed using SPSS and case study data were thematically analysed.

Results: Participants reported increasing decisional conflict and decreasing social support, recovery and quality of life over the two time points. Linear regression indicated that higher recovery scores predict better quality of life ratings and as ratings for social support decline this is associated with lower quality of life. Correlational analysis indicated that lower decisional conflict is associated with higher quality of life. Thematic analysis indicated that 'connectedness and recovery' is a product of 'navigating the system of care' and the experience of 'choice and involvement' achieved by individuals seeking help.

Conclusions: These results indicate that quality of life for people experiencing mental health difficulties is positively associated with social support and recovery and negatively associated with decisional delay.

37. Shared decision-making in ongoing outpatient psychiatric treatment.

Objective: Research on patient involvement in decision-making in psychiatry has focused on first encounters. This study investigated what decisions are made, level of patient involvement and factors influencing patient involvement in ongoing outpatient visits.

Methods: 72 visits conducted by 20 psychiatrists were video recorded. Patients had a diagnosis of depression or schizophrenia.

Results: On average, there was one medication related and one other decision per visit. Some psychiatrists involved patients more in decisions, as did female psychiatrists. Involvement was lower when patients had more negative symptoms.

Conclusion: Involvement in decision-making appears to be influenced by the individual psychiatrist and specific symptoms but not visit length.

Practice implications: It is noteworthy that patient involvement is not influenced by length of the visit given that this would be a barrier in busy clinical practice. The next step would be to identify the communication patterns of psychiatrists who involve patients more in decision-making.

38. Seven-day shared decision making for outpatients with first episode of mood disorders among university students: A randomized controlled trial.

Providing appropriate treatment to patients with a first episode of mood disorders is crucial for recovery from the disorders. Although shared decision making (SDM) has been proposed as a promising model in psychiatric
practice, an appropriate SDM approach has not yet been established. The aim of the current study was to evaluate the effects of an originally developed seven-day SDM program for outpatients with a first episode of mood disorders among university students. University students with a first episode of mood disorders were randomly allocated into two arms: SDM and control. The participants in the SDM arm received the seven-day SDM program, which included option presentation consultation, external deliberation with a decision aid booklet, decision coaching by a nurse, and decision-making consultation. The control arm received usual care. The primary outcome was patient-perceived involvement. We enrolled 88 participants. Compared with usual care, the SDM program significantly improved patient-perceived involvement in treatment decision making without taking up clinicians' time. The program did not lead to worse symptoms of mood disorders. In conclusion, sharing treatment decision making with university students with a first episode of mood disorders is feasible.

39. **Trial of an electronic decision support system to facilitate shared decision making in community mental health.**

**Objectives:** Involvement of community mental health consumers in mental health decision making has been consistently associated with improvements in health outcomes. Electronic decision support systems (EDSSs) that support both consumer and provider decision making may be a sustainable way to improve dyadic communication in a field with approximately 50% workforce turnover per year. This study examined the feasibility of such a system and investigated proximal outcomes of the system's performance.

**Methods:** A cluster randomized design was used to evaluate an EDSS at three urban community mental health sites. Case managers (N=20) were randomly assigned to the EDSS-supported planning group or to the usual care planning group. Consumers (N=80) were assigned to the same group as their case managers. User satisfaction with the care planning process was assessed for consumers and case managers (possible scores range from 1 to 5, with higher summary scores indicating more satisfaction). Recall of the care plan was assessed for consumers. Linear regression with adjustment for grouping by worker was used to assess satisfaction scores. A Wilcoxon rank-sum test was used to examine knowledge of the care plan.

**Results:** Compared with case managers in the control group, those in the intervention group were significantly more satisfied with the care planning process (mean ± SD score=4.0 ± .5 versus 3.3 ± .5; adjusted p=.01). Compared with consumers in the control group, those in the intervention group had significantly greater recall of their care plans three days after the planning session (mean proportion of plan goals recalled=75% ± 28% versus 57% ± 32%; p=.02). There were no differences between the clients in the intervention and control groups regarding satisfaction.

**Conclusions:** This study demonstrated that clients could build their own care plans and negotiate and revise them with their case managers using an EDSS.

40. **Shared decision-making reduces drug use and psychiatric severity in substance-dependent patients.**

**Background:** In the last decades, shared decision-making (SDM) models have been developed to increase patient involvement in treatment decisions. The purpose of this study was to evaluate a SDM intervention (SDMI) for patients dependent on psychoactive substances in addiction health care programs. The intervention consisted of a structured procedure to reach a treatment agreement and comprised 5 sessions.

**Methods:** Clinicians in 3 treatment centres in the Netherlands were randomly assigned to the SDMI or a standard procedure to reach a treatment agreement.

**Results:** A total of 220 substance-dependent patients receiving inpatient treatment were randomised either to the intervention (n = 111) or control (n = 109) conditions. Reductions in primary substance use (F((1, 124)) = 248.38, p < 0.01) and addiction severity (F((8)) = 27.76, p < 0.01) were found in the total population. Significant change was found in the total population regarding patients' quality of life measured at baseline, exit and follow-up (F((2, 146)) = 5.66, p < 0.01). On the European Addiction Severity Index, SDMI showed significantly better improvements than standard decision-making regarding drug use (F((1, 164)) = 7.40, p < 0.01) and psychiatric problems (F((1, 164)) = 5.91, p = 0.02) at 3-month follow-up.

**Conclusion:** SDMI showed a significant add-on effect on top of a well-established 3-month inpatient intervention. SDMI offers an effective, structured, frequent and well-balanced intervention to carry out and evaluate a treatment agreement.

41. **Shared decision-making: increases autonomy in substance-dependent patients.**
This study examines the effect of a shared decision-making intervention (SDMI) on patients' and clinicians' self-perceived interpersonal behavior. Clinicians (n = 34) in three addiction treatment centers in the Netherlands were randomly assigned to SDMI or treatment decision-making as usual. Patients receiving inpatient treatment in 2005-2006 were included (n = 212). Baseline characteristics were measured by the European Addiction Severity Index (EuropASI) and the Composite International Diagnostic Interview-Substance Abuse Module (CIDI-SAM). Treatment goals were assessed using the Goals of Treatment Questionnaire (GoT-Q) plus a Q-sort ranking procedure. Interpersonal behavior was measured by Interpersonal Checklist-Revised (ICL-R) at baseline, end of treatment, and 3-month follow-up. Repeated measures analyses of variance and multiple hierarchical linear regression analysis were used. The key finding of this study was that SDMI is associated with an increase of patient autonomy (independent behavior) and control behavior. The study limitations have been noted.

Clinic perspective; interprofessional collaboration

### 42. Practitioners' positive attitudes promote shared decision-making in mental health care.

**Rationale and aims:** There is a growing expectation of implementing shared decision making (SDM) in today’s health care service, including mental health care. Traditional understanding of SDM may be too narrow to capture the complexity of treatments of mental health problems. Although the patients' contribution to SDM is well described, the contribution from the health care practitioners is less explored. Therefore, our aim was to explore the attitudes of practitioners in mental health care and the associations between practitioners' attitudes and SDM.

**Method:** We performed a cross-sectional study where practitioners reported their sharing and caring attitudes on the Patient-Practitioner Orientation Scale (PPOS) and age, gender, profession, and clinical working site. The patients reported SDM using the CollaboRate tool. We used a mixed effect model linking the data from each practitioner to one or more patients. We presented the findings and used them as background for a more philosophic reflection.

**Results:** We included 312 practitioners with mean age 46.1 years. Of the practitioners, 60 held a medical doctors degree, 97 were psychologists, and 127 held a college degree in nursing, social science, or pedagogy. Female practitioners reported higher sharing (4.79 vs 4.67 [range 1-6], P = .04) and caring scores (4.77 vs 4.65 [range 1-6], P = .02) than males. The regression model contained 206 practitioners and 772 patients. We found a higher probability for the patient to report high SDM score if the practitioner reported higher sharing scores, and lower probability if the practitioner worked in ambulatory care.

**Conclusions:** SDM in mental health care is complex and demands multifaceted preparations from practitioners as well as patients. The practitioners’ attitudes are not sufficiently explored using one instrument. The positive association between practitioners' patient-centred attitudes and SDM found in this study implies a relevance of the practitioners' attitudes for accomplishment of SDM processes in mental health care.

### 43. Psychiatric service staff perceptions of implementing a shared decision-making tool: a process evaluation study.

**Purpose:** Shared decision making, SDM, in psychiatric services, supports users to experience a greater sense of involvement in treatment, self-efficacy, autonomy and reduced coercion. Decision tools adapted to the needs of users have the potential to support SDM and restructure how users and staff work together to arrive at shared decisions. The aim of this study was to describe and analyse the implementation process of an SDM intervention for users of psychiatric services in Sweden.

**Method:** The implementation was studied through a process evaluation utilizing both quantitative and qualitative methods. In designing the process evaluation for the intervention, three evaluation components were emphasized: contextual factors, implementation issues and mechanisms of impact.

**Results:** The study addresses critical implementation issues related to decision-making authority, the perceived decision-making ability of users and the readiness of the service to increase influence and participation. It also emphasizes the importance of facilitation, as well as suggesting contextual adaptations that may be relevant for the local organizations.

**Conclusion:** The results indicate that staff perceived the decision support tool as user-friendly and useful in supporting participation in decision-making, and suggest that such concrete supports to participation can be a factor in implementation if adequate attention is paid to organizational contexts and structures.

### 44. Multiple perspectives on shared decision-making and interprofessional collaboration in mental healthcare.
Shared decision-making is an essential element of patient-centered care in mental health. Since mental health services involve healthcare providers from different professions, a multiple perspective to shared decision-making may be valuable. The objective of this study was to explore the perceptions of different healthcare professionals on shared decision-making and current interprofessional collaboration in mental healthcare. Semi-structured interviews were conducted with 31 healthcare providers from a range of professions, which included medical practitioners (psychiatrists, general practitioners), pharmacists, nurses, occupational therapists, psychologists and social workers.

Findings indicated that healthcare providers supported the notion of shared decision-making in mental health but felt that it should be condition dependent. Medical practitioners advocated a more active participation from consumers in treatment decision-making, whereas other providers (e.g. pharmacists, occupational therapists) focused more toward acknowledging consumers' needs in decisions, perceiving themselves to be in an advisory role in supporting consumers' decision-making. Although healthcare providers acknowledged the importance of interprofessional collaboration, only a minority discussed it within the context of shared decision-making. In conclusion, healthcare providers appeared to have differing perceptions on the level of consumer involvement in shared decision-making. Interprofessional roles to facilitate shared decision-making in mental health need to be acknowledged, understood and strengthened, before an interprofessional approach to shared decision-making in mental health can be effectively implemented.

45. Shared decision-making and interprofessional collaboration in mental healthcare: a qualitative study exploring perceptions of barriers and facilitators.

Shared decision-making and interprofessional collaboration are important approaches to achieving consumer-centered care. The concept of shared decision-making has been expanded recently to include the interprofessional healthcare team. This study explored healthcare providers' perceptions of barriers and facilitators to both shared decision-making and interprofessional collaboration in mental healthcare. Semi-structured interviews were conducted with 31 healthcare providers, including medical practitioners (psychiatrists, general practitioners), pharmacists, nurses, occupational therapists, psychologists and social workers. Healthcare providers identified several factors as barriers to, and facilitators of shared decision-making that could be categorized into three major themes: factors associated with mental health consumers, factors associated with healthcare providers and factors associated with healthcare service delivery. Consumers' lack of competence to participate was frequently perceived by mental health specialty providers to be a primary barrier to shared decision-making, while information provision on illness and treatment to consumers was cited by healthcare providers from all professions to be an important facilitator of shared decision-making. Whilst healthcare providers perceived interprofessional collaboration to be influenced by healthcare provider, environmental and systemic factors, emphasis of the factors differed among healthcare providers. To facilitate interprofessional collaboration, mental health specialty providers emphasized the importance of improving mental health expertise among general practitioners and community pharmacists, whereas general health providers were of the opinion that information sharing between providers and healthcare settings was the key. The findings of this study suggest that changes may be necessary at several levels (i.e., consumer, provider and environment) to implement effective shared decision-making and interprofessional collaboration in mental healthcare.

46. Primary care professional's perspectives on treatment decision making for depression with African Americans and Latinos in primary care practice.

Increasing interest has been shown in shared decision making (SDM) to improve mental health care communication between underserved immigrant minorities and their providers. Nonetheless, very little is known about this process. The following is a qualitative study of fifteen primary care providers at two Federally Qualified Health Centers in New York and their experience during depression treatment decision making. Respondents described a process characterized in between shared and paternalistic models of treatment decision making. Barriers to SDM included discordant models of illness, stigma, varying role expectations and decision readiness. Respondents reported strategies used to overcome barriers including understanding illness perceptions and the role of the community in the treatment process, dispelling stigma using cultural terms, orienting patients to treatment and remaining available regarding the treatment decision. Findings from this study have implications for planning SDM interventions to guide primary care providers through treatment engagement for depression.

47. Psychological predictors of medical residents' perspectives on shared decision-making with patients: a cross-sectional study.
Background: Shared Decision Making (SDM) is an ideal model for resident-patient relationship which may improve medical outcomes. Nevertheless, predictive psychological factors influencing residents' perspective regarding SDM are unclear. The current study investigated the relationship between two psychological factors, mental health and personality traits, and residents' views toward SDM.

Method: In a cross-sectional study, 168 medical residents of the Babol University of Medical Sciences studying in 13 field specialties were recruited. The residents completed three questionnaires including Shared Decision-Making Questionnaire (SDM-Q-Doc, physician version), General Health Questionnaire (GHQ-12), and Big Five Personality (NEO-FFI).

Results: Residents had an overall agreement of about 88% regarding SDM with patients. There was no significant difference between male and female residents in terms of the degree of agreement for SDM. Concerning SDM, there was no significant relationship either between residents' views and neuroticism, extraversion, agreeableness, and conscientiousness. In multivariate regression, mental health did not predict the SDM, but openness to experience negatively predicted residents' views concerning SDM ($\beta = -0.388$, $p < 0.001$).

Conclusion: The residents' personality trait of openness to experience was a significant negative predictor of SDM with patients. A better understanding of how psychological factors relate to residents' perspectives may help clinicians properly discuss the treatment options with the patient thereby encouraging them for SDM or to consider their own preferences.

48. Consultant psychiatrists' experiences of and attitudes towards shared decision making in antipsychotic prescribing, a qualitative study.

Background: Shared decision making represents a clinical consultation model where both clinician and service user are conceptualised as experts; information is shared bilaterally, and joint treatment decisions are reached. Little previous research has been conducted to assess experience of this model in psychiatric practice. The current project therefore sought to explore the attitudes and experiences of consultant psychiatrists relating to shared decision making in the prescribing of antipsychotic medications.

Methods: A qualitative research design allowed the experiences and beliefs of participants in relation to shared decision making to be elicited. Purposive sampling was used to recruit participants from a range of clinical backgrounds and with varying length of clinical experience. A semi-structured interview schedule was utilised and was adapted in subsequent interviews to reflect emergent themes. Data analysis was completed in parallel with interviews in order to guide interview topics and to inform recruitment. A directed analysis method was utilised for interview analysis with themes identified being fitted to a framework identified from the research literature as applicable to the practice of shared decision making. Examples of themes contradictory to, or not adequately explained by, the framework were sought.

Results: A total of 26 consultant psychiatrists were interviewed. Participants expressed support for the shared decision-making model, but also acknowledged that it was necessary to be flexible as the clinical situation dictated. A number of potential barriers to the process were perceived however: The commonest barrier was the clinician's beliefs regarding the service users' insight into their mental disorder, presented in some cases as an absolute barrier to shared decision making. In addition, factors external to the clinician - service user relationship were identified as impacting on the decision-making process, including environmental factors, financial constraints as well as societal perceptions of mental disorder in general and antipsychotic medication in particular.

Conclusions: This project has allowed identification of potential barriers to shared decision making in psychiatric practice. Further work is necessary to observe the decision-making process in clinical practice and also to identify means in which the identified barriers, in particular 'lack of insight', may be more effectively managed.

49. Clinician descriptions of communication strategies to improve treatment engagement by racial/ethnic minorities in mental health services: A systematic review.

Objective: To describe studies on clinician communication and the engagement of racial/ethnic minority patients in mental health treatment.

Methods: Authors conducted electronic searches of published and grey literature databases from inception to November 2014, forward citation analyses, and backward bibliographic sampling of included articles. Included studies reported original data on clinician communication strategies to improve minority treatment engagement, defined as initiating, participating, and continuing services.

Results: Twenty-three studies met inclusion criteria. Low treatment initiation and high treatment discontinuation were related to patient views that the mental health system did not address their understandings of illness, care or
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stigma. Treatment participation was based more on clinician language use, communication style, and discussions of patient-clinician differences.

**Conclusion:** Clinicians may improve treatment initiation and continuation by incorporating patient views of illness into treatment and targeting stigma. Clinicians may improve treatment participation by using simple language, tailoring communication to patient preferences, discussing differences, and demonstrating positive affect.

**Practice implications:** Lack of knowledge about the mental health system and somatic symptoms may delay treatment initiation. Discussions of clinician backgrounds, power, and communication style may improve treatment participation. Treatment continuation may improve if clinicians tailor communication and treatment plans congruent with patient expectations.

Patient perspectives, experiences, and needs

50. **Shared decision-making in mental health care-A user perspective on decisional needs in community-based services.**

**Background:** Shared decision-making (SDM) is an emergent research topic in the field of mental health care and is considered to be a central component of a recovery-oriented system. Despite the evidence suggesting the benefits of this change in the power relationship between users and practitioners, the method has not been widely implemented in clinical practice.

**Objective:** The objective of this study was to investigate decisional and information needs among users with mental illness as a prerequisite for the development of a decision support tool aimed at supporting SDM in community-based mental health services in Sweden.

**Methods:** Three semi-structured focus group interviews were conducted with 22 adult users with mental illness. The transcribed interviews were analyzed using a directed content analysis. This method was used to develop an in-depth understanding of the decisional process as well as to validate and conceptually extend Elwyn et al.’s model of SDM.

**Results:** The model Elwyn et al. have created for SDM in somatic care fits well for mental health services, both in terms of process and content. However, the results also suggest an extension of the model because decisions related to mental illness are often complex and involve a number of life domains. Issues related to social context and individual recovery point to the need for a preparation phase focused on establishing cooperation and mutual understanding as well as a clear follow-up phase that allows for feedback and adjustments to the decision-making process.

**Conclusions and Implications for Practice:** The current study contributes to a deeper understanding of decisional and information needs among users of community-based mental health services that may reduce barriers to participation in decision-making. The results also shed light on attitudinal, relationship-based, and cognitive factors that are important to consider in adapting SDM in the mental health system.

51. **Service users' experiences of participation in decision making in mental health services.**

Service user participation in decision making is considered an essential component of recovery-oriented mental health services. Despite the potential of shared decision making to impact service users knowledge and positively influence their experience of decisional conflict, there is a lack of qualitative research on how participation in decision making is promoted from the perspective of psychiatric service users. In order to develop concrete methods that facilitate shared decision making, there is a need for increased knowledge regarding the users' own perspective. The aim of this study was to explore users' experiences of participation in decisions in mental health services in Sweden, and the kinds of support that may promote participation. Constructivist Grounded Theory (CGT) was utilized to analyse group and individual interviews with 20 users with experience of serious mental illness. The core category that emerged in the analysis described a 'struggle to be perceived as a competent and equal person' while three related categories including being the underdog, being controlled and being omitted described the difficulties of participating in decisions. The data analysis resulted in a model that describes internal and external conditions that influence the promotion of participation in decision making. The findings offer new insights from a user perspective and these can be utilized to develop and investigate concrete methods in order to promote user's participation in decisions.

52. **"Just be straight with me:" an exploration of Black patient experiences in initial mental health encounters.**

It is advantageous for a clinician to understand how patients feel about their initial encounters, but it can be difficult to discern what is and what is not working. This qualitative, exploratory study is guided by the question, "What happens during an initial mental health encounter between a Black patient and a non-Black provider that leads the patient to
describe it as a good or poor experience?" The findings are based on face-to-face, postintake interviews with 14 Black patients seen by 11 non-Black providers as part of the Patient-Provider Encounter Study. The objective is to explore the initial interpersonal interactions between Black patients and their non-Black mental health providers and to better understand how patients come to describe the encounter as good (favorable) or poor (unfavorable). A framework inclusive of 5 specific elements is introduced that maps the patient's conceptualization process about how judgments are made about the encounter. Owing to the naturalistic and exploratory nature of the study, a research hypothesis was not established. Instead, we observed how patients scanned the interaction with the provider, made assessments about their provider, and determined whether their experience was positive or negative. The implications of these findings will help to improve the interactions in mental health settings between minority patients and their providers.

53. Factors associated with shared decision-making preferences among veterans with serious mental illness.

**Objective:** This study evaluated preferences for shared decision making with respect to mental health treatment in a sample of veterans who were diagnosed as having serious mental illness.

**Methods:** Participants were 239 outpatients receiving care from the Department of Veterans Affairs who completed self-report questionnaires assessing demographic factors, shared decision-making preferences, psychiatric symptom severity, and the therapeutic relationship with their second-generation antipsychotic prescribers (N=21). Preferences were assessed in regard to three components of decision making: knowledge about mental illness, options about mental health treatment, and decisions about mental health care.

**Results:** Most participants (85%) indicated that they preferred to be offered options and to be asked their opinions about mental health treatment. More variability was noted in preferences for obtaining knowledge and making final treatment decisions; 61% preferred to rely on their providers' knowledge and 64% preferred their provider to make treatment final decisions. Greater preferences for participation in shared decision making were found among African American clients, those currently working for pay, those with college or higher education, those with other than a schizophrenia spectrum diagnosis, and those who reported a poorer therapeutic relationship with their prescribers.

**Conclusions:** The degree to which veterans with serious mental illness desired to participate in their mental health care differed in terms of the aspect of care and across demographic and clinical factors. A thorough assessment of shared decision-making preferences is an important component of recovery-oriented, client-centered care.

54. Shared decision making in pharmacotherapy decisions, perceived by patients with bipolar disorder.

**Background:** Shared decision making has been promoted as standard care, but there has been debate on the possible types. On the one hand, there is a more 'instrumental'/objective approach focused on the exchange of information, but an 'interpersonal'/subjective patient involvement has been suggested as well. In this study we aim to investigate this further by assessing both actual and perceived patient involvement in medical decisions.

**Methods:** Eighty-one consultations between patients with bipolar disorder and their clinicians were observed and scored using the OPTION scale. Afterwards, the patients’ experienced involvement was explored with the SDM-Q-9. Furthermore, several patient characteristics were gathered. Correlations between the scores were examined.

**Results:** The clinicians scored on average 34.6 points on the OPTION scale. In contrast, patients scored on average 77.5 points on the SDM-Q-9, suggesting that patients felt more involved in the consultation than was observable.

**Conclusion:** Our patients with bipolar disorder feel involved in pharmacotherapy decisions, but this is not scored in objective observations. Our data suggest that there are implicit, interpersonal aspects of patient involvement in shared decision making, a concept that deserves further attention and conceptualisation.


**Background:** Shared decision making is a widely accepted standard of patient-centred care that leads to improved clinical outcomes, yet it is commonly underutilised in the field of mental health. Furthermore, little is known regarding patient decision making around antipsychotic medication, which is often poorly adhered to. We aim to explore psychiatric patients' experiences of antipsychotic medication decision making in order to develop a patient decision aid to promote shared decision making.

**Methods:** Focus groups were conducted with patients with chronic psychotic illnesses (n = 20) who had previously made a decision about taking or changing antipsychotic medication. Transcripts were coded and analysed for thematic content and continued until thematic saturation. These themes subsequently informed the development of a decision aid with the help of expert guidance. Further patient input was sought using the think aloud method (n = 3).
Results: Twenty-three patients participated in the study. Thematic analysis revealed that 'adverse effects' was the most common theme identified by patients surrounding antipsychotic medication decision-making followed by 'mode and time of administration', 'symptom control' and 'autonomy'. The final decision aid is included to provoke further discussion and development of such aids.

Conclusions: Patients commonly report negative experiences of antipsychotic medication, in particular side-effects, which remain critical to future decision making around antipsychotic medication. Clinical encounters that increase patient knowledge and maximise autonomy in order to prevent early negative experiences with antipsychotic medication are likely to be beneficial.

56. Shared decision making in public mental health care: perspectives from consumers living with severe mental illness.

Objective: Most theoretical and empirical work regarding decision making in mental health suggests that mental health consumers have better outcomes when their preferences are integrated into quality of life decisions. A wealth of research, however, indicates that providers have difficulty predicting what their clients' priorities are. This study investigates consumer decision-making preferences and understanding of construction of decisions in community mental health.

Methods: People living with severe mental illness being treated in the public mental health care system (N=16) participated in qualitative interviews regarding case management decision making as a part of a larger study investigating a decision support system to facilitate shared decision making. Interviews were transcribed, coded, and cross-case thematic analyses were conducted.

Results: Mental health consumers generally endorse a "shared" style of decision making. When asked what "shared" means, however, consumers describe a two-step process which first prioritizes autonomy, and if that is not possible, defers to case managers' judgment. Consumers also primarily focused on the relationship and affective components of decision making, rather than information-gathering or deliberating on options. Finally, when disagreements arose, consumers primarily indicated they handled them.

Conclusions: Mental health consumers may have a different view of decision making than the literature on shared decision making suggests. Mental health consumers may consciously decide to at least verbally defer to their case managers and remain silent about their preferences or wishes.

57. Preferences for participation in decision making among ethnically diverse patients with anxiety and depression.

This study explored preferences for treatment decision making using the Control Preferences Scale and Problem-Solving Decision-Making Scale among a sample of ethnically diverse adults (N = 60) seeking treatment for anxiety and depression. Most participants expressed a desire for participation in shared decision making. Being Hispanic was significantly associated with a more passive role in decision making. Participants preferred more involvement in decision making versus problem solving tasks for both mental and general health vignettes, and more involvement in mental health versus general health decision-making. More research is needed to confirm tentative results on the influence of sociodemographic variables on preferences for role and participation in treatment decision making and the variation in these preferences. Treatment seeking individuals with anxiety and depression have identifiable preferences for participation in decision making. Asking about patient preferences and a better understanding of variability in preferences may improve patient-provider communication.

58. Factors influencing patients' preferences and perceived involvement in shared decision-making in mental health care.

Background: Although research has suggested that patients desire to participate in shared decision-making, recent studies show that most patients take a passive role in their treatment decisions. The discrepancy between patients' expressed desire and actual behaviors underscores the need to better understand how patients perceive shared decision-making and what factors influence their participation.

Aims: To investigate patients' preferences and appraisals of their involvement in treatment decisions.

Methods: Fifty-four qualitative interviews were conducted with veterans receiving outpatient mental health care at a U.S. Veterans Affairs Medical Center. Interviews were analyzed using thematic analysis.

Results: Participants outlined several factors that influence their preferences and involvement in treatment decisions. These include the patient-provider relationship, fear of being judged, perceived inadequacy, and a history of substance abuse.
Conclusion: Patients' preferences and willingness to engage in shared decision-making fluctuate over time and are context dependent. A better understanding of these factors and a strong patient-provider relationship will facilitate better measurement and implementation of shared decision-making.

59. Understanding the Role of Past Health Care Discrimination in Help-Seeking and Shared Decision-Making for Depression Treatment Preferences.

As a part of a larger, mixed-methods research study, we conducted semi-structured interviews with 21 adults with depressive symptoms to understand the role that past health care discrimination plays in shaping help-seeking for depression treatment and receiving preferred treatment modalities. We recruited to achieve heterogeneity of racial/ethnic backgrounds and history of health care discrimination in our participant sample. Participants were Hispanic/Latino (n = 4), non-Hispanic/Latino Black (n = 8), or non-Hispanic/Latino White (n = 9). Twelve reported health care discrimination due to race/ethnicity, language, perceived social class, and/or mental health diagnosis. Health care discrimination exacerbated barriers to initiating and continuing depression treatment among patients from diverse backgrounds or with stigmatized mental health conditions. Treatment preferences emerged as fluid and shaped by shared decisions made within a trustworthy patient-provider relationship. However, patients who had experienced health care discrimination faced greater challenges to forming trusting relationships with providers and thus engaging in shared decision-making processes.

60. What can patients do to facilitate shared decision making? A qualitative study of patients with depression or schizophrenia and psychiatrists.

Purpose: Patient involvement in decision making is endorsed by patients and professionals. While research has recently been conducted on how professionals can promote shared decision making (SDM), little is known about how patients can also facilitate SDM.

Methods: Seven focus groups were conducted: 3 with psychiatrists and 4 with patients with schizophrenia or depression. The focus groups were transcribed and independently coded line by line by 2 researchers. Data were analyzed using content analysis.

Results: Seven themes related to patient attitudes and behaviors were identified: honesty and openness with one's psychiatrist and oneself, trust in one's psychiatrist and patience with the treatment, respect and politeness, informing the psychiatrist and giving feedback, engagement/active participation during the consultation, gathering information/preparing for the consultation and implementing decisions. Barriers (e.g., avolition, lack of decisional capacity, powerlessness during involuntary treatment) and facilitators of active patient behavior were also identified.

Conclusions: There are various ways in which patients can facilitate SDM/play a more active role in decision making, with patients emphasizing being open and honest and psychiatrists emphasizing being active in the consultation. Interventions to increase active patient behavior may enhance SDM in mental health care.


Objective: People with mental illness struggle with symptoms and with public stigma. Some accept common prejudices and lose self-esteem, resulting in shame and self-stigma, which may affect their interactions with mental health professionals. This study explored whether self-stigma and shame are associated with consumers' preferences for participation in medical decision making and their behavior in psychiatric consultations.

Methods: In a cross-sectional study conducted in Germany, 329 individuals with a diagnosis of a schizophrenia spectrum disorder or an affective disorder and their psychiatrists provided sociodemographic and illness-related information. Self-stigma, shame, locus of control, and views about clinical decision making were assessed by self-report. Psychiatrists rated their impression of the decision-making behavior of consumers. Regression analyses and structural equation modeling were used to determine the association of self-stigma and shame with clinical decision making.

Results: Self-stigma was not related to consumers' participation preferences, but it was associated with some aspects of communicative behavior. Active and critical behavior (for example, expressing views, daring to challenge the doctor's opinion, and openly speaking out about disagreements with the doctor) was associated with less shame, less self-stigma, more self-responsibility, less attribution of external control to powerful others, and more years of education.

Conclusions: Self-stigma and shame were associated with less participative and critical behavior, which probably leads to clinical encounters that involve less shared decision making and more paternalistic decision making.
Paternalistic decision making may reinforce self-stigma and lead to poorer health outcomes. Therefore, interventions that reduce self-stigma and increase consumers' critical and participative communication may improve health outcomes.

62. **Shared decision-making in psychiatry: a study of patient attitudes.**

**Objectives:** Shared decision-making (SDM) is promoted as beneficial in mental healthcare, despite a dearth of supportive evidence. We aimed to obtain patients' perspective on SDM in a ‘real world’ hospital sample.

**Methods:** Structured validated questionnaires were used to examine SDM with regard to treatment choices, and whether SDM influences attitudes towards treatment. The Mini-Mental State Examination was used to assess decision-making capacity.

**Results:** A total of 109 individuals participated, with 60% reporting experiencing SDM. SDM positively correlated with positive attitudes to medication. Those detained under the Mental Health Act had lower levels of SDM.

**Conclusions:** SDM leads to more positive attitudes towards medication and may improve adherence with treatment. SDM may particularly benefit those subjects to involuntary treatment and is not onerous to practice.

63. **Patients’ Experiences of Participating Actively in Shared Decision-Making in Mental Care.**

**Background:** Patients in mental care express a wish for more active participation. Shared decision-making is a way of increasing patient participation. There is lack of research into what the shared decision-making process means and how the patients can participate in and experience it in the context of mental care.

**Objective:** To describe patient participation in shared decision-making in the context of indoor mental care.

**Method:** A qualitative content analysis of data from in-depth interviews with 16 patients was performed.

**Results:** One main theme was revealed: thriving in relation to participating actively in a complementary ensemble of care, which represented the red thread between 2 themes: having mental space to discover my way forward and being in a position to express my case.

**Conclusion:** Patients can participate actively in shared decision-making when the patients' and the mental health-care professionals' joint expertise is applied throughout their mental care. The patients experience thriving when participating actively in a complementary ensemble of care.

64. **Clients’ experiences of shared decision making in an integrative psychotherapy for depression.**

Mental health and general health care research has shown that practitioners can facilitate patient involvement in shared decision making (SDM) and that the approach can benefit patients who wish to take part in decisions around their care. Yet patient experiences of SDM within a psychotherapy context have been little researched. This study examined how clients experienced SDM in a collaborative-integrative psychotherapy. A grounded theory approach used interpersonal process recall interviewing and supplementary semi-structured interviews to investigate 14 clients' experiences of SDM in pluralistic psychotherapy for depression. Verbatim transcripts were coded into 819 meaning units across six categories containing 13 subcomponents that comprised a single, core category. The six categories were (a) experiencing decisions as shared, (b) psychotherapists supporting clients to become more active in the decision-making process, (c) both parties presenting and recognizing expert knowledge, (d) clients felt recognized as an individual and accommodated for by their psychotherapist, (e) clients felt comfortable engaging with the decision-making process, and (f) daunting for clients to be asked to take part in decision discussions. A core category emerged of “Psychotherapists encourage client participation and progressively support clients to provide information and contributions towards shared treatment decisions that could be led equally, or marginally more by one party.” Such support was particularly useful when clients had difficulty contributing as part of decision discussions. Client preferences for SDM change across clients and across decisions, highlighting the importance of practitioners remaining flexible to individual clients when using the approach.

65. **Patient Preferences and Shared Decision Making in the Treatment of Substance Use Disorders: A Systematic Review of the Literature.**

**Background:** Shared Decision Making (SDM) as means to the involvement of patients in medical decision making is increasingly demanded by treatment guidelines and legislation. Also, matching of patients' preferences to treatments has been shown to be effective regarding symptom reduction. Despite promising results for patients with substance
Recommendations on Increasing the Uptake of Shared Decision-Making in Integrated Behavioral Health Care

use disorders (SUD) no systematic evaluation of the literature has been provided. The aim is therefore to give a systematic overview of the literature of patient preferences and SDM in the treatment of patients with SUD.

**Methods:** An electronic literature search of the databases Medline, Embase, Psyndex and Clinical Trials Register was performed. Variations of the search terms substance use disorders, patient preferences and SDM were used. For data synthesis the populations, interventions and outcomes were summarized and described according to the PRISMA statement. Methodological quality of the included articles was assessed with the Mixed Methods Appraisal Tool.

**Results:** N = 25 trials were included in this review. These were conducted between 1986 and 2014 with altogether n = 8,729 patients. Two studies found that patients with SUD preferred to be actively involved in treatment decisions. Treatment preferences were assessed in n = 18 studies, where the majority of patients preferred outpatient compared with inpatient treatment. Matching patients to preferences resulted in a reduction on substance use (n = 3 studies), but the majority of studies found no significant effect. Interventions for SDM differed across patient populations and optional therapeutic techniques.

**Discussion:** Patients with substance use disorders should be involved in medical treatment decisions, as patients with other health conditions. A suitable approach is Shared Decision Making, emphasizing the patients' preferences. However, due to the heterogeneity of the included studies, results should be interpreted with caution. Further research is needed regarding SDM interventions in patient populations with substance use disorders.

66. **Patients' understanding of shared decision making in a mental health setting.**

Shared decision making is a fundamental component of patient-centered care and has been linked to positive health outcomes. Increasingly, researchers are turning their attention to shared decision making in mental health; however, few studies have explored decision making in these settings from patients' perspectives. We examined patients' accounts and understanding of shared decision making. We analyzed interviews from 54 veterans receiving outpatient mental health care at a Department of Veterans Affairs Medical Center in the United States. Although patients' understanding of shared decision making was consistent with accounts published in the literature, participants reported that shared decision making goes well beyond these components. They identified the patient-provider relationship as the bedrock of shared decision making and highlighted several factors that interfere with shared decision making. Our findings highlight the importance of the patient-provider relationship as a fundamental element of shared decision making and point to areas for potential improvement.

67. **Role preferences of patients with alcohol use disorders.**

**Aims:** Shared decision making (SDM) is increasingly demanded in medical decision making. SDM acknowledges patients' role preferences in decision making processes. There has been limited research on SDM and role preferences in substance use disorders; results are promising. Aim of this study was to investigate role preferences of patients with alcohol use disorders (AUD), and to identify predictors of these preferences.

**Method:** Cross-sectional data collected from June 2013 to May 2014 in four detoxification wards in Germany during a randomised controlled trial (RCT, Registration Code 01GY1114) was analysed. Of the 250 patients with AUD who were included in the RCT, data from 242 patients [65% male; mean age = 45.2 years (sd = 10.3)] were analysed. Participants' role preferences were assessed with the Control Preference Scale. Potential correlates were drawn from instruments used in the RCT; multinomial logistic regression was used.

**Results:** 90% (n = 217) of the AUD patients preferred an active or shared role in decision-making, 10% (n = 25) preferred a passive role. Patients' desire for help was associated with their role preference (OR = 3.087, p = .05). The model's goodness of fit was Nagelkerke's R2 = 0.153 [χ2 (24) = 25.206, p = .395].

**Conclusions:** Patients' preference for an active role in decision-making underscores the importance of involving patients in their treatment planning. Patients' desire for help seems to be an important determinant of paternalistic decision making. However, further research is needed to determine whether patients' role preferences are related to their behavior during their treatment referral and recovery.
Training and education

68. Effectiveness of the DECIDE Interventions on Shared Decision Making and Perceived Quality of Care in Behavioral Health with Multicultural Patients: A Randomized Clinical Trial.

**Importance:** Few randomized clinical trials have been conducted with ethnic/racial minorities to improve shared decision making (SDM) and quality of care.

**Objective:** To test the effectiveness of patient and clinician interventions to improve SDM and quality of care among an ethnically/racially diverse sample.

**Design, setting, and participants:** This cross-level 2 × 2 randomized clinical trial included clinicians at level 2 and patients (nested within clinicians) at level 1 from 13 Massachusetts behavioral health clinics. Clinicians and patients were randomly selected at each site in a 1:1 ratio for each 2-person block. Clinicians were recruited starting September 1, 2013; patients, starting November 3, 2013. Final data were collected on September 30, 2016. Data were analyzed based on intention to treat.

**Interventions:** The clinician intervention consisted of a workshop and as many as 6 coaching telephone calls to promote communication and therapeutic alliance to improve SDM. The 3-session patient intervention sought to improve SDM and quality of care.

**Main outcomes and measures:** The SDM was assessed by a blinded coder based on clinical recordings, patient perception of SDM and quality of care, and clinician perception of SDM.

**Results:** Of 312 randomized patients, 212 (67.9%) were female and 100 (32.1%) were male; mean (SD) age was 44.0 (15.0) years. Of 74 randomized clinicians, 56 (75.7%) were female and 18 (4.3%) were male; mean (SD) age was 39.8 (12.5) years. Patient-clinician pairs were assigned to 1 of the following 4 design arms: patient and clinician in the control condition (n = 72), patient in intervention and clinician in the control condition (n = 68), patient in the control condition and clinician in intervention (n = 83), or patient and clinician in intervention (n = 89). All pairs underwent analysis. The clinician intervention significantly increased SDM as rated by blinded coders using the 12-item Observing Patient Involvement in Shared Decision Making instrument (b = 4.52; SE = 2.17; P = .04; Cohen d = 0.29) but not as assessed by clinician or patient. More clinician coaching sessions (dosage) were significantly associated with increased SDM as rated by blinded coders (b = 12.01; SE = 3.72; P = .001; Cohen d = 0.78). The patient intervention significantly increased patient-perceived quality of care (b = 2.27; SE = 1.16; P = .05; Cohen d = 0.19). There was a significant interaction between patient and clinician dosage (b = 7.40; SE = 3.56; P = .04; Cohen d = 0.62), with the greatest benefit when both obtained the recommended dosage.

**Conclusions and relevance:** The clinician intervention could improve SDM with minority populations, and the patient intervention could augment patient-reported quality of care.

69. Does Shared Decision Making Improve Care at Community Mental Health Clinics?

**Background:** Shared decision making (SDM) is a collaborative client–provider interaction that aims to encourage clients’ self-efficacy and voice in treatment decision making. SDM needs to be extended from medical settings to diverse clientele with complex mental health and social needs in community mental health (CMH). The Moving Patient Outcomes toward Wellness and Recovery (mPOWR) system is a CMH-based SDM tool and training package that spans multiple life-functioning and community living skill domains.

**Objectives:** This study investigated the effectiveness of mPOWR in diverse urban and rural CMH settings, with primary aims to (1) improve client and provider participation in SDM and engagement in mental health treatment; (2) increase client understanding of treatment and personal treatment progress; and (3) increase client functionality, personal quality of life, and perceived support for their therapeutic outcomes. As secondary study aims, study exit interviews provided qualitative data to ascertain general impressions of mPOWR and perceived barriers and benefits of mPOWR.

**Methods:** In a quasi-experimental design, 240 existing clients (60 per clinical study site) who met study eligibility criteria (over 18; participating in CMH services for a serious mental health need in 4 target sites; able to provide informed consent; proficient in English, Spanish, or Chinese; and lacking a primary substance use disorder) were randomly selected for study inclusion. Clients in one pair of urban and rural intervention sites received mPOWR, and clients in the other pair of control urban and rural sites received CMH treatment as usual. Clients were followed every 6 months over 24 months. Primary outcomes were treatment engagement and SDM participation as measured by decision satisfaction and communication satisfaction, client understanding of treatment options, and perceived therapeutic support via a working alliance with providers. Secondary outcomes were treatment progress, global quality of life, and client functionality as measured by mental and physical health. Latent growth curve analyses compared study outcomes over time between intervention and control groups.
**Results:** mPOWR did not yield greater improvement in primary or secondary outcomes compared with treatment as usual. Instead, the most robust effect was driven by urban (in older adults) versus rural (all adults) location, with urban participants reporting lower baseline levels on treatment engagement and participation in SDM, perceived therapeutic support, treatment progress, general quality of life, client functionality, and treatment understanding (in the urban control site). Urban sites also reported greater declines in treatment engagement and SDM participation, working alliance, treatment understanding, and treatment progress and global quality of life in later study time points. Qualitative exit interview data suggested that external factors (institutional or client life events) and implementation challenges were the most salient barriers to mPOWR effectiveness, not the structure or content of mPOWR itself. Some clients reported positive experiences and perceived benefits from mPOWR.

**Conclusions:** SDM interventions with clients with mental illness in CMH settings did not affect any study outcomes. More effectiveness and treatment adaptation research is needed to further investigate how to promote the successful use of interventions like mPOWR for behavioral health issues in CMH.

70. **Shared decision-making in medication management: development of a training intervention.**

Shared decision-making is a collaborative process in which clinicians and patients make treatment decisions together. Although it is considered essential to patient-centred care, the adoption of shared decision-making into routine clinical practice has been slow, and there is a need to increase implementation. This paper describes the development and delivery of a training intervention to promote shared decision-making in medication management in mental health as part of the Shared Involvement in Medication Management Education (ShIMME) project. Three stakeholder groups (service users, care coordinators and psychiatrists) received training in shared decision-making, and their feedback was evaluated. The programme was mostly well received, with all groups rating interaction with peers as the best aspect of the training. This small-scale pilot shows that it is feasible to deliver training in shared decision-making to several key stakeholders. Larger studies will be required to assess the effectiveness of such training.

71. **Effectiveness of Shared Decision-Making Training Program in People with Schizophrenia in South Korea.**

**Purpose:** This study aimed to investigate the effects of shared decision-making (SDM) training program on self-esteem, problem-solving ability, and quality of life in people with schizophrenia.

**Design and methods:** A quasi-experiment with a nonequivalent control group pre-posttest design was conducted. The self-esteem scale, the problem-solving ability scale, and the WHOQOL Scale were used.

**Findings:** The SDM training program was effective in improving their self-esteem, problem-solving ability, and quality of life in people with schizophrenia.

**Practice implications:** The SDM training program can be used in various mental health fields such as hospitals, mental health centers, and rehabilitation facilities.

72. **Shared decision-making for psychiatric medication: A mixed-methods evaluation of a UK training programme for service users and clinicians.**

**Background:** Shared decision making (SDM) is recognised as a promising strategy to enhance good collaboration between clinicians and service users, yet it is not practised regularly in mental health.

**Aims:** Develop and evaluate a novel training programme to enhance SDM in psychiatric medication management for service users, psychiatrists and care co-ordinators.

**Methods:** The training programme design was informed by existing literature and local stakeholders consultations. Parallel group-based training programmes on SDM process were delivered to community mental health service users and providers. Evaluation consisted of quantitative measures at baseline and 12-month follow-up, post-programme participant feedback and qualitative interviews.

**Results:** Training was provided to 47 service users, 35 care-coordinators and 12 psychiatrists. Participant feedback was generally positive. Statistically significant changes in service users’ decisional conflict and perceptions of practitioners’ interactional style in promoting SDM occurred at the follow-up. Qualitative data suggested positive impacts on service users’ and care co-ordinators confidence to explore medication experience, and group-based training was valued.

**Conclusions:** The programme was generally acceptable to service users and practitioners. This indicates the value of conducting a larger study and exploring application for non-medical decisions.
Assessment of a decision aid or intervention

73. Use of a Web-Based Shared Decision-Making Program: Impact on Ongoing Treatment Engagement and Antipsychotic Adherence.

Objective: The authors examined the impact of a Web-based shared decision-making application, MyCHOIS-CommonGround, on ongoing outpatient mental health treatment engagement (all users) and antipsychotic medication adherence (users with schizophrenia).

Methods: An intervention study was conducted by comparing Medicaid-enrolled MyCHOIS-CommonGround users in 12 participating mental health clinics (N=472) with propensity score-matched adults receiving services in nonparticipating clinics (N=944). Medicaid claims were used to assess ongoing treatment engagement and antipsychotic adherence (among individuals with schizophrenia) one year prior to and after entry into the cohort. Multilevel linear models were conducted to estimate the effects of the MyCHOIS-CommonGround program over time.

Results: No differences during the baseline year were found between the MyCHOIS-CommonGround group and the matched control group on demographic, diagnostic, or service use characteristics. At one-year follow-up, engagement in outpatient mental health services was significantly higher for MyCHOIS-CommonGround users than for the control group (months with a service, 8.54±.22 versus 6.95±.15; β=1.40, p<.001). Among individuals with schizophrenia, antipsychotic medication adherence was also higher during the follow-up year among MyCHOIS-CommonGround users compared with the control group (proportion of days covered by medication, .78±.04 versus .69±.03; β=.06, p<.01).

Conclusions: These findings provide new evidence that shared decision-making tools may promote ongoing mental health treatment engagement for individuals with serious mental illness and improved antipsychotic medication adherence for those with schizophrenia.

74. Effectiveness of a multi-facetted blended eHealth intervention during intake supporting patients and clinicians in Shared Decision Making: A cluster randomised controlled trial in a specialist mental health outpatient setting.

Objective: To investigate the effectiveness of a multi-facetted blended eHealth intervention, called SDM-Digital Intake (SDM-DI), in which patients and clinicians are supported in Shared Decision Making during the intake process.

Methods: The study is a two-arm matched-paired cluster Randomised Controlled Trial in a specialist mental health outpatient setting with two conditions: SDM-DI and Intake as Usual (IAU). Four intake teams were allocated to each arm. All patients who followed an intake, were asked to participate if they were capable to complete questionnaires. Decisional Conflict (DC), referring to patients’ engagement and satisfaction with clinical decisions, was the primary outcome. Secondary outcomes were patient participation, applying Shared Decision Making (SDM), working alliance, treatment adherence and symptom severity. Effects were measured at two weeks (T1) and two months (T2) after intake. Multilevel regression and intention-to-treat analyses were used. Additionally, the influence of subgroups and intervention adherence on DC were explored.

Results: At T1, 200 patients participated (47% intervention, 53% control), and at T2 175 patients (47% intervention, 53% control). At T1 and T2, no differences were found between conditions on DC. Subgroup analyses showed that effects of SDM-DI on DC were not modified by primary diagnoses mood, anxiety and personality disorders. Compared to IAU, at T2, patients reported positive effects of SDM-DI on SDM (β 7.553, p = 0.038, 95%CI:0.403-14.703, d = 0.32) and reduction of symptoms (β -7.276, p = 0.0497, 95%CI:-14.544--0.008, d = -0.43). No effects were found on patient participation, working alliance and treatment adherence. Exploratory analyses demonstrated that if SDM was applied well, patients reported less DC (β =-0.457, p = 0.000, 95%CI:-0.518--0.396, d = -1.31), which was associated with better treatment outcomes.

Conclusion: Although, this trial fails to demonstrate that SDM-DI by itself is sufficient to reduce DC, the results are encouraging for further efforts in improving and implementing the SDM intervention.

75. Implementing CommonGround in a community mental health center: Lessons in a computerized decision support system.

Objective: Although shared decision making (SDM) is a key element of client-centered care, it has not been widely adopted. Accordingly, interventions have been developed to promote SDM. The aim of this study was to explore the implementation process of one SDM intervention, CommonGround, which utilizes peer specialists and a computerized decision support center to promote SDM.
Method: As part of a larger study, CommonGround was implemented in 4 treatment teams in a community mental health center. The implementation process was examined by conducting semistructured interviews with 12 staff members that were integral to the CommonGround implementation. Responses were analyzed using content analysis. Program fidelity and client program use were also examined.

Results: Although key informants identified several client and staff benefits to using CommonGround, including improved treatment engagement and availability of peer specialists, most clients did not use CommonGround consistently throughout the implementation. Key informants and fidelity reports indicated a number of program (e.g., technological difficulties, increased staff burden) and contextual barriers (e.g., poor fit with service structure, decision support center location, low staff investment and high turnover) to the successful implementation of CommonGround. Strategies to maximize the implementation by increasing awareness, buy-in, and utilization are also reported.

Conclusions and implications for practice: This implementation of CommonGround was limited in its success partly as a result of program and contextual barriers. Future implementations may benefit from incorporating the strategies identified to maximize implementation in order to obtain the full program benefits. (PsycINFO Database Record.)

76. Implementing a digital clinical decision support tool for side effects of antipsychotics: a focus group study.

Background In medicine, algorithms can inform treatment decisions by combining the most up-to-date evidence about side effect profiles of medications, which are comparable in efficacy. Their use provides opportunities for improved shared clinician–patient decision-making when initiating therapy. We designed a decision support tool (DST) that incorporated the latest evidence regarding antipsychotic side effects. The tool allowed patients to select one side effect commonly associated with antipsychotics that they wished to avoid; the tool then provided a list of suggested medications and ones to avoid.

Objective To explore qualitatively the acceptability and usefulness of the DST from the perspectives of patients and psychiatrists.

Methods This qualitative study took place at a mental health and community hospital in Oxford, UK, in 2018. Four patients/carers and four psychiatrists were recruited to two focus groups to explore their perceptions of the tool. Data were thematically analysed.

Findings demonstrated a high degree of acceptability and potential usability of the DST for patients and psychiatrists. The main themes to emerge relating to the DST were ‘prescribing preferences and practices’, ‘consideration and awareness of side effects’, ‘app content, layout and accessibility’, ‘influence on clinical practice’ and ‘role in decision-making’.

Conclusions A proof-of-concept clinical study will incorporate the recommendations produced from the findings into the tool’s design.

Clinical implications Digital DSTs provide opportunities for the most up-to-date information on medication side effects to be used as the basis for shared clinician–patient decision-making. This tool has the potential to improve adherence to psychiatric medication, with benefits to clinical outcomes and healthcare resourcing.


Electronic shared-decision making programs may provide an assistive technology to support physician-patient communication. This mixed methods study examined use of a web-based shared decision-making program (MyCHOIS-CommonGround) by individuals receiving specialty mental health services, and identified qualitative factors influencing adoption during the first 18 months of implementation in two Medicaid mental health clinics. T-tests and χ2 analyses were conducted to assess differences in patient use between sites. Approximately 80% of patients in both clinics created a MyCHOIS-CommonGround user profile, but marked differences emerged between clinics in patients completing shared decision-making reports (79% vs. 28%, χ2(1) = 109.92, p < .01) and average number of reports (7.20 vs. 3.60, t = -3.64, p < .01). Results suggest high penetration of computer-based programs in specialty mental health services is possible, but clinic implementation factors can influence patient use including leadership commitment, peer staff funding to support the program, and implementation strategy, most notably integration of the program within routine clinical workflow.

**Purpose:** Mobile applications (apps) have created new opportunities in the field of alcohol dependence (AD) within new paradigms of shared decision-making and self-management. The aim of this study is to report the results of a pilot study testing the usability of and satisfaction with a mobile app (called SIDEAL) in AD patients.

**Methods:** Adult AD outpatients were included. SIDEAL was installed on patients' personal phones. The Timeline Followback (TLFB) method for the preceding 6 weeks was administered both at baseline and after 6 weeks (end of the study). Self-reports from the app were also assessed at the end of the study and compared to data provided by the TLFB. An online questionnaire about usability and satisfaction was administered to participants after completion of the study. Exploratory efficacy analyses were conducted.

**Results:** Twenty-four patients were included (mean age 48 years (SD 11.3), women 50%). Most patients (22/24) selected a goal to reduce their consumption. Patients used the self-register module of the app for an average of 80% of the study days. The consumption and medication self-register modules were the most valued, as along with the weekly feedback provided by the app about participants' weekly rate of usage. Participants' satisfaction with the app was high. Significant reductions were observed in alcohol consumption (binge drinking days in the last 6 weeks declined from 25 (SD 18.6) to 5.8 (SD 8), p < 0.001; mean daily alcohol consumption in standard units declined from 6.5 (SD 4.3) to 1.9 (SD 1.8), p < 0.001). On most days (88%), patients achieved their self-imposed objectives.

**Conclusion:** SIDEAL is a well-accepted and highly used app by AD patients that could improve their efficacy in managing their AD. Further larger, randomized studies are warranted.

79. **Computer Administered Safety Planning for Individuals at Risk for Suicide: Development and Usability Testing.**

**Background:** Safety planning is a brief intervention that has become an accepted practice in many clinical settings to help prevent suicide. Even though it is quick compared to other approaches, it frequently requires 20 min or more to complete, which can impede adoption. A self-administered, Web-based safety planning application could potentially reduce clinician time, help promote standardization and quality, and provide enhanced ability to share the created plan.

**Objective:** The aim of this study was to design, build, and test the usability of a Web-based, self-administered safety planning application.

**Methods:** We employed a user-centered software design strategy led by a multidisciplinary team. The application was tested for usability with a target sample of suicidal patients. Detailed observations, structured usability ratings, and Think Aloud procedures were used. Suicidal ideation intensity and perceived ability to cope were assessed pre-post engagement with the Web application.

**Results:** A total of 30 participants were enrolled. Usability ratings were generally strong, and all patients successfully built a safety plan. However, the completeness of the safety plan varied. The mean number of steps completed was 5.5 (SD 0.9) out of 6, with 90% (27/30) of participants completing at least 5 steps and 67% (20/30) completing all 6 steps. Some safety planning steps were viewed as inapplicable to some individuals. Some confusion in instructions led to modifications to improve understandability of each step. Ratings of suicide intensity after completion of the application were significantly lower than preratings, pre: mean 5.11 (SD 2.9) versus post: mean 4.46 (SD 3.0), t27=2.49, P=.02. Ratings of ability to cope with suicidal thoughts after completion of the application were higher than preratings, with the difference approaching statistical significance, pre: mean 5.93 (SD 2.9), post: mean 6.64 (SD 2.4), t27=-2.03, P=.05.

**Conclusions:** We have taken the first step toward identifying the components needed to maximize usability of a self-administered, Web-based safety planning application. Results support initial consideration of the application as an adjunct to clinical contact. This allows for the clinician or other personnel to provide clarification, when needed, to help the patient build the plan, and to help review and revise the draft.

80. **Patient-provider communication: understanding the role of patient activation for Latinos in mental health treatment.**

This article highlights results from the Right Question Project-Mental Health (RQP-MH), an intervention designed to teach skills in question formulation and to increase patients' participation in decisions about mental health treatment. Of participants in the RQP-MH intervention, 83% were from a Latino background, and 75% of the interviews were conducted in Spanish. The authors present the steps participants undertook in the process of becoming "activated" to formulate effective questions and develop decision-making skills in relation to their care. Findings suggest that patient activation and empowerment are interdependent because many of the skills (i.e., question formulation, direct patient-provider communication) required to become an "activated patient" are essential to achieve empowerment. Also, findings suggest that cultural and contextual factors can influence the experience of Latinos regarding participation in
health care interactions. The authors provide recommendations for continued research on the patient activation process and further application of this strategy in the mental health field, especially with Latinos.

**FULL CITATIONS**

**Overview/uncategorized**


**Identification of barriers and enablers to implementation**


Reported outcomes


Clinician perspectives; interprofessional collaboration


Patient perspectives, experiences, and needs


Recommendations on Increasing the Uptake of Shared Decision-Making in Integrated Behavioral Health Care


Training and education


Assessment of a decision aid or intervention


