VIEWPOINT

Time to Support Extensive Implementation of Shared Decision Making in Psychiatry

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Shared decision making (SDM) is a health communication approach focusing on patient-clinician interactions around treatment decisions, with the goals of improving clinical and functional outcomes and providing personalized care.[1] The fundamental principles of SDM involve (1) eliminating power asymmetries between clinician and patient; (2) acknowledging that there are at least 2 expert participants: a patient having lived-experience expertise, a clinician having professional expertise, and sometimes a family member[2]; (3) eliciting patient preferences for their involvement in the decision-making (autonomously, conjointly with clinician input, letting clinician make decisions) and eliciting the patient's specific values that could guide the decision (eg, reducing medication adverse effects); (4) discussing at least 2 treatment options (eg, taking, tapering, or stopping antipsychotic medications); (5) making a decision that aligns with the patient's goals, preferences, and values that also makes clear the risks involved in particular decisions[3]; and (6) accepting that the patient's choice of treatment plan may differ from the clinician's recommendation. SDM has been endorsed as the gold standard of patient-clinician interaction in preference-based care by the National Academy of Medicine in the US and the National Institute for Health and Care Excellence in the UK. Studies in the last decade of individuals with serious mental illness (SMI) demonstrating the feasibility of using SDM, and showing the potential for improved outcomes, support the recent acknowledgment of SDM as an essential practice by the American Psychiatric Association[4] and the Substance Abuse and Mental Health Services Administration.

Despite the potential contribution of SDM in mental health, it has yet to be successfully adopted for use in routine psychiatric care, especially for discussing treatment with individuals with SMI. Several patient-, clinician-, and system/policy-related barriers impeding SDM implementation among individuals with SMI have been identified[5] but only partly addressed. For example, a positive shift toward SDM has occurred at the system/policy level, with greater acceptance of the notion of SDM in psychiatry by the American Psychiatric Association[4] and Substance Abuse and Mental Health Services Administration. At the patient level, recent systematic reviews indicate increased development and testing of patient decision aids and SDM interventions. Clinician-related barriers to SDM in psychiatry, however, have received far less empirical investigation. Because psychiatrists are an essential part of SDM, the purpose of this Viewpoint is to discuss critical, yet-to-be-addressed, clinician-related barriers that serve as the "elephant in the room," impeding extensive implementation of SDM in psychiatry.

Beliefs About Cognitive Difficulties and Ability to Engage in SDM

Research on clinicians' perspectives of SDM indicates that the main barrier preventing psychiatrists and other mental health clinicians from initiating SDM with patients with SMI is the belief that the latter have low decisional capacity and cognitive and motivational deficits.[6-8] These beliefs are predominantly associated with patients having SMI rather than with patients having other, non–mental-health diagnoses.[5,9] Evidence for the presence of cognitive and motivational deficits in SMI is based on a variety of data such as patient performance on clinical and experimental cognitive tests, for example the Iowa Gambling Task, and measures evaluating competency to provide informed consent for treatment, for example the MacArthur Competence Assessment Tool. The presence of deficits based on such evaluations can lead psychiatrists to erroneously assume that patients with SMI cannot participate in SDM. Yet, there is no research evaluating whether performance on measures of cognitive functioning, motivation, or competency predicts ability to engage in an SDM process.

Stigmatization and Discrimination in SDM

Making the judgment that patients with SMI cannot participate in SDM because of cognitive limitations is a form of stigmatization, which may lead to unintentional discrimination in offering SDM. Discrimination means treating someone differently because of stigmatic beliefs. A few studies showed that high levels of stigma among patients or their caregivers are associated with less participation in decision-making, less SDM, and more paternalistic decision-making.[10] However, the role of stigma in whether clinicians and psychiatrists offer SDM remains unclear.

Possibility of Coercive Treatment

Unlike other medical clinicians, psychiatrists can initiate coercive treatment and involuntary hospitalization when they believe that a patient poses a potential risk to themselves or to others. The power to admit a patient coercively contradicts the SDM principle of eliminating the power asymmetry between clinician and patient, and therefore presents an obstacle to implementing SDM.[8] Psychiatrists may even be unaware that this power asymmetry affects their interactions, but it may result in patients' reluctance to engage in SDM with the psychiatrist for fear of losing their freedom, government benefits, or social support if the 2 disagree about treatment.[8]

Conclusions and Recommendations

The purpose of this Viewpoint is to promote SDM in psychiatry by addressing critical clinician-related barriers

that impede extensive implementation of SDM in the field. We believe that most psychiatrists appreciate the potential contribution of SDM to patients and to the quality of the care they can provide. Yet, many struggle with practicing SDM daily in the clinic. Evidence-based decision aids and SDM interventions are needed, as well as the development of SDM measures that acknowledge the unique risks of using SDM in psychiatry compared with other medical fields. From the psychiatrist's perspective, engaging patients in SDM can be risky because it opens up the possibility that patients with cognitive difficulties and reduced decisional capacity will make choices the psychiatrist might not agree with, especially because many decisions in psychiatric care are preference based.[3] The possibility of coercive treatment that is largely unique to the psychiatric encounter and the impact of psychiatrists' stigma on initiation of SDM are additional barriers that need further exploration.

To integrate SDM into routine psychiatric care, we first recommend that it be part of medical education and training. Medical students and residents need to learn the importance and the challenges of conducting SDM with psychiatric patients, and they must acquire the skills necessary to engage people with SMI in this practice. The differences between informed consent, clinical decision-making, and SDM should be emphasized as part of training because many use these terms interchangeably. Second, the use of SDM in psychiatry should be recommended as part of the shared responsibility between psychiatrists and patients to ensure that the care patients receive supports their recovery and does not result in harm to them or to others. Historically, this was viewed as the physician's responsibility, which likely led to the use of coercive practices. A key concept in SDM is that of a "level playing field" between patient and clinician, with each bringing specific expertise to the encounter. Using SDM to create psychiatric advance directives indicating patient preferences for care when they are incapacitated by illness may reduce or even prevent the use of coercion. This could transform an involuntary, coercive decision to, perhaps, a shared one. Third, research is needed to explore the association between SDM performance and outcomes in cognitive functioning, motivation, and decision capacity. We are unaware of research that has directly addressed this question.

To conclude, to promote the practice of SDM in psychiatry, research is needed to address key clinician-related barriers: to understand the association, if any, between SDM, cognitive and motivational impairments, and decision capacity; to develop strategies to address coercive situations in advance; and to further address clinicians' stigma about patients with SMI.

ARTICLE INFORMATION

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