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Engaging an outpatient adult with depression in shared decision-making to improve outcomes

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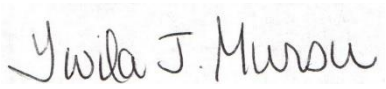
X 

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Abstract

A patient with mental health issues faces decisions regarding treatment options. A provider knows information about diseases, tests, treatments, medications. A patient brings insight about circumstances, values and beliefs, goals for life and healthcare preferences. Often a patient with mental health issues like depression may not have one specific best choice to make. For example, when a patient faces the possibility of needing an antidepressant medication there may not be one best option. A provider and patient need to explore and compare the benefit, harm, and risk of each medication. They collaborate in a shared decision-making process (SDM). They partner to ensure that the best decisions are made. This process factors in the best clinical evidence available along with the values and preferences of the patient. This independent study uses a meta-analysis of completed randomized control tests. These studies are analyzed and reviewed to review the effectiveness of SDM. A patient with depression who engages and shares information in partnership with a provider regarding treatment will attain better health care decisions and outcomes. The implications for health care providers show emerging evidence that supporting a patient in shared decision-making can improve patient satisfaction, patient outcome, and adherence to treatment.

Introduction

Major depression is a common illness and a leading cause of disability worldwide. According to the World Health Organization (2016), more than 350 million individuals worldwide have the disorder. It is a chief contributor to the global burden of disease. The Agency for Healthcare Research and Quality (AHRQ) reports 16% of U. S. adults are affected with major depressive disorder during their lifetime. The study further states "In 2000, the U.S. economic burden of depressive disorders was estimated to be at $83.1 billion" (p. 1). The most common treatment options for depressive disorders include therapy and psychopharmacology.

When a patient and provider collaborate and partner to make a decision together; that process is known as shared decision-making (SDM). Engaging an outpatient with depression in SDM improves outcomes. The Mayo Clinic (2016) found a provider and patient bring different perspectives when clinical decisions are made. A provider has the best clinical evidence regarding disease, tests, treatments, medications. A patient brings insight about circumstances, values and beliefs, goals for life and healthcare preferences (Coulter & Collins, 2011; Mayo Clinic, 2016; Minnesota Shared Decision-Making Collaborative, 2016; U.S. Department of Health and Human Services, 2010). Often mental health issues may not have one specific best choice of treatment. For example, there may not be one best choice for prescribing an antidepressant. A provider and patient need to explore and compare the benefit, harm, and risks of each medication.

Sansone & Sansone (2012) state depression is a treatable condition but often a patient does not adhere to antidepressant agents. There are multiple reasons why a patient discontinues a medication. A patient may choose to discontinue medications due to cost, misunderstanding about medication use, potential abuse issues, forgetfulness, side effects and difficulty with follow

up appointments. These factors are universal across health care in the United States. These factors shape patient decisions in adhering to medication management for mental health issues such as depression.

This paper analyzed and reviewed studies for the effectiveness of SDM. When outpatients with depression engaged in SDM they had improved patient outcomes. A handout was developed to be utilized by a provider and patient. This handout provides tools that can be used collaboratively to facilitate SDM for an individual seeking assistance with depression.

Purpose

The purpose of this paper is to consider how engaging an outpatient with depression in SDM will improve patient outcomes. A handout discussing SDM was created to be utilized by a provider and patient.

Allen and Brock, (2000) discuss the change in communication skills in health care in the past 20 years. More training is now available and provided for staff. A patient has greater health care awareness via technology and does not want to be spoken down to. How a health care provider communicates can affect how a patient reacts and engages in treatment. A provider needs to remember that each patient is an individual and has different needs and priorities. A provider needs to involve each patient in SDM to obtain the best treatment plan.

The goal of the SDM process is the development of a treatment plan to which a patient will adhere. Currently, evidence indicates that overall adherence to treatment is low. An example of the cost of non-adherence is illustrated by the fact that between one- and two-thirds of prescribed medications are either partially taken or not taken at all (Allen & Brock, 2000).

Prescribing medications can be a complex decision requiring partnership between a patient and provider. SDM embraces current science, patient experiences, patient right to

autonomy, informed decision-making, the provider's expertise, and skill in forming an alliance. SDM provides a dynamic means to assess a treatment's advantages and disadvantages within the context of recovering a life after a diagnosis of a major mental disorder (Deegan & Drake, 2006).

The Agency for Health Care Research and Quality (2011) shares that almost two of five patients do not respond to initial treatment. Other systematic reviews have concluded that one antidepressant does not perform better than another antidepressant. An important future pharmacologic research agenda item will be to focus on making the initial treatment strategy more effective. One potential approach includes looking at ways to better predict the treatment response to optimize initial treatment selections (e.g., through genetic analysis). Another approach includes exploring whether combinations of antidepressants at treatment initiation would improve response rates. Furthermore, studies need to explore patient preferences about dosing regimens and the level of acceptance that an individual patient has for various adverse events.

When SDM is utilized, a patient experiences a complex view of decision-making around the use of medication. Decisions on medication use may alter in light of life circumstances, the presence or absence of symptoms of mental illness, and the presence or absence of side effects. Deegan and Drake (2006) share sexual side effects might be tolerated by a patient who is in crisis and isolated, but may be less well accepted as that patient recovers and begins to form relationships with others. The use of psychiatric medication may need to be viewed differently by a provider to help foster a patient discussion. A patient and provider may need to look at managing symptoms of depression with or without medications. Dialogue of what side effects the patient willing to tolerate warrants further consideration.

Significance

Consumer-driven advocacy movements and national policy recommendations led mental health care service systems to move toward a patient-centered model of service provision over the last decade. Patients and their families have promoted a recovery model of care that emphasizes empowerment, hope, self-direction, personal responsibility, and mutual respect (Bellack, 2006; Klingaman, et al., 2015).

Using the SDM model, as fostered by consumer driven advocacy, the provider presents an unbiased view of the pros and cons for all options, including *do nothing*. This may require the patient do to homework (read about a treatment, watch a video, etc.) and then return for further discussion. The patient tells the provider about personal factors that might make one option seem better than another. These factors include personal values, goals, preferences and circumstances. Together, the patient and provider use this information to decide which option best reflects the patient's needs and values (Minnesota Shared Decision-Making Collaborative, 2016).

The immediate goal of SDM is to align care as closely as possible to the patient's wishes. What follows is typically an improvement in satisfaction with care. In the longer term, SDM offers the possibility that individual outcomes, as well as the efficiency and effectiveness of the system of care, will be improved. A patient needing an antidepressant can discuss with the provider the side effect concerns she has about a specific medication. The provider in turn can use this discussion to help narrow the medication choices to avoid this side effect. This discussion can result in the patient adhering to the medication they are prescribed. Patient satisfaction and outcomes, as well as system efficiency and effectiveness, are measurable constructs. Research has only begun to measure the impact of SDM to determine whether it can

achieve these goals (Institute for Clinical Systems Improvement, 2016; Mathias, Saylers, Rollins, & Frankel, 2012; Mayo Clinic, 2016; Minnesota Shared Decision-Making Collaborative, 2016; Wills & Holmes-Rovner, 2003).

Patel, Schnall, Little, Lewis-Fernandez, & Pincus (2014) share that a patient has the expertise derived from living the experience of their disorder. A provider must also recognize the increased importance of utilizing SDM with minority populations to better understand preferences and cultural values. Improving cultural competency is critical for a provider with the task of eliciting an understanding of a patient's depression. Communicating in common terms takes two to three follow-up visits. Follow-up visits involve strategies including understanding a patient's social community and views on depression. It is important to understand culturally appropriate terms for distress within a culture. This may demonstrate a respect that may help increase willingness to engage in the treatment decision-making process.

Oftedahl (2013) looks at how a provider designs and crafts the way care is delivered in focusing efforts on the patient needs and not the institution. The patient lives in the real world and not in a clinic or hospital. A patient has to go out and engage in behaviors that are going to be necessary to improve health. Patient activation shows how a provider is able to meet a patient at the level of their ability to manage that care. A provider needs to know if a patient has not only the motivation and resources, but if values are aligned with a provider recommendation. A provider needs to understand what drives a patient to make changes. How a provider activates and challenges towards a better quality of life is crucial in how a patient feels about their functioning. This dialogue plays a significant role in the outcome of patient treatments.

Theoretical Framework

Charles, Gafni, & Whelan (1997) discuss the idea that in health care there are primarily three types of decision-making models. The paternalistic model consists of the patient being in a passive role and the provider becomes the expert in the decision-making role. The provider often informs the patient which intervention is best. The patient in this model primarily follows the recommended treatment. This type of decision-making works well in an emergency situation where a rapid decision must be made.

The informed decision-making model limits the role of a provider to transfer information to the patient (Charles, Gafni, & Whelan, 1997). In this model, information sharing occurs primarily from the provider to the patient. The physician's role is to give information and communicate the technical or knowledge to the patient. This second model allows a patient to make decisions with information that a provider gives them.

The third decision-making model is SDM. According to Charles, Gafni, and Whelan (1997), there are specific characteristics that set this model apart from the others. First of all, SDM involves at least two participants – the patient and the provider. Both the patient and the provider participate in the process of treatment decisions. Patient preferences are gathered during this time. The provider acts as an expert in presenting available treatment options.

A second important characteristic is that in SDM a provider needs to be careful to not impose his/her values onto the patient. Recognizing cultural differences towards trusting provider recommendations is important in the patient relationship. It is crucial in SDM that information is shared and questions are not only encouraged but welcomed. The provider needs to share treatment alternatives and the potential consequences for the patient in order to obtain informed consent. This information can help the patient evaluate the choices (Charles, Gafni, & Whelan, 1997).

Thirdly, when a treatment choice is made in SDM, both parties agree to the decision. Both parties may not be convinced that this is the best possible treatment for the patient. However, they both need to agree that it is the treatment to implement. The provider may endorse the patient's choice as part of a negotiated agreement in which the patient's views count (Charles, Gafni, Whelan, 1997).

Charles, Gafni, Whelan (1997) are not the only researchers to discuss this type of provider/patient relationship. Hildegard Peplau's Theory of Interpersonal Relationships adds into the thinking of what a nurse/provider does with patients (Halter, 2014). Peplau developed the first systematic theoretical framework for psychiatric nursing. Peplau developed a paradigm shift from a model focused on medical treatments to an interpersonal relational model of nursing practice. She viewed nursing as an educative instrument to help patients and communities use their capacities in living more productively (Halter, 2014).

Peplau's theory is mainly concerned with the processes by which the nurse helps a patient to make positive changes in their health care status and well-being. Her theory identifies the stages of the nurse/patient relationship. It uses the technique of process recording to help students hone their communication and relationship skills. These skills include observation, interpretation, and intervention. The nurse listens to the patient and develops impressions about the meaning of the patient situation. By doing this process, the nurse can view the patient as a unique individual. The nurse's inferences are then validated with the patient for accuracy. Peplau's theory aligns with the model of SDM (Halter, 2014).

Peplau proposed an approach which nurses are both participants and observers in therapeutic conversations. It is important that the nurse is self-aware and focuses on the social and personal needs of the patient. Peplau also promoted interventions to reduce anxiety with the

aim to of improving the patient's ability to think and function at a more satisfactory level. (Halter, 2014).

In reviewing Peplau's theory, SDM aligns in focusing on the social and personal needs of individuals to make decisions regarding treatment (Halter, 2014; Institute for Clinical Systems Improvement, 2016). A decision-making aid can help one discuss what values and priorities a patient looks at for treatment. For example, a depressed patient seeking an antidepressant medication could have an active conversation with their provider to recognize which side effect profile may be the most concerning. A side effect of sexual dysfunction could be a concern for a recently married young male. The cost of medication could impact an elderly adult on fixed income to be compliant. The possibility of weight gain from medications may influence a young female in her decisions. By taking the time to listen to the patient, a provider can start to tune in to the variables that a patient considers and jointly develop a plan with a higher rate of adherence.

Definitions

Shared decision-making - a model that allows a patient and his/her provider to make health care decisions together. It takes into account the best clinical evidence available, as well as the patient's values and preferences. Shared decision-making is a way to achieve outcomes that matter most to the patient. The process of SDM includes several steps. There is recognition that a decision needs to be made. There is identification of partners in the process as equals. There is exploration of understanding and expectations. The patient identifies preferences. The patient and provider negotiate options. The decision is shared by those involved. Follow-up is arranged to evaluate decision-making outcomes. (Charles, Gafni, Whelan, 1997; Mayo Clinic,

2016; Minnesota Shared Decision-Making Collaborative, 2016; U.S. Department of Health and Human Services: SAMSHA, 2010).

Decision-making aids - a tool to facilitate a shared decision-making conversation between the patient and provider. These tools can help patients understand the clinical evidence and help them identify their preferences. Decision aids do not advise people or advocate for one option over another. Instead, they prepare patients to make informed, values-based decisions with their provider (Deegan & Drake, 2006; Mayo Clinic, 2016; U.S. Department of Health and Human Services: SAMSHA, 2010).

Process

A search was performed using the University of North Dakota Harley French Library of the Health Sciences. Fineout-Overholt, Melnyk, Stillwell, & Williamson (2010) recommend searching the databases such as Cochrane, PubMed, which includes Medline, and Cumulative Index to Nursing and Allied Health Literature (CINAHL).

The first search was done using the Cochrane database. Mateo and Foreman (2014) recommend using Boolean operator such as AND to define the relationship of keywords. Keywords used were *depression and shared decision-making* which yielded two results. In reviewing articles, one of these articles was clinically relevant.

The second database search was done on PubMed. Keywords here initially were *depression and shared decision-making*. This lead to 4,154 results. Filters were added to include clinical trials, articles in past five years, English language and human subjects. The search was then narrowed to 93 articles Manual review of these articles determined one of the articles was clinically appropriate.

The third database used was CINAHL. CINAHL headings were used to narrow the search. Initiation of keywords of *depression and shared decision-making* were used with the return of sixty- one articles. Date range of publications from 2011 to 2016 was added reducing number of articles to 18. Manual review of these articles found three articles to be pertinent.

The fourth database used was PsychINFO. Search fields included adulthood, human, English language, years 2010-2015. Use of the headings *depression and shared decision-making* resulted in 31 articles. Manual review of these articles determined that five pertained to the topic.

Information from Institute of Clinical Systems Improvement workshop yielded additional resources on SDM. A search on Minnesota Shared Decision-Making Collaborative (2016) website lead to two articles. A search on the website of Substance Abuse and Mental Health Services Administration lead to additional articles on depression and SDM. The remainder of articles were found in the bibliography and citation sections of journal articles reviewed.

The target population of this paper are mental health providers and patients. The goal of this paper is to develop a brochure which explains the SDM process for providers and patients. This brochure will include information on decision aids that can promote education and communication between a provider and patient looking at options for treatment of depression.

Review of the Literature

Shared decision-making (SDM)

Nearly every psychiatric patient is capable to understand treatment choices and make rational decisions. There are many models and decision aids (DAs) to assist with SDM that are in existence. SDM is a model that can strengthen relationships with a patient and provider by

allowing effective communication and including patient experience in the process (Hostetter & Klein, 2012; Mayo Clinic, 2016; Minnesota Shared Decision-Making Collaborative, 2016; U.S. Department of Health and Human Services, 2010; U.S. Department of Health and Human Services: SAMSHA, 2010). SDM is recommended for conditions such as depression as there are options for treatments that a patient can choose from.

During the SDM process a clinician contributes evidence-based medical knowledge, experiences and attitudes. A patient will share perspectives, expectations, goals and information regarding needs, values and daily life concerns. Hence, a decision on a subsequent treatment can be drawn within the framework of evidence-based medicine and individual patient preferences (Coulter & Collins, 2011; Drake, Cimpean, & Torrey 2009; Holmes-Revner, M, 2007; LeBlance et al. 2015; Minnesota Shared Decision-Making Collaborative, 2016; Stratis Health, 2016; U.S. Department of Health and Human Services/SAMHSA, 2010).

Through SDM, a provider helps a patient understand the importance of values and preferences in making the best decisions. Experience shows when a patient knows they have options for the best treatment, screening test, or diagnostic procedure, most want to participate with their provider in making the choice (Barry, & Edgman-Levitan, 2012; DeJongh & Haight, 2012; Mayo Clinic, 2016).

Fosgerau, & Davidsen (2014) studied general practitioners and psychiatrists from Denmark. The authors utilized conversation analysis and systemic functional linguistics application to examine patient interviews. This study showed that SDM does not always take place during interviews. A physician or psychiatrist did not prompt or explore the patient perspective in depth. Often a provider did not offer their full expertise by not considering patient perspectives. An important lesson from this study shows patients are less likely to disclose

perspectives about medications to a provider without an existing and trusting relationship. An established relationship could lead to more SDM with his or her provider about medication treatment options. This study also brings in the cultural perspective as many viewpoints of the patient are affected by the views of medication in society.

SDM holds the promise of transforming the healthcare relationship between a provider and patient into a relationship of equals with diverse expertise. The SDM approach shifts responsibility for understanding and making decisions to the patient who is working in collaboration with his or her provider. SDM upholds the autonomy of a health care patient by engaging them in shaping the course of treatment.

Shared decision-making and treatment of depression

Drake, Cimpean, & Torrey (2009) utilized the SDM concept by building it into their illness management and recovery. These seven randomized control trials were revealing. With SDM, a patient would increase quality of decisions, knowledge, participation, and values incorporation. Trials involving psychiatric patients also found better adherence and depression symptoms outcomes at three, six, nine, and 12 months.

King, Cederbaum, Kurzban, Norton, Palmer, & Coyne (2015) found that a patient who believed their provider would respectfully facilitate depression treatment reported greater bonds, SDM, and openness with the provider. Empathy and expression help increase patient trust in a provider to facilitate depression treatment. Individuals who have this experience feel safe sharing their early symptoms with providers. This leads to earlier intervention and treatment of depression.

McCabe, Khanom, Bailey, & Priebe (2013) looked at a multivariate analysis of 72 patients with depression or schizophrenia. Twenty psychiatrists were involved in the study. The

study looked at what decisions are made, level of patient involvement, and factors influencing patient involvement in ongoing outpatient visits. This study showed involvement in SDM seems to be influenced by the individual psychiatrist and specific symptoms more than any other factors.

The studies focused on shared decision-making process for the treatment of depression found higher patient engagement with their provider. Higher patient engagement with SDM showed improved patient outcomes for patients with depression (Drake, Cimpean, & Torrey, 2009; King, Cederbaum, Kurzban, Norton, Palmer, & Coyne, 2015; McCabe, Khanom, Bailey, & Priebe, 2013).

Shared decision-making and systemic reviews

Duncan, Best & Hagen (2010) reviewed study designs of randomized controlled trials, quasi-randomized control trials, controlled before and after studies, and interrupted time series. Participants in these studies were professionals, patients, and family members. The studies were noted to have difficulty in interpretation as they cannot be related back to the original assessment scales. This study did not show SDM to have effects on clinical outcomes.

Friedrichs, Spies, Harter, & Buchholz (2016) completed a systematic review of 25 trials of SDM with individuals with substance use disorders. This systematic review had 8,729 patients involved with SDM interventions. The authors found that putting emphasis on substance and social related outcomes showed improvement of psychiatric symptoms. This review had no negative outcomes and it is possible that this review could have bias. However, it seems to state that SDM can be effective with substance abuse disorders as well as depression.

Johnston (2013) did a systematic review of 13 articles that included prospective cohort studies, randomized control studies, retrospective cohort studies and qualitative studies. This

review included 235,363 participants of men and women ages 17 to 95 who lived in the following countries: the Netherlands, the United Kingdom, Finland, Australia, and the United States. Each of these studies included individuals with depression, their range past experiences with depression and antidepressant agents, and providers willing to do SDM with these individuals. When a patient openly shared their knowledge and experience at the beginning of the treatment process, SDM removed barriers. Effective communication opened the door for a patient to include their experiences into treatment decisions. Strengthening the patient-provider relationship leads to better outcomes for patient engagement and empowerment. The study showed the importance of understanding the relationship between patient experience and treatment adherence.

Legare, Ratte, & Graham (2008) reviewed 38 studies including 3,231 physicians to gain understanding pertaining to SDM. The systemic review showed benefits that a health professional gains by asking a patient what role they want to play in their health. This systemic review states that providers need to be able to perceive that shared decision-making with a patient will have a positive outcome on the patient or process of care to fully engage in SDM.

Positive gains in the provider-patient relationship with SDM is noted in the control trials and studies. Specific data to measure patient outcomes varies but there is no negative outcomes noted for the relationships between provider and patient (Duncan, Best, & Hagen, 2010; Friedrichs, Spies, Harter, & Buchholtz, 2016; Johnston, 2013; Legare, Ratte, Gravel, & Graham, 2008).

Shared decision-making and specific patient populations

Dwight-Johnson, Unutzer, Tang & Wells (2001) examined patients with depression at 46 primary care clinics over a six-month period. The study included treatment preferences, patient

characteristics, and use of depression treatments. Intervention choices of psychotropic medications verses psychotherapy were offered to 742 patients with depression. This study showed that patient preferences for treatment did not change during the first six months of intervention. Patient choice can improve the likelihood of receiving preferred treatment methods.

Hamann, et al. (2016) took a different perspective and explored SDM in an acute mental health setting. There were four focus groups of 16 patients who had diagnosis of schizophrenia, bipolar, or major depression and three focus groups of 21 physicians who participated in the study. This study looked at seven themes of patient attitudes and behaviors. Patient openness and honesty in consultation with a psychiatrist enhanced active patient behavior. This led to a patient having a more active role in the SDM process. A possible limitation to this study that was not discussed was if a patient on the inpatient unit would have limited abstract thinking which could influence the interview process.

Klingaman et al. (2015) used a randomized control trial with 239 veterans to explore how consumer preferences for SDM and the therapeutic relationship were related to visit satisfaction. Veterans between the ages of 18-70 were given an item questionnaire that reviewed items to capture patient satisfaction with their providers. Patients were also given a behavioral and symptom identification scale. This study found that assessment and tailoring of treatment approaches to patient preferences must be considered in conjunction with the therapeutic relationship. This validates that patient satisfaction is enhanced with cultivating SDM.

Patel, Schnall, Little, Lewis-Fernandez, & Pincus (2014) brought in more cultural diversity into the review of SDM in underserved immigrant minorities and their providers. This qualitative study had a random sample primary care professionals as well as African Americans

and Latinos in the study. The study showed a provider fostered SDM by openly acknowledging cultural differences. Respectful information had a positive effect on engaging a patient. Providers spent time educating patients about their depression. Providers that addressed the cultural stigma and framed depression as a treatable medical illness saw beneficial outcomes. This opens up the opportunity for mutual discussions. One limitation of this study was 13 of 15 of the providers were female which may have biased the results.

Simmons, Hetrick & Jorn (2013) studied patients ages 12-18 to see how SDM could be utilized. This qualitative study utilized interviews that were transcribed and then appraised. This study found an ideal model for young people with major depressive disorder is a collaborative approach to decision-making. This study provides empirical data for the importance of including youth in treatment decisions as well as recommendations for implementing into guidelines.

Specific patient population studies with SDM showed active engagement by patients. The active engagement of patients increased the likelihood of patients receiving their preferred treatment method. The providers and patients utilizing SDM process showed an enhanced patient satisfaction (Dwight-Johnson, Unutzer, Tang, & Wells, 2001; Hamann et al., 2016; Klingaman et al., 2015; Patel, Schnall, Little, Lewis-Fernandez, & Pincus, 2014; Simmons, Hetrick, & Jorn, 2013).

Shared decision-making (SDM) and decision-making aids (DAs)

Decision-making aids (DAs) are tools used to help consumers understand and clarify their choices and preferences in regard to a discrete decision within SDM. DAs are offered in a variety of forms, from printed brochures to interactive electronic tools. Some are designed to be

completed by a health care consumer in advance of a professional consultation; others are designed for completion during the clinical encounter (Holmes-Rovner et al., 2007).

DAs are often utilized in the context of SDM. Holmes-Rovner et al. (2007) discussed at the International Patient Decision Aid Standards Symposium that DAs have been shown to improve patient knowledge of treatment options. DAs support realistic expectations of treatment outcomes for a patient. DAs increase comfort with choices and decrease decisional uncertainty. SDM helps to reduce anxiety and participation. DAs increase the agreement between a patient's values and choices.

The specific aims of DAs and the type of decision support they provide may vary slightly. DAs provide evidence-based information about a health condition, the options, associated benefits, harms, probabilities, and scientific uncertainties. DAs help patients to recognize the values-sensitive nature of the decision. It can clarify the value placed on the benefits, harms, and scientific uncertainties (Holmes-Rovner et al., 2007).

According to the International Patient Decision Aids Standards (IPDAS) Collaboration, DAs are evidence-based tools designed to help a patient to participate in making specific and deliberated choices among healthcare options. Patient DAs supplement (rather than replace) a providers' counseling about options (Elwyn et al., 2006).

Friedrichs, Spies, Harter & Buchholz (2016) found various decision support tools for SDM proven applicable and effective. Information brochures, education and coaching methods have been found important for a provider. However, no binding conclusion about the most effective tool can be drawn. DAs have shown a positive effect on patient-practitioner communication. Patients gained knowledge about their illness and autonomy with the treatment decision. Although an increase in adherence was found, research on treatment effects is

inconclusive. There was no effect on patient depression symptoms and no effect on patient schizophrenia symptoms. However, a decrease in psychiatric symptoms and drug consumption was found for patients with substance use disorders (Fredericks, Spies, Harter & Buchholz, 2016).

Stacey et al. (2014) completed a systemic review of 115 studies containing 34,444 patients. This was a follow up to their 2008 review. This review used randomized controlled studies of DA. The authors found high evidence that utilizing DAs compared to standard care improves an individual's knowledge regarding treatment options. DAs reduces an individual's decisional conflict of feeling uninformed and unclear about personal values. It included having no intervention, usual care, alternative interventions, or a combination of interventions. This study found that DAs improve communication between a patient and provider and did not worsen health outcomes. The weakness of this study pertains to the fact that not every patient was dealing with mental health issues. There is also limited information in regard to the adherence of the treatment choice after four to 36 months.

The ultimate goal of patient DAs is to improve decision-making in order to reach a high-quality decision. Over the past decade, there has been considerable debate about the definition of a *good decision*, when there is no single *best* therapeutic action and choices depend on how a patient values benefits versus harms (Sepucha, Fowler, & Mulley, 2004). Recent studies have found use of decision aids to have a positive effect on patient satisfaction (DeJongh & Haight, 2012; Mayo Clinic, 2016 Stacey, et al., 2014).

SDM and antidepressant medication

The Agency for Healthcare Research and Quality (AHRQ) (2011) completed a meta-analysis with second-generation antidepressants. Ninety-two randomized control trials were

reviewed. The meta-analysis found no substantial differences in efficacy with second-generation antidepressants in treating major depressive disorder.

Mathias, Saylers, Rollins, & Frankel (2012) worked with 40 patients with severe mental health issues as well as three psychiatrists and one nurse practitioner. The authors explored how decisions are made in medication management consultations. This study used direct observation to review the interactions and observe for themes in the decision-making process. This study showed that there was some discussion with a provider and patient, however, a true SDM process was not completed.

Park, et al., (2014) highlighted the importance of understanding consumer preferences for SDM during medication management visits. Patients with serious mental illnesses vary in their preferences for SDM. Preferences differ across various elements of SDM. This research used Levinson, Kao, Kuby, and Thisted's (2005) model of preferences for SDM. The model identifies three elements of patient preferences: obtaining knowledge; being provided with and asked one's opinion about treatment options; and making final treatment decisions. Satisfaction is influenced by the degree to which patient expectations are met. Patient preferences for SDM may be important predictors of satisfaction with the SDM occurring during treatment visits.

The SDM process with antidepressant medications varies according to the patient and provider. Provider and patient discussions review antidepressant medication options but discussions may not always be a true SDM process (Mathias, Saylers, Rollins, & Frankel, 2012; Park et al., 2014).

SDM, DAs, and antidepressant medication

DeJongh & Haight (2012) explored prototype decision-making aids in their outpatient clinics to discuss antidepressant use and found that there are common topics that a patient would

like further information on. When a provider utilized DAs, it was found that the DAs improved patient interaction and increased involvement in treatment for depression.

LeBlanc, et al. (2015) utilized depression medication choice. The authors used a series of cards each highlighting the effect of available options on an issue of importance to a patient for use during face to face interactions. One hundred seventeen clinicians and 301 patients engaged in this cluster randomized trial with adults with moderate to severe depression considering antidepressant treatment. This SDM tool helped a provider and patient to engage in conversation and understanding of side effects of antidepressant medications. This tool helped to find treatment options that best fit the values, preferences, and goals of a patient in a timely way.

Wills, & Holmes-Rovner (2003) conducted a cross sectional observation regarding medication decisions and decision scales. The 97 patients showed that there was satisfaction with decisions scales from a patient perspective. Satisfaction is related to how a patient uses their medications. An important finding is to recognize to actively engage patients, strengthen patient education, and work on treatment decisions to improve patient outcomes.

Shared decision-making on antidepressant medication with decision aids reveal treatment options that fit the goals, values, and preferences of patients. Providers who used decision aids with their patient found improved interaction as well as increased involvement with treatment choices (DeJongh & Haight, 2012; LeBlanc, et al., 2015; Wills & Holmes-Rovner, 2003).

Summary

The review of literature demonstrates that mental health conditions have serious consequences for individuals and society. Clinical guidance recommends engaging a patient in treatment decisions since individuals have a right to self-determination. It is likely a patient will adhere to treatments with greater fidelity with this practice.

The SDM model recognizes a patient has a drive to find meaning and purpose in life. The SDM model identifies control should be placed into the hands of the patient verses the provider. In utilizing this, a provider sees that collaborative discussion with the patient and their family provides benefits. The SDM model holds firm that the patient should be able to have autonomy to determine treatment choices.

Discussion

Interpretation

Shared decision-making (SDM) is recommended by U.S. Department of Health and Human Services/SAMHSA, (2010); Mayo Clinic, (2016); Institute for Clinical Systems Improvement, (2016); Minnesota Shared Decision-Making Collaborative, (2016) and should become a routine part of mental health care. In review of the literature, SDM leads to patient treatment options that fit accordingly to personal values and recovery priorities.

If a provider engages a patient in a systematic way with SDM, a patient will discuss their thoughts, preferences, and values more easily. Acceptable treatment choices for a patient, decreased health care costs, treatment adherence, and better health outcomes typically follow (Minnesota Shared Decision-Making Collaborative, 2016; U.S. Department of Health and Human Services: SAMSHA, 2010).

In reviewing literature, research has shown value in engaging patients in SDM. A patient receiving SDM aids can come to an appointment ready to discuss health care options. This can increase efficient use of time during the appointment. The DAs used can help stimulate, reinforce, and deepen treatment discussions (Charles, Gafni, Whelan, 1997; Coulter & Collins, 2011; Institute for Clinical Systems Improvement, 2016; Mathias, Saylers, Rollins, & Frankel, 2012; Mayo Clinic, 2016; Minnesota Shared Decision-Making Collaborative, 2016; U.S.

Department of Health and Human Services, 2010; U.S. Department of Health and Human Services: SAMSHA, 2010; Wills & Holmes-Rovner, 2003).

A patient with mental health issues such as depressive disorders typically wants to be involved in care decisions. The ability to share values and preferences for treatment plans is important. A patient has the legal right to make treatment decisions. By providing an opportunity with SDM, a patient is more likely to engage, follow agreed treatment recommendations, and have a positive outcome (U.S. Department of Health and Human Services: SAMSHA, 2010).

SDM can vary according to tools that are used. A provider needs to understand patient communication preferences. A variety of DAs that can enhance SDM are helpful. At times, a patient needs an immediate treatment decision. However, a patient may not be ready to make a decision during the first visit. Time to process the information and make an informed decision is often required. A provider needs to be flexible and available to keep a patient engaged in the process (Coulter & Collins, 2011; U.S. Department of Health and Human Services: SAMSHA, 2010).

Using SDM as a part of routine mental health services makes sense. Various organizations have resources that include workbooks, worksheets, tip sheets, videos and interactive, computer based decision aids, on medications and other treatment approaches. These resources help a patient prepare for meetings with their providers. SDM leads to discussions on treatment options that fit accordingly to personal values and priorities for patient recovery (Institute for Clinical Systems Improvement, 2016; Mayo Clinic, 2016; Minnesota Shared Decision-Making Collaborative, 2016; U.S. Department of Health and Human Services, 2010; U.S. Department of Health and Human Services: SAMSHA, 2010).

A provider can engage a patient in systematic ways for decision-making. It allows a patient to easily discuss thoughts, preferences and values. This leads to acceptable treatment choices. When a patient feels heard, multiple benefits are possible. Treatment adherence can improve. Dropping out of treatment lessens. Decreased health care costs and better health outcomes can result (Coulter & Collins, 2011; U.S. Department of Health and Human Services: SAMSHA, 2010).

The research reviewed in this paper has shown the benefits of placing a mental health patient at the center of the decision-making process. The relationship and trust between a patient and provider is strengthened. SDM provides a model through which transformation of the mental health field might be answered (U.S. Department of Health and Human Services: SAMSHA, 2010).

The report of the President's New Freedom Commission on Mental Health 2003 calls for mental health care to be consumer and family driven (Institute of Medicine, 2006). The Institute of Medicine's (IOM) (2006) report asserts that the patient receiving care should be at the center of that care at all times. Mental health care should be respectful of and responsive to patient needs and preferences. In addition, the report called for providing decision-making support to all mental and/or substance-use health care patients.

Among the fundamental aspects of mental health care identified in SAMHSA's National Consensus Statement on Mental Health Recovery (2006) are self-direction; individualized care; person-centered care; and care that supports empowerment, individual responsibility, and recovery. The 2007 Action Plan of the Annapolis Coalition on the Behavioral Health Workforce includes as its first goal "Significantly expand the role of individuals in recovery, to participate in, ultimately direct, or accept responsibility for their own care" (U.S. Department of Health and

Human Services, SAMSHA, 2010. p. 15). Recent documents from SAMHSA support allowing a patient and family with the primary decision-making role for mental health care offered and received.

SDM has several elements. It is important that a provider understands the patient and knows the disorder. The patient defines the problem. The patient understands the clinical problem. The provider listens to understand the patient knowledge. In SDM it is important to understand the worries, fears, concerns, or expectations of a patient. This helps with patient goal setting. Discussing potential options is important in reviewing the risks and benefits of patient treatments. The provider should discuss information about intervention options and indicate the pros and cons with the patient. It is important that the patient receives the information at a comfortable level of understanding. The team also must hear the views of the patient on various interventions.

A provider needs to encourage a patient to be involved in the formulating of intervention plans. Asking about patient preferences leads to satisfaction with the decision. Patients also need to have the opportunity to review the decisions that they may make as well. At different life stages treatment options may vary. Age, clinical condition, or new information may need to be considered. The overall view of the research reviewed shows that SDM is complex. It may be implemented to different degrees by each individual provider. Research has shown that there are challenges in measuring the effects of SDM on patient outcomes. Current research is lacking on long term outcomes. Research implied that there are benefits to the provider/patient relationship and a patient feels validated during SDM encounters.

Implications for Nursing

The research points to many implications for the practice of nursing. As health care professionals, we need to be aware of how much information providers present to a patient at a time. A provider can easily overload a patient without being aware. At times, health care professionals need to be sure that providers can match the information with the patient and his/her need. When discussing health care issues, a provider needs to be aware it is an emotional time for patients. This may affect the ability of a patient to make a sound decision. Brock and Allen (2000) remind that a practitioner often delivers information in a preferred manner of communication that is in the comfort zone of the provider. Information is not always provided in a manner a patient prefers. A provider needs to be aware to dialogue with a patient to hear what is valued and held as important.

Even with limited research on SDM in mental health care, evidence exists that components of SDM result in positive outcomes for health care patients. The use of patient-centered communication reduces patient stress and improves functional status. Patients who report fully expressing themselves and receiving all the requested information had better functional outcomes than those who did not. The ability of a provider to display concern, warmth, and interest was an influential predictor of patient satisfaction. A patient who believes they are actively involved in treatment decisions generally has better outcomes. A patient that feels a low sense of control over decisions is associated with less behavioral involvement in care, poorer self-rated health, and increased illness burden. Further education to providers on SDM could lead to better health outcomes for patients.

Providing education to a provider and patient regarding DAs can strengthen the use of DAs. Development of guidelines for DAs to help with SDM could increase effectiveness as

patients participate and adhere to treatments despite the side effects, costs and burdens. Development of user friendly DAs could promote engagement from both provider and patient.

Poor communication and adherence is costly and could lead to potential policy changes. A patient does not achieve the best recovery and quality of life if not following a reasonable treatment plan. Looking at an evolving complex health care system, there is a need to recognize that a provider is responsible to help manage cost of care. One way is to include a patient in decision-making to improve knowledge of options and cost of cares. It is becoming critical for a health care provider to inform a patient of choices. Listening to patient preferences and values can greatly impact adherence to treatment which can reduce unnecessary medical costs (Allen & Brock, 2000).

Outcome/Dissemination

The process of engaging patients and providers in SDM was shared with five family practice providers and six patients in a rural family practice clinic in Ortonville, MN. The providers and patients were given a brochure on SDM (see Appendix) and DAs on antidepressants created by the Mayo Clinic to review and provide feedback.

The patient feedback demonstrated willingness to be an engaged partner in their healthcare. One patient believed there would be better understand and more control by being able to utilize SDM. A second patient believed by having a SDM conversation, she would be on the same page as her provider and able to agree or disagree. This patient felt DAs were helpful as a visual item to review and think about. A third patient stated she was more apt to be willing to work with her provider if her opinion was considered in the decision process. The remaining patients all had similar comments about having their perspective valued in treatment options.

The first barrier identified stated that a patient may be shy and scared to share her opinion with a provider. A second barrier identified that there may be times when a patient may decline to participate due to not understanding the SDM process. As a result, a patient may want to only do what the doctor recommends. The third identified barrier was time.

The provider feedback showed SDM to be positive on many levels. One provider believed that utilizing this process empowered and activated patients. This provider believed that this is something to utilize at initial diagnosis as well as routine follow-ups and medication adjustment appointments. Another provider thought the patient could understand the reality verses the perception of treatment by utilizing DAs and SDM. A third provider perceived improved changes of a good response by engaging a patient in SDM. The remaining providers believe that SDM can improve patient engagement. The barriers identified were the time it may take to have this conversation with a patient. However, providers felt that a patient would be better informed.

Summary/Conclusions

In summary, engaging an outpatient with depression in SDM to improve outcomes should be incorporated as best practice. A physician is a clinical expert and can provide a wealth of knowledge and clinical practice experience to a patient consultation. However, a physician can often develop a short list of first choice antidepressants medications which may not be appropriate for each patient. A patient is an expert in self-defining the overall level of depression and the degree in which it interferes with day-to-day activities. By providing details about their daily lifestyle, a patient provides important information necessary for the success of antidepressant treatments. Engaging in SDM and/or utilizing DAs can help strengthen the

relationship and treatment outcomes for a patient suffering from depression (DeJongh, & Haight 2012).

Treatment options vary in their burden on a patient. SDM offers an opportunity to help the patient select a treatment to which they can adhere. When conversations discussing options occur, a patient and clinician actively engage and consider the attributes and issues of available options. This empathic approach results in the clinician and patient co-creating a decision and a plan of care (Mayo Clinic KER UNIT, 2016).

Institute for Clinical Systems Improvement (2016) collaborative care model shows structured attention to patient preferences. There are educational materials/protocols for education material. Patients can work on self-management skills such as journaling. The collaborative care with SDM has shown better medication compliance and reduced risk of relapse, reduced suicidal ideation (Holmes-Rovner et al., 2007; Loeb, Bayliss, Binswanger, Candrian, & deGruy, 2012).

The Institute of Clinical Systems Improvement (2016) found this process can help create conversations on available options, potential consequences of each option, and the ability to make a choice based on mutual understanding. The Minnesota Shared Decision-Making Collaborative (2016) finds that incorporating patient preferences and values are more likely to have positive results and better follow through. A patient with direct involvement has more informed choices and better health outcomes. It also reduces health care costs.

In conclusion, the evidence shows SDM can impact a patient in a positive way. "Until we help people think about decisions and what's important to them, we are not getting at the problems they face" (Stratis Health, 2010). In reviewing studies, SDM is emerging as best practice in health care. A patient with depression who engage in SDM with a provider has

improved outcomes. Moving forward as an advanced practice nurse, this practitioner looks forward to engaging patients with SDM. Utilizing the best clinical evidence available along with preferences and values will provide a patient the best choice for positive outcomes.

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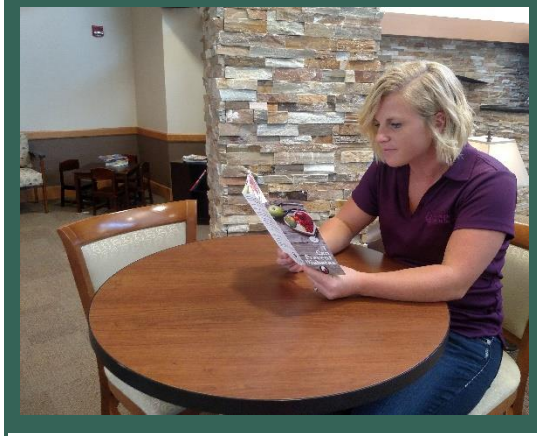
What is shared decision-making?

Shared decision-making (SDM) is emerging as best practice in health care.

SDM is a method where a patient using a mental health service and their provider improve communication about treatment options. Providing information and decision tools helps improve communication. SDM balances evidenced based practice on mental health conditions and treatment options with patient's preferences, goals, values, and beliefs.

SDM explores how different options may affect the patient's life and recovery. The end result is a mutually agreeable treatment plan.

Shared Decision-Making



"When people have the opportunity to carefully consider their care, they tend to have less decisional conflict."
- Patricia Deegan, PhD.

Decision-Making Aids:

Decision-making aids are tools that show the possibilities of treatment, care or support possibilities. Listed below are some decision-making aids that can be utilized for treatment of depression and other mental health services.

Mayo Clinic Antidepressant Guide:

http://shareddecisions.mayoclinic.org/files/2013/11/mc5733-43brochure.pdf

Ottawa Health Research Institute:

https://decisionaid.ohri.ca/AZlist.html

SAMHSA - Substance Abuse and Mental Health Services Administration

http://store.samhsa.gov/

http://media.samhsa.gov/consumersurvivor/sdm/Print_Video/Print_and_Video_Video.html

http://media.samhsa.gov/consumersurvivor/sdm/DA_files/PDFs/CT_Side_effect_chart.pdf

Common Ground

https://www.patdeegan.com/commonground

Benefits of Shared Decision-Making:

- Improved knowledge and understanding
- Allows discussion of pros and cons for treatment options
- Greater comfort with decisions
- Better treatment adherence
- Improved confidence and coping skills
- Improved health behaviors
- Build skills in self-advocacy and informed decision-making.
- Develop plans that people who use mental health services find meaningful and useful
- Build skills in recovery-oriented practices

Standards to use Decision-Making Aids:

- Provides information on options and probable effects of each option
- Based on latest scientific evidence
- Options presented in balanced way
- Describes what happens in the course of condition if no action is taken
- Provides support to patients to clarify and express his/her values as they relate to decision
- Any conflicts of interest should be disclosed.