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Incorporating shared decision making in mental health care requires translating knowledge from implementation science

M. Slade[1] provides a broad overview of the literature on shared decision making (SDM) with a focus on mental health care. The overview is timely and pertinent, as SDM is considered a central component of the widely accepted recovery model of mental health services[2]. We are encouraged by Slade's focus on implementation, which is the current challenge facing SDM practice across all settings and countries.

Slade highlights significant challenges to decision aid uptake, including quality control and the overwhelming number of those aids. The movement toward quality control of decision aids is over ten years old. The International Patient Decision Aids Standards Collaboration (http://ipdas.ohri.ca) has provided criteria to judge the quality of patient decision aids. Certification is also underway and has the potential to improve the quality of the growing number of those aids.

However, we agree that the current model of decision aid development and maintenance is unsustainable. The use of technology is being harnessed to address this challenge. For example, the SHARing Evidence to Inform Treatment decisions (SHARE-IT) project is an initiative designed to automate decision aid production based on guideline updates[3].

While decision aids are useful adjuncts to SDM, it is important to clarify that the practice of SDM does not require a decision aid. Informing patients of their options, eliciting their preferences and integrating these patient preferences into the health care decision is a practice that requires communication skills, not just tools. Only a clinician who has the necessary communication skills can appropriately use a decision aid during the consultation. The use of decision aids can indeed promote the engagement of patients in the decision making process, but there are also other ways of fostering SDM, including patient-mediated interventions that prompt patients to ask questions[4].

We agree with Slade's second challenge that SDM implementation endeavors could potentially be more successful if better integrated into other innovations in mental health care. This argument is especially compelling from a clinician's perspective. By branding SDM as the most important singular new intervention that clinicians must adhere to in their portfolio of skills and interventions, we undermine its potential and may cause resistance. More work is needed to integrate SDM with other health care innovations in particular fields of health care. Thus, the mental health field has the potential to take the lead, for example, through the integration of SDM and advance directives and joint crisis plans[5].

Slade highlights the important ethical tension between beneficence and patient autonomy to make decisions. An overemphasis on beneficence-focused treatment at the expense of patient autonomy can result in treatment decisions that represent the clinician's values imposed on the patient. This is particularly concerning in mental health care, where the effectiveness of treatments is often overstated, despite only modest gains and significant potential side effects.

As Slade indicates, the question most often raised in mental health care relates to an individual's decision making capacity. While individuals with mental illness may have impaired cognitive abilities, most desire and have the capacity to be involved in treatment decision making, including those with severe conditions such as schizophrenia and major depression[6]. Similar to patients with other cognitive disabilities, strategies are available to increase participation in decision making among individuals with severe mental illness, such as the use of multiple display formats when communicating treatment options and risks.

Of course, these individuals are not always capable of becoming involved in a decision making process; this ability may vary over the course of their illness. In such cases, joint crisis plans may be useful. For example, when a patient's decision making capacity is reduced, a clinician or family member can draw on the patient's stated preferences that were gathered when the patient was capable of making a decision. Such plans could be beneficial in institutional settings where patient autonomy is even more restricted.

Nevertheless, research has shown that most people diagnosed with a mental illness have a similar level of decision making capacity as a healthy comparison group from the general population[6]. Increased awareness of this ability would be an important step toward increasing patient engagement in SDM.

This appeal for reducing the stigma towards mentally ill patients by not denying them their decision making capacities is related to the prominent and broader call for a culture change in health care

practice. In order to achieve this culture change in the clinical world and move away from paternalism, we need to do more than just change attitudes and norms of individual health care professionals. Change is needed at all levels, from individual to organizational and institutional.

Slade correctly points out that when considering how to transform mental health care systems – both regarding SDM and other possible upcoming changes – it could be helpful to "use language and constructs from other sectors to inform this transformation"[1]. When discussing the implementation of SDM, whether in mental health care or in other clinical areas, we should carefully consider translating knowledge from the field of implementation science to influence clinical care. For successful implementation we need to take a range of basic sciences (e.g., behavioral science, psychology, communication, economics) into account; thus, social marketing can only be one piece of the jigsaw.

We recommend the Consolidated Framework for Implementation Research[7] to develop a theoretically based implementation strategy. This stresses the need to foster implementation at different levels (e.g., individual, organizational, policy) and describes social marketing as one among a range of other activities (e.g., education, role modeling, training) to engage stakeholders at the individual level. Another seminal model is the Behavior Change Wheel[8], which can be used to design behavior change interventions to foster routine implementation of SDM.

In summary, we applaud Slade for his effort to push forward the SDM agenda in the mental health field. We agree with his conclusion that implementation challenges are the key concern. Social marketing and insights from the hospitality industry are unique and helpful, but they must be combined with implementation science to effectively amplify the voice of those with mental illness in making treatment decisions through an SDM process.

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Mental health shared decision making in the US

M. Slade's paper[1] presents the most accurate, balanced and up-to-date summary of shared decision making in mental health care that is currently available. Because his review takes a decidedly UK perspective, I will address some of the related issues in the US.

The US health care system (more accurately, the US health care non-system) continues to be extraordinarily expensive and ineffective. Health care services in the US have been created by vested interest groups: private hospitals, pharmaceutical companies, insurance agencies, device makers, professional guilds, specialty care groups, large health conglomerates, for-profit nursing homes, and so on. All of these entities prosper in the US by providing services that maximize profits rather than patient outcomes.

Although patient-centered care is widely endorsed as a principle in the US[2], it is more honored in the breach than the observance. In mental health, the call for patient-centered care and shared decision making seems unlikely to shift care away from hospitals, expensive medications, specialists, facility-based rehabilitation, and other profit-generating services, even though studies show that patients would prefer other services such as safe housing, employment, peer supports, and help with general functioning[3,4]. People with mental illness recognize the need to address the social issues that cause and exacerbate mental disorders. But shared decision making may not include the services they want and need.

Medical solutions to social problems are very expensive and ineffective. Yet social factors often determine exacerbations of mental illness and cause excessive, unnecessary mental health treatment. Consider the current trends to increase mental hospital beds and to incarcerate people with mental illness. The erosion of low-cost housing and the absence of employment opportunities, rather than true increases in the prevalence or severity of mental illness, underlie these misguided initiatives. In fact, hospitals and prisons often harm people with mental illness by decreasing self-esteem and opportunities, harm society by increasing stigma and segregation, and harm government by wasteful spending.

The crux of the US problem is that prevention and social safety net services, though preferred by people with mental health challenges, do not generate profits. Effective interventions for primary, secondary and tertiary prevention in mental health exist, but in the US we spend minimally in these areas. Northern European countries, by contrast, spend less on health care but more on the social safety net: prenatal services, early childhood care, maternal leave, family support, early education, nutrition, early behavioral health interventions, safe housing, and psychosocial supports for people with disabilities[5].

Consider the examples of supported housing[6], supported employment[7], and supported medication management[8]. These interventions are highly effective, strongly desired by people with mental illness, and clearly helpful for recovery. But they are rarely available because social services