tal health problems is depicted by the media may have an important impact on their use and perhaps also their effectiveness, decreasing or reinforcing stigma related to mental health problems. Without explicitly addressing issues of stigma and shame, those who feel alienated with mental health needs will remain mistrustful of those perceived as privileged, while, at the same time, those offering support will continue to place responsibility on those appearing to be unwilling to accept help.

We need to empower a massive trusted workforce to deliver effective psychotherapies, harvesting the results of over five decades of research, to the large numbers in our societies who need them. This will require not only a significant change in the training of those delivering these treatments, but also an increased willingness on the part of mental health professionals to immerse themselves in the concerns of minority groups. Allyship requires a commitment which is long-term, not just during crises.

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The importance of listening to patient preferences when making mental health care decisions

Listening to patient preferences when making health care decisions is increasingly considered an essential element of evidence-based practice. Patient preferences refer to the specific activity, treatment and provider conditions that patients desire for their health care experience[1,2]. For example, patients may prefer medication or psychotherapy, have preferences for one type of medication over another based on side effects, or have preferences for one type of psychotherapy over another based on the focus of the treatment (e.g., present cognitions or past relational conflicts). As another example, patients may have preferences about their provider's experience level, personal style (e.g., humor, personal examples), or demographics (e.g., age, gender, race, ethnicity, sexual orientation).

Two main arguments can be made for including patient preferences in the decision-making process in mental health care – one based on ethics and another based on outcomes.

First, attending to patient preferences is in line with ethical principles of respect for patients' rights and dignity[3]. As the party whose life will be most affected by the treatment, patients should have a say in what that treatment will look like. Importantly though, ethical principles also require providers to ensure that patients receive adequate care. As such, ethical practice entails active participation from both providers and patients, which should include discussion and incorporation of patient preferences in treatment to the extent possible.

Second, the existing research on clinical outcomes supports accommodating patient preferences[2,4,5]. Studies suggest that patients are more willing to initiate and engage in treatments that match their preferences. Evidence of this can be found in a meta-analysis including data from 187 randomized clinical trials comparing medication management strategies to psychotherapies[4]. Even though participants in these studies all agreed to be randomized to an intervention, 8.2% dropped out after learning of their assignment, and dropout rates were 1.76 times higher for the medication conditions than psychotherapy. Presumably, the assigned intervention did not match patient preferences in many of these cases. In another meta-analysis that directly tested the preference effect in clinical medicine, data from 32 studies indicated that preference accommodation resulted in greater treatment initiation, though only small improvements in treatment outcomes[5].

More recently, we conducted a meta-analysis examining the preference effect in psychotherapy and medication management for mental and behavioral health concerns[2]. This meta-analysis included data from 53 studies and over 16,000 patients. We found that patients whose preferences were accommodated were almost two times (odds ratio, OR=1.79) more likely to complete their treatment compared to patients who did not receive a preferred option. In addition, preference accommodation was associated with more positive treatment outcomes (d=0.28). The preference effects were consistent regardless of whether the choice was between two forms of psychotherapy or between psychotherapy and medication. Further, the preference effect was consistent across preference types (e.g., treatment, activity and provider) as well as patient demographics.

Taken together, this body of research suggests that accommodating patient preferences is linked with improvements in both treatment initiation and outcomes.

There are several possible explanations for the positive effect of preference accommodation in mental health care. First, patients may often be good judges of what treatments are best for them. Specifically, they know what they have already tried, what generally works or does not work for them, and what they are willing to engage in. Even the most effective treatment will have a 0% chance of success if the patient is unwilling to engage in it.

Second, allowing patients to have a choice may enhance motivation. Research shows that, when individuals are allowed to make choices, they are more invested to make sure that the choice

they made is the "right" one[6]. Thus, patients who get to pick their treatment might be more likely to fully engage in it (i.e., more consistent in their follow through, exerting more effort to achieve recovery). Allowing patients to participate in the decision-making process also encourages an overall collaborative approach to treatment. In psychotherapy, in particular, collaboration is a key part of the therapeutic alliance, which is consistently linked with positive treatment outcomes[7].

In addition, involvement in the decision-making process can build hope for patients, who often seek treatment in a demoralized state (e.g., low self-efficacy beliefs, low well-being). When "expert" providers express beliefs that patients can make good decisions by involving them in the decision-making process, this can lead patients to also believe in themselves and their decision-making capabilities. Increased hope and self-efficacy beliefs can in turn lead to improved treatment outcomes[8].

Given ethical arguments and the existing research support, it is essential that mental health care providers work to include patient preferences. These can be accommodated in a variety of ways. First, providers can assess initial preferences by using a pretreatment questionnaire or having a simple discussion at the start of the intake appointment. This discussion can focus on provider preferences, activity preferences, and broad treatment preferences (e.g., medication vs. psychotherapy). Second, after reviewing the patient's presenting problems and background information, providers can share information about potential specific treatment options. This information should include a discussion of the nature of the treatments, their relative efficacy, side effects, and other potential pros and cons. Third, both parties (patient and provider) should discuss preferences and come to a collaborative decision[9]. This process can occur repeatedly throughout treatment, as patient preferences may change over time.

At times, providers may be unable to fulfill patients' preferences in one area or another (e.g., patient asks for a specific type of provider that is unavailable, patient prefers a treatment approach that the provider is not competent in). When this happens, providers can seek to understand the reasons behind the specific preference and see if those reasons can be addressed through another option. Providers should also seek to provide those patients with several other choices in different areas (e.g., frequency of appointments, format of meetings), so the patients can still feel like they are participating in the decision-making process.

Listening to patient preferences and taking steps to accommodate them when making mental health care decisions can enhance treatment experiences and improve treatment outcomes. It should, therefore, become part of ordinary clinical practice.

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