

Psykiatri

Welcome to Workshop 6

How Technology Can Support Recovery and Shared Decision Making in Psychiatry and Rehabilitation

14:00-14:15: The paradigm of Shared Decision Making v/ Lisa Korsbek, senior researcher, Ph.D., Competence Center for rehabilitation recovery and shared care, Mental Health Treatment Care in the Capital Region

14:15-15:00: How Technology Can Support Recovery and Shared Decision Making in Psychiatry and Rehabilitation v/ Patricia Deegan, Ph.D., independent consultant, Adjunct Professor at Dartmouth College School of Medicine and at Boston University AND the creator of CommonGround, U.S.

15:00-15:15: Questions and discussion

15:15-15:30: Possibilities and Prospects for Shared Decision Making, decision aids and CommonGround in Denmark v/ Lisa Korsbek

REGION



What do you see?
By shifting perspective you might see an
old woman or a young woman.

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"I'm afraid you've had a paradigm shift."

The Paradigm of Shared decision making (SDM) in Mental Health Care

- Is an ethical need and a key element for good clinical practice
- Is based on knowledge and research
- Is related to the concept of recovery
- Holds the promise of transforming the relationship between providers and consumers of health care into a relationship of equals with diverse expertise and change the understanding and perception of mental illness.

SDM definition



A precise definition of SDM has yet to be established.

However, the key characteristics have been identified:

- At least two people, acting as partners, are involved. Generally, these are the health care provider and consumer.
- Both partners take steps in sharing a treatment decision.
- The two partners share information about treatment options.
- The partners arrive at consensus regarding the preferred treatment options

Charles, Gafni, & Whelan, 1997; Schauer, Everett, del Vecchio, & Anderson, 2007

”A collaborative process between a client and a practitioner both of whom recognize one another as experts and work together to exchange information and clarify values in order to arrive at health care decisions”

Patricia Deegan, Psychiatric Services 2008



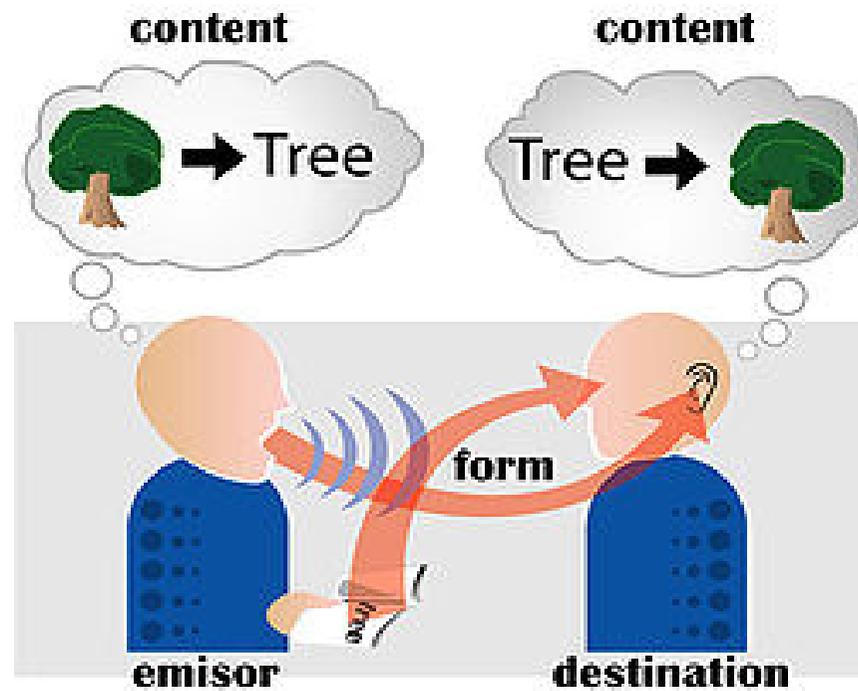
The definition imply:

- The consumer is as much an expert (as provider/clinician/staff)
- The consumer is an equally important expert
- Decisions about treatment is a common concern

Or as Pat has formulated it:

“SDM is founded on the premise that two experts are in the consultation room. . . neither. . . should be silenced, and both must share information in order to arrive at the best treatment decisions possible.”

It also means....



SDM goes beyond the traditional model of health care

Because

- Shared decision making provides consumers with information, choices, and a process in which their need and preferences can be heard and responded to
- Thereby the clinician-patient relationship in SDM has become more of a partnership

It also goes beyond a limited biological model

- Because it involves the practitioner in exploring with the consumer his or her personal experience of illness, values regarding autonomy, risk, treatments, and outcomes, and preferences for being involved in decision making



The model in the middle

The traditional or paternalistic model

- The therapist is active, the client passive
- The therapist selects the treatment that he/she considers to be right for the client
- The patient must accept this

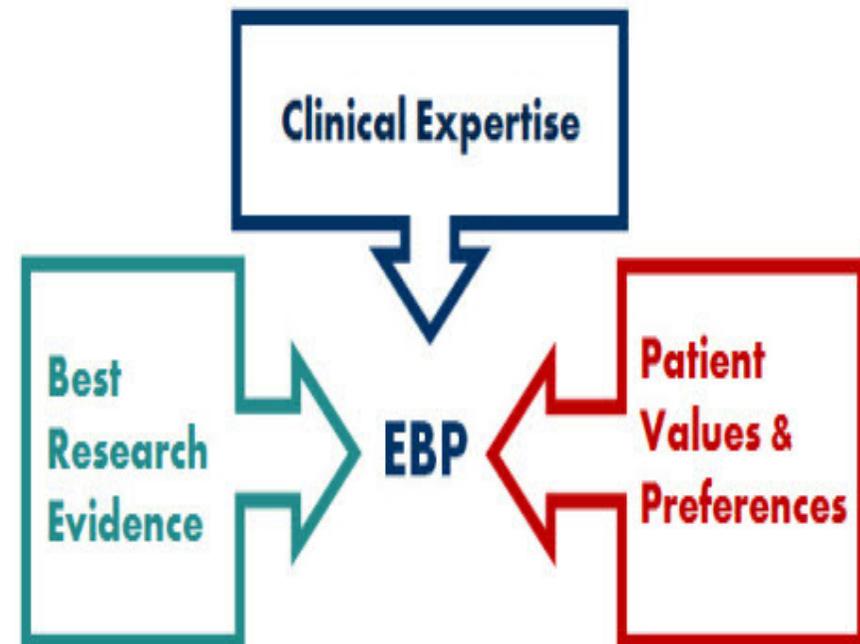
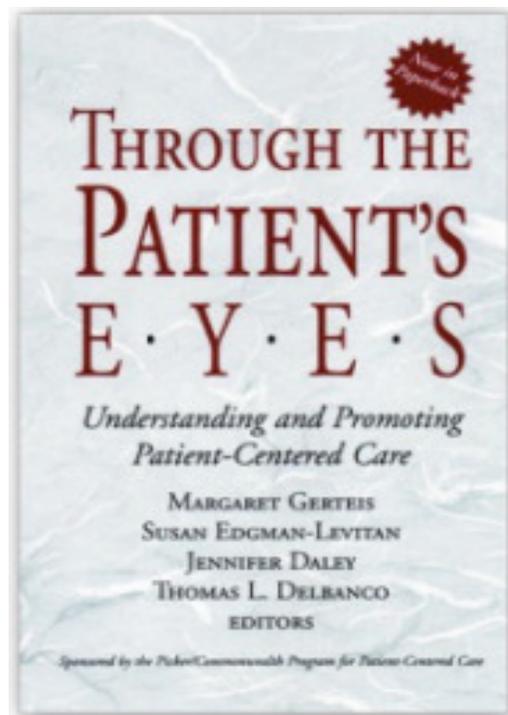
Shared decision making

- The therapist and client are both active and exchange all necessary information on treatment and on those aspects of the client, which may be relevant, including attitudes and values
- The therapist can advise on the basis of her/his expertise
- The client can advise care about things that may be significant
- Together they find out which treatment is most appropriate

The informed choice (Informed choice model)

- The client is active, the therapist's role is limited to providing the necessary information
- The client decides what treatment is right for him/her
- The practitioner must accept this

An ethical need - and a key element for good clinical practice



Not a term reserved to the mental health field

On the contrary:

Shared decision making has been on the agenda in general health care for a much longer time than in the mental health care, so:

- The majority of the research until date evaluating SDM has been conducted in general health populations (e.g. cancer, diabetes and cardiac patient groups)
- Tools/decision aids for shared decision making exist in abundance in general medical health care, but there are still few – internationally seen – in the field of mental health care

Knowledge and research

- Research on shared decision making in mental health services lags considerably behind work in general medicine and urgently needs attention
- But the last 5-8 years has given us important knowledge and evidence
- A number of studies have been conducted, primarily with consumers with depression or schizophrenia, over the last 5-8 years.

Some of the research

- Adams JR, Drake RE, Wolford GL. Shared decision-making preferences of people with severe mental illness. *Psychiatr Serv* 2007; 58:1219–1221
- Hamann J, Langer B, Winkler V, et al. Shared decision-making for in-patients with schizophrenia. *Acta Psychiatr Scand* 2006; 11:265–273
- Bunn MH, O'Connor AM, Tansey MS, et al. Characteristics of clients with schizophrenia who express certainty or uncertainty about continuing treatment with depot neuroleptic medication. *Arch Psychiatr Nurs* 1997; 11:238– 248
- Arora NK, Mchorney CA. Patient preferences for medical decision making: who really wants to participate? *Med Care* 2000; 38:335–341
- Hamann J, Cohen R, Leucht S, et al. Do patients with schizophrenia wish to be involved in decisions about their medical treatment? *Am J Psychiatr* 2005;62:2382–2384.

The studies shows, among other things

- That people with serious mental disorders including schizophrenia, are open to SDM
- That people with serious mental illness in general want to be part of the decisions to be taken concerning their disease
- A study (Adams et al 2007) shows, for example that people with mental illness generally prefer more influence on decisions than it is offered

The studies shows too:

- That people with serious mental illnesses are able to participate in SDM
- That the desire to participate in SDM is due to many things that can vary from person to person, but in particular:
 - Bad previous experience of psychiatric treatment (especially forced treatment)
 - A desire to promote own recovery process

SDM and recovery

Recovery is the heart of Shared decision

The focus is on:

- Mental health care as centered on the needs and desires of the consumer.
 - It means that consumers set their own recovery goals and have choices in the services they receive.
 - For mental health providers it means assisting consumers in achieving goals that are personally meaningful.

In fact:

- The role of the treatment team is to support clients through decisional conflict to achieve optimal use of personal medicine and psychiatric medicine in the recovery process (Deegan)



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But

SDM is not an easy task, it requires:

Decision aids



Decision aids

Concrete tools that gives the individual consumer the necessary basis for decision, for example:

- Interactive web programs
- Other media
- Pamphlets and/or other written material

A Cochrane review based on 55 RCT'er within decision aid in health care concludes:

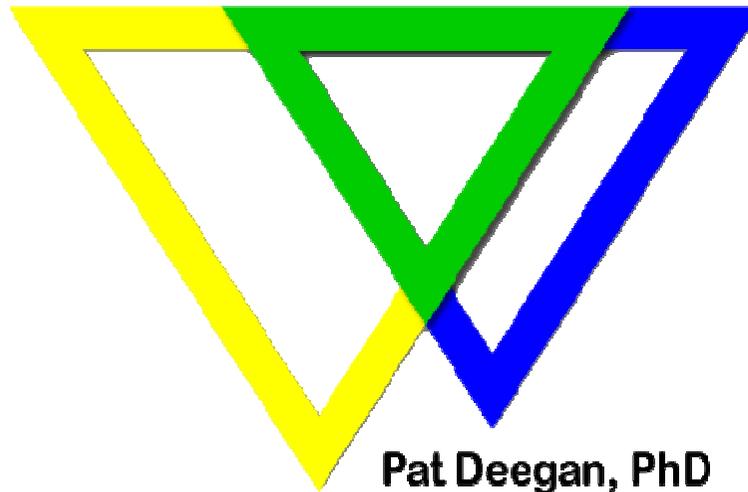
- Decision aids increases patient's involvement in decision making
- Increases patient's knowledge base for decision making
- Increases patient understanding of the opportunities and risks of each treatment
- Reduces potential conflicts in combination with decision making

O'Connor A, Bennett C, Stacey D, et al.

Do patient decision aids meet effectiveness criteria of the international patient decision aid standards collaboration? A systematic review and meta-analysis. *Med Decis Mak* 2007; 554–574)

Pat Deegans decision aid

CommonGround



Pat Deegan, PhD
& Associates, LLC