Involvement in decision making: the devil is in the detail

M. Slade[1] highlights that there is superficial, not deep agreement between stakeholders about the idea of shared decision making (SDM) in mental health care. To begin to unpack why this may be so, it is important to reflect on decision making about what, when and with whom.

Firstly, what kinds of decisions are made in mental health care? They range from life-changing decisions, sometimes when the person is deemed to no longer have capacity or to have reduced capacity to make decisions (e.g., involuntary admission to hospital, medical treatment in dementia, starting psychotropic medication) to more routine decisions relating to, for example, changing medication, addressing physical health, consent to share information, and referral to other services (e.g., drug and alcohol, day opportunities).

Some decisions require explicitly overriding the patient's preferences in his/her best interest. The danger is that this practice "leaks" into other decisions, due to a cognitive bias that people with mental health problems are perceived to be less worthy or capable of being involved in decisions when capacity is intact. Hence, it is important to question and safeguard our practice against these assumptions. Specific interventions may be required when decisional capacity is reduced, e.g., preparing patients in an acute ward for planning talks with their psychiatrist to increase their ability to participate in decision making[2].

Secondly, different types of decisions are taken at specific junctures in an illness trajectory, e.g. starting a psychotropic medication is a much bigger decision than changing the dose of an existing medication. Mental health problems tend to be episodic, so that the ability to process information and motivation to participate varies over time. For example, the presence of negative symptoms has been found to be associated with less involvement in decision making[3].

Thirdly, who is involved in decision making in mental health care? In addition to the patient and clinician, carers are frequently involved. Decision making in three-way communication, i.e., patient-doctor-carer, is undoubtedly more nuanced and delicate than two-way communication. With three people, there is the potential for two people to become aligned in support of a particular course of action. This could be the patient and carer (e.g., in a bid to reduce or stop medication), or the doctor and carer (e.g., in a bid to increase medication or admit the patient), or the doctor and patient (e.g., in a bid to keep the patient out of hospital). Sometimes, patients feel that carers are acting as advocates. At other times, they feel that carers are working against them with clinicians to make decisions that they do not agree with. At all times, clinicians need to gauge the expectations, needs and preferences of both parties in a fine balancing act.

Understanding the extent to which SDM is implemented is intricately linked to how it is measured. As Slade points out, "decision making is a complex and dynamic social interaction"[1]. Most research to date, with some notable exceptions[4-7], is based on what people *say* about SDM. Perhaps the most informative means of researching decision making is to record and analyse what people do rather than what they say they do. This approach facilitates an understanding of the dilemmas faced by both clinicians and patients *in situ* and the resources they deploy to deal with them. It offers a window on how clinicians and patients *jointly* construct the clinical encounter[8].

In an observational study of decision making in outpatient clinics in the UK, involving people with a diagnosis of schizophrenia or depression, there was striking variation in the extent to which different psychiatrists involved patients in decision making across their consultations. Out of a total possible score of 48 using the Observing Patient Involvement (OPTION) scale, scores ranged from 0 to 38. The differences in how psychiatrists communicated were overwhelmingly explained more by their individual style than by socio-demographic, structural or clinical factors[3].

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This shows that there is widely varying practice but also some good practice, which can be identified and disseminated. It would be interesting to explore what attitudes are associated with communication practices that involve patients more in decision making.

Decision aids are helpful in drawing attention to and focusing discussion on various aspects that need to be considered in making a decision. However, they should not detract from the clinician-patient interaction, as *how* decision aids are actually used in interactions is important in determining whether they are effective. For example, subtle differences in how clinicians ask questions have consequences for what patients say[9]. This is critical for decision making. For example, asking a patient if he/she has questions with the commonly deployed "Any questions?" is designed not to elicit any further information, whereas asking "Do you have some questions?" is more likely to elicit further discussion. Asking about medication with questions such as "No problems with the medication?" invites the patient to confirm that there are no problems, making it very difficult for the patient to discuss concerns he/she may have and influence subsequent treatment proposals. Clinicians need to be aware of how question design shapes patient responses, in order to involve patients in a meaningful rather than a superficial way.

Training clinicians so that they are aware of the subtle differences in how they communicate with patients generally, and in decision making specifically, was found to improve clinician-patient communication and the therapeutic relationship[10]. Eliciting the patient's experiences and listening are fundamental: they are the starting point for identifying what decisions are made and whether these reflect the patient's concerns. Working with patients to reach a shared understanding of concerns is the first step in identifying *what* needs to be addressed. Addressing this fundamental issue is likely to circumvent some of the difficulties that currently undermine SDM in mental health care.

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