



# The Shared Decision-Making Process in the Pharmacological Management of Depression

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Published online: 23 September 2019  
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## Abstract

Shared decision making (SDM) is a model of interaction between doctors and patients in which both actors contribute to the medical decision-making process. There is an international consensus across medicine about the importance of SDM interventions, which have raised great interest in mental healthcare over the last decade. Yet SDM is not widely adopted, particularly in the field of psychiatry. The purpose of the present article is to examine, from a patient and physician perspective, the importance of SDM in the management of healthcare with a focus on mental health; it reviews the enablers and barriers (and how to overcome them) to implementing a SDM process in psychiatric practice. SDM models have been developed recently for involving patients with depression in the decision-making process, which could result in augmenting the proportion of patients who adhere to their antidepressant or other treatments for a duration that complies with the current recommendations. To implement this approach, more physicians need training in the SDM approach and access to appropriate tools that help engage in collaborative deliberation, and practice generally needs to be reorganized around the principles of patient engagement.

## Key Points for Decision Makers

Models of shared decision making (SDM) are not widely adopted in psychiatric practice.

SDM may help improve adherence to antidepressant medication

Physicians need training in practicing an SDM process with patients with depression.

## 1 Key Features of Depression Treatment

Major depressive disorder (MDD) is a complex, heterogeneous, and potentially long-term condition that gives rise to serious handicaps and disabilities [1]. Following

a stepped approach in depression care, the physician may start prescribing nonpharmacological therapies [2, 3] before proceeding to pharmacological treatments that can effectively mitigate the burden of depression, though this approach is sometimes subject to controversy [4, 5]. Treatment guidelines recommend continuous use of antidepressants for several months to reach and maintain remission, but this is far from being achieved in current practice [6]. In everyday medical practice, the efficacy of antidepressants is reduced by low patient adherence rates and premature discontinuation, which contribute to an increased risk of relapse [7–10] and the chance of developing a chronic disease and increased morbidity and mortality. In fact, only a limited proportion of patients sufficiently adhere to their treatment [11, 12], which may be related to several factors. First, patients organize their drug intake around their own priorities, which may be very different from prescribers' priorities, since most patients value their personal concerns and/or their social roles more than the benefits of a prescribed treatment. Second, factors associated with early discontinuation of antidepressant treatment include stigma and patient skepticism toward treatment [13, 14]. Patients are reluctant to start antidepressants because of the fear that it can be difficult to withdraw from every psychotropic drug [12]. Third, patients are generally aware

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of the side effects of antidepressant medications but do not necessarily distinguish the differences between drug classes [15]. Typically, there is a reluctance to start or continue antidepressants because patients have either developed side effects or believe they will. As long-term adherence to antidepressant treatment is primarily determined by the balance between the perceived necessity and perceived harmfulness of the medication [13, 14], tolerability becomes an increasingly important factor, with a longer duration of treatment as depressive symptoms recede [12]. It is important that clinicians present this information to patients in meaningful ways [16, 17]. Fourth, another factor is the absence of a perceived clinical benefit during the initial stages of treatment, as the efficacy of most antidepressant drugs against depressive symptoms generally builds over several weeks. Clinicians are advised to inform patients of the likely delayed onset of a perceived benefit of antidepressant drugs [18].

All these factors were reported in a clinical audit (TAILOR [Target Antidepressant Initiation choice to unLock positive patient Outcomes and Response]) involving 7650 patients and 1873 general practitioner clinics in Australia (data on file; results represent findings collected up to June 2018). Importantly, most patients had concerns about starting antidepressant treatment because of possible side effects, the most frequently mentioned being weight gain, sleep disturbance, and sexual dysfunction. This audit identified the importance of involving the patient in the decision-making process; once the treatment options were presented, the patient could share the decision on what management to follow. Clearly, targeted and tailored communication offers promise for fomenting discussion and reducing barriers to an appropriate initial treatment of depression.

A gap sometimes exists between patients' views and professionals' views, a gap mainly related to the patients' health beliefs and the physicians' attitudes. What depressed patients consider important in defining remission from depression may differ from what a physician sees as important [19, 20]. In a survey involving 535 psychiatric outpatients treated for MDD, the three items most frequently judged by the patients to be very important in determining remission were the presence of features of positive mental health, such as optimism and self-confidence, a return to their usual, normal self, and a return to their usual level of functioning. The patients endorsed a statement about absence of symptoms with nearly similar frequency [20].

It is critical to improve the process by which patients and clinicians together select and implement antidepressants; it should augment the proportion of patients who adhere to their antidepressant treatment for a duration that complies with the current recommendations.

## 2 Shared Decision Making (SDM): Findings from Somatic Medicine

The number of patients who discontinue drug therapy prematurely can be lowered when patients can decide which treatment they prefer [21]. Alternatively, the research has documented that lack of patient information, problems within the doctor–patient communication, and low patient participation in the medical decision-making process are key predictors of patient reluctance to engage in or continue with treatment [22, 23].

Models of shared decision making (SDM) have been developed as a strategy for involving patients in the decision-making process, which could result in improved clinical outcomes. SDM approaches emerged as a reaction to medicine's traditional "paternalism," wherein physicians exercise the dominant role in treatment decision making [24]. SDM is a collaborative process in which clinicians and patients work together to reach a consensus about treatment or diagnostic decisions; it is a process whereby clinicians present patients with technical information regarding the disease (diagnosis, etiology, prognosis) and the benefits and risks of the available treatment options and patients inform clinicians about their beliefs, values, goals, experiences, and preferences about the consequences of those treatment options. SDM involves the provision of evidence-based information about options, outcomes, and uncertainties, together with decision-support counseling and a system for recording and implementing patients' "informed preferences" [25]. Bringing these two types of expertise together should produce better decisions. SDM is especially relevant (1) when there is more than one reasonable option, (2) when the scientific evidence about the effectiveness or safety of available treatments is scarce, (3) when treatments show a similar balance between benefits and risks, or (4) when possible benefits and harms of each option affect patients differently.

Overall, there is international consensus across medicine about the importance of SDM, and it is widely supported [26]. Policy makers may perceive SDM as desirable because of its potential to (1) reduce overuse of options not clearly associated with benefits for all; (2) enhance the use of options clearly associated with benefits for the vast majority; (3) reduce unwarranted healthcare practice variations; and (4) promote the right of patients to be involved in decisions concerning their health.

SDM interventions have been successfully implemented when treating various illnesses, such as breast and prostate cancer [27]. Patients have shown reduced psychological distress and improved functioning [28, 29], and they have achieved better health outcomes when perceiving themselves as more involved in the decision-making process

[30]. Better outcomes include increased compliance with decisions [31], reduced stigma, and increased involvement [32]. Of note, however, a systematic review of trials testing the impact of SDM on outcomes in physical health made a more skeptical conclusion, as only half of the reviewed trials indicated a positive effect [33].

### 3 The Importance of SDM in Mental Healthcare

Following beneficial applications of SDM in caring for physical illnesses [34], researchers have incorporated principles and elements of SDM for different mental health interventions. In this field, SDM is associated with enhanced patient satisfaction, adherence, empowerment, and guideline-concordant care [23, 35–37].

SDM interventions have been developed for depressed individuals [31, 38–42]. Loh et al. [23] found that, after an SDM intervention, depressed primary care patients displayed significantly greater participation in decision making and greater treatment satisfaction. A systematic review [43] identified 11 randomized controlled trials, including one focusing on depression [44]. Five trials, including the two mental health trials, showed positive outcomes associated with SDM, but the reviewers concluded that the overall evidence was encouraging but inconclusive. SDM can lead to reduced substance use and improved quality of life [45], and is associated with increased patient autonomy [46]. In a systematic literature review, Samalin et al. [47] identified three 6-month studies demonstrating that SDM interventions using decision aids effectively improved depressed patients' satisfaction and engagement in the decision-making process. Regarding treatment adherence or reduced depression severity, results remain inconclusive [23], but the clinician–patient alliance and communication can be associated with improved antidepressant treatment adherence [48, 49]. Studies comparing the effects of SDM with usual care on patient adherence in mental disorders are ongoing [50].

## 4 Implementing an SDM Process in Mental Health

### 4.1 Patient and Physician Roles

Patients increasingly expect, as a right, to be active participants in decisions about the management of their disease; for many patients, the time spent meeting with their physician—the clinical encounter—is the most opportune moment for them to become engaged in their own health through the process of SDM. The patient's point of view was gathered through the testimony of a patient advocate (see Box 1),

who considers SDM a win–win relationship, an intervention to be systematically implemented as it helps improving adherence to medication by alleviating patients' fears. Most patients with mental disorders wish to be involved in the decision-making process [39, 51, 52]. Most patients, including depressed individuals, welcome information about a wide range of topics, including their medical condition and pertinent treatments [40, 53, 54]; side effects of medications are of special interest for patients [37]. Patients with depressive disorders desire an active participation in the decision-making process [55], meaning they are more likely to take an active role in the process than patients with mild forms of hypertension, heart disease, and severe diabetes [56].

Studies of individuals experiencing severe mental illnesses have found that (1) most patients desire a greater participation in treatment decisions; (2) greater personal experience living with the illness is associated with greater desire for such involvement; and (3) most patients participate in SDM interventions when offered the opportunity [57, 58].

Clinicians can clarify the patient's understanding and make or explicitly defer a decision [59]. After initiation of the treatment, frequent patient–physician contacts may increase the probability that patients will continue therapy in the long term [22].

### 4.2 Common Misconceptions

There are several common misconceptions about using an SDM process in patients with depression. The first is that physicians may experience time and cost constraints. An in-depth assessment of needs that considers the patients', relatives', and experts' views is expected to be a highly time- and cost-consuming process. Most physicians failed to use the SDM process when consulting patients with depression, and they tended to “treat first and involve patients later” and felt that discussing differences among the choice of medications was not a good use of time [60]. However, the SDM process follows a usual consultation in depression and is not believed to add cost or extend more than a few minutes to the time needed for the consultation [61–63].

A second misconception is that “the patient feels unsupported if left to decide,” but the SDM process is clearly a shared activity, and it must be emphasized that the decision will be made together.

Third, some healthcare professionals express doubts, saying that patients do not want to be involved in decisions. As noted, most depressed patients wish to actively participate in treatment decision making and generally want more involvement than patients with other general medical problems. Of course, some patients may prefer that their physician alone select the appropriate intervention; thus, older, less educated, and physically sicker

patients typically prefer less active roles in the decision-making process [64–67] to minimize anxiety associated with the process.

Finally, physicians sometimes claim they are “already using the SDM approach,” but there is evidence to the contrary [68–70]. Evidence suggests that physicians performed poorly on standardized measures of the SDM process, such as the OPTION scale (“observing patient involvement”) [71].

In view of these misconceptions, it is clear that the first step for those advocating the uptake of SDM is to ensure that physicians support the underlying rationale.

### 4.3 Barriers to Practicing an SDM Process

There are barriers to practicing an SDM process in mental health. First, SDM involves a shift in power arrangements, so there is a challenge to the clinician’s autonomy and authority, particularly in the field of mental health. A study found that participants using psychiatric outpatient services said they were helped to understand the information but the selection of treatment was not a consensus decision [72]. It may become difficult for patients to support SDM if it apparently involves conversations always ending up with the clinician’s view prevailing [73]. It is important to identify and re-evaluate discrepant patient–clinician values and to provide patients with the skills, information, and motivation to participate equally and fully in the medical decision-making encounter [14, 52, 56, 64, 74]. Ideally, the physician should enable the patient to gain the following skills so the process is equitable: (1) how to ask questions about their condition and possible treatments; (2) how to seek out information; (3) how to evaluate information regarding treatment and decisions; (4) how to discuss treatment options with their physician, questioning the reasoning behind treatment decisions; and (5) how to communicate their needs, values, and preferences to physicians. This is, of course, time consuming and may add to the consultation time but would certainly be worth the effort.

As engaging in SDM may require knowledge, confidence, and high levels of health literacy, there may be a risk that SDM primarily attracts and benefits those who are natural information seekers, who are educated, empowered, and able to advocate for their needs, while marginalizing other patients. It therefore becomes essential to promote SDM by tailoring communication, information, and SDM interventions to the specific needs of traditionally disengaged individuals and by using tools and processes that are sufficiently accessible [75].

Clinicians may also find it difficult to access or communicate evidence, whereas patients may have a fear of being judged [76].

### 4.4 Overcoming Barriers

Barriers to implementing SDM can be overcome with a consistent approach and changes to practice processes. Changing practices involves the use of formal decision-support tools that may target behavior change in either clinicians or patients.

Decision aids are tools designed to educate patients about treatment options and help them make informed choices. These evidence-based interventions are designed to engage patients and clinicians in an SDM process and translate research evidence into patient-centered care [42, 77]. Materials have been developed in different formats, such as paper and pencil instruments, videos, audio-guided workbooks, web-based tools [78], and interactive software that can be used alone by the patient or in interaction with the healthcare professional. A consult decision-aid prototype was recently developed with evidence from Cochrane reviews [79]. Decision aids may also encourage patients to think about their personal values and preferences regarding the benefits and risks of the different treatment options and the influence these treatment options could have on their lives and well-being. Decision aids do promote SDM when used during the clinical encounter [80], and, in comparison with standard counseling, they can produce greater patient knowledge about treatment options and more realistic expectations about treatment, as well as increase the likelihood of receiving a treatment that is consistent with personal values [34, 81].

These approaches have been evaluated in depression, and they did help primary care clinicians and patients select antidepressants together that best fit with the patient’s values, preferences, and goals, improving the decision-making process, as well as patient participation and satisfaction without adding to the consultation time [23, 61].

## 5 Conclusion

Improving the process by which patients and clinicians together select and implement antidepressants should augment the proportion of patients who adhere to their antidepressant treatment for a duration that complies with the current recommendations. Treatment initiation and adherence stem from: (1) the reciprocal influences and interactions of individuals and healthcare professionals; (2) the degree to which participants agree about treatment goals and the methods for achieving them; (3) communication styles that actively engage both partners in a decision-making dialogue; (4) the individual’s belief that treatment is beneficial despite required effort, or even possible negative consequences (side effects); and (5) the individual’s confidence in their ability



to initiate, pursue, and follow through with the treatment regimen.

For depressed individuals, it is important to improve the frequency of SDM because it respects patient autonomy and promotes patient engagement and empowerment in a manner directly relevant to the helplessness and hopelessness intrinsic to depression. SDM may indirectly improve clinical outcomes because there is some evidence that, when patients have made well-informed decisions, they also adhere to their medication better and receive guideline-concordant treatment [43, 47]. Finally, more physicians need training in the approach by having access to appropriate tools that help them engage in collaborative deliberation, and more practices need to be reorganized around the principles of patient engagement.

### Compliance with Ethical Standards

**Conflict of interest** Prof. Malcom Hopwood has served as a board member for Phoenix and the Royal Australian and New Zealand College of Psychiatrists, Summer Foundation; received speaker's fees/honoraria from Eli Lilly, Health Ed, Janssen-Cilag, Lundbeck, Psych Scene, and Servier; served on advisory boards or provided consultancy for Lundbeck and Servier; received travel support from Bionomics, Eli Lilly, Janssen-Cilag, Lundbeck, and Servier; and received clinical trial/research support from Bionomics, ISSCR, Lundbeck, NHMRC, Ramsay Health Foundation, Servier, VNI, and the Weary Dunlop Foundation.

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### Box 1: Interview of Mrs C., a French patient advocate and patient teacher

Why are patients reluctant to follow a pharmacological treatment plan?

Mrs C.: "When speaking about nonadherence to a pharmacological treatment, we often think of the fear of adverse effects, skepticism toward therapeutic efficacy, and the fear of addiction. These are not the only issues; for example, taking a medicine also reminds you of your illness daily, which can prevent you from living normally. Patients stop taking the treatment as they feel better."

What is the priority for patients to adhere to treatment?

Mrs C.: "SDM is one of the priority solutions allowing patients to adhere to treatments. Both the patient and the doctor get involved in decision making and negotiate for the best option. We negotiate all the time; why not with

our doctor? When the doctor and the patient make a mutual agreement, the patient is more engaged. The SDM process holds clear benefits for patients who become an actor in their own treatment; they decide together and are more committed. There are also benefits for the doctor who can better know the patients and engage in a true partnership based on communication; it's a win-win relationship. Of course, there will probably be a longer consultation time to achieve agreement between the two parties, but this is worth it."

Do patients want to be more involved?

Mrs C.: "All patients want to be involved. Doctors often inform patients of the benefits, the risks, the therapeutic options, ... and the clinician's view prevails at the end. In the SDM process, information and decisions are shared. The difficulty for the doctor is to give the therapeutic options while remaining neutral regarding the choice. Hopefully, there are now clear, precise, and neutral tools to help in generating a mutually agreed decision."

Are patients sufficiently informed about therapeutic options and related side effects?

Mrs C.: "Unfortunately, they are not. By knowing the options and related side effects, the patient has the choice. For example, a woman may be reluctant to gain weight but prefer to be a bit "tired" in the morning, whereas a man may prefer the opposite option. Some doctors can be reluctant to provide an exhaustive list of the side effects, but patients can easily have access to this information with the many internet forums and blogs available. In fact, the doctor is the most legitimate person to give a complete picture of the side effects, to give details on the existing solutions, and to clearly explain the benefit-risk balance that most of the patients ignore.

The expertise of the patient must be taken into account. It is important for patients to talk about their beliefs, preferences, values, and needs. Chronic patients are experienced. They often follow forums on the internet, they learn a lot about their disease and share their experience; it's a collective intelligence. The patient becomes an expert in "living with"; it is important not to underestimate this expertise."

What steps forward do you suggest?

Mrs C.: "First, training in SDM should be obligatory for all doctors; second, patients and the general public should receive more information about SDM."

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