

VU Research Portal

Shared decision making in mental health care

Metz, M.J.

2018

document version

Publisher's PDF, also known as Version of record

[Link to publication in VU Research Portal](#)

citation for published version (APA)

Metz, M. J. (2018). *Shared decision making in mental health care: the added value for patients and clinicians*. [, Vrije Universiteit Amsterdam].

General rights

Copyright and moral rights for the publications made accessible in the public portal are retained by the authors and/or other copyright owners and it is a condition of accessing publications that users recognise and abide by the legal requirements associated with these rights.

- Users may download and print one copy of any publication from the public portal for the purpose of private study or research.
- You may not further distribute the material or use it for any profit-making activity or commercial gain
- You may freely distribute the URL identifying the publication in the public portal

Take down policy

If you believe that this document breaches copyright please contact us providing details, and we will remove access to the work immediately and investigate your claim.

E-mail address:

vuresearchportal.ub@vu.nl

Chapter 1

General introduction

Introduction

This thesis focuses on the added value of active involvement of patients in decision making about treatment in specialist mental health care, so-called Shared Decision Making (SDM). We also investigate whether the use of periodic outcome measurements during treatment (Routine Outcome Monitoring, ROM) and electronic health (eHealth) could support patients and clinicians in applying SDM. Until now, in mental health care very little was known about the feasibility and effectiveness of the integration of SDM with ROM and eHealth.¹ To better understand the field of study, first background information on Dutch mental health care is given. Second, the definition, evidence and implementation level of Shared Decision Making, Routine Outcome Monitoring and eHealth are described. Next, the multidimensional construct Decisional Conflict, which assesses the quality of clinical decision making, is explained. Subsequently, the aim of this thesis and the research questions examined are given. This chapter ends with the applied methods and outline of this thesis.

Background

Mental health care in the Netherlands

The Dutch mental health care sector consists of different segments of providers. The general practitioner functions as gatekeeper. Almost all Dutch citizens are registered with a general practitioner who deals with most of their medical problems. Patients with mild mental health problems are treated by the primary care providers i.e. the general practitioner assisted by a mental health physician assistant. Patients with mental health problems which are beyond the capability of the primary care provider, are referred to the curative mental health care. Since 2014 the curative mental health care has been divided into two segments. First, the general basic mental health care for people with moderate, non-complex mental health disorders and people with stable chronic problems. Second, specialist mental health care for people with severe, complex mental health conditions.^{2,3}

Annually, about 700.000 patients are treated in the curative mental health care by an estimated number of 175 mental health care organisations, varying from large, regional mental health care organisations to small practices.⁴ In total,

about 89,000 employees are working in the mental health care sector.⁴ This thesis focuses on the patient group above the age of 18 with various mental health disorders treated in specialist mental health care. Most prevalent treated primary diagnoses for adults (18-64 years) are mood (24%), anxiety (15%) and personality (14%) disorders. For elderly (65+ years) cognitive (34%) and mood (29%) disorders are most treated.⁴ The mean duration of treatment in curative mental health care is 17.5 months.⁴

Shared Decision Making

In mental health care, attention for the implementation of SDM is increasing.⁵⁻⁹ Throughout this dissertation SDM is defined as the collaborative approach in which patients, together with their companions, and clinicians share available information about choices in treatment from both perspectives and where patients are supported in participating actively in decision making about treatment.¹⁰ This dialogue aims to take place on an egalitarian footing, involving patients' knowledge from experience, values and wishes, as well as scientific knowledge and clinicians' expertise.^{5,10} The SDM method encompasses several steps: 1) introduction of the choice(s), eliciting goals and exploring the roles of patients and their companions; 2) give meaning to available information sources; 3) explore options; 4) weigh options and 5) making a shared decision.¹⁰⁻¹⁴

Research in mental health care showed that SDM can have a positive influence on the level of informed patients, the degree of actively engaged patients in treatment, patient satisfaction, treatment adherence and treatment outcomes.^{5,15-18} Despite these promising insights and the increasing attention for SDM, SDM has not yet been broadly implemented in mental health care, and hence there is much to improve in patients' participation in clinical decision making.¹⁹⁻²⁴ To bridge the gap between the promising evidence and lagging implementation of SDM, it is important to support clinicians and patients in their switch towards another way of working.^{20,25,26} Patients need access to information and tools to prepare themselves for the decision making process about treatment. As described in the sections below, Routine Outcome Monitoring and eHealth are considered to be promising tools to use during this decision making process.^{1,13,27,28}

Routine Outcome Monitoring

Clinical feedback from outcome measurements in everyday practice, so-called Routine Outcome Monitoring (ROM), could be helpful for both patients and clinicians in decision making about treatment.²⁹⁻³¹ ROM is a personalized source of information and implies regular measurements of clinical outcomes during treatment. ROM has the primary goal to provide feedback on the patients' progress during treatment^{29,30}, and consequently has the potential to be a useful tool involving patients in their treatment process and to be used as a source of information while choosing appropriate treatment options.^{1,13,31,32} Research pointed out that ROM can enhance the communication between patients and clinicians, and, when patients and clinicians both are provided with this feedback information, ROM can have beneficial effects on mental health status, especially for patients who are not responding to treatment favourably.^{30,32-35}

In addition to the primary, original goal of ROM i.e. 1) Giving feedback to patients and clinicians targeting to evaluate treatment, ROM could also be used for other purposes i.e. 2) learning and improving within teams with ROM feedback on an aggregated level; 3) research with naturalistic ROM data, and 4) external use for performance measurement and accountability.³⁶⁻³⁸ Since the nationwide dissemination of ROM from 2010 onwards³⁶, attention has been especially focused on the last mentioned fourth goal of ROM. Therefore, clinicians experienced ROM as a tool for management and external control, which led to resistance and hampered the use of ROM by clinicians and patients in day-to-day practice.³⁹⁻⁴³ This has given ROM in the Netherlands a negative connotation, which is unfortunate as ROM, if tailored to the patient group and used as feedback instrument during treatment, is still a promising tool for patients and clinicians to evaluate the progress and communicate about treatment.^{1,13,30-32,44}

In 2011 GGz Breburg developed and implemented a model for SDM using ROM in a centre for patients with combined physical and mental disorders. This approach was evaluated in a pilot study, which showed the feasibility of the implementation and the utility of ROM as a personalized source of information during decision making about treatment.^{1,13} A Randomised Controlled Trial was recommended aimed to test the effectiveness of SDM combined with ROM

more thoroughly.¹ Regarding the opportunities of ROM and the, in general, suboptimal use in clinical practice, in 2014 in Dutch mental health care a government sponsored National Quality Improvement Collaborative (QIC)⁴⁵ was initiated aiming to enhance the nationwide uptake of ROM in routine clinical practice. In this QIC initiative ROM was embedded in a SDM framework. In this dissertation the implementation of ROM and the effectiveness of SDM using ROM has been evaluated.

Electronic Health (eHealth)

In this thesis we also investigate whether electronic health (eHealth) could foster SDM. EHealth is a very broad concept; several definitions have been used to describe eHealth activities.⁴⁶ In our research eHealth implies an internet-supported intervention, which focuses on the intake process and includes educational and therapeutic interventions aimed at exploring treatment needs, expectations and preferences of patients intended to prepare patients for the intake consultations and to give them the opportunity to play an active role in decision making about treatment.^{46,47} This so-called blended eHealth intervention is self-guided and human-supported as well. This means that patients follow eHealth partly independent with some degree of automated feedback, while it also incorporates human interventions for support, guidance and feedback.⁴⁶ Nowadays, there is increasing attention for the implementation of eHealth in mental health care.^{46,48,49} EHealth interventions are promising to stimulate active patient participation^{27,28,50} and to enhance treatment outcomes.⁵¹⁻⁵³ Despite these promising results of studies investigating eHealth interventions, until now the amount and quality of the evidence is low.⁵¹⁻⁵³ Therefore, more studies are needed to establish these findings.⁵¹⁻⁵³

Quality of clinical decision making

With the implementation of SDM, there is an increasing need to evaluate the quality of its application in clinical practice.^{54,55} A construct that may be helpful is Decisional Conflict. Decisional Conflict is a multi-dimensional and transactional construct that covers both the decision making process and the quality of the decisions made and is related to the way of collaboration between patients and clinicians. Decisional Conflict gives insight into the degree in which patients are engaged in and also whether patients feel comfortable about important clinical decisions that are made about their treatment.^{56,57}

A low level of Decisional Conflict is very important, because when patients experience less Decisional Conflict, their adherence to treatment and health outcomes are likely to improve, whereas more Decisional Conflict could have negative consequences such as drop-out, dissatisfaction with the treatment, poorer health outcomes and reduced quality of life.^{57,58} SDM can improve the decision-making process and reduce Decisional Conflict.^{17,18,54,59}

General aim and research questions

This thesis contributes to the field of knowledge on the quality of clinical decision making in specialist mental health care, and subsequently encompasses how and whether Shared Decision Making (SDM) using Routine Outcome Monitoring (ROM) and eHealth could optimise patient participation and the quality of clinical decision making. Overall we hypothesized that the application of SDM using ROM and eHealth should lead to less Decisional Conflict, more patient participation in decision making, a better working alliance, more treatment adherence and better treatment outcomes. As illustrated in Figure 1, we argued that a better application of SDM first might lead to positive effects on the proximal dependent outcome and process parameters, which were closely related to the SDM construct, i.e. Decisional Conflict, process of Shared Decision Making, patient participation and working alliance.^{17,18,54,59-61} Subsequently, we expected that, if patients are satisfied about the collaboration with their clinician, they had the opportunity to participate actively in decision making and experienced less Decisional Conflict, this might in turn influence the secondary, distal dependent outcome parameters higher treatment adherence and better treatment outcomes.^{57,58,62-67} Although, better scores on the proximal dependent outcome variables would be a benefit per se^{62,68,69}, achieving better results on the distal dependent outcome parameters treatment adherence and outcome, which were indirectly related to a higher level of SDM, would be the most important final outcomes of our interventions.⁶⁹

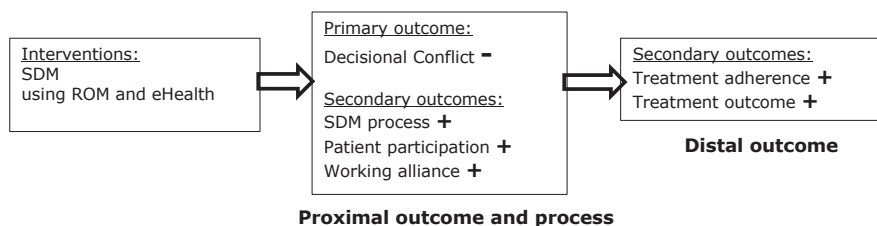


Figure 1. Initial model: the influence of SDM on primary and secondary outcomes.

The general research question of this thesis ‘Does the implementation of SDM using ROM and eHealth lead to less decisional conflict, more patient participation in clinical decision making, better working alliance, more treatment adherence and better treatment outcomes’ is divided into the following sub-questions:

1. What is the relevance and usefulness of Decisional Conflict to evaluate clinical decision making in daily practice, and how can it be described, illustrated in a model and measured?
2. Whether are patients in specialist mental health care experiencing Decisional Conflict and what is the influence of socio-demographic and clinical characteristics?
3. What are the effects of the National Quality Improvement Collaborative on the actual use and perceived utility of ROM in routine clinical practice?
4. What are the effects of the implementation of SDM using ROM, facilitated by the National Collaborative, on Decisional Conflict, working alliance and treatment outcome?
5. What are the effects of a multi-faceted blended eHealth intervention during the intake process supporting SDM on Decisional Conflict, patient participation, applying SDM, working alliance, treatment adherence and treatment outcome?

Methods and outline of this thesis

To answer the research questions, described above, we conducted a review of literature, a nationwide and a regional study. The nationwide data collection was part of the National Quality Collaborative and took place in order to

gain knowledge about the use of ROM in daily practice and get insight into the effectiveness of applying SDM using ROM in routine clinical practice. In addition to this national initiative, where especially the clinician was supported in applying SDM during treatment, GGz Breburg, a specialist mental health care organisation in the southern part of the Netherlands, takes a step forward in improving SDM by developing a multi-faceted blended eHealth intervention in the intake process. In this initiative, both patients and clinicians were supported in SDM. This regional study at GGz Breburg evaluated this multi-faceted intervention in the intake process.

The outline of this thesis, which consists of three parts, and the designs of the different studies are described in brief below. For further details on the research methods the reader is referred to the various chapters of this thesis.

Part I: Decisional Conflict: a concept to assess the quality of clinical decision making

Part I focuses on the concept Decisional Conflict, a construct which evaluates the quality of clinical decision making and gives insight into patients' engagement in and satisfaction with clinical decisions.

Chapter 2 answers research question 1, and provides insight from a literature study covering a description of the multi-dimensional construct Decisional Conflict and illustrated this concept in a model. We also described the usefulness and measurement of Decisional Conflict in clinical practice.

In **Chapter 3** research question 2 is answered. This chapter describes the results of a cross-sectional study exploring the level of DC experienced by patients in specialist mental health care and the influence of patients' characteristics on Decisional Conflict. This study was performed on the baseline data of the RCT aimed to investigate the added value of Shared Decision Making using Routine Outcome Monitoring.

Part II: The impact of the National Quality Collaborative on improving Shared Decision Making using ROM.

In **Part II** we focus on the National Quality Collaborative aiming to implement ROM in a SDM framework. In this second part research questions 3 and 4 are answered. **Chapter 4** provides the results of an implementation study

investigating the actual use and perceived utility of ROM in clinical practice, which was assessed by a survey for clinicians participating in 21 intervention and 14 control teams. Clinicians of the intervention and control teams completed this survey at the beginning and end of the National Collaborative. This study included a parallel group design with matched pairs of participating teams in which a cluster randomised controlled trial (RCT) was embedded.

Chapter 5 describes the study protocol and **Chapter 6** the results of the nationwide RCT investigating the effectiveness of SDM using ROM. This two-arm matched-paired cluster RCT was performed to investigate the effects of this SDM-ROM approach primary on patients' perception of Decisional Conflict, and secondary on working alliance and treatment outcomes. In total, 186 patients (94 intervention, 92 control) and 57 clinicians (25 intervention, 32 control) from 4 organisations (matched pairs; 7 intervention and 7 control teams) across the Netherlands participated in this trial.

Part III: The effectiveness of supporting Shared Decision Making using a multi-faceted blended eHealth intervention during intake: a regional initiative.

In **Part III** research question 5 is answered. This part describes the development and evaluation of a regional, multi-faceted blended eHealth intervention supporting SDM during intake. **Chapter 7** describes the study protocol and **Chapter 8** the results of the RCT investigating this regional, multi-faceted initiative in the intake process of GGz Breburg. In order to gain insight in the effectiveness of this intervention, we conducted a two-arm matched-paired cluster RCT. The primary outcome was Decisional Conflict. Secondary outcomes were patient participation, SDM-process, working alliance, treatment adherence and symptom severity. In total, 8 teams (matched pairs; 4 intervention and 4 control), 56 couples of intake clinicians, who jointly performed the intake (29 intervention, 27 control), and 200 patients (94 intervention, 106 control) participated in this trial.

Finally, in **Chapter 9** the main findings of this thesis are presented and discussed from a broader perspective. This chapter also describes the contribution of this entire dissertation to our understanding of the implementation of SDM using ROM and eHealth and its added value for patients and clinicians. In addition, implications for clinical practice and further research are suggested. The thesis ends with a summary and acknowledgements in Dutch.

References

1. Van der Feltz-Cornelis C, Andrea H, Kessels E, Duivenvoorden H, Biemans H, Metz M. Does routine outcome monitoring have a promising future? An investigation into the use of shared decision making combined with ROM for patients with a combination of physical and psychiatric symptoms. *Tijdschr Psychiatr*. 2014; 56: 375–84.
2. Westra D, Wilbers G, Angeli F. Stuck in the middle? A perspective on ongoing pro-competitive reforms in Dutch mental health care. *Health Policy*. 2016; 120: 345-349.
3. Van Mens K, Lokkerbol J, Janssen R, Van Orden ML, Kloos M, Tiemens B. A cost-effectiveness analysis to evaluate a system change in mental healthcare in the Netherlands for patients with depression or anxiety. *Adm Policy Ment Health*. 2017. doi:10.1007/s10488-017-0842-x
4. GGZ Nederland. Sector rapport ggz 2013: feiten en cijfers over een sector in beweging. Amersfoort: december 2015.
5. Patel SR. Recent advances in Shared Decision Making for Mental Health. *Cur Opin Psychiatry*. 2008; 21: 606-7.
6. Barr PJ, Scholl I, Bravo P, Faber MJ, Elwyn G, McAllister M. Assessment of patient empowerment: a systematic review of measures. *PLoS One* 2015; 13 May: doi:10.1371/journal.pone.0126553.
7. Härter M, Elwyn G, van der Weijden T. Policy and practice developments in the implementation of shared decision making: an international perspective. *Z Evid Fortbild Qual Gesundheitswes*. 2011. 105: 229–5. doi:10.1016/j.zefq.2011.04.018
8. Ten Haaft G, van Veenendaal H. Versnellen van gedeelde besluitvorming in Nederland: opmaat naar een onderzoeks-/innovatieprogramma Samen beslissen [Increasing Shared Decision Making in the Netherlands]. ZonMw, CZ 2016. <https://www.zonmw.nl/nl/actueel/nieuws/detail/item/versnellen-van-gedeelde-besluitvorming-in-nederland/>. Accessed April 2016.
9. Pieterse A, Brand P, Basoski N, Stiggelbout A. Een investering van arts en patiënt in betere zorg: Alles wat u moet weten over gedeelde besluitvorming [An investment of clinician and patient in quality of health care: Everything you need to know about shared decision making]. *Medisch Contact*. 2017; 12: 34-3.
10. Elwyn G, Forsch D, Thomson R, Joseph-Williams N, Lloyd A, Kinnersley P. Shared Decision Making: a model for clinical practice. *J Gen Intern Med*. 2012; 27: 1361-7.
11. Staveren van R. Stand van zaken gezamenlijke besluitvorming in de Praktijk: patiëntgerichte gespreksvaardigheden. *Ned Tijdschr Geneesk*. 2011; 155: A3777.
12. Stiggelbout AM, Pieterse AH, Haes de JCJM. Shared Decision Making: Concepts, evidence and practice. *Patient Educ and Couns*. 2015; 98: 1172-1179.
13. Metz M, Biemans H, Kessels E, Van der Feltz-Cornelis C. Gebruik van ROM bij Shared Decision Making, een praktijkvoorbeeld. *Nederlands Tijdschrift voor Evidence Based Practice*. 2015; 5: 4-6.
14. Elwyn G, Durand MA, Song J, Aarts J, Barr PJ, Berger Z, et al. A three-talk model for shared decision making: multistage consultation process. *BMJ*. 2017. doi:10.1136/bmj.j4891
15. Malm U, Ivarsson B, Allebeck P, Falloon IRH. Integrated care in schizophrenia: a 2-year randomised controlled study of two community-based treatment programs. *Acta Psychiatr Scand*. 2003. 107: 415-423.
16. Clever SL, Ford DE, Rubenstein LV, Rost KM, Meredith LS, Sherbourne CD, Wang NY, Arbelaez JJ, Cooper LA. Primary care patients' involvement in decision-making is associated with improvement in depression. *Med Care*. 2006; 44: 398-405.
17. Westermann GMA, Verheij F, Winkens B, Verhulst FC, Van Oort FVA. Structured shared decision-making using dialogue and visualization: a randomised controlled trial. *Patient Educ Couns*. 2013; 90: 74-81.
18. Stacey D, Légaré F, Lewis K, Barry MJ, Bennett CL, Eden KB, et al. Decision aids for people facing health treatment or screening decisions (review). *Cochrane Database Syst Rev*. 2017. doi:10.1002/14651858.CD001431.pub5
19. Adams J, Drake R, Wolford G. Shared decision-making preferences of people with severe mental illness. *Psychiatr Serv*. 2007; 58: 1219-21.

20. Joseph-Williams N, Elwyn G, Edwards A. Knowledge is not power for patients: A systematic review and thematic synthesis of patient-reported barriers and facilitators to shared decision making. *Patient Educ Couns.* 2014; 94: 291-309.
21. Hamann J, Cohen R, Leucht S, Busch R, Kissling W. Do patients with schizophrenia wish to be involved in decisions about their medical treatment? *Am J Psychiatry.* 2005; 162: 2382-2384.
22. Hamann J, Mendel RT, Fink B, Pfeiffer H, Cohen R, Kissling W. Patients' and psychiatrists' perceptions of clinical decisions during schizophrenia treatment. *J Nerv Ment Dis.* 2008; 196: 329-332.
23. Dahlqvist-Jönsson P, Schön UK, Rosenberg D, Sandlund M, Svedberg P. Service users' experiences of participation in decision making in mental health services. *J Psychiatr Ment Health Nurs.* 2015; 22: 688-697.
24. Puschner B, Becker T, Mayer B, Jordan H, Maj M, Fiorillo A, et al. Clinical decision making and outcome in the routine care of people with severe mental illness across Europe (CEDAR). *Epidemiol Psychiatr Sci.* 2016; 25: 69-70.
25. Légaré F, Turcotte S, Stacey D, Ratté S, Kryworuchko J, Graham ID. Patients' perceptions of sharing in decisions: a systematic review of interventions to enhance shared decision making in routine clinical practice. *Patient.* 2012; 5: 1-19.
26. Ramon S, Morant N, Stead U, Perry B. Shared decision-making for psychiatric medication: A mixed-methods evaluation of a UK training programme for service users and clinicians. *Int J Soc Psychiatry.* 2017; 63: 763-772.
27. Krausz M, Ward J, Ramsey D. From telehealth to an interactive virtual clinic. *E-Mental Health.* Springer international publishing Switzerland. 2016: doi:10.1007/978-3-319-20852-7_15
28. Korsbek L, Tønder ES. Momentum: a smartphone application to support shared decision making for people using mental health services. *Psychiatr Rehabil J.* 2016; 39: 167-72.
29. De Beurs E, Den Hollander-Gijsman ME, Van Rood YR, Van der Wee NJ, Giltay EJ, Van Noorden MS, et al. Routine outcome monitoring in the Netherlands: practical experiences with a web-based strategy for the assessment of treatment outcome in clinical practice. *Clin Psychol Psychother.* 2011; 18: 1-12.
30. Carlier IVE, Meuldijk D, Van Vliet IM, Van Fenema EM, Van der Wee NJA, Zitman FG. Routine outcome monitoring and feedback on physical or mental health status: evidence and theory. *J of Eval Clin Pract.* 2012; 18:104-110.
31. Eisen SV, Dickey B, Sederer LI. A self-report symptom and problem rating scale to increase inpatients' involvement in treatment. *Psychiatr Serv.* 2000; 51: 349-353.
32. Gondek D, Edbrooke-Childs J, Fink E, Deighton J, Wolpert M. Feedback from outcome measures and treatment effectiveness, treatment efficiency, and collaborative practice: a systematic review. *Adm Policy Ment Health.* 2016; 43: 325-343.
33. Knaup C, Koesters M, Schoefer D, Becker T, Puschner B. Effect of feedback of treatment outcome in specialist mental healthcare: meta-analysis. *Br J Psychiatry.* 2009; 195: 15-22.
34. Shimokawa K, Lambert M.J, Smart DW. Enhancing treatment outcome of patients at risk of treatment failure: meta-analytic and mega-analytic review of a psychotherapy quality assurance system. *J Consult Clin Psychol.* 2010; 78: 298-311.
35. Guo T, Xiang YT, Xiao L, Hu CQ, Chiu HF, Ungvari GS, et al. Measurement-Based Care versus Standard Care for Major Depression: a randomized controlled trial with blind raters. *Am J Psychiatry* 2015; 172: 1004-13.
36. GGZ Nederland & Zorgverzekeraars Nederland (2010) Bestuurlijk akkoord d.d. 5 juli 2010.
37. Wees van der PH, Nijhuis-van der Sanden MWG, Ayanian JZ, Black N, Westert GP, Schneider EC. Integrating the use of patient-reported outcomes for both clinical practice and performance measurement: views of experts from 3 countries. *Milbank Q.* 2014; 92: 754-75.
38. Roe D, Drake RE, Slade M. Routine Outcome Monitoring: an international endeavour. *Int Rev Psychiatry.* 2015; 27: 257-260.
39. Delespaul PEG. Routine Outcome Measurement in the Netherlands – A focus on benchmarking. *Int Rev Psychiatry.* 2015; 27: 320-28.
40. Nuijen J, Van Wijngaarden B, Veerbeek M, Franx G, Meeuwissen J, Van Bon-Martens M. Implementatie van ROM ter ondersteuning van de dagelijkse zorgpraktijk in de GGZ. Een landelijke meting van de implementatiegraad en een verdieping aan de hand van praktijksituaties. Utrecht: Trimbos-instituut 2015.

41. De Jong K, Tiemens B, Verbraak MJPM, Beekman ATF, Bockting CLH, Bouman TK, et al. Red ROM als kwaliteitsinstrument. *Tijdschr Psychiatr.* 2017; 59: 242-244.
42. De Beurs E. Over ROM en benchmarken: reactie van SBG op rapport van de Algemene Rekenkamer en de actie 'Stop ROM'. *Tijdschr Psychiatr.* 2017; 59: 238-241.
43. Van Os J, Berkelaar J, Hafkenscheid EA, Cahn W, Corstens D, Delespaul P, et al. Benchmarken: doodlopende weg onder het mom van 'ROM'. *Tijdschr Psychiatr.* 2017; 59: 247-250.
44. Tasma M, Liemburg EJ, Knegtering H, Delespaul PAEG, Boonstra A, Castelein S. Exploring the use of Routine Outcome Monitoring in the treatment of patients with a psychotic disorder. *Eur Psychiatry.* 2017; 42: 89-94.
45. Dutch mental health care a government-sponsored National Quality Improvement Collaborative (QIC); www.doorbraakrom.trimbos.nl
46. Barak A, Klein B, Proudfoot J. Defining internet-supported therapeutic interventions. *Ann Behav Med.* 2009; 38: 4-17.
47. Metz MJ, Elfeddali I, Krol DGH, Veerbeek MA, De Beurs E, Beekman ATF. A digital intake approach in specialized mental health care: study protocol of a cluster randomised controlled trial. *BMC Psychiatry.* 2017; 17: 86-12
48. Folker AP, Mathiasen K, Lauridsen SM, Stenderup D, Dozeman E, Folker MP. Implementing internet-delivered cognitive behavior therapy for common mental health disorders: A comparative case study of implementation challenges perceived by therapists and managers in five European internet services. *Internet Interventions.* 2018; 11: 60-70.
49. Tweede kamer der Staten-Generaal, Brief van staatssecretaris van Volksgezondheid, Welzijn en Sport. 2017-2018, 25 424, nr. 388.
50. Priebe S, McCabe R, Bullenkamp J, Hansson L, Lauber C, Martinex-Leal R, Wright DJ. Structured patient-clinician communication and 1-year outcome in community mental healthcare: Cluster randomised controlled trial. 2007. *Br J Psychiatry.* 191: 420-426.
51. Andersson G, Cuijpers P, Carlbring P, Riper H, Hedman E. Guided internet-based vs. face-to-face cognitive behaviour therapy for psychiatric and somatic disorders: a systematic review and meta-analysis. *World Psychiatry.* 2014; 13: 288-295.
52. Arnberg FK, Linton SJ, Hultcrantz M, Heintz E, Jonsson U. Internet-delivered psychological treatments for mood and anxiety disorders: a systematic review of their efficacy, safety, and cost-effectiveness. *PLOSone.* 2014; 9. doi:10.1371/journal.pone.0098118.
53. Olthuis JV, Watt MC, Bailey K, Hayden JA, Stewart SH. Therapist-supported internet cognitive behavioural therapy for anxiety disorders in adults. *Cochrane Database Syst Rev.* 2016. doi:10.1002/14651858.CD011565.pub2
54. Sepucha KR, Borkhoff CM, Lally J, Levin C.A, Matlock DD, Ng CJ e.a. Establishing the effectiveness of patient decision aids: key constructs and measurement instruments. *BMC Med Inform Decis Mak.* 2013; 13: S12.
55. Barr PJ, Elwyn G. Measurement challenges in shared decision making: putting the 'patient' in patient-reported measures. *Health expect.* 2015; 19: 993-1001.
56. LeBlanc A, Kenny DA, O'Connor AM, Légaré F. Decisional conflict in patients and their physicians: a dyadic approach to shared decision making. *Med Decis Making.* 2009; 29: 61-7.
57. O'Connor AM. User-Manual-Decisional Conflict Scale (16 item statement format). Ottawa Hospital Research Institute; 1993, updated 2010.
58. Hickman RL, Daly BJ, Lee E. Decisional conflict and regret: consequences of surrogate decision making for the chronically critically ill. *Appl Nurs Res.* 2012; 25: 271-275.
59. Hölzel P, Kriston L, Härter M. Patient preference for involvement, experienced involvement, decisional conflict, and satisfaction with physician: a structural equation model test. *BMC Health Serv Res.* 2013; 13: 231.
60. Bieber C, Müller KG, Blumenstiel K, Hochlehnert A, Wilke S, Harmann M, Eich W. A shared decision making communication training program for physicians treating fibromyalgia patients: Effects of a randomized controlled trial. *J Psychosom Res.* 2008; 64: 13-20.
61. Matthias MS, Fukui S, Kukla M, Eliacin J, Bonfils KA, Firmin RL et al. Consumer and relationship factors associated with shared decision making in mental health consultations. *Psychiatr Serv.* 2014; 1488-1491.

62. Drake RE, Cimpean D, Torrey WC. Shared decision making in mental health: prospects for personalized medicine. *Dialogues Clin Neurosci*. 2009; 11: 455-463.
63. Haskard Zonierek KB, DiMatteo MR. Physician communication and patient adherence to treatment: a meta-analysis. *Med Care*. 2009; 47: 826-834.
64. Ardito RB, Rabellino D. Therapeutic alliance and outcome of psychotherapy: historical excursus, measurements, and prospects for research. *Front Psychol*. 2011; 2: 1-11.
65. Priebe S, Richardson M, Cooney M, Adedeji O, McCabe R. Does the therapeutic relationship predict outcomes of psychiatric treatment in patients with psychosis? A systematic review. *Psychother Psychosom*. 2011; 80: 70-77.
66. De Leeuw M, Van Meijel B, Grypdonck M, Kroon H. The quality of the working alliance between chronic psychiatric patients and their case managers: process and outcomes. *J Psychiatr Ment Health Nurs*. 2012; 19: 1-7.
67. Thompson L, McCabe R. The effect of clinician-patient alliance and communication on treatment adherence in mental health care: a systematic review. *BMC Psychiatry*. 2012; 12: 1-12
68. Drake RE, Deegan PE. Taking issue: shared decision making is an ethical imperative. *Psychiatr Serv*. 2009; 60: 8.
69. Slade M. Implementing shared decision making in routine mental health care. *World Psychiatry*. 2017; 16: 146-153