Shared decision making in mental health care

Metz, M.J.

2018

document version
Publisher's PDF, also known as Version of record

Chapter 2

Providing insight into the construct Decisional Conflict and its usefulness in evaluating Shared Decision Making

Margot J. Metz, Marjolein A. Veerbeek, Iman Elfeddali, Edwin de Beurs,
Christina M. van der Feltz-Cornelis, Aartjan T.F. Beekman.

Tijdschrift voor Psychiatrie 2018; 60(6): 397-202

Abstract

Background

The increased attention for Shared Decision Making (SDM) in mental health care creates a need to evaluate its application. The construct decisional conflict, which refers to the satisfaction of patients regarding both the decision making process and the decisions made, could be of added value.

Aim

Clarifying decisional conflict and reflecting on its feasibility to evaluate SDM in mental health care.

Method

A literature study exploring the construct of Decisional Conflict was conducted, followed by a translation of the results into a visual model.

Results

Decisional Conflict is a multi-dimensional construct and consists of factors influencing the decision making process (information, support, values clarity), level of uncertainty concerning the options and the quality of the decision making. Decisional conflict can be illustrated in a model and assessed with the Decisional Conflict Scale.

Conclusion

Decisional Conflict is informative and useful in the evaluation of the application of SDM and improvement of the quality of the decision making in mental health care as well. This is of importance since patients who experienced less decisional conflict are more engaged in treatment and show better clinical outcomes.

Introduction

In the health care system, there is an increasing trend towards active participation by patients in their treatment.[1-3] Shared Decision Making (SDM), which is the dialogue in which patients, their advocates and clinicians jointly decide on treatment, dovetails with this trend. This dialogue takes place as much as possible on an egalitarian footing, involving input from each party: the patient's knowledge from experience, values and wishes, as well as scientific knowledge and clinician's expertise.[4,5] SDM takes account of the role the patient and his/her advocates can and wish to play in this process.[5-7] In a previous issue of this journal, Van der Feltz et al. (2014)[8] created a model to illustrate the SDM approach. In recent years there has been a growing interest in SDM within mental health care.[9-13] Mental health research has shown that SDM can make a positive contribution to the following: well-informed patients, an active role for patients in their treatment, patient satisfaction, adherence to therapy, treatment in keeping with guidelines, and better health outcomes.[4,14-21]

With the implementation of SDM, there is an increasing need to evaluate its quality.[21-23] A construct that may be of help and which we describe in this article is Decisional Conflict (DC). DC provides insight from the patient's perspective both into patient satisfaction with the decision making process and the extent to which patients feel comfortable with the decisions taken about their treatment. These decisions often go hand in hand with feelings of uncertainty in the patient, often because there are several more or less equal options with various pros and cons which may affect the patient's daily life.[24-27] To date, DC has been little used in mental health care[10,28], while various studies in general health care have shown that DC is eminently suitable for evaluating the use of SDM in treatment practice.[21, 28-31] The aim of this article is to gain insight into the concept of DC, to illustrate the concept in a model and to describe how DC can be used in evaluating SDM in mental health care.

Methods

As part of two ongoing studies on SDM[10,32], an in-depth literature study was conducted on the DC construct. A search was conducted, first in PubMed and subsequently in Psycinfo, Medline and Cinahl of articles on DC in general and mental health care since 1975. The search was based on the following six keywords: decisional conflict AND health care, decisional conflict AND mental health*, decisional conflict AND definition, decisional conflict AND patient characteristics, decisional conflict AND measurement, decisional conflict scale. These searches yielded 183 articles, which were initially assessed on the basis of the titles and abstracts. We included all articles from general and mental health care in which DC was described as a concept and/or evaluation measure, and we checked the references of these studies for further possible relevant studies. In total, 30 articles on DC were deemed relevant to this literature analysis, with four of them specific to mental health care.

Results

In this paragraph, the construct Decisional Conflict (DC) is further refined and illustrated by means of a model. We also explore its relevance and usefulness in practice, and we describe how the extent of DC can be measured.

DC is a multi-dimensional concept[26] that from the patient's perspective both illuminates the decision-making process and exposes the quality of the decisions made. In the original definitions[24,33,34] DC was described as the degree of uncertainty in patients about taking difficult decisions involving choices that impact on their personal lives and may incur a certain risk, loss or challenge. When confronted with these difficult choices, for example concerning treatment options, there may be risks to be considered or uncertainty about the future; there may be considerable consequences in terms of loss or gain; value judgements may need to be made, and there may be regret about the advantages or disadvantages of rejected or chosen options.[25,27]

This uncertainty, also known as decision ambivalence, occurs during the decision-making process, undergoes change during this process, and is

related to the interaction between patient and clinician.[27,35,36-38] A number of pre-conditions, which are central to SDM and are part of the DC construct, can reduce the level of uncertainty in patients about treatment decisions during the decision making process. These are: feeling adequately informed about the content of the treatment options, including the pros and cons; feeling supported and not pressured when making choices; being clear about which personal values are important to themselves in taking an appropriate decision. When this process takes place to the patient's satisfaction, the patient feels a greater degree of certainty about which choice is the best. This improves the quality of the decision making, and results in patients being (more) likely to stick to the decisions taken. In brief, the level of DC, which can initially be high when confronted with making difficult decisions, decreases when the decision-making process runs satisfactorily.[26,29,30,39-42]

As has been outlined above, and illustrated in Figure 1, DC illuminates both the decision-making process and the quality of the ensuing decisions as well as the sequence involved.[26,43] Figure 1 shows that information, support and clarity about personal values are important pre-conditions in the decision-making process and can influence the uncertainty about the available choices and subsequently the quality or indeed the outcome of the process.

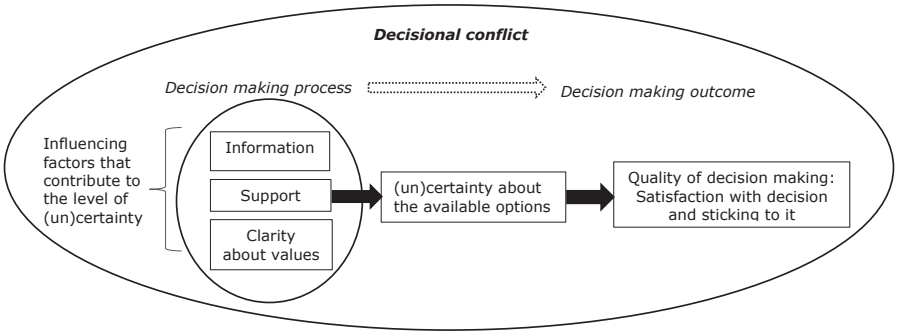

Figure 1. Decisional conflict Model

Various studies have shown that the use of supportive interventions in the area of SDM can improve the decision making process and its outcomes and reduce DC.[21,28-31,44] This is relevant for treatment in practice, because when patients experience less DC, their adherence to treatment increases and health outcomes improve.[26,42,45-47] When there is little or no SDM, and the decision making process is not optimal -for example because of insufficient information, lack of support, or pressure from others, and insufficient clarity about personal values- then the likelihood increases that a large degree of decisional conflict will remain and the decision taken may be out of line with the patient's preferences.[27,42,46] This may have negative consequences, such as stress, delaying decision making, disappointment, drop-out, dissatisfaction with the treatment, complaints, poorer health outcomes and reduced quality of life.[26, 40,42,45-47]

Measuring DC

The quality of decision making from a patient's perspective can be illustrated by means of DC. DC is measured by a self-report questionnaire -the Decisional Conflict Scale (DCS)- which contains 16 items and is scored on a five-point scale.[26] The questionnaire has good psychometric properties. More information is available in the DCS manual.[26] We refer to Metz et al. (2015)[10] for the Dutch translation of the DCS.[26] In addition to the overall scale, the DCS also has five subdomains, reflecting the various dimensions of DC. These subdomains are: information, support, clarity about personal values, uncertainty about the available options and quality of the decision making. Accordingly, the DCS measures both the decision making process and the outcome of the process. The scores on the scales are generally converted to a range of 0 to 100. A low score on the questionnaire means a low level of DC is experienced. At the same time, research in general health care has established cut-off points which indicate the score that shows no DC (<25), a low level of DC ($\geq$25-$\leq$37.5) and the point from which a high level of DC (>37.5) is experienced.[26] The fact that only a small number of articles on DC in mental health care was found[10,28,32,48] indicates that to date, few studies within mental health care have been conducted with DC as outcome measure. Consequently, no cut-off values have yet been established for DC in mental health care. In view of the multi-facetted nature of the concept of DC, it is important to look not only at the overall score, but to consider the various dimensions of DC via its subdomains. This would help to

clarify which aspects of the decision making process patients find satisfactory and which aspects are in need of improvement.

Conclusion

The increasing focus on Shared Decision Making (SDM) has given rise to a need to evaluate its application and to improve our understanding of the decision making process concerning treatment choices and the factors that are important to a satisfactory conclusion of this process for patients. Decisional Conflict (DC) affords insight into influencing factors, the decision making process and the quality of the decision making and is measured by the Decisional Conflict Scale (DCS). In view of the different dimensions of DC it is important to look not only at the overall score, but particularly at the subdomains of the DCS (information, support, clarity about personal values, uncertainty about choices and quality of the decision making). Moreover, it is also recommended that cut-off points be calculated for the DCS in mental health care as well, which would indicate the level of DC during the decision making process and the threshold for negative consequences for treatment.[40] By using DC as an evaluation measure when evaluating SDM, the decision making process and the extent of SDM in treatment practice can be evaluated and where necessary optimised.[21,39] When patients experience a high level of DC, this means the decision making process and the application of SDM have not proceeded optimally.[27,29,42,46,47] Because this can have the above described negative consequences for treatment outcomes, it is important to reduce DC by improving the application of SDM. A number of studies [21,28-31] have shown that interventions that support SDM can reduce DC. Within the field of mental health care, there are, as yet, few known studies with DC as outcome measure.[10,28,32,48] This is despite the fact that DC is also informative and useful in mental health care, for the purpose of evaluating SDM from the patient's perspective, in order to improve the quality of the decision making process where necessary.

References

1. Anderson RM, Funnell MM. Patient empowerment: reflections on the challenge of fostering the adoption of a new paradigm. Patient Educ and Couns. 2005; 57: 153-157.
2. Härter M, Elwyn G, Weijden van der T. Policy and practice developments in the implementation of shared decision making: an international perspective. Z. Evid. Fortbild. Qual. Gesundhwes. 2011; 105: 229–233.
3. Barr PJ, Scholl I, Bravo P, Faber MJ, Elwyn G, McAllister M, Assessment of patient empowerment-a systematic review of measures. PLoS One. 2015; May 13. doi:10.1371/journal.pone.0126553.
4. Patel SR. Recent advances in Shared Decision Making for Mental Health. Curr Opin Psychiatry. 2008; 21(6): 606-612.
5. 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.
6. Van Staveren R. Stand van zaken gezamenlijke besluitvorming in de Praktijk: patiëntgerichte gespreksvaardigheden. Ned Tijdschr Geneeskd. 2011; 155: A3777.
7. Stiggelbout AM, Pieterse AH, Haes de JCJM. Shared Decision Making: Concepts, evidence and practice. Patient Educ and Couns. 2015; 98: 1172-1179.
8. Van der Feltz-Cornelis C, Andrea H, Kessels E, Duivenvoorden H, Biemans H, Metz M. Shared Decision Making in combinatie met ROM bij patiënten met gecombineerde lichamelijke en psychische klachten; een klinisch empirische verkenning. Tijdschr Psychiatr. 2014; 56(6): 375–84.
9. Landelijk Platform GGZ (LPGGz), Nederlandse Vereniging voor Psychiatrie (NVvP), GGZ Nederland, Landelijke Vereniging van Vrijgevestigde Psychologen en Psychotherapeuten (LVVP), Nederlands Instituut van Psychologen (NIP), Ineen organiseert de eerste lijn e.a. Agenda GGZ voor gepast gebruik en transparantie: achtergrondnotitie. November 2015.
10. Metz MJ, Franx GC, Veerbeek MA, Beurs de E, Van der Feltz-Cornelis CM, Beekman ATF. Shared decision making in mental health care using Routine Outcome Monitoring as a source of information: a cluster randomised controlled trial. BMC Psychiatry. 2015; 15: 313.
11. Ministerie van Volksgezondheid Welzijn en Sport (VWS), Schippers E.I. Brief aan Tweede Kamer over Samen beslissen. October 2015.
12. Ten Haaft ten G, Veenendaal van H. notitie 'Versnellen van gedeelde besluitvorming in Nederland: opmaat naar een onderzoeks-/innovatieprogramma Samen beslissen'. ZonMw, CZ, April 2016.
13. Zorginstituut Nederland, www.zorginstituutnederland.nl/werkagenda/uitvoering-subsidieregelingen/subsidieregeling-transparantie-over-de-kwaliteit-van-zorg/thema-2016-samen-beslissen
14. Ludman E, Katon W, Bush T, Rutter C, Lin E, Simon G et al. Behavioural factors associated with symptom outcomes in a primary care-based depression prevention intervention trial. Psychol Med. 2003; 33(6): 1061-70.
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 e.a. Primary care patients' involvement in decision-making is associated with improvement in depression. Med Care. 2006; 44: 5: 398-405.
17. Hamann J, Langer B, Winkler V, Busch R, Cohen R, Leucht S, et al. Shared decision making for in-patients with schizophrenia. Acta Psychiatr Scand. 2006; 114: 265-273.
18. Loh A, Simon D, Wills CE, Kriston L, Niebling W, Härter M. The effects of a shared decision-making intervention in primary care of depression: a cluster-randomised controlled trial. Patient Educ and Couns. 2007; 67: 324-332.
19. Loh A, Leonhart R, Wills CE, Simon D, Härter M. The impact of patient participation on adherence and clinical outcome in primary care of depression. Patient Educ and Couns. 2007; 65: 69-78.

20. Joosten EAG, de Jong CAJ, de Weert-van Oene GH, Sensky T, van der Staak CPF. Shared decision-making reduces drug use and psychiatric severity in substance-dependent patients. Psychother Psychosom Med Psychol. 2009; 78: 245-253.
21. Sepucha KR, Borkhoff CM, Lally J, Levin C.A, Matlock DD, Ng CJ et al. Establishing the effectiveness of patient decision aids: key contructs and measurement instruments. BMC Med Inform Decis Mak. 2013; 13 (Suppl 2): S12.
22. Faber M, Harmsen M, Burg van der S, Weijden van der T. Gezamenlijke besluitvorming & zelfmanagement. Scientific Institute for Quality of Healthcare (IQ Healthcare). 2013
23. Barr PJ, Elwyn G. Measurement challenges in shared decision making: putting the 'patient' in patient-reported measures. Health expect. 2015; 19: 993-1001.
24. NANDA. Taxonomy I-Revised. St. Louis, MO: author. 1990
25. Song MK, Sereika SM. An evaluation of the Decisional Conflict Scale for measuring the quality of end-of-life decision making. Patient Educ and Couns. 2006; 61: 397-404.
26. O'Connor AM. User-Manual-Decisional Conflict Scale (16 item statement format). Ottawa Hospital Research Institute; 1993, updated 2010.
27. Légaré F, LeBlanc A, Robitaille H, Turcotte S. The decisional conflict scale: moving from the individual to the dyad level. Z. Evid. Fortbild. Qual. Gesundhwes. 2012; 106: 247-252.
28. 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 and Couns. 2013; 90: 74-81.
29. 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.
30. Becerra-Perez MM, Menear M, Turcotte S, Labrecque M, Légaré F. More priary care patients regret health decisions if they experienced decisional conflict in the consultation: a secondary analysis of a multicentre descriptive study. BMC Fam Pract. 2016; 17: 156. doi:10.1186/s12875-016-0558-0.
31. Stacey D, Légare 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; issue 4. doi:10.1002/14651858.CD001431.pub5
32. Metz MJ, Elfeddali I, Krol DGH, Veerbeek MA, Beurs de E, Beekman ATF et al. A digital intake approach in specialized mental health care: studyprotocol of a cluster randomised controlled trial. BMC Psychiatry. 2017; 17: 86.
33. Janis IL, Mann L. Decision making: A psychological analysis of conflict, choice, and commitment. New York: Free Press. 1977
34. O'Connor AM. Validation of a decisional conflict scale. Med Decis Making. 1995; 15: 25-30.
35. 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: 61-68.
36. Misra-Hebert AD, Kattan MW. Comment on: Decisional Conflict, Regret, and the Burden of Rational Decision Making. Med Decis Making. 2017; May: E360-361.
37. Vickers, AJ. Decisional Conflict, Regret, and the Burden of Rational Decision Making. Med Decis Making. 2017; January: 3-5.
38. Vickers, AJ. Response to 'Comment on: Decisional Conflict, Regret, and the Burden of Rational Decision Making. Med Decis Making. 2017; May: E362.
39. Scholl I, Koelewijn-van Loon M, Sepucha K, Elwyn G, Légaré F, Härter M et al. Measurement of shared decison making – a review of instruments. Z. Evid. Fortbild. Qual. Gesundhwes. 2011; 105(4): 313-324.
40. Knops AM, Goossens A, Ubbink DT, Legemate DA, Stalpers LJ, Bossuyt PM. Interpreting patient decisional conflict scores: behavior and emotions in decisions about treatment. Med Decis Making. 2013; January: 78-84.
41. Coylewright M, Branda M, Inselman J.W, Shah N, Hess E, LeBlanc A et al. Impact of sociodemographic patient characteristics on the efficacy of decision aids. Circ Cardiovasc Qual Outcomes. 2014; 7: 360-367.

42. Thompson-Leduc P, Turcotte S, Labrecque M, Légaré F. Prevalence of clinically significant decisional conflict: an analysis of five studies on decision-making in primary care. BMJ Open. 2016;6:e011490. doi:10.1136/bmjopen-2016-011490
43. Koedoot N, Molenaar S, Oosterveld P, Bakker P, Graeff de A, Nooy M et al. The decisional conflict scale: further validation in two samples of Dutch oncology patients. Patient Educ and Couns. 2001; 45: 187-193.
44. Osaka W, Nakayama K. Effect of a decision aid with patient narratives in reducing decisional conflict in choice for surgery among early-stage breast cancer patients: A three-arm randomized controlled trial. Patient Educ and Couns. 2017; 100: 550-562.
45. 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.
46. Katapodi MC, Munro ML, Pierce PF, Williams RA. Testing of the decisional conflict scale: genetic testing hereditary breast, ovarian cancer. Nurs Res. 2011; 60(6): 368-377.
47. Cormiers des A, Légaré F, Simard S, Boulet LP. Decisional conflict in asthma patients: a cross sectional study. J asthma. 2015; 52(10): 1084-1091.
48. Randenborgh van A, Jong de-Meyer R, Hüffmeier J. Decision Making in Depression: differences in decisional conflict between healty and depressed individuals. Clin. Psychol. Psychother. 2010; 17: 285-298.