A Program to Support Shared Decision Making in an Outpatient Psychiatric Medication Clinic

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This column presents preliminary findings of an intervention to support shared decision making in psychopharmacology consultation. The waiting area in an urban psychiatric medication clinic was transformed into a peer-run Decision Support Center featuring a user-friendly, Internet-based software program with which clients could create a one-page computer-generated report for use in the medication consultation. The Decision Support Center was used 662 times by 189 unique users from a young-adult and general adult case management team from October 2006 to September 2007. All clients had severe mental disorders. Only ten clients refused to use the intervention at some point during the pilot study. Focus groups with medical staff (N=4), clients (N=16), case managers (N=14), and peer-specialist staff (N=3) reported that the intervention helped to create efficiencies in the consultation and empower clients to become more involved in treatment-related decision making. A randomized controlled trial is currently in process. (*Psychiatric Services* 59: 603–605, 2008)

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The Institute of Medicine (1) has found the quality chasm framework to be applicable to health care for people with mental health and substance use disorders, and it cites shared decision making as one of the top ten rules to guide the redesign of health care. Shared decision making has been defined as 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 (2,3).

Decision aids for practitioners and clients have been developed in general health care to support the shared decision-making process (4). Decision aids are particularly helpful in reducing decisional conflict associated with making challenging choices in which there are benefits and risks associated with treatment or when empirical evidence is inconclusive or incomplete (5). Deegan and Drake (6) have argued that shared decision making and the use of decision aids related to medication management in psychiatry is an ethical imperative, is consistent with the long-standing tradition of building therapeutic alliances in treatment collaboration, and is a superior approach to medical paternalism and insistence on medication compliance.

In this column, we describe a 12-month pilot program to begin to identify best practices for shared decision making in an outpatient psychiatric medication clinic. The primary intervention was the transformation of a typical waiting area in an urban, midwestern psychiatric medication clinic into a peer-run Decision Support Center (DSC). Services at the DSC included establishing peer-specialist protocols to support a welcoming environment, offering a healthy snack and beverage, assisting clients in completing a one-page computer-generated report for use in the medication consultation, giving clients access to health-related information via the Internet, providing informal peer support, and providing support with completing decision aids for helping clients address areas of decisional conflict related to medication use. Medication appointments were redefined to include 30 minutes of work in the DSC before meeting with a physician or nurse.

The intervention

The centerpiece of the DSC was an Internet-based computer program designed to be accessible to everyone, including those with low literacy. The software program required no prior computer experience and no keyboarding. The program could be read or listened to. Two computers with touch screens and headphones were installed at semiprivate study carrels in the DSC. Peer specialists were available to assist clients with using the software if support was requested or required.

The computer program opens with an introduction to the concept of recovery from mental illness, written from a peer perspective, and includes three-minute video vignettes of people talking about their recovery and how they achieved it. Then clients are reminded of their unique "personal medicines" or those things they do that give life meaning and purpose and help to create wellness (7). Next, they complete a survey in which they rate their symptoms and psychosocial functioning since their last visit. Questions in the survey can be customized to reflect unique client concerns, such as behavioral indicators of relapse—for example, trouble sleeping more than two nights in a row or losing more than $10 in a week while gambling. This is followed by a prompt to report how they have been using or not using prescribed medications.

Then clients are asked about 11 common concerns that people who use psychiatric medicine often experience—for example, concerns about how medication might affect one's health. Finally, clients are asked to indicate their goal for the meeting with the practitioner. They print their report, and it is forwarded electronically to the nurse or psychiatrist. Additionally, clients can choose to tour the electronic version of the report and to interact with it. For instance, they might choose to listen to what their report means and then touch an icon to learn more about their prescribed medicine or to learn about behavioral coping strategies for anxiety or distressing voices.

Clients go to the medication consultation with the one-page report in hand. The practitioner reviews the report with the client, highlighting areas of concern and progress. When viewed on a laptop, the electronic report presents the practitioner with autogenerated prompts indicating specific decision support tools that may help clients work through decisional uncertainty about using medicine. For instance, a client might have used the software program to indicate decisional uncertainty related to side effects of a medication. When viewed by the practitioner, the software autogenerates options such as a trade-off worksheet and a decisional balance worksheet for the client and practitioner to consider. Adapted from the Ottawa Personal Decision Guide (8), the decisional balance and trade-off worksheets guide clients in listing the pros and cons of using medicine, rating the relative importance of these concerns, and problem solving to offset the concerns. If the client and practitioner agree to use a decision support tool, they can also indicate whether case management or peer-specialist support is desired to complete it. After discussing the report, the practitioner is invited to enter a shared decision that reflects the practitioner-client consensus on the next steps in treatment. An example of a shared decision is "I will begin walking each morning because my doctor and I want to see if that helps lift my depressed mood. I will keep a mood calendar to track the effects of walking combined with mood-stabilizing medicine and review it at my next appointment. A peer specialist will show me how to use the mood calendar."

Pilot study

Two case management teams operating out of the urban mental health center were selected to pilot the intervention over a 12-month period (October 2006 to September 2007): a general adult team (N=112) and a young adult team (N=77) for a total of 189 clients. All clients on these two teams were eligible to participate in the DSC and use the software. A total of 112 clients (59%) were men, and 77 (41%) were women. Ninety-six (51%) were African American, 74 (39%) were white, four (2%) were Hispanic, two (1%) were American Indian, and 13 (7%) were from another or unknown race. A total of 108 (57%) had an axis I diagnosis of psychotic disorder, 72 (38%) were diagnosed as having mood disorders, and 91 (48%) had co-occurring substance use disorders. A total of 157 (83%) were unemployed during the study period.

After institutional review board approval from the Human Subject Committee–Lawrence Campus and informed consent were obtained, clients from the two case management teams received a letter announcing the opening and intended use of the DSC. Use of the new resource was encouraged but was not mandatory. Peer specialists completed a log of clients' activities in the DSC, and this allowed us to create an observational record for each use of the software. Semistructured focus groups were conducted by the authors. The purpose was to describe people's experience with the DSC. Focus groups were held at three and six months with case management staff (N=14) and at four months with medical staff (N=4), peer-specialist staff (N=3), and a subset of clients who volunteered to participate (N=16). The audiotaped group sessions were transcribed and coded to identify themes.

During the 12-month pilot study, the DSC and the software program were used to generate a total of 662 reports. The number of times that clients used the software ranged from one to ten, depending on how often clients came to clinic. A total of 189 clients used the software program during the 12-month pilot study. Only one client consistently declined to use the software. An additional nine people either initially refused and eventually started to use the software or started to use the software and refused at some point in the pilot study. Reasons for not using it included "no reason," fear of germs, privacy concerns, and unwillingness to sign forms of any type.

Focus group findings

Three prescribers and four nurses (medical practitioners) staffed the medication clinic. Four of the medical practitioners in the clinic worked with clients in the pilot study and participated in the focus groups. The 14 case managers and the three peer-specialist staff members who had clients participating in the intervention also participated in the focus groups. All of the four medical staff members in the focus group agreed that the one-page report generated by the software helped to create efficiencies in the consultation. Specifically, the report helped them focus more quickly on clients' concerns. It helped to enrich the dialog, giving a more holistic understanding of clients in the context of their lives and helping to deepen a shared understanding of clients' concerns and come to an agreement on how to move forward with treatment.

Additionally, medical practitioners

were impressed with the fact that there were a number of instances in which clients were willing to disclose information via the computer, information not previously disclosed in face-to-face assessments. Medical practitioners noted that in some instances the software program acted as assistive communication technology for clients who were experiencing acute psychosis—that is, the software organized clients' concerns into a succinct report at a time when clients could not organize their story orally. Medical practitioners felt that at times it was challenging to work with all the information in the report, but they also felt that it helped to build their skills in shared decision making and helped to activate clients' involvement in the consultation. From the perspective of medical practitioners, scheduling and supporting clients to arrive at the DSC 30 minutes before seeing the prescriber were the most significant challenges in implementing this intervention.

Sixteen clients were asked to participate in the focus groups, and all 16 agreed. In client focus groups, the software's three-minute recovery vignettes were a popular feature that helped to generate hope. Clients felt the program helped to amplify their voice and ensured that their concerns were noted and addressed during the busy consultation. Clients reported feeling a sense of accomplishment and pride in completing the reports each time they came to clinic. They enjoyed the numeric scales on the one-page report because they could gauge their progress. After a number of uses, one client said that the program became tedious, although he still valued the program in that it helped him in communicating with the medical team.

Additional support for the intervention

Some anecdotes may help to illustrate the power of this intervention. One person used the software to first disclose his use of alcohol and the role it played in his concern about taking medicine as prescribed; another was able to report a drug and alcohol relapse noting, "It is much easier to tell the computer." A woman used the software to report that she was trying to become pregnant. A young mother used the software to report her decisional conflict about using medicine: should she use the sedating medication and run the risk of sleeping through her infant's sleep apnea monitor? In her case, the software helped shift the medical team's focus from medication compliance to parenting support. Another woman used the software, peer support, and a decision aid to sort through her concerns about using medications. On the one hand, the medications helped with symptoms, but on the other hand, they made her "sleep too hard," which in turn, meant that she might sleep through a break-in in her crime-ridden neighborhood. Shared decision making allowed the team to refocus support.

A young man used the software program to tell his psychiatrist that one of the most important things in his life was his "hip-hop abs." Together the psychiatrist and the client used that information to create a shared decision about the next steps in treatment—that is, the client would use a second-generation neuroleptic while closely monitoring weight gain at home and at the clinic, and a contingency plan was developed should weight become a problem. Finally, a person was able to benefit from the intervention's use of peer staff. Practitioners thought that because of negative symptoms, this man could not initiate relationships. However, when he was supported in the use of the software by a peer with whom he had previously spent time in the hospital, he began bathing before appointments, greeting the peer specialist at the DSC, and asking her questions about what it was like to be employed and how she achieved that.

Conclusions

Our pilot study had a number of limitations. Our sample was small and was not randomly generated. The ability to generalize from this study to other groups is questionable. Additionally, medical staff who assisted in the development of the software program were also the practitioners in the study. Therefore, this study does not give a good indicator as to staff "buy in" to an intervention such as the one described here.

In conclusion, the DSC is one of the first shared decision-making centers in psychiatry, and the early experience is promising. There is evidence that clients are actively involved in their participation in the psychiatric consult, that the computer program helps them tell their "story," and that the agenda of the psychopharmacology consult is more likely to focus on the consumer's needs and desires when the intervention is used. There is also evidence that persons with major mental disorders in both the general adult and young-adult population are willing to routinely use a computer interface in a medical context. A randomized controlled trial is currently under way and will better gauge the effects of this promising intervention.

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Dr. Deegan has applied for a patent on the software program described in this study. The other authors report no competing interests.

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