

# Adapting Shared-Decision Making to Severe Mental Illness

Johannes Hamann, München, 11.09.2015

# Declaration of interest

- I have received lecture honoraria from Janssen, Lilly and Otsuka.
- I have received research support from Janssen and Lilly.

# SDM and ACP

- Different things!
- SDM aims at engaging patients in decision at the time of the decision
- The adaption of SDM to severe mental illness aims at allowing more patients to participate in decision making (and avoiding situations that would require advance directives)

# Agenda

- What is SDM?
- Experiences from mental health
- An adaption for the more critical situations

# Shared Decision Making (SDM)

- **Shared decision-making (SDM)** is an approach in which clinicians and patients communicate together using the best available evidence when faced with the task of making decisions. Patients are supported to deliberate about the possible attributes and consequences of options, to arrive at informed preferences in making a determination about the best course of action which respects patient autonomy, as well as ethical and legal norms.

# Shared Decision Making (SDM)

- at least two participants, the clinician and patient are involved
- both parties share information
- both parties take steps to build a consensus about the preferred treatment
- an agreement is reached on the treatment to implement

# SDM in mental health – liked by everyone

- Advocated by guidelines (APA, NICE etc.)
- Welcomed by patients (Hamann 2004, Adams 2007, etc.) and consumers (“ethical imperative”)
- Generally seen as positive by psychiatrists (Hamann 2009, Seale 2006)

# SDM in mental health – it is NOT implemented

- Only 30% of acute inpatients feel that decisions were shared
- 60% of patients would decide differently without their psychiatrist (Hamann 2008)
- 66% say they never had been offered a choice between two drugs (Corry 2001)



# The double bind of psychiatrists

- Head of a Bavarian state hospital:
- *„We always share decisions with our patients.*
- *But it is not possible with these patients!“*

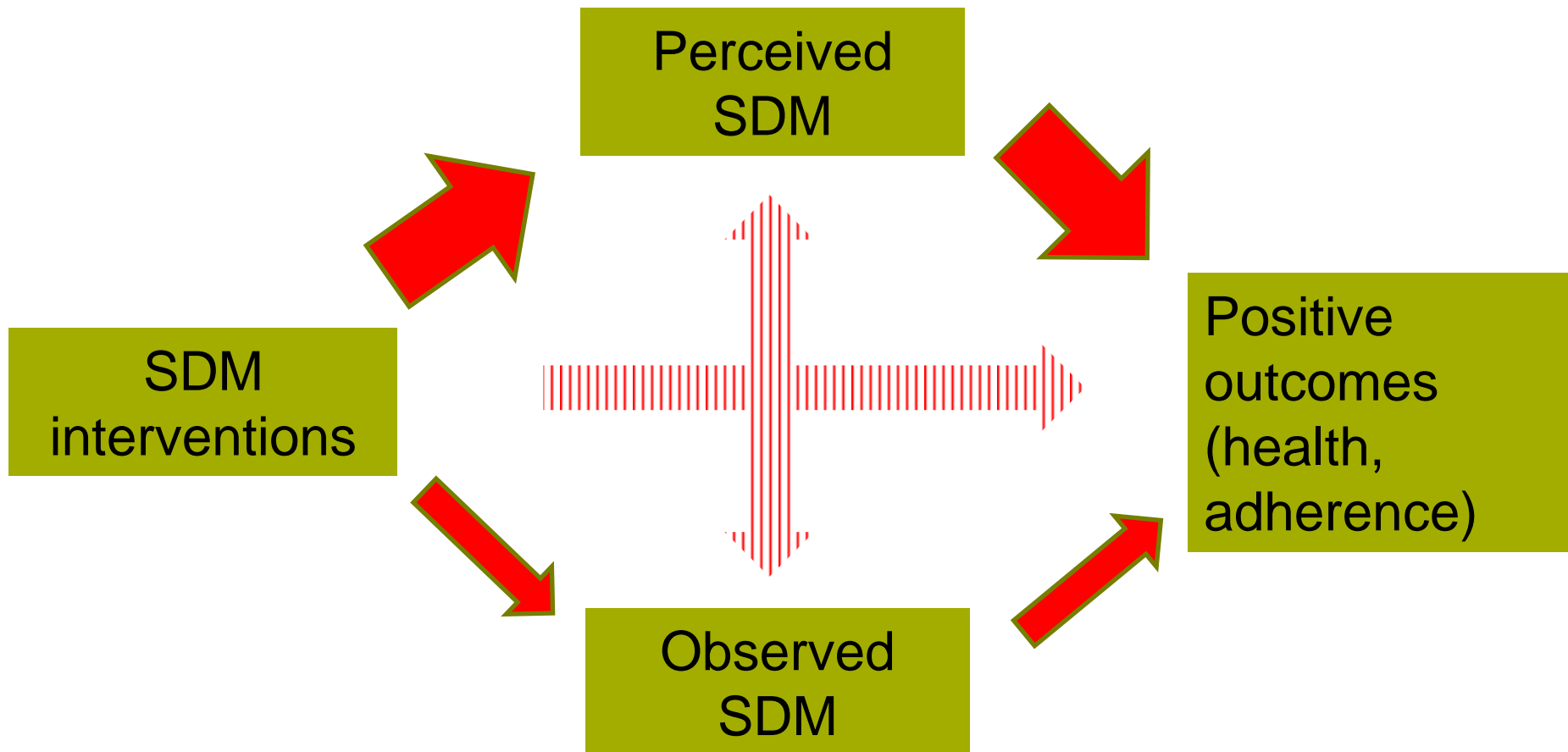
# The double bind of psychiatrists (survey among N=352 psychiatrists)

- 51% of German psychiatrists report regularly applying shared decision making
- Decision making styles are tailored to individual patients and decision topics.
- SDM useful for well-informed and compliant patients
- SDM not useful in cases of potentially reduced decisional capacity.
- Psychosocial matters (work therapy, future housing, psychotherapy) are considered more suitable for shared decision making than medical and legal decisions

# SDM in mental health is NOT implemented – major barriers

- Time constraints
- Misconception that SDM is already implemented
- Fear of negative consequences and “wrong decisions” (especially in severe mental illness/for “important” decisions”)
- Passivity of patients (negative symptoms, sedation, depression etc.)

# SDM interventions in mental health are not yet proven effective (???)



# SDM<sup>PLUS</sup>

Johannes Hamann & Stephan Heres

# Basic idea

- For severe mental illnesses both patients and health care professionals have problems implementing SDM (fear of wrong decisions, negative symptoms etc.)
- Double empowerment strategy necessary to implement SDM (skills for patients and professionals)
- → complex intervention may booster effects

# 1. Patient Empowerment

First adaption of SDM to severe mental illness:

- patients need to be empowered to become active partners in SDM
- Validated elements: SDM-training for patients, questions prompt sheets, psychoeducation etc.

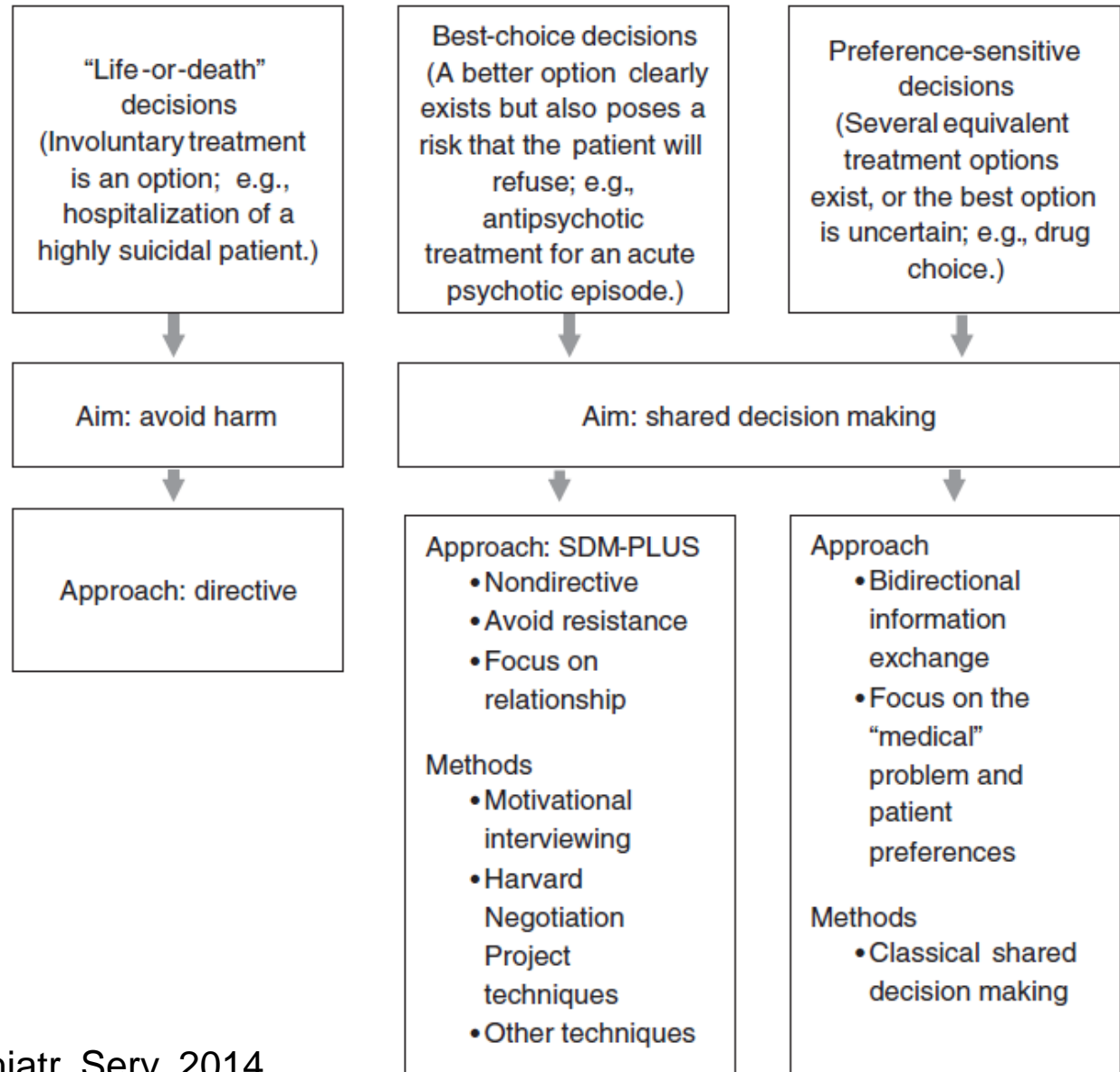
## 2. Empowerment of professionals

- Second adaption of SDM (expansion of methods)
  - Decision analysis
  - Preparation for “difficult decisions”
  - Communication techniques for SDM, special focus on patients’ resistance

Existing workshop for both elements → SDM<sup>PLUS</sup>



# Decision analysis



Vielen Dank

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