

EDITORIAL

Shared Decision Making in the Treatment of Depression

Ng Chong Guan¹, Syahrir Zaini²

¹Department of Psychological Medicine, Faculty of Medicine, University of Malaya, Kuala Lumpur, Malaysia

²Department of Pharmacy Practice, Kulliyyah of Pharmacy, International Islamic University Malaysia, Kuantan, Pahang, Malaysia

Shared Decision Making (SDM) is considered as one of the distinctive components of patient-centred care (PCC) that permits and promotes patients to participate actively in their health related management [1]. SDM is currently a widely recognized aspect of PCC in this modern era of healthcare standard globally [2]. In psychiatric practice, the relationship between clinician and patient is crucial to delivering the optimum mental health care services [3]. Besides SDM, another related and important component of PCC is the collaborative treatment alliances [4-8]. Altogether, these constructs have contributed to a wider understanding of medication adherence and service engagement concepts [9-12].

PCC requires that healthcare provider holistically consider any related information about the patient by understanding the unique human being characteristics prior to making a diagnosis of the patient's ailment [13]. Participation of patients in their healthcare had been advocated by the World Health Organization (WHO) since 1977 [14]. More recently, the effort to improve healthcare quality and efficiency by patients' participatory and active roles had been recognized by WHO in the "Vienna Recommendations on Health Promoting Hospitals" [15]. Since then, PCC has been

viewed as good medicine, but remains lack of understanding and implementation [16].

PCC can be described as the care that involves (1) exploration of visit reasons and concerns of the patients, (2) search for the complete understanding of the patients' world, (3) find for the common ground of the question problem and management agreement, (4) enhancement of health promotion and prevention (5) improvement of a continuing relationship between the healthcare providers and the patients [17]. Even though there is lack of conclusive reports on PCC benefits, other important features such as positive health outcome, greater improvement in symptom burden, greater enablement, and patient satisfaction have been reported [18-21].

In SDM, clinicians and patients discuss treatment options by sharing the best available evidence, via two-way communication to exchange knowledge and information, formally and experientially, and finally, together decide on action course of the medical treatment, where patients engagement and autonomy are promoted [22, 23]. The participation of patient is influenced by autonomy, which refers to the decision-making dimension of the patient's role and improving patient autonomy means helping patients to decide on their own [24].

This collaborative process is focusing on individual preferences and values, which consider the mutual respect and open communication [25].

The traditional “paternalistic” model, which consists of only the clinician is making decision is contributing to the lack of patient involvement in making preferred decision [26]. SDM has been adopted as the central role to the recovery model and has led to an increasing emphasis of patients’ role as active participants in their treatment plan [27]. The success in mental health care requires a free flow of information and feedback sharing among all participants which include patients and clinicians, so that each of them are on track with any changes that will occur throughout the treatment process [28]. However, until recently, SDM has been given lack of consideration in psychiatry [29-31].

Major depression is one of the common psychiatric disorders, which has been ranked as the principle factor for disability worldwide by the WHO [32]. Major depressive disorder (MDD) is also related to the reduced role functioning and quality of life, medical morbidity, and mortality [33, 34]. Therefore, suitable management which contains prevention and treatment for depression should be focused more in this era. The most commonly used treatment in the management of depression is antidepressant, which is portrayed by the increment of prescribing trend over the last decades [35-38]. However, despite of the prescription given, the prevalence of antidepressant non-adherence is high. Almost half (56%) of the patients will discontinue their antidepressants within the first 6 months [39, 40]. Several studies reported that 6 -12% patients never take the antidepressants as prescribed by their doctors [41, 42].

There are many factors contribute to the antidepressant non-adherence, which include worries of side effects, lack of guidance by healthcare providers during treatment, insufficient knowledge, a pessimistic believe towards antidepressants use and the depression itself [43]. It is suggested that clinicians, pharmacists and other healthcare providers to provide more information and support during the initiation of antidepressant. In other words, SDM plays an important role in improving the antidepressant adherence and depression management outcomes [44]. In certain conditions, patients with severe mental illness will also require full information related to their treatment and they are keen to involve actively in this professional relationship [45-48]. Although barriers and challenges will always be there, it is important to take wise action in transforming the traditional “paternalistic” model of clinical decision making into a current “informed” decision making model. This effort will eventually assist to make a successful PCC in the treatment of depression [49, 50].

References

- [1] Smith, M.A.J.O.N., *The role of shared decision making in patient-centered care and Orthopaedics*. 2016. 35(3): p. 144-149.
- [2] Barry, M.J. and S.J.N.E.J.o.M. Edgman-Levitan, *Shared decision making—the pinnacle of patient-centered care*. 2012. 366(9): p. 780-781.
- [3] Chakrabarti, S., *Treatment alliance and adherence in bipolar disorder*. World journal of psychiatry, 2018. 8(5): p. 114-124.

- [4] Hughes, J.C., et al., *Types of centredness in health care: themes and concepts*. 2008. 11(4): p. 455-463.
- [5] Little, P., et al., *Preferences of patients for patient centred approach to consultation in primary care: observational study*. 2001. 322(7284): p. 468.
- [6] Mead, N., P.J.S.s. Bower, and medicine, *Patient-centredness: a conceptual framework and review of the empirical literature*. 2000. 51(7): p. 1087-1110.
- [7] Morgan, S. and L.H.J.J.o.h.n. Yoder, *A concept analysis of person-centered care*. 2012. 30(1): p. 6-15.
- [8] Slater, L.J.C.N., *Person-centredness: a concept analysis*. 2006. 23(1): p. 135-144.
- [9] Drake, R.E., P.E. Deegan, and C. Rapp, *The promise of shared decision making in mental health*. 2010.
- [10] Hobbs, J.L.J.N.r., *A dimensional analysis of patient-centered care*. 2009. 58(1): p. 52-62.
- [11] James, K. and A.J.M.H.R.J. Quirk, *The rationale for shared decision making in mental health care: a systematic review of academic discourse*. 2017. 22(3): p. 152-165.
- [12] Robinson, J.H., et al., *Patient-centered care and adherence: Definitions and applications to improve outcomes*. 2008. 20(12): p. 600-607.
- [13] Eklund, J.H., et al., *"Same same or different?" A review of reviews of person-centered and patient-centered care*. 2018.
- [14] Bissell, P., et al., *From compliance to concordance: barriers to accomplishing a re-framed model of health care interactions*. 2004. 58(4): p. 851-862.
- [15] *The Vienna Recommendations on Health Promoting Hospitals Available from*. 1997 26 Novemer 2018]; Available from: http://www.euro.who.int/__data/assets/pdf_file/0009/99801/E90777.pdf
- [16] de Haes, H., N.J.P.e. Koedoot, and counseling, *Patient centered decision making in palliative cancer treatment: a world of paradoxes*. 2003. 50(1): p. 43-49.
- [17] Stewart, M.J.B.B.M.J., *Towards a global definition of patient centred care: the patient should be the judge of patient centred care*. 2001. 322(7284): p. 444.
- [18] Chewning, B., J.B.J.P.e. Wiederholt, and counseling, *Concordance in cancer medication management*. 2003. 50(1): p. 75-78.
- [19] Michie, S., et al., *Patient-centredness in chronic illness: what is it and does it matter?* 2003. 51(3): p. 197-206.
- [20] Stevenson, A.t.J.A.f.p., *Compassion and patient centred care*. 2002. 31(12): p. 1103.

- [21] Stewart, M., et al., *The impact of patient-centered care on outcomes*. 2000. 49(9): p. 796-796.
- [22] Elwyn, G., et al., *Implementing shared decision making in the NHS*. BMJ 2010. 341: p. c5146.
- [23] Charles, C., et al., *Shared decision-making in the medical encounter: what does it mean?(or it takes at least two to tango)*. 1997. 44(5): p. 681-692.
- [24] Stiggelbout, A.M., et al., *Ideals of patient autonomy in clinical decision making: a study on the development of a scale to assess patients' and physicians' views*. Journal of Medical Ethics, 2004. 30(3): p. 268.
- [25] Morant, N., E. Kaminskiy, and S. Ramon, *Shared decision making for psychiatric medication management: beyond the micro-social*. Health Expect, 2016. 19(5): p. 1002-14.
- [26] Shepherd, A., O. Shorthouse, and L. Gask, *Consultant psychiatrists' experiences of and attitudes towards shared decision making in antipsychotic prescribing, a qualitative study*. BMC psychiatry, 2014. 14(1): p. 127.
- [27] Alguera-Lara, V., et al., *Shared decision making in mental health: the importance for current clinical practice*. Australasian Psychiatry, 2017. 25(6): p. 578-582.
- [28] Sundet, R., *Collaboration: Family and therapist perspectives of helpful therapy*. Journal of Marital and Family Therapy, 2011. 37(2): p. 236-249.
- [29] Durand, M.-A., et al., *Do interventions designed to support shared decision-making reduce health inequalities? A systematic review and meta-analysis*. 2014. 9(4): p. e94670.
- [30] Joosten, E.A., et al., *Systematic review of the effects of shared decision-making on patient satisfaction, treatment adherence and health status*. 2008. 77(4): p. 219-226.
- [31] Patel, S.R., S. Bakken, and C.J.C.o.i.p. Ruland, *Recent advances in shared decision making for mental health*. 2008. 21(6): p. 606.
- [32] Murray, C.J. and A.D. Lopez, *Evidence-based health policy--lessons from the Global Burden of Disease Study*. Science, 1996. 274(5288): p. 740-743.
- [33] Üstün, T.B., et al., *Global burden of depressive disorders in the year 2000*. Br J Psychiatry, 2004. 184(5): p. 386-392.
- [34] Spijker, J., et al., *Functional disability and depression in the general population. Results from the Netherlands Mental Health Survey and Incidence Study (NEMESIS)*. Acta Psychiatrica Scandinavica, 2004. 110(3): p. 208-214.
- [35] Nederlof, M., et al., *Guidance by physicians and pharmacists during antidepressant therapy: Patients' needs and suggestions for*

- improvement. BMC Psychiatry, 2017. 17(1).
- [36] Mojtabai, R. and M. Olfson, *National trends in long-term use of antidepressant medications: results from the US National Health and Nutrition Examination Survey*. The Journal of clinical psychiatry, 2014. 75(2): p. 169-177.
- [37] Mars, B., et al., *Influences on antidepressant prescribing trends in the UK: 1995–2011*. Social psychiatry and psychiatric epidemiology, 2017. 52(2): p. 193-200.
- [38] Abbing-Karahagopian, V., et al., *Antidepressant prescribing in five European countries: application of common definitions to assess the prevalence, clinical observations, and methodological implications*. European journal of clinical pharmacology, 2014. 70(7): p. 849-857.
- [39] Ereshefsky, L., et al., *The 6-month persistence on SSRIs and associated economic burden*. Journal of Medical Economics, 2010. 13(3): p. 527-536.
- [40] Serna, M.C., et al., *Duration and adherence of antidepressant treatment (2003 to 2007) based on prescription database*. European Psychiatry, 2010. 25(4): p. 206-213.
- [41] Aznar-Lou, I., et al., *Initial medication non-adherence: prevalence and predictive factors in a cohort of 1.6 million primary care patients*. British Journal of Clinical Pharmacology, 2017. 83(6): p. 1328-1340.
- [42] Pottegård, A., et al., *Primary non-adherence in general practice: A Danish register study*. European Journal of Clinical Pharmacology, 2014. 70(6): p. 757-763.
- [43] van Geffen, E.C., et al., *The decision to continue or discontinue treatment: experiences and beliefs of users of selective serotonin-reuptake inhibitors in the initial months--a qualitative study*. Res Social Adm Pharm, 2011. 7(2): p. 134-150.
- [44] Malpass, A., et al., *"Medication career" or "moral career"? The two sides of managing antidepressants: a meta-ethnography of patients' experience of antidepressants*. Social science & medicine, 2009. 68(1): p. 154-168.
- [45] Delman, J., et al., *Facilitators and barriers to the active participation of clients with serious mental illnesses in medication decision making: The perceptions of young adult clients*. The journal of behavioral health services & research, 2015. 42(2): p. 238-253.
- [46] Deucher, A.B., et al., *Participation in medical decision-making across Europe: An international longitudinal multicenter study*. European Psychiatry, 2016. 35: p. 39-46.
- [47] Hamann, J., et al., *Patient participation in antipsychotic drug choice decisions*. Psychiatry research, 2010. 178(1): p. 63-67.

[48]Torrey, W.C. and R.E. Drake,
*Practicing shared decision making
in the outpatient psychiatric care of
adults with severe mental illnesses:
redesigning care for the future.*
Community Mental Health Journal,
2010. 46(5): p. 433-440.

[49]Del Piccolo, L. and C. Goss,
People-centred care: new research

*needs and methods in doctor–
patient communication. Challenges
in mental health.* Epidemiology and
psychiatric sciences, 2012. 21(2): p.
145-149.

[50]Slade, M., *Implementing shared
decision making in routine mental
health care.* World psychiatry,
2017. 16(2): p. 146-153.

Corresponding Author

Ng Chong Guan

Department of Psychological Medicine,
Faculty of Medicine, University of Malaya,
50603, Kuala Lumpur, Malaysia

Tel: +60379492068

Email: chong_guan@um.edu.my