Shared-Decision Making, a Rare Practice in Psychiatry? A Clinical Audit in a Rural Mental Health Service

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Introduction

Between the phrase “Nothing about me without me” and the treatment that patients receive, there is often a gap of reality. We suggest that shared-decision making (SDM) might be the bridge.

Pivotal to patient-centred care, SDM tailors treatment to individual health needs and personal preferences, improves patients’ satisfaction and treatment adherence whilst reducing decisional conflict as well as becoming increasingly determinant in the use of evidence-based treatment algorithms. It involves a conversation about options and possible outcomes where the clinician has the expertise, and the patient is given the last word.

Although SDM is widely implemented by health services, in psychiatry, it is far from standardised, and it is assumed to be contingent on the nature of the clinical work. Good record keeping is instrumental in its application.

The present study sought to assess the implementation of SDM in a general adult community-based mental health service in rural Ireland.

Methods

A retrospective cross-sectional analysis of consecutive new referrals was carried out over the same four-month period in 2018 and in 2019 (March to June).

The initial patient report was analysed as to whether it contained a reference to key elements of SDM (Fig. 1).

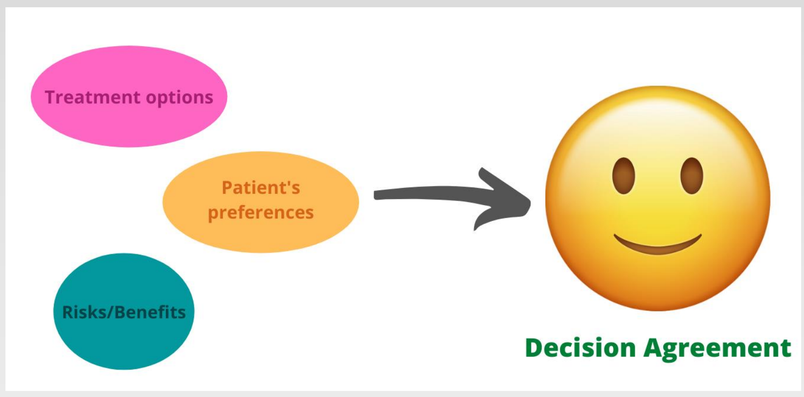

Fig.1 Key aspects of Shared-Decision Making

Results

Out of the 86 community referrals received during the period considered, 47 were able to be screened, and 39 were either not accepted for assessment, the patient did not attend for the appointment, or had inconclusive data. Over 70% (72.3%, n= 34) assessments had no documented elements of SDM (Fig. 2A). The remaining contained one or more elements of SDM (27.6%, n= 13) and were assessed by a single doctor.

A re-audit was carried out following a brief educational intervention with junior doctors (provision of written information on SDM and one-to-one reflective discussion, in at least one case). Of 40 community referrals received, 32 were analysed. We found that in 18 (56.3%), there was a documented reference to key elements of SDM (Fig.2B). Referrals processed by doctors taking part in the audit were excluded to avoid the Hawthorne effect.

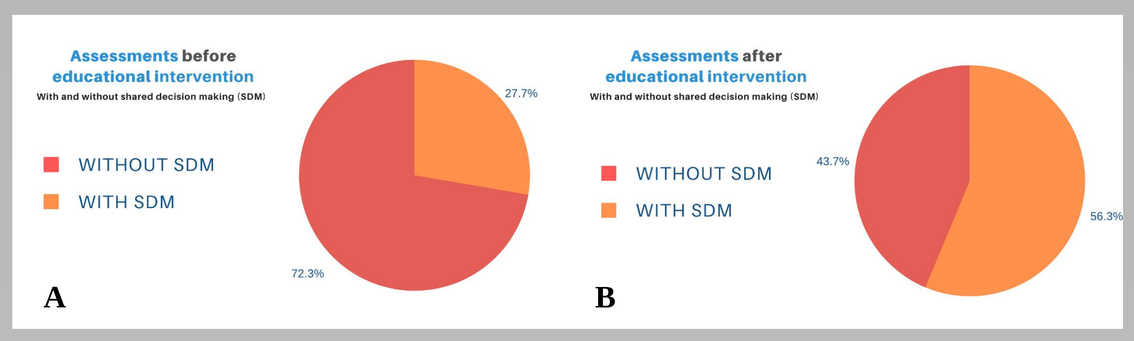

Fig.2 Changes in shared decision making elements before and after an educational intervention

Discussion

The initial audit showed that over 70% of the community mental health assessments carried out in the service did not contain written evidence of the implementation of SDM and that the assessments that did include principles of SDM belonged to a single doctor. An *ad hoc* educational intervention increased the number of referrals containing elements of SDM to 56% as shown in a re-audit carried out in 2019. Raised awareness on the importance of SDM was achieved nonetheless, there were no organisational plans for further development on formal and sustained training on SDM, at the end of the audit cycle.

Conclusions

SDM is yet unestablished as a standard practice in the Irish community mental health care and, when implemented, is likely to be insufficiently recorded. Further educational intervention could play a role in patient-centered care by facilitating, supporting and safeguarding patients’ decision-making capacity. Desirable cultural changes could be attained by investing in staff training and patients’ education. Such interventions may require the development of decision tools to optimise and consolidate the practice and, should ideally be adapted to the local context, performed with organisational support.

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