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Beyond Shared Decision-Making: Collaboration in the Age of Recovery From Serious Mental Illness

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The role that people with serious mental illness (SMI) play in making decisions about their own treatment and rehabilitation is attracting increasing attention and scrutiny. This attention is embedded in a broader social/consumer movement, the *recovery movement*, whose agenda includes extensive reform of the mental health system and advancing respect for the dignity and autonomy of people with SMI.

Recovery from SMI should not be confused with recovery as used in substance-abuse services. There are similarities, but recovery from SMI is profoundly different from recovery in the substance-abuse context. In the case of SMI, recovery refers to pursuit of meaning, hope, empowerment, and connectedness whether symptoms improve or not. Similarly, psychiatric treatment and rehabilitation for SMI is quite distinct from the popular meaning of substance-abuse “rehab,” referring to rehabilitation in functional skill sets and pursuit of meaningful goals. Among other pursuits, the recovery movement has prioritized the need to increase treatment involvement. Even more than in other areas of health care, identified

SMI patients often find themselves excluded from decisions that pervasively affect their lives.

Shared decision-making (SDM) is an approach for enhancing consumer participation in health-care decision-making. SDM translates straightforwardly to specific clinical procedures that systematically identify domains of decision-making and guide the practitioner and consumer through making the decisions.

SDM has a number of positive attributes, making it attractive to mental health stakeholders, including recipients of mental health care, providers in varying disciplines, family members, guardians, and advocates. Inherent in health-care decision-making is the need to balance the practitioner’s technical expertise with the personal values and preferences of the patient (i.e., the recipient of drug treatment), which SDM manages by identifying specific aspects of treatment for the practitioner and patient to apply their knowledge and experience. The practitioner is assigned technical aspects of treatment decisions, and the patient is intended to focus on value-based aspects. This strategy works well in the context of a narrowly focused treatment requiring no further patient participation beyond consenting to treatment, choosing among several prescriptive options, weighing their benefits against side effects, and swallowing the pill.

However, in a broader context, the connotation of *shared* is arguably inconsistent with values of the recovery movement, in that it cedes to another person some part of a fully autonomous person’s right to make decisions. There is a natural connotation that a provider may choose *not* to share aspects of decision-making based on preference or clinical judgment of patient ability. This plays out in real-life patient–practitioner in-

teractions; for example, psychiatrists are less likely to involve patients in decisions if they deem the patient too symptomatic. However defensible the distinction between technical and value-based decisions in the context of psychopharmacotherapy, it is much less defensible in the other domains of decision-making that directly affect people with SMI, such as where to live and whether to work.

Collaborative decision-making (CDM) is a set of guiding principles that avoids the connotations and limitations of SDM. CDM looks broadly at the range of decisions to be made in mental health care, and assigns consumers and providers equal responsibility and power in the decision-making process. It recognizes the diverse history, knowledge base, and values of each consumer by assuming patients can lead and contribute to decision-making, contributing both value-based information and technical information. In our effort to update the language used to more accurately mirror the theoretical intent of the decision-making approach discussed and decrease confusion, we will use the term CDM throughout the rest of the article. Although the past work discussed in this article usually mirrors the CDM model, this is the first article using the term CDM or collaborative decision-making. Most past work has used the term SDM or shared decision-making.

Although our terminology for CDM is new, the concept itself has been in development for at least 40 years. CDM evolved from the work of ethicist Robert Veatch in the 1970s, in the context of considering bioethics in medical encounters. There has been particular emphasis on increasing choice and patient independence in treatment decisions in oncology in an attempt to create a more mutual relationship between patients

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and practitioners. Gill Hubbard and his colleagues published a systemic review in 2008 of oncology patient-treatment preferences, and found that the preferences were significantly heterogeneous. About half of pa-

itioner, as well as other stakeholders in the process if relevant and desired by the consumer. In addition, it is balanced by the interactive nature of consumer and practitioner participation. The reciprocal exchange

consumer and practitioner share responsibility for making the final decision. It is essential that decisions are open for continued consideration and revision after the initial decision is made. In that sense, decision-making is an iterative process.

CDM is a broader model of decision-making that is adaptable across treatment decisions

tients preferred CDM; over a quarter preferred paternalistic decision-making, such as practitioners directing decision-making; and less than a quarter preferred active decision-making, i.e., patients directed their own decision-making. Patients and physicians agree less than half of the time on preferred roles in decision-making. Patients in oncology are able to have the decision-making style they desire about half of the time. There is clearly a general preference for more CDM than patients are currently experiencing, but perhaps what is more important is that patients have varying individual needs and preferences, for which traditional decision-making models have little allowance.

All of these issues contributed to the development of CDM for mental health care. CDM developed because of an ethical desire to position consumers and practitioners in similar places in the decision-making hierarchy, but it has also become clear that many consumers prefer individualized and collaborative treatment. In addition, this approach is valued by leading researchers and organizations in the mental health field. For example, the United States Department of Health and Human Services (DHHS) Substance Abuse and Mental Health Administration (SAMHSA) has highly promoted CDM, and the National Institutes of Health (NIH) National Institute on Mental Health emphasized personalized treatment in general in their 2015 Strategic Report. The American Psychological Association has included individualization as a key component to evidence-based practice, as noted in their 2005 report. As will be discussed further in this article, CDM is an effective way to achieve individualization in the pursuit of high-quality care.

The CDM model has been heavily supported because it is a balanced decision-making model that includes the participation and opinion of both the consumer and prac-

itioner. This approach allows for increased access to information for both patient and practitioner so that each can have the most informed opinion possible. Both patient and practitioner are treated as experts with their own field of expertise: Practitioners are experts in diagnosis, treatment, and the literature associated with their treatment fields, and consumers are experts of their own history, including treatments and experiences that have been more or less useful in the past. This approach allows for a collaborative playing field on which all people involved in the decision-making process can bring their expertise and opinions, which are valued, even if different from those of the others in the process.

Steps of CDM

Dr. Cathy Charles and her colleagues formulated three major steps in an ideal CDM process. The first step is information sharing. During this step, the consumer shares his or her needs, preferences, and all other relevant information with the practitioner and other stakeholders. In return, the practitioner shares treatment alternatives that are relevant to the consumer's current needs, including the benefits and risks to each treatment. The second step is deliberation. During this step, consumers weigh the pros and cons of each treatment alternative within the context of their individual needs and preferences. The practitioner offers opinions, but it is important that the practitioner uses this time to help consumers reflect on what makes the most sense for them, rather than to influence the consumer based on the practitioner's preference. The last step is joint agreement. The consumer and practitioner, along with any other stakeholders in the decision, negotiate an agreement based upon each person's understanding of what makes the most sense within the context of the consumer's current needs. Both the con-

sumer and practitioner share responsibility for making the final decision. It is essential that decisions are open for continued consideration and revision after the initial decision is made. In that sense, decision-making is an iterative process.

Charles' model is essential to understanding the primary mechanisms of CDM. It is, however, important to recall that CDM is not a mechanistic intervention. By design, the exact process of CDM is likely to vary by person and decision. CDM is a broader model of decision-making that is adaptable across treatment decisions, from changing a medication dosage to choosing a guardian. As was previously discussed, people receiving care have a range of preferences regarding treatment decisions. One of the central tenets of CDM is to provide a flexible framework across decisions and preferences. That framework should always include a collaborative, respectful, and thoughtful interaction between the consumer, provider, and other stakeholders, including an exchange of relevant information. It should also be congruent with the recovery model, particularly patient autonomy and empowerment. The exact process itself is likely to vary, but the guiding principles should not.

CDM and the Recovery Movement

Psychologist Patricia Deegan, in her 1988 article, contended that recovery should not be defined in a traditionally clinical sense, solely using outcomes like symptom remission or independent living. Instead, concepts like *nonlinear growth* and *personal development* are key to the recovery movement. There is no final outcome in this version of recovery, because it is considered to be a continually evolving process. By focusing on self-determination, purpose, and management of symptoms, individuals cultivate a life that is satisfying and meaningful to them, even if symptoms and related dysfunction continue. This model has been embraced by a number of researchers and consumers, and has been integrated into treatment programs for people with SMI at agencies such as the United States Department of Veterans Affairs.

An essential aspect of recovery is *empowerment* and the ability to hold social roles that are valued by the individual and

the community rather than stigmatized. The focus on empowerment partly arose from historical and contemporary experiences with stigma and inadequate treatment among people with SMI. These

CDM emphasizes personal accountability throughout the process rather than just when symptoms are remitted

harmful experiences fundamentally deny individuals autonomy and humanity. Therefore, empowerment, or the ability to take action, to be included, to be independent, and to make decisions, is fundamental to the recovery movement and to an individual's recovery within that paradigm.

The paradigm shift toward increased autonomy and empowerment coupled with a scientific awareness of the importance of individualization in treatment created a need for a reconsideration of how decisions are made in treatment. CDM is not the only option, but researchers and other stakeholders key to the recovery movement have championed CDM because of its fit in the recovery movement.

CDM has connected so well within the recovery movement because it allows for the control valued by consumers to increase their own empowerment and social stature even when symptoms are acute. Indeed, it emphasizes personal accountability throughout the process rather than just when symptoms are remitted. This notion of personal accountability is particularly important, as CDM balances accountability between consumers and practitioners, increasing both choice and responsibility in domains where historically consumers had little of either. The model acknowledges that consumers and practitioners often have different values and goals within the context of treatment, and further, allows treatment goals to be individualized to consumers within their own recovery framework.

Associated stakeholders accept and even prefer the CDM model. Research has consistently found that people with SMI want to be involved with decisions about their mental health treatment. A number of studies show variability in treatment preferences across groups and within groups depending

on the treatment decision being made, but one of the most encouraging aspects of CDM is its flexibility, which allows clients and practitioners to negotiate appropriate decision-making approaches. The logical

connection among CDM and the recovery movement, consumer preferences, and wide-ranging stakeholder support indicates that CDM is a good fit for mental health systems moving toward recovery-oriented care.

Present Application of CDM and Barriers to Application

Most practitioners across disciplines and services do not use CDM, although there are exceptions. Many practitioners believe CDM is applicable only to particular clinical contexts and particular patient characteristics, and therefore become the arbiter of CDM application, which is antithetical to the intention of CDM. Psychiatrists tend to apply CDM more frequently than other physicians, although individual psychiatrist use of CDM is still quite varied. Psychiatrists and other physicians rarely elicit patient preferences, which suggests that practitioners are more likely to adapt their communication style based on perception of each patient rather than based on patient preference. Clive Seale and his colleagues found support for this idea; in their 2006 study, psychiatrists were less likely to use CDM when they believed patients with schizophrenia to be more symptomatic or to lack insight.

Fortunately, patient-practitioner interactions become more collaborative and better mirror patient preferences when patients request a particular treatment, suggesting that although the baseline approach of practitioners is typically paternalistic or neutral, they are open to a more collaborative approach if patients initiate it. These findings underline why switching language from SDM to CDM is important. Although many practitioners may already be using some aspects of CDM in practice, other aspects, like eliciting pa-

tient preferences, remain rare, inhibiting mutual exchange of information and limiting patient autonomy and responsibility in treatment decisions. Multiple strategies to maximize collaboration, as discussed in the recommendations section, are likely to improve implementation.

In addition, practitioners, consumers, and families foresee the difficulty in moving from a paternalistic model to a collaborative model. For example, many stakeholders worry about the ingrained tendency to expect paternalism even if it isn't what they want. Stakeholders also anticipate that to apply CDM, all participants in the decision-making process will have to learn new skills. Practitioners will have to learn how to educate consumers and families and engage in a different kind of interaction with them. Consumers will also have to learn how to engage in CDM and how to use CDM to consider treatment alternatives in the greater context of their lives. It is clear that barriers to CDM exist across individual, practitioner, and system levels, indicating that a culture shift needs to occur for CDM to be accessible to the average mental health consumer.

Outcomes Associated With CDM

When CDM is implemented, it is associated with a range of positive outcomes. Among the positive outcomes is improved treatment satisfaction among consumers. Asunción Lara and her colleagues' work suggests that access to information explaining reasoning and additional background behind treatment is a key component improving satisfaction.

CDM is also associated with increased adherence, engagement, and general participation in services. For example, The Cochrane Collaboration's systemic review of 86 studies found that consumers using decision aids are more active in treatment. Consumers are less likely to drop out of treatment if they are able to choose their desired treatments, whereas consumers who have inadequate or other problematic communication with their practitioners are less likely to engage in treatment. This again emphasizes the need for collaborative treatment rather than merely personalized treatment.

Use of CDM may also lead to better clinical outcomes. Although research regarding this finding is mixed, multiple studies have found that patients who are more involved in

decision-making or who receive the treatment of their choice experience greater relief from mental health symptoms, greater quality of life, and better social functioning.

pointment when CDM was implemented in treatment of schizophrenia. Harnessing this may enhance CDM further; for example, a warmer and more engaged provider may

and examples of each of these are discussed. See also Table 1 for an overview of CDM methods.

CDM may also improve outcomes through increased practitioner satisfaction and performance

This effect might be long-lasting; there is evidence that depression symptoms remain remitted for 18 months after CDM engagement, and people with schizophrenia continued to have improved social functioning two years after CDM engagement.

These promising outcomes are partially the result of specific aspects of CDM. By using CDM to increase knowledge about treatment options and improve self-efficacy in self-management and self-monitoring, consumers become more satisfied and adherent to treatment and more able to independently apply knowledge and skills learned from treatment. CDM carves a pathway toward positive treatment outcomes.

CDM may also improve outcomes through increased practitioner satisfaction and performance. Although providers rarely initiate CDM, they are more satisfied with the outcome of treatment when a CDM intervention is used. In addition, Donald Steinwachs and his colleagues found that practitioners were warmer and more engaged in the ap-

help a consumer disclose troubling symptoms or consider trying a difficult therapeutic approach.

This emphasizes why a complete CDM approach rather than a more narrowly focused SDM approach is important; successful CDM improves a range of important outcomes through multiple pathways rather than being confined solely to changes in approach to appointments.

Current Methods of CDM

Researchers and practitioners have developed multiple approaches to increase collaboration in decision-making. These approaches range in the amount of structure and practitioner oversight required for implementation. Overall, *decision support* requires the least administrative or practitioner-level structure and oversight to initiate, *decision aids* require a comparatively moderate amount of structure and oversight, and *manualized decision-making* requires the most structure and oversight. Definitions

Decision-support tools. Decision-support tools are generally documents, electronic resources, or videos that communicate information about diagnoses and treatment possibilities to consumers. For instance, the Option Grid is a single page document that illustrates costs and benefits of different treatment possibilities via answers to frequently asked questions. Clinicians using the Option Grid reported that it improved communication by communicating respect and reciprocity to consumers and easing the information transfer by standardizing and organizing the most salient information in an accessible way.

Decision aids. Decision aids are typically documents or electronic resources that guide consumers through treatment decisions, often using interactive methods like surveys to tailor information to each consumer’s particular needs and enhance communication between consumers and practitioners. Annette O’Connor and her colleagues found that the use of decision aids in making medical decisions decreases unnecessary surgeries by 25%. Implementation of decision aids for assistance in CDM in medical treatment has been embraced by some eminent medical facilities including Dartmouth–Hitchcock Medical Cen-

Table 1. *Methods of Improving Collaborative Decision-Making*

Characteristics	Decision supports Option grid	Decision aids YourSchizophreniaCare	Manualized approaches CommonGround	Skills-training approaches Collaborative decision-skills training
Example				
Key features	<ul style="list-style-type: none"> Minimally structured Communicates information about diagnosis or treatment System- or provider-level intervention 	<ul style="list-style-type: none"> Moderately structured Provides guidance for specific decisions System- or provider-level intervention 	<ul style="list-style-type: none"> Highly structured Guides patient–provider interaction for specific decisions System- or provider-level intervention 	<ul style="list-style-type: none"> Highly structured Teaches skills necessary to make a range of decisions Consumer-level intervention
Potential drawbacks	<ul style="list-style-type: none"> Difficult for some consumers to use independently Consumers dependent on provider or agency to provide Not generalizable 	<ul style="list-style-type: none"> Difficult for some consumers to use independently Consumers dependent on provider or agency to provide May require staff training and/or technological resources Not generalizable 	<ul style="list-style-type: none"> Requires restructuring of program Requires staff training and/or hiring Expensive Consumers dependent on provider or agency to provide Primarily targeted at medication decisions 	<ul style="list-style-type: none"> Requires staff training and/or hiring Some consumers may have difficulty participating due to cognitive deficits

ter, Massachusetts General Hospital, and University of California, Los Angeles.

Manualized approaches. Manualized approaches are typically structured

Skills-training modalities are central to recovery-oriented treatments

approaches to the medical or psychiatric appointment itself, often including decision support, decision aids, and peer or practitioner oversight before or after the appointment to guide patients through the decision-making process and follow up on progress. For instance, Patrick Raue and his colleagues at Cornell University developed a manualized approach for older adults with depression seeking treatment in primary care. This approach includes an initial 30-min in-person session evaluating symptoms; providing psychoeducation about depression and treatment alternatives; discussing the consumer's experience, values, and preference; discussing possible barriers to treatment and ways to overcome them; and finally, coming to a mutual decision regarding the best treatment for that consumer and a referral based on that decision. Consumers are then followed for two weeks with two 10–15 min phone calls regarding implementation, adherence, barriers, and other needed issues.

Current Methods of CDM in SMI Populations

There have been a limited number of CDM tools developed specifically for the SMI population. The examples discussed here are representative but not exhaustive. The first of these is an online decision-support system developed at Dartmouth College by Steven Andrews and his colleagues. This system has two components, the first being a Web based decision-support tool that assists people with mental health problems in treatment decision-making, and the second being a design component that allows practitioners to create individualized information for their clients.

Multiple decision aids have been developed for the SMI population. For example, Steinwachs and his colleagues developed an interactive Web based tool to complete prior

appointments with the goal of increasing initiation of discussions about treatment among patients with schizophrenia. The tool includes a survey that yields individualized recommendations and videos illustrating

ways to initiate discussions with practitioners. A randomized controlled trial comparing this intervention to a control group found that the intervention group spent more time in the appointment and contributed more to the discussion. Participants in the intervention disclosed more about their lifestyles, asked more questions, and asked for clarification more often. During appointments with the intervention group, clinicians tended to be warmer and more engaged.

CommonGround, developed by Patricia Deegan, is perhaps the leading manualized CDM protocol for people with SMI in the United States at present. This approach reorganizes the basic structure of community clinics so that the clinic is focused around CDM and related recovery principles. CommonGround includes an enhanced visit with a 30-min session between consumers and peers prior to a psychiatric appointment. During the enhanced visit, consumers and peers work through a computer application that includes a survey that gathers the consumers' symptoms and current concerns and goals. The application creates individualized suggestions and a document for the consumers to present to their practitioners during their appointments. This creates structure for the appointments and assists the consumers in providing their prescribers relevant information.

Although this protocol has been implemented in multiple clinics in the United States, there is conflicting data on its effectiveness. Bradley Stein and his colleagues conducted an initial archival study comparing outcomes from a community clinic before and after implementing CommonGround, and found that use of CommonGround did not impact adherence to psychiatric medication. A set of recent studies by Kelsey Bonfils and Michelle Salyer at Indiana University–Purdue University Indianapolis found a number of barriers to implementation, including difficulties matching

the structure of CommonGround with the existing service structure, low staff buy-in, and technological problems. As a result, use of CommonGround was low. However, consumers reported improved symptoms and an increased sense of recovery.

Skills-Training as a Consumer-Oriented Tool

We suggest another approach that could be implemented alongside previously outlined modalities. A natural way to increase CDM in a program for people with SMI (e.g., psychiatric rehabilitation) would be through skills training. Skills training is a modality conducted in either group or individual formats, focused on increasing deficient skill areas common for people with SMI. Skills-training modalities are central to psychiatric rehabilitation in particular and recovery-oriented treatments in general because they focus on increasing functionality and independence, which enables consumers to direct their lives and recovery processes through new or improved abilities. Skills-training modalities have been developed and implemented for varied areas of functioning, including neurocognitive skills, social skills, wellness management, and relapse prevention and have generally shown positive outcomes across a number of settings.

Although other protocols to increase CDM in treatment have shown promise, there are practical reasons to consider a skills-training modality instead of, or in addition to, modalities focused on increasing practitioner skills or increasing decision-making structure in session. Practicality is of considerable importance, because CDM is intended to be implemented in nonacademic clinical settings, which are often publicly funded and therefore administrative choices are made based on cost and efficiency rather than on benefit alone. Although other approaches like CommonGround have promise, they have a high initial cost in resources and staff which is likely to deter publicly funded settings from implementing them.

The first of these practical considerations is cost. The cost of several of the CDM aids and protocols already developed are significant, with some modalities requiring the development or reorganization of treatment facilities to center around the modality, computers, or tablets to access interactive

material prior to or during sessions and/or additional staff. Although some treatment facilities may have the resources to reorganize, buy resources, and hire or train staff, this is unlikely to be the case in an average

psychiatric appointment. Some decision aids in particular may require additional time on behalf of the practitioner to distribute and interpret. A skills training approach would focus on changing the approach of the ses-

A skills-training modality creates the opportunity for clients to engage in or initiate CDM at any point with any person

public agency. A skills training intervention requires fewer resources, usually including paper materials and staff time.

Even in cases where agencies do have enough financial and other resources to implement these modalities, it is questionable whether administrative bodies will choose to do so. Therefore, another practical consideration is ease of implementation. Skills training is a low-cost and easy implementation option. In a psychiatric rehabilitation program, a CDM skills training could merely be added to the existing group schedule and led by existing staff clinicians.

The systemic and cultural processes at play in service settings is also an important practical consideration when considering CDM interventions. Although many advocacy groups and professional organizations have promoted the recovery movement and associated services, public agencies have been slower to implement changes, partially as a result of continued and considerable pressure to maintain traditional treatment approaches and systems. The ingrained culture of the mental health system supports the paternalistic model, and a significant overhaul would be necessary to create a culture that makes recovery-oriented service naturally accessible to stakeholders across the system. In the long term, reorganizing service systems toward the recovery movement (like CommonGround intends to) may be feasible, but this process may be more effective if small steps toward such a goal are taken first. In this instance, by assisting consumers in gaining skills, they are able to advocate for personalized, recovery-oriented services even if it is not a built-in part of their current service system.

The last practical consideration is time constraints, one of the major concerns regarding implementing CDM in an average

session, so that communication between the practitioner and consumer is the nucleus of decision-making. Hamann found that when physicians change their approach to consultation to improve CDM when treating people with schizophrenia, length of sessions was not significantly longer than practitioners delivering traditional treatment. Therefore, one way to overcome administrative concerns is to use modalities that will not increase session time but rather are conducted separately as an ingrained component of psychiatric rehabilitation.

Beyond practical considerations, focusing collaborative decision modalities on improving consumer knowledge and skills may be a more effective choice than other approaches. Skills training is more flexible, more generalizable, and more self-directed than any of the options discussed previously. Consumers can gain collaborative decision skills, enabling them to initiate CDM during psychiatric appointments. These skills can generalize beyond psychiatric appointments; consumers can take these skills with them to other agencies and practitioners, to medical appointments, and into their personal life, unlike a decision aid used specifically for particular practitioners or agencies. A skills-training modality allows consumers to directly access CDM, rather than being dependent on agency and practitioner choices. It also allows for the continuing recalibration of the decision-making process, which is important given the naturally dynamic characteristics of interpersonal communication and decision-making, unlike more structured protocols. This fits within the larger picture of the recovery movement, which has focused on empowerment, autonomy, and personalization over standardized treatment.

Psychiatrists engage in CDM to the extent that they are likely to offer information regarding treatment alternatives, including pros and cons of each treatment. However, they are unlikely to elicit consumer preferences. When consumers initiate the decision-making process, treatment decisions are more likely to reflect consumer preference. CDM is by nature a mutual process and for it to be successful, it is necessary that both stakeholders have and use appropriate skills. By increasing consumers' communication skills in context of a psychiatric appointment, consumers will be able to take an assertive stance and share their own opinions.

A skills-training modality also better fits a collaborative model. Decision interventions including those previously discussed, like Option Grid and CommonGround, usually require that a practitioner or agency provide the intervention to the client for each specific decision or appointment. This naturally reduces the client's autonomy in decision-making, and reduces the amount of decisions the client can participate in. As we move away from an SDM model to a CDM model, it is essential that interventions maximize client autonomy in decision-making processes. A skills-training modality creates the opportunity for clients to engage in or initiate CDM at any point with any person, enhancing their autonomy and therefore creating a more collaborative process.

We are aware of three skills-training modalities that have been developed in the past to increase collaboration in mental health treatment planning. These modalities have initial indication of effectiveness; for example, the Right Question Project-Mental Health intervention developed by Margarita Alegria at Harvard increases empowerment and treatment engagement among primarily Hispanic patients. However, these modalities have been developed in academic settings and like most other CDM interventions, are not generally available. Increasing accessibility to CDM for all people requires an emphasis on implementation and dissemination of effective CDM tools and interventions.

Overall, there are many reasons to consider adapting or creating a skills-training modality to improve CDM in SMI. This approach is likely to be more practical and easier to implement in an average treatment setting compared to other approaches, including considerations like finances, staffing,

and use of additional resources. Such an approach may be preferable because it increases the generalizability of skills learned and increases consumers' ability to be autonomous rather than dependent on administrative choices. There is evidence from skills-training modalities already developed that such an approach is effective in increasing adherence, participation, and responsibility in treatment. Given this, we propose a new approach, discussed below.

Recommendations for Improving and Increasing CDM in SMI

Given the state of the current research and implementation of CDM for SMI, we make eight recommendations for improving and increasing CDM among people with SMI.

1. Throughout this article, we have argued for a change in terminology, from SDM to CDM. CDM sets the bar high in expectations for practitioners and flexibility for patients. We recommend that researchers, practitioners, and other stakeholders adhere to this change, as it more accurately encompasses the intention of the CDM process. In addition, as more stakeholders learn about this model of decision-making, it is important that the language involved correctly connotes high levels of reciprocity, consumer autonomy, and consumer empowerment. This will enhance understanding and implementation of the approach.
2. A skills training should be developed and implemented to help people with SMI initiate and engage in CDM in mental health-relevant situations with their treatment team and other stakeholders. We have already begun this work, and an initial feasibility study of the resulting group-skills training, collaborative decision-skills training (CDST), was favorable. Preliminary results from that study indicate that CDST increases knowledge and skills related to CDM, sense of recovery, and preference for involvement in decision-making. A skills-training modality like CDST has the potential to target many of the areas identified in the body of work completed thus far, including maximizing congruence with the recovery model, increasing

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consumer initiation of treatment planning, and counteracting paternalistic expectations of encounters.

3. During these skills trainings and at other key points (e.g., first episode protocols, crisis interactions, inpatient settings), it is recommended that psychoeducational experiences, including intake processes and family meetings, focus on increasing empowerment related to the decision-making process. Becoming a patient in the mental health system is often highly disempowering, causing a shift in expected locus of control given heuristics and explicit education regarding the sick role. It is essential that dismantling the expectation that mental health interactions are necessarily paternalistic and disempowering starts early and continues regularly in each individual's path toward recovery.
4. Mental health interactions must fulfill expectations that it is possible, if wanted, to engage in CDM rather than paternalism. This change in provider–consumer interaction requires significant staff training, as the expectation for staff has been to participate in a paternalistic model. Staff training must be all encompassing, as restructuring interactions is necessary for all disciplines and roles, particularly for people with SMI, who often have di-

verse mental health teams. Training must emphasize ability to engage in decision-making for all consumers, not just consumers judged “well enough” to participate. Antistigma psychoeducation for staff is key to increasing CDM and generally increasing recovery orientation of programming.

5. Family members and other stakeholders, including guardians and fiduciaries, must also be a target of interventions and psychoeducation. Family members are often a significant part of treatment teams for people with SMI, and family members may hold the same expectations about paternalism and stigmatizing beliefs as other treatment team members. Family interventions are recommended and should focus on simultaneously empowering the consumer and supporting the family.
6. For CDM to succeed, pursuit of evidence-based practice and the recovery model must be seen as congruent aims. As we have discussed, recovery approaches like CDM are best practices, which must be funded in equal measure and given equal consideration with other best practice approaches.
7. We have generally argued for incremental steps taken in treatment settings. These are important goals to increase

CDM in SMI, but system-level change is also necessary, should primarily be accomplished through policy change requiring greater and more effective implementation of recovery-oriented and effective treatments for SMI, and greater organizational involvement by stakeholders, particularly people with lived experience.

8. Although the majority of research thus far has focused on CDM during treatment goal setting, CDM should not only be a goal for one-on-one treatment-related decisions. CDM should be and must be a goal for broader, systemic decisions. This generalization of CDM should expand to issues like treatment development and evaluation, program development and evaluation, policy development and evaluation, advocacy, and research. The peer movement is the best and most visible example of creating valued space for people with SMI and other mental health issues to be meaningfully involved in mental health systems. Greater embrace and consideration of the voices of people with lived experience are essential at all levels of the mental health system.

Keywords: serious mental illness; collaborative decision-making; recovery movement; treatment decisions