Psychiatric Providers' Willingness to Participate in Shared Decision Making When Prescribing Psychotropics

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Saadia Ali, PharmD, BCPP¹, Tawny L. Smith, PharmD, BCPP^{2,3},
Lisa Mican, PharmD, BCPP^{2,4}, and Carolyn Brown, PhD²

Abstract

Background: Patients with mental health disorders experience difficulty in selecting treatments. With a paternalistic approach, patients are not offered an opportunity to provide input. Shared decision making (SDM) occurs when providers and patients collaborate on informed treatment decisions. Research on psychiatric providers' perceptions toward SDM is limited. **Objective:** This pilot study aimed to determine psychiatric providers' willingness to engage in SDM and factors that influence willingness. **Methods:** This cross-sectional, self-report study measured willingness, attitude, experiences, and barriers related to SDM as well as demographic/practice characteristics. A survey was e-mailed to psychiatric providers at 3 psychiatric institutions. **Results:** Out of 80 providers e-mailed, 29 (36.3%) responded. Providers had a favorable attitude toward SDM (3.26 ± 0.24 , range = 1–4) and a high willingness to use SDM (3.43 ± 0.50 , range = 1–4). The most common SDM methods were discussions (96.6%) and written material (89.7%). Common perceived barriers included limited patient capacity (86.2%) and limited time with patient (62.1%). Current SDM users (3.46 ± 0.51) had a higher willingness to engage in SDM than noncurrent users (3.00 ± 0.00), $t = 4.63$, $df = 25.0$, $P < .001$. Attitude and willingness were positively related ($r = .62$, $P < .001$). Attitude did not vary based on demographic/practice characteristics. **Conclusions:** Willingness to use SDM was positively related to a favorable attitude toward SDM. Larger, geographically diverse, randomized controlled trials need to be conducted to evaluate the willingness of psychiatric providers to conduct SDM.

Keywords

adherence, communication, counseling, mental health, patient education, pharmacist/physician issues, psychiatry

Introduction

Within mental health care, patients may struggle with selecting from the various pharmacological treatment options available to them. For patients, making a decision may be especially difficult among treatments that have unclear benefits and a risk of significant adverse effects (eg, antipsychotics).¹ The decision-making process may result in a delay in treatment selection and a decrease in follow-through once a treatment is selected.¹

On the other end of the spectrum, a paternalistic approach, where the health care provider makes the treatment selection without input from the patient, may prevent patients with mental illnesses from stating their treatment preferences.^{1–4} To select a treatment option that balances optimal patient outcomes and patient preferences, it is reasonable to consider using a 2-way avenue of communication. Concordance occurs when the patient and health professional finalize a health care decision together, such as selecting a treatment option. It refers to the interaction between patient and provider rather than a patient's medication-taking behavior. This is considered a more patient-centered approach.⁵

Shared Decision Making

Concordance is similar to shared decision making (SDM), which entails an understanding between the patient and provider that is based on the patient's medication-taking preferences.^{2–4} Patients and providers collaborate to develop a treatment decision based on patients' experiences and preferences and providers' knowledge about treatments.^{6,7} Charles et al developed a decision-making model that can be applied to SDM consisting of (a) 2-way information exchange, (b) discussion (eg, prioritizing treatment options), and (c) selection of treatment aligning with patient preference.⁸ To facilitate deliberation about treatments, SDM is

¹Houston Methodist Hospital, Houston, TX, USA

²The University of Texas at Austin, TX, USA

³Seton Healthcare Family, Austin, TX, USA

⁴Austin State Hospital, Austin, TX, USA

Corresponding Author:

Saadia Ali, PharmD, BCPP, Houston Methodist Hospital, 6560 Fannin Street, Scurlock Tower #1562, Houston, TX 77030, USA.
Email: sali6@houstonmethodist.org

executed via decision aids, which serve to clarify options for patients. Examples of these tools include worksheets (eg, Substance Abuse and Mental Health Services Administration [SAMHSA] medication side effect profile worksheet), interactive online tools (eg, SAMHSA antipsychotic tool), workbooks, and videos.⁹ Patients may utilize decision-making aids independently or with the help of a provider or peer. These tools enhance patients' knowledge of treatments, increase patient participation, and provide a sense of comfort with the treatment options.¹

Role of SDM in Mental Health

SDM promotes patient empowerment, autonomy, and quality of life in mental health.⁷ The role of SDM in mental health is further supported by the idea that decision aids may relieve decisional conflict that patients with mental illness experience due to stigma, side effects, and situations where there are multiple treatment options.^{7,10} Although limited evidence exists in psychiatry, there are reports that SDM results in positive outcomes.¹ In a prospective national cohort study of depressed primary care patients, greater involvement of patients in decision making was associated with a higher probability of reporting guideline-concordant care and symptom improvement.¹¹

Factors Influencing Psychiatric Providers' Use of SDM

The Theory of Planned Behavior (TPB) is a useful and valid model to understand individual behavior and served as the conceptual framework for this study.¹² The TPB framework contains 3 main components: attitude toward the behavior, subjective norm regarding the behavior, and perceived behavioral control over the behavior.¹³ The 3 TPB components separately influence an individual's intention to perform the behavior, or in this case, to use SDM. An individual's intention or, in this case, willingness to use SDM influences his/her behavior (eg, SDM use). Thus, according to the TPB, a provider with a favorable attitude toward SDM will more likely use SDM. This study focused on the attitude and willingness components of the TPB.

Psychiatrists generally view SDM positively.⁵ Goosensen et al demonstrated that although psychiatrists are willing to incorporate SDM, they are not willing to ask patients' preferences about involvement in decision making.¹⁴ This study also found that SDM is currently practiced at a low level in psychiatric settings. Based on these findings, there seems to be a disconnect between attitude toward SDM, willingness to engage in SDM, and actual use of SDM.

SDM and Barriers

Provider-perceived barriers can inhibit engagement in SDM. Barriers to SDM include poor patient health literacy,

impact of unwanted side effects on motivation to participate in treatment, and discrepancy between actual medication adherence versus patient report.^{2,7,15} Time constraints are also recognized as a barrier and may be a reason that SDM is currently practiced at the level of information exchange in psychiatry.¹⁶ Other perceived barriers include limited materials and providers' concerns about their ability to communicate risks to patients.¹⁷

Study Purpose

While psychiatric providers may generally demonstrate a positive attitude toward SDM, research on the extent to which SDM is practiced by providers, as well as their willingness to practice SDM when prescribing psychotropic medications, is limited. There is also limited understanding about the influence of attitudes and experience on the willingness to engage in SDM in mental health. Gaining a better understanding of these relationships may facilitate health care organizations in identifying areas of improvement to enhance psychiatric providers' decision-making practices. The initial step of this research was to survey psychiatric providers in various practice settings to gain insight into their perceptions toward SDM. Specifically, this study aimed to (a) determine psychiatric providers' attitudes and experiences with SDM, (b) examine the relationship between providers' attitudes and experiences and their willingness to engage in SDM, (c) determine if attitudes toward SDM differ based on providers' demographic/practice characteristics, and (d) identify providers' perceived barriers to SDM.

Methods

Sample

An electronic survey with a cover letter defining SDM was e-mailed to 80 psychiatric providers (psychiatrists, psychiatric residents, and physician extenders [nurse practitioners and physician assistants]) from 3 institutions that researchers were affiliated with, including a state hospital, a private teaching hospital, and an outpatient clinic in Texas. The a priori total sample size of 127 was based on an estimated medium effect size of 0.15, an α level of .05, a power level of 0.8, and 12 predictors. However, since only 80 providers were actually available, the authors were aware that the study would be underpowered for multivariate analyses even with a 100% response rate. Thus, no multivariate models were run in this pilot study and only descriptive bivariate associations are reported. The final power level was 0.36. Providers' e-mail addresses were obtained from an internal e-mail provider group. An electronic survey was used because online surveys are expected to be more convenient and have a faster response rate than mailing surveys. Two follow-up reminder e-mails with the survey link were

sent 1 week and 2 weeks after the initial e-mail in March and April 2013. The participants' responses were anonymous. Participants were not financially compensated to complete the survey. This study was approved by the institutional review board at the affiliated university.

Measures

The survey contained 5 primary sections that measured attitude, willingness, past/present experience, barriers, and demographic and practice characteristics.

Attitude toward SDM was measured using the Leeds Attitude to Concordance Scale II (LATCon II).¹⁸ The LATCon II has been tested and validated in the psychiatric provider population.⁵ It is a 20-item self-report scale developed by Knapp et al that was created to assess health professionals' and student practitioners' attitudes toward SDM in selecting medications. Studies report a reliability of .71 to .83 (Cronbach's α statistic) for the LATCon II.^{5,18} The respondent rated each item on a 4-point Likert-type scale, ranging from *strongly disagree* (1) to *strongly agree* (4). Scores were averaged (range of 1-4), and higher scores indicated a more positive attitude toward SDM. Five negatively worded items are reverse scored.

SDM experience was measured by 2 items: (a) I currently use SDM to prescribe psychotropic medications (yes/no) and (b) I used SDM in the past to prescribe psychotropic medications, but do not use SDM anymore (yes/no). A respondent's "yes" response to either item was categorized as having SDM experience. Respondents were also asked to select SDM methods and tools they use or have used in the past or have encouraged their patients to use or review prior to meeting with them about psychotropic medications. The list of SDM methods included the following: (a) worksheets (eg, SAMHSA Medication Side Effect Profile worksheet), (b) online programs (eg, SAMHSA antipsychotic decision-making aid), (c) written material (eg, pamphlets) about psychotropic medications, (d) discussions where the provider educates the patient about side effects of the medications and the patient expresses his/her preferences, (e) other (please specify), and (f) none. Respondents were able to select more than one SDM method. Respondents were asked if there were certain clinical situations in which they would choose not to practice SDM when prescribing psychotropic medications and to describe these types of situations if they answered "yes."

Willingness to engage in SDM when prescribing psychotropic medications was measured using 2 items: (a) I am willing to use SDM with my patients when prescribing psychotropic medications and (b) I plan to use SDM with my patients when prescribing psychotropic medications in the next 6 months. Each item required a response to a 4-point Likert-type scale ranging from *strongly disagree* (1) to *strongly agree* (4). The 2 items were averaged (range of 1-4),

and higher scores indicated a greater willingness to engage in SDM when prescribing psychotropic medications.

Respondents were asked to select up to 5 barriers that they perceived to be impediments to SDM implementation. The barriers commonly reported in the literature populated the list and included the following: (a) limited time with patient to incorporate SDM, (b) not applicable in practice setting, (c) perception that patient's view of SDM does not align with provider's view, (d) do not agree with the concept of asking patients about their preferred role in SDM, (e) limited support from the employer/organization, (f) limited materials or staff to implement SDM, (g) limited reimbursement for incorporating SDM into practice, (h) SDM does not align with current approach, (i) limited patient capacity (eg, mania, psychosis, altered mental status, dementia, poor insight, acute agitation), (j) legal issues related to commitment of patients, (k) patients who are children, (l) other (please specify), and (m) none.^{1,19}

Demographic data on age (34 years or younger, 35-44 years, 45-54 years, 55-64 years, 65 years or older), gender (male/female), and ethnic/racial background (Caucasian/non-Hispanic white, Asian American/Pacific Islander, Mexican American/Hispanic, African American/non-Hispanic black, American Indian or Alaska Native, Other) were collected. Respondents were also asked about the percentage of time spent practicing in outpatient and inpatient settings, professional position (psychiatrist, psychiatric resident, physician extender), years of experience in prescribing psychotropic medications, age group primarily treated (geriatric, adults, child/adolescent), current affiliation with an academic institution (yes/no), average time per day spent on direct patient care, and average number of patients seen during that time.

The questionnaire was pretested and assessed for content validity by 5 respondents. Questionnaire items were modified (ie, minor wording changes) based on pretest results and recommendations.

Data Analysis

Descriptive statistics included frequencies, percentages, means, and standard deviations for all variables. Cronbach's α was used to assess the reliability of the LATCon II scale. Bivariate relationships between willingness, attitude, SDM experience, and demographic and practice characteristics were analyzed using correlations, *t* tests, and ANOVA procedures. Statistical significance was assessed at $P \leq .05$. This study used SAS version 9.3.

Results

Of the 80 psychiatric providers e-mailed, 29 completed the survey for a response rate of 36.3%. Almost half of the respondents ($N = 14$, 48.3%) were 34 years or younger and

Table 1. Demographic and Practice Characteristics of Psychiatric Providers (N = 29).

Characteristic	N ^a	%
Age		
34 years or younger	14	48.3
35-44 years	8	27.6
45-54 years	2	6.9
55-64 years	3	10.3
65 years or older	1	3.4
Gender		
Female	20	69.0
Male	8	27.6
Transgender	0	0.0
Ethnicity/race		
Caucasian/non-Hispanic white	17	58.6
Asian American/Pacific Islander	6	20.7
Mexican American/Hispanic	4	13.8
African American/non-Hispanic black	1	3.4
American Indian or Alaska Native	0	0.0
Other	0	0.0
Position		
Psychiatrist	15	51.7
Psychiatric resident	13	44.8
Physician extender	0	0.0
Primary patient population		
Adult (18-64 years)	23	79.3
Child/adolescent (17 years and younger)	4	13.8
Geriatric (65 years and older)	1	3.4
None	0	0.0
Academic affiliation		
Yes	25	86.2
No	3	10.3
	Mean (±SD)	
Portion of time spent providing direct patient care in the inpatient setting (%)	65.50 (±37.19)	
Portion of time spent providing direct patient care in the outpatient setting (%)	34.50 (±37.19)	
Experience prescribing psychotropics (years)	9.21 (±10.08)	
Time spent practicing direct patient care (ie, interacting about psychotropics) (hours per day)	7.11 (±2.30)	
Patients seen practicing direct patient care (ie, interacting about psychotropics) (patients per day)	9.79 (±3.85)	

^aFrequency may not equal N = 29 because of missing responses.

8 (27.6%) were 35 to 44 years (Table 1). With regard to position, 15 (51.7%) were psychiatrists and 13 (44.8%) were psychiatric residents. Academic affiliation was reported by 25 (86.2%) of the respondents. A total of 23 (79.3%) providers primarily prescribed psychotropics to the adult population. The average portion of time that was spent providing direct patient care (ie, discussing psychotropic medications) in the inpatient setting was 65.5% (±37.19).

The overall attitude score was 3.26 (±0.24), corresponding to a favorable attitude toward SDM (Table 2). Attitudes did not vary based on demographic or practice characteristics. The overall willingness score was 3.43 (±0.50), indicating a high willingness to engage in SDM when prescribing

psychotropic medications. Attitude and willingness were positively related ($r = .62$, $P < .001$).

Nearly all (N = 26, 89.7%) respondents were current SDM users. Of the two noncurrent users, one reported never using SDM while the other reported using SDM in the past. Bivariate analyses showed that current SDM users (3.46 ± 0.51) had a significantly higher willingness than noncurrent users (3.00 ± 0.00), $t = 4.63$, $df = 25.0$, $P < .001$, to engage in SDM when prescribing psychotropic medications. The most common methods of SDM included discussions (96.6%), written material (89.7%), and worksheets (13.8%; Table 3).

A total of 26 (89.7%) respondents reported clinical situations in which they would not engage in SDM including

Table 2. Attitudes of Psychiatric Providers Toward SDM^a.

Attitude Item	Mean (± SD)
Doctors should try to help patients make as informed a choice as possible about the benefits and risks of alternative treatments.	3.78 (±0.42)
It is always important for doctors to listen to patients' personal understanding of their condition.	3.74 (±0.45)
Doctors should give patients the opportunity to talk through their thoughts about their illness.	3.70 (±0.47)
Doctors should encourage patients to express their concerns about medicine taking.	3.70 (±0.47)
Doctors and patients should agree a treatment plan that takes account of both their views.	3.63 (±0.49)
Prescribing should take account of patients' expectations of treatment.	3.59 (±0.50)
During the consultation, both the doctor and the patient should state their views about possible treatments.	3.59 (±0.50)
Doctors should make clear when the benefits of the medicine are uncertain.	3.59 (±0.50)
A good treatment decision is made when both the doctor and patient agree on the treatment use.	3.56 (±0.51)
The doctor and the patient should find a common ground on what the problem is and jointly agree on what to do.	3.44 (±0.51)
The best use of treatments is when it is what the patient wishes and is able to achieve.	3.37 (±0.63)
Patient involvement in the prescribing process always leads to better outcomes.	3.33 (±0.62)
Doctors should be more sensitive to how patients react to the information they give.	3.33 (±0.48)
*The doctor is the expert, and the patient's role is to do as the doctor says.	3.26 (±0.71)
*Taking account of patients' views about medicines is not always necessary for appropriate prescribing.	2.81 (±0.83)
*It is not always necessary for doctors to take account of patients' priorities.	2.81 (±0.74)
Patients should be able to assume as much responsibility as they wish for their own treatment.	2.74 (±0.66)
The consultation between the doctor and the patient should be viewed as a negotiation between equals.	2.59 (±0.64)
*During the doctor–patient consultation, the patient's decision is the most important.	2.22 (±0.58)
*It is sometimes appropriate for the doctor to make treatment decisions without the patient's input.	2.04 (±0.76)
Overall attitude score	3.26 (±0.24)

Abbreviation: SDM = shared decision making.

^a1 = *strongly disagree*; 2 = *disagree*; 3 = *agree*; 4 = *strongly agree*. Cronbach's α = .72; higher scores indicate a more favorable attitude toward SDM.

*Reverse coded items.

Table 3. SDM Methods Used by Psychiatric Providers.

Method	N ^a	%
Discussions	28	96.6
Written material	26	89.7
Worksheets	4	13.8
Video clips	3	10.3
Other	3	10.3
Online programs	2	6.9
None	0	0.0

Abbreviation: SDM = shared decision making.

^aPercentages sum to greater than 100% because of multiple responses.

psychosis, altered mental status, dementia, and patients that pose a danger to themselves or others. The most commonly reported perceived barriers were limited patient capacity (86.2%), limited time with patient (62.1%), and limited materials/staff (51.7%; Table 4).

Discussion

In this study, psychiatric providers had a favorable attitude toward SDM, which is similar to the results of another mental health SDM study.⁵ To date, there are limited studies that quantify psychiatric providers' attitude or willingness toward

Table 4. Perceived Barriers to SDM of Psychiatric Providers.

Barrier	N ^a	%
Limited patient capacity	25	86.2
Limited time with patient	18	62.1
Limited materials/staff	15	51.7
Patients who are children	13	44.8
Legal issues	10	34.5
Limited reimbursement	6	20.7
Not applicable in practice setting	3	10.3
Perception that patient's view of SDM does not align with provider's view	3	10.3
Other	3	10.3
Limited support from the employer/organization	2	6.9
Do not agree with concept of asking patients about preferred role in SDM	0	0.0
SDM does not align with current approach	0	0.0
None	0	0.0

Abbreviation: SDM = shared decision making.

^aPercentages sum to greater than 100% because of multiple responses.

SDM using a theoretically based context. This study supports that there is a positive relationship between psychiatric providers' attitudes toward SDM and their willingness to engage in SDM based on the TPB model.

A majority of the respondents reported experience with SDM. Contrary to these findings, observational studies have found that SDM is being practiced at a low level in psychiatric settings and that providers spend most of the consultation time defining the problem rather than involving the patient in the decision-making process.^{14,16} A potentially positive response bias, low response rate, and small sample size may explain the difference in this study's findings of favorable attitude toward SDM and SDM experience. Providers with current experience had a significantly higher willingness to engage in SDM compared to noncurrent users. This finding should be interpreted with caution since only 2 noncurrent users participated in this study. Nevertheless, nonusers may have had a negative experience with SDM, perceived more barriers impeding them from engaging in SDM, or may lack understanding of SDM compared to users. Differences between users and nonusers need further study.

In this study, attitudes did not vary based on providers' demographic and practice characteristics. These results were different from previous studies' findings where sex correlated with attitude. Previous studies show that women scored significantly lower attitude scores than men.^{2,5} In addition, our findings indicate that providers across various settings (ie, outpatient, inpatient, academic, private, public) had a favorable attitude toward SDM and thus may be willing to implement a SDM program. However, it should be noted that a majority of the respondents practiced in a private inpatient setting or outpatient clinic; thus, the current findings may not accurately reflect the attitudes of those in other practice settings. Furthermore, the small sample size and potential response bias in this study may explain why no differences were detected in attitudes based on practice characteristics and demographics.

While providers reported a favorable attitude and high willingness to engage in SDM, more than half of the respondents identified that limited patient capacity, limited time with the patient, and limited materials/staff are common impediments to SDM implementation. Furthermore, a majority reported situations in which they would not engage in SDM, such as encounters with patients who have dementia or psychosis or those who are drug-seeking. The barriers and exceptions reported in this study are congruent with the literature, which include lack of applicability due to patient characteristics or clinical situation and time constraints.^{1,19} It is imperative to devise strategies to overcome these identified barriers prior to SDM implementation. It may be reasonable to engage peer support specialists in overcoming these barriers in sites that do not currently utilize them. Peer support specialists are trained mental health consumers with similar experiences as patients and can assist patients in developing communication skills, completing decision-making tools such as worksheets, and preparing for provider

consultations.¹ Increasing the availability of decision aids and providing education to psychiatric providers about these tools may also help overcome the perceived barrier of limited materials. Furthermore, pharmacists may be utilized to deliver SDM in addition to medication education in clinical settings.

More than half of the respondents identified discussions and written material as tools they use to facilitate SDM. This finding aligns with the idea that SDM in psychiatry is practiced primarily at the level of bidirectional information exchange.^{5,8} It is unknown whether these discussions are solely an exchange of facts or if they reach the processing/deliberation stage of SDM. Providers may benefit from an educational in-service on tools to facilitate the decision-making process.

Given these findings, several areas of future research may be warranted. Larger scale studies with providers should be conducted in other states and across different practice sites to validate findings from this pilot study. In addition, future research efforts may be directed toward the development of methods to positively influence providers' attitudes and the examination of the impact of these methods on providers' attitudes toward SDM. Our study is one of the first to show that it may be worthwhile to increase favorable attitudes toward SDM in order to bolster providers' willingness to engage in SDM practices. In addition, more information regarding psychiatric providers' depth of SDM knowledge needs to be obtained as SDM is a fairly new concept in psychiatry.

Findings from this study should be interpreted within several limitations. The study design was a cross-sectional study and did not reflect changes in responses over time. Because a self-report survey was used, this study was vulnerable to social desirability and response bias. This study has limited generalizability and statistical power due to the small sample size, low response rate, and practice sites limited to one geographical area. Geographically diverse studies with larger sample sizes need to be conducted to better understand psychiatric providers' attitudes, willingness, experience, and perceived barriers toward SDM.

Conclusion

This study found that psychiatric providers had a favorable attitude toward SDM and a high willingness to use SDM. Approximately 93% of the providers were current SDM users. Current users of SDM as well as those with a favorable attitude toward SDM had a significantly higher willingness to engage in SDM. The most common barriers to SDM use were limited patient capacity, limited time with patient, and limited materials/staff. Common SDM methods were discussions and written material, which imply that SDM is being conducted at the level of information exchange only.

Authors' Note

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Declaration of Conflicting Interests

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