Shared Decisionmaking in Mental Health: Stakeholder Information Needs

Edith Kealey, MSW
Molly Finnerty, MD

Overview

- Shared Decisionmaking in Health and Mental Health
- The NYSOMH Psychiatric Services and Clinical Knowledge Enhancement System (PSYCKES)
- Information Needs of Consumers and Families

Models of Healthcare Decisionmaking

- Traditional medical model: physician as expert determines best course of treatment, and consumer complies with treatment
- Informed choice model: physician provides information about options but does not recommend treatment, and consumer decides on course of treatment
- Shared decisionmaking model: physician and consumer share information about options and preferences to reach consensus re: treatment

The Shared Decisionmaking Paradigm

- Involves both consumer and physician
- Provides consumer with sufficient and adequate information regarding options (decision aids)
- Empowers consumer in developing and sharing preference with physician
- Respects autonomy of individual as treatment decision is negotiated between consumer and physician

Shared Decisionmaking in Psychiatry

- Consumers want and are able to participate in healthcare decisions (Bunn et al., 1997).
- SDM does not increase time burden on physicians (Hamann et al., 2006).
- SDM can lead to increased knowledge and improved self-efficacy (Ludman et al., 2003).

The Role of Decision Aids

- DAs serve as a bridge between scientific evidence and personal values (Deegan, 2006)
  - To provide information on options and outcomes
  - To provide examples of decisionmaking processes
- Decision aids supplement, but do not replace, the clinician-consumer relationship

Information Needs in Mental Health

- Consumers and families do not feel they receive adequate information about medications (Cleary et al., 2005; Happel et al., 2004).
- General information, such as brochures and computer-based resources, is not sufficient to meet information needs (Patton & Esop, 2005).
- Access to information is hampered by stigma and staff ambivalence (Powell et al., 2006; Pollack et al., 2004).

Clinical Decision Support in NYS

- NYSOMH developed PSYCKES to support quality improvement and clinical decisionmaking regarding prescribing practices in state psychiatric hospitals.
- Reports contains information on all psychotropic medications prescribed in NYSOMH hospitals since 1990.
  - Dose, duration, quality of trial

PSYCKES Sample Report

PSYCKES Facilities **Facility A (08/31/2004):** Clinician Reports Management Reports Data Quality Reports Fiscal Reports Help

Report Date: 08/31/2004

Automated Prescribing Summary

Name:	Patient F. 10000000192	DOB	01/10/32	Primary Diagnosis:	Schizoaffective 29570
Facility	Facility A	Age	73	Other Psych Diag.:	Personality DO 30120
State ID:	556942	LOS	81.2 month(s)	Medical Diagnoses:	Cardio-pulm 4139 4140
Case #:	31713	Ward	Ward_B		Derm 6929 6827
					ENT 3899 3669
					Endocrine 25000

Medication Class/ Hospitalization	Dates		Duration	Current Dose	Max Dose	Max Dose Trial	Dose Timeline (mg/d)						Dose at DC	Normal Range	Trial Type
	start	stop	(months)	(mg/d)	(mg/d)	(mg/d)	1d	1wk	2wk	4wk	8wk	12wk	(mg/d)		
ANTIPSYCHOTICS															
Facility A	**10/17/85**	**10/10/97**	**145.9**												
Loxapine	08/08/91	03/25/93	19.8 **H**		150	150	100a	100a	100a	100a	100a	100a		60 - 250	ADC
Haloperidol	03/25/93	03/29/93	0.1 **L**		8		8							1 - 40	I
Haloperidol Decanoate	03/29/93	09/14/93	5.6 **H**		10	10	10	10	10	10	10	10		1 - 40	ADC
Haloperidol	10/05/93	10/19/93	0.5 **L**		4*		4	4*	4					1 - 40	I
Thiothixene	10/18/93	04/05/95	17.8 **H**		15a	10	5	5	5	5	5	10		6 - 60	ADC
Trifluoperazine	04/05/95	07/03/95	3 **H**		15a	15	10	15a	15a	15a	15a	15a		2 - 60	ADC
Trifluoperazine	08/02/95	09/29/95	1.9		10	10	10	10	10	10	10			2 - 60	ADC
Trifluoperazine	12/14/95	02/06/96	1.8		7a	7	5	7a	7a	7a				2 - 60	ADC
Risperidone	04/18/96	08/31/96	4.5 **H**		20a **H**	20 **H**	6	6	6	6	14a	20a		2 - 10	ADC
Risperidone	10/01/96	01/26/97	3.9 **H**		20a **H**	20 **H**	20a	20a	20a	20a	20a	20a		2 - 10	ADC
Risperidone	05/12/97	07/23/97	2.4		20a **H**	20 **H**	20a	20a	20a	20a	20a			2 - 10	ADC
Facility A	**12/29/97**	**present**	**81.2**												
Risperidone	12/29/97	11/27/99	23.3 **H**		20a **H**	20 **H**	20a	20a	20a	20a	20a	20a		2 - 10	ADC
Risperidone	04/17/00	06/15/00	2		5a	5	3	5a	5a	5a	5a			2 - 10	ADC
Risperidone	08/22/00	10/13/00	1.7		6	6	6	6	6	6				2 - 10	ADC
Risperidone	03/28/01	04/04/03	24.6 **H**		6	6	6	6	6	6	6	6		2 - 10	ADC
Olanzapine	06/26/01	07/13/01	0.6 **L**		15		15	15	15					5 - 20	I
Chlorpromazine	09/09/01	04/04/03	19.1 **H**		100 **L**	100 **L**	100	100	100	100	100	100		200 - 2000	I
Olanzapine	04/04/03	05/02/03	0.9		10	10	10	10	10	10				5 - 20	ADC
Quetiapine	05/03/03	07/16/03	2.5		50 **L**	50 **L**	50	50	50	50	50			150 - 750	I

Using PSYCKES to Support Consumer and Family Information Needs

- Little is known about medication information needs of consumers and families
- OMH Bureau of Recipient Affairs and Recipient Advisory Council have expressed support for PSYCKES as a potential decision aid for consumers
- What modifications might need to be made?

Goals

- Identify medication information needs of consumers and families
- Identify the strengths and weaknesses of existing PSYCKES reports in serving those needs
- Explore attitudes about the use of administrative data
- Identify strategies for providing access to PSYCKES data

Methods

- Focus groups held at 3 state psychiatric centers in the New York City area
- Participants:
  - 3 consumer groups: 8-11 per group
  - 3 family groups: 2-10 per group
- Transcripts analyzed using constant comparative methodology.

Results: Medication Information Needs

- Barriers to Medication Information
- Medication Information Needs
- Sources of Medication Information
- Medication Decisionmaking

Barriers to Medication Information

- Consumers are seen in multiple locations by multiple doctors.
  - Consumers generally lack detailed knowledge of past medications.
- Families can help but can be overwhelmed, especially at onset of illness.
  - Consent process is difficult to navigate.

Medication Information Needs

- Consumers and families want to know:
  - Medication names, dates, doses
  - Indications
  - Side effects
- Prefer multiple (oral and written) formats
- Medication education is a process that cannot be resolved in a single visit.
- Families need different information depending on stage of illness.

Sources of Medication Information

- Information resources include pharmacists, peers, doctors, family members, advertisements, and the Internet.
- Families value connection to community resources.

Medication Decisionmaking

- Gaps in histories contribute to suboptimal decisions.
- Side effects are a crucial aspect of medication experience and should be included in decisionmaking process.
- Adherence is more likely when the rationale of the medication is explained.

Results: Using PSYCKES to Support Information Needs

- Include in Advanced Directives and Wellness Plans
- Share with all treating physicians, including medical providers and hospital staff
- Use as educational tool prior to hospital discharge

Using PSYCKES to Support Information Needs

- Use an integrated, chronological format
- Include both brand and generic names
- Provide opportunities for consumers to add comments (e.g. side effects)

Results: Data sharing and access

- Interested in use of technology such as swipe cards and secure Websites in addition to paper reports
- Families concerned about possible misuse

For more information …

- Visit www.omh.state.ny.us/psyckes