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▶ Shared decision-making: increases autonomy in substance-dependent patients.

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An innovative Dutch study tested a way of involving substance users as equals in decisions over issues addressed in their treatment. The effect was to give these typically submissive personalities a greater sense of control over their lives. Just as influential was the lead offered by the clinician's personality.

Summary Drawing on motivational interviewing, 'shared decision-making' aims to facilitate collaboration between clinician and patient via a structured system for reaching joint decisions on goals and expectations for treatment. It is considered particularly appropriate for chronic illnesses whose management involves a wide range of decisions about changing one's lifestyle. The underlying aim is to even out the asymmetry in knowledge and power between doctors and patients by informing patients and promoting their sense of autonomy and/or control.

The study tested an intervention for addiction developed on shared decision-making principles. Specifically, patients and clinicians complete the Goals of Treatment Questionnaire. Derived from the Camberwell Assessment of Need, it lists 24 domains in which the patient may have problems. These include drinking and drug use, but also others such as physical and mental health, psychological distress, housing, eating, relationships, social life, and daytime activities. Patients tick indicating whether they definitely, possibly, or definitely do not want to work on each of these issues during treatment. Clinicians do the same, except that they indicate whether the patient should be encouraged to work on these issues. In the shared decision-making intervention, this is extended by ranking how important each issue is in relation to the others; 24 cards corresponding to the questionnaire's items are grouped into two piles duplicating the 'definite' and 'possible' choices, then within each pile sorted in order of importance and priority. During counselling patients and clinicians compare their choices, typically

generating dialogue over the feasibility and benefits of the various treatment goals and expectations.

For the study this shared decision-making intervention was spread over five sessions. In the first the patient completed their version of the goal selection and ranking exercise. A week later clinician and patient met again to compare this with the clinician's version, resulting in the negotiation of agreed goals formalised in a treatment contract. Halfway through treatment patients and clinicians repeated the selection and ranking exercise so that goals and expectations were reviewed and adapted to progress and needs at that stage. At the end of treatment (or if treatment had been prematurely terminated, at an exit interview) the goals and expectations in the treatment contract were reviewed, and new ones explored through a further goal selection and ranking exercise. Finally, three months after treatment had ended patient and clinician met again to review the goals and expectations agreed at the end of treatment and to evaluate the treatment and how well how the patient was doing.

How the study was conducted

These five sessions took place in the context of a three-month cognitive-behavioural inpatient programme for drug and/or alcohol dependent patients in need of further help after outpatient treatment. Clinicians at the three centres in the study may have used motivational interviewing and other ways of assessing patient needs and goals, but none used the kind of structured method tested by the study. The centres' 31 available clinicians (mainly social and nursing workers) joined the study, and were randomly allocated to carry on as usual or to be trained in and implement the shared decision-making intervention during counselling. They were allocated patients in the normal way, without respect to whether they were implementing the intervention, meaning that patients too were allocated to the intervention in a quasi-random manner. Nearly all those asked to join the study did so, resulting in 107 patients being treated by clinicians assigned to shared decision-making and 105 to treatment as usual. However, just 76 patients adequately completed all three sets of personality questionnaires (at the start of the study, end of treatment, and three months later) intended to assess the impact of the intervention. The study's findings are based on these patients, who as far as the researchers could tell were similar to the other patients. Typically they were men in their 30s and 40s with long-standing alcohol dependence and quite severe psychological or emotional problems.

Main findings

As intended, the structured shared decision-making process resulted in patients feeling more able to make their own decisions and more in control and (the opposite end of this dimension) less submissive. These assessments were made on the basis of a self-report personality survey and not specifically in relation to treatment, but life in general. Compared to where they had started, at the end of treatment and three months later these patients had moved further towards the autonomy/control end of this dimension than patients treated as usual, a statistically significant difference. Importantly though, they remained towards the 'friendly and cooperative' end of the other major personality dimension rather than asserting their control in an aggressive or competitive manner. However, the pattern of this friendly attitude changed differently for the two groups; patients engaged in shared decision-making had moved further towards being extravert,

open and sociable, while treatment-as-usual patients assessed as relatively more silent and reserved.

On both of the major personality dimensions, it also seemed that patients were drawn towards their clinician's way of relating. Regardless of the intervention, the greater the starting gap between the patient's submissiveness and the clinician's sense of being autonomous and in control, the further during treatment the patient moved towards also being assessed as autonomous and in control. Similarly, the greater the gap between the friendliness of the clinician and the relative lack of friendliness of the patient, the further along this dimension the patient moved towards also being assessed as friendly. Conversely, clinicians rated initially as relatively aggressive had patients who during treatment also moved towards being assessed as aggressive.

The authors' conclusions

For the authors the findings supported their theory that the shared decision-making intervention would lead patients to become more independent and more able to stand up for themselves, reflected in their greater movement towards feelings of autonomy, control and extraversion. These effects were additional to the tendency for patients whose personalities and interpersonal styles were at variance with those of their clinicians to move towards their clinicians' profiles over the course of treatment. The implication is that one task of addiction treatment – whose patients are typically relatively submissive – might be to teach patients to stand up for themselves better. Clinicians who embody this attribute foster such a change, as does engaging the patient systematically and comprehensively in treatment-related decisions over their lives. It must however be remembered that these results were derived only from a minority of patients. It may also be that simply expecting the intervention to facilitate patient autonomy was an active ingredient, a kind of placebo effect.

FINDINGS An earlier report from the same study assessed whether the intervention affected the patients' drinking and drugtaking and other problems and their quality of life. Unlike the featured report, it was based on all 212 patients, not the minority who completed all three personality assessments.

Among the many dimensions measured at the start of the study and repeated at the three month follow-up, only on two had shared decision-making patients improved significantly more – the severity of their psychological/emotional and their drug use problems. There was no significant differential impact on use of alcohol – the main substance used by most patients – nor on their primary substance use problem, or how many remained dependent. Neither was there on quality of life or problems related to health, family and employment, among the other issues assessed. On several of these dimensions – especially drink problems – shared decision-making patients had improved more, but too slightly and inconsistently to create a statistically significant difference.

Thanks for their comments on this entry Evelien Joosten of the Radboud University in The Netherlands. Commentators bear no responsibility for the text including the interpretations and any remaining errors.

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