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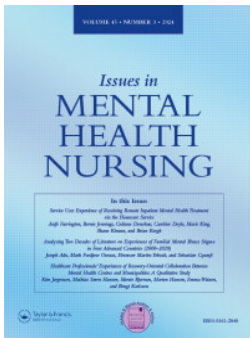
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This is the Published version of the following publication

Hormazábal-Salgado, Raúl, Whitehead, Dean, Osman, Abdi D and Hills, Danny (2024) Person-Centred Decision-Making in Mental Health: A Scoping Review. *Issues in Mental Health Nursing*, 45 (3). pp. 294-310. ISSN 0161-2840

The publisher's official version can be found at
<http://dx.doi.org/10.1080/01612840.2023.2288181>
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To cite this article: Raúl Hormazábal-Salgado, Dean Whitehead, Abdi D. Osman & Danny Hills (2024) Person-Centred Decision-Making in Mental Health: A Scoping Review, *Issues in Mental Health Nursing*, 45:3, 294-310, DOI: [10.1080/01612840.2023.2288181](https://doi.org/10.1080/01612840.2023.2288181)

To link to this article: <https://doi.org/10.1080/01612840.2023.2288181>



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Published online: 17 Jan 2024.



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Person-Centred Decision-Making in Mental Health: A Scoping Review

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ABSTRACT

Person-centred decision-making approaches in mental health care are crucial to safeguard the autonomy of the person. The use of these approaches, however, has not been fully explored beyond the clinical and policy aspects of shared and supported decision-making. The main goal is to identify and collate studies that have made an essential contribution to the understanding of shared, supported, and other decision-making approaches related to adult mental health care, and how person-centred decision-making approaches could be applied in clinical practice. A scoping review of peer-reviewed primary research was undertaken. A preliminary search and a main search were undertaken. For the main search, eight databases were explored in two rounds, between October and November 2022, and in September 2023, limited to primary research in English, Spanish or Portuguese published from October 2012 to August 2023. From a total of 12,285 studies retrieved, 21 studies were included. These research articles, which had mixed quality ratings, focused on therapeutic relationships and communication in decision-making (30%), patients' involvement in treatment decision-making (40%), and interventions for improving patients' decision-making engagement (30%). While there is promising evidence for shared decision-making in mental health care, it is important that healthcare providers use their communicational skills to enhance the therapeutic relationship and engage patients in the process. More high-quality research on supported decision-making strategies and their implementation in mental health services is also required.

Background

Decision-making is crucial in respecting the person's right to make their own decisions while supporting their accountability in the process. According to the World Health Organization, (2022), the ability to make decisions about one's own life, including the choice of one's own mental health care, is significant to a person's autonomy and personhood (Tonelli & Sullivan, 2019). The most currently discussed person-centred approaches for decision-making in mental health care are shared decision-making and supported decision-making (Simmons & Gooding, 2017).

Shared decision-making involves both the person and the mental health care provider. In shared decision-making, the person (often assisted by a member of their support network) brings expertise of their own personal values, goals, and preferences, while the health care provider contributes with their understanding of the health issue and available treatment options (Drake et al., 2009). Similarly, supported decision-making can help people make their own decisions about their mental health care while preserving their autonomy (World Health Organization, 2022). Supported

decision-making ensures support for people whenever they require it, including accessibility to advocates and the provision of relevant information (World Health Organization, 2021). The main difference is that in supported decision-making, the decision-maker is always the person with a mental health issue (World Health Organization, 2022). Both concepts, shared decision-making and supported decision-making, have begun to arise in mental health research, policy, and practice when discussing person-centred decision-making in mental health care (Simmons & Gooding, 2017). Although similar in meaning, the concepts have quite different origins (Simmons & Gooding, 2017). Shared decision-making arises from health care services and is related to treatment decision-making (Simmons & Gooding, 2017). Conversely, supported decision-making comes from the standpoint of human rights and disabilities, including persons with mental disorders (Simmons & Gooding, 2017). Although incorporating decision-making strategies into mental health care is a promising strategy, comprehensive research and targeted treatments must be conducted to help enhance mental health care (Wills & Holmes-Rovner, 2006).

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While the implementation of shared and supported decision-making in mental health services has been explored in the literature, the evidence-base remains limited (Davidson et al., 2015; Penzenstadler et al., 2020; Slade, 2017). The main areas related to supported decision-making implementation are in end-of-life care and intellectual and/or psychosocial disabilities (Davidson et al., 2015; Harding & Taşcıoğlu, 2018; Watson et al., 2017). Ethical and cultural challenges of decision-making implementation in mental health care have been identified, particularly about the tension between *rights-based* and *duty-based* frameworks related to patients and healthcare providers (Slade, 2017). The former framework refers mainly to respect of the patient's human right to autonomy, whereas the latter framework is rooted in the ethical principle of beneficence, leading clinicians to apply a therapeutic regime when patients have impaired decisional capacity (Slade, 2017). A similar imbalance exists in institutional settings where healthcare providers 'override' the decisional process without patient involvement (Slade, 2017).

Two searches were undertaken in this review, a preliminary search to explore the existing literature in the topic, and the main research to find relevant studies. The topic for the preliminary search was the same of the main search, that is, adult decision-making in mental health care. The preliminary search was conducted before the actual review by using the search terms included in the search strategy below. The first or exploratory search of Medline, PROSPERO, the Joanna Briggs Institute of Evidence Synthesis, and the Cochrane Database of Systematic Reviews showed several published reviews of the literature in shared decision-making. These studies have been mostly focused on the clinical outcomes of psychiatric disorders, such as anxiety and depression, health service outcomes, and patient knowledge/involvement (Aoki et al., 2022; Marshall et al., 2021). A further focus of supported decision-making reviews was the development and implementation of this approach in mental health services (Davidson et al., 2015; Penzenstadler et al., 2020). Notwithstanding that, this exploratory or preliminary search revealed no review contained both terms plus a description of the decision process in psychiatry. For this reason, the objective of this scoping review is to identify and collate studies that have made an essential contribution to the understanding of shared, supported, and other decision-making approaches related to adult mental health care, and how person-centred decision-making approaches could be applied in clinical practice. For example, some people might consider family support and personal preferences when making decisions about their mental health care. A scoping review has been conducted because this tool is suitable for determining the breadth or depth of a body of literature on a particular subject by providing a clear picture of the amount of literature and studies that were accessible and an overview (wide or comprehensive) of their main points (Munn et al., 2018). The research questions posited were, what are the primary aspects of shared, supported, and other person-centred descriptions of decision-making in mental health care? And what are the most effective strategies to implement decision-making approaches in mental health practice?

Methods

The Preferred Reporting Items for Systematic Review—Scoping Review (PRISMA-ScR) checklist served as the basis for conducting and reporting this scoping review (Tricco et al., 2018).

Inclusion and exclusion criteria

The key inclusion criteria were peer-reviewed literature of primary research published in English, Spanish or Portuguese relating to people aged 18 years and older, with mental illnesses and/or cognitive impairment, discussing two or more aspects of patient decision-making (e.g. pharmacologic treatment and family support), shared decision-making and/or supported decision-making in mental health care, aligned with patient-centred decision-making as stated by the author(s), and/or discussing at least one strategy of implementation of decision-making in mental health services.

Papers were excluded if they were literature reviews, letters to the editor, case studies and opinion letters. Research papers were also excluded if they were centred on caregiver decision-making on behalf of the individual, and/or other decision-making processes, such as clinical decision-making and surrogate decision-making, as both do not adhere to a person-centred decision-making approach.

Search strategy

The search method combined free text and Medical Subject Headings (MeSH) phrases. Databases searched for relevant and related literature were the Academic Search Complete, APA PsycArticles, APA PsycInfo, CINAHL Complete, MEDLINE, PubMed, Scopus, and Web of Science. The search was undertaken in two rounds, being the first conducted in November 2022 including only items published during the period of October 31, 2012, to October 31, 2022, limiting it to 10 years in consideration of changing evidence, policies, and legislation worldwide. The second search was conducted in September 2023 and encompassed the period between November 1, 2022, and August 31, 2023. The following search terms were applied: “decision-making” OR “decision making process” OR “shared decision making” OR “supported decision making” AND “mental health” OR “emotional health” OR “psychological health” AND adult* OR “middle aged” OR aged OR elderly AND implementation OR “implementation strategies” OR “implementation methods.”

The included citations were chosen for screening based on the title, abstract, and full text. Study records were managed in EndNote™ 20 (The EndNote Team, 2013). Study selection and data extraction were undertaken with the Covidence systematic review application online (Veritas Health Innovation, 2022). Data synthesis was conducted using thematic analysis, adopting an interpretative paradigm for interpreting the views of others through inductively organising study results into themes of related concepts (Braun, 2021). This scoping review did not require institutional ethical approval.

Separate title and abstract screening via Covidence were performed by two of the authors (author 1 and author 3), with author 2 mediating differences. After that, author 4 moderated the votes while author 1 and author 2 conducted full-text evaluations, after which the selected papers were extracted.

Figure 1 illustrates the process of article selection. Nine-thousand six hundred and ninety-five studies were initially eligible for inclusion, 8,301 of which were retained after removing 1,394 duplicates. After title and abstract screening, 8,213 records were excluded, leaving 88 studies for full-text screening. Upon exclusion of 62 studies, 26 were left for quality assessment.

Quality assessment

To ensure the quality of the studies, only scientific papers reported in peer-reviewed publications that had a pertinent sample for the phenomenon being examined and relevant study findings were retrieved. Before a decision was made regarding the inclusion of an article, two researchers read the whole text of each potential qualifying article. Discussions among the study team members were used to resolve disagreements. The selected papers were further assessed for quality using the Mixed Methods Appraisal Tool (MMAT), version 2018 (Hong et al., 2018), and The Joanna Briggs Institute (JBI) critical appraisal tools—namely the Checklist for Analytical Cross-Sectional Studies, Checklist for Cohort Studies, Checklist for Qualitative Research, Checklist for Randomised Controlled Trials, and Checklist for Quasi-Experimental Studies (Joanna Briggs Institute, 2022). To apply the checklists, the researchers determined acceptable classifications as a team, namely “good,” “fair” and “poor.” Studies with no more than one item being not present or unclear were classified as of good quality, studies with up to three unclear or not present items received a “fair” classification, and those with more than three items which were unclear or not present were classified as of “poor” quality. Disagreements in the quality assessment were solved within the research team. Based on the methodology of the study, fifteen of the included studies were given a “good” quality rating whilst six received a “fair” rating (Table 2). The ten studies that received a “poor” quality rating were excluded, leaving 21 papers for inclusion in the final data synthesis (Figure 1).

Data synthesis

Table 1 provides a summary of the key findings of the included articles. For each of the areas of interest, data was condensed, organised, and compared on variables and sample characteristics in a matrix. Two methods of data comparison, data analysis and data display, were used to find patterns and themes in the data such as (Whittemore & Knafl, 2005).

Results

The 21 included studies addressed three main themes—therapeutic relationships and communication in decision-making, patient involvement in treatment decision-making,

and interventions to improve patient decision-making engagement. Most studies (18) focused on shared decision-making and only one was focused on supported decision-making (Kokanović et al., 2018). The remaining four studies focused on informed decision-making and patient-centred decision-making (Hines et al., 2018), congruence in decision-making preferences regarding compulsory hospital admission (Morán-Sánchez et al., 2020), and treatment decision-making (Myers et al., 2019; Thomas et al., 2022). Seven studies were conducted in the USA, three studies in the United Kingdom, two studies each in Norway, Spain, and Germany, and one study each in Australia, Ethiopia, Japan, Sweden, and Switzerland. Twelve studies were qualitative, eight were quantitative and one was a mixed-design study.

Therapeutic relationship and communication in decision-making

Six of the included papers stressed the significance of dialogue and the therapeutic alliance for patient decision-making. Five papers were focused on shared decision-making and supported decision-making was the focus of only one study (Kokanović et al., 2018). A greater consumer-provided relationship, or the relationship between the patient and the healthcare professional, can be achieved by adopting a shared decision-making approach, with a higher level of patient involvement (Matthias et al., 2014). The length of the therapeutic relationship is important because longer relationships between the patient and healthcare provider lead patients to feel more comfortable in processes such as expressing disagreement (Matthias et al., 2014). The extent of patient involvement in shared decision-making discussions also depends on factors like the personal initiative of the patients to be engaged in the process, and the communication style of health care professionals (Gurtner et al., 2022). The best communication style to promote shared decision-making in a psychiatric inpatient setting is bidirectional, allowing the patient to express their concerns and questions while getting feedback from the professionals (Gurtner et al., 2022).

According to Haugom et al., (2022), the main obstacles to shared decision-making were the reluctance of health professionals to offer patients their expected level of involvement and insufficient information about the course of their illness and treatment options. For psychiatric patients admitted into hospital involuntarily, communication issues between them and their physicians were found to be the main obstacles to shared decision-making, as well as the busy and noisy clinical ward environment where these interactions take place (Giacco et al., 2018). In this context, the ability of the healthcare provider is critical to foster a conversation characterised by trust, respect, clear guidance, and equality while involving family, partners, or friends, thus helping patients express their needs (Grim et al., 2016).

Similarly, there are further barriers and facilitators related to implementing supported decision-making (Kokanović et al., 2018). The main barriers were patient perceptions of

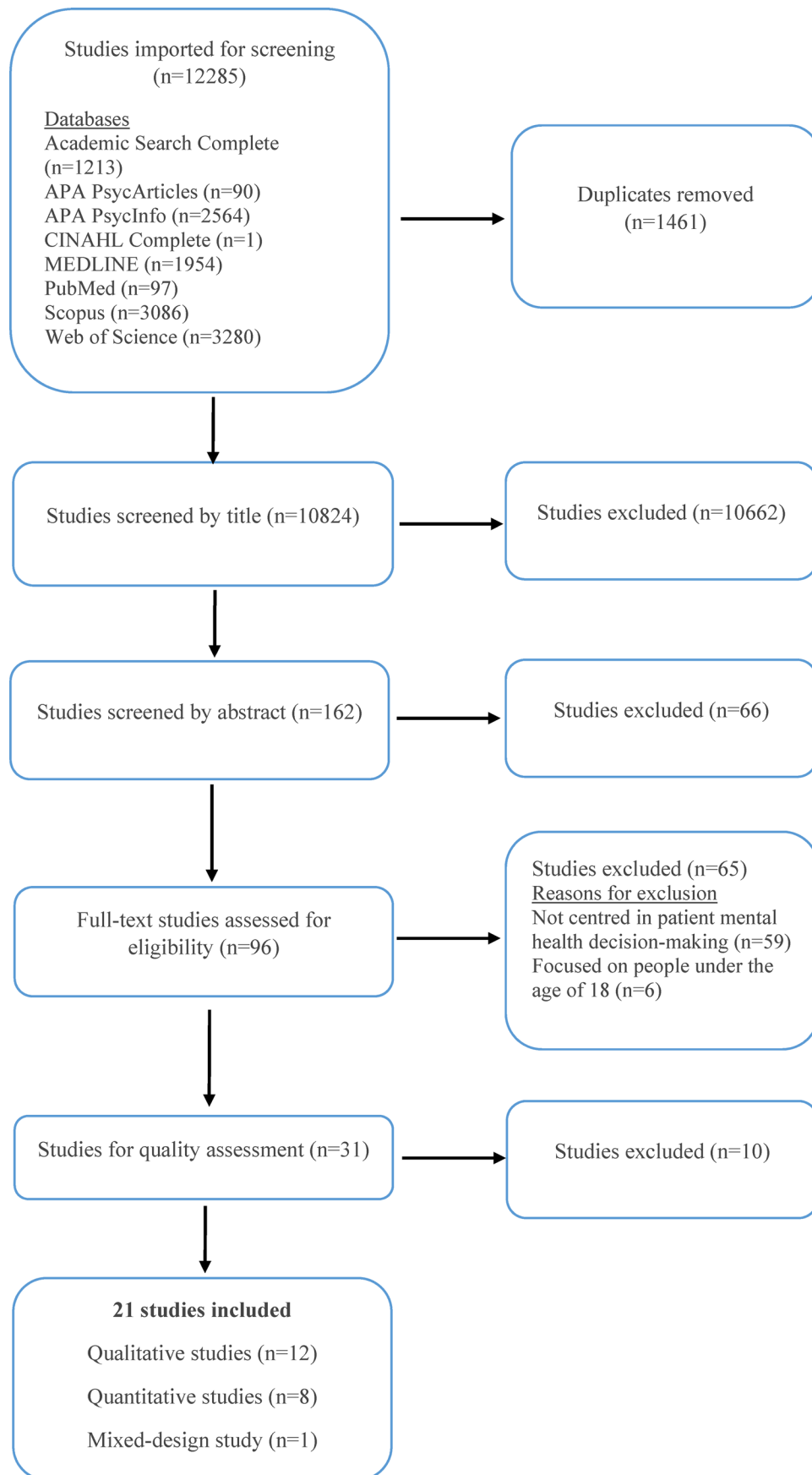


Figure 1. Screening flow chart.

impersonal interactions with mental health practitioners, impersonal care structures, long wait periods for appointments, stigma from professionals, and the erroneous assumption of patient incapacity in decision-making (Kokanović et al., 2018). Effective communication skills and empathic relationships with health care professionals were facilitators for implementing supported decision-making (Kokanović et al., 2018).

Patient involvement in treatment decision-making

The involvement of patients in treatment decision-making was the subject of nine of the included studies, seven of which are focused on shared decision-making, one explored informed decision-making and patient-centred decision-making (Hines et al., 2018) and one was focused on treatment decision-making (Myers et al., 2019). Engagement and active participation of the patient during the consultation with their psychiatrist is central for successful shared decision-making (Hamann et al., 2016). Additionally, respect and politeness, openness, and trust with their psychiatrist, gathering information and preparing for the consultation besides informing the psychiatrist and giving feedback are crucial (Hamann et al., 2016). Matthias et al., (2012) present a typology to comprehend effective decision-making for people with mental illnesses and mental health professionals, and whether this process meets the criteria for shared decision-making. Their findings reveal that the process fails to meet these criteria because patient preferences were not considered in the final decisional outcome, even though both patients and health care providers often come to a resolution together when discussing an aspect of treatment (Matthias et al., 2012). Abate et al., (2023) carried out an explanatory sequential mixed method study in a sample of 423 patients with mental illness, finding that nearly half of participants had low level of shared decision-making involvement during psychiatric treatment. Low shared decision-making was associated to several barriers such as poor social support, no community-based health insurance, and poor perceived compassionate care (Abate et al., 2023). Moreover, patients manifested concerns related to service quality, psychosocial factors like social support, and human resources (Abate et al., 2023). As a result of the low involvement, patients felt that in spite of having the knowledge to actively participate in shared decision-making, they were not always given the chance to do so, feeling that their opinions were neglected, and their autonomy invalidated (Sather et al., 2019). In this context, an individual care plan was seen as an important mechanism to alleviate and overcome the power imbalance between practitioners and patients (Sather et al., 2019).

Similar findings were described by Hines et al., (2018), who conducted a cross-sectional study centred on informed decision-making and patient-centred decision-making, with a sample of 76 African-American participants. The authors found that only 9% of treatment choices for depression satisfied fundamental criteria for informed decision-making, meaning that the process was not person-centred (Hines

et al., 2018). Risks and benefits were only presented in less than one of every six decisions, even though the nature of the decision was always discussed, and treatment alternatives were reviewed half of the time (Hines et al., 2018).

Different degrees of involvement in shared decision-making were preferred by patients (Mundal et al., 2021; Park et al., 2014). Park et al., (2014) assessed shared decision-making preferences in mental health treatment in a sample of 239 veterans diagnosed with a serious mental illness, finding that most patients preferred to be offered options and to be asked their opinions about treatment. More than half of patients preferred a passive role in decision-making by relying on their providers' knowledge, letting their providers make final treatment decisions (Park et al., 2014). Greater preferences for participation have been found among African Americans, patients receiving an income for their work, with a college degree or higher education, with a diagnosis other than schizophrenia, and with a poorer therapeutic relationship with their prescribers (Park et al., 2014). Similarly, the preferences in decision-making varied according to gender, age group and educational level, with some groups of patients showing reluctance to accept pharmacological treatment whereas others remained unconcerned (Mundal et al., 2021). Young and middle-aged men tended to feel in control of their disease compared with older women who attributed the control of their disease to their psychiatrists (Mundal et al., 2021).

The involuntary use of mental health services in the context of patient involvement in shared decision-making has been explored by Morán-Sánchez et al., (2020). The authors carried out a cross-sectional study, including 107 outpatients diagnosed with schizophrenia and bipolar disorder, and a history of compulsory admission (Morán-Sánchez et al., 2020). They assessed congruence in decision-making experience and preferred style by using a control preference scale, finding that respecting the wishes of the person in decision-making is important in preventing compulsory admission (Morán-Sánchez et al., 2020).

Myers et al., (2019) focused on factors that shaped treatment decision-making in young adults after an initial hospitalisation for psychosis, finding that a difficulty for patient involvement in decision-making was their multiple mental health-related concerns. Their main concerns were getting back to normal, insufficient mental health care on offer, police involvement in their pathway to care, feeling worse, and needing help with navigating strained relationships (Myers et al., 2019). Further concerns were independence in the future, paying for mental health care, distrusting mental health diagnoses, managing social pressure to use substances, and feeling disempowered by hospitalisation experiences (Myers et al., 2019).

Interventions for improving patient decision-making engagement

Interventions to enhance patient decision-making in mental health care were the focus of six of the included studies, with five focused on shared decision-making and one on treatment

Table 1. Summary of the characteristics of the selected studies.

No.	Author(s), year	Country	Article title	Journal, volume, and issue	Design and purpose	Sample	Methods	Findings	Limitations
1	Giacco et al., 2018	United Kingdom	Shared decision-making with involuntary hospital patients: a qualitative study of barriers and facilitators.	BJPsych Open, 4(3).	Qualitative. To identify barriers and facilitators to shared decision-making with involuntary patients.	Focus groups: 24 patients, six of which required an interpreter (mean age = 38.4) and 16 clinicians. Individual interviews: six patients with interpreter (mean age = 37.7).	Randomised sampling of patients to preserve anonymity. Four focus groups and six individual interviews. Thematic analysis.	Obstacles for decision-making: Communication issues between patients and physicians. The busy and noisy environment of wards.	Recruitment limited to a specific area, East London. Sample based on ethnicity was not carried out. The main methodology used was focus groups, which may be less sensitive to individual experiences.
2	Grim et al., 2016	Sweden	Shared decision-making in mental health care—A user perspective on decisional needs in community-based services.	International Journal of Qualitative Studies on Health and Well-being, 11.	Qualitative descriptive. To investigate decisional and information needs among patients with mental illness as a prerequisite for the development of a decision support tool aimed at supporting shared decision-making in community-based mental health services in Sweden.	Twenty-two adult patients with mental illness aged 24 to 62 years old.	Three semi-structured focus group interviews. Directed content analysis of the interviews.	Inductive and deductive approach. Fostering decision-making: Conversations with healthcare provider characterised by trust, sincere interest, respect, clear guidance and equality. Involving family, partners, or friends during provider encounters. Early information sharing. Scheduled a follow-up and reviewed a visit.	Findings limited because of the small number of respondents. The needs of patients of community based mental health services are not totally represented.
3	Gurtner et al., 2022	Switzerland	Shared Decision Making in the Psychiatric Inpatient Setting: An Ethnographic Study about Interprofessional Psychiatric Consultations	International Journal of Environmental Research and Public Health, 19(6).	Qualitative, ethnographic study. To gain a better understanding of how psychiatric inpatients and the interprofessional care team interact during regular interprofessional psychiatric consultations.	Participants included patients and healthcare providers. Seventy-one interprofessional psychiatric consultations that differed in context (place and form) and culture (way of interacting).	Participant observation using a structured observation protocol. Conversations with the participants. Field notes.	The extent to which patients are involved in the discussion and decision making depended on individual factors: The communication style of health care professionals. The personal initiative of the patients to be engaged.	The ethnographic approach could also have biased the actions of both the health care professionals and the patients.
4	Haugom et al., 2022	Norway	Experiences of shared decision making among patients with psychotic disorders in Norway: a qualitative study.	BMC Psychiatry, 22(1).	Qualitative descriptive exploratory. To describe and explore experiences of shared decision-making among patients with psychotic disorders in mental health care.	Ten community mental health centres with a psychiatric disorder whose ages ranged between 32 to 72 years, mean age = 53 years.	Inductive approach: Individual interviews. Transcription of the interviews. Qualitative content analysis.	Obstacles for decision-making: Insufficient information about patients' health situation and treatment options. Reluctance from health professionals to give patients the level of involvement they would like.	Transcripts not returned to the participants for comments and/or corrections. Participants did not provide feedback on the findings. Study conducted in a limited geographical area may only represent local practices. Half of the participants mainly received care and treatment from their psychiatrist. All interviewees were treated at a community mental health centre that implemented evidence based antipsychotic medications.

(Continued)

Table 1. Continued.

No.	Author(s), year	Country	Article title	Journal, volume, and issue	Design and purpose	Sample	Methods	Findings	Limitations
5	Kokanović et al., 2018	Australia	Supported decision-making from the perspectives of mental health service users, family members supporting them and mental health practitioners.	The Australian and New Zealand journal of psychiatry, 52(9).	Qualitative. To explore from several perspectives the barriers and facilitators to supported decision-making in an Australian context.	Twenty-nine mental health patients (aged between 18 to 65 years old) who were mostly female, aged over 40 years. Twenty-nine family members supporting them and 32 mental health practitioners, including psychiatrists.	Narrative interviews. Thematic analysis.	Communication skills from professionals and empathic relationships with health care professionals foster decision-making. Barriers for decision-making: Perception of impersonal interactions. Long wait periods for appointments. Impersonal care structures. Stigma, with the assumption of decision-making incapacity.	Possible sampling bias because participants opted in. Supported decision-making is an emerging practice and participants had difficulty in drawing on current experience.
6	Matthias et al., 2014	The United States	Consumer and Relationship Factors Associated With Shared Decision Making in Mental Health Consultations	Psychiatric Services, 65.	Cross-sectional. To explore the association between shared decision making and consumers' illness management skills and consumer provider relationships.	79 consumers were audio recorded. Consumers' ages ranged from 23 to 71 years (mean age = 53 years).	Audio recording of medication management appointments. Independent coding. Correlation analyses.	Adopting a shared decision-making approach could lead to a greater consumer-provider bond. A high level of shared decision-making is associated with a higher likelihood of taking medications as prescribed. Agreement was associated to shorter consumer-provider relationships, because longer relationships might lead participants to feel more comfortable expressing disagreement rather than keeping silent.	Only three providers were included, limiting the analysis of relevant factors like gender, years of experience and attitudes. Causality cannot be established due the cross-sectional nature of this study. The exclusion of consumers with symptom exacerbations may have limited the ability to examine a wider range of decision-making. Study conducted at a single setting.
7	Abate et al., 2023	Ethiopia	Patient's involvement in treatment decision-making Level of shared decision making and associated factors among patients with mental illness in Northwest Ethiopia: Explanatory sequential mixed method study	PLoS one, 18(4).	Explanatory sequential mixed method study. To examine the level and factors associated with shared decision-making practice in Ethiopia.	Quantitative data: 423 patients from two specialised hospitals providing mental health services. Qualitative data: 10 participants were selected purposively for the in-depth interview. (Mean age = 33.02 years).	Quantitative data: Descriptive statistics analysis. Multivariate logistic regression. Qualitative data: Interviews. Thematic analysis. Triangulation with quantitative data.	Nearly half of participant's had low level of shared decision-making involvement during treatment. Low shared decision-making was associated to poor perceived compassionate care, no community-based health insurance, and poor social support. From the patients, there are concerns related to service quality, psychosocial, and human resources.	Findings might be prone to a response bias due to the patients' self-report. The questionnaire has some sensitive issues, which may suffer from social desirability. Patients who had admitted in inpatient and Emergency psychiatry ward were not included.

(Continued)

Table 1. Continued.

No.	Author(s), year	Country	Article title	Journal, volume, and issue	Design and purpose	Sample	Methods	Findings	Limitations
8	Hamann et al., 2016	Germany	What can patients do to facilitate shared decision making? A qualitative study of patients with depression or schizophrenia and psychiatrists	Social Psychiatry and Psychiatric Epidemiology, 51.	Qualitative. To explore both patients' and psychiatrists' views on how patients can facilitate shared decision making in acute mental health settings.	Seven focus groups were conducted: 3 with psychiatrists and 4 with patients with schizophrenia or depression (mean age = 41.8 years).	Seven focus groups. Independent transcription and coding by two researchers. Data analysed using content analysis.	The main factors involved in decision-making are: Honesty and openness with one's psychiatrist and oneself. Trust in one's psychiatrist and patience with the treatment. Respect and politeness. Informing the psychiatrist and giving feedback. Engagement/ active participation during the consultation. Gathering information/preparing for the consultation. Implementing decisions. Multiple Barriers (e.g. avolition, lack of decisional capacity, powerlessness during involuntary treatment). Only 9% of the treatment choices for depression have satisfied the criteria for informed decision-making. Risks and benefits were only presented in less than 1 in 6 observed decisions. Clinicians are aware of the significance of the patients' social context.	Relatively small sample size. The inclusion of rather ill and chronic patients. Thinking about the shared decision-making requires abstraction, which may be affected in some of the interviewed patients.
9	Hines et al., 2018	The United States	Informed and patient-centred decision-making in the primary care visits of African Americans with depression.	Patient Education and Counselling, 101(2).	Cross-sectional analysis from secondary data. To examine the prevalence and extent of informed decision-making and patient-centred decision-making in primary care visits of African Americans with depression.	Seventy-six African American research participants, mean age = 47.3 years.	Analysis of audiotaped clinical encounters and post-visit surveys. Patient-centredness of visit dialogue was characterised.	The small sample size limits the reliability of the estimates. Participants may differ from those who chose not to participate. A single geographical region was included, and the results may not be generalisable to other regions. Patients interviewed up to two weeks after the clinical encounter. Most participants were members of a support program and received person-centred care before the study. Only one visit per participant was observed. Interviewing both parties involved in the conversation was not possible. The development of the relationship over time could not be analysed. Findings were not intended to be generalisable.	
10	Matthias et al., 2012	The United States	Decision Making in Recovery-Oriented Mental Health Care.	Psychiatric rehabilitation journal, 35(4).	Qualitative observational. To explore how consumers and providers make decisions in medication management consultations (shared decision-making).	Four providers and 40 consumers with severe mental illness (10 consumers per provider) from a community mental health centre (mean age = 43.5 years).	Observations were audio-taped and transcribed. Thematic Analysis.	Consumers' preferences are not considered in the final choice. Outright disagreement led to a better representation of the consumer's preference in the final decision.	

(Continued)

Table 1. Continued.

No.	Author(s), year	Country	Article title	Journal, volume, and issue	Design and purpose	Sample	Methods	Findings	Limitations
11	Morán-Sánchez et al., 2020	Spain	Compulsory admissions and preferences in decision-making in patients with psychotic and bipolar disorders	Social Psychiatry and Psychiatric Epidemiology, 55(5).	Cross-sectional. To explore the relationship between compulsory admissions and congruence in decision-making preferences in mental health settings.	One-hundred and seven outpatients with diagnoses of schizophrenia or bipolar disorder with a history of compulsory admissions (mean age = 48.04 years).	Participants used the Control Preference Scale to assess congruence in decision-making experienced and preferred style. Descriptive statistics and multivariate analyses.	Patients a history of compulsory incorporation of their preferences in decisional outcomes. Predictors of compulsory admission are: Unmatched participation preferences in shared decision-making. Having a regular psychiatrist. The severity of the psychiatric condition.	Research carried out in an urban setting with a small number of patients; limiting generalisation. Some predictors of compulsory admission might have not been included. Decisional conflict measured with a self-report questionnaire.
12	Mundal et al., 2021	Spain	Exploring patterns in psychiatric outpatients' preferences for involvement in decision-making: a latent class analysis approach	BMC Psychiatry, 21(133).	Cross-sectional. To identify different latent class typologies of patient preferences for involvement in the shared decision-making process, and to investigate how patient characteristics predict these typologies in mental healthcare settings.	Three-hundred psychiatric outpatients aged 18 years and older, treated in two outpatient healthcare departments (mean age = 44.4 years).	Administration of questionnaires. Latent class analysis (LCA). Descriptive statistics.	Preference typologies varied according to gender, age group and educational level. Some groups showed reluctance to accept pharmacological treatment whereas others remained unconcerned. Young and middle-aged men tended to feel that they were in control of their disease contrasted by older women who attributed the control of their disease to their psychiatrists.	Results must be interpreted cautiously due to the cross-sectional nature of the study. Small patient samples. A convenience sample was used, limiting the generalisability of the findings. Information of those who refused to participate was not collected.
13	Myers et al., 2019	The United States	Decision Making About Pathways Through Care for Racially and Ethnically Diverse Young Adults With Early Psychosis	Psychiatric Services, 70(3).	Qualitative (Prospective longitudinal ethnographic). To elicit factors that shaped treatment decision making for young adults and their key supporters after an initial hospitalisation for psychosis to generate hypotheses about how to improve service engagement.	Eighteen young adults primarily from racial-ethnic minority groups and 19 of their self-identified key supporters (n=37) as they made decisions about treatment (mean age = 21.9 years).	Home visits, interviews, and hospital-based fieldwork during the 12-week critical period after an initial hospitalisation for psychosis. Analysis conducted through inductive coding and constructivist grounded theory methods.	The main concerns were getting back to normal, the insufficient mental health care on offer, police involvement in their pathway to care, feeling worse, and needing help with repairing strained relationships. Further concerns were independent life in the future, paying for mental health care, distrusting mental health diagnoses, managing social pressure to use substances, feeling disempowered by hospitalisation experiences, and managing transportation challenges.	Difficulty retaining participants. Small sample size.

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Table 1. Continued.

Author(s), year	Country	Article title	Journal, volume, and issue	Design and purpose	Sample	Methods	Findings	Limitations
14 Park et al., 2014	The United States	Factors Associated with Shared Decision-Making Preferences Among Veterans With Serious Mental Illness	Psychiatric Services, 65(12).	Cross-sectional analysis (secondary analysis). To evaluate preferences for shared decision making with respect to mental health treatment in a sample of veterans who were diagnosed as having serious mental illness.	Two-hundred and thirty-nine outpatients aged between 18 and 70 years old, receiving care from the Department of Veterans Affairs (mean age = 54.3 years).	Completion of a self-reported questionnaire. Analysis through multivariate linear regression.	Most participants preferred to be offered options and to be asked their opinions about mental health treatment. More than half of participants preferred to rely on their providers' knowledge and let treatment decisions. Greater preferences for participation were found among those: African American clients. Working for pay. College or higher education. Other than a schizophrenia spectrum diagnosis. Poorer therapeutic relationship with their prescribers.	Sample composed mostly of older men. Only participants receiving a second-generation antipsychotic were considered. Data about the length of time that participants had been seeing their provider was not available for analysis. The assessment of participation in shared decision-making has not been validated in a psychiatric setting. Unclear degree of representation of shared decision-making due to the self-reported data. Replication is necessary to confirm the study findings due to the exploratory nature of the study.
15 Sather et al., 2019	Norway	Patients' perspectives on care pathways and informed shared decision making in the transition between psychiatric hospitalisation and the community	Journal of Evaluation in Clinical Practice, 25.	Qualitative descriptive. To explore former patients' views of pathways in transition between district psychiatric hospital centres and community mental health services.	Ten informants, three men and seven women with a mean age at 40 years, from five different communities.	Three focus group interviews. Transcription and analyses of findings. Thematic analysis.	Participants feel they have the knowledge to actively participate in decision-making, but they are not always given the chance to be more active. Individuals see their opinions are neglected, invalidating their autonomy. An individual care plan is seen as important to switch the power imbalance between practitioners and patients.	The findings are non-generalisable because the focus was the health planning system in a region of Norway. Small sample size.
16 Alegria et al., 2018	The United States	Interventions for improving patients' decision-making involvement: Effectiveness of the DECIDE Interventions on Shared Decision Making and Perceived Quality of Care in Behavioural Health Patients with Multicultural Patients. A Randomised Clinical Trial.	JAMA Psychiatry, 75(4).	Cross-level 2 × 2 randomised clinical trial. To test the effectiveness of patient and clinician interventions to improve SDM and quality of care among an ethnically/racially diverse sample.	Seventy-four clinicians at level 2 and 312 patients (nested within clinicians) at level 1 from 13 Massachusetts behavioural health clinics. 49% aged between 18-34 5% aged 65 and older	Random selection of participants. Intervention: six coaching telephone calls to promote communication and therapeutic alliance. Assessment by a blinded coder.	An intervention is effective to improve shared decision-making when the patient and clinician have different primary languages.	Causality cannot be established with cross-sectional data. Low intervention participation rate of clinicians. Assessment of multiple measures of shared decision-making and testing both interventions simultaneously.

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Table 1. Continued.

No.	Author(s), year	Country	Article title	Journal, volume, and issue	Design and purpose	Sample	Methods	Findings	Limitations
17	Aoki et al., 2019	Japan	Psychiatric outpatients' shared experiences with decision-making: a qualitative descriptive study	Journal of Communication in Healthcare, 12(2).	Qualitative. To explore patients' experiences of a shared decision-making program developed for psychiatric outpatients who faced new treatment decisions.	Ten psychiatric outpatients aged 25–72 years with a range of psychiatric conditions (e.g. bipolar disorder, depression).	Individual semi-structured interviews. Thematic analysis.	Anticipatory anxiety and becoming involved in decision-making in the first consultation. Less decisional conflict with the psychiatrist after the second consultation. Facing mental illness, involving others, and deepening knowledge are relevant while at home.	Small sample size with restricted recruitment. Findings not generalisable to other populations. Control groups were not incorporated due to the qualitative nature of the analysis.
18	Farrelly et al., 2016	United Kingdom	Barriers to shared decision making in mental health care: qualitative study of the Joint Crisis Plan for psychosis	Health Expectations, 19.	Qualitative. To understand how stakeholders perceived the intervention and the barriers to shared decision-making in the form of a joint crisis plan.	Fifty service users (mean age = 39 years) with psychotic disorders and 45 clinicians.	Focus group and interviews. Analyses through grounded theory methods.	The main barriers for shared decision-making are ambivalence about care planning, perceptions that shared decision-making was already done, concerns of clinicians about the appropriateness of patients' choices, and limited availability of choices. The intervention of a joint crisis plan effectively addressed these barriers.	Limitations not reported by the authors.
19	Hamann et al., 2020	Germany	Implementing shared decision-making on acute psychiatric wards: a cluster-randomised trial with inpatients suffering from schizophrenia (SDM-PLUS).	Epidemiology and Psychiatric Sciences, 29.	Randomised clinical trial. To examine whether shared decision-making (SDM) is facilitated by an approach which is specifically adapted to the needs of acutely ill patients (SDM-PLUS).	A total of 257 patients from 12 acute psychiatric wards of five psychiatric hospitals.	Participants were recruited at their admission. Treatment teams and patients of intervention wards were trained. Staff and patients of the control wards continued in usual conditions.	The SDM-PLUS approach led to higher perceived involvement in decision-making. Intervention group patients showed better therapeutic alliance, treatment satisfaction and self-rated medication compliance. The adoption of behavioural approaches (e.g. motivational interviewing) for SDM may yield a successful application to mental health.	Potential bias of the results due to lower participation of patients in the intervention group. Unknown extent to which the proposed strategies were implemented by health care staff. Low number of questionnaires returned by patients during follow-up.
20	Lovell et al., 2018	United Kingdom	Embedding shared decision-making in the care of patients with severe and enduring mental health problems: The EQUIP pragmatic cluster randomised trial	PLoS ONE, 13(8).	Randomised clinical trial. To test whether we could deliver a practical and feasible intervention in routine community mental health services to embed shared decision-making for patients with severe mental illness, by improving patient and carer involvement in care planning.	A total of 604 patients and 90 carers.	Cluster randomised community mental health teams to the training intervention or usual care. Primary and secondary outcomes were collected by self-report, six months after allocation. Analysis completed using Stata 13.	Results showed no statistically significant difference in the primary outcome between the intervention and usual care at 6 months. Significant effects on only one secondary outcome, service satisfaction, were found. The intervention had no significant effects on patient perceptions of autonomy support, or other outcomes.	The volunteer sites may not be fully representative of the general population. Measures of service use and contact with professionals were based on self-report. It is possible that telephone administration of follow-up assessments might impact on patient responses.

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Table 1. Continued.

No.	Author(s), year	Country	Article title	Journal, volume, and issue	Design and purpose	Sample	Methods	Findings	Limitations
21	Thomas et al., 2022	The United States	Treatment decision-making needs among emerging adults with early psychosis	Early Intervention in Psychiatry, 16.	Qualitative. To identify the range of treatment decisions that emerging adults face during their initial engagement in an early intervention in psychosis program and elucidate barriers and facilitators to decision-making.	Twenty emerging adults with early psychosis (mean age = 20.20 years). They were interviewed during the first six months after enrolment in an early intervention in psychosis program.	Semi structured interviews. Integrated thematic analysis approach. Data analysis facilitated by NVivo 12 Plus.	Emerging adults in an early intervention in psychosis program may benefit from interventions designed to reduce decisional conflict. Decisions pertaining to life and treatment goals and to starting and continuing psychiatric medication were selected as the most difficult/complicated. Decision-making barriers included: not having the right amount or type of information/knowledge Social factors Lacking internal resources Unappealing options. Facilitators are obtaining information/knowledge, social supports, considering personal values, and time were decision-making facilitators.	Relatively homogeneous participant demographic makeup limits generalisability. Adults with barriers to autonomous decision making and those who chose not to enrol into the program were not included. Interview probe questions may have artificially inflated the frequencies of reported decision points, barriers and facilitators.

decision-making (Thomas et al., 2022). Aoki et al., (2019) examined the experiences of 10 psychiatric outpatients of a three-stage shared decision-making intervention including first consultation, decision aid review at home, and second consultation. Patients described anticipatory anxiety to becoming involved in decision-making in the first consultation, shifting towards less decisional conflict and a more active involvement after the second consultation (Aoki et al., 2019). While at home, patients were able to access the information from the decision aids, giving them time to consider their options carefully and involving others (Aoki et al., 2019). Hamann et al., (2020) conducted a cluster-randomised trial to examine if the approach called SDM-PLUS facilitated shared decision-making in acutely-ill psychiatric patients in inpatient settings. The results show that this approach led to higher perceived involvement in decision-making with a better therapeutic alliance and treatment satisfaction (Hamann et al., 2020). Therefore, the adoption of behavioural approaches like motivational interviewing for shared decision-making could be successful (Hamann et al., 2020). Conversely, the cluster randomised trial of Lovell et al., (2018) showed that a shared decision-making intervention for community mental health services had no significant effects on patient perceptions of autonomy support, or other primary outcomes at six months of the intervention. The authors found significant effects on only one secondary outcome, and service satisfaction (Lovell et al., 2018).

Interventions should address the main barriers and facilitators for successful patient engagement in treatment decision-making (Thomas et al., 2022) and shared decision-making (Alegria et al., 2018; Farrelly et al., 2016). Adults in an early intervention psychosis program, for instance, may benefit from interventions designed to reduce decisional conflict, and decisions pertaining to treatment goals and life outcomes (Thomas et al., 2022). Interventions should address patient needs for a successful decision-making involvement, specifically facilitators and barriers (Thomas et al., 2022). Facilitators are obtaining information or knowledge, personal values being considered, time for decision-making and social support (Thomas et al., 2022). The main barriers were lack of internal resources, social factors, unappealing options, and insufficient information or knowledge about the available options (Thomas et al., 2022). For shared decision-making, further barriers were perceptions that shared decision-making was already done, ambivalence about care planning, limited availability of choices, and concerns of clinicians about the appropriateness of patient's choices (Farrelly et al., 2016). In this context, an intervention of a joint crisis plan effectively addressed these barriers (Farrelly et al., 2016). Given that different cultural backgrounds between patients and clinicians can be a barrier for decision-making, a clinical intervention targeting a culturally diverse sample population can improve shared decision-making (Alegria et al., 2018). This shared decision-making intervention, focused on identifying resources, asking questions and communicating preferences, can be effective when the patient and clinician have different primary languages (Alegria et al., 2018).

Table 2. Quality assessment of each article.

No	Authors and year of publication	Type of study design	Quality assessment tool	Rated quality
1	Abate et al., 2023	Explanatory sequential mixed method study	Mixed Methods Appraisal Tool (MMAT), version 2018	Good
2	Alegria et al., 2018	Randomised clinical trial	JBI Critical Appraisal Checklist for randomised control trials (CACRCT)	Good
3	Aoki et al., 2019	Qualitative	JBI Critical Appraisal Checklist for qualitative research (CACQR)	Good
4	Farrelly et al., 2016	Qualitative	JBI Critical Appraisal Checklist for qualitative research (CACQR)	Fair
5	Giacco et al., 2018	Qualitative	JBI Critical Appraisal Checklist for qualitative research (CACQR)	Good
6	Grim et al., 2016	Qualitative	JBI Critical Appraisal Checklist for qualitative research (CACQR)	Good
7	Gurtner et al., 2022	Qualitative, ethnographic study	JBI Critical Appraisal Checklist for qualitative research (CACQR)	Good
8	Hamann et al., 2016	Qualitative	JBI Critical Appraisal Checklist for qualitative research (CACQR)	Good
9	Hamann et al., 2020	Randomised clinical trial	JBI Critical Appraisal Checklist for randomised control trials (CACRCT)	Good
10	Haugom et al., 2022	Qualitative descriptive exploratory	JBI Critical Appraisal Checklist for qualitative research (CACQR)	Good
11	Hines et al., 2018	Cross-sectional analysis from secondary data	JBI Critical Appraisal Checklist for analytical cross-sectional studies (CACACS)	Fair
12	Kokanović et al., 2018	Qualitative	JBI Critical Appraisal Checklist for qualitative research (CACQR)	Good
13	Lovell et al., 2018	Randomised clinical trial	JBI Critical Appraisal Checklist for randomised control trials (CACRCT)	Good
14	Matthias et al., 2012	Qualitative observational	JBI Critical Appraisal Checklist for qualitative research (CACQR)	Good
15	Matthias et al., 2014	Cross-sectional	JBI Critical Appraisal Checklist for analytical cross-sectional studies (CACACS)	Fair
16	Morán-Sánchez et al., 2020	Cross-sectional	JBI Critical Appraisal Checklist for analytical cross-sectional studies (CACACS)	Fair
17	Mundal et al., 2021	Cross-sectional	JBI Critical Appraisal Checklist for analytical cross-sectional studies (CACACS)	Fair
18	Myers et al., 2019	Qualitative	JBI Critical Appraisal Checklist for qualitative research (CACQR)	Fair
19	Park et al., 2014	Cross-sectional survey (secondary analysis)	JBI Critical Appraisal Checklist for analytical cross-sectional studies (CACACS)	Fair
20	Sather et al., 2019	Qualitative	JBI Critical Appraisal Checklist for qualitative research (CACQR)	Good
21	Thomas et al., 2022	Qualitative	JBI Critical Appraisal Checklist for qualitative research (CACQR)	Good

Discussion

The purpose of this scoping review was to identify and collate studies that have made an essential contribution to the understanding of shared, supported, and other decision-making approaches related to adult mental health care, and how person-centred decision-making approaches could be applied in clinical practice. An in-depth analysis of 21 quantitative, qualitative, and mixed-design studies was conducted. The preliminary evidence suggests that person-centred decision-making in mental health care has the potential to improve patient experiences and health outcomes, compared to clinician-led decision-making. The general findings highlight the importance of the main facilitators, namely the therapeutic alliance and communication between the patient and health care professionals, as well as information sharing, patient agency, positive beliefs towards health services, support from others, and respect for patient wishes. The main barriers for decision-making participation are reluctance from professionals to involve patients in this process, communication issues, scarce information about treatments, perceptions of impersonal care and stigma. Nevertheless, the findings also show a large predominance of studies focused on shared decision-making, with little presence in the literature of other decision-making approaches, including supported decision-making. This review found implementation strategies for shared decision-making and one for treatment decision-making, but no for supported decision-making. The most effective strategies for embedding shared decision-making in mental health practice are focused on communication and the therapeutic alliance and should address barriers such as limited availability of choices, and

concerns about patient decisional capacity. These strategies have been proven effective in both inpatient and outpatient settings, except for one strategy tested in a community mental health care setting. Similarly, interventions that aim to improve treatment decision-making must address the barriers while enhancing the decision-making facilitators, e.g. therapeutic alliance, information sharing, patient agency, and so forth.

The focus of the literature in shared decision-making is certainly important due to its multiple applications in different mental health care settings, given its relevance for the main emergent topics from this review, namely therapeutic relationship, patient involvement, and interventions for patient involvement in decision-making. The potential applications include patients in inpatient units (Giacco et al., 2018; Morán-Sánchez et al., 2020), participants with experiences in both inpatient and outpatient units (Hamann et al., 2016; Haugom et al., 2022), transition from the hospital to the community (Sather et al., 2019), recovery centres (Matthias et al., 2012), and outpatient clinics (Alegria et al., 2018; Aoki et al., 2019; Farrelly et al., 2016; Grim et al., 2016; Matthias et al., 2014; Mundal et al., 2021; Park et al., 2014). As per the findings of this review, the main benefits of shared decision-making are a better patient-healthcare provider relationship (Matthias et al., 2014), patient engagement in the decision-making process (Hamann et al., 2016), lower anticipatory anxiety (Aoki et al., 2019), preventing compulsory hospital admission (Morán-Sánchez et al., 2020), and reduced decisional conflict (Thomas et al., 2022). Conversely, the main barriers for shared decision-making are reluctance to involve patients (Haugom et al., 2022), communication issues upon hospital admission (Giacco et al.,

2018), and overlooking patient preferences (Matthias et al., 2012; Sather et al., 2019). One of the main reasons for these barriers in clinical practice could be the fact that patients with severe mental illness struggle to be seen as competent by healthcare providers, often feeling omitted from involvement in shared decision-making, with their needs and capabilities not being adequately recognised (Dahlqvist Jönsson et al., 2015). Having said that, acutely ill patients can be effectively engaged in shared decision-making due to the increased awareness of decisional ability that they maintain, while counteracting the negative impact of stigma (Scholl & Barr, 2017). This could help to counteract additional obstacles for shared decision-making such as self-stigma, perceived power imbalances, and a lack of confidence in their knowledge (Burns et al., 2021). Given that many decisions in mental health care are preference sensitive, respecting the patient's wishes is the basis of a successful implementation of shared decision-making in mental health care settings, leading to favourable health outcomes (Simmons et al., 2010). Regarding research in shared decision-making, there is limited understanding of how to conduct studies where the healthcare professionals are directly involved in the delivery of shared decision-making in mental health care (Ramon et al., 2017). Addressing underexplored areas of shared decision-making implementation in mental health care could lead to more effective decision-making interventions and further inform the guidance of future policy, practice, and research (Ramon et al., 2017).

This review detected a significant gap in terms of the application and implementation of supported decision-making in mental health practice. Supported decision-making was the subject of only one study, with empathetic relationships being the main facilitators and highlighting the impersonal care and assumptions of patient decisional incapacity as the main barriers (Kokanović et al., 2018). Experiencing severe mental illness does not necessarily imply that patients cannot make decisions about their own health care, since they may be able to understand treatment alternatives and make decisions based on their genuine needs (Munjal, 2016). On the contrary, supported decision-making can be beneficial for people with severe intellectual disabilities through a very close relationship with the supporter to gain knowledge about the patient's life history and preferences (Watson et al., 2017). This is due to one of the main benefits of supported decision-making, the consideration of patient's human rights in areas like law, policy and clinical practice, reason why this approach should be inherently included in mental health care (Simmons & Gooding, 2017). Also, supported decision-making, alongside with antidepressants, can be beneficial for those with suicidal ideation via telehealth (O'Callaghan et al. 2022). However, one of the drawbacks is that supported decision-making is not always incorporated in health interventions due to obstacles like the insufficient clinical time from the healthcare professional to support the patient in making a decision, and a lack of resources, including human resources (Gordon et al., 2022). There is a critical need for exploration and use of supported decision-making in clinical practice to make it proactively inclusive, especially for those who experience discrimination and inequities

(Gordon et al., 2022). The implementation is complex and requires time, resources, and attitude changes from care providers and patients, in processes like informed consent, decisional conflict, and prospective decision-making (Davidson et al., 2015). A literature review found that none of the studied implementation models for supported decision-making have followed the requirements from The Convention on the Rights of Persons with Disabilities, adopted at the United Nations Assembly by many countries (Penzenstadler et al., 2020). This means that mental health practice differs, and implementation of supported decision-making remains unsatisfactory as a result (Penzenstadler et al., 2020). For these reasons, further research in the use and implementation of supported decision-making in mental health services is strongly required.

This review identified six studies where patient-centred decision-making interventions were explored, none of which was focused on supported decision-making. While most interventions centred in shared decision-making (Alegria et al., 2018; Aoki et al., 2019; Farrelly et al., 2016; Hamann et al., 2020) and one in treatment decision-making (Thomas et al., 2022) were proven to be effective, one intervention focused on shared decision-making did not yield the same results, meaning that greater investment of resources is required in community mental health care settings for a successful implementation (Lovell et al., 2018). These findings suggest that the evidence regarding the barriers for the implementation process of decision-making interventions is scarce, perpetuating the knowledge gap. The main barriers in decision-making preclude the operationalisation of person-centred care practices in mental health services, jeopardising the empowerment of patients in their decision-making (Smith et al., 2019). It is important to not only identify the main obstacles to decision-making but also the main causes of the maintenance and recurrence of these barriers in clinical mental health practice, optimising the strengths of all parties involved. For this reason, future research should explore practical solutions to overcome these barriers besides understanding how shared decision-making impacts adults with mental health and psychiatric disorders across all healthcare settings (Burns et al., 2021; Tambuyzer et al., 2014). Organisational, service, professional and operational policies, and guidelines should be reviewed to guarantee that they reflect the values and principles of a recovery approach, thus influencing mental health practice (Cusack et al., 2017). On this basis, a good leadership is the cornerstone of a successful implementation of person-centred decision-making, requiring the integration of a range of disciplines, such as behavioural science, psychology, communication, and economics (Scholl & Barr, 2017). Leaders must be facilitators by promoting, enabling, and supporting the process at all levels of the health system (Campos & Reich, 2019). For the healthcare team, this support encompasses the provision of resources, like training programs and adequate facilities to assist patients in mental health services provided in both inpatient and outpatient settings. A successful implementation of person-centred decision-making approaches in clinical practice could standardise the processes that comprise the therapeutic relationship.

The therapeutic relationship between the patient and the health care provider are based on therapeutic communication. The studies in this review support the idea that communication in decision-making can be both a challenge and a potential. The challenge comes with the communication barriers that arise in the therapeutic relationship, where clinicians may unilaterally decide the mental health treatments without consulting the patient through a process of shared decision-making (Younas et al., 2016). Similarly, the quality of the therapeutic relationship with mental health nurses is an issue of great concern for patients, the reason being mainly the limited time that nurses spend with them (Moyo et al., 2022). The rise of health care system demands challenge the therapeutic relationship in nursing, potentially delivering suboptimal mental health care to patients with complex comorbidities and life situations (Harris & Panozzo, 2019). Consequently, patients perceive disenchantment, uncertainty and not being engaged in treatment and medication decision-making as the main barriers to decision-making (O'Driscoll et al., 2014). On the other hand, effective communication in the therapeutic relationship has the potential to ensure patient participation in decision-making, which is the cornerstone of this relationship (O'Driscoll et al., 2014). This demonstrates the need for training health care providers in communication skills to establish a therapeutic alliance that promotes patient decision-making (Ashoorian & Davidson, 2021). Developing communication skills to meet the challenges that come with the therapeutic relationship between the health care provider and the patient should therefore be mandatory for those helping mental health patients be autonomous, providing them with opportunities to engage in mental health care decision-making. Addressing the needs of patients in the therapeutic relationship is fundamental for delivering individualised care, thus enhancing patient decision-making and the quality of nursing care in mental health care settings.

Limitations

This review has important limitations. Primarily, although most of the included studies met the inclusion criteria, when interpreting the findings, it should be done with caution as seven studies of just fair methodological quality were included. Having said that, these studies were included as they were relevant in understanding patient decision-making in mental health care. Lastly, papers published in languages other than English, Spanish and Portuguese were not considered for the review, potentially excluding studies that could have helped to better understand decision-making in mental health care.

Conclusions

The evidence from this scoping review of the peer-reviewed literature underscores the importance of supported person-centred decision-making approaches, which may positively impact outcomes like patient involvement in decision-making and satisfaction with care. There is

substantial research in shared decision-making and other treatment-related decision-making approaches in mental health care, whereas supported decision-making requires further attention. The critical aspects for shared, supported and other decision-making approaches are communication, information provision, social and professional support, patient perceptions of care, misconceptions about patient decisional capacity, and the willingness of health care providers to involve patients in decision-making. The most successful strategies for shared decision-making and other patient decisional approaches have incorporated all these areas in the tested interventions, leading to better outcomes. On the contrary, the main barriers and facilitators involved in supported decision-making as well as the implementation of this approach in mental health services remain unexplored.

Given the potential of supported decision-making in embedding human rights in mental health care, especially for those with severe mental illness, supported decision-making interventions should be the focus of future inquiry. Likewise, for all person-centred decisional approaches, there is potential for these strategies to be explored, specifically around implementation in mental health services in both inpatient and outpatient settings. Therefore, a recommendation for nursing practice is conducting further high-quality research with the purpose of exploring innovative decision-making approaches to make this process more integrative, comprehensive, and pertinent to the needs of the individual. A further focus of future research should be the complex implementation challenges of person-centred decision-making in mental health practice, which outcomes could lead to improvements in the quality of nursing care.

Disclosure statement

The authors report there are no competing interests to declare.

Funding

The author(s) reported there is no funding associated with the work featured in this article.

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