EDITORIAL

Shared Decision Making in the Treatment of Depression

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Shared Decision Making (SDM) is considered as one of the distinctive components of patient-centred care (PCC) that permits and promotes patients to participate actively in their health related management [1]. SDM is currently a widely recognized aspect of PCC in this modern era of healthcare standard globally [2]. In psychiatric practice, the relationship between clinician and patient is crucial to delivering the optimum mental health care services [3]. Besides SDM, another related and important component of PCC is the collaborative treatment alliances [4-8]. Altogether, these constructs have contributed to a wider understanding of medication adherence and service engagement concepts [9-12].

PCC requires that healthcare provider holistically consider any related information about the patient by understanding the unique human being characteristics prior to making a diagnosis of the patient’s ailment [13]. Participation of patients in their healthcare had been advocated by the World Health Organization (WHO) since 1977 [14]. More recently, the effort to improve healthcare quality and efficiency by patients’ participatory and active roles had been recognized by WHO in the “Vienna Recommendations on Health Promoting Hospitals” [15]. Since then, PCC has been viewed as good medicine, but remains lack of understanding and implementation [16].

PCC can be described as the care that involves (1) exploration of visit reasons and concerns of the patients, (2) search for the complete understanding of the patients’ world, (3) find for the common ground of the question problem and management agreement, (4) enhancement of health promotion and prevention (5) improvement of a continuing relationship between the healthcare providers and the patients [17]. Even though there is lack of conclusive reports on PCC benefits, other important features such as positive health outcome, greater improvement in symptom burden, greater enablement, and patient satisfaction have been reported [18-21].

In SDM, clinicians and patients discuss treatment options by sharing the best available evidence, via two-way communication to exchange knowledge and information, formally and experientially, and finally, together decide on action course of the medical treatment, where patients engagement and autonomy are promoted [22, 23]. The participation of patient is influenced by autonomy, which refers to the decision-making dimension of the patient’s role and improving patient autonomy means helping patients to decide on their own [24].
This collaborative process is focusing on individual preferences and values, which consider the mutual respect and open communication [25].

The traditional “paternalistic” model, which consists of only the clinician is making decision is contributing to the lack of patient involvement in making preferred decision [26]. SDM has been adopted as the central role to the recovery model and has led to an increasing emphasis of patients’ role as active participants in their treatment plan [27]. The success in mental health care requires a free flow of information and feedback sharing among all participants which include patients and clinicians, so that each of them are on track with any changes that will occur throughout the treatment process [28]. However, until recently, SDM has been given lack of consideration in psychiatry [29-31].

Major depression is one of the common psychiatric disorders, which has been ranked as the principle factor for disability worldwide by the WHO [32]. Major depressive disorder (MDD) is also related to the reduced role functioning and quality of life, medical morbidity, and mortality [33, 34]. Therefore, suitable management which contains prevention and treatment for depression should be focused more in this era. The most commonly used treatment in the management of depression is antidepressant, which is portrayed by the increment of prescribing trend over the last decades [35-38]. However, despite of the prescription given, the prevalence of antidepressant non-adherence is high. Almost half (56%) of the patients will discontinue their antidepressants within the first 6 months [39, 40]. Several studies reported that 6 -12% patients never take the antidepressants as prescribed by their doctors [41, 42].

There are many factors contribute to the antidepressant non-adherence, which include worries of side effects, lack of guidance by healthcare providers during treatment, insufficient knowledge, a pessimistic believe towards antidepressants use and the depression itself [43]. It is suggested that clinicians, pharmacists and other healthcare providers to provide more information and support during the initiation of antidepressant. In other words, SDM plays an important role in improving the antidepressant adherence and depression management outcomes [44]. In certain conditions, patients with severe mental illness will also require full information related to their treatment and they are keen to involve actively in this professional relationship [45-48]. Although barriers and challenges will always be there, it is important to take wise action in transforming the traditional “paternalistic” model of clinical decision making into a current “informed” decision making model. This effort will eventually assist to make a successful PCC in the treatment of depression [49, 50].

References


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