

Training Providers in Shared Decision Making for Trauma Treatment Planning

Bella Etingen, Jonathan D. Hessinger, and Holly A. Hunley
Edward Hines Jr. Veterans Health Administration Hospital, Hines, Illinois

The U.S. Department of Veterans Affairs (VA)/Department of Defense (DoD) Clinical Practice Guideline (CPG) for the Management of Posttraumatic Stress Disorder (PTSD) and Acute Stress Disorder strives to advance the VA's practice of recovery-oriented, evidence-based, patient-centered care (PCC) for veterans with PTSD. A core foundation of PCC is that care is individually tailored to meet the needs and preferences of each patient. Accordingly, the 2017 update to the CPG specifically recommends the use of shared decision making (SDM), an individualized collaborative approach to treatment planning, in the PTSD treatment planning process. Although SDM has been promoted by the CPG throughout the VA and SDM training is being developed, no systemic training was available at the time the guidelines were updated. Additionally, while early research has studied the impact and experience of SDM for the patient, no work has explored provider experiences with SDM for those who work with trauma populations. This project bridges this gap by examining survey data collected 6 months following a formal SDM training to staff and trainees working with veterans who have experienced trauma within a trauma clinic at a large VA hospital. After the training, clinicians understood SDM and were engaging in SDM with their patients. Patients indicated that they were satisfied with and felt like an active participant in the treatment planning process. Clinician assumptions about the SDM process and barriers to SDM shown in previous research were also demonstrated. Implications for future research and practice, such as using decision aids in PTSD treatment planning and targeting clinician beliefs about SDM, are discussed.

Impact Statement

Recent PTSD clinical practice guidelines recommend engaging patients in SDM, however, research on SDM for PTSD treatment planning is lacking. We found that provider-facing SDM training promotes understanding and use of SDM among PTSD care team members, and patients are satisfied with the incorporation of SDM into PTSD treatment planning. Further development of provider-facing SDM training for PTSD care, such as the virtual training VA recently rolled, is warranted.

Keywords: posttraumatic stress disorder, shared decision making, patient preferences, mental health care, veterans

Patient-centered care (PCC), an approach to health care delivery that prioritizes individualized care tailored to the unique needs and

preferences of each patient, is currently a core focus of many health care institutions (Bechtel & Ness, 2010). The Department of Veterans Affairs (VA) is among the largest institutions providing behavioral health care in the United States (U.S.). In fiscal year 2018, the VA provided behavioral health services to more than 636,000 veterans with posttraumatic stress disorder (PTSD; Harpaz-Rotem & Hoff, 2019). In a continued effort to support patient-centered, recovery-oriented care for veterans with PTSD, the 2017 update to the U.S. Department of Veterans Affairs/Department of Defense (VA/DoD, 2017) *Clinical Practice Guideline for the Management of PTSD* includes the recommendation to utilize a shared decision-making (SDM) process for PTSD treatment planning.

SDM has been defined as a collaborative interpersonal process between patients and providers that incorporates individual patient values and preferences along with the best available scientific evidence to design treatment plans (Elwyn et al., 2012). Literature specifies three key components of SDM: (1) *team talk* (formerly

This article was published Online First October 22, 2020.

 Bella Etingen, Center of Innovation for Complex Chronic Healthcare (CINCCCH), Edward Hines Jr. Veterans Health Administration Hospital, Hines, Illinois; Jonathan D. Hessinger and Holly A. Hunley, Trauma Services Program (TSP), Mental Health Service Line (116B), Edward Hines Jr. Veterans Health Administration Hospital.

Bella Etingen and Jonathan D. Hessinger share lead authorship.

The views expressed in this article are those of the authors and do not necessarily represent the views, position or policy of the Department of Veterans Affairs or the U.S. Government.

Correspondence concerning this article should be addressed to Bella Etingen, Center of Innovation for Complex Chronic Healthcare (CINCCCH), Edward Hines Jr. Veterans Health Administration Hospital, 5000 South 5th Avenue (151H), Hines, IL 60141. E-mail: bella.etingen@va.gov

referred to as *choice talk*), which involves identifying that patient choice regarding treatment options exists and explicitly encouraging collaborative decision-making; (2) *option talk*, which involves providing the patient with detailed information about available treatment options, including information on risks/benefits, effectiveness and expected courses of treatment; and (3) *decision talk*, which involves discussing patient's treatment preferences and selecting a treatment plan in collaboration with the patient (Elwyn et al., 2012).

Writings about the importance of SDM processes in modern medicine can be dated back to 1959 (Menzel, Coleman, & Katz, 1959), and currently, this practice is integral to the PCC movement. Although the application of SDM to mental health-related treatment decisions is more recent, early evidence has shown that SDM approaches may improve engagement (Hessinger, London, & Baer, 2017; Mott, Stanley, Street, Grady, & Teng, 2014; Watts et al., 2015) and retention (Mott et al., 2014) in evidence-based psychotherapy (EBP) for PTSD as well as lead to improvements in PTSD symptoms (Watts et al., 2015). Because of the growing literature supporting the use of EBPs for PTSD, VA has developed resources intended to support staff and veteran engagement in these interventions. The release of a decision aid by the VA National Center for PTSD (NCPTSD), a document that guides the delivery of education to patients about the availability of and evidence-base for EBPs for PTSD, is one such resource to guide use of SDM principles and promote utilization of SDM during PTSD treatment planning in VA.

Provider Perceptions of SDM

While recent SDM studies have focused on patient engagement in treatment decision-making, research indicates that additional focus on provider utilization of SDM may be warranted, particularly given documented challenges with provider engagement in SDM in physical (Gainer et al., 2017; Molenaar, Korstjens, Hendrix, de Vries, & Nieuwenhuijze, 2018; Schoenfeld et al., 2019) and behavioral (Beitinger, Kissling, & Hamann, 2014; Patel, Schnall, Little, Lewis-Fernández, & Pincus, 2014) health disciplines. Examples of such challenges include providers' perceptions of time constraints, belief that the opportunity for SDM does not exist within the clinical encounter, and perceptions that certain patient characteristics make SDM ineffective (Legare & Witteman, 2013; Schoenfeld et al., 2019). Notably, the belief that specific patient characteristics or clinical settings preclude patients from engaging in SDM only furthers the inequity between patients and providers in the decision-making process, which SDM in its essence attempts to minimize.

Patient Perceptions of SDM

In fact, these beliefs may drive providers to interact with patients in a way that discourages patients from engaging in SDM conversations with them. For instance, literature indicates that patient perceptions of power imbalance in the patient-provider relationship is a significant barrier to them engaging in SDM (Joseph-Williams, Elwyn, & Edwards, 2013). However, research has demonstrated that patients with PTSD symptoms overwhelmingly desire information about PTSD and treatment options (Watts, Zayed, Llewellyn-Thomas, & Schnurr, 2016) as well as involve-

ment in treatment decisions (Harik, Hundt, Bernardy, Norman, & Hamblen, 2016). In addition, engaging patients in SDM for mental health care has been associated with improved patient satisfaction (Klingaman et al., 2015; Swanson, Bastani, Rubenstein, Meredith, & Ford, 2007).

Need for Provider SDM Training

Despite the potential of SDM in improving PTSD care and resources available to clinicians, efforts focused on bridging the gap between these resources, research, and clinical practice are lacking. In fact, a contemporary qualitative study suggests that, despite efforts to train clinicians in EBPs, providers overwhelmingly continue to develop diagnostic impressions through unstructured assessment and develop treatment plans based in large part on their own perception of patient needs (Stewart, Chambless, & Stirman, 2018).

On the other hand, many mental health providers may believe that they intuitively engage in SDM given their training in building therapeutic alliance through the transtheoretical psychotherapy components that highlight collaboration with patients. However, recent research has suggested that, in some circumstances, health care providers may believe they are engaging patients in SDM but follow-up data does not necessarily corroborate this (Couët et al., 2015; Evong, Chorney, Ungar, & Hong, 2019; Jackson, Storch, Jackson, Becher, & O'Malley, 2020; Tamirisa et al., 2017).

Taken collectively, literature indicates that formal standardized training programs for providers on how to engage their patients in SDM are warranted, however, at the time this work was conducted no such training existed. (Of note, the VA has recently developed an interactive, web-based, provider-facing training focused on SDM and incorporating SDM into PTSD care). In the present work, we aimed to bridge this gap by developing and implementing an SDM training program for behavioral health providers working in a PTSD clinical team with patients who have symptoms of PTSD, and exploring the impacts of this training on provider experiences with and their patients' perceptions of SDM.

Method

Design

The present project looked to explore provider perception and uptake of SDM six months after a locally provided training in a VA PTSD clinical team. Results were collected via an anonymous, voluntary survey that providers who received the training were asked to complete. Additionally, veteran patients of the providers working in this clinic completed satisfaction questionnaires to gauge patient views of the treatment planning visits and specifically, the incorporation of SDM in that interaction.

Participants/Setting

Study efforts took place within a PTSD clinical team at a large midwestern VA hospital that serves urban and rural veteran populations. Prior to SDM implementation, the clinic redesigned its workflow processes to support routine use of the SDM framework in treatment planning sessions. Along with this redesign, clinic staff were provided with educational materials outlining the es-

sential elements of SDM with examples of how to incorporate those elements into discussions with patients. At the request of staff and to orient new staff and trainees to clinic procedure, a 1-hr training in SDM was developed and implemented in the clinic to promote uniformity in provider utilization of the SDM process. All clinic staff were invited to participate. Upon deployment of this training, the clinic also began to distribute a voluntary feedback form for patients to complete following their treatment planning session to assess patient perception of the interaction.

Training Details

The SDM training included both didactic and interactive elements. For background, providers were first given a general history of SDM as well as a history of SDM specific to mental health care delivery. Training materials then explained the role of SDM within the context of their particular clinical activities, including a discussion about where/when providers currently use SDM. This discussion helped to explore when SDM may be occurring to some extent in the clinic already, but also demonstrated the need for additional efforts to standardize SDM practice across the clinic. Providers were then presented with a theoretical model of SDM (Elwyn et al., 2012) and specific details on the essential elements of SDM (e.g., choice talk, option talk, and decision talk). Following this, the trainer led the providers in a set of interactive activities, including a demonstration of how to engage patients in SDM using hypothetical case examples representative of the clinic population, followed by a role-play.

Data Collection: Providers

About 6 months after the training, all clinic staff who participated in the training were invited to complete an online survey. The survey included 20 items designed to evaluate the provider's knowledge and beliefs about SDM, utilization of the practice, and perception of barriers to engaging in these practices (consistent with Legare & Witteman, 2013; e.g., "I feel confident that I know what SDM is and how to utilize it with patients," "I utilize SDM at every treatment planning session," and "The biggest barriers to utilizing SDM are . . ."). Response options included closed-ended items and responses on five-point Likert scales (i.e., 5 [*strongly agree*] to 1 [*strongly disagree*]; 5 [*very likely*] to 1 [*very unlikely*]), as well as open-ended items (e.g., "What additional training [if any] do you think would be helpful regarding SDM for PTSD?"), as appropriate based on the question at hand. Participation in the survey was voluntary, and responses were anonymous.

Data Collection: Patients

The patient feedback form included seven items six of which were modeled after the Combined Outcome Measure for Risk Communication and Treatment Decision-Making Effectiveness (COMRADE) scale (Edwards et al., 2003), a psychometrically sound measure of patient perceptions of SDM during medical encounters. This form was intended to gauge patients' perceptions of and satisfaction with facets of SDM their providers engaged them in during their treatment planning encounter. COMRADE items were adapted for use in this specific mental health context and for length to decrease patient burden. Responses were mea-

sured on a five-point Likert scale, ranging from 1 (*strongly disagree*) to 5 (*strongly agree*). In addition to these questions, patients were asked to report how many treatment options they recalled the provider presenting to them.

Data Analysis

Survey responses were examined using descriptive statistics (i.e., proportions; means, ranges and standard deviations). Data analyses were conducted using IBM SPSS Statistics for Windows, Version 23 (IBM Corp., 2018). The provider training and subsequent feedback forms were completed as part of a clinic quality improvement (QI) effort. Patient survey data were also part of a larger analytic data set examining general clinical outcomes, which was deemed to be research and approved by local institutional review board (IRB) and research and development (R&D) committees.

Results

Sample: Providers

Of the 16 behavioral health providers working within the clinic at the time, 14 completed the SDM training and were invited to participate in the provider survey. Of these individuals, 12 completed a survey (86% participation rate). Of our respondents, 67% were licensed psychologists or social workers, and 33% were masters-level social work or doctoral-level psychology trainees (see Table 1).

Sample: Patients

Patient feedback was analyzed from 129 veterans who attended an initial session in the clinic during the time frame of the QI effort (see Table 2). Of note, formal diagnostic assessments for PTSD are not collected at the initial session because this session focuses on treatment planning based on individual patient treatment goals; formal trauma-related assessments including the Clinician-Administered PTSD Scale for DSM-5 (CAPS-5; Weathers et al., 2018) are then completed during subsequent sessions to confirm current diagnosis. Subjects included veterans between the ages of 23 and 75, from a variety of combat eras and trauma types (e.g., combat, military sexual trauma [MST], nonmilitary trauma) who completed the feedback form. Patient data was excluded if responses suggested that the veteran did not adequately attend to survey items (e.g., strongly agreeing with both Items 5 and 6).

Results: Provider Survey

Knowledge of SDM. The majority (75%) of providers who responded to the survey were able to identify the names of all three essential elements of SDM (i.e., choice, option, and decision talk; see Table 1). Most (64%) stated that choice talk was the facet of SDM that they were most likely to forget.

Use of SDM. Most respondents (82%) indicated that they are likely to discuss treatment options they are not trained in with patients. All (100%) stated that they present 'no treatment' as an available option to their patients. The majority reported that they discuss options beyond EBPs that are available to patients (92%

Table 1

Provider Perceptions and Use of SDM (n = 12)

Provider response option	<i>M</i>	<i>SD</i>	Range	%
Position type (<i>n</i> = 12)				
Licensed provider				66.7
Trainee (e.g., extern, intern, postdoctoral fellow)				33.3
Possess knowledge of SDM and how to use it in practice (<i>n</i> = 12)				
Agree				83.3
Neither agree nor disagree				16.7
Disagree				0.0
Uses SDM at every treatment planning session (<i>n</i> = 12)				
Agree				75.0
Neither agree nor disagree				25.0
Disagree				0.0
Believes it is valuable to use SDM in practice (<i>n</i> = 12)				
Agree				100.0
Neither agree nor disagree				0
Disagree				0
Believes coming to a treatment decision is more important than how the decision is made (<i>n</i> = 12)				
Agree				0.0
Neither agree nor disagree				16.7
Disagree				83.3
Always engages in all three components of SDM (<i>n</i> = 12)				
Agree				33.3
Neither agree nor disagree				33.3
Disagree				33.3
Believes treatment planning should be determined by the following: (<i>n</i> = 12)				
50% provider/50% patient				58.3
55% provider/45% patient				25.0
75% provider/25% patient				16.7
75% patient/25% provider				0.0
Identified the following as the three components of SDM: (<i>n</i> = 12)				
Uncovering need, option, decision				0.0
Option, decision, review				25.0
Choice, option, decision				75.0
Recovery, choices, plan				0.0
Endorses that patients do not have enough knowledge to make the best treatment choices (<i>n</i> = 12)				
Agree				8.3
Neither agree nor disagree				25.0
Disagree				66.7
Believes SDM is a fancy name for something they were already doing (<i>n</i> = 12)				
Agree				66.7
Neither agree nor disagree				8.3
Disagree				25.0
Average reported amount of time (in min) spent on SDM in a treatment planning session (<i>n</i> = 11)	20.6	4.2	15.0–30.0	
Present treatment options to patients that they personally do not provide (<i>n</i> = 11)				
Likely				81.8
Neither likely nor unlikely				0.0
Unlikely				18.2
Discuss treatment options outside of (their clinic) with patients (<i>n</i> = 11)				
Likely				91.9
Neither likely nor unlikely				9.1
Unlikely				0.0
Average number of treatment options they typically discuss with patients (<i>n</i> = 11)	4.5	1.8	2.0–7.0	
Reports having used the VA NCPTSD treatment decision aid in practice (<i>n</i> = 11)				
Yes				18.2
No				72.7
Do not know what the decision aid is				9.1
Reports having had a patient use the VA NCPTSD treatment decision aid on their own (<i>n</i> = 11)				
Yes				0.0
No				90.9
Do not know what the decision aid is				9.1
Reports presenting “no treatment” as a treatment option (<i>n</i> = 11)				
Yes				100.0
No				0
Reports that the SDM component they are most likely to forget is: (<i>n</i> = 11)				
Choice				63.6

(table continues)

Table 1 (continued)

Provider response option	<i>M</i>	<i>SD</i>	Range	%
Option				9.1
Decision				0.0
None				27.3
The biggest barriers to using SDM are (check all that apply): (<i>n</i> = 11)				
Time				54.5
Patient not wanting to engage (or wanting me to make decision)				36.3
Personal comfort with SDM				9.1
Belief that SDM will improve decisions/outcomes				0.0
Other (i.e., more training [needed])				9.1

Note. Sample sizes noted next each question represent the number of providers who responded that item. SDM = shared decision making; NCPTSD = National Center for PTSD; VA = US Department of Veterans Affairs.

agree/strongly agree). Most (73%) had not used the NC-PTSD decision aid with their patients.

Perceptions of SDM. All (100%) respondents believed that it is valuable to engage in SDM with patients. The majority (58%) perceived that treatment planning should be determined in equal partnership with patients (e.g., the decision should be made with equal input from the provider and patient). However, most respondents (67%) agreed that “SDM is a fancy name for something [they] are already doing.”

Experiences with SDM. Respondents reported spending approximately 21 min, on average, engaging in SDM with patients during treatment planning visits (range = 15–30 min). Respondents reported presenting patients with approximately four treatment options during these discussions (range = 2–7 options). When asked to report perceived barriers to SDM, most providers (55%) endorsed time constraints, and another 36% reported perceptions that the patient does not want to engage.

Need for SDM training. In response to an open-ended question asking providers to note what additional training (if any) would be helpful to them regarding SDM for PTSD, respondents mentioned training strategies such as role plays, administrative training, occasional refreshers, and educational materials.

Table 2

Patient Demographic Characteristics (N = 129)

Characteristic	<i>M</i>	<i>SD</i>	Range	%
Age	50.5	15.5	23.0–75.0	
Gender				
Male				92.2
Female				7.8
Race/ethnicity				
White (non-Hispanic)				50.4
African American (non-Hispanic)				32.6
White (Hispanic)				11.6
African American (Hispanic)				2.3
Asian				0.8
Unknown				2.3
Service era				
Vietnam				29.5
Post-Vietnam				10.1
Persian Gulf				19.4
OEF/OIF/OND and other post-9/11				41.1

Note. OEF = Operation Enduring Freedom; OIF = Operation Iraqi Freedom; OND = Operation New Dawn.

Results: Patient Survey

On average, veterans reported having been presented with four treatment options (range = 0–12 options) during their treatment planning visit, with four (24%) and five (25%) options being the most commonly reported (see Table 3). Patient perceptions of treatment planning visits were largely positive, with most (95%) indicating that the visit was helpful, that the provider gave them an opportunity to ask questions during the visit (98% agree/strongly agree) and that they received enough information about treatment options during the visit (95% agree/strongly agree). Nearly all veteran respondents (98%) reported agreeing that they had an active voice in their treatment decision making, and that they felt confident about moving forward in their treatment (90% agree/strongly agree) following the treatment planning visit.

Discussion

This project is among the first to examine SDM training for mental health providers generally, and for PTSD-focused mental health providers specifically. Our findings indicate that, following participation in the SDM training, behavioral health providers who deliver PTSD care understood SDM and reported engaging in SDM with their patients during the treatment planning process. Further, patients seen in the clinic after the providers received the training generally indicated that they were satisfied with and felt like an active participant in the treatment planning process and were confident in moving forward with the developed treatment plan.

Of note, the training that we describe in this article was relatively short in duration and did not include follow-up troubleshooting or checking-in with veterans after encounters about their perceptions of how the visit went and the extent to which they believe principles of SDM were utilized. The providers in our sample who completed the training noted that SDM training programs may be bolstered by additional supports or enhanced training elements, including administrative training, occasional refreshers, role plays and educational materials. To optimize such programs, these suggestions could be incorporated into future SDM training curriculum for behavioral health providers.

Although many of the providers in our sample reported believing they were already doing SDM as part of their clinical practice, a majority of the sample identified they were most likely to forget to explicitly highlight the collaborative nature of the dialogue (i.e.,

Table 3
Patient Perceptions of and Experiences With SDM (N = 129)

Survey item/response option	<i>M</i>	<i>SD</i>	Range	%
Number of treatment options patient was presented with (<i>n</i> = 119)	4.0	1.7	0.0–12.0	
0				0.8
1				3.4
2				17.6
3				16.0
4				24.4
5				25.2
6				7.6
7				1.7
8				2.5
12				0.8
Believed that their appointment was helpful (<i>n</i> = 129)				
Agree				94.6
Neutral				4.6
Disagree				0.8
Believed their provider allowed for the opportunity to ask questions (<i>n</i> = 129)				
Agree				98.4
Neutral				0.8
Disagree				0.8
Believed their provider gave them enough information about treatment options (<i>n</i> = 129)				
Agree				95.3
Neutral				3.1
Disagree				1.6
Believed they had an active voice in their treatment planning (<i>n</i> = 129)				
Agree				98.4
Neutral				0.8
Disagree				0.8
Believed their provider made their treatment decision for them (<i>n</i> = 129)				
Agree				7.8
Neutral				11.6
Disagree				80.6
Felt confident moving forward with their treatment plan (<i>n</i> = 129)				
Agree				89.9
Neutral				9.3
Disagree				0.8

Note. Sample sizes noted next each question represent the number of patients who responded that item. SDM = shared decision making.

engage in choice talk). Anecdotally, some providers in the clinic have indicated that they assume the collaborative nature is implicit in their interaction with patients. This is supported by our current data, wherein the majority of participating providers indicated believing that SDM is “just a fancy name for something [they] already do.” Although it may be the case that formal SDM discussion can be a natural extension of existing practices for some providers, particularly those who are trained in motivational enhancement techniques, training programs could be a useful refresher for these skills as well. Future research should assess the utility of SDM training among all clinicians - as an initial training for those who are less versed in engaging patients in SDM and as a refresher to further enhance SDM knowledge and skills for those who have been regularly using these techniques in practice; such studies may also examine potential differences in needed training content and format (e.g., refresher training may require less detailed materials or be shorter in duration).

Relatedly, previous studies have found a divide between provider and patient perceptions of SDM—whereas providers often report that they engage patients in SDM, patients’ views are not always aligned (Elwyn et al., 2012; Mulley, Trimble, & Elwyn, 2012). Researchers have postulated that while providers may view a regularly practiced informed consent process as synonymous to

SDM, the explicit collaborative decisional process is not included in the review of risks/benefits of given options. To ensure that interactions are reflective of true SDM and both patients and providers are happy with the dynamic of the collaborative conversations, no part of the process should be “assumed.” Instead, providers should take care to explicitly incorporate all aspects of SDM into these conversations.

Our data further suggest that treatment options presented to patients during ‘option talk’ may be influenced by provider factors. This is aligned with previous literature showing that behavioral health providers are more likely to present or emphasize specific treatment options that are in line with their theoretical orientation (e.g., psychodynamic, CBT, humanistic; Garcia, DeBeer, Mignogna, & Finley, 2019). In our sample, nearly 20% of providers indicated that they did not present treatment options to patients if they were not trained in those specific interventions.

In some instances, providers may not discuss an available treatment option with a patient if they are not entirely confident the patient can access that treatment. Further, about one third of our provider sample was comprised of trainees, and it is possible that trainee respondents were predominantly comfortable providing treatment options in which they were trained. Conversely, trainees may present patients with a comprehensive range of treatment

options available to them, with the intention of later consulting senior colleagues who are skilled in the ultimately selected treatment (e.g., through supervision encounters). In general, however, this finding suggests that some providers may not be discussing the full range of treatment options with patients during treatment planning sessions, and strategies to combat this are needed. One potential strategy is for providers to use standardized decision aids (such as the one released by the VA NCPTSD) during treatment planning conversations, to ensure that the full range of available treatment options are being discussed consistently with all patients.

The theoretical goal of SDM is to create a “two experts in the room” model, wherein there is a 50/50 split in decision-making power between the patient and the provider. However, some providers may be challenged in “sharing” the expertise. Although this power balance was specifically addressed in the SDM training described above, just over 40% of participating providers responded that they maintain either “55%” or “75%” of the treatment planning decision (s) should be weighted toward provider expertise. This finding suggests that some providers may feel that their clinical expertise should remain at the forefront of the decision-making process, which may pose an obstacle on the provider side to engaging in true SDM during their treatment planning interactions with patients.

Utilization of the PTSD treatment decision aid developed by the VA NCPTSD was low within the sample, highlighting that research focusing on uptake of decision aids for treatment of PTSD may be warranted. This finding may be attributable to the fact that the decision aid had only been available for a relatively limited amount of time when this project was conducted. However, anecdotally, some providers have indicated feeling as though this decision aid was not inclusive of all treatment options for PTSD or trauma-related symptoms. Thus, decision aids outlining the full breadth of site-specific options, while staying consistent with current clinical practice guidelines and clinical science, may increase patient/provider utilization of such tools by increasing applicability and specificity.

The primary barriers to SDM engagement often cited in the literature were also identified as such by providers in the sample. However, it is understood that certain factors perceived to be barriers to engaging in SDM among providers may not actually be barriers in practice. For example, while providers may perceive that they do not have enough time to engage in true SDM with a patient during a PTSD treatment planning discussion, our results suggest that providers spent about 20 min doing so in practice, which should not preclude them from engaging in SDM with their patients during standard 60-min long appointments.

While SDM does have benefits, it is important to note that if patients would rather not participate in their treatment planning/decision making, those wishes should be respected as well. However, it is important to make sure that the process is explained to them and that they are explicitly asked whether they would like input in their treatment planning, rather than providers simply assuming that patients are not interested because they seem disengaged. The latter situation could be particularly problematic in that hesitation on the part of the patient may actually reflect other hesitations or the need to warm up to treatment in general/establish a rapport with the provider, not a true disinterest in participating in their treatment planning.

Implications for Care and Future Directions

The literature is consistent across multiple disciplines that patients appreciate and engage in SDM. This is supported by our findings that, following the provider SDM training, nearly all of the veterans in our sample reported believing that their appointment was helpful, perceiving that they had an active voice in their treatment planning, and feeling confident moving forward with their treatment plan. The impact of SDM on treatment outcome or how such outcomes should be defined in the mental health SDM literature is less clear, however. Future work should explore ways of conceptualizing and measuring the impact of SDM on treatment engagement and outcomes. Possible measures of meaningful outcomes to assess in this context could include quality of life measures, symptom inventories, patient satisfaction/experience with treatment, and/or treatment initiation and completion/dropout rates.

Of note, as part of the current effort, we did not complete any formal assessment or observation of the extent to which clinic staff were utilizing SDM in practice; however, engaging in SDM during a patient’s treatment planning session was included in updated clinic practice documents, which all providers had agreed to follow. Additionally, trainees were observed (via required supervision) on whether they were following these clinical practices. Future work in this area would benefit from standardized direct observation of SDM processes to better evaluate the extent to which providers actually engage in SDM in practice, as well as their experiences with SDM. For example, individual provider beliefs, values, and treatment orientations could be an important factor in shaping what treatment options are discussed and how they are presented. It may be possible that provider reluctance, not hesitation on the part of the patient, could be a barrier to the SDM experience.

Limitations

The present project lacks comparative provider and patient data prior to the implementation of SDM training and the clinic redesign. Therefore, we were unable to examine patient satisfaction prior to implementation of the SDM training and clinic redesign. In addition, we did not have comparative data examining pretraining views on SDM among providers who completed the survey. This limits conclusions regarding the true impact the training had on provider beliefs and behavior related to SDM. Future work focused on the development and assessment of provider training should include this element and may also benefit from leveraging mixed-methods approaches to data collection. The findings of provider feedback are limited in their ability to be generalized to other settings given the single-site nature of the work, limited clinician sample, and that the focus of the training was the SDM process specifically for PTSD treatment planning within a clinic that delivers solely PTSD care. In addition, because a validated survey measure to assess behavioral health provider perspectives about SDM training has not been developed, we used a nonvalidated measure to collect provider data, which further limits generalizability.

Conclusion

Overall, our results indicate that patients like SDM and feel that it was incorporated into their treatment planning following the provider-facing training. In addition, these patients reported being confident with their treatment moving forward after their treatment planning visit, which could have positive implications on treatment engagement and outcomes. Further, PTSD clinic providers largely reported seeing SDM as a positive and useful treatment planning strategy following formal training. However, some providers may have beliefs about SDM that serve as barriers to engaging their patients in SDM, and these beliefs should be addressed with additional, focused training efforts. Whether or how PTSD treatment engagement and outcomes are influenced by use of SDM during treatment planning remains unclear, as does how context-specific or provider-level factors influence SDM experiences. Future research to address these important questions is warranted.

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Received February 18, 2020

Revision received August 17, 2020

Accepted August 20, 2020 ■