



Practitioners' positive attitudes promote shared decision-making in mental health care

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Abstract

Rationale and aims: There is a growing expectation of implementing shared decision making (SDM) in today's health care service, including mental health care. Traditional understanding of SDM may be too narrow to capture the complexity of treatments of mental health problems. Although the patients' contribution to SDM is well described, the contribution from the health care practitioners is less explored. Therefore, our aim was to explore the attitudes of practitioners in mental health care and the associations between practitioners' attitudes and SDM.

Method: We performed a cross-sectional study where practitioners reported their sharing and caring attitudes on the Patient-Practitioner Orientation Scale (PPOS) and age, gender, profession, and clinical working site. The patients reported SDM using the CollaboRate tool. We used a mixed effect model linking the data from each practitioner to one or more patients. We presented the findings and used them as background for a more philosophic reflection.

Results: We included 312 practitioners with mean age 46.1 years. Of the practitioners, 60 held a medical doctors degree, 97 were psychologists, and 127 held a college degree in nursing, social science, or pedagogy. Female practitioners reported higher sharing (4.79 vs 4.67 [range 1-6], $P = .04$) and caring scores (4.77 vs 4.65 [range 1-6], $P = .02$) than males. The regression model contained 206 practitioners and 772 patients. We found a higher probability for the patient to report high SDM score if the practitioner reported higher sharing scores, and lower probability if the practitioner worked in ambulatory care.

Conclusions: SDM in mental health care is complex and demands multifaceted preparations from practitioners as well as patients. The practitioners' attitudes are not sufficiently explored using one instrument. The positive association between practitioners' patient-centred attitudes and SDM found in this study implies a relevance of the practitioners' attitudes for accomplishment of SDM processes in mental health care.

The work was carried out at Sørlandet Hospital, Division of mental health, PO box 416, 4604 Kristiansand, Norway.

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KEYWORDS

mental health services, Patient-Practitioner Orientation Scale, personnel attitude, shared decision-making

1 | INTRODUCTION

In the last decades, the focus of modern health care service has moved from strictly illness cure towards a broader care perspective where patient perspectives, quality of life, and empowerment of the individuals are included.¹ Expectations regarding patient focus beyond illness focus are increasing. Health leaders and governmental authorities have continuously expressed a stronger expectation of inclusion of shared decision making (SDM) in all decisions about treatment in health care.^{2,3} The core components of SDM are not unambiguously described, but the most frequently used components are patient values and options.⁴ SDM is a conceptualization of the mutual process where the patient and the practitioner acknowledge each other's expertise and collaboratively identify the best treatment decisions.⁵ Such processes are expected to lead to better treatment choices supporting the patient's individual needs.⁶ This has been underscored by Drake and co-workers who has set up SDM as an ethical imperative, addressing the moral obligation included in all professional practice⁷; although recent literature suggest there may be provisos from the practitioners to the SDM practice.^{8,9}

The turn towards patient-centeredness in medicine is a construct developed from gradual changes in the holistic understanding of what it is to be a human being.¹⁰ More overriding societal changes regarding social and ethical principles, like the shift towards self-realization and individualism, lead the main focus in health care from information and adherence. This also contributes to a shift from the scientific explanations to relieve the patients' suffering into a state where the practitioners understand the patient as a unique human being and offers treatments along with this recognition.¹⁰ SDM is suggested to prevent cases of non-adherence to treatment based on disagreement¹¹ and is valued by patients.¹² Consultations prepared for SDM aim to provide space for mutual exchange of information and interpretation of the situation to converge into a shared decision on the basis of the knowledge of the different experts. Therefore, it is a premise that the patient perspective is explored and taken sufficiently into account by the service. Patients must be empowered to participate without specific limitation in SDM, both when it comes to recognition of the situation and its possibilities, and regarding personal preferences.^{1,13} The situation is unique for each patient and every patient is an expert on his or her own life, being in possession of core knowledge necessary to perform SDM. The personal aspects include the life-world of the patient, including family traditions and cultural affiliation.¹⁴ It is a premise for fulfilling the SDM process that the service facilitates and encourages the patient to bring individual perspectives into the process. To assess the extent and the quality of SDM several tools have been developed.¹⁵

1.1 | The complexity of SDM in mental health care

Morant and co-workers have suggested that the understanding of SDM as a process restricted to one clinical encounter is too narrow and limited for mental health care.¹⁶ The main objection to this understanding lies in the nature of mental illness and its demand for complex management. As the traditional SDM is a microsocial process limited to the particular consultation involving the patient and the practitioner, SDM in mental health care includes a longer-term relationship, a context where other key players like relatives and people in the patients' supportive network are included, functional and cultural features of the health care system, and the recognition that the illness evolves through periods of recovery and relapse.^{5,16,17} This multiple involvement and long-term perspective emphasize the complexity of the process. Taken together, all these elements call for considering SDM in mental health care as a continuous, multipersonal process, not completed within a limited time period or with a single decision.^{18,19} Ozdemir and Finkelstein have suggested that the long-time nature of chronic conditions provides a knowledge ripeness of how the illness and its suffering is understood and that we should be aware of the changes in the patients' self when recovering and the complexity that develops regarding decisions made.²⁰ As many of the mental illnesses are long-term conditions, we suggest this is relevant for how practitioners in mental health care understand the patient views. This recognition eventually reveals the gap between the scientific explanation of the condition and the patient's understanding of the suffering and restriction of life.

1.2 | Meeting the needs of the self-determination theory

Besides availability of practical tools like questionnaires or internet-based programs, practitioners should advantageously be aware of the understanding of the more theoretical aspects forming the basis for good outcome of the SDM. Self-determination theory (SDT) postulates three psychological needs for human identity, the forming of the self, and well-being.²¹ The first is the need for competence, which powers human exploration in order to master the environment. The second is the need for autonomy, understood as the experience of making your own choices and being the author of your own life. The third need is the need for relatedness, where people try to achieve a sense of belonging to others in their surroundings. We emphasize that fulfilment and continuous recognition of these existential needs are important requisites in an SDM process, and that the interventions that facilitate fulfilment of these needs can improve the quality of life and support patients breaking thought behavioural patterns.²² By taking the self-determination

theory-perspective of successful decision-making processes into account, we should reframe how knowledge is valued in the patient-practitioner interaction.

1.3 | The importance of practitioner attitudes

Yelovic argues that the patient's experience must be understood and utilized by the practitioners in a more consistent manner to fully exploit the potential present in the clinical encounter.¹¹ Expertise among health care professionals in this field expands from informal clinical experience working on a specific field, rather than from formal skills gained from education. Such informal experience is not reachable solely through any certification or formal education. Additionally, the recognition that the patient has a valuable expertise to offer must be present. Together, these skills facilitate fruitful interactions in SDM processes.

The importance of patients' preparations for SDM processes have been emphasized, while the practitioners' entrance to the same process is less investigated. Practitioners' attitudes can be understood and conceptualized in different ways. Some efforts have been done to explore the health care providers' perspectives of the service, but these do not specifically concern the attitudes of the practitioners.²³ Earlier studies regarding the attitudes of practitioners in mental health mainly concern the attitudes towards mental disorders and people suffering from these.²⁴⁻²⁷ A broader insight into more fundamental attitudes regarding illness itself and treatment approaches would extend our understanding of the conditions influencing the outcome of clinical encounters. This should include considerations about sharing information and power in clinical decisional processes. However, the literature in the field are rather scarce.

The attitudes towards the content of clinical encounters held by the practitioners, expressed by behavioural styles, influence the clinical encounter and the patient-practitioner relationship.¹⁴ The behavioural styles are outlined as a patient-centred style and a disease-centred style, respectively. The patient-centred style is referred to as a sharing dimension, where information is abundantly shared between the patient and the practitioner, and where the practitioner focuses on the patient's life more than strictly on the illness. The disease-centred style is referred to as a caring dimension, where the practitioner shares less information with the patient and keeps a dominant focus on the illness when decisions are made. The practitioner's attitude influences the decisions made for the patient treatment and follow-up, and safeguarding the patient needs and facilitating the SDM processes have different conditions. Thus, the practitioners' attitudes should be the centre-of-attention and integrated in educations throughout their professional lives. We presume that the behaviour styles among the practitioners are linked to their personality, their education, and their professional experience.²⁸ Findings in previous studies indicate that the comprehensive clinical experience included in post-graduate education contributes to practitioners' developing sensitivity to the needs of the patient and what they express as important to themselves. This sensitivity in turn

influences the attitudes and contributes to beneficial patient-practitioner meetings, which elevate the unique knowledge each individual patient develops regarding his or her own challenges.^{11,29} We hypothesized that practitioners' attitudes towards SDM are diverse, but play an important role for the treatment climate and the patients' experiences of treatments.

1.4 | Aim

This study aimed to explore (a) sharing and caring attitudes of practitioners in mental health care and (b) the influence of practitioners attitudes on patients' perceptions of SDM.

We will present and use empirical data as a starting point for a philosophical analysis of the associations between the practitioner attitudes and the concept of SDM.

2 | MATERIAL AND METHODS

2.1 | Context

This was a cross-sectional study including patients and practitioners at the Division of Mental Health and Addiction Service at Sørlandet Hospital Trust during the third week of January 2017.

Sørlandet Hospital Trust is a publicly run hospital which serves a population of 300 000 people in the southern part of Norway.³⁰ The Division of Mental Health and Addiction Service provides acute and long-term treatment as well as forensic psychiatry, child and adolescent psychiatry, geriatric psychiatry, and specialized treatment of substance-related disorders. In 2017, the division held 280 beds, had 4150 admissions, and 184 000 consultations.

Professionals with independent treatment responsibility were included in the study by the study personnel after written and oral information from the head of the division and from the study team. They completed a questionnaire covering background demographic information, education, and clinical experience, and topics regarding practitioner attitudes and beliefs.

The inclusion of patients were done by their practitioner as they arrived for their appointment. Patients received information about the study from posters in the clinics and from the hospital staff at their arrival. Participating patients must be aged 16 years or older, with at least one earlier contact regarding the current issue. Patients were only included at their first visit if they had more than one contact with the service during the week of the study. Inpatients were included after 24 hours of hospital admission. Ambulatory-treated patients were given domestic treatment and follow-up, on account of lacking the ability to attend an outpatient clinic or benefit from its treatment offers. Patients receiving ambulatory treatment are less attentive to regular treatments, and thus more likely to be subject to compulsory treatment.

Patients were not included if, for any reason, participation was considered contraindicated or if the patient was considered unsuitable for a paper-based questionnaire. The patients completed a

questionnaire containing demographic information and experiences and attitudes regarding mental health care service. Clinical information and information about their treatment were obtained from the patient records.

All patients and practitioners provided a written informed consent.

2.2 | Instruments

2.2.1 | The Patient-Practitioner Orientation Scale

The Patient-Practitioner Orientation Scale (PPOS) explores attitudes towards SDM among practitioners.^{31,32} The instrument is a self-report assessment tool and has been validated and translated into Norwegian, and has been used in previous studies.^{32,33} As attitudes are internal orientations, we found it appropriate to use a self-report assessment tool for this study. The paper and pencil instrument was originally developed to measure patients' attitudes towards their role in medical care and is well validated. Later, it was refined to also measure practitioners' attitudes and is shown to be a relevant assessment tool with regard to patient satisfaction.^{34,35} The PPOS consists of 18 statements where the practitioners rate the degree of agreement on sharing information and power during the visits rated on a 6-point Likert scale, where 1 = "strongly agree," 2 = "moderately agree," 3 = "slightly agree," 4 = "slightly disagree," 5 = "moderately disagree," and 6 = "strongly disagree." Nine of the items refer to the sharing dimension, which is explained as an expression for patient-centred behavioural style. The remaining items refer to the caring dimension, which is described as the disease-centred behavioural style. The sharing and caring dimensions represent independent features and are not appropriate for comparisons. A third style, the doctor-centred style, is explained with low scores on both dimensions according to the manual, but is not further explored in this study. Reliability analyses showed a Cronbach's α of .64 on the sharing dimension and a Cronbach's α of .42 on the caring dimension. All values in the corrected item-total correlation analysis were low positive, and no item weighted particularly negative.

2.2.2 | The CollaboRate

The CollaboRate measurement tool evaluates the patient experiences of SDM. In order to assess patient experiences, we found it appropriate to apply a patient-related outcome measure (PROM).³⁶ The CollaboRate is translated into Norwegian,³⁷ and is well validated. It has been shown to be useful in different patient populations and levels of care, and is equipped with a comprehensive description of interpretation.^{4,38} According to this, we appraised it to be a suitable instrument for our purpose. The CollaboRate comprises three single questions dealing with tutoring and feedback to the patient about the health situation and attention paid by the practitioners to what matters most to the patient. Response options are ordinal on a scale 0 to 9, where 0 represents "no effort was made" and 9 "every effort was made."³⁹ After adding the responses from the three questions, an ordinal score of 0 to 27 emerges. This score is multiplied by

3.704 to give a recalculated response percentage score between 0 and 100. A ceiling effect is described for the instrument as a considerably share of the patients reported on the upper part of the scale in earlier studies.³⁸⁻⁴⁰ As our purpose was to investigate associations between practitioner attitudes and patient experiences, we considered the CollaboRate suitable for this study, in spite of these reports. Reliability analyses yielded a Cronbach's α of .91 on the patient version and .89 on the therapist version. All values in the corrected item-total correlation analysis were high positive, so the questions partly overlapped.

2.3 | Data analyses

We performed descriptive analyses to explore the PPOS reports from the practitioners. Comparisons of means were performed by independent *t* tests.

To investigate associations between the practitioners' reports on PPOS and the patients' reports on CollaboRate, we performed a logistic mixed effect model. Then, the individual patient scores on CollaboRate were correlated to the scores on PPOS of their practitioner.

The outcome of the model was "high SDM score," defined as a score of 80 or more on the CollaboRate scale, which corresponds to a sum score of more than 21 out of maximum 27; eg, represents a score of a minimum of 8 at one question and 7 at the two others.

Several independent factors were included in the model. The practitioners' age was kept as a continuous variable in the analyses, as we assumed a linear effect. The practitioners' professions were divided into five groups for descriptive presentation: medical doctors, psychiatrists, psychologists, psychologists holding a post graduate clinical specialization, and college-educated practitioners, which were nurses, social workers, or pedagogues. Practitioners holding other professions were not included in the analyses. The college-educated practitioners were used as reference group during comparisons of means because of the majority of practitioners in this group. For the regression analyses, the medical doctors and psychiatrists were merged into one group and the psychologists, with or without clinical specialization, were merged into a second group; whereas the college-educated practitioners were kept as a third group. This was done because of their similarity in educational topics and clinical tasks, and limited numbers in some of the groups used for descriptive analyses. The medical doctor group was set as reference group in the regression analyses because of their main role in treatment-related decisions. The working sites, wherein the patients received their treatment, were divided into four: outpatient care, ambulatory care, day care, and inpatient care. The outpatient group was set as the reference group during analyses as this treatment was provided to the majority of patients and is regarded among the practitioners as the cornerstone of the services offered by specialist mental health care. The two dimensions of the PPOS scores, sharing and caring, were handled as independent, continuous scores during analyses.

Results were presented as odds ratios (OR) with 95% confidence intervals (CI). An association with a *P* value < .05 was considered

statistically significant. Data analyses were performed using IBM SPSS⁴¹ version 23 and Stata 15.

2.4 | Ethical approval

The study was approved by the Norwegian Regional Committees for Medical and Health Research Ethics 21.11.2016 (no 2016/1781) and the Research Department at Sørlandet Hospital 18.01.2017 (no: 17/00104).

3 | RESULTS

Among the 312 practitioners included in the study, mean age was 46.1 years (SD 11.6) and two thirds were women. There were 60 medical doctors, 97 psychologists, 127 with a college degree in nursing, social science or pedagogy, and 28 holding other professional degrees. There were most practitioners ($n = 151$) working in the outpatient care, whereas 25 practitioners had ambulatory work, 23 worked at inpatient care, and 14 worked at day care. Characteristics of the study population are shown in Table 1. Not all practitioners answered all the questions on the questionnaire. Working site in the clinic was specified by 213 practitioners. Therefore, information about working site was missing for 99 practitioners. Age and gender was specified by 303 and 305 practitioners, respectively.

TABLE 1 Baseline characteristics of the study population and distribution regarding gender, profession, and clinical treatment site

Practitioners	Mean	SD	N	%
Age (years), $n = 305$	46.1	11.6		
Gender, $n = 303$				
Male			101	33.3
Female			202	67.7
Education, $n = 312$				
MD			44	14.2
MD psychiatrist			16	5.2
Psychologist			85	27.4
Psychologist specialist			12	3.9
College education			127	40.3
Other ^a			28	9.0
Working site, $n = 213$				
Outpatient care			151	70.7
Ambulatory care			25	11.6
Day care			14	6.5
Inpatient care			23	10.7

Note. N is the number of practitioners responding to the different variables.

Abbreviation: SD, standard deviation.

^aOther professions were not further described, and not included in the analyses.

The practitioners reported a slightly higher mean score on the sharing dimension than on the caring dimension using the PPOS instrument. For the sharing dimension, mean score was 4.75 (range 1-6; 95% CI, 4.69-4.81). The mean score for the caring dimension was 4.72 (range 1-6; 95% CI, 4.67-4.77). Distribution and comparisons of the PPOS scores among the practitioners are shown in Table 2.

The female practitioners showed significant higher scores on both sharing and caring dimensions, compared with the male practitioners (4.79 vs 4.67, $P = .041$ and 4.77 vs 4.65, $P = .023$, respectively).

Compared with the college educated practitioners, medical doctors without postgraduate specialist education reported a lower score on the sharing dimension, which refers to a less patient-centred attitude (mean 4.46 vs 4.83, $P < .001$). There were no significant differences between the other professions. We also found a significant lower sharing score for the practitioners working in inpatient care compared with practitioners in outpatient care (4.44 vs 4.81, $P = .002$). The medical doctors without postgraduate education reported a lower caring score than the college educated practitioners (4.61 vs 4.75, $P = .005$). We found no differences between the other professions or on working sites on the scores on the caring dimension.

From our linked data, we identified 206 paired datasets with one practitioner and one or more patient. A total of 772 patients were linked to a practitioner, with a mean of 3.7 patients per practitioner (range 1-22). Results from the logistic mixed effects regression analysis with patient CollaboRate score more than 80 as dependent variable are shown in Table 3.

Our findings show that patients are more likely to report high SDM scores if their practitioner reports higher scores on the sharing dimension (OR 1.97, $P = .03$); ie, reports a more patient-centred attitude. The probability for patients to report high SDM scores was not associated with practitioner's age, gender, or profession, or by the practitioners' reports on the caring dimension of PPOS, which relates to disease-centeredness. Patients whose therapists work in ambulatory care were less probable of reporting a high SDM score compared with those whose therapists work in outpatient care. There were no differences in the probability of reporting high SDM scores among the rest of the working sites.

4 | DISCUSSION

This study points out that practitioners specific attitudes are relevant for the patient's experience of SDM. We found a positive association between practitioners' patient-centred attitudes and patient experiences of SDM in mental health care, which implies the relevance of taking the practitioner attitudes into account for accomplishment of SDM processes in mental health care.

An SDM process is a meeting between competent individuals that hold different expertise. Thus, each contribution is important for success. Recognition of the human experience and the life-world of the other is considered among the soft skills, which taps deep into our empathy and is a product of our life as a whole, but is also the quality of clinical experience and learned clinical skills. Set against this, both

TABLE 2 Distribution of the sharing and caring scores of PPOS among the different gender, professions and working site of the practitioners

Practitioners	N	Mean Sharing Score	SD	95% CI	P value	Mean Caring Score	SD	95% CI	P value
Respondents	312	4.75	0.52	4.69-4.81		4.72	0.43	4.67-4.77	
Gender n = 303									
Male	101	4.67	0.57	4.55-4.77	.04 ^a	4.65	0.49	4.55-4.75	.02 ^a
Female	202	4.79	0.48	4.72-4.86	Ref	4.77	0.40	4.71-4.83	Ref
Profession n = 284									
Medical doctor	44	4.46	0.54	4.29-4.62	<.001 ^b	4.61	0.40	4.48-4.73	.05 ^b
Medical doctor specialist psychiatry	16	4.84	0.29	4.69-5.00	.86 ^b	4.67	0.57	4.36-4.97	.48 ^b
Psychologist	85	4.83	0.46	4.73-4.93	1.00 ^b	4.80	0.44	4.70-4.89	.40 ^b
Psychologist specialist psychology	12	4.81	0.40	4.55-5.06	.89 ^b	4.88	0.51	4.55-5.21	.41 ^b
College education	127	4.83	0.47	4.74-4.91	Ref	4.75	0.41	4.68-4.82	Ref
Working site n = 213									
Out-patient care	151	4.81	0.50	4.73-4.89	Ref	4.74	0.47	4.66-4.81	Ref
Ambulatory care	25	4.64	0.40	4.47-4.81	.12 ^c	4.72	0.32	4.58-4.86	.82 ^c
Day care	14	4.86	0.29	4.68-5.04	.73 ^c	4.87	0.47	4.51-5.23	.35 ^c
Inpatient care	23	4.44	0.70	4.14-4.75	.002 ^c	4.68	0.35	4.53-4.83	.55 ^c

Note. N for gender and treatment site is the number of practitioners responding to the different variables. N for education is after omission of the practitioners who reported other professions.

Abbreviations: CI, confidence interval; PPOS, Patient-Practitioner Orientation Scale; SD, standard deviation.

^aSignificance of differences in score between males and females.

^bSignificance of differences in scores between the labelled profession and the college educated practitioners.

^cSignificance of difference in scores between the labelled treatment sites and outpatient care.

the attitudes and the clinical experience of the practitioners are essential attributes for the SDM process. They are elements of the practitioners skills, and thus a premise to find the best way forward regarding treatment plans where the patient experiences and perspectives are integrated. This can explain our finding of lower reports on the sharing scores by medical doctors without postgraduate specialist education, but not by psychiatrists. As the medical education concerns mainly biomedical factors, the postgraduate specialist education to a greater degree concerns clinical experience of importance for patient centeredness.

Van Baalen and co-workers have discussed decision-making processes in professional multidisciplinary teams.²⁹ Multidisciplinary teams provide space where information and interpretations can converge into a shared team decision, a decision derived from the socially distributed process. So, rather than exclusively focusing on the individual clinician's reasoning and knowledge, clinical decision making is claimed as a social knowing. SDM processes have many similarities to clinical decisions made in multidisciplinary teams, although fundamentally different approaches. Contrasting to this multidisciplinary teams' decision-making processes, the principal contributor—the patient—is present in SDM processes. The fundamental quality in SDM lies in the outcome where the participations' contributions evolve to a socially distributed process, where the knowledge evolves to a more extensive knowledge than the individual knowledge carried by each participating individual.

The International College on Person-Centred Medicine (ICPCM) has produced declarations on different topics concerning person-centred medicine. Through this work, they have aimed to reframe our understanding of the concept of health by recognizing health and health care as dynamic and complex systems.⁴² In addition to the aspects of attitudes that PPOS are dealing with, there are several other ways to consider and to assess the balance of power in clinical encounters and what kind of influence the practitioners' attitudes play. Street and co-workers have combined PPOS scores and communication control patterns and pointed out the importance of communication in quality health care.⁴³ They suggested that attitudes enhancing active patient participation and practitioner partnership building are claimed to mutual increase each other. From this, we interpret partnership building and active patient participation as important, but not exhaustive, facilitators for SDM because the complex and dynamic process involves individual factors that change over time.

Earlier studies have suggested that the practitioners' attitudes, but not the patients' attitudes, towards patient-centeredness are a key factor for generating higher patient satisfaction, better adherence, and improved health outcome.^{31,35} The opposite has also been postulated that patients whose doctors were not as patient-centred were less satisfied.³⁴ Therefore, we assert that practitioners' attitudes are relevant features, which beneficially should be incorporated into the understanding of SDM processes. It has been suggested that the

TABLE 3 Logistic mixed effects regression analysis with patient CollaboRate score more than 80 (ie, high SDM-score) as dependent variable, $n = 772$ patient-practitioner pairs contain all variables in the model

Independent Variables	Univariable Mixed Effect Logistic Regression			Multivariable Mixed Effect Logistic Regression		
	OR	95% confidence interval	P value	OR	95% confidence interval	P value
Age, years	1.02	1.00-1.04	.02	1.02	1.00-1.04	.08
Gender						
Male	1.00	0.66-1.52	.99	0.98	0.65-1.48	.91
Female	Ref			Ref		
Profession						
College education	1.03	0.60-1.78	.90	0.94	0.52-1.72	.84
Psychologist/specialist clinical psychology	0.95	0.54-1.68	.88	1.00	0.53-1.88	1.00
MD/psychiatrist	Ref			Ref		
Working site						
Ambulatory treatment	0.42	0.24-0.75	.01	0.44	0.25-0.79	.01
Inpatient treatment	0.59	0.31-1.13	.11	0.68	0.34-1.39	.29
Daycare treatment	0.73	0.37-1.40	.34	0.85	0.43-1.69	.64
Outpatient treatment	Ref			Ref		
PPOS score						
Sharing ^a	2.22	1.23-4.02	.01	1.97	1.09-3.56	.03
Caring ^a	0.67	0.35-1.29	.23	0.82	0.43-1.57	.54

Abbreviations: OR, odds ratio; PPOS, Patient-Practitioner Orientation Scale.

^aSharing and caring scores on the PPOS, range 1 to 6.

application of the different practitioner behavioural styles fit patients with the equal orientations at best.³¹ Therefore, not necessarily all practitioners need to show sharing attitudes or develop their sharing attitude further to increase patient satisfaction. Some patients prefer disease-centred practitioners and should be equipped with treatment plans according to this. Nevertheless, the attitudes of the practitioners are relevant to pay attention to when patients are allocated in the clinics so that the best possible fit can be arranged and good conditions for successful treatments are facilitated.

The premise for implementing SDM is an active patient who is capable of making up an opinion of what matters most and is able to express it. SDM is one structured element in the ongoing turn from paternalistic health care, where the patient is a passive recipient of the health service's expertise, towards patient centeredness. A patient-centred health care requires and facilitates the autonomous patient, where SDM is one element in the accomplishment.⁴² In mental health care, this can be a challenge because of the patients' condition. We believe, however, that also patients in mental health care are able to express their opinions and wishes for treatment despite significant burden of disease. We even think that being included in decisions about treatment is positive for mentally ill patients, and can facilitate the recovery process. We suggest that patient-centeredness should be regarded as an attitude permeating the entire service rather than isolated actions performed by individual practitioners.

The development of the autonomous patient capable of practicing SDM requires the health care service to be the driving force. The service is expected to guide the patient into an active and autonomous mode in order to develop patient-centeredness in health care service. Possible entanglements might appear when the autonomous patient, firstly, is activated by the health care service, and, secondly, is treated by the same clinics now supposed to practice patient-centeredness. It is a paradox, and could be demanding, for the service to both enable the patient for active participation in SDM processes and, thereafter, to comply the patients' requirements developed from facilitation of the autonomy process.

4.1 | Data considerations

As we linked the data from each practitioner to data from one or more patients, a mean regression with CollaboRATE score as a continuous variable was not possible. Additionally, the residuals of the patients CollaboRate scores were not normally distributed. Thus, the preconditions for linear regression models were not met. A dichotomizing into CollaboRate maximum score (a score of 100) or not did not yield any meaningful product, and a model with the maximum scores alone in one group was not regarded correct, mainly because of our experience of the diversity of the patient approaches to such scoring scales. As patients differ in personality and understanding of the questions, not

only top scores should be regarded as “good.” Some patients would never use the extremes on a scale, regardless of how strongly they agree or disagree to a statement. Because of this, with a scale ranged 0 to 100, the study group specified a cut-off of 80 as the dependent variable for the dichotomy CollaboRate score.

In this study, we collected information about the practitioners' attitudes towards their behavioural styles and explored associations towards patients' experience of SDM. We did not assess the patient attitudes towards their behavioural styles. As we regard attitudes as an internal feature and the experiences of SDM as an expression of an external event, they represent fundamentally different aspects. An additional exploration of patient attitudes towards behavioural styles using PPOS would add important contributions to understand the complexity of SDM processes. We searched in PubMed and Embase using the terms “PPOS,” “CollaboRate,” and the MeSH-terms “personnel attitudes” and “shared decision making,” but could not find earlier studies exploring these associations.

4.2 | Strengths and limitations

In order to analyse and understand the underlying complexity in the SDM processes in mental health care, the assessment methods we used in this study have obvious shortcomings. As a measure of practitioners' attitude, we explored only one facet; the behavioural styles measured by PPOS. This is not sufficient to characterize the polygonal influence practitioners make on the patient perceptions. Thus, in order to suggest professional competencies necessary to implement SDM throughout the mental health care service, the sharing and caring attitudes measured by the PPOS is only one of many essential qualities to appraise. The person-centred health care, wherein SDM is a culmination of patient-practitioner relationship and communication, contain complex structures and high-dimensional interactions among multiple factors.⁴² The competencies sufficient for this multiple task are comprehensive and not suitable to be assessed through one single instrument. Future initiatives for development of relevant instruments to identify and structure professional skills necessary for SDM are desirable.

The patients attending the service are diverse with regard to diagnosis, illness duration, symptom burden, and functioning. We did not analyse diagnostic information of function level in this paper. From service knowledge, we assume that inpatient care and ambulatory care are offered to patients with more severe disease symptoms or in more acute illness phases than outpatient care. As we know, patient-practitioner relationships are complex and mutually influenced. It would be of interest to investigate patient characteristics further. However, professional attitudes are suggested internal and exist overarching and prior to individual patient visits.

4.3 | Further implications

Until now, focus on SDM preparations and the barriers and facilitators have been on the patients' characteristics. We suggest that the focus

should be turned more towards the health care service and the role of the practitioners. Practitioners' attitudes affect patients' perceptions of SDM. Evolution of attitudes are complex and develop to a great extent through clinical experience. The soft skills necessary to fulfil SDM are challenging to teach, describe, and measure. In spite of the difficulties, it is important that the service continues to implement SDM and assess the effort to realize the patient's health service.

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CONFLICT OF INTEREST

The authors declare no conflict of interest.

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