REVIEW ARTICLE

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Shared decision making for adults with severe mental illness: A concept analysis

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Abstract

Aim: Shared decision making for adults with severe mental illness has increasingly attracted attention. However, this concept has not been comprehensively clarified. This review aimed to clarify a concept of shared decision making for adults with severe mental illness such as schizophrenia, depression, and bipolar disorder, and propose an adequate definition.

Methods: Rodgers' evolutionary concept analysis was used. MEDLINE, PsychINFO, and CINAHL were searched for articles written in English and published between 2010 and November 2019. The search terms were "psychiatr*" or "mental" or "schizophren*" or "depression" or "bipolar disorder", combined with "shared decision making". In total, 70 articles met the inclusion criteria. An inductive approach was used to identify themes and sub-themes related to shared decision making for adults with severe mental illness. Surrogate terms and a definition of the concept were also described.

Results: Four key attributes were identified: user–professional relationship, communication process, user-friendly visualization, and broader stakeholder approach. Communication process was the densest attribute, which consisted of five phases: goal sharing, information sharing, deliberation, mutual agreement, and follow-up. The antecedents as prominent predisposing factors were long-term complex illness, power imbalance, global trend, users' desire, concerns, and stigma. The consequences included decision-related outcomes, users' changes, professionals' changes, and enhanced relationship.

Conclusions: Shared decision making for adults with severe mental illness is a communication process, involving both user-friendly visualization techniques and broader stakeholders. The process may overcome traditional power imbalance and encourage changes among both users and professionals that could enhance the dyadic relationship.

KEYWORDS
bipolar disorder, depression, review, schizophrenia, shared decision making

1 | INTRODUCTION

The treatment and rehabilitation of people with severe mental illness (SMI) such as schizophrenia, depression, and bipolar disorder, have progressed toward recovery-oriented care rather than simply symptom relief. Recovery is a way of living a meaningful life even with limitations caused by mental illness, overcoming the challenges of the disability (Deegan, 1988). The recovery weighs control being placed in the hands of the service users and not in those of the health professionals (Jacobson, 2001). Accordingly, recovery-oriented care craves for the collaborative nature of interactions between people with SMI and health professionals (Duncan, Best, & Hagen, 2010).

In this regard, instead of a paternalistic decision-making model, where the health professionals take the initiative, shared decision making (SDM) has been increasingly promoted in the mental health field as an ideal model. SDM is an ethical imperative (Drake & Deegan, 2009) and has started to be seen as a key element in the delivery of user-centered care (Barry & Edgman-Levitan, 2012). SDM leads to a central part of the recovery paradigm described above, which originates from the service user's right to autonomy and self-determination (Storm & Edwards, 2013). It may reduce medical care costs by reducing hospital admissions among people with SMI (Cosh et al., 2017). It can also decrease the costs associated with the use of unnecessary or unwanted prescriptions (Latimer, Bond, & Drake, 2011). Several studies have found that most adults with SMI wanted to be involved in decision making (Park et al., 2014; Velligan, Roberts, Sierra, Fredrick, & Roach, 2016), and are able to participate (Aoki, Furuno, Watanabe, & Kayama, 2019a; Aoki et al., 2019b; Duncan et al., 2010; LeBlanc et al., 2015).

Hence, SDM has now been adopted at the national policy level in many Western countries (van Hoof et al., 2015) and has extended to Asian and African countries (Singh, 2015; Stein, 2014). Interventions or training programs to promote SDM for adults with SMI have been developed in both outpatient and inpatient settings. They involve various stakeholders such as clinicians, nurses, social workers, and peer supporters. The decisions involved are also diverse, and include treatment, medication, care plans, and community care after discharge from hospital.

However, despite the growing reports in the literature, a theoretical concept of SDM in the mental health field has not been explored thus fur, and no concept analysis of SDM for adults with SMI has been performed. The absence of a clear concept of SDM for people with SMI has made it harder to understand the needs and roles of health professionals in the process. This situation has caused confusion and in turn made collaboration between service users and health professionals more difficult. Describing and defining the concept of SDM for adults with SMI could therefore provide appropriate guidance for health professionals including nurses.

Given the above, SDM for adults with SMI was viewed an appropriate term for more verification using the concept analysis methodology.

This review aimed to describe the findings of an evolutionary concept analysis of the term SDM in the mental health field, particularly adults with SMI.

2 | METHODS

Rodgers' (2000) evolutionary method was used for this review. This evolutionary method is particularly appropriate because of the changes in the concept of SDM over the last few decades, its dynamic nature and its adaptability to different settings and situations. This meant it was necessary to use a method that would allow comparison of changes over time, and the use of SDM for SMI in different studies. As SDM for adults with SMI has been increasingly recognized and widely implemented in various settings, we focused on how it is used, as well as clarified and defined its concept in context. This review followed six steps: (a) identify the concept of interest; (b) select the appropriate realm (sample and setting) for data collection; (c) collect data relevant for identification of (i) attributes, (ii) the concept's contextual basis (antecedents and consequences), and (iii) surrogate terms; (d) analyze data regarding the above components; (e) identify an example of the concept if appropriate; and (f) describe the implications, hypotheses, and future development opportunities (Rodgers, 2000).

2.1 | Data sources

A systematic search was conducted using the terms "psychiatr*" or "mental" or "schizophren*" or "depression" or "bipolar disorder" combined with "shared decision making" as key words within the titles or abstracts in the online databases such as MEDLINE, PsychINFO, and CINAHL.

2.2 | Data selection

The inclusion criteria were:

- empirical studies among adults with SMI (schizophrenia, depression, and/or bipolar disorder) and/or health professionals caring for adults with SMI;
- articles that focused on SDM between adults with SMI and health professionals; and
- English articles published from 2010 to November 2019.

This period was selected to ensure a contemporary analysis of this concept.

The exclusion criteria were:

- review articles, discussion articles, and protocol articles;
- articles casually citing "SDM";
- studies that excluded adults with SMI; and
- studies among parents or guardians of children with SMI.

We excluded parents or guardians of children with SMI to avoid confusion between surrogate and own decision making, because surrogate decision making might have different elements.

The initial search strategy revealed 1,185 articles. This was reduced to 497 articles when duplicates were removed, limited to articles in mental health settings. The abstracts of 497 articles were examined and the relevance to SDM for adults with SMI was assessed. Review articles, discussion articles, and protocol articles were excluded. Articles regarding SDM for people with other mental illnesses except SMI or children with mental health problems were also removed. Following this assessment, 89 articles were retained. An additional hand-searched article relevant to SDM for adults with SMI was included. The full text of these 90 articles was obtained, and each paper was read once to examine the general subject of the work and its relevance. As a result, some articles casually citing the term were excluded before the analysis. In total, 70 articles met the inclusion criteria and were included in the concept analysis (Appendix 1). Figure 1 illustrates the flowchart of article selection.

2.3 | Data analysis

The coding procedure was conducted by adopting the Rodgers' (2000) evolutionary method. First, the articles were read and examined to gain the essence of this concept. Thereafter, they were reviewed once again for systematic data extraction and assuring their validity. Second, the extracted data were divided into categories using thematic analysis to determine attributes,
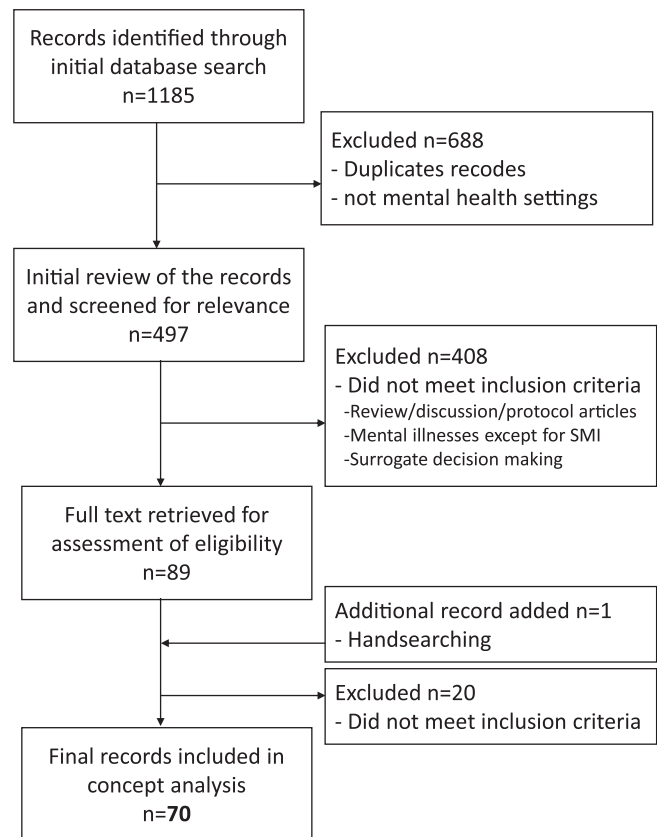

FIGURE 1 Flow chart of article selection

antecedents, or consequences. Data that express this concept ideas through other words were extracted as surrogate terms. To ensure the validity and reliability of the analysis, the process of the analysis was supervised by a nursing researcher experienced in this method of analysis.

3 | RESULTS

3.1 | Attributes

3.1.1 | User–professional relationship

The relationship between the service users and health professionals served a foundation attribute to cultivate SDM in the mental health field. SDM in mental health care values the philosophy of *partnering* with the service users (Hamera, Pallikkathayil, Baker, & White, 2010). In particular, the relationship with *collaborative* attitude as equals is central to SDM (Alegria et al., 2018; Chong, Aslani, & Chen, 2013b; Eliacin, Salyers, Kukla, & Matthias, 2015; Hamera et al., 2010; Kreyenbuhl et al., 2016; Matthias, Fukui, & Salyers, 2017; Mikesell, Bromley, Young, Vona, &

Zima, 2016; Stead, Morant, & Ramon, 2017; Paudel, Sharma, Joshi, & Randall, 2018; Woltmann & Whitley, 2010; Zisman-Ilani et al., 2019). The health professionals work to build an *alliance* with the service users for the success of SDM (Paudel et al., 2018). Other valued characteristics of the user–professional relationship are *openness*, *honesty*, and *transparency*, not selectively and discriminative when sharing decision making with the service users (Chong, Aslani, & Chen, 2013ab; De Las Cuevas et al., 2011; Hamann et al., 2016; Mahone et al., 2011; Martin, Perlman, & Bieling, 2015; Mikesell et al., 2016; Nott, Mcintosh, Taube, & Taylor, 2018; Schön, Grim, Wallin, Rosenberg, & Svedberg, 2018; Stead et al., 2017).

3.1.2 | Communication process

Communication process was the densest attribute, which consisted of the following five phases: goal sharing, information sharing, deliberation, mutual agreement, and follow-up.

Goal sharing
Goal sharing was described as the initial phase of the communication process. The goal for the decision is not granted by the health professionals unilaterally, but set together with the service users through discussion (Matthias et al., 2017). It is the user's own goal, which is individual recovery-oriented (Matthias et al., 2017; Paudel et al., 2018; Woltmann, Wilkniss, Teachout, McHugo, & Drake, 2011; Yamaguchi et al., 2017). Thereafter, both parties share the service user's identified personal goal (Finnerty et al., 2019; Paudel et al., 2018; Yamaguchi et al., 2017).

Information sharing
The next phase of the communication process was *information sharing* that emerged as a multidimensional concept described below. Table 1 shows articles that contributed on *information sharing* and the related subthemes.

Description of condition. In the beginning, the service users' current *condition* was shared. The health professionals inform the psychiatric diagnosis to the service users. Information about symptoms and related behaviors are shared. Such information regarding illnesses is often provided by *psychoeducation*. Furthermore, *description of condition* involves the user's problem formulation by deciding the current problem, and identifying the how and why of the problem.

Options. *Options* were the most frequently discussed in the information sharing phase. All available options for the service user's current condition or problems are offered. The options are treatment options, care plan options, or rehabilitation options depending on the setting. The service users and health professionals explore the options by discussing *modules*, *pros and cons*, *research evidence*, *costs*, and *uncertainties* of each option.

Impact on daily life. How the service user's condition or proposed available options would *impact on their daily life* was explored. The service users and health professionals discuss how those things impact on the service user's personal circumstances, including social functioning and lifestyle.

Users' views. Several aspects of the service *users' subjective views* were shared. Those are individual treatment/care *wants* and *expectations* including informational *needs*, own *opinions*, *preferences/values* containing what is the most important to the user. *Past experiences* of the service users were also shared. Moreover, the service users voice *concerns* or *doubts* about health conditions, treatment options, or their future.

Self-help resources. The reference about *self-help resources* of the service users was also discussed. This includes *personal wellness strategies* such as developing coping skills to relieve symptoms, awareness of warning signs, and acquiring environmental support systems for *relapse prevention*.

Professionals' views. The *health professionals' views* were contributed as well. The professionals add *recommendations* giving their *clinical expertise* with some examples of *previous experiences* that are related to the illness and its treatment.

Peers' recovery experiences. In many articles, not only health professionals' views but also peer specialists' perspectives based on their own *recovery experiences* were introduced as reference opinions.

Deliberation
The third phase of the communication process was the *deliberation*.

Reviewing. The service users and health professionals *review* together the information shared thus far (Goscha & Rapp, 2015; Zisman-Ilani et al., 2019). For deeper understanding, the health professionals offer the users sufficient time to ponder that information in more detail,

T A B L E 1   Attributes of shared decision making for adults with severe mental illness

Themes	Sub-themes	Article
User–provider relationship		
	Partnership/collaboration	Alegria, Chong[b], Mikesell, Schön, Eliacin, Stead, Hamera, Kreyenbuhl, Matthias[2017], Paudel, Perestelo, Woltmann[2010], Zisman-ilani
	Alliance	Paudel
	Openness/honesty/ transparency	Chong[a,b], De las Cuevas[2011], Hamann[2016], Mahone, Martin, Mikesell, Nott, Schön, Stead
Communication process		
	Goal sharing	Aoki[a], Bonfils, Schön, Finnerty[2019], Fukui[2015], Goscha, Grim, Luken, Stead, Kreyenbuhl, Matthias[2017], Paudel, Sather, Solberg, Woltmann[2010,2011], Yamaguchi, Zaini
	Information sharing	
	Description of condition	Alegria, Aoki[a,b], Chong[a,b], Eliacin, Finnerty[2019], Fukui[2014], Goscha, Grim, Hamann[2016], Martin, Metz[2018], Patel, Paudel, Raue, Van der Krieke, Zaini
	Psychoeducation	Chong[b], Raue, Van der Krieke
	Options	Alegria, Aoki[a,b], Brooks, Chong[b], Finnerty[2019], Fukui[2014], Goscha, Hamann[2016], Kivelitz, Klausen, Mahone, Matthias[2017], Park, Patel, Paudel, Schön, Shepherd, Stead, Velligan, Zaini, Zisman-ilani
	Modules	Chong[b], Goscha, Hamera, Kivelitz, LeBlanc, Martin, Patel, Raue, Stead, Van der Krieke, Zaini, Zisman-ilani
	Pros and cons	Aoki[a,b], Chong[a], Ehrlich, Eliacin, Fukui[2014,2015], Grim, Hamann[2016], Hamera, Kivelitz, LeBlanc, Luken, Mahone, Martin, Matthias[2017], Nott, Paudel, Perestelo, Ramon, Raue, Shepherd, Stead, Van der Krieke, Velligan, Verwijimeren, Zaini, Zisman-ilani
	Research evidence	Finnerty[2018], Fukui[2015], Kreyenbuhl, LeBlanc, Perestelo, Verwijimeren
	Costs	Hamera, Raue, Zaini
	Uncertainties	Campbell, De las Cuevas[2011], Fukui[2014,2015]
	Impact of daily life	Aoki[a,b], Fukui[2015], Grim, Hamera, Kivelitz, Klausen, LeBlanc, Mahone, Matthias[2017], Metz[2018], Patel, Ramon, Yamaguchi, Zaini
	Users' views	
	Wants/expectations/needs	Chong[a], Eliacin, Giacco, Goscha, Grim, Klausen, Lovell, Metz[2018], Mikesell, Paudel, Sather, Schön, Shepherd, Van der Krieke, Woltmann[2011]
	Opinions	Chong[a], Giacco, Ishi, Klingaman, Matthias[2012], Paudel, Sather, Woltmann[2011]
	Preferences/values	Alegria, Aoki[a,b], Brooks, Campbell, Chong[a], Eliacin, Finnerty[2018,2019], Fukui[2014,2015], Giacco, Goscha, Grim, Hamann[2011,2016], Kreyenbuhl, LeBlanc, Mahone, Matthias[2012,2014], Metz[2018], Mikesell, Patel, Paudel, Ramon, Raue, Sather, Schön, Shepherd, Solberg, Stead, Stein, Van der Krieke, Woltmann[2010,2011], Yamaguchi, Younas, Zaini, Zisman-ilani
	Past experiences	Aljumah, Eliacin, Goscha, Grim, Hamann[2016], Klausen, Kreyenbuhl, Mahone, Mikesell, Ramon, Raue, Sather, Stead, Van der Krieke, Zaini, Zisman-ilani
	Concerns/doubts	Alegria, Aoki[b], Bonfils, Chong[a], Ehrlich, Fukui[2015], Goscha, Grim, Hamann[2016], Hamera, Luken, Matthias[2012], Patel, Ramon, Raue, Stead, Stein, Van der Krieke, Yamaguchi
	Self-help resources	
	Personal wellness strategies	Stead, Hamera, Paudel, Finnerty[2019], Goscha, Grim, Yamaguchi, Campbell
	Relapse prevention	Paudel, Finnerty[2019]
	Professionals' views	
	Recommendations	Aoki[a,b], Chong[a], Grim, Hamera, Patel, Shepherd, Van der Krieke
	Clinical expertise	Fukui[2015], Luken, Mikesell, Stead

(Continues)

TABLE 1 (Continued)

Themes	Sub-themes	Article
	Previous experiences	Kreyenbuhl, Stead, Van der Krieke, Zaini
	Peers' recovery experiences	Ali, Aoki[a], Bonfils, Campbell, Finnerty[2019], Goscha, Metz[2018], Paudel, Stead, Yamaguchi
	Deliberation	
	Reviewing	Aoki[a,b], Eliacin, Goscha, Grim, Hamann[2016], Patel, Paudel, Perestelo, Raue, Sather, Schön, Shepherd, Van der Krieke, Woltmann[2010], Zisman-ilani
	Preparation for encounters	Aoki[a,b], Bonfils, Goscha, Grim, Hamann[2016], Metz[2018], Schön, Van der Krieke
	Mutual agreement	Alegria, Aoki[a,b], Chong[a], De las Cuevas[2011], Eliacin, Fukui[2014], Goscha, Grim, Hamann[2016], Ishi, Klingaman, Mahone, Matthias[2012,2014], Park, Paudel, Perestelo, Shepherd, Woltmann[2010,2011], Yamaguchi, Zisman-ilani
	Follow-up	Goscha, Grim, Luken, Matthias[2012], Paudel, Ramon, Schön, Shepherd
User-friendly visualization		
		Ali, Aoki[a,b], Campbell, Chong[b], Grim, Kivelitz, Martin, Metz[2018], Schön, Stead, Van der Krieke, Velligan, Woltmann[2010,2011], Wright-Berryman, Zaini
	Using support tools	Ali, Aljumah, Aoki[a,b], Bonfils, Campbell, Chong[b], Finnerty[2018,2019], Goscha, Grim, LeBlanc, Lovell, Luken, Martin, Metz[2018], Mikesell, Ramon, Raue, Sather, Schön, Stead, Stein, Van der Krieke, Woltmann[2010,2011], Yamaguchi, Zisman-ilani
Broader stakeholder approach		
	Interprofessional collaboration	Aljumah, Chong[a,b], Giacco, Ishi, Paudel, Sather, Stead, Younas, Zaini, Zisman-ilani
	Involving carers	Aoki[a,b], Chong[b], Eliacin, Giacco, Grim, Hamann[2016], Kivelitz, Klausen, Shepherd, Stead, Velligan

and even gather extra information, at home without any stress or pressure (Schön et al., 2018).

Preparation for encounters. During the deliberation, the users can *prepare for further encounters* on the decision-making process (Aoki et al., 2019ab; Bonfils et al., 2018; Goscha & Rapp, 2015; Grim, Rosenberg, Svedberg, & Schön, 2016; Hamann et al., 2016; Metz et al., 2018; Schön et al., 2018; van der Krieke et al., 2013).

Mutual agreement

The fourth phase of the communication process was the *mutual agreement*. The service users and health professionals discuss and finally arrive at a consensus about diagnostic decisions and further treatment plans (Perestelo-Perez et al., 2017). They make decisions together, and collaboratively agree on the decision (Grim et al., 2016).

Follow-up

Being offered *follow-up* encounters was described as the important phase. This is because questions or worries of the service users might arise after the decision (Schön et al., 2018). The health professionals follow the progress of the users to monitor how long a decision remains in effect and the possibilities for revising the decision (Grim et al., 2016). Continuous evaluation and adaptation are needed (Grim et al., 2016).

3.1.3 | User-friendly visualization

The attribute of *user-friendly visualization* was mainly derived from the information sharing phase of the communication process. When explaining the diagnosis and related options, the health professionals are devoid of medical jargon (Grim et al., 2016), rather they are familiar with plain language, simple statistics, and narrative stories in consideration of the users' different literacy and recovery levels (Martin et al., 2015; Velligan et al., 2016; Zaini et al., 2018). Tailor-made verbal information is essential (Chong et al., 2013b), and combination with visible information is also important (Grim et al., 2016). The health professionals incorporate readily understood graphs and icons including personalized graphics about their mental health conditions in their written summaries (Metz et al., 2018). For the service users, getting information visually facilitates not only ease of understanding but also opportunity to review it at home (Aoki et al., 2019a). The service users can print the checkbox form and take it with them to further encounters

(van der Krieke et al., 2013). In that context, much of the reports in the literature have used various types of decision aids (booklets, web-based online instruments, tablet and smartphone) as *support tools* to facilitate the decision-making process.

3.1.4 | Broader stakeholder approach

In many articles, *broader stakeholders* had important roles during the SDM process (e.g., health professionals, formal/informal carers). For a shared decision to be carried out, all health professionals who are in the clinical team should be informed and they should contribute as needed (Giacco, Mavromara, Gamblen, Conneely, & Priebe, 2018). *Interprofessional collaboration* consisting of different professions (e.g., psychiatrists, nurses, psychologists, pharmacists, social workers, occupational therapists) is perceived to facilitate SDM by addressing time constraints, allowing more opportunities for the users to discuss their concerns and opinions (Chong et al., 2013a). Nurses can serve as a bridge between the user and the psychiatrist, translating technical information and helping them as a decision coach, to further clarify the user's preferences and values (Aoki et al., 2019b; Paudel et al., 2018; Raue et al., 2019). Furthermore, engaging the *involvement of loved ones as other potential carers*, such as family members, and providing them information about mental illness and treatments are identified as facilitators to the SDM process (Chong et al., 2013b). The family members can provide valuable input about the service users' experiences with treatments (Eliacin et al., 2015).

3.2 | Antecedents

Six antecedents and five related sub-themes were extracted (Appendix 2).

3.2.1 | Long-term and complex illness

The first antecedent was characteristic to this targeted population on the premise. SMI is a long-term complex disorder fluctuating over time and often recurring (Grim et al., 2016; Hamann et al., 2016; Lukens, Solomon, & Sorenson, 2013). Subsequently, as treatment decisions are also complex and are frequently made (Fukuiet al., 2014; Grim et al., 2016), it is important to consider symptom severity and the phase of the mental health disturbance during the decision-making process (Luciano et al., 2019). Lukens et al. (2013) insist that success in long-term care is dependent upon active user involvement because it is the user and not the health professional who is most responsible for making the decision.

3.2.2 | Power imbalance

This antecedent was ascribed as the traditional relationship between the service users and health professionals in the mental health field. An inevitable and very real power structure exists between the users and health professionals (Fukui et al., 2014). Mental health services have a history showing that health professionals have been hesitant about patient's active involvement in decision making (Ishii et al., 2017). It is crucial to be aware of hierarchies and disparities of power in any decision-making process (Stacey et al., 2016). SDM implies giving up decisional power (Hamann et al., 2012) and aims to change the traditional power asymmetry by strengthening the exchange of information and the decisional position of the users (Hamann, Bühner, & Rüsch, 2017a). Mikesell et al. (2016) suggest that the service users can treat the professionals' expertise and knowledge as superior, but they do not have to perceive it as such, just because of the professionals' authority.

3.2.3 | Global trend

Several global trends which challenge traditional professionals' authority were emphasized in many articles. First, the active participation of the users in the decision-making process has been increasingly advocated (Klausen, Blix, Karlsson, Haugsgjerd, & Lorem, 2017; Perestelo-Perez et al., 2017). Government policies in many countries are currently more interested in promoting *user-centered healthcare* (Chong et al., 2013b; Klingaman et al., 2015; Sather, Iversen, Svindseth, Crawford, & Vasset, 2019; Younas, Bradley, Holmes, Sud, & Maidment, 2016). Second, in recent years, every part of mental health care is being committed to recovery, increasing emphasis of the users' roles as active participants (Mahone et al., 2011). SDM in the mental health field is conceptually congruent with this *recovery movement*, as it is considered to be a central component of the recovery-oriented system (Park et al., 2014). Third, *information technology* can offer the users more involvement in self-understanding and self-care of their mental illnesses (Woltmann et al., 2011). Compared with the past, the users have a greater access to information regarding their diseases and treatments (Hamera et al., 2010). The internet is no longer a rare resource for finding general information based on research evidence, in addition to the experience-based knowledge of others (Grim et al., 2016).

3.2.4 | Users' desire

Besides the global trend above, many articles reported that the service users themselves have a considerable desire to participate in decision making about their own treatment. Being offered options and being asked one's views about treatments for mental illness are nearly universally preferred (Park et al., 2014). Few users endorse a paternalistic, professional-driven, decision-making style (Woltmann & Whitley, 2010). Inpatients are no exception. Involuntary hospital users also wish to be involved in decisions within the hospital (Giacco et al., 2018). The service users are willing to be part of their care and learn more how to manage their own health problems (Sather et al., 2019). Furthermore, they want to share responsibility for deciding what the best treatment/care is (De Las Cuevas, Peñate, & de Rivera, 2014).

3.2.5 | Concerns

Despite the positive global trend and service users' desire, the concerns regarding SDM peculiar to SMI were also identified. First, the health professionals' concerns were raised about the *capacity of users* with SMI to participate in decision making. Lack of cognitive ability associated with illnesses was frequently proposed as concerns to engaging the users in SDM. Whether the users would be able to communicate effectively with health professionals was described (An, Kim, & Kim, 2017). Second, *time constraints* were raised. SDM tends to be perceived of as a time-consuming method (Schön et al., 2018). Particularly, outpatients' services have many users to visit in a very short time (Zaini et al., 2018). This may make it difficult to prioritize time for implementing new methods (Schön et al., 2018).

3.2.6 | Stigma

Several articles pointed out stigma associated with mental illness. Many mental health service users feel the stigma associated with their diagnosis (Klausen et al., 2017; Lovell, Bee, & Brooks, 2018). This negatively influences the users' attitudes on SDM (Chong et al., 2013b). When the users suffer from self-stigma and shame, then their behaviors may become less participatory and less critical during the communication with the health professionals (Hamann et al., 2017a). The health professionals' perception of the stigma associated with mental health services also exists within themselves or the healthcare system itself (Chong et al., 2013b).

3.3 | Consequences

Four consequences and 12 related sub-themes were extracted (Appendix 3).

3.3.1 | Decision-making related outcomes

One of the widely cited consequences was decision making-related outcomes. SDM could activate the service users to take *great engagement* in decision making, motivating them to be involved in the decision-making process (Hamann et al., 2011). Thereby, SDM led the users with SMI to *less conflict* (Metz et al., 2019; Perestelo-Perez et al., 2017), *more satisfaction* (LeBlanc et al., 2015; Woltmann et al., 2011), and being *more responsible* for their decisions and actions (Hamann et al., 2011). SDM did *not extend time* required for decision-making consultation/encounters (Aoki et al., 2019b; Bonfils et al., 2018; LeBlanc et al., 2015).

3.3.2 | Users' changes

Several changes of the service users were identified through the SDM process. First, the service users became more *knowledgeable* about mental illnesses, treatment options, rehabilitation services, and themselves (LeBlanc et al., 2015; Perestelo-Perez et al., 2017; Woltmann et al., 2011). Second, SDM could boost the service users' behaviors in *persisting on the chosen treatment/care* (Hamann et al., 2011; Ishii et al., 2017; Raue et al., 2019). Third, the service users could feel *empowered* and more self-respect (Hamann, Parchmann, & Sassenberg, 2017b; Lovell et al., 2018), and then became less dependent on the health providers (Lukens et al., 2013). Rather, they implemented *active self-management* of illnesses while developing strategies to cope and take charge of their life with SMI (Matthias, Salyers, Rollins, & Frankel, 2012; Matthias et al., 2017). Fourth, SDM could *promote the service users' wellness* (Goscha & Rapp, 2015; Ramon, Morant, Stead, & Perry, 2017). Not many but some studies reported that SDM could improve the users' condition and some symptoms (Zaini et al., 2018; Metz et al., 2019).

3.3.3 | Professionals' changes

The health professionals also changed in some aspects. SDM contributed to becoming more aware of the health professionals' own communication patterns with the service users (Schön et al., 2018). The health professionals became more *aware of the users' views* including concerns and worries (Woltmann et al., 2011). Furthermore, they gained

confidence to open dialogs about mental illnesses and related options with the service users (Ramon et al., 2017).

3.3.4 | Enhanced relationship

Besides each party's changes described above, the user–provider relationship was also enhanced. SDM led the service users to view the relationship with their psychiatrists as improved and reliable as it could increase the effectiveness of communication between two parties (Goscha & Rapp, 2015; Yamaguchi et al., 2017). The service users and health professionals moved toward more equal and collaborative discussion (Ramon et al., 2017). SDM could help to demonstrate an equalization of decision-making power (Grim et al., 2016; Hamann et al., 2011). It could also build trust and strengthen the therapeutic relationship between the user and professional (Martin et al., 2015; Matthias et al., 2014).

The attributes, antecedents and consequences emerging from this review are summarized in Figure 2.

3.4 | Surrogate terms

Surrogate terms of SDM for adults with SMI included "concordance" (Ali, Smith, Mican, & Brown, 2015; De Las Cuevas et al., 2011), "patient involvement in decision-making" (Giacco et al., 2018; Hamann et al., 2016; McCabe, Khanom, Bailey, & Priebe, 2013) "consumer involvement in decision-making" (Chong et al., 2013a; Matthias et al., 2017; McCabe et al., 2013), and "involvement in care planning" (Lovell et al., 2018) to describe SDM about care and treatment between users and professionals. "Recovery-oriented care" (Paudel et al., 2018; Schön et al., 2018), "consumer-oriented approach" (Hamann et al., 2017a), and "patient-centered approach" (Shepherd, Shorthouse, & Gask, 2014) were also surrogate terms for SDM for adults with SMI to describe respect for users' preferences, autonomy, and active management.

4 | DISCUSSION

4.1 | Theoretical definition

Shared decision making for adults with SMI is a communication process based on a user–professional relationship in various settings. It is delivered through sharing goals and information to reach agreement, including follow-up. The process can be promoted by involving user-friendly visualization techniques and broader stakeholders. SDM for adults with SMI may overcome
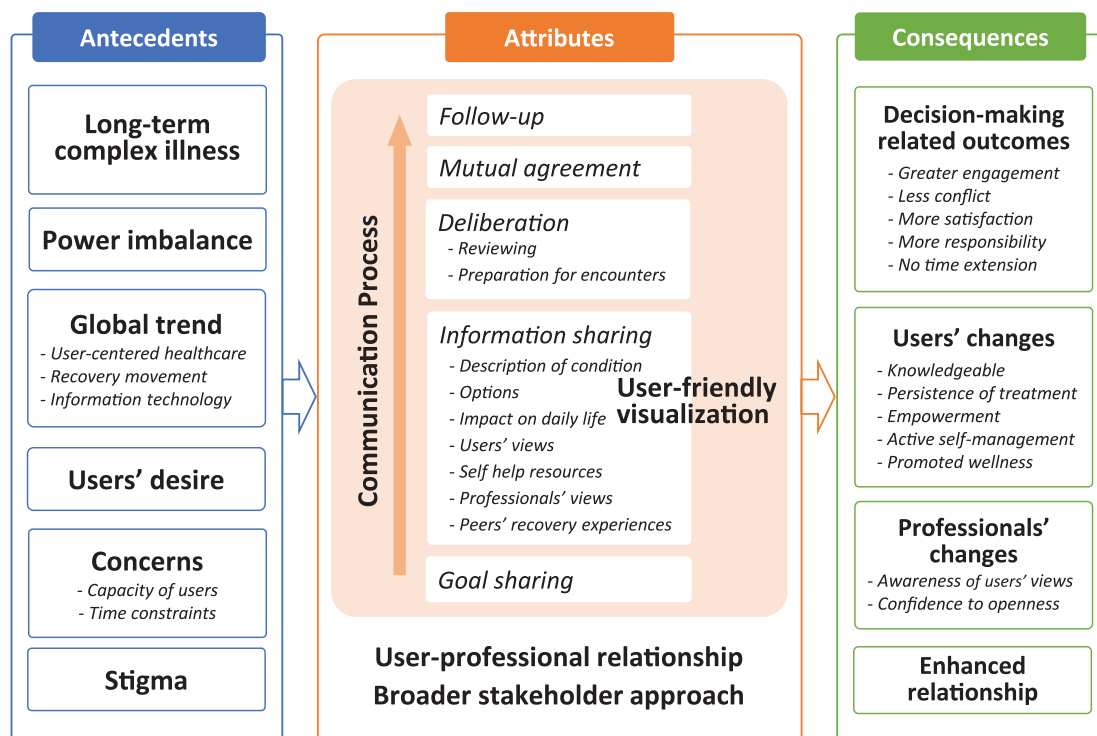

FIGURE 2 Concept model of shared decision making for adults with severe mental illness

traditional power imbalances and bring about changes among both users and professionals that could enhance the dyadic relationship.

4.2 | Traits of SDM for adults with SMI

Charles, Gafni, and Whelan (1997) defined an SDM model that has the most widely recognized core features in the medical field. This model involves at least two participants – physician and patient (Charles et al., 1997). Both parties share information, take steps to build a consensus about the preferred treatment, and reach an agreement on the treatment to implement (Charles et al., 1997). Although the SDM literature in the mental health field has been developing in alliance with the Charles model similar to other somatic areas, this concept analysis could provide two worthwhile findings that would be helpful to understand the theoretical principles of SDM, which are peculiar to people with SMI. Especially, multidimensional concepts emerging from the information-sharing phase are noteworthy. First, even in treatment decision-making where medication options are proposed, it appears to be important to share their self-help resources for symptom relief or relapse prevention. Individuals with SMI are developing their own wellness activities using their strengths to cope with long-term complex illnesses. Martin et al. (2015) suggest that the service users' strengths could be integrated into treatment discussions. Next, although providing the line of research evidence regarding treatment options is emphasized when conducting SDM in somatic areas (Légaré et al., 2018), recovery experiences of others would be helpful for people with SMI during the SDM process. Along with an interprofessional approach that could promote eliciting the service users' frank and honest views, giving a chance to access narrative stories of people with similar conditions might be useful.

4.3 | Overcoming barriers to SDM for adults with SMI

Several antecedents that might become barriers to implement SDM in the mental health field appeared, but there were also attributes that could overcome these barriers. First, despite the concerns about users' capacity to participate in the decision-making process, this review found the feasibility of SDM for adults with SMI, giving practical examples including those in acute wards (An et al., 2017; Hamann et al., 2011, 2017; Ishii et al., 2017; Kivelitz et al., 2018; Stacey et al., 2016; Velligan et al., 2016; Zisman-Ilani et al., 2019). Using

user-friendly visualization could be a bridge to allay such concerns and worries about the users' capacity. As the antecedent shows, SMI is a long-term complex disease and faces various decisions depending on the illness severity or individual life stage. On each occasion, it is crucial for the health professionals to ensure that the users' abilities are properly assessed. Otherwise, the decisions that should be in the users' hands might be driven by the health professionals following the traditional hierarchy. Second, contrary to the time constraints assumed, the consequences have identified no time extension thus far. As Chong et al. (2013a) suggest, interprofessional collaboration could work for alleviating this matter related to busy outpatient services. Third, stigma may also become a barrier to implement SDM. As the attribute shows, SDM requires understanding of their own current condition. People must overcome their debilitating self-stigmatization to face their own mental illness (Corrigan & Watson, 2002). It is considered that the greater the stigma, the more difficult it is to overcome the debilitating effect of one's own self-stigmatization. Health professionals who support the decision-making processes of adults with SMI need to assume that the service users are struggling with stigma and must listen carefully to their feelings while simultaneously sharing their own goals as a partner (Amador, 2012). Moreover, behaviors and efforts to create a stigma-free society are also needed.

SDM for adults with SMI may be able to overcome those barriers and bring about changes that could enhance the user–professional relationship.

5 | LIMITATIONS

This review included only papers written in English; therefore, possible relevant reports in other languages were excluded.

6 | CONCLUSIONS

SDM for adults with SMI is a communication process involving user-friendly visualization techniques and broader stakeholders. The process may overcome traditional power imbalance and bring about changes to both users and professionals that could enhance the dyadic relationship. The findings may be useful for understanding the theoretical structure for the current usage of this term. The results are helpful in carrying out treatment/care decision making in line with the service users' values.

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SUPPORTING INFORMATION

Additional supporting information may be found online in the Supporting Information section at the end of this article.