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Role preferences of patients with alcohol use disorders

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HIGHLIGHTS

- Clinicians should regularly ask patients about role preferences, since patients with AUD do need to make various decisions.
- Involving patients in decision-making is consistent with the recommendation of the German S3 guideline for alcohol.
- Patients' treatment readiness seems to be an important determinant of their involvement.

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ABSTRACT

Aims: Shared decision making (SDM) is increasingly demanded in medical decision making. SDM acknowledges patients' role preferences in decision making processes. There has been limited research on SDM and role preferences in substance use disorders; results are promising. Aim of this study was to investigate role preferences of patients with alcohol use disorders (AUD), and to identify predictors of these preferences.
Method: Cross-sectional data collected from June 2013 to May 2014 in four detoxification wards in Germany during a randomised controlled trial (RCT, Registration Code 01GY1114) was analysed.

Of the 250 patients with AUD who were included in the RCT, data from 242 patients [65% male; mean age = 45.2 years (sd = 10.3)] were analysed. Participants' role preferences were assessed with the Control Preference Scale. Potential correlates were drawn from instruments used in the RCT; multinomial logistic regression was used.
Results: 90% (n = 217) of the AUD patients preferred an active or shared role in decision-making, 10% (n = 25) preferred a passive role. Patients' desire for help was associated with their role preference (OR = 3.087, p = .05). The model's goodness of fit was Nagelkerke's R^2 = 0.153 [χ^2 (24) = 25.206, p = .395].
Conclusions: Patients' preference for an active role in decision-making underscores the importance of involving patients in their treatment planning. Patients' desire for help seems to be an important determinant of paternalistic decision making. However, further research is needed to determine whether patients' role preferences are related to their behavior during their treatment referral and recovery.

1. Background

Over the last decades, patient-advocate groups, legislation, and research findings stressed the importance of involving patients in medical decision-making (Crawford et al., 2003; Joosten, De Jong, de Weert-van Oene, Sensky, & van der Staak, 2011; National Institute for Health & Excellence [NICE], 2010). At patient level, involvement can be realised by using shared decision making (SDM; Coulter, 1997). SDM is a bilateral process between patients and treatment providers, which leads to joint and equitable decisions about the patients' treatments (Elwyn, Edwards, Kinnersley, & Grol, 2000; Légaré & Witteman, 2013). During the SDM process, clinicians contribute evidence-based medical

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knowledge, experiences, and attitudes, whereas patients share their individual perspectives, expectations, and goals, as well as information regarding their own needs, values, and daily life experiences. Hence, treatment decisions can be made within the framework of evidence-based medicine, but also integrate patients' individual preferences (Elwyn, Frosch, & Rollnick, 2009). Interventions to facilitate SDM, like e.g. decision aids for different health conditions or communication skills trainings for clinicians, had positive effects (Loh et al., 2007; Stacey et al., 2014) and were included in various treatment guidelines (Deutsche Gesellschaft für Psychiatrie und Psychotherapie Psychosomatik und Nervenheilkunde [DGPPN] et al., 2009; Leitlinienprogramm Onkologie der AWMF et al., 2012).

In addition to SDM, there are paternalistic and informed models of decision-making. Using the paternalistic model, a clinician has sole decisional authority, whereas in the informed model, the patient claims decision-making autonomy (Charles, Gafni, & Whelan, 1999). However, patients vary regarding their role preference during decision-making. Studies show that patients whose role preferences were not considered, acquired significantly less treatment knowledge (OR = 0.44, $p < .001$), regretted their decision significantly more (OR = 2.91, $p < .001$) (Livaudais, Franco, Fei, & Bickell, 2013), and showed less adherence to prescribed medication (Chi $^2 = 11.66$, $p = .003$) (De las Cuevas, Peñate, & de Rivera, 2014b). Therefore, it is important to clarify patients' role preferences before decisions are being made (Charles, Whelan, & Gafni, 1999). Another reason for clarifying role preferences repeatedly is that they may vary over time (Edwards & Elwyn, 2006).

Research revealed that patients with various health conditions would like to be informed if there is more than one treatment alternative (Frosch & Kaplan, 1999; Guadagnoli & Ward, 1998). Approximately 63% of cancer patients (Singh, Butow, Charles, & Tattersall, 2010) and 51% of individuals from the general population (Coulter & Magee, 2003) preferred to be involved in their treatment decisions instead of letting the clinician make the treatment decision (which were 23% of cancer patients and 26% of the general population, respectively). The majority of patients with psychiatric disorders preferred shared over paternalistic decision-making e.g. in anxiety disorders 55% SDM vs. 7% paternalistic, in bipolar disorders 65% (SDM) vs. 5% (paternalistic), or in unipolar depression 55% SDM and 5% paternalistic (Liebherz, Härter, Dirmaier, & Tlach, 2015; Liebherz, Tlach, Härter, & Dirmaier, 2015).

Patients' role preferences during treatment decisions might depend on their socio-demographic characteristics and clinical factors, especially the severity of the illness. Younger (Brom et al., 2014; Hamann et al., 2009; Levinson, Kao, Kuby, & Thisted, 2004), higher educated (Brom et al., 2014; Hamann et al., 2007), and female patients (Hamann et al., 2007; Levinson et al., 2004) were found to prefer a more active or shared role. However, Brom et al. (2014) and De las Cuevas, Peñate, and de Rivera (2014a) found inconclusive associations among these variables. Regarding patients' clinical characteristics, Brom et al. (2014) reported that more severely depressed patients with breast cancer preferred a paternalistic style of decision-making, whereas less depressed patients preferred a more informed role. Levinson et al. (2004) obtained similar results; patients with a better health status preferred informed decision-making.

To date, there is little research on SDM and role preferences in the treatment of alcohol use disorders (AUD) (Friedrichs, Spies, Härter, & Buchholz, 2016). However, SDM interventions could reduce the severity of both drug addiction and mental health problems (Joosten, de Jong, de Weert-van Oene, Sensky, & van der Staak, 2009), alcohol (Neumann et al., 2006) and nicotine use (Willemsen, Wiebing, & van Emst, 2006). When choosing a treatment goal, AUD patients were found to prefer a shared or informed decision-making role (Sobell, Sobell, Bogardis, Leo, & Skinner, 1992). Outpatients with an AUD who were educated at university and suffered from less severe alcohol problems prefer informed decision-making (Sobell et al., 1992).

To address above mentioned research gaps, the aim of the present study was to assess role preferences of patients currently in treatment for their AUD regarding their subsequent treatment decision. Additionally, we assessed which variables were associated with AUD patients' role preferences.

2. Method

2.1. Design and procedure

This study was conducted as part of a randomised controlled trial that included two measurement points: baseline and 6-month post-treatment discharge. The Ethics Committee of the Hamburg Medical Association granted ethical approval (Registration Number PV4325). Data collection occurred between June 2013 and May 2014 on wards of four German psychiatric clinics offering qualified medical detoxification. In addition to medication-assisted detoxification, *qualified* detoxification programs included psychosocial support with the aim to enhance patients' motivation for referral of additional treatment and continued abstinence (Arbeitsgemeinschaft der Wissenschaftlichen Medizinischen Fachgesellschaften [AWMF] et al., 2015). Qualified detoxification lasts up to three weeks. Patients who were admitted to the qualified detoxification unit signed an informed consent and completed a self-report questionnaire. Two days later, an individual interview was conducted including a comprehensive assessment of the severity of the patient's illness. The goal of the interview was to arrive at a shared decision regarding the patient's subsequent treatment after the current treatment (for additional details, see Buchholz et al., 2014). In this study, only baseline data was analysed, and only instruments that were used in the analyses are described here.

2.2. Participants

Patients who were *included* in the study had to (1) have had a primary diagnosis of alcohol dependence, (2) have been admitted to a qualified detoxification program and (3) have given written informed consent. Patients were *excluded* if they (1) had been already referred to further treatment, (2) were in treatment for reasons other than alcohol dependence, (3) needed crisis intervention, (4) were severely cognitively impaired, psychotic, illiterate, or had insufficient German language skills.

2.3. Measures

Patients were asked to complete the Control Preference Scale (CPS; Degner, Sloan, & Venkatesh, 1997), on which they indicated their role preferences regarding medical decision-making by choosing one of five statements that could be categorised into three response options, as shown in Table 1 (see Singh et al., 2010). The CPS was shown to be valid and reliable for use in cross-sectional studies (Degner et al., 1997).

Patients were also administered the Measurements in the Addictions for Triage and Evaluation (MATE; Schippers, Broekman, Buchholz, & Cox, 2011), which is a semi-structured interview based on the biopsychosocial model of health (World Health Organisation [WHO], 2001). The MATE yields 20 summary scores, such as severity of dependence and depression, which can be further summarized into four dimensional scores: addiction severity, severity of psychiatric co-morbidity, severity of social disintegration, and history of treatment for a substance-use disorder. The MATE has acceptable psychometric properties, and it is feasible for use in routine treatment and in research settings (Buchholz, Rist, Küfner, & Kraus, 2009; Schippers, Broekman, Buchholz, Koeter, & van den Brink, 2010).

The patients' treatment motivation was assessed with the Motivation for Treatment Scale (MfT; De Weert-Van Oene, Schippers, De Jong, & Schrijvers, 2002; Schippers & Broekman, 2012) The MfT consists of the four scales *General problem recognition,* which is a stage