DECISIONAL CAPACITY IN PSYCHIATRIC INPATIENT SETTINGS: UNDERSTANDING AND ADDRESSING KEY BARRIERS TO SHARED DECISION MAKING

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Research indicates that the degree to which shared decision making (SDM) is implemented within inpatient care across the VHA varies significantly. International literature on this topic suggests that clinicians' concern around patients' reduced decisional capacity is a frequently reported barrier to SDM implementation, yet determining decisional capacity for SDM is complex. To date, it is unclear how clinicians within the US are currently determining patients' ability to participate in decision-making, particularly in situations when there is less certainty around this determination (e.g., concerns of reduced decisional capacity, acute symptoms, liability concerns). While solutions have been proposed, the literature remains divided on the best approach in adapting SDM to address these barriers, and none have been explicitly implemented within the United States. As such, the current study interviewed 25 acute mental health inpatient psychiatrists across 17 unique VHA sites to: 1) determine how psychiatric inpatient psychiatrists are determining patients' ability to make medication management decisions and, 2) gather psychiatric inpatient psychiatrists' perspectives on the perceived acceptability and adaptability of key elements proposed as possible solutions in the literature (i.e., capacity-adjusted sliding scale SDM, SDM-PLUS, Shared Risk Taking). Through emergent thematic analysis, the current study identified a complex relationship between risk, capacity, and mental health law that influences providers' level of collaboration within medication management decisions. Further, providers indicated a preference for a combination of approaches to address reduced decisional capacity as a barrier to SDM. The current study proposes elements for future SDM interventions and future directions to further address reduced decisional capacity and facilitate SDM within acute mental health inpatient care.

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Introduction

Shared decision-making (SDM), the collaborative process in which both the clinician and patient share an equal role in treatment decisions, is considered an ethical imperative within mental health treatment for individuals with serious mental illness (SMI; Drake & Deegan, 2009) and a prominent element of recovery-oriented care (ROC) within psychiatric inpatient settings (McGuire et al., 2021). However, research indicates that the degree to which SDM is implemented within inpatient care varies significantly (Eliacin et al., 2022) despite research indicating people with SMI often prefer to be involved in the treatment decision-making process (e.g., have options for treatment, share their preferences; Adams et al., 2007; Eliacin et al., 2015; Hamann et al., 2005; Park et al., 2014). While few research studies on SDM in psychiatric inpatient care have been conducted within the United States (Eliacin et al., 2022; Shue et al., 2022), international literature on this topic suggests that clinicians' concern around patients' reduced decisional capacity is a frequently reported barrier to SDM implementation (Becher et al., 2021; Beyene et al., 2018; Chong et al. 2013; Hamann et al., 2009; Hamann, et al., 2016; Hipp & Kangasniemi, 2022; Wesseldijk-Elferink et al., 2021), yet determining decisional capacity for SDM is complex. Specifically, decisional capacity in medical terms involves clinicians determining patients' ability to provide informed consent using explicit guidelines (e.g., four pillars of decisional capacity), yet there also may be more implicit determinants involved in this process (e.g., clinician's level of risk tolerance, organizational limitations, differing perspectives on how patient symptoms interfere with the decision-making process; Zisman-Ilani et al., 2021a). To date, it is unclear how clinicians are currently determining patients' ability to participate in decision-making, particularly in situations when there is less certainty around this determination (e.g., concerns of reduced decisional capacity, acute symptoms, liability concerns). Given inconsistent SDM implementation in acute mental health settings within the US (Eliacin et al., 2022; Shue et al., 2022) and the nature of the inpatient setting itself (e.g., clinicians are treating individuals who are in acute crisis, amplifying capacity concerns), it is imperative to determine a model that effectively guides psychiatric inpatient clinicians towards adopting SDM in these difficult situations. While approaches that may address some of these concerns have been proposed, the literature remains somewhat divided on the best approach in adapting SDM to address these concerns, and none have been explicitly implemented within a United States acute mental health inpatient unit.

Given the complexities within decisional capacity as a barrier to SDM in inpatient care and proposed approaches yet to be tested within the United States acute mental health care, the current study aims to first gain a deeper understanding of how psychiatric inpatient clinicians are determining whether patients are able to participate in the decision-making process, particularly in situations that are more uncertain (e.g., concerns of capacity in patients with acute symptoms or reduced insight). Additionally, the current study aims to gather psychiatric inpatient clinicians' feedback in the acceptability and adaptability of specific intervention elements proposed as possible approaches to address decisional capacity as a barrier in SDM.

SDM Conceptualization

The concept of SDM has existed since the 1980s when it was proposed by the President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research in its report on properly obtaining informed consent

(President's Commission, 1982; Childress & Childress, 2020). Following this report, researchers across the medical field began efforts to clearly define SDM. In 1997 (and later expanded upon in Charles et al. 1999), Charles and colleagues published a seminal paper on key characteristics of SDM within the context of life-threatening diseases and early-stage breast cancer. They defined SDM as "middle ground" between a paternalistic model (i.e., the clinician is fully in control of the medical decision) and an informative model (i.e., the patient is in complete control of the decision after receiving the appropriate medical information from the clinician). Characteristics of SDM within the proposed model included: (1) the clinician and the patient are involved in the decision (possibly also including family, caretakers, or a team of clinicians), 2) the clinician offers expertise in possible choices for treatment of a particular problem and the patient offers expertise in their own unique needs and treatment goals, 3) both the clinician and patient discuss preferences for treatment options (e.g., pros/cons of options based on the patient's values), and 4) an agreed upon decision between the clinician and patient is reached, even if that decision is to not participate in treatment or that the patient will seek a second opinion (Charles et al., 1997, 1999). In the updated model, Charles et al. (1999) also emphasize the dynamic nature of clinical decision-making. They note that it is possible to switch between different decision-making models in a single session (e.g., start out shared, switch to paternalistic), but that this switch should be based on patient preferences. For example, some patients may prefer that the clinician take a more active role in the decision while others may prefer to make the decision on their own after the clinician shares the medical information (Charles et al., 1999).

However, Charles and colleagues' (1997, 1999) work was not the only attempt at SDM conceptualization. Multiple other researchers created their own definitions or expanded on pre-existing definitions across different areas of medical practice (e.g., Elwyn et al., 1999, 2000; Towle & Golphin, 1999). The variety of different definitions and the failure to build on one proposed model of SDM created difficulties in SDM conceptualization for clinical practice. As such, Makoul and Clayman (2006) attempted to define essential components of SDM across different conceptualizations. They defined essential elements of SDM to be 1) the clinician and patient define the problem to be addressed, 2) the clinician and patient review options for treatment, 3) the patient and clinician discuss pros/cons of each option, 4) the patient and clinician discuss the patient's ability to follow through with the different treatment plans, 5) the clinician provides knowledge or recommendations, 6) the clinician and patient check understanding of facts/perspectives, 7) a decision is made or deferred, and 8) the clinician and patient arrange follow-up to discuss outcomes of decision or reach resolution in decision.

Interestingly, Makoul and Clayman (2006) argue that eliciting patient preferences for their role in decision making is an ideal element, but not considered essential for SDM (i.e., it is not always feasible or necessary). Additionally, within the model there is no explicit guidance on who makes the final decision. Similar to Charles et al. (1999), Makoul and Clayman (2006) suggest that treatment decision-making in practice will most likely never be perfectly shared. Throughout the session, the degree of decision sharing may fluctuate from clinician-led to patient-led; however, Makoul and Clayman (2006) note that even if the patient ultimately prefers the clinician to make the final decision, if the essential elements of SDM are present, then it should still be considered SDM. Further, unlike Charles et al., (1997, 1999), Makoul and Clayman (2006) suggest that mutual agreement on the decision is ideal, but not essential for SDM given that differences of opinion between the clinician and patient may still exist even after the SDM process.

SDM in SMI Treatment

With SDM's rising prominence in the medical field in the 1990s and early 2000s, researchers in mental health care recognized its compatibility with the psychiatric rehabilitation movement given SDM's focus on collaboration, respect for patient autonomy, and person-centered care (Drake et al., 2010). Indeed, in 2003, recommendations from the President's New Freedom Commission on Mental Health Report (Department of Health and Human Services, 2003) called for patients to have "participation in a full partnership with providers on decisions about treatment and services" (p. 36). Since its uptake as an important concept in mental health care, SDM interventions for SMI treatment have primarily been implemented within psychiatric outpatient settings such as community mental health centers (Zisman-Ilani et al., 2017; Thomas et al., 2021). These interventions have utilized decision-aids (e.g., information presenting pros/cons of certain treatment options to help patients choose between options according to their preferences), digital decisional support tools, patient trainings in communication skills, clinician training in eliciting patient values/preference (either for current treatment or future treatment such as in joint crisis planning), shared care planning and/or training to facilitate patient motivation or patient participation in goal setting (Zisman-Ilani et al., 2017; Thomas et al., 2021). Although findings tend to be mixed when comparing across studies, research on SDM interventions within SMI treatment have shown positive effects across a variety of outcomes, including, but not limited to: treatment engagement/adherence, decisional conflict, treatment satisfaction, decision-making competence/skills, treatment knowledge or knowledge about mental health, employment status, quality of life, and global functioning (Thomas et al., 2021).

SDM Implementation in Acute Mental Health Care

While the majority of outpatient SDM interventions for SMI have been conducted within the United States (Zisman-Ilani et al., 2017), to date, SDM interventions for the acute mental health inpatient units in the United States have yet to be developed. Only three articles discuss SDM within acute mental health care in the US (Eliacin et al., 2022; McGuire et al., 2021; Shue et al., 2022), and all are from the same larger study (i.e., McGuire et al., 2021). Within that larger study, McGuire et al. (2021) operationalized ROC in acute mental health care based on pre-existing ROC guidelines provided by the Veterans Health Administration (VHA) and created the Recovery-oriented Acute INpatient (RAIN) scale. Within this scale, there is an item measuring "SDM for medication management." According to this item, excellent quality and consistency of SDM implementation is achieved when: 1) there is a discussion of patients' needs, preferences, as well as risks and benefits of medication including alternative treatment options, 2) the conversation begins and ends with the patients' interests/preferences and involves this input within the decision-making process, 3) there is active use of decision-aids to exchange relevant information about medications, 4) there is use of "teach back" techniques to evaluate patients' understanding of information, and 5) patients are also presented with the option to decline medication (McGuire et al., 2021).

Using this item to determine the top and bottom scoring sites across 34 VHA acute mental health units (6 and 8 sites, respectively), Eliacin et al., (2022) examined inpatient staff's understanding and process of SDM implementation. Results revealed three different decision-making processes described by providers: 1) patients were excluded from treatment decisions completely, 2) patients were informed of treatment options with limited influence on the actual decision, and 3) patients and clinicians worked collaboratively to come to a decision together (Eliacin et al., 2022). Eliacin and colleagues (2022) found that option two was the most prevalent across sites. Within this option, clinicians believed that it was their responsibility to convince patients to take medications, and SDM was a process of obtaining informed consent (i.e., could either accept or decline the clinician's recommended treatment option). Further, while staff generally had a good understanding of the concept of SDM across sites, data from site observations showed that this knowledge did not always translate into practice. Lastly, in another secondary analysis looking at sites scoring high and low on the inpatient treatment planning item of the RAIN scale, Shue et al., (2022) found that medication decisions in both high and low sites tended to mostly involve the prescriber with varying levels of patient input in this process. Taken together, SDM, as measured by the RAIN scale, seems to vary across acute mental health settings across the US and is rarely implemented to its fullest capacity.

Barriers to SDM Implementation in Acute Mental Health Care

International studies have also examined the state of SDM implementation across psychiatric inpatient care. Within this literature, clinicians from a range of professions within the treatment team have discussed their hesitancy to implement SDM. For example, in a study surveying both inpatient and outpatient psychiatrists treating individuals with schizophrenia, psychiatrists were more willing to practice SDM with informed patients who were willing to comply with antipsychotic treatment and less willing to engage with patients with reduced decisional capacity (Hamann et al., 2009). Similarly, in Chong et al., 2013, psychiatric inpatient clinicians expressed caution when implementing SDM due to potential fluctuations in patients' ability to make decisions. Indeed, multiple studies across psychiatric care mentioned clinician concerns around patients' ability to effectively participate in decision-making (Becher et al., 2021; Beyene et al., 2018; Chong et al. 2013; Hamann et al., 2009; Hamann, et al., 2016; Hipp & Kangasniemi; 2022, Wesseldijk-Elferink et al., 2021). However, how clinicians determine whether or not patients are able to participate in decision-making may depend on multiple factors.

Decisional Capacity, Acute Symptoms, and Reduced Insight

Within the medical literature, reduced decisional capacity has a very specific definition. Specifically, decisional capacity is rooted in the process of providing informed consent in treatment, and assessing decisional capacity involves four major elements (sometimes referred to as four pillars): 1) whether or not the patient is able to demonstrate understanding of the risk and benefits of a certain treatment or the treatment options (including the option of no treatment), 2) whether or not the patient is able to demonstrate appreciation of those risk and benefits, 3) whether or not the patient is able to show reasoning in making the decision, and 4) whether or not the patient is able to communicate their choice (Barstow et al., 2018). Additionally, capacity assessment should be limited to a specific point in time and a specific treatment decision and completed by a licensed healthcare provider. This is in contrast to lack of *competency*, which refers to the impairment in decision-making in general (e.g., across all medical decisions) and is determined by the court system (Barstow et al., 2018).

Many physicians may assess decisional capacity based on clinical judgement (Barstow et al., 2018); however, for more accurate determinations, it is recommended that both clinical judgement and objective measures be used (Lim & Marin, 2011; Radenković, 2023). For example, there are brief measures that can assess cognitive impairment in patients (Saint Louis University Mental Status Examination; Tariq et al., 2006) as well as formal measures of decisional capacity (e.g., the MacArthur Competence Assessment Tool-Treatment (MacCAT-T, although named as competency, this measure assesses decisional capacity), Grisso et al., 1997; the Aid to Capacity Evaluation (ACE), Etchells et al., 1999). Although many of these assessments have been found to improve the reliability of clinician assessments of capacity (Lim & Marin, 2011), guidance on a gold-standard approach across clinical practice is lacking (Seyfried et al., 2013) and it is unclear whether these measures are used consistently in clinical practice, particularly in psychiatric inpatient care. Additionally, literature in assessing decisional capacity recommends using a "sliding scale" approach in how rigidly clinicians adhere to the four pillars based on perceived consequences of the decision (Drane, 1984; Lim & Marin, 2011; Radenković, 2023). Specifically, if there is an effective treatment that has minimal risk and there are few alternatives, then a patient may only need to be aware of the treatment and that they will receive it to provide informed consent (Drane, 1984; Lim & Marin, 2011; Radenković, 2023). However, if a treatment carries greater than minimal risk, benefits are less definitive, or there are alternative effective treatments, the patient must meet more of the criteria (e.g., understand the risks and benefits, alternative treatments, and express a choice) to participate in the decision. The most stringent criteria of decisional capacity should be applied when the treatment could be life-saving and refusal could result in severe consequences (e.g., death; Drane, 1984; Lim & Marin, 2011; Radenković, 2023). However, previous research suggests that clinicians inconsistently apply this sliding-scale method (Hermann et al., 2015).

Based on the medical definition, certain symptoms of SMI may interfere with decision-making capacity. Specifically, descriptions of what it means to sufficiently "appreciate" treatment risks and benefits includes the ability to have insight and acceptance of the illness (Lim & Marin, 2011; Radenković, 2023). Indeed, chronic psychiatric conditions, such as schizophrenia, are seen as a risk factor for impaired decisional capacity (Barstow et al., 2018). Moreover, previous research indicates reduced insight is one of the strongest predictors of reduced decisional capacity in psychiatric inpatients, and authors argue that decisional capacity and insight conceptually overlap (Cairns et al., 2005).

On the other hand, some literature suggests the presence of SMI may not necessarily equate to automatic reduction in decision-making capacity (i.e., people with schizophrenia and healthy controls both showed substantial heterogeneity in decision-making capacity; Jeste et al., 2006). Further, in a study assessing patients with schizophrenia's ability to provide informed consent in clinical research, patients performed worse on a measure of decisional capacity compared to healthy controls, but this performance was strongly related to cognitive impairment, and only modestly related to psychotic symptoms (Carpenter et al., 2000). It is also important to note that when patients were offered additional support in understanding study information, patients were able to perform within the range of healthy controls on the decisional capacity measure (Carpenter et al., 2000). Further, although reduced insight is a strong predictor of decisional capacity, authors also note this is not an absolute association, meaning it is possible for someone to lack insight, yet maintain decisional capacity (Cairns et al., 2005).

Lastly, within the literature discussing providers' perspectives on reduced decisional capacity as a barrier to SDM, there is variation in whether reduced decisional capacity, acute symptoms, and reduced insight are considered elements of the same construct. Providers in some studies conflated these factors into one barrier category. For example, in focus groups of both inpatient and outpatient psychiatrists, decisional capacity was often mentioned as a barrier to SDM, and this was conceptualized as patients' lacking insight, particularly in patients with schizophrenia (Hamann et al., 2016). Further, providers in Becher et al., (2021) classified the most frequently cited barrier as symptoms, and this larger category discussed by providers could be broken into impaired decisional capacity, severe symptoms, and impaired communication. However, Hamann et al. (2009) used principal component analysis on items describing patient characteristics that may be barriers to SDM in patients with schizophrenia and found that impaired decisional capacity included items related to acute symptoms while a distinct category was created for impaired insight. Specifically, concerns surrounding impaired decisional capacity included patients' symptomatology (e.g., thought disturbance), low education level, preference for the clinician to make the decision, and high suggestibility

(Hamann et al., 2009), In contrast, impaired insight was classified under "negative attitudes towards treatment" along with reservations about antipsychotic treatment, poor compliance, and poor therapeutic alliance. Interestingly, within this study, psychiatrists reported that patients with "negative attitudes towards treatment" (including reduced insight) would be "probable" partners in SDM, meaning psychiatrists would maybe practice SDM with patients in these situations. However, psychiatrists rated the "impaired decisional capacity" category as the situation where they would mostly likely not participate in SDM (Hamann et al., 2009).

The Broader Context

One must also consider the broader context in which clinicians are determining decisional capacity. Specifically, determinations made about patients' decisional capacity and ability to participate in SDM are also dependent on clinicians' morals, values, biases, and environmental influences that either explicitly or implicitly factor into the decision (Hermann et al., 2015). For example, previous research suggests decisional capacity assessment is influenced by clinicians' perceived importance of maintaining public image, avoiding humiliation, and maintaining power (Hermann et al., 2015). Indeed, the concept of risk and clinician liability may be important when considering reduced decisional capacity as a barrier to SDM. For example, a psychiatrist may believe that if they participate in SDM with a patient who lacks insight or is highly symptomatic (regardless of official capacity determinations), the patient will choose the option of no medication, which may result in negative outcomes for the patient (Hamann & Heres, 2014) and the clinician may fear that they will be deemed liable for those outcomes (Zisman-Ilani et al., 2021a). Although official determination of decisional capacity should not include whether or not the patient's preferred decision agrees with the clinician's preferences (Barstow et al., 2018), clinicians may be enticed to cite reasons commonly associated with reduced decisional capacity (i.e., the presence of reduced insight or acute symptomatology) as reasons to use more paternalistic approaches, particularly in these "risky" situations (Deegan, 2014).

However, it is important to note clinicians' cautiousness to practice SDM in these scenarios may not solely be based on their preference for paternalistic approaches or even their personal values. Indeed, there may also be organizational policies and procedures that limit clinician's ability to consider patient preferences (Zisman-Ilani et al., 2021a). For example, policies designed to protect against liability concerns for the overall organization or time pressures to "stabilize" the patient to make room on the unit for more patients may incentivize clinicians into making these assumptions about patients' decisional capacity, particularly in acute mental health care where symptom acuity, perceived risk of withholding medications, and time and space constraints may be more prevalent. In addition to understanding what factors go into determining reduced decisional capacity within SDM, it is imperative to also understand the perceived risk clinicians are faced with during SDM, particularly in situations where the patients' capacity may be in question, and how other contextual elements (e.g., organizational policies and procedures prioritizing safety) influence these decisions.

Taken together, there are multiple aspects to consider when conceptualizing reduced decisional capacity as a barrier to SDM within psychiatric inpatient care. For example, it is unclear whether clinicians are using certain clinical indicators (e.g., symptoms, reduced insight) as a proxy for decisional capacity or if they are formally assessing the four pillars of decisional capacity. Additionally, it is possible clinicians are citing reduced decisional capacity as barriers to SDM more frequently when there is perceived risk of negative outcomes for the patient, the provider, or the organization. Clarifying how clinicians conceptualize and assess patient's decisional capacity and ability to participate in SDM is imperative to supporting SDM implementation, particularly in US acute mental healthcare, a setting that has been neglected within SDM intervention research.

Suggested Solutions

Due to clinician concerns surrounding patients' decisional capacity, perceived risk, and SDM implementation, some researchers have proposed ways to incorporate elements of SDM within complex clinical situations. For example, researchers in the medical field (not specific to psychiatric inpatient care) argue that the presence of reduced decisional capacity is not grounds for automatically excluding the possibility of SDM. Specifically, Lahey and Elwyn (2020) suggest that patient autonomy and the role of a surrogate decision maker should be adjusted on a sliding scale (i.e., full, partial, or no SDM) rather than using an all-or-nothing approach. In the capacity-adjusted sliding scale SDM model, the clinician should engage in elements of SDM that are possible regardless of capacity, such as describing the decision that is needed, providing information on the different treatment options in terms that are accessible to the patient, and eliciting patient preferences as much as possible (Lahey & Elwyn, 2020). However, Lahey and Elwyn (2020) note that when decisional capacity is questioned, clinicians should engage in a formal assessment of capacity and/or consult an ethics board when required, although it is not clear when such assessment would be required. Following capacity assessment, the engagement of a surrogate decision-maker (i.e., healthcare power of attorney, spouse, child, or close friend) should be adjusted accordingly. For example, if the patient can make simple decisions (i.e., whether to take medications or not) but struggles to make more nuanced decisions (i.e., which medication might be best) then the surrogate may play the role of patient advocate and support the patient in decision-making. However, if the patient lacks decision-making capacity completely for the treatment decision, then the surrogate may have to make the decision on the patient's behalf, ideally based on the patient's best interest (including the patients' perceived preferences/values). While this model has been proposed in the literature, there is no research formally testing its effectiveness or feasibility within any healthcare context, including psychiatric inpatient care. Additionally, this model does not address how clinicians may handle situations where decisional capacity is unclear and patient preferences for treatment may be seen as "risky," such as refusing medication.

The SDM-PLUS model is another proposed solution that considers complex scenarios surrounding decisional capacity and perceived risk and has been formally tested within psychiatric inpatient care (Hamann & Heres, 2014). SDM-PLUS incorporates a solution to situations in which clinicians may be concerned with the negative outcomes of participating in SDM with patients who may lack insight, are highly symptomatic, and/or may have reduced decisional capacity. Within this model, Hamann and Heres (2014) suggest clinicians first learn to classify decisions into three categories: 1) "life-or-death situations" in which a particular decision may impose an immediate threat of harm to the patient or someone else (e.g., decisions surrounding discharging a patient that is experiencing clear suicidal ideation), 2) "best-choice" decisions where a better choice exists, but there is also perceived risk that the patient will refuse this option (e.g., antipsychotic treatment for someone who is acutely psychotic), or 3) “preference-sensitive” decisions that have several equivalent options for treatment and the best option is uncertain. Then based on this classification, the amount of what Hamann and Heres (2014) deem “classical SDM” is adjusted or supplemented with other methods. For example, for “life-or-death” decisions, the clinician must ultimately make the decision to avoid harm, while for “preference-sensitive” decisions, classical SDM is always appropriate. The innovation of SDM-PLUS exists for the “best-choice” decision category, when patients are refusing or are ambivalent about the “best choice” treatment. Hamann and Heres (2014) argue that this scenario is the most challenging for psychiatrists because neither the classical SDM model, which requires some agreement between patient and clinician, nor the paternalistic model, which may increase patient resistance to treatment, are effective.

To solve this problem, the SDM-PLUS model suggests promoting SDM through additional methods such as using motivational interviewing and negotiation techniques from the Harvard Negotiation Project (Hamann & Heres, 2014). Hamann and Heres (2014) argue that techniques from these methods overlap with classical SDM. Indeed, Elwyn and colleagues (2014) suggest that motivational interviewing and SDM are both rooted in respecting patient autonomy and both focus on exchanging information about the patient’s preferences including the patient’s values, goals, and barriers to treatment while listening reflectively, summarizing, and affirming patient perspectives. Additionally, negotiation techniques from the Harvard Negotiation Project recommend that clinicians determine their own preferences (the “best-choice” option) and then determine other options they would be comfortable with if the patient does not agree to the "best choice" option (similar to providing options in SDM; Hamann & Heres, 2014).

SDM-PLUS was implemented across 12 acute mental health inpatient units in Germany through a randomized controlled trial and included patients diagnosed with a schizophrenia spectrum diagnosis and their treatment team (Hamann et al., 2020). The implementation components included two half-day staff trainings on SDM-PLUS using PowerPoint presentations, written case vignettes, and role plays for resident and consultant psychiatrists for which training was mandatory, as well as nurses, psychologists, social workers, and occupational therapists for which training was optional. Patients were also provided group SDM skills training that was established in previous intervention research (i.e., Hamann et al., 2011). Patients in control units received treatment as usual. Results revealed significant increases in patients' perceived involvement in decision-making compared to patients on control units. Secondary outcomes revealed that patients on the SDM-PLUS units also had better therapeutic alliance with their provider, were more satisfied with care, and had better attitudes towards medication and self-rated treatment adherence (Hamann et al., 2020). However, no significant differences were found between groups in long-term treatment adherence, quality of life, or hospital readmissions, and it is unclear whether different implementation components had different effects on outcomes (e.g., was patients' perceived involvement in decisions increased by the clinician training in SDM-PLUS, the patient training in SDM skills, or both?).

Further, in a secondary analysis of qualitative interviews of psychiatrists and patients that participated in SDM-PLUS, Becher et al. (2021) found a variety of levels of

SDM implementation present ranging from no SDM (i.e., coercion) to a combination of participation and coercion, and in less frequent cases, full SDM; in addition, patient symptoms (symptoms that may impair decisional capacity) were still the most frequently cited barrier to SDM by clinicians after the intervention. Becher and colleagues (2021) concluded that in some instances (e.g., patients with acute symptoms), a combination of paternalism and SDM may be better than no SDM at all (i.e., taking an "as much SDM as possible" approach). Lastly, while Lahey and Elwyn (2020) provide guidance on how to incorporate surrogate decision makers (e.g., caretakers) in their sliding scale approach, Hamann et al. (2020) note that one limitation of SDM-PLUS is the lack of consideration of the role of caretakers within the treatment decision-making process.

A third suggested solution for practicing SDM and in light of decisional capacity concerns is from the perspective of shared risk taking. Zisman-Ilani and colleagues (2021a) support the idea that the inherent risk that comes with clinicians engaging in joint decision making with patients during difficult situations, such as when the patient's decisional capacity is unclear, is the critical underlying barrier that prevents most clinicians from implementing SDM. However, Zisman-Ilani et al. (2021a) assert this shared risk has not yet been addressed in SDM literature. Further, they believe that successful SDM is dependent on interpersonal exchange of thoughts and feelings between the patient and clinician. As such, Zisman-Ilani and colleagues (2021a) proposed the concept of shared risk taking as a new element to add to the classical understanding of SDM for patients with SMI. That is, discussion of risk should not be limited to discussion of the medical risk and benefits of a certain treatment as described in many SDM models, but also should include joint reflection between the patient and clinician on the emotions and thoughts connected to risks of all treatment options– for both of them. For example, the patient and clinician should each reflect on the worries, fears, and hopes when thinking of a particular decision (e.g., openly reflecting on the patient's and clinician's concerns around a particular treatment decision). Zisman-Ilani et al. (2021a) note that this reflection may facilitate joint understanding between the patient and clinician of their respective opinions and increase commitment and motivation to come to a solution that promotes positive outcomes for the patient. Additionally, during this process, the clinician should still conduct a thorough risk assessment of the decision, including safety implications and the patient's decision-making capacity. Lastly, Zisman-Ilani and colleagues (2021a) note that treatment decisions are not made within a vacuum, they are made taking into account the broader picture of the patient's life. As such, the patient and clinician should consider the meaning behind the specific behavior in question. For example, clinicians could explore with the patient how they came to have certain beliefs about antipsychotic medication use, how taking medications may or may not facilitate patients accomplishing their goals in life, and whether the risk of discontinuing medication or taking the medication would be a risk worth taking. In this way, risks of starting a certain treatment, or in not participating in treatment, are further considered in the broader context of the patient's life, and not just from the standpoint of "generic medical risks" (p. 462; Zisman-Ilani et al., 2021a). While shared risk taking has not been formally implemented or tested in research, Zisman-Ilani and colleagues (2021a) note that in order to implement this approach, research should explore how patients and clinicians conceptualize risk in decision-making. Lastly, as mentioned above, Zisman-Ilani and colleagues (2021a) also emphasize the importance of understanding organizational policies and procedures that may hinder or promote patients and clinicians to engage in shared risk taking.

But Which Model is Best? Conflict in the Field

Multiple models have been proposed for psychiatric inpatient care, each with innovative techniques to use during the SDM process. The capacity-adjusted sliding scale SDM approach introduces adjusting surrogate decision-making involvement based on capacity level, the SDM-PLUS model introduces the use of motivational interviewing and negotiation tactics in clinical situations that are more uncertain (e.g., patient is refusing the "best choice" and capacity is less clear), and shared risk taking introduces the idea of patients and clinicians sharing their emotional experience behind risk taking and coming to a joint understanding of meaning behind certain patient or clinician choices. However, despite these proposed approaches, there still remains conflict in the field about the best solution, particularly surrounding the underlying principles that each model promotes.

Specifically, both SDM-PLUS and the capacity-adjusted sliding scale SDM approach rely on the principle that some SDM is better than none. For example, the capacity-adjusted sliding scale approach may ultimately lead to the surrogate decision maker making the final decision for the patient, yet identification of the problem, information sharing, and elicitation of patient preferences still occurs (Lahey & Elwyn, 2020). Additionally, Hamann and Heres (2014) and Lahey and Elwyn (2020) also both highlight that SDM should not be confused with the informed-choice model (i.e., where patients are fully in charge of decision-making), and SDM can still exist even when decisions are made by the clinician. Indeed, while some SDM conceptualizations definitively include the necessity for mutual agreement on the decision at the end of the SDM process (e.g., Charles et al., 1997), other models note that this is ideal, but not an essential component of SDM (e.g., Makoul & Clayman, 2006). Moreover, some research suggests that patients view just one element of SDM --"feeling heard" (e.g., the clinician actively listening to their concerns)—as the most important aspect of the SDM process (Beyene et al., 2018; Huang et al., 2020). As such, perhaps implementing the parts of SDM that are feasible in a given clinical situation is the best approach.

However, some researchers within recovery-oriented care for people with SMI have argued that adaptations such as those proposed in SDM-PLUS are essentially reinventing paternalistic approaches. For example, in a response to Hamann and Heres (2014)'s proposal of SDM-PLUS, Deegan (2014) argues that introducing the idea of the "best choice" decisions supports the idea that if the patient is compliant, then SDM is possible, but if there is disagreement about treatment between the patient and clinician, the patient is classified as having reduced insight or reduced decisional capacity, and SDM becomes riskier for the clinician (Deegan 2014). Deegan (2014) also argues that motivational interviewing and SDM are actually two distinct interventions with different aims (i.e., SDM supports making decisions that are more collaborative, while motivational interviewing supports behavior change in the patient) and these should not be combined. Moreover, Deegan (2014) states that using antipsychotic medications can have profound effects on people's lives outside of medical risk, and is not always the "best choice" decision, contrary to Hamann and Hermes (2014) belief that this is the gold-standard treatment for acute symptoms. Along with this viewpoint, previous research suggests that clinicians may overestimate the efficacy of antipsychotic medications and underestimate their adverse effects, calling into question whether antipsychotic treatment is the best treatment for all individuals experiencing a psychotic disorder (Morrison et al., 2012). Further, the operationalization of SDM for medication management within recovery-oriented acute mental health care includes the expectation that patients are offered the option of not taking medications (McGuire et al., 2021). Lastly, Deegan (2014) argues that reduced decisional capacity in people with SMI is “the exception rather than the rule” (p. 1487), citing research indicating only 4% of individuals with schizophrenia in the general population participating in research fell below capacity requirements in a longitudinal study (Stroup et al., 2011). Deegan (2014) firmly believes that rather than adapting the SDM model, *the system* in which it is operating should be adapted (e.g., organizational change in the form of funding resources, champions for change, and on-site support).

Both Deegan (2014)’s response to the proposed SDM-PLUS model and Zisman-Ilani et al. (2021a)’s proposed shared risk-taking hold the perspective that decisions made within recovery from SMI have wider implications and meaning in the patient’s life beyond medical risks/benefits. These recovery-oriented views often conflict with psychiatrists’ medical training in minimizing risk and maximizing safety (Zisman-Ilani et al., 2021a). For example, in a response to Deegan (2014)’s criticisms, Hamann and colleagues (2015) assert that in critical situations in which decisional capacity (which may include reduced insight and increased acuity) is questioned and concerns of perceived risk are high, classical SDM is simply not possible.

Determining the Path Forward

In summary, a frequently identified barrier to SDM within acute mental health care is concern surrounding decisional capacity; however, this barrier is multifaceted and it is unclear how clinicians are currently assessing decisional capacity within SDM as well as which elements from the proposed solutions would work best within acute mental health systems in the United States. Gaining clarity on how clinicians are conceptualizing and assessing decisional capacity may help determine which, or what combination, of suggested solutions is best. For example, if clinicians consistently use formal assessment, the most frequent problem related to SDM may be genuine lack of decisional capacity in patients to provide informed consent; perhaps education on how to best incorporate the capacity-adjusted sliding scale approach may be the best approach given legal implications warranting the involvement of a surrogate decision maker. However, if clinicians determine lack of capacity informally (e.g., based on diagnosis, acute symptoms or lack of insight), perhaps education or time-saving supports for properly evaluating decisional capacity will be important in SDM implementation.

Moreover, one also must consider the clinician and the context in which they are practicing medicine. For example, clinicians may feel worried or fearful for patients if they make a particular treatment decision, and these emotions may be based on the perceived risk clinicians are concerned with when patients decision-making abilities are questioned or when patients prefer to not have the "best" treatment (e.g., preference for no medications). In this case, incorporating elements of shared risk taking or motivational interviewing may be useful, but not without understanding larger organizational barriers that prevent risk taking. Lastly, perhaps all of the above-described components to decisional capacity are challenging to clinicians during SDM, in which case an integrative approach across models may be best. Given the conflict in the field on what may be the best solution to address decisional capacity and SDM, understanding the viewpoint of those that would be implementing these approaches may be important to distinguish a path forward for future intervention development. For example, while psychiatrists are inherently trained within the medical model of minimizing risk, is there room within this model to incorporate elements of shared risk taking, such as offering the option of not taking medication?

Lastly, psychiatric inpatient care can differ dramatically across the world. For example, in one SDM intervention conducted in German acute mental health units, patients had an average length of stay of 48.9 days (Hamann et al., 2006). This is in stark contrast to patients in a study conducted within the United States, who had an average length of stay around one week (Eliacin et al., 2022; Shue et al; 2022). Given the majority of literature on SDM within psychiatric inpatient care is international, understanding what clinicians are currently doing when questions surrounding decisional capacity arise and what may need to occur to adapt solutions to the US inpatient settings is imperative.

Current Study

Within the Consolidated Framework for Implementation Research (CFIR), the use of pre-implementation assessment and adaptation is encouraged to increase the likelihood of successful implementation (Damschroder et al., 2009). Formative evaluation (FE), defined by Stetler et al. (2006) as "a rigorous assessment process designed to identify potential and actual differences on the progress and effectiveness of implementation efforts" (p. S2), is one method that can be used during pre-implementation to effectively adapt and modify a proposed intervention to maximize effectiveness of future implementation efforts (Stetler et al., 2006). Additionally, a subtype of FE, developmental evaluation, is often used to during the pre-implementation of a project to formally assess the degree of current implementation, factors that influence current practice, perceived acceptability of the project, and possible barriers, facilitators, and modifications needed to maximize future implementation efforts (Stetler et al., 2006). Research indicates conducting a developmental evaluation, particularly among targeted users of the intervention (e.g., psychiatrists implementing SDM in psychiatric inpatient care), may also facilitate future commitment to the implementation project (Stetler et al., 2006). In line with a developmental evaluation approach within the CFIR, the current study seeks to gain clarity in the ways in which decisional capacity is conceptualized and assessed within SDM in psychiatric inpatient medication management as well as the acceptability and adaptability of proposed solutions in the literature within the context of United States' acute mental health care. Doing so may help to inform future adaptations of proposed interventions from the literature to develop an SDM model that overcomes decisional capacity concerns and is specific to acute mental health units within the United States.

The current study aimed to address two research questions: 1) How are psychiatrists determining patients' ability to make decisions? and 2) What are psychiatrists' perspectives on the acceptability (i.e., whether they like the intervention or not, perceived effectiveness in addressing the problem) and adaptability (i.e., what might need to change to make this work, including barriers/facilitators) of key elements proposed in possible solutions in the literature (e.g., role of surrogate decision-maker, motivational interviewing, negotiation tactics, sharing emotional experience of risk taking and exploring the personal meaning behind decisions with patients). The current study sought to accomplish these efforts through qualitatively interviewing psychiatrists working in acute mental health units within the United States' Veterans Health Administration (VHA), the nation's largest integrated health system. Psychiatrists were chosen as the main focus of this study as they are often the head clinician within the treatment team in charge of making decisions regarding decisional capacity and patient autonomy (Stacey et al., 2016). Medication management decisions were specifically chosen as the focus of this study because medication treatment is often the first line of treatment in acute mental health settings. Additionally, previous research suggests that these decisions may be some of the most challenging to incorporate SDM for psychiatrists. Specifically, medication decisions are one of most frequent types of decisions to cause decisional conflict among patients and clinicians (Hamann et al., 2008), and psychiatrists treating individuals with schizophrenia (both inpatient and outpatient) report being less willing to participate in SDM with patients for medical and/or legal decisions compared to psychosocial treatments (Hamann et al., 2009). Lastly, while researchers have identified decisional capacity as a barrier and possible solutions, a deeper exploration of this barrier is necessary to understand potential mechanisms of change and to inform intervention adaptation and development. Qualitative methods were chosen for the study due to their focus on in-depth, rich exploration of a particular phenomenon, specifically focusing on the lived experience of those who are immersed in it (Polkinghorne, 2005).

Setting Context

The VHA maintains a number of standardized policies and procedures related to acute mental health care that are important to review to provide specific context to the topic of acute mental health, decisional capacity, and medication decision making. The overall goal of inpatient services within the VHA, as stated by the *Inpatient Mental Health Services* directive (Department of Veteran Affairs, 2023) is to "provide a safe and secure therapeutic environment to stabilize Veterans experiencing acute distress and improve their functional status so they no longer require acute hospitalization." (p.13). Services provided on the acute mental health units within the VHA can vary by location, but ideally should include: 1) evidence-based psychopharmacology 2) 5 to 6 hours per day of evidence-based group programming (e.g., psychoeducation, social skills training, Illness Management and Recovery, 3) evidence-based psychotherapy (e.g., cognitive behavioral therapy, acceptance and commitment therapy), and 5) case management and discharge planning (Department of Veteran Affairs, 2023). Further, these services should be organized and provided by a multidisciplinary treatment team composed of at least three different professional backgrounds (typically nursing, social work, psychiatry, psychotherapy provider). Additional members of the team could include clinicians in peer support services, art therapy, vocational rehabilitation, occupational therapy, nutrition services, or chaplain services (Department of Veteran Affairs, 2023).

In addition to descriptions of the purpose and structure of VA acute mental healthcare, the most recent inpatient mental health VHA directive also mentions how inpatient mental health should foster ROC (Department of Veteran Affairs, 2023). This directive states that within ROC, Veterans are encouraged to be "actively engaged in the process of defining personal goals based on their self-chosen values, interests, roles, and aspirations" (p. A-1). While this document does not mention SDM specifically, staff are encouraged to "work collaboratively with Veterans and each other to foster an environment and therapeutic milieu that communicates hope and caring." (p. A-1). Lastly, the guidelines on specific clinical programming required in acute mental healthcare include patient education on medication management and assistance in helping patients understand and recall information about their medications. Additionally, patients should be provided "dedicated time for patients to reflect and discuss their goals and progress" as well as "motivational interviewing focused on treatment engagement." (p. 3, Department of Veteran Affairs, 2023).

In regards to refusal of treatment within psychiatric inpatient care at the VHA, both voluntarily and involuntarily admitted patients (e.g., admitted under immediate, 24-hour hold, or emergency detention, 72-hour hold) have the right to refuse treatment (including medication). The ability to administer forced medication is typically obtained through the court system in the form of temporary commitment. VHA mandates that all facilities must follow state guidelines to obtain commitment (i.e., guidelines vary by state; Department of Veteran Affairs, 2023). As an example, in the state of Indiana, temporary commitment is obtained through a petition to the court, typically following an emergency detention, and should include an examination by a physician within the past 30 days that suggests that the patient is mentally ill and is dangerous (i.e., has a substantial risk of harming themselves or others) or gravely disabled (i.e., in danger of harm due to not being able to properly take care of themselves independently) and is in need of care (Indiana Disability Rights, 2017). Patients may appeal this commitment and/or petition to the court to make changes to their mandated treatment (including medication treatment).

In regard to determination of decisional capacity, the VHA follows the standard guidance across medicine related to the four pillars of decisional capacity (Department of Veteran Affairs, 2009). The VHA maintains that a clinician must obtain or perform and document an assessment of decision-making capacity if the patient's capacity is in question; however, the nature of this assessment/evaluation is unclear. If the clinician believes that decisional capacity is unlikely to return in a reasonable amount of time, then they must obtain an authorized surrogate decision-maker (Department of Veteran Affairs, 2009). The order in which a surrogate decision-maker is prioritized is: 1) healthcare agent (i.e., person selected by patient and named in a durable power of attorney for health care to make healthcare decisions on the patient's behalf), 2) legal guardian, 3) next-of-kin (in the order of: spouse, child, parent, sibling, grandparent, and grandchild), and 4) close friend (Department of Veteran Affairs, 2009). Lastly, the VHA emphasizes that even if the patient has reduced decisional capacity, the clinician must still explain the procedure or treatment to the patient (Department of Veteran Affairs, 2009).

While the policies and procedures highlighted above provide context to what is required within the VHA, the guidance on SDM within psychiatric inpatient care is vague, leaving room for subjective interpretation and clinical judgement that may vary across psychiatrists. The current study focused on gathering information from psychiatrists that goes beyond these policies and procedures and was specific to their experiences assessing patients' ability to participate in and/or make medication management decisions in psychiatric inpatient care, particularly when considering decisional capacity concerns.

Methods

Overview

Individual semi-structured interviews were completed with 25 VHA acute mental health psychiatrists to understand how patients' ability to make medication management decisions is determined. Additionally, during the interviews psychiatrists were presented with information on three different approaches proposed in the literature for conducting SDM in the presence of possible impairments in decisional capacity and were asked question on the perceived acceptability and adaptability of these approaches to their specific units. Qualitative data was analyzed using emergent thematic analysis (Braun & Clarke; Guest et al., 2014; Hsieh & Shannon, 2005; Crabtree & Miller, 2023). Further information on the study setting, recruitment of participants, interview guide development and procedures, and analysis, is presented below.

Setting and Participants

Psychiatrists were recruited from VHA acute mental health units across the United States. The final sample included 25 psychiatrists (22 attending psychiatrists, three residents) from 17 unique sites. Participants were asked to describe their unit (e.g., average length of stay, number of beds, average census) within the semi-structured interview (see Table 1). Most participants reported an average length of stay ranging from four to 10 days, which is consistent with previous research that identifies the average length of stay for patients with VHA acute mental health to be roughly one week (Eliacin et al., 2022; Shue et al., 2022). The shortest length of stay reported was two to five days while the longest and most variable length of stay reported was anywhere from 3 days to "months" when the unit was having difficulty finding long-term placement for a patient, although this was described as an outlier scenario. Providers' report of inpatient beds ranged from 8 to 60 beds across 17 unique sites, with the modal bed number across sites being 25. Average census also widely varied from 6 Veterans reported by two units to one unit reporting an average census of 30 Veterans. Most reports of average census fell within the 16 to 25 range.

Study recruitment began January, 2024, with interviews conducted from February to April, 2024. Participants were recruited through purposive and snowball sampling methods. Specifically, psychiatric inpatient psychiatrists, residents, fellows, and their associated contact information were identified using VHA inpatient mailing lists (e.g., national inpatient mailing list, residents in psychiatry mailing lists) and a search of VHA employee contact lists (i.e., staff directories through VA Outlook, VAMC and/or VISN intranet sites). The current author (EB) attempted to contact potential participants through VA email (using approved VA encryption service) to provide information on study participation including a study information sheet. If providers did not respond, EB sent at least one additional email reminder approximately one week after the first email was sent; however, some providers only received one contact attempt due to sample size being met and recruitment discontinuing. For the snowball portion, EB asked participants at the end of interviews if they would be willing to provide names other inpatient psychiatrists, fellows, or residents at their site or other sites they are familiar with who may be willing to participate. Contact information from these provided names was gathered using staff directories through VA Outlook and an initial recruitment email was sent to these potential participants. Following this email, recruitment procedures were identical to above descriptions.

In all, 190 inpatient psychiatrists, residents, or fellows were identified as possible participants. Of the 190 providers contacted, 104 did not respond to contact attempts via email. Additionally, 54 declined to participate. While many providers declined without providing a reason, reasons mentioned for declining included being too busy in their clinical role, no longer working on a VA acute mental health unit, and discomfort with being recorded. Further, seven providers responded, but were then lost to follow-up when trying to schedule an interview. Recruitment ended after recruiting 25 participants (i.e., the study goal) and adequate data saturation was met (see below for details in determining data saturation). Providers that responded to the email with interest in participation were sent a VA Microsoft Teams invite for a call (with video on or off depending on personal preference) based on an agreed upon time and date. The current study was an IRB exempt study and did not require written consent; however, participants were provided with subject information sheets that explained the study and that were reviewed with EB prior to beginning the interview.

Interview Procedure

Following verbal consent, participants participated in recorded semi-structured interviews. The average length of interviews was approximately 46 minutes, with the shortest interview lasting 30 minutes and the longest lasting one hour. The interviews were conducted and recorded virtually via VA Microsoft Teams (see Appendix A for interview guide). Following brief explanation of the study and specific questions about their unit (e.g., number of beds, average census), interviews began with a "grand tour" question (Spradley, 1979) to establish rapport and learn about their role within VHA acute mental health services. Regarding the first aim of the study, participants were asked a series of questions regarding their general process for medication decision-making with patients and assessment of decisional capacity. To address the second aim of the study, participants were provided with a brief description of each of the three suggested approaches to increasing shared decision-making when situations where decisional capacity is questioned (i.e., capacity-adjusted sliding scale SDM, the SDM-PLUS model, Shared Risk Taking). During these explanations, an infographic for each model was shared on the screen using the screen share option within Teams to aid comprehension/understanding (see each infographic in Appendix B). Following each description, participants were asked questions to gather their perspective on the acceptability and adaptability of each approach based on their experiences within their respective acute mental health units. Lastly, EB asked participants for permission to contact them again via VA encrypted email if any additional questions arise from their responses during data analysis.

Data Saturation Analysis

Obtaining an adequate sample size within qualitative research methods typically consists of continued sampling of participants until data saturation has been met (Morse, 2015). In general, data saturation refers to the point in data collection/analysis where little to no new and useful information is produced by the data (Morse, 2015). Following Guest et al. (2020)'s method in determining appropriate sample size for data saturation, the current study totaled the number of codes that were found within the first five interviews, used a run length of two interviews (i.e., the number of additional interviews used to determine new information gained), and a threshold of $\leq 5\%$ new information gained. Specifically, the current study identified 27 unique codes within the first five interviews conducted. The next two interviews generated nine new codes. Nine codes divided by 27 codes indicates 33% new codes gained, which is well above the threshold of $\leq 5\%$ new information gained. This process was repeated incorporating the last interview of one "run length" with the addition of one new interview (e.g., new codes generated from interview 3 and 4, then interview 4 and 5, etc.) until the percentage of new codes generated from each run length was $\leq 5\%$ from the original 27 codes. This method of determining data saturation was achieved with 10 interviews, which is line with previous research using this method (~12 interviews; Guest, 2020).

However, Hennink et al. (2017) suggest that data saturation should not be determined solely based on whether all the themes have surfaced (i.e., code saturation), but also whether researchers fully understand these themes (i.e., meaning saturation). Specifically, Hennink et al. (2017) found that a larger sample size (16 to 24 interviews) was needed to obtain meaning saturation. As such, an additional 15 interviews were conducted to increase the likelihood the current study developed a rich understanding of the majority of codes/themes.

Qualitative Analysis

All interview recordings were transcribed and de-identified prior to data analysis using recommendations provided by Saunders et al. (2015) (e.g., de-identifying transcripts for data management, further de-identification for data shared within manuscript, using "smoke-screens" such as changing reported gender when necessary). Further, participants were assigned a participant identification number which was used for participant tracking and data analysis. Audio recordings and transcripts were stored securely behind IRB-approved VA and University firewalls. Below is a description of codebook development and further analysis following coding of the data.

Codebook Development

Codebook development utilized an "editing organizing style" (Crabtree & Miller, 2023, p. 190) of emergent thematic analysis where researchers reviewed the text and began to segment the data by identifying information most pertinent to the research questions (See Appendix C for complete codebook). Specifically, EB and a second coder (IL) each independently read the first six transcripts and marked phrases or segments they found to be significant (i.e., relating to the current study's aims). Microsoft Word was utilized where each team member highlighted text and added comments in the margins describing their thoughts on why they viewed it as significant. Following this activity, EB and IL met to discuss the first five transcripts and develop initial codes that emerged from the highlighted data. After the development of an initial codebook, EB and IL utilized a "template organizing style" (i.e., using a developed "template" or codebook to organize the data; Crabtree & Miller, 2023) such that each researcher attempted to apply the initial codebook to two new transcripts. After each coding the same two transcripts, EB and IL met to discuss codes, resolve discrepancies, and develop a final coded transcript for each interview. Once the codebook stabilized (after 10 transcripts as noted above), EB and IL each began coding one transcript independently and one transcript together (three transcripts total) each week to maintain reliability in coding and ensure trustworthiness of coded data. After each round of coding, EB and IL met to discuss the transcripts and come to a coding consensus with any noted discrepancies. This process was repeated until all 25 transcripts were coded.

During code development, different types of codes were utilized. Specifically, process codes (using gerunds; Saldaña, 2021) were utilized to describe provider's descriptions of their medication decision-making process and capacity assessment process in the interviews. For example, the code "defaulting to autonomy" described when providers assumed a Veteran had capacity unless proven otherwise, therefore, opening the door to allow Veterans some level of autonomy in the medication management decision. Another code type employed in the codebook were "description" or "topic" codes (Saldaña, 2021). These codes are specific for coding particular topics of interest. For example, "SS Barriers" was used anytime a provider mentioned a barrier to using the sliding scale method to SDM on their unit. Lastly, versus codes (Saldaña, 2021) were employed to capture conflicting values that emerged in the interviews that may influence providers' determination of patients' ability to participate in the decision-making process. For example, "stabilization vs. recovery" was used anytime providers mentioned discussion around promoting recovery on the unit and/or goal for stabilization.

Emergent Thematic Analysis

Following coding, all final coded transcripts were entered into the qualitative data analysis software ATLAS.ti version 24.2.1 for Mac to further analyze the data. Multiple methods were utilized to synthesize coded data into larger themes related to the aims of the current study. For Aim 1 of the study, the emergent thematic analysis utilized connecting and legitimating methods ("chunking" and "displaying" p. 233-234; Crabtree and Miller, 2023) such that EB pulled quotes using the query tool within ATLAS.ti for each of the process codes (i.e., chunking related texts together). EB read over the chunks of text for each process code and looked for larger patterns that emerged. For example, larger "themes" were developed from reading chunks of data related to "red flags" for possible impaired decisional capacity in patients. Data was also compared against one another. For example, "red flags" data was compared against "circumstances that may limit patient involvement" data and it was determined that providers described similar constructs for both. EB then developed a "display" that described how patients' decisional capacity assessment related to different medication management decision making scenarios (i.e., depicted in Figure 1 and described further in Table 2). To create this display, EB determined where data from each process code fit within the larger figure. For Aim 2, similar methods were applied where EB utilized "chunking" the data together based on codes and searching for patterns and differences within the codes. For example, larger themes represented in Tables 4-9 were developed based on patterns observed in the "chunks" of text for each of the descriptive codes ("SS Barriers", "SS Facilitators", etc.).

Ensuring Rigor

A number of strategies were implemented based on recommendations (Guest et al., 2014; Hamilton 2020; Morse, 2015; Levitt et al., 2017) to ensure rigor (i.e., trustworthiness of data) within qualitative research. Specifically, negative and deviant case analysis was implemented (i.e., actively searching and identifying cases that contradict or deviate from an identified pattern in the data; Guest et al., 2014). The "versus codes" were particularly useful in implementing this approach such that provider descriptions and points of view on either side of the code were searched for and coded. Additionally, guided by recommendations in promoting qualitative methodological integrity (Levitt et al., 2017), researchers involved in data collection and analysis considered how their own perspectives influenced or guided data collection and analysis. This was accomplished through reflexive discussion and memoing (Levitt et al., 2017) throughout data collection, with researchers noting how their prior assumptions about psychiatrists, patient decisional capacity, and SDM may have influenced the interpretation of the data. For example, EB and IL discussed in consensus meetings reactions to the participants points of view and often recognized that our point of view was heavily influenced by our desire to promote patient autonomy and our recovery-oriented training in psychology which sometimes differed from the biomedical viewpoint that participants held. This difference in training often guided our initial reactions to be somewhat critical of certain processes within medication management decision making and capacity assessment (e.g., providers discussions around convincing the patient to take medications, even when capacity is somewhat limited, to stabilize as quickly as possible). With this knowledge in mind, EB was careful in further analysis of codes to understand the larger context that some of these decisions may be made in (e.g., overall goal of stabilization on the unit, demand to free up beds as quickly as possible). Additionally, to ensure rigor, researchers used an inductive approach in data analysis, ensuring findings were generated from and grounded in the data itself (e.g., providing example quotes that are descriptively rich as supportive evidence of findings; Levitt et al., 2017; Morse, 2015). Lastly, the use of a detailed and precise codebook, independent coders, and consensus checks were additional strategies the current study used to manage the researcher perspective and increase reliability of findings (Guest et al., 2014; Morse, 2015).

Results

Aim One: How Are Providers Determining Patients' Ability to Make Medication Decisions?

Interviews confirmed that assessment of patients' decisional capacity for medication treatment is often determined through the clinical interview using specific guidelines (i.e., four pillars of decisional capacity) and only more formally considered if providers notice red flags that may indicate the patient does not demonstrate adequate capacity. Additionally, throughout interviews, psychiatrists discussed risks associated with medication treatment as a factor that determines how adherent they are to capacity guidelines for informed consent. Further, interviews revealed that providers' threshold for determining patients' decisional capacity increases when assessing whether patients can be actively involved in the decision vs. when assessing whether patients can provide informed consent. Specifically, providing informed consent to treatment required a lower threshold of decisional capacity. However, collaborative patient involvement in making medication decisions (e.g., providers' willingness to go with the patients' preference for treatment, discussion around patients' goals as it relates to medication) requires a higher threshold of demonstrated capacity. Further, determining capacity for informed consent is often considered a binary decision (yes, patient has capacity– the decision-making process can continue, or no the patient lacks capacity – surrogate or court involvement is needed). However, once patients demonstrate they have enough capacity to provide informed consent, capacity is often considered to be more of a spectrum as it relates to level of collaboration in the decision (level of demonstrated capacity may indicate how much collaboration is allowed).

Additionally, interviews indicated that psychiatrists' assessment of patients' capacity to be more involved in the medication decision, beyond simple consent, is nested inside a larger process that integrates psychiatrists' consideration of multiple factors (e.g., four pillars plus risk, patient agreement with provider, and policy). This process, illustrated in Figure 1, ultimately dictates the level of patient participation a provider may facilitate in the medication treatment decision. Each component of this process (i.e., how providers are determining patients' ability to consent to treatment and how their determining level of capacity needed for collaboration in medication treatment), is further described below.

Assumption that Patient Has Capacity Until Proven Otherwise

As mentioned above, interviews revealed that prior to more formal considerations of capacity, many providers mentioned holding the assumption that their patients have capacity to consent and participate in a medication treatment decision unless there are factors that indicate otherwise. Therefore, for many patients a direct assessment of capacity is not necessary. For example, one provider stated:

> So, we assume that all patients have capacity until they've shown us that they don't…so, you know, 'this is the medication we recommend. This is what we think is wrong with you' but if they say 'no, I'm perfectly fine, this is normal and I'm already dead' well, clearly they can't make that decision, but everybody else is assumed to have capacity. (P102)

As described by participant 102, the process of assuming adequate capacity and moving into medication decision-making with the patient is often not stepwise or linear. Many providers identified that patients' responses in medication decision-making may actually determine their capacity. For example, as described by participant 102, the discussion about medications themselves may reveal additional red flags (e.g., lack of insight combined with risk) that notify them that perhaps the patient does not have capacity to make these decisions on their own. As reflected at the top of Figure 1, if providers are not given a reason to doubt capacity (i.e., they do not notice red flags), then they may carry on with their medication decision-making process, where patients are more active in the decision (i.e., scenario 1 presented in Figure 1/Table 2) or patients decide not to take medications (i.e., scenario 2 in Figure 1/Table 2).

Red Flags Indicating Possible Capacity Impairment

While providers mentioned that many patients bypass capacity considerations, providers also discussed common cues or “red flags” that indicate they should further consider a patient's decisional capacity as a possible barrier to the patient’s ability participate in medication decisions. Providers were explicitly asked “Are there certain symptoms (e.g., acuity level or specific symptoms in general) that are “red flags” where you are automatically concerned about patients’ decision-making ability?” as well as “What circumstances might change your view on how involved patients should be?” Common red flags emerged from participant responses including symptom severity (e.g., acute psychosis, mania, depression) which often led to impaired insight into treatment decision; descriptions of patients who were at higher risk of harm to self or others (including aggression towards staff) or who have the inability to care for oneself; acute intoxication (e.g., admitted on the unit while still impaired from a substance); neurocognitive processes such as memory impairment, dementia, or delirium; communication difficulties such as disorganized speech or catatonia that limits ability to discuss medications; involuntary admission status possibly indicating a lack of insight or acuity level that interferes with treatment decision-making; and lastly, a history of medication non-adherence. See Table 3 for example provider quotes for each of the red flags.

In addition to commonalities in red flags for capacity that emerged from participant responses, many providers held nuanced understandings of these red flags. Specifically, many red flags were not considered to be complete indicators for lack of ability to provide informed consent, yet providers noted these red flags certainly limited patients' capacity to fully participate in the decision. For example, some providers believed that adequate decisional capacity for informed consent can still be held even in the presence of lack of insight:

> I would consider [lack of insight] a red flag. But, just because someone lacks insight, you can still have a risk benefit discussion even if they don't fully understand the benefits, right?...And even if someone doesn't fully grasp that they have schizophrenia or what their issues are, they can still discuss the potential risks of a medication. I don't think that lack of insight definitively means that they lack capacity. (P104)

However, this provider later mentioned that red flags for capacity such as psychosis (including lack of insight into their problem) may limit the amount of collaboration that goes into making the decision:

> In those kinds of psychotic cases, I cannot be as collaborative. It can still be collaborative, but there is a reduction in the collaboration ability because if we're starting off from different goals, their goal is to stop the people from coming after them, my goal is to stop them from being concerned or worried about the people coming after them. Those are really different goals. So, in that case legally, I'm gonna end up taking a more paternalistic view…I do go over risks and benefits of the medications, but it's often more terse. (P104)

At times, however, red flags for decisional capacity, particularly risk of harm or inability to care for oneself (i.e., grave disability), can completely halt patient autonomy in the decision, regardless of capacity. Many providers discussed filing for court orders for patients with high risk of harm (identified red flag to capacity), who are refusing treatment, and who may lack insight into the risk of going without treatment. This scenario is reflected in Figure 1 with scenario 7. When providers described filing for a court order, providers also mentioned the ultimate goal of restoring capacity so that they may have the option to participate in medication management decisions down the road:

> There's been a handful of cases where I would go to my mentor [asking], "how do you deal with feeling bad? Because this person really wants to leave and they don't get it and they just are miserable every single day and they're locked in this hospital…" And my mentor did a good job of basically saying right now, this patient is not doing well and your hope is to get their brain doing better for the future so that they get to make these choices using their best brain…and that's some of the paternalism that comes in with psychiatry. (P103)

However, despite the goal of capacity restoration, providers differed in whether they believed certain red flags could be restored to a point where patients could participate in medication decisions within their stay on the inpatient unit. For example, similar to scenario 4 in Table 2, many providers mentioned the possibility of symptoms (and therefore capacity that was previously limited due to symptom acuity) improving with time on the unit which may improve their ability to participate in treatment decisions: "Sometimes you have a patient that comes in and they don't really seem like they can participate. But then as they improve then they can. So just kind of remembering that it can change with treatment or time." (P105). However, another provider did not believe there is much change in capacity over the course of an acute inpatient stay, particularly in context of the psychosis, as antipsychotics often don't become fully effective until around 6 months of use.

Lastly, as noted in Table 2, some providers discussed how knowing their patient's history with medication adherence may factor into their evaluation of decisional capacity to participate in medication decisions. Specifically, many patients return to the inpatient unit more than once. As such, providers may be more familiar with the common difficulties the patient faces both while on inpatient and in maintaining medication adherence/safety while outpatient. One provider spoke to how this red flag influences their tolerance in working with the patient vs. more quickly filing for court-ordered treatment:

> There're other situations where, for example, we know the history of the veteran. We know historically the veteran has not been compliant or adherent to taking medications, and we know that a court order sometimes is what's necessary. So rather than delay care, sometimes we'll proceed with filing for court order sooner, rather than later. (P109)

Assessment of Capacity

Interviews indicated that if providers notice red flags in their conversations with patients about medications, they will then more closely assess decision-making capacity. All providers stated that they assess decisional capacity through clinically interviewing patients, making sure to ask questions that assess the four pillars of decisional capacity. Many referenced this as the "Applebaum Criteria" after the development of the four criteria by Paul Applebaum (Applebaum & Grisso, 1988). In addition, some providers noted that if neurocognitive difficulties such as dementia were a main concern, they may refer patients for a neuropsychiatric evaluation to determine level of decisional capacity; however, this practice seemed to be used in rare cases and more for discharge planning (e.g., nursing home placements). Further, some attending psychiatrists that were interviewed described having residents conduct the majority of the clinical interviews with patients about medications while others described often meeting with the patients along with their students during rounds or following up with patients after the resident has met with them.

The four pillars of capacity, reflected in Figure 2, were described in a similar manner across interviews. In addition to the four pillars of capacity, providers often discussed determining how strictly to adhere to each pillar (i.e., the degree to which the patient needed to demonstrate each pillar) as dependent on the risk of the treatment:

> The way in which I think of decision-making capacity and the way I've read about it being described in the literature a lot is that it kind of exists on a sliding scale with a lower bar needed for a lower risk decision than a higher bar for a higher risk decision. (P113)

This provider went on to explain that a simple change in medication dosage is considered lower risk whereas starting an antipsychotic medication such as clozapine is higher risk. Additionally, while the four pillars provide a loose framework for assessing decisional capacity, providers indicated largely using clinical judgement rather than formal assessment tools such as a measure or questionnaire. While providers noted a strength of this approach is the ability to account for subtlety in cases, other providers noted the possibility for low "interrater reliability":

> You know every case is going to be different in capacity. You know, we do a lot of capacity evaluations. I work also on the consult service sometimes here, so we're very familiar with capacity and how, I think…there's a lot of differences in interrater reliability. (P109)

Additionally, providers discussed the importance of assessing capacity for a specific decision at a specific time and having these discussions throughout the patients' stay on the unit. This specificity of time and type of decision assessed may create nuanced situations in which patients have capacity to provide informed consent (for treatment), but do not have enough capacity to fully participate in the decision-making process to choose the treatment:

> Capacity is like a sliding scale. They may be able to have capacity to [consent] to treatment with an antipsychotic, but they are still pretty disorganized and kind of unable to really appreciate and weigh the different options and in those situations, you know, I would go based on prior response to medication or like based on their specific symptoms and medical comorbidities. (P108)

As such, the threshold of capacity that providers believe patients need to simply accept medication treatment is lower than the threshold of decisional capacity that providers deem necessary for more collaborative decision-making with patients, such as SDM. Indeed, one provider mentioned that “the majority of our patients do meet that criteria” (P122) in reference to enough capacity to provide informed consent, yet this provider indicated that more variance exists in whether patients have enough capacity to “engage in conversations about medications,” a necessary component of SDM. Indeed, the four pillars of capacity described in interviews indicated that patients should be able to demonstrate reasoning between options, understanding of the situation and their illness, and ability to communicate choice, all of which may be needed in a higher degree for patients to be able to collaborate effectively with providers in medication decisions and all of which can vary based on “red flags” such as lack of insight or disorganization.

Interaction Between Agreement, Risk, and Policy. Interviews revealed that providers’ capacity assessment may be influenced by the interaction of additional factors, including level of agreement between patient and provider on medication treatment, the level of risk the patient is of harming themselves or others, and policy. For example, one of the four pillars of decisional capacity assesses the patient’s ability to appreciate the situation. Many providers discussed “lack of insight,” which often led to refusal of any medication treatment by the patient, as a major barrier in relation to these criteria, particularly when the patient demonstrates higher risk of harming themselves/others or grave disability: “It depends on how severely impaired they are, so if there’s severe enough impairment, like if they are suicidal with a severe attempt and they can consent to meds, but they won't, it's like yeah, no, you need medication.” (P102). In this instance, a certain level of agreement with the provider's recommendation for medication treatment may factor into the assessment of the patient's decisional capacity because the patient is not appreciating the higher risk situation and the need for stabilization through medication. However, one provider described the importance of making sure providers do not impart their own beliefs about whether or not the patient needs medication into the capacity assessment:

> Especially, you gotta make sure that you're not imparting your own moral values onto the patient's situation because they're allowed to have a different thought process… but if you can in good faith say that you're not and you really just think this person doesn't have insight…insight is integrally a part of the Applebaum criteria…and so yeah, insight is definitely one that is an indication that capacity is not there, but it's not an absolute. (P106)

One factor that protects against "imparting providers' morals" may be mental health law determining criteria for forced medication. For example, most providers indicated that the patient's potential risk of harm ultimately determines how much autonomy they allow the patients to have when the interaction of lower insight and disagreement exists in capacity assessment:

> We certainly will see people who are not well, who may be floridly psychotic responding to internal stimuli or gravely depressed. And again, as long as they're not an imminent risk to themselves or others, we don't pursue involuntary medications. For those people, one of the things I like to remind trainees of is that it is not illegal to be psychiatrically ill. So if you're able to provide for your food and basic shelter, but you have all sorts of inner voices or delusional ideas that's within your rights. And we would never pursue involuntary medications for that unless there was evidence of suffering. (P122)

Despite this serving as protection for overly relying on forced medication, providers may differ in their level of risk tolerance or what they consider as risk of harm. For example, while participant 122 believed "florid psychosis" was not necessarily considered a high risk of harm unless their behavior was harming themselves or others, one provider considered *staying* in a state of severe psychosis or mania as risk of harm:

> So you [are supposed to] take your risperidone once a day, but you aren't taking it, you're refusing to take it and your mania or your psychosis is not getting better and this is now a danger to allow your brain to stay in that diseased state and so now we need to [consider] that this patient doesn't have the true capacity to understand how staying in this state is actively damaging their brain. And we have an ethical obligation to get him into a state where he can make that [choice]. (P106)

Mental health law and VA policy also adds a layer of complexity when determining the interaction of risk and agreement in capacity assessment. For example, the decision of whether or not to file in court may be heavily influenced by patient's agreement to treatment and the state in which the provider is filing in. If the patient is higher risk, but is willing to take medications, providers often do not file for court commitment, regardless of capacity, given the sheer number of cases the court must sift through:

> The court says: "we have a ton of patients on our calendar. If you have a patient that's agreeable to taking the medication, and it seems like they get the basic gist of what's going on, don't send them to court because you question how well they can decide because we have an entire panel of patients who do not want to take the medicine and desperately need it." (P103).

Lastly, mental health law and organizational policy in VA acute mental health units may limit patient autonomy in the presence of lower capacity to make medication decisions. Specifically, many providers referenced the overall purpose of VA inpatient as the "stabilization" of patients. For example, participant 119 describes their goal on inpatient is to "achieve compliance and stabilization as quickly as possible so that they can leave. On the outpatient side, the conversations might be different. But for us, our goals are ultimately, 'let's get you discharged' and usually we can align on that." This provider noted using the common goal of discharge to incentivize patients to take their medications. However, some providers noted that patients' symptom severity may improve over time without medication or with just the use of PRNs ("as needed" medications that patients may be comfortable taking), even to the point of being able to be discharged or improving their capacity to participate in later medication discussions. However, the push to stabilize patients and discharge them as soon as possible may also limit the amount of time providers have to allow natural recovery processes that may lead to restoration of capacity:

> Usually we might give them, you know, a period where we might say, OK, maybe the initial assessment, we weren't able to kind of get the message through…maybe they'll be in a better frame of mind in a little while, so there are some cases where we might wait a 24-hour period before we proceed with the court order or requesting a court order. (P109)

Decision-Making Scenarios

As noted above, agreement, risk, and policy interact with assessment of capacity using the four pillars to shape the degree to which providers will foster patient involvement in the medication decision. For example, a combination of risk and treatment refusal (which often also indicates lack of insight and lower capacity given the situation) often leads providers to file for a court order. However, when the patient has enough capacity to consent, refuses meds, but does not meet full criteria for filing in court, providers described four different scenarios that may occur (scenarios 2-5 in Table 2). Factors influencing when providers decide to use each of these four approaches was less clear in interviews. For example, provider's often described scenario 3 (negotiating/convincing), 4 (factoring in time), and 5 (ordering meds and offering regardless of disagreement) as efforts to avoid scenario 7 (filing for commitment in court). However, providers seemed to differ in the time they were willing to give prior to filing for commitment. As mentioned above, this difference may also be influenced by organizational pressure to "stabilize" and discharge patients as quickly as possible.

Additionally, adherence to SDM guidelines in each of these scenarios was not assessed and is outside the scope of this study; however, providers often described elements of SDM (e.g., offering and talking through different options, ultimate decision is made by patient) when describing scenario 1 and 2 in Table 2. Of note, multiple providers also stated that having discussions with patients about the different options and coming to an agreement (as described in scenario 1) was more common than needing to force medications in their experience: "It should be very collaborative and there are certainly some inpatients where it can be very, very collaborative. And it's not as many as you would see on outpatient. I still do think it's the majority where it can be very collaborative" (P104). This collaborative approach also includes instances where providers honor patients' preference of no medication (scenario 2). However, collaboration seemed less consistent in the remaining scenarios given the interaction of risk, agreement, and policy on provider's assessment of patients' capacity to make the decision. For example, while some providers described using SDM techniques (i.e., discussions with patients around their concerns about treatment, honoring patient's preference for a "less ideal" treatment choice) in scenario 3, providers also described instances where they (or others) tried to "convince" the patient to take medications:

> If family can convince the patient or staff can convince the patient, or we can say, you know, 'I know you really want to get out of here if you take the med then a week after the loading injection, you get the maintenance injection and we've got nothing left to do for a month, you wanna get out of here? Sure. They'll generally say hell yeah. (P112)

While scenario 6 (surrogate makes the decision) and 7 (court order) are objectively the most limiting for medication SDM, some providers described still trying to give patients as much autonomy as possible. For example, one provider described allowing patients to still participate in deciding which medication they might take despite being court-ordered to take it. However, another provider mentioned that their facility could improve in involving patients in medication treatment decisions post-court order:

> I do think for patients with a little bit more insight after commitment is granted, we could see how their mind has changed, at least after the commitment is granted. Being at the hearing can be an awakening enough for patients to know like 'ohh maybe there is a problem' or 'I controlled my medications up to this point. I still have a way to control them from now on', but after commitment is granted a lot of times, we just kind of take their autonomy away. (P115)

Aim Two: Gather Inpatient Psychiatrists Perceived Acceptability and Adaptability of Key Elements from Three SDM Approaches

In addition to understanding how inpatient psychiatrists are determining patients' ability to make medication management decisions, during the interview the current study also briefly presented three different approaches described in the literature that facilitate SDM in challenging situations, such as when patients have reduced decisional capacity (see interview guide in Appendix A). Psychiatrists were asked questions related to the acceptability of the approaches (i.e., likes and dislikes about the approach, perceived effectiveness in facilitating patient involvement in the decision) as well as adaptability of the approaches (i.e., what might need to change to make the approach work for their specific units through understanding barriers and facilitators). Results on acceptability and adaptability are presented below for each approach.

Capacity-Adjusted Sliding Scale Approach

The capacity-adjusted sliding scale approach (Lahey & Elwyn, 2020) suggests providers adjust the role of a surrogate decision maker as the patient's decisional capacity decreases to facilitate as much patient involvement in the decision as possible. For example, if a patient can provide informed consent to medication treatment, but struggles to choose between medications, perhaps a surrogate may play the role of a patient advocate in that they help the patient decide between medications. However, if the patient does not have capacity to provide informed consent, the surrogate may make the decision on behalf of the patient's best interest.

Perceived Acceptability. Table 4 presents a summary of likes and dislikes mentioned by providers regarding the capacity-adjusted sliding scale approach. Overall, there were mixed responses to the use of a surrogate to help patients make choices in medication. On one hand, some providers discussed the potential for this approach to increase overall buy-in for the treatment plan with family members or caretakers of the patients, which has the potential to facilitate medication adherence following discharge to outpatient. Additionally, providers also mentioned that they liked the use of the surrogate as a patient advocate, particular if they are someone close to the patient: "I think a family member would know best in terms of the patients like personal values." (P108)

However, some providers were hesitant to involve family due to the potential for increased conflict:

> The downside is I think sometimes, especially in psychiatry, when there is a lower ability of the patient to make the decisions for themselves, if there are situations where that's transient—like for instance somebody who has bipolar disorder and you involve the family member with the decision making for them, sometimes that can drive a wedge in between the patient and that surrogate who you're hoping is going to be an advocate for the person and not adversarial. (P100)

Further, a major dislike and identified barrier to this approach was that 1) finding/using a surrogate could be difficult and 2) certain state laws prevented the use of surrogates for psychiatric medications. For example, one provider described that within their state, a family member cannot sign for any medications unless the patient is under conservatorship which is a lengthy and complex process to obtain. Others noted many patients do not want family involved or do not have an easily identified surrogate to contact:

> So even if they have low decisional capacity, there's not a guardian, there's no POA [power of attorney], there's no family, there are no close friends. There's really not a surrogate decision maker. We've had a similar situation where we kind of had to go through leadership to get like a surrogate decision maker and it's a very, very, very slow process to make that happen. (P107)

As participant 107 noted, many providers also shared concerns that efforts to identify surrogates would delay care too long.

Despite concerns around the use of the surrogate, some providers liked the flexibility of the “spectrum” approach to capacity. Many providers commented on how this approach allows them to capture “nuance” in capacity as it relates to patient autonomy in decision-making:

> I like that it's a gradient, like it's not all yes or no. There's a middle ground and they're considering the surrogate…regardless of the patient’s initial capacity decision, we're still trying to explain everything to them and treat them as if they are engaging in shared decision making. (P111)

On the other hand, some providers were less inclined to say capacity was on a spectrum due to the inherent binary decision that must be made (i.e., does this patient have capacity to make the decision? Y/N). One provider sought to reconcile this discrepancy and noted that the “nuance” still exists in a series of binary decisions, which this sliding scale captures: “So it's more black-and-white. But when somebody has capacity to make decision A&B but not C, that's where [this approach] would come in handy.” (P102)

Other providers discussed the sliding scale approach being too vague or abstract. For example, some providers were unsure how they would classify capacity as “low, medium, high” on the sliding scale and these categories felt subjective.

In addition to likes and dislikes, providers were asked about their perceived comfort using this approach and provider responses were mixed. Some providers believed that they were already using elements of this approach and were therefore comfortable with it:

> I think we probably already do a version of this already. We try to engage and have shared decision making with our people who have full capacity. When they don't have full capacity, we kind of do our best to either work with them or, you know, some of them will have POA's or family members who they'd rather be talked to and we pursue that too…So I think we already do a version of this just kind of naturally. (P107)

Others noted they were comfortable with this approach despite not being able to use surrogates to consent for psychiatric medications:

> I think we pretty much [use this approach]…when the patient has capacity, they can make their own decisions unless we disagree with that…And you know getting the family buy-in is generally what we try to go for with a patient-centered approach--trying to involve everybody in the patients care that they allow to be involved in their care. (P112)

However, some providers noted that they would not be able to use surrogates as frequently due to the barriers mentioned above, which decreased their comfort with this approach.

Providers also discussed whether they believed this approach would facilitate patient involvement in the medication decision-making process. As mentioned above, some providers believed they already used a capacity-adjusted sliding scale approach; therefore, it would not change patient involvement. However, others noted that this model serves as a reminder that other options exist outside of filing for court orders:

> I believe that if you know people are taught to have this gradient model than they would utilize the tools and the approaches more appropriately rather than just kind of assuming, OK, the patient doesn't want to talk about medications, now we have to go to court or. So I would think it would definitely increase patient involvement and I would say shared decision making, which is the goal. (P109)

Lastly, one provider noted that patients may trust a family member or an outpatient provider more than their inpatient psychiatrist, who they have just met, which may facilitate their engagement in the decision:

> I think it's reasonable that they would trust people they know better, like the outpatient psychiatrist or the family member. And so I think that is why those relationships that they've already built to be part of their decision making in the acute setting makes perfect sense. (P121)

Perceived Adaptability. To gather information on possible adaptations that need to be considered, providers were also asked to identify factors that may facilitate their ability to implement the approach, barriers that may hinder their ability, as well as changes to the approach that would need to be made for it to work on their unit. Facilitators and barriers that emerged from providers' responses are presented in Table 5. Overall, most providers acknowledged that while this approach works well in a medical setting, adaptations would need to be made for it to work in inpatient acute mental health. As mentioned above, the largest barrier to using this approach was the challenges providers discussed in trying to use surrogates in medication management decisions within inpatient care. To address this difficulty, one provider requested that language around mental health law be incorporated into the approach:

> Just mainly the language around the surrogate and talking about the family's role versus the courts role because they are very different….so just the language of what these different things are using--the family as a mouthpiece versus having to [use] the court. (P103).

Similarly, some providers noted that patients with lower capacity are often taken to court rather than engaging a surrogate decision maker, so clearer incorporation of the use of the court system would be needed to adapt this approach in their setting. Another provider requested clarification that they may use surrogates "within reason" if finding a surrogate becomes too long or complex of a process:

> By VA policy, if they have twelve siblings, all twelve siblings are supposed to have a shared decision-making role and of course, all 12 siblings aren't going to be there unless they're like, I don't know, the best Catholic family you've ever found. And so I guess it would have to always have something like “within reason.” (P106)

Two providers noted that having someone pre-identified as a possible surrogate to use in the patients’ electronic medical record could be useful in mitigating the length of time it takes to identify a surrogate. Further, despite many providers indicating discomfort in identifying and using surrogates, one provider mentioned that their unit does not have difficulties identifying surrogates, given family involvement is integrated into the unit’s care model:

> I mean, typically someone has a contact. There are times when a person has capacity and they say please don't contact any of my emergency family members and then we don't do that. But I would say the vast majority of the time, uh, contact with family is part of the care. (P121)

Regarding other suggested changes, some providers requested clearer guidance on what each category on the sliding scale may look like clinically and how to determine this, particularly because categorizing capacity as “low, medium, or high” seemed subjective. Further, some providers suggested the addition of other dimensions (e.g., acuity) that they consider when determining capacity and patient involvement in the decision. For example, one provider suggested that the acuity of the patient should be considered in the approach because it determines whether medication is “optional versus highly necessary”:

> I can imagine different scenarios where, say, a patient who is floridly psychotic who's not taking antipsychotics, needs that antipsychotic in order to stabilize so they can actually finally discharge, whereas other patients who are maybe struggling with depression, maybe a mild to moderate level of depression, there could be an option to offer medication, but the patient might decline, refuse and there may be good or bad reasons for it. (P109)

In addition to changes, providers also noted factors that may facilitate the implementation of this approach on their unit. Multiple providers offered the idea that an outside "champion" (i.e., separate from unit staff) may be best suited to educate the unit on this approach. For example, multiple providers mentioned that their local ethics committee with the hospital may be well suited to have conversations about this approach given their expertise on capacity. Multiple providers also discussed the importance of utilizing the interdisciplinary treatment team in helping the patient make decisions about medications. For example, providers discussed utilizing social work to help identify surrogate decision makers to create less burden for psychiatrists. Others noted using this approach is easier when providers continuously check-in with the patient, as this facilitates greater knowledge on the patient's behavior and functioning from multiple time points to make decisions about their capacity and how involved they should be:

> I think the other thing too though is being around the unit. So, you know, I'll walk by when they're in groups. So how is [their capacity] when they're with their colleagues, how is it when I'm walking around and I check in on, you know, [the patient] in her room?... It's not just that one time that you saw the patient. (P120).

SDM-PLUS Approach

The SDM-PLUS approach (Hamann & Heres, 2014) was developed for inpatient mental health medication decisions and suggests techniques that may aid in SDM during more difficult scenarios such as when the patient has reduced decisional capacity due to exacerbation of symptoms. SDM-PLUS suggests SDM approaches need to be adjusted in these difficult scenarios depending on whether the decisions is 1) life-or-death (i.e., decision must be directive to avoid harm), 2) best choice (i.e., a better medication option clearly exists but there is a chance the patient may refuse it), or 3) preference-sensitive (i.e., all medications options are equally effective and the choice is large based on patient preferences). Different techniques are suggested for each decisional category.

Perceived Acceptability. Table 6 presents a summary of the likes and dislikes mentioned by providers regarding the SDM-PLUS approach. Overall, many providers mentioned that this approach felt "more compatible" to inpatient care compared to the capacity-adjusted sliding scale approach. One provider mentioned they believed SDM-PLUS was more "in line with clinical practice" compared to the capacity-adjusted sliding scale because categories based on the acuity of the decision (i.e., life-or-death, best-choice, and preference sensitive decisions) "have the capacity kind of roped into it, it's an underlying given that this is based off of capacity" (P106). Based on this response, this provider may not often explicitly consider capacity in decision-making with patients about medications, but rather may make implicit assumptions about the capacity based on acuity of the decision and risk. Indeed, many providers shared that they liked the incorporation of acuity of the decision as a factor that influences how they might respond in medication decisions with patients: "So I think I like that you are taking that acuity into account because that that is a big component of when you're looking at capacity." (P118)

However, providers had mixed reviews on the applicability of the three types of decisions presented in the approach. Some providers felt these three categories accurately captured most scenarios that occur within medication management while others felt that in clinical practice, these categories are subjective. For example, one provider noted the subjectivity of "life-or-death" as they appear within the acute mental health inpatient unit, particularly regarding whether the threat is imminent or simply just possible:

> People can say they're suicidal, but are we talking about something that's parasuicidal or are we talking about somebody who had a plan intent and means and motives and actually engaged in preparatory behaviors? So, I think maybe that's another critique…there is still an inherent subjectivity to some of these categories. (P114)

Another provider also described similarly feeling confused when considering "life-or-death" decisions within medication management. They discussed the possibility that emergency PRNs counted within this category, yet noted that even when PRNs are needed, "best choice" and even "preference-sensitive" decisions can appear within these discussions with the patient. However, one provider believed most of the medication decisions they made with patients fell into "life-or-death" because this was the criteria to keep them on the unit in the first place: "Like again, I'm not going to keep a person on the unit who is refusing an antipsychotic medication for an acute psychotic episode. If it's not life-or-death, then they need to leave, right?" (P104).

In addition to mixed responses to the decision categories of the SDM-PLUS approach, providers had differing views on the suggested techniques under each decision category. Some providers felt the use of motivational enhancement techniques such as motivational interviewing within "best-choice" decisions was beneficial: "We do use a lot of motivational interviewing up here and other techniques trying to get them to understand, like the other benefits of their decision, like say, if they do agree to take the medication" (P111). While others found this technique to be difficult within the context of acute mental health:

> So, we're looking at best choice decisions, you know, like refusing an antipsychotic. You can do things like motivational interviewing and negotiation, but that can be really hard, right? For somebody that's psychotic. So sometimes you know traditional motivational interviewing techniques don't always work, you know? And again, it can be hard to motivate someone to do that without being outright coercive. (P118)

Another provider similarly foresaw problems with the use of negotiation and stated it may be a "slippery slope" and "ethically gray" with possibilities of having "undue influence" over the patient. One provider noted only using negotiation as a last resort in acute situations such as when a patient with higher risk wants to discharge against medical advice: "We tell them well, if you take your medications, you'll leave, like, that's the fastest way you're gonna leave. So that gets them to take the medications." (P115). However, this provider warned this approach was not the "best option in the long run." Interestingly, many providers seemed to view the purpose of techniques used in the best choice category of SDM-PLUS was to get the patient to agree to a certain treatment plan, rather than to facilitate a collaborative process regardless of the final decision. As such, multiple providers felt that the techniques listed under the best choice decision category (e.g., motivational interviewing, negotiation) sometimes fell short in practice:

> Sometimes there's still that disagreement, and you guys aren't on the same page. And then usually that's when if it's to the point where you know they meet criteria for commitment, we go that route or you know, just don't prescribe anything. (P108)

Lastly, many providers shared their belief that the techniques in each category are not mutually exclusive to that particular category. For example, some providers discussed how one does not always have to be "directive" in life-or-death scenarios (i.e., elements of SDM are possible across decisions). For example, one provider noted:

> I still think even in those contexts there's room for shared decision making. Like maybe somebody's suicidal, but it doesn't mean that there's not a room for autonomy within the limits that we're able to keep someone safe. So, while we may have to be somewhat directive like "no, you may not be discharged"…I want to allow patients to exercise their autonomy in that higher-stakes column. (P114)

Another provider mentioned that separating techniques into each category is limiting: "If I were to only use the approaches they've listed here at the bottom [under best-choice decisions], it just may not be sufficient to really get where you need to go." (P121). Indeed, many providers discussed the "fluidity" of these techniques, meaning that often in clinical practice, multiple techniques across this model are employed regardless of the "type" of decision. Despite the dislike of the separation of techniques into each type of decision, many providers noted liking having a list of specific techniques to use when considering different scenarios with patients (e.g., motivational interviewing or using negotiation to compromise on a less ideal medication treatment plan).

Regarding comfort with the approach, similar to the capacity-adjusted sliding scale approach many providers believed they were already implementing elements of the SDM-PLUS approach and were therefore comfortable using this approach: "We do this, yeah, we do this a lot here. So I'm pretty comfortable." (P111). Further, many felt they had already adopted the spirit of the approach while not necessarily naming specific techniques used from SDM-PLUS. For example, one provider described often trying to "cater our approach to the decision making based on the risk assessment in general with the patient…So I think I've done this a decent amount of times to feel comfortable." (P109).

Lastly, providers were asked whether they think SDM-PLUS would improve patients' participation in medication-management decisions on the unit. While some providers noted skepticism given thoughts that this model was very close to what was already being done on their unit, others noted that the model's aim of incorporating SDM in both best choice and preference-sensitive decisions may promote more patient autonomy in decisions. For example, in response to the above question, one provider shared:

> I hope so, yeah. Like at least making whoever is taking care of the patients aware that this is the best practice, it's not always going to be directive or it's not always going to be getting them to do what you want, it's making it a two-way road. (P105)

Perceived Adaptability. Overall, providers' perceived facilitators and barriers for adopting SDM-PLUS on their unit (Table 7) were similar to perceived barriers and facilitators for implementing capacity-adjusted sliding scale approach. Specifically, providers again mentioned time constraints as one possible barrier and in particular, the realistic time it may take to change patients' perspective on medication treatment. This concern contributed to negative reactions towards the use of motivational interviewing, as providers were skeptical of whether perspectives on medications can be changed within a short inpatient stay (e.g., 5-7 days on average). One provider noted: "I think if we were like a three-month long program or 90-day program or something like that, then maybe motivational interviewing might be an approach for acute psychotic episodes" (P104). Others shared that large caseloads can limit the time spent with each patient: "When I have 8 patients, it's fine, [but] when the other psychiatrist is out, I have [the entire caseload] of patients, which is very sad. [If] you spend 10 minutes with each patient, that's over 2 hours and you go to your charting." (P101). As a means to adapt the approach to units that may have higher caseloads, one provider suggested utilizing the interdisciplinary treatment team to carry out the elements of SDM-PLUS (e.g., psychologist doing motivational interviewing with patients around medication decisions).

As mentioned above, many providers disliked the use of the three decisional categories (life-or-death, best choice, and preference-sensitive) due to the subjectivity and added complexity in trying to determine where a decision falls within the approach. To adapt SDM-PLUS to their unit, some providers suggested further clarifying the differences between each category while other providers suggested removing the three specific decision categories completely and depicting acuity of decision as a spectrum where all listed techniques may be implemented at any given point:

> I think that you can do many of these different things at the same time. I think you can be directive and have bidirectional information exchange at the same time. I think that you can be directive with a patient and educate them and take into consideration their comments while also being directive. (P110)

Others noted adding "classical shared decision making" across the categories because they believed this still remains an option regardless of acuity of the decision:

> I think allowing for more autonomy in the first column [life-or-death decisions]. It doesn't really fit into the recovery model that we utilize here. We want people to be able to exercise their preferences as much as possible within the reasonable limits of what we can safely do. (P114)

Regarding facilitators for implementing SDM-PLUS, one provider mentioned they would need to gain other provider buy-in on the unit to be able to implement this approach:

> I think probably [a facilitator] would be buy-in from nursing staff and the physicians is the biggest thing. Most of the physicians, this is gonna be really useful, a subset I think do have that binary thought process "court order or no court" kind of a thing and so getting them to do more with this middle category [best choice decisions] and being able to recognize it when it's present I think is probably the biggest thing. (P103)

Further, multiple providers discussed team agreement on the treatment plan as important to implement SDM-PLUS. For example, one provider described the importance of team agreement on the best choice treatment plan so that providers can advocate for the same plan when interacting with patients and prevent patients from using "one piece of information" they hear from a provider to "validate their bad decisions". Lastly, similar to the discussion within capacity-adjusted sliding scale approach, multiple providers mentioned the utility of having a third-party champion or trainer on the unit, such as an ethics committee member within the hospital. Others noted not feeling competent in conducting motivational interviewing and negotiation such that they would need more training in this area.

Shared Risk-Taking Approach

Zisman-Ilani et al. (2021a) discussed the inherent risk that psychiatrists may feel when patients play a more active role in the decision-making process, particularly in medication decisions when these risks involve safety concerns for both the patient and the provider. Further, this risk may also be amplified when patients' decisional capacity is called into question due to symptom exacerbations or cognitive deficits often present in patients with SMI. They note that there are risks associated with all decisions, no matter which treatment option is chosen. As such, Zisman-Ilani et al. (2021a) proposed shared risk taking as an updated approach to SDM where providers not only go over medical risks/benefits, but also jointly reflect with patients about each other's thoughts and feelings associated with taking such risks, no matter the option chosen. Through this reflection, the inherent risk is made explicit and is given meaning within the broader context of the patient's life (i.e., discussion around whether the risk of a particular decision is a risk worth taking given the patient's goals in life). Results on perceived acceptability and adaptability of the shared risk-taking approach are presented below.

Perceived Acceptability. Provider likes and dislikes of the shared risk-taking approach are presented in Table 8. Overall, multiple providers discussed liking this approach because it was patient-centered (e.g., promoting patient autonomy, focused on patients' broader goals) and had the potential to facilitate rapport between the psychiatrist and patient. Further, some providers valued that the model incorporates their perspectives in the decision through joint reflection with the patient:

> I like the transparency that the physician has with the patient, talking with them about umm, their own fears and their own concerns for the patient. I think if done the right way, uh can show care and compassion for the patient. (P103)

Additionally, one provider also appreciated that this model is described in terms of shared risk:

> I do like the fact that everything is described as risk and that's kind of what I guess what we do here is ultimately risk mitigation. Um and there's both legal and ethical limits to how much we can actually mitigate that, so I think this is actually decent description of what's actually going on. (P124)

Providers also liked how the model encouraged joint reflection about risks of different treatment options, including the option to not take medication:

> If your psychosis is always just sort of there, but it's not inhibiting your ability to care for yourself, maybe the risks of my medications are more risky until better options are available. It's a continual risk/benefit analysis that has to be done. (P106)

However, other providers interpreted shared risk taking as a method to explore with patients how medication non-adherence may affect their functioning while outpatient with goal of increasing medication buy-in with the patient:

> And you know, it really highlights trying to get the buy-in from the patient, which I think is very important and also trying to understand where they're coming from and trying to get the patient to understand a little bit about where you're coming from as well. (P118)

Regarding dislikes for this approach, many of the providers' dislikes were described as barriers for implementation (e.g., can only be done is specific scenarios) and as such is presented under adaptability. General dislikes include not having clarity on what to do when there is still disagreement after joint reflection of shared risk: "there's still some concreteness for some people about…well, once we've done this whole approach and we're still at odds and then what?" (P100).

Further, one provider noted that joint reflection about their own concerns about patients' possible treatment decisions may put the psychiatrist in "vulnerable positions" with some patients where they have the chance to take advantage of providers' empathy:

> If you take this approach with maybe a patient with like personality disorder or like you know who has other motivations, sometimes you can put yourself in a really vulnerable position, because then they can say like, "oh well then if you want me to take this, then I need…like I need you to get me this housing or I need to make sure that I get my benefits." Or, you know, whatever it might be. (P114)

Multiple providers noted that this approach would not address decisional capacity as a barrier to patients' involvement in the decision because they believed joint reflection was only possible with a higher level of capacity. For example, one provider noted using this approach with:

> Patients who you can already kind of engage in a productive conversation…I don't think if somebody's acutely like manic or something, I don't know how helpful this is going to be because it's gonna be very hard to have like a full conversation about, you know, what are your goals. And let me tell you what I'm worried about because their brains aren't processing completely appropriately. (P107)

Further, one provider noted that on acute inpatient, it was often not possible to discuss the broader goals of the patient's life given the acute focus on patients' immediate needs:

> [Broader picture of their life] I guess is the phrase that really sticks with me as just inappropriate because that's an outpatient thing… Umm, we're acute. You know we are: "where are you gonna sleep tonight? Where are you know you gonna get food tonight?" Not kind of "What are your goals in life? Where do you want to, You know, where do you wanna be in five years?" It's never that. It's where are you going to sleep tonight. (P104)

Providers were also asked whether they believed shared risk taking would improve patient involvement in the medication management decisions. Providers noted it being helpful to use this approach when there is a disagreement between patient and provider. Additionally, providers discussed a benefit of this approach as taking a more neutral stance in the medication decision making process, which may ultimately foster more patient participation:

> You know, if we didn't come in specifically with like an intention of like medicating a patient, we just came in, we looked at the medical risks and benefits, we looked at the broader picture of the life of the patient and then, you know, talked jointly with patient about their anxieties or worries about decisions, what the medications could potentially do to them, what their preconceived notions are, I do think that would improve participation from a patient standpoint. (P109)

Regarding providers' comfort in using shared risk taking, most providers noted feeling comfortable with the broad ideas presented in the approach, yet felt there needed to be more concrete guidance to follow implement it. Others noted that joint reflection in terms of sharing their own thoughts and emotions with patients felt at times like "boundary crossing":

> I would say sometimes I do that, sometimes I don't, cause maybe it's like a boundary crossing in some sense, like "ohh, I'm worried about you"…but I think with certain patients it can be helpful like depending on your rapport and how well you know them. (P102)

Lastly, like the two approaches described above, several providers noted that they believed they were already practicing some elements of this approach.

Perceived Adaptability. Just as with the above approaches, providers were asked questions surrounding adaptability of shared risk taking (See Table 9 for list of barriers and facilitators). Overall, providers noted that shared risk taking would not be appropriate across all clinical scenarios because they perceived joint reflection to be difficult with patients who may have lower capacity due to acuity of symptoms or lack of insight. Multiple changes to the model were suggested to address this barrier. One suggestion was to combine this approach with one of the models above. For example, one provider noted:

> I would almost take the approaches from here and kind of blend them in with the last model [SDM-PLUS] just because I like the variables [from SDM-PLUS]. So I would take some elements from here that I think are really useful like the approaches and the aims and put that into the second model if it's not already there (P109)

Another provider requested adding more guidance within the approach on how to conduct joint reflection with patients who may have lower decisional capacity due to exacerbation of symptoms. Lastly, one provider discussed removing wording around discussing the decision in the context of the patient's broader life goals, as they felt this was not possible on inpatient.

Additionally, some providers mentioned that despite efforts to engage, some patients are not willing to participate in joint reflection, particularly with a provider they have only known for a few days:

> I think that having this kind of conversation is probably going to work better for situations where the psychiatrist and the patient have had a relationship over time. Certainly, I know a good number of people over time who've had repeated admissions, but many patients don't come in very often, so I don't have a relationship over time to where patients are gonna trust me enough to have an extended conversation and consider advice. (P122)

One suggested solution for this difficulty was the coordination with outpatient providers to help have these discussions with patients on the unit due to the possibility of them having better rapport with patients. Further, one provider noted that sometimes these discussions have better outcomes when conducted by non-prescribing provider such as a psychologist:

> I think it can sometimes be helpful to hear that coming from a third party because I am the one ultimately who's doing the prescribing. So in in sort of the spirit of avoiding a conflict of interests sometimes having a third person who's not a prescriber come in can be really helpful. (P114)

As such, utilizing the interdisciplinary team may be necessary to implement shared risk taking.

An additional barrier providers discussed was difficulties with interpersonal effectiveness and less training on therapeutic approaches that seem to be emphasized in shared risk taking. One provider noted that they would not trust some of the psychiatrists on the unit to have these discussions with patients given this approach requires a "a mature interpersonal style." This provider noted "you would imagine you go into psychiatry and you've got good people skills, but that's not always the case" (P103). Another provider noted that training in medical school often conflicts with this approach:

> I think with psychiatry we're more trained to be stoic. And so, we just kind of like listen to the patient, we could maybe ask some questions back, but we don't do a whole lot of like oh, "I feel you, like, I get it" like, it's not something that they trained us well for. (P115)

In addition to interpersonal effectiveness and training in medical school, providers discussed needing more training on the specifics of how to implement the model, as right now the approach felt too conceptual and broad. One provider suggested that "joint reflection" be focused solely on the patients' thoughts and feelings and less about the provider's reactions to shared risks. Another provider noted perhaps developing a sample conversation between patient and provider could be helpful in training providers who may not naturally jointly reflect with patients. Similarly, one provider noted that specific guidance would also improve barriers in measuring fidelity to this approach, as right now it may be difficult to know when shared risk taking requirements have been met.

Providers' Overall Preferences Across Approaches

At the end of the interview, providers were asked which approach they would prefer to use to increase patient involvement in medication management decisions on the unit (see Table 10 for provider preferences for each approach). Based on these responses, providers seemed to prefer the approach that they perceived allowed them the most flexibility in clinical care, allowed them to take into consideration many different factors that may impact their decision about patient's ability to make decisions about their medication (i.e., insight, acuity, when there are disagreements, etc.), and that seemed the most applicable to an inpatient setting. Of the providers that chose just one approach, five preferred using SDM-PLUS. Additionally, out of the 13 providers who chose a combination of approaches, 12 preferred to use elements of SDM-PLUS along with other approaches. As such, SDM-PLUS seems to appeal to the widest number of providers (17 out of 25). The second most preferred approach was shared risk taking, which was chosen in combination (n = 11) or alone (n = 4) by 15 out of 25 participants. Finally, the capacity-adjusted sliding scale approach was chosen in combination (n = 9) or alone (n = 3) by 12 out of the 25 participants.

As mentioned above, a little more than half (n = 13) of providers stated that they would prefer to use a combination of approaches. Of the providers that wanted to use more than one approach, six providers noted wanting to pull elements from all three approaches depending on the scenario. For example, one provider succinctly described their reasoning as:

> The first one [capacity-adjusted sliding scale] shows there are three [options]. It is not just court or agreement, and so the first one is a is a good overview of "hey, there are three types [of options] and then the second one [SDM-PLUS] is, "here's what you do with the three types" and then the third one [shared risk taking] is "don't be a jerk about it." (P103)

Additionally, providers within this group indicated they would often shift between approaches in service of what works for a particular situation or patient:

> Again, I think it's an amalgam of everything. I frequently say that I'm a frustrated psychoanalyst and that can help inform my opinions of what's driving the patient, but ultimately, I'm a pragmatist. And you do what works. (P112)

Another provider preferred SDM-PLUS, but also wanted to integrate "elements" of the capacity-adjusted sliding scale and shared risk-taking approaches:

> I think [SDM-PLUS] is probably my preferred. I think [shared risk taking] when appropriate is a nice way to kind of supplement [SDM-PLUS]. Like if there are like disagreements at any point really trying to better understand patients' reservations about the specific treatment plan, I think that's when [shared risk taking] would be very valuable. And then, yeah, there's also always value in engaging family too in [capacity-adjusted sliding scale]. (P108)

The second highest combination of preferred approaches after using all three was using elements of SDM-PLUS and shared risk taking. Many noted that the basic structure of SDM-PLUS fit well within their inpatient setting, yet incorporating elements of shared risk taking would be important in certain situations such as when there is a disagreement between patient and provider about the medication treatment plan.

In addition to those who preferred to use a combination of approaches, others preferred just one approach. Providers that preferred to use SDM-PLUS by itself noted that it felt most applicable to acute mental health inpatient settings, it offered specific approaches to take with patients such as use of motivational interviewing when "classical SDM" was less possible, and it incorporates acuity of the decision into how they approach decision-making with the patient. Providers that preferred to use the shared risk-taking approach described liking that it was not "prescriptive" or "algorithmic" like the other approaches seemed to be and it puts the patient as "part of the decision" more than the other models regardless of symptom acuity or capacity concerns. Lastly, those that preferred to use the capacity-adjusted sliding scale noted that it "reflects the spectrum most clearly of how inpatient works" (P104) referring to how collaboration is adjusted to decisional capacity, although as noted above, some also had concerns about difficulties using a surrogate decision maker on inpatient.

Discussion

Reduced decisional capacity is identified as a barrier to SDM implementation in inpatient acute mental health (Becher et al., 2021; Beyene et al., 2018; Chong et al. 2013; Hamann et al., 2009; Hamann, et al., 2016; Hipp & Kangasniemi, 2022; Wesseldijk-Elferink et al., 2021). While there are guidelines for evaluating decisional capacity for informed consent to treatment (i.e., four pillars; Applebaum & Grisso, 1988), little is known about how inpatient psychiatrists assess decisional capacity in the context of SDM, particularly given complex factors that are often present in acute mental health that may contribute to reduced decisional capacity (i.e., acuity of symptoms, lack of insight). Further, while approaches to SDM in the literature have been suggested to aid in situations where patients may have reduced decisional capacity, the literature remains divided on the best approach, and none of these have been formally tested within the United States. The current study aimed to determine how providers are assessing patients' decisional capacity to make medication management decisions and gather perspectives on the acceptability and adaptability of proposed approaches to aid in implementing SDM in complex clinical scenarios that often occur within acute mental health care.

Overview of Aim One Results

Results confirmed that inpatient psychiatrists evaluate patients' decisional capacity for medication decisions using the four pillars of decisional capacity (i.e., Applebaum's criteria; Applebaum & Grisso, 1988). Further, providers discussed often assuming patients maintain capacity unless they are prompted to consider capacity further by "red flags" present during the clinical interview. Once cued by red flags, providers reported that they determine decisional capacity through clinical judgement and speaking with patients about medication treatment and rarely (if ever) use formal tests beyond referring to neuropsychology in rare occasions (e.g., patients with suspected dementia). Providers' descriptions of how their capacity assessment was then used to determine their level of collaboration were less clear and often involved multiple factors. For example, providers' descriptions of capacity assessment involved consideration of risk, which interacted with providers assessment of patients' insight and whether to file for court commitment. Lastly, many providers reported a belief that patients needed to demonstrate a higher level of decisional capacity to be granted more collaboration in the decision compared to the level of capacity needed for informed consent. Further discussion of results is presented below.

Assessment of Decisional Capacity: Connection Between Four Pillars and Provider Collaboration

According to the literature, providers within inpatient acute mental health often cite patients' reduced decisional capacity as a barrier to implementing SDM with patients (Becher et al., 2021; Beyene et al., 2018; Chong et al. 2013; Hamann et al., 2009; Hamann, et al., 2016; Hipp & Kangasniemi, 2022; Wesseldijk-Elferink et al., 2021). Applebaum & Grisso (1988) defined decisional capacity as "the right of patients to accept or refuse recommended treatment" (p.1635). Further, Applebaum and Grisso (1988) noted that assessing capacity is often an implicit process that occurs through natural conversation between patients and providers and is only formally assessed when "substantive questions" arise about the patient's capacity to consent to treatment. Consistent with this definition, inpatient psychiatrists within the study described assuming patients maintain decisional capacity for a particular decision unless they notice "red flags" from the patient that may suggest otherwise. After this, they refer to the four pillars as guidelines more explicitly to gain an understanding of the patients' capacity through the clinical interview. No providers in the current study reported using specific measures to assess capacity, despite research recommending the use of both clinical interviewing as well as more formal measures for accurate determinations of capacity (Palmer & Harmell, 2016).

Further, while providers could more clearly describe assessing decisional capacity as it relates to consent to treatment (i.e., described using four pillars as guidelines), providers' descriptions of the relationship between decisional capacity assessment (i.e., four pillars) and their decision on how collaborative to be with a patient was more complex, often involving clinical judgement using a multitude of interrelated data points (elements of the four pillars, agreement on treatment plan between patient and provider, level of risk, and mental health policy guidelines). In addition, many providers held a belief that a higher level of decisional capacity is needed to participate collaboratively in the decision compared to simply consenting to treatment. As such, providers described many patients meeting criteria to be able consent to medications, and fewer patients meeting criteria for higher levels of collaboration in the medication decision, such as SDM, given clinical challenges that they believed impacted their decisional capacity (i.e., acute mania or psychosis leading to reduced ability to appreciate their illness or the consequences of certain decisions). Despite this belief, across interviews, hesitation and uncertainty around *how much* capacity is required for SDM and *how to assess for that* arose time and time again. For example, some providers shared their belief that capacity fluctuates on a spectrum. However, other providers noted having difficulties formally assessing capacity using a spectrum in clinical practice due to mental health policy, such as court filings for forced treatment, which forces a binary decision on patient's capacity for a medication decision (i.e., the patient either maintains capacity or lacks capacity). This confusion was further illustrated when discussing the capacity-adjusted sliding scale model with providers, where many noted they would have difficulty classifying capacity into "low, medium, and high" categories. This feedback in interviews indicates that while providers may believe capacity is on a spectrum with level of collaboration, there are no widely accepted guidelines on *how much* capacity is needed to participate in SDM.

Indeed, no studies exist investigating how capacity assessment using the four pillars maps on to patients' ability to participate in SDM or what level of decisional capacity is needed to use SDM (Zisman-Ilani et al., 2021b). Further, Applebaum & Grisso (1988) developed the four pillars as guidelines in determining decisional capacity for informed consent, and not specifically for determining *levels of capacity* needed for degrees of collaboration that exists beyond informed consent. Similarly, formal measures exist in determining patients' capacity to consent to treatment and these have been tested within SMI populations (Jeste et al., 2006; Kaup et al., 2011; Wong et al., 2005), yet these measures have never been tested in association with patients' ability to participate in SDM. Further, research indicates that cognitive difficulties are the strongest predictor of incapacity, not symptomology, in SMI (Palmer & Harmell, 2016) despite study providers often referencing symptoms as reasoning for reduced capacity during interviews. Research indicates that the use of specific semi-structured instruments that measure capacity to consent for treatment (e.g., MacArthur Competence Assessment

Tool for Treatment) improves the accuracy of capacity evaluations (Radenković, 2023). As such, results suggest future research is needed in determining how existing assessment of capacity may relate to patients' objective ability to participate in elements required for SDM or perhaps the creation of new capacity measures specific to participation in SDM, as no measures currently exist in assessing capacity for SDM.

The lack of research on how assessment using four pillars relates to patients' ability to participate in SDM forces providers to solely rely on clinical judgement, which may create room for error (i.e., providers mistakenly directly attribute deficits in four pillars of capacity to the patient's ability to collaborate in the decision). Indeed, research suggests that certain cognitive biases such as anchoring (i.e., over-relying on the first information they receive) and personality traits (i.e., discomfort with uncertainty, risk-tolerance) have been associated with diagnostic inaccuracies and medical errors (Saposnik et al., 2016). Further, research has found that providers tend to overestimate the effectiveness of antipsychotics and underestimate adverse effects despite common concerns about side effects from patients (Deegan et al., 2024; Read & Williams, 2019). Providers' beliefs about the effectiveness of antipsychotics may impact their assessment of the patients' capacity should the patient refuse this medication.

Clinically, however, it is reasonable to assume aspects of the four pillars overlap with common elements of SDM. For example, the ability to reason with information could be related to the ability to discuss pros and cons of medications. This connection between capacity and elements in SDM were evident in interviews (e.g., difficulties having in-depth conversations about options with patients with more acute symptoms). Further, there has been research to suggest that deficits in capacity, such as ability to appreciate having a mental illness, were associated with decisions related to treatment refusal, particularly in patients with psychosis or mania while receiving psychiatric inpatient care (Owen et al., 2009). Similar to Owen et al. (2009), our providers attributed patients' inability to appreciate consequences (i.e., one of the four pillars) to their refusal of medication, particularly in higher risk situations (e.g., higher risk of harming themselves). Taken together, it remains unclear the degree to which providers are making false assumptions about patients' capacity and the degree to which these deficits do indeed disrupt SDM capabilities. As such, future research on the predictive validity of providers' capacity assessment on patients' objective performance of SDM may inform whether clinical errors are occurring and whether a more standardized assessment of capacity is needed to correct these errors. However, regardless of the degree to which providers are accurately predicting capacity as a barrier to SDM using clinical judgement alone, providers' reports on their clinical experience struggling to navigate challenges associated with capacity in the context of SDM (e.g., difficulties navigating conversations about meds with patients who are in acute psychosis) denote the need for real time adaptations to SDM to increase implementation in acute mental health (see aim 2 discussion for more on possible adaptations).

Consideration of "Red Flags" for Capacity and Patient Involvement in the Decision

During interviews providers were also asked about "red flags" that may indicate further capacity assessment is needed and what factors may "change their minds" on how involved patients can be in the decision. Interestingly, responses to each of these questions were virtually identical and could be collapsed into one table (Table 3). This may indicate that providers' identified red flags for impaired decisional capacity also tend to be red flags that influence provider's perceptions on how collaborative they can be with patients, further providing evidence that provider's beliefs about patients' capacity and SDM abilities are highly connected.

Most of the red flags mentioned seemed to directly relate to one or more of the four pillars of decisional capacity. For example, many providers mentioned cognitive decline, memory problems, and dementia as red flags that warrant further capacity evaluation, which has been related to reduced performance on four pillars assessment (e.g., understanding and ability to use reason; Moye et al., 2006). Further, conditions that impair patients from clearly communicating a choice (i.e., one of the four pillars; Applebaum & Grisso, 1988) were also considered red flags (for example, disorganized speech). However, two red flags (i.e., involuntary admission status and history of medication non-adherence) seemingly led to preconceptions about the patients' decisional capacity (and therefore ability to participate in the decision) *prior* to initial conversations between provider and patient. For example, as noted in Table 3, one provider mentioned that if they see a history of medication non-adherence through chart review, they may begin to question capacity prior to seeing the patient. Another provider discussed how involuntary admission may indicate that patients are not in the "right frame of mind" to discuss their medication, yet was careful to note involuntary admission status was not "an absolute contraindication." On one hand, external pressure to free-up bed space and to "stabilize and discharge" patients as quickly as possible may lead providers to rely on clinical heuristics such as these to decide when to reduce collaboration in service of saving time. However, these heuristics are ultimately assumptions that have potential to reduce patient autonomy unnecessarily and increase bias towards patients prior to the patient having the ability to demonstrate their own capabilities.

Indeed, bias exists within assessment of decisional capacity. For example, Garrett et al. (2023) found that psychiatric liaison consult requests for capacity evaluations across an urban medical center in the US were disproportionately placed for Black and Hispanic patients compared to White and Asian patients. Further factors such as stigma towards SMI from providers and can impede capacity assessment (Mertens et al., 2025). Some providers in the current study were careful to note that red flags were not complete predictors of capacity and should be treated as one datapoint among many. This reflection is extremely important given above research indicating provider bias's impact on capacity assessment.

Additional recommendations of limiting bias within capacity assessment have been made in the literature. For example, Garrett et al. (2022) suggests treatment teams take time to gain a better understanding of the patient's perspective in order to compromise, rather than considering disagreements, such as when a patient refuses a certain treatment plan, as a "capacity problem." Interestingly, this approach is similar to the shared risk-taking approach (Zisman-Ilani et al., 2021a) that was described to providers in the current study (i.e., jointly reflecting on patients' and providers' perspective underlying the preferred treatment choices prior to acting on treatment plan).

Lastly, in addressing involuntary admission specifically as a barrier to SDM, Burn et al. (2019) created an intervention to promote patient involvement in decisions despite being involuntary admitted to the unit. This intervention highlights the necessity to provide options and explore preferences in treatment decisions despite involuntary admission on the unit. As such, providers must consider capacity to make decisions as time-specific and decision-specific, meaning although patients may lack capacity to make the decision on whether or not to be admitted to the unit (i.e., involuntary admission status), they may still be able to make decisions about their treatment. Similarly, although patient's history may indicate difficulty with medication adherence, the current study recommends that providers meet with patients prior to making assumptions to limit possible bias in capacity for SDM.

Risk's Influence on Capacity Assessment and Provider's Willingness to Collaborate

Interviews indicated that the presence of certain red flags (i.e., level of patient risk and insight) interacted with providers' agreement with the patient's treatment choice and mental health policy (i.e., guidelines to be granted commitment/mandatory medications) in a seemingly circular manner to form overall impressions on the patients' capacity to make the medication decision. For example, providers described their willingness to agree or disagree with the patient's preferred choice as highly contingent on the level of risk of harm (e.g., is the patient at risk of harming themselves or others if they are discharged with their preferred treatment choice?). Further, if the patient was perceived "higher risk," the refusal of medication could be used as evidence in a court filing demonstrating incapacity and the need for involuntary commitment which can include mandated medication treatment (i.e., making a case that the patient lacks sufficient insight/appreciation of the situation and is at risk of harm, and therefore, is not capable of making this decision) (Scenario 7 in Table 2).

On the other hand, providers described taking an alternate route when patients were willing to consent to the provider's preferred medication plan yet still had reduced insight and higher risk of harm without treatment. In this case, they often lowered their threshold for adequate capacity for patients to provide informed consent and did not file in court (Scenario 1 in Table 2). The main difference between these two scenarios, which would seemingly create significantly different patient experiences (autonomy taken away in one scenario, autonomy maintained in another) came down to patient agreement on the treatment plan. If the patient agreed to take medication, the provider's perception of the patient's insight level and overall potential risk for harm shifted and the patient was considered to have adequate capacity to make the decision. Taken together, despite providers noting in the interviews that disagreement on the treatment plan did not necessarily mean the patient lacked insight, a certain level of risk of harm made agreement on the treatment plan necessary and completely halted SDM.

Perhaps, as one provider noted, these situations described are simply "some of the paternalism that comes in with psychiatry," particularly within inpatient settings where criteria to be admitted includes risk of harm. Indeed, literature on risk-sensitive decisional capacity assessment has identified the above phenomenon as "asymmetrical competence," where the patient who accepts a medication is assessed to have capacity while refusal equates to incapacity due to higher risk associated with refusal of medication (Hermann et al., 2015; Wilks, 1999). This asymmetrical competence phenomenon can be ethically problematic, as providers focus more on patients' capacity to refuse or disagree rather than capacity to consent, even when there might be legitimate reasons for the patient to not want a particular medication (Palmer & Harmell, 2016). Additionally, further complexities arose in interviews when using this method of capacity assessment as providers' perceptions of "risk" seemingly varied. For example, providers had differing viewpoints on what was considered “life-or-death” decisions in discussion around the SDM-PLUS model, with some focused on more immediate medical emergencies vs. more distal possibilities of harm when discharged. As such, provider’s level of risk-tolerance may influence their capacity assessment, and in turn, their level of collaboration with patients. This is consistent with literature in capacity assessment, that found that clinicians tend vary in how they apply this risk-dependent standard (Hermann et al., 2015).

Whether risk-dependent capacity assessment is ethical has been debated in capacity assessment literature for roughly 30 years (Wilks, 1999; Kim & Berns, 2023). While further exploration of this debate is beyond the scope of the current study, it is clear that the context in which the current study’s providers are operating in would most likely prevent risk from being taken out of the equation in capacity assessment. For example, changing capacity assessment would require significant change in mental health law as the current four pillars approach closely aligns with the legal framework around competence in court (Applebaum & Grisso, 1988). Further, sometimes risks associated with patients’ preferred choice is a legitimate reason to reduce patient autonomy, particularly if impairments in capacity lead the patient to make this choice when they otherwise wouldn’t for themselves. Thirdly, the current legal framework may incentivize providers to go to court in higher risk situations where disagreement exists to reduce threats of liability, even when less autonomy-limiting options might be possible. Lindor et al. (2016) discuss liability and SDM in the context of emergency medicine and note that while increasing patient autonomy in the decision should improve the patient-provider relationship, there is concern that SDM conducted with patients with lower capacity could lead to more lawsuits. However, to date, no research exists on effect of SDM implementation on liability.

Taken together, results revealed providers in the study seemed to be caught between a delicate balance of patient autonomy and risk with the latter often taking precedence in the decision when the scale tips towards it. In other words, this assessment of risk then impacted their assessment on capacity and the level of patient autonomy that the provider was willing to grant. Thus, results confirmed Zisman-Ilani et al. (2021a)'s perspective that in order to implement SDM in psychiatry when patient capacity is questioned, SDM must take into consideration shared risk between patient and provider on the decision, particularly in acute mental health care where risk is inherently higher. As such, future SDM interventions for acute mental health should consider ways in which providers can promote patient autonomy when higher risk is present both for the patient (i.e., risk of harm) and provider (i.e., liability concerns).

Other Factors Influencing Provider's Willingness to Collaborate

The interaction of risk and four pillars may direct providers' decision on whether to file for commitment (and therefore significantly limit and/or halt patient involvement in the decision); however, determining how capacity relates to other scenarios described in results (Table 2) is less clear. For example, providers described situations where patients did not agree with medication plan, but were not at "enough risk" to make a case in court, in which case they did not file and held the stance that people had "the right to be mentally ill if they wanted to be," often going with the patients' less preferable choice (scenario 2). Yet, there were additional scenarios described where providers attempted to convince or negotiate with patients to go with the provider's preferred treatment plan (scenario 3), sometimes going as far to order the medication and offer it to the patient later even if the patient refused medication when meeting with the psychiatrist (scenario 5). This description of efforts to convince the patient to take medication is consistent with prior research on SDM in inpatient acute mental health across the VHA (Eliacin et al., 2022). Specifically, through qualitatively interviewing VHA acute mental health inpatient providers about how they conduct SDM for medication management decisions, Eliacin et al. (2022) found that the most frequent descriptions of SDM involved inpatient providers trying to convince patients to take medications.

Further, providers in the current study mentioned in interviews that they generally are “less collaborative” when patients have less capacity to participate in the decision beyond simply consenting to the providers’ preferred treatment plan for medication. As such, it is possible providers’ perceptions of patients’ decisional capacity is a factor that helps differentiate which scenario they implement. However, other factors may also play into providers’ level of collaboration across these scenarios. For example, in scenario 4, providers opted to give the patient time on the unit to possibly improve with medications patients are willing to take as needed for mood (e.g., PRNs). The provider describing scenario 4 in Table 2 noted that they use this approach to avoid court as they are hesitant to take away autonomy if other options might be available, such as restoring capacity through PRNs or giving patients a controlled environment to stabilize without medications. Given this provider’s description, perceived importance of patient autonomy may also affect whether providers use this option. Further, some providers believed that decisional capacity would not improve given the short length of stay in acute mental health care, even with the use of medications such as antipsychotics. One provider mentioned antipsychotics often take 4-6 months to become fully effective and when the medication is first started on the unit, it typically has a sedating effect. As such, provider perceptions on whether it is possible to restore capacity while still on the unit may also indicate how much time they are willing to give for patients to stabilize prior to immediately trying to make a case in court.

Further, organizational factors such as pressures to stabilize and discharge as quickly as possible may limit providers' ability to keep a patient on the unit for longer periods of time without a clear medication treatment plan. Indeed, time constraints have been identified as a barrier to implementation of SDM in mental health care (Verwijmeren & Grootens, 2024). Length of stay in psychiatric inpatient care has significantly dropped since the 1980s in the US due to deinstitutionalization (Tulloch et al., 2011). This trend was also promoted through law under US supreme court's Olmstead decision (1999), which promotes patients' recovery in the least restrictive environment. While shorter length of stay in acute mental health promotes patient freedom to live in the community, it also may hinder patient autonomy while on the inpatient unit. Specifically, providers may feel pressure to discharge patients quickly from the unit, which may give less time to come to a compromise on treatment prior to filing in court. For example, one provider mentioned in the interview waiting 24 hours at most to try and compromise on treatment prior to deciding to file in court. Future research is needed to understand whether these factors, such as pressure to discharge quickly, views on autonomy, or beliefs about capacity restoration, moderate the relationship between providers' perceptions of patient capacity and provider's level of collaboration with patients as reflected in scenarios 2-5 in Table 2.

Overview of Aim Two Results

Regarding aim two of the current study, results indicated that providers most preferred a combination of the different approaches to use depending on the clinical context. Further, the overall framework of SDM-PLUS appealed to the most providers, followed by shared risk taking and lastly with the least appeal, the capacity-adjusted sliding scale approach. Additionally, each approach seemed to capture a different aspect of SDM within acute mental health that providers viewed as important. For example, one provider succinctly described capacity-adjusted sliding scale being a nice framework to remind providers that reduced capacity does not necessarily mean they have to go for court commitment, SDM-PLUS provides specific techniques to use in these instances of reduced capacity, and shared risk taking incorporates factors that improve rapport when delivering these elements through joint reflection. However, each approach also had apparent drawbacks that providers deemed as less adaptable within inpatient care. Summarizing provider feedback on acceptability and adaptability across approaches indicates important elements to consider for future SDM interventions for inpatient acute mental health.

Acceptability and Adaptability Across Approaches: Implications for Future Interventions

As discussed above, providers most preferred to use a combination of approaches depending on the clinical scenario presented. Further, discussion of the acceptability and adaptability of each approach revealed that relying on just one approach would not sufficiently address the complexities involved in the relationship between capacity and SDM. As such, discussion is presented not by approach, but by the elements discussed within each approach that providers had the strongest feedback about (either negative or positive). Through discussion of this feedback, recommendations for future SDM interventions are made. Elements to consider for future SDM interventions are reflected in Figure 3, as well as a summary of future directions for research to best address decisional capacity as a barrier to SDM.

Use of Surrogate Decision-Makers: Possibility of Peer Support?

Within discussions about the capacity-adjusted sliding scale approach (Lahey and Elwyn, 2020), providers noted that they valued the idea that patient autonomy could be facilitated across the spectrum of capacity. However, barriers including a combination of policy (i.e., state law preventing surrogates from consenting to mental health medication) and concern about patients' social support (i.e., difficulty finding next of kin to act as surrogate), seemed to limit the acceptability of the capacity-adjusted sliding scale approach.

Some providers suggested possible adaptations in the model to address above concerns. For example, two providers discussed adapting the model to incorporate court-orders, if necessary, in the "low decisional capacity" category as sometimes providers are forced to file in court if patient risk of harm is high. Interestingly, no providers discussed the possibility of utilizing peer support specialists as supports in the decision-making process with patients, which might be particularly helpful in the "medium capacity category," and a possible solution to the barrier of finding a surrogate to support the patient. While many patients may lack family or caregivers who are willing to visit and be involved in their care on the unit, the peer support specialist on the interdisciplinary treatment team could possibly fill this role. Indeed, research indicates peer-facilitated decision support interventions have improved patient and provider communication about the decision (Zisman-Ilani & Byrne, 2023). Additionally, peers may be able to support patients in becoming more self-confident to interact with providers. Further, Zisman-Ilani & Byrne (2023) propose that while SDM interventions in mental health often are centered around medication management, peer support specialists also hold unique expertise in psychosocial interventions and community supports that could influence patients' decision on their overall treatment plan. Indeed, peer support staff played a critical role in assisting patients within CommonGround, a decision support system designed to promote SDM within outpatient psychiatric medication management decisions for people diagnosed with SMI (Deegan et al., 2008). As such, peer support specialists may be uniquely appropriate to serve as a decision support when patients with reduced decisional capacity are deciding on medication choices within inpatient care (i.e., the "medium" category of capacity-adjusted sliding scale model) and should be considered in future SDM interventions within acute mental healthcare.

The Need for Alternatives

As mentioned above, some providers in the study appreciated that the capacity-adjusted sliding scale approach conceptualized capacity on a spectrum, indicating that at times, there may be patients who maintain capacity to consent, but still have reductions in capacity for more nuanced decisions and could use extra support. However, the use of a surrogate as a decision supporter seemed to be controversial among providers. While peer support specialists are one option in helping facilitate decision-making in these scenarios, it would require a shift in the SDM process. In traditional SDM in the literature, typical elements include 1) the clinician and patient define the problem to be addressed, 2) the clinician and patient review options for treatment, 3) the patient and clinician discuss pros/cons of each option, 4) the patient and clinician discuss the patient's ability to follow through with the different treatment plans, 5) the clinician provides knowledge or recommendations, 6) the clinician and patient check understanding of facts/perspectives, 7) a decision is made or deferred, and 8) the clinician and patient arrange follow-up to discuss outcomes of decision or reach resolution in decision (Makoul & Clayman, 2006). However, when the patient needs extra support, this model does not discuss how to provide that. As such, in order to promote SDM when reduced decisional capacity is a barrier, alternative approaches to SDM must be incorporated into interventions in inpatient care. One potential intervention to consider is supported decision making. Supported decision making was originally developed for individuals with intellectual and cognitive disabilities to reduce the need for substitute decision making (e.g., guardians making decisions on behalf of people through a legal guardianship) and includes identifying and enlisting the support of trusted family, friends, or others in the patient's community to help them make a particular decision (Jeste et al., 2018). However, research on treatment outcomes using supported decision making both within people with intellectual disabilities and within people with SMI is scarce (Jeste et al., 2018). While research on outcomes and implementation are underway, legislation has increasingly adopted principles of supported decision making within the United States. As such, supported decision making may also be a promising approach to consider in the context of acute mental health. However, to be fully implemented within acute mental health, future research would need to identify what level of capacity/risk would qualify a person for supported decision making versus a court commitment.

Further, providers noted that having a pre-identified "surrogate" to help support the patient in decision making would be helpful to reduce the burden of trying to locate next of kin. Within the model of supported decision making, the patient would theoretically have a person identified that helps them in making healthcare decisions. Apart from peer support possibly filling this role, it is possible the supporter could be identified prior to hospital admission through the use of a psychiatric advance directive. Advance directives are legal documents that patients can create while they maintain capacity to make decisions about their healthcare for times when they may become incapacitated (e.g., when they experience an acute phase of their mental health condition) (Elbogen et al., 2007). Within these documents, patients can select their preferences for future mental healthcare treatment including medications and *who* they want to be involved in their care. These could significantly increase SDM at times when patients may lack capacity and could provide documentation of possible surrogates/decision supports when capacity is reduced. Despite this potential benefit, little is known about the frequency of advanced directives within inpatient mental health care in the US. A study conducted in 2006 indicates that only 4-13% of mental health consumers have used a psychiatric advance directive (Swanson et al., 2006), and since the early 2000s, research has seemingly lost focus on the use of advance directives in United States mental healthcare. More recent research within Israel has investigated barriers to using advance directives in acute mental health. Barriers identified included negative attitudes of staff towards using them and limited support from leadership to use them (Hornik-Lurie et al., 2018). Further, only two providers in the current study mentioned the use of advance directives within their care. One provider discussed the possibility of using an advance directive with pre-identified family that the patient has identified as decision supports, yet noted this is not common. Taken together, supported decision making and the use of psychiatric advance directives may support SDM within a larger spectrum of capacity, yet research (and likely clinical practice) is limited in implementing these approaches. Future SDM interventions must consider adding additional elements (i.e., supported decision making, increasing use of advanced directives) to the larger SDM framework to address reduced decisional capacity as a barrier to SDM within acute mental health care.

Inclusion of Risk and Acuity of Decision in SDM Approaches

As discussed in aim one results, capacity assessment seemingly interacts with risk/acuity factors that ultimately contributes to providers' willingness to engage in SDM. Consistent with this finding, many providers appreciated that the SDM-PLUS model included consideration of the acuity of the decision and that the shared risk-taking approach considered risk explicitly in the decision. These findings highlight the importance of including acuity of decision and risk into future SDM models of inpatient care. However, the ways in which risk and acuity of decision were included in SDM-PLUS and shared risk taking had mixed feedback. For example, providers noted confusion and negative feedback around the categorization of the level of acuity and the techniques suggested for each level of acuity in SDM-PLUS. Further, some providers were particularly uncomfortable with the inclusion of provider's self-disclosure of their own thoughts and feelings about the decision within shared risk taking. Taken together, ideas from these approaches may require further adaptation and training to increase provider buy-in.

Flexibility to Use Clinical Judgement. Within SDM-PLUS, providers reported appreciating that specific techniques were suggested in the model depending on the acuity of the decision; however, classifying decisions into a specific acuity category proved to be more complex for providers in clinical practice. For example, provider-specific beliefs about what a "life-or-death" decision was on the unit differed and created confusion on what clinical scenario fit within this category. Further, many providers believed elements of SDM were possible across all acuity categories depending on the scenario, which was not reflected in the model description. As such, solely basing which SDM technique to use based on acuity of the decision proved to be less feasible according to providers' feedback. To reconcile this dilemma, it may be advantageous to structure a future SDM intervention not on acuity and risk entirely, but offer a wide range of techniques providers can use when these considerations appear clinically. As a helpful framework, one might consider how evidence-based interventions in psychotherapy such as a Dialectical Behavioral Therapy (DBT) are structured (Linehan, 2014). Within DBT, there is a large handbook of "skills" that providers can rely upon depending on the patient's presenting concern. A combination of clinical judgement and patients' presenting concerns/behaviors dictate which skill the provider chooses to use with the patient. However, an adherent "DBT session" has an overarching structure that includes basic elements (e.g., chain analysis, levels of validation, etc). Within SDM, it may be helpful to have a range of skills providers can rely upon when barriers such as reduced decisional capacity and higher risk come up in the meeting while also having a larger "structure" (i.e., identify a problem, discuss options including risks/benefits, etc.) that determines adherence to SDM within inpatient care.

Specific Techniques. Within both SDM-PLUS and shared risk taking, certain techniques were suggested for use when there may be disagreement between the patient and provider and capacity is questioned. For example, within SDM-PLUS's "best choice decision" category, it is recommended that providers use motivational interviewing (MI) and negotiation techniques to come to a compromise on a medication or treatment plan that both the provider and patient are in agreement with. In shared risk taking, it is recommended that providers and patients jointly reflect on each other's thoughts and feelings regarding associated risks of a particular treatment decision, including reflecting on how these decisions align with patients' larger goals in life. Feedback on these specific techniques from study providers was mixed. For example, some had concerns that the same factors that may interfere with decisional capacity (e.g., reduced insight, symptom acuity) also may interfere with the feasibility of doing MI with patients in acute phases of their mental health condition. Literature within SMI populations has found MI can increase intrinsic motivation to engage in psychosocial treatments (Fiszdon et al., 2022). Further, completing up to four sessions of MI with patients with acute psychosis has been proven feasible in a study conducted within acute mental health inpatient care in Sweden (Panchalingam et al., 2025). As such, MI techniques are seemingly possible within SMI populations, including with patients experiencing acute phases of psychosis, although more research is needed to understand MI's feasibility within acute mental health inpatient contexts within the United States. Further, many providers discussed MI to be helpful in the context of substance use, but were more skeptical in its use in the context of medication decisions. Research has indicated that MI can be used in encouraging medication adherence in SMI populations (Kisley et al., 2012; Laakso, 2011;

Panchalingam et al., 2025); however, some would argue that the use of MI to encourage medication adherence is actually antithetical to SDM. As noted in the current study's introduction, Deegan (2014) argues that the use of MI in SDM may perpetuate "clinical circular reasoning" where traditional SDM is only possible when the patient agrees with a particular treatment option; when the patient disagrees, SDM becomes risky and the patients' capacity is questioned. Deegan (2014) argues for designing infrastructure (funding, support from leadership, and on-site coaching) to support routine SDM use rather than integrating new techniques into SDM to adapt it. However, as noted in discussion of aim one, the "clinical circular reasoning" is already occurring within acute mental health, and there may be times when it is warranted. For example, the example quote for scenario 7 in Table 2 describes a patient who could have a reasonable conversation about medication, yet due to limited insight into their illness, they did not want medication treatment; however, they also struggled to care for themselves in the community without medication and as such, a court order was filed. In this instance, refusal of medication did impact the provider's view on their decisional capacity (e.g., ability to appreciate consequences of not taking meds), yet this patient needed this medication to live and care for themselves independently.

Instead of resistance to changing SDM, techniques such as MI could be useful as long as there is specific guidance on *how* providers use them. For example, some providers discussed how techniques such as MI within SDM-PLUS may be useful in convincing patients to agree to their treatment plan, but these techniques were designed within the SDM-PLUS model to reach "mutually satisfactory agreements" (p. 1484, Hamann & Heres, 2014), not to convince patients of the providers' choice. Indeed, elements of MI described in SDM-PLUS include “avoid confrontation, including listening reflectively, evoking change talk, and exploring common ground.” (p. 1485, Hamann & Heres, 2014). As such, MI can be used to motivate the patient for treatment, particularly when risk is high and the other alternative is court, and this may actually prevent more paternalistic approaches (i.e., court commitment) if the patient is able to come to a compromise with the provider. In this way, the use of MI in SDM may prevent paternalism rather than perpetuate it; however, it is imperative that if these techniques are encouraged in SDM, they are taught as a way towards compromise, not coercion or convincing.

Providers also had concerns about specific techniques discussed in shared risk taking to manage concerns about risk. For example, similar to concerns about MI, some providers were skeptical that patients could engage in meaningful conversation about their goals and risks associated with medications, particularly in times of reduced decisional capacity. While connecting a particular treatment to patients’ larger life goals is an important component of recovery-oriented SDM, it may be important to teach providers how to scaffold this approach to meet patients where they are at in terms of abilities to think about their goals, wants, and desires. For example, multiple psychosocial interventions for treating individuals with SMI, including those experiencing disorganization and acute psychosis, hold the belief that psychotic experiences and how they impact the patients’ life can be mutually understood by both the patient and the provider (Metacognitive Reflection and Insight Therapy; Lysaker & Klion, 2018; Recovery-Oriented Cognitive Therapy, Beck et al., 2021). While these therapies take time to see large change in patient’s lives, it may be important to consider how certain techniques from these therapies can be integrated into SDM to facilitate discussion with patients who have may have reduced capacity and symptom exacerbations. For example, in recovery-oriented cognitive therapy, providers are instructed to discuss with patients the things that excite or interest them and encourage them to engage in these activities while on the unit in order to access the patients' "adaptive mode" (i.e., when they are feeling their best and most themselves). Incorporating skills, such as how to access the "adaptive mode," may facilitate further discussion of patient's goals in life and how medications do or do not fit into those goals in a relatively brief format that fits within psychiatric inpatient medication management.

However, as discussed in results, some providers believed that having more in-depth discussions about how medications align with patients' goals in life was not the job of inpatient providers (e.g., "We're acute…we are: 'where are you gonna sleep tonight? Where are you know you gonna get food tonight?' Not kind of 'What are your goals in life? Where do you want to, you know, where do you wanna be in five years?' It's never that" P104). In part, this belief may stem from the misalignment between what the VHA identifies as the primary goal if inpatient (e.g., stabilization) and overarching principles of recovery-oriented care (e.g., empowering the individual to live a self-directed, meaningful life). Indeed, one identified barrier to SDM in mental healthcare is policies around mental healthcare delivery, such as organizational focus on short-term interventions, relapse prevention, and aversion to risk (Verwijmeren & Grootens, 2024). However, many providers in the current study also discussed the importance of SDM to increase buy-in from patients, which may then increase medication adherence when the patient is discharged. A fundamental component of SDM is to help patients identify pros/cons of medications, which includes helping them understand how this treatment may or may not align with their goals. Perhaps to increase provider buy-in to these discussions, future SDM interventions should emphasize that discussions of goals do not have to be discussions of "5-year plans," but rather simple things that they enjoy doing or want to do in the future (similar to the described "adaptive mode" above). In this way, the discussion of how these smaller goals align with medication may seem more manageable to inpatient providers.

In addition to how to facilitate discussion with patients within shared risk taking, some providers also viewed joint reflection with patients and disclosure of their own thoughts and feelings regarding certain risks of a decision as "boundary crossing." Others noted that other psychiatrists on the team, including residents, may struggle with interpersonal skills that are required for this specific technique. Further, one provider noted that in medical school, they were trained to be "stoic" when speaking with patients. Despite these concerns, providers acknowledged that joint reflection can improve rapport with patients when possible. However, while joint reflection may feel novel to some providers within the current study, it is also a skill that is imperative in SDM, as SDM is inherently intersubjective (Elwyn et al., 2017). Indeed, within guidance on SDM for psychotherapy within the VHA (Karlin & Wenzel, 2018), providers are instructed to express empathy, genuineness, and warmth while engaging in SDM with veterans. These common factor approaches are often taught within the context of delivering psychotherapy. Research on training in psychotherapy within psychiatry both in Europe and the US indicates that the while psychiatry residents recognize the value of training in psychotherapy, they often feel they do not receive quality training in delivering psychotherapy from their training programs and tend to lose interest in psychotherapy further along in their residency, partly due to their low self-perceived competency in this area (Salgado & von Doellinger, 2024). This sentiment was seemingly present in some of the providers when discussing elements of shared risk taking, who felt particularly vulnerable with patients if they engaged in joint reflection. Future SDM interventions for acute mental health must consider emphasizing the common factors associated with SDM (warmth, empathy, joint understanding) to be incorporated in interactions with patients as well as providers' training in demonstrating these interpersonal skills to their patients.

Additional Factors for Future SDM Interventions to Consider

Through discussion of the acceptability and adaptability of each suggested approach, additional factors were identified that may be important to consider in future SDM interventions for inpatient acute mental healthcare. Firstly, across all approaches, providers believed that they were already implementing each approach to some degree, yet research on SDM implementation within psychiatric inpatient units across the VHA indicates SDM is rarely implemented to its fullest (Eliacin et al., 2022; Shue et al., 2022). While the current study relied solely on providers' self-report, discrepancy in reports on SDM versus actual SDM implementation demonstrated in previous research (Eliacin et al., 2022) indicates that direct observation of SDM within the unit is imperative for future SDM interventions. Further, research indicates that providers tend to overestimate their "patient-centeredness" (Boardman & Dave, 2020). As such, on-site coaching, observation, and feedback may increase provider buy-in into the importance of engaging in further training on SDM.

Another important factor discussed during interviews was considering who was actually meeting with patients to discuss medications. Some attending psychiatrists in the study reported relying on residents to have most discussions with patients about medications. While the small number of residents interviewed in the current study limited the ability to make comparisons in knowledge about SDM, it is possible residents have less experience navigating complex scenarios using SDM such as when patients have reductions in capacity and exacerbations of mental health concerns (e.g., acute psychosis). Research on interventions to train medical students on SDM have been proven effective in increasing education and motivation to use SDM in the future (Leblang et al., 2022). However, it is unclear how much training on SDM currently occurs within medical students' training. Determining how much training on SDM residents have and their comfort level in SDM implementation may be an important area of future research given the frequency in which residents may be interacting with patients on the unit during medication management decisions.

Additionally, across approaches providers discussed importance of utilizing the entire interdisciplinary treatment team as a way to decrease burden on the psychiatrist in implementing some of these approaches (e.g., recommending that perhaps the psychologist on the unit could conduct MI within SDM-PLUS). Within research, models of SDM have been proposed that incorporate a treatment team rather than a dyad of patient and provider (Lewis et al., 2016). Given the emphasis on team cohesion within the current study's interviews, models of SDM that incorporate interprofessional collaboration should be considered in future SDM interventions within inpatient acute mental healthcare.

Reflection on Perspective Shift

In accordance with self-reflection as a means of ensuring rigor in the current study's qualitative analysis, I offer reflections on how my perspectives have shifted throughout this project. Prior to beginning this project, I came from a background working with patients with SMI as a psychologist in training and researching recovery-oriented care both within inpatient and outpatient settings. These experiences significantly shaped my views on the importance of recovery-oriented care, promoting self-determination and empowering patients to live a self-directed life outside of their diagnosis. As such, I am passionate about the underlying principles that SDM represents: patient autonomy, self-direction, and giving patients the dignity to fail or make a choice that doesn't work out the way they had hoped. Prior to the project, I was also involved in other research projects investigating SDM implementation in acute mental health and often felt disappointed that SDM seemed like the exception rather than the norm in this setting. I held the belief that inpatient providers did not reflect the same values I had as a psychologist and were often more concerned with reduction in symptoms/risk and promoting stabilization, and less concerned about the decision-making process that occurred to accomplish these goals. I was under the assumption that psychiatrists should be educated in how to shift their practice to be more consistent with SDM, including correcting possible misinterpretations about a patients' decisional capacity to participate in the decision.

However, also during this project, I started providing clinical care full-time for the first time in my graduate student career. Through this experience, I was able to put myself in the psychiatrists' shoes more deeply than before. I too began to regularly encounter complex clinical situations where patients had increased risk of harm. Sitting with uncertainty, tolerating the discomfort when patients make risky choices, and considering whether they would make the same choices under different circumstances is a deeply unsettling experience, even within an outpatient context. I can see that while values may differ at times across professions, there remains a deep care for patients' wellbeing. Through interviews, I found this deep care and compassion to be present in the psychiatrists I interviewed and through this, I found common ground between psychiatry and my field of psychology. They conceptually understood the benefits of SDM and some even championed the promotion of patient autonomy, yet their own level of risk-tolerance seemed to be directly tied to their perceptions of patients' capacity for SDM. From this, I have come to believe that to mitigate provider hesitancy to use SDM, as well as promote SDM in times when patients may have reduced capacity, increased guidance on how to approach risk-related concerns in SDM must be provided in future SDM interventions with the acceptance that in some contexts, SDM must be adapted.

Further, while most psychiatrists were indeed concerned with risk and stabilization when considering patients' capacity to participate in the decision, my perspective shifted as I began to understand the larger context. Inpatient acute mental health care was designed within the VHA for fast-paced stabilization and discharge. This model shortens the time providers have in coming to compromises with patients on treatment or allowing a natural recovery process to occur without medications. If higher risk is involved, this often leads providers to try to convince the patient to take medications or file for commitment to then be able to stabilize the patient and mitigate risk for discharge. SDM was designed with outpatient in mind. When disagreements occur within outpatient, perhaps the patient can take time to live their life according to their choice and re-evaluate at a different time. This is not an option within inpatient as patients must demonstrate some level of improvement in a short amount of time to be discharged given the ultimate goal of stabilization and risk mitigation. As such, I believe that not only do we need to further educate providers on elements of SDM and when to utilize them, there may be times when another model is a better fit. In other words, if the goal of SDM interventions is to promote patient autonomy, other models, such as supported decision making or the use of advance directives, must also be considered alongside SDM.

Overall, while there remain fundamental differences in my training as a psychologist in recovery-oriented care and the biomedical training psychiatrists receive, the psychiatrists I interviewed certainly valued patient autonomy, yet were caught in a larger system faced with complex patient concerns that makes SDM very challenging. It is important that research on this matter does not forget psychiatrists' difficulties with implementing SDM as not just an individualized problem, but also with systemic barriers and inherent clashes between stabilization and recovery models of care.

Limitations

The current study is the first to investigate how inpatient psychiatrists within the United States are conceptualizing and assessing patients' ability to participate and make decisions. Additionally, the study is the first to understand United States' inpatient psychiatrists' perceptions of acceptability and adaptability of proposed SDM approaches for situations when patients' decisional capacity or ability to participate in decisions is in question. However, this study also has limitations. Specifically, generalizability of results beyond the VHA is limited, such as psychiatrists' perspectives within community hospitals in the United States. Future research on SDM within community psychiatric inpatient units is important given previous research on SDM within psychiatric inpatient care in the United States has solely been conducted within the VHA (Eliacin et al., 2022; McGuire et al., 2021; Shue et al., 2022). Additionally, because the current study used purposive sampling methods, it is possible that the psychiatrists represented in the current study self-selected to be in the study because of their views on the importance of SDM, capacity assessment, or recovery-oriented care. The current study cannot determine whether these views are fully representative of inpatient psychiatrists across VHA. Moreover, understanding the perspective of the patient within SDM and decisional capacity is beyond the scope of the current study; however, patients remain important stakeholders within SDM implementation in psychiatric inpatient care. Future research is needed to understand patient preferences and perspectives on SDM within acute mental health care in the United States. Further, research within SDM notes that observer and provider perspectives on SDM implementation are often incongruent (Kasper et al., 2012) and this has been noted within psychiatric inpatient research (Eliacin et al., 2022). While the current study aimed to gather a deeper understanding of the provider perspective, future research measuring how provider perspectives, patient perspectives, and observer ratings of SDM diverge or converge within difficult clinical situations (e.g., reduced decisional capacity, acute symptoms, reduced insight) is important to get a clearer picture of current SDM implementation. Lastly, descriptions of approaches used in the interview guide were created from what was present in research papers about them and may have lacked nuance that researchers who created them could further provide. As such, results should not be used as evidence on the overall effectiveness of each of these approaches, but rather as discussion on important considerations for new interventions designed to navigate reduced decisional capacity and foster SDM within acute mental healthcare.

Aim One Conclusions

Overall, results indicated that providers use Applebaum & Grisso (1988)'s four pillar of decisional capacity as guidelines, using a sliding scale on how adherent patients need to be to four pillars based on the level of risk associated with decision. Providers directly use four pillars to determine whether the patient can consent to treatment (i.e., for informed consent). Additionally, providers factor in capacity when considering how collaborative to be with patients; however, there are no set guidelines on the level of capacity needed for each degree of collaboration. While not formally tested in the current study, the lack of formal guidelines could create subjectivity and room for clinical error in assuming a patient cannot participate further in a decision, which may lead to providers reducing their level of collaboration with patients in the decision erroneously. As such, future research is needed to inform how patients' decisional capacity relates to patients' ability to participate in SDM, and the degree to which providers are making errors in their judgement using their current capacity adjustment system. Results gathered from this research may reduce subjectivity in clinical practice.

Secondly, within the assessment process, providers also rely on "red flags" to cue them to further consider patients' decisional capacity. Some of these red flags may directly correlate with impairments in capacity as defined by the four pillars (i.e., conditions impacting patients' ability to communicate); however, others have the potential to introduce undue bias in clinical judgement (i.e., patient's previous non-medication adherence, involuntary admission status). Clinically, within capacity assessment for SDM, providers must consider potential assumptions/heuristics they are using to determine capacity and level of collaboration. Further, it is important for "red flags" to be considered as *risk factors*, yet not *complete indications* for incapacity to limit further bias in the assessment. Lastly, while red flags such as patient medication adherence history can be a useful datapoint, providers must consider that capacity to engage in SDM, like any capacity assessment, is a time-specific decision that should be based in the present.

Thirdly, considerations of risk were intertwined with capacity assessment (i.e., how strictly they adhered to capacity criteria). However, level of risks associated with patient preferences in the decision are not always straightforward. For example, providers varied in what they described as "high risk." Results indicate future SDM interventions for acute mental health must consider how SDM might be possible in the delicate balance between risk (both for patient and for provider) and patient autonomy which is often at play within psychiatric inpatient care.

Lastly, while risk often dictated whether or not providers completely halted collaboration and filed for court-ordered commitment, additional factors, such as length of stay, provider attitudes towards autonomy, and beliefs about the feasibility of restoring capacity while on the unit may moderate the relationship between patients' decisional capacity and providers' level of collaboration in other scenarios. Future research on these relationships may inform how they may be navigated to promote as much SDM as possible across common decision-making scenarios on inpatient, such as those reflected in Table 2.

Aim Two Conclusions

Gathering providers' feedback regarding the acceptability and adaptability on the use of the capacity-adjusted sliding scale, SDM-PLUS, and shared risk taking revealed that a combination of approaches may best to address reduced decisional capacity as a barrier to SDM. Additionally, through this feedback, implications for future SDM interventions were formulated. Firstly, providers' reluctance in using surrogates indicates the need to find possible alternatives within the capacity-adjusted sliding scale approach, such as using peer support specialist as decision supports on the unit. Further, approaches outside of traditional SDM should be considered to facilitate assessing capacity on a spectrum (e.g., supported decision making, advance directives). Second, as noted under aim one, risk and acuity of the decision are factors that must be considered when addressing reduced decisional capacity as a barrier to SDM. Providers appreciated this focus within SDM-PLUS and shared risk taking, however also noted concerns about how acuity and risk was incorporated. Future SDM interventions should consider structuring SDM intervention similarly to a psychotherapy treatment manual, such as DBT. Third, special attention should be brought to how to increase training and feasibility on the use of specific skills (e.g., MI, joint reflection), as well as how to incorporate factors important to inpatient care (e.g., interprofessional collaboration, residents' role/training in SDM, and importance of on-site coaching and observation). Overall, while the study confirmed that reduced decisional capacity is a complex barrier to navigate within SDM implementation, the study also revealed a wealth of future directions for research into navigating capacity as it relates to SDM. Through this research, increased implementation of SDM within inpatient acute mental healthcare may be possible.

TABLES

Table 1. Participant's Self-Reported Site Descriptions During Interviews

Site	Average Length of Stay (Days)	Number of Beds	Average Census	Number of Providers from Each Site
1	7	25	18	1
2	7 to 10	16	16	6
3	9	20	18 to 20	2
4	7	18	Not reported	1
5	5	14	14	1
6	3 to 7	10	6	1
7	5 to 7	25	16	2
8	10	40	20 to 25	1
9	4	38	23	2
10	2-5	24	10	1
11	5	28	"in the teens or lower"	1
12	7	60	30	1
13	3 to "months"	12	10 to 11	1
14	7	8	6	1
15	Not reported	25	13	1
16	5 to 7	20	15	1
17	13-14	29	21	1

Note. Providers reported these site descriptions within the interview; data may not be exact representations of each unit. If providers' report were different across the same site, an average was taken of the two reports. Ranges are reported when providers reported a range rather than a single number.

Table 2. Possible Medication Decision Making Scenarios Observed in Interviews

	Provider Decision Making Process for Medication Management Observed from Interviews	Examples
Scenario 1	Offers patient options and discusses risk/benefits of different medications. Patient chooses medication (level of collaboration may be modified for level of insight/cognitive functioning/capacity)	*"And then if medications are part of the solution to determining how we help the patient move forward, great. And we make recommendations to the patient. The patient ultimately makes the decision about whether they're gonna be on the medication and what medication they will be on. And that is 95% of the time how it works... we really try as much as possible to be the sort of facilitators and recommending medical experts, but not the judge and jury for all of it."* P100
Scenario 2	Go with patient preference to not take meds	*"I think especially with psychosis like there's a lot of patients who may be psychotic, I mean, hopefully not floridly psychotic, but, you know, have a lot of psychotic symptoms, but still understand, you know, the risk benefits and alternatives to taking medication, and if then if they choose not to take the medication, but we still believe that they don't meet the criteria for involuntary admission. Then we'd have to let them go, even if they didn't take meds. So I mean, people are allowed to be psychotic. So I mean they can do that if they want. But yeah, we don't try and take a paternalistic standpoint and say like, 'oh, you're psychotic you have to take meds' like it really depends on if they're actively doing things to harm themselves or others or can't take care of their very basic needs."* P111
Scenario 3	Negotiate with patient on a compromise on medication (can include some convincing)	*"If the patient is not wanting to take a medication, we try to figure out why they're not taking it and then trying to figure out if you don't want this then why are you here and trying to figuring out what their motivations are and then hopefully by looking at…they might not be here because of what you think that they need help with which might be acute psychosis. They might be here because they just feel like they're anxious or they're nervous or something like*

		that. Then you can kind of talk to them about, well, you know, here's a medication that can help with both of those things. And then you can kind of come to a compromise with them on that.” P105
Scenario 4	Give patient time to improve with PRNs and/or longer stay on unit.	*“I try as much as possible to avoid court because we're taking away people's rights and it's not a decision I wanna make lightly. And a lot of times time will help with mania and psychosis. So if they're on the unit and they're willing to remain on the unit, even if they don't want the medications I'm recommending, I will often give them several days of remaining on the unit, even if they're not taking medications to hope that maybe the mania improves, something breaks. I'll put some PRN's on board that might help break the mania or psychosis to see if we can get them to a healthier place without needing the courts to get involved.”* P107
Scenario 5	Patient disagrees with provider, but provider orders med anyways and patient ends up taking med when offered by nurse	*“So then he went on to Mirtazapine, was maybe getting a little bit better, but he was like refusing to go up and so I was like this guy's been here almost a month and no one's being aggressive enough with the meds. So I basically told him I was like, look, here's what we're going to do, you're taking the 15 mg of Mirtazapine, I'm going to offer you 30 tonight. I'm gonna have it there. You can take it or you're not, but I'm gonna offer it to you. I think you're going to try it because at this point I think you know that you're not doing that well, you're telling me you had side effects with this medication, but you were having the same side effects before you were on medication, on different medications. So sometimes the best thing to do is just offer the medication, and if it's a QHS medication, they'll either take it or they don't”* P124
Scenario 6	Provider and surrogate decision maker make final decision based on patient preferences/best interest. May still need to go to court to obtain	*“A fair number of our patients that are very impaired have guardians where they've already been determined to be non-decisional and adjudicated to be incompetent. So a fair number of our patients have powers of attorney where they've decided that somebody else should make decisions for them. And when that doesn't occur,*

	consent/commitment depending on state laws	*we try to use that next of Kin and there's a hospital policy that defines, uh, how will you go through that process. And at the most paternal level we make that decision on behalf of the patients, consistent with the policy of the hospital."* P110
Scenario 7	Seek court order for temporary commitment/medication and/or forced medication procedures pending hospital guidelines	*"I kind of have a patient like this recently where she was gravely disabled, you know, she had poor insight into her mental health. She was insistent that she preferred being manic to being on medication as it affected her like weight, and made her sleepy. But she was alright with how her mental illness was affecting her because she preferred that. Um, you know? And she was able to have a somewhat rational conversation about that. But she's also just, you know, very, very sick and unable to care for herself. And you know we got commitment for her."* P108

Table 3. Symptoms and Factors Deemed as Red Flags Concerning Patients' Decision-Making Ability

Red Flags	Examples
Symptom severity (psychosis, mania, depression), particularly when it impairs insight	*"You know right now in the unit we have a couple of manic patients and pretty psychotic patients and it's definitely a bit of a red flag with the medications and our conversations. They're both currently requesting medications that are completely not indicated, which can be a frustrating experience because we're trying to walk a fine line here between including them in their treatment and trying to help them feel like their concerns are being validated, that we're listening to them and we're trying to help them. But it's also hard to rationalize with somebody who's manic. 'But you know what? You're antidepressant is not a good choice right now, given that you're currently manic' and uh, so that can be hard because they're not really logically able to think through the consequences like this."* P107
High risk (for harm to self/others or gravely disabled, including aggression or behavioral issues towards staff)	*"Yeah, that's a good question. I would say in general, if they're making decisions that would place themselves at risk or place other people at risk or making decisions where I feel like they can't take care of themselves. That would kind of raise some red flags."* P101
Acute intoxication	*"If they are coming in acutely intoxicated and not kind of listening to anybody or doing anything, you know, if they're not really able to engage in any meaningful way."* P105
Neurocognitive processes (memory impairment, cognitive impairment, dementia, delirium, not oriented to person, place, time)	*"I would say the largest ones would be a dementing illness. So someone who doesn't have memory or insight into what's going on and maybe not even being oriented, so dementia and delirium syndromes tend to have faulty cognition."* P113
Communication difficulties (e.g., disorganization, catatonia, "non-verbal")	*"But disorganization, if someone is not able to carry on a linear conversation, make a linear sentence to start off with,*

	which is a chunk [of patients], then I'm going to say that they probably don't have capacity." P104
Involuntary admission status	*"But many of our vets, you know, come here involuntarily. And as such, you know, that's sometimes a red flag. It's not an absolute contraindication, but it's usually a red flag for us that these patients may not be in the right frame of mind to be able to have that capacity to discuss their medications. So we have a conversation usually post meeting [with the team] and we talk about whether we think the patient is understanding of treatment and would they take the medications and all that and then we'll usually have a decision about adjusting medications sometimes in lieu of telling the patient, if we think in that moment we've talked to the patient that they didn't seem to really appreciate the need for medications."* P109
History of medication non-adherence	*"Yeah. Umm, I think if I also look back at their history and [in] the chart, there is a lot of medication hopping going on. Then I'm like, OK, you're willing to start medications, but you don't always want to stay on them. You always find a reason. Then I might [think]--do you truly understand how this medication works? And then I'm thinking about capacity in that aspect"* P117

Table 4. Capacity-Adjusted Sliding Scale Approach Likes and Dislikes

Likes	Dislikes
• Potential to facilitate treatment plan buy-in from caregiver or family • Use of surrogate as patient advocate • Term "surrogate" can include court system • Spectrum offers ability to capture nuance in capacity and decision-making • Intuitive, simple model that explains standard practice • Facilitates as much patient involvement as possible across capacity levels	• Possibility of conflict between family, patient, and provider • Surrogate is not often feasible/used on acute mental health inpatient unit • Decisional capacity for a specific treatment decision is a binary decision, not on a spectrum • Potential to be used inappropriately/Too abstract, vague

Table 5. Capacity-Adjusted Sliding Scale Approach Facilitators and Barriers

Facilitators	Barriers
• Ethics committee (or third-party champion) to explain this model to unit staff • Interdisciplinary team approach (e.g., divide tasks to make model more manageable in time constraints) • Continuously checking in on patient's decisions/capacity	• Classifying on spectrum of capacity adds an additional layer of complexity/subjectivity to capacity assessment • Difficulty using/identifying surrogate decision makers in inpatient care • Time needed for aspects of this approach

Table 6. SDM-PLUS Approach Likes and Dislikes

Likes	Dislikes
• Use of motivational enhancement techniques in the approach • Model captures most scenarios that occur in inpatient • Incorporates acuity/severity of decision into medication decision-making process • Provides specific techniques/different options to use with good examples	• Use of motivational enhancement techniques in the approach • Separating techniques into different categories • Acuity categories are unclear/not relevant to inpatient • Use of "negotiation tactics" in model • Does not incorporate family involvement

Table 7. SDM-PLUS Approach Facilitators and Barriers

Facilitators	Barriers
• More training on techniques in model (e.g., third party champion/trainer) • Interdisciplinary team approach (e.g., unit psychologists deliver MI) • Provider buy-in to the model • Agreement on treatment plan among team members	• Patient acuity/willingness to engage • Time constraints, including time needed to change a patient's perspective on medication treatment • Complexity of model • Lack of training in motivational interviewing • Lack of cohesion among treatment team

Table 8. Shared Risk-Taking Approach Likes and Dislikes

Likes	Dislikes
• Promotes patient autonomy/focuses on patient's goals • Potential to increases rapport with patients/maintains positive regard for patients even during disagreements • Incorporates the provider's perspective in the decision • The model is described in terms of shared risk • Encourages providers to explore with patients how medication non-adherence may affect patients' functioning while outpatient • Potential to increase medication buy-in from patient	• No clarity on what to do if there is still disagreement after this conversation • Potential to put provider in vulnerable position with some patients (e.g., sharing their honest concerns with patients may be utilized against them) • Less focus on capacity • Too vague

Table. 9. Shared Risk-Taking Approach Facilitators and Barriers

Facilitators	Barriers
• Interdisciplinary team approach • Specific examples of how to implement approach • Coordination with outpatient care • Mental health law/policy • Good rapport with patients	• Incompatible with rounding • Patient's lower capacity and risk/willingness to engage • Provider's level of interpersonal effectiveness/discomfort with vulnerability • Time constraints • Difficulties in measuring fidelity to this approach

Table 10. Provider Preferences for Each Approach

Model Preference	Providers (n)
Prefers Using >1 Approach	13
Combination of All Three Approaches	6
SDM-PLUS and Shared Risk Taking	4
Sliding Scale and SDM-PLUS	2
Sliding Scale and Shared Risk Taking	1
Prefers SDM-PLUS	5
Prefers Shared Risk Taking	4
Prefer Sliding Scale	3

FIGURES

Figure 1. Observed Role of Decisional Capacity in Pathway to Provider's Medication Management Decision-Making

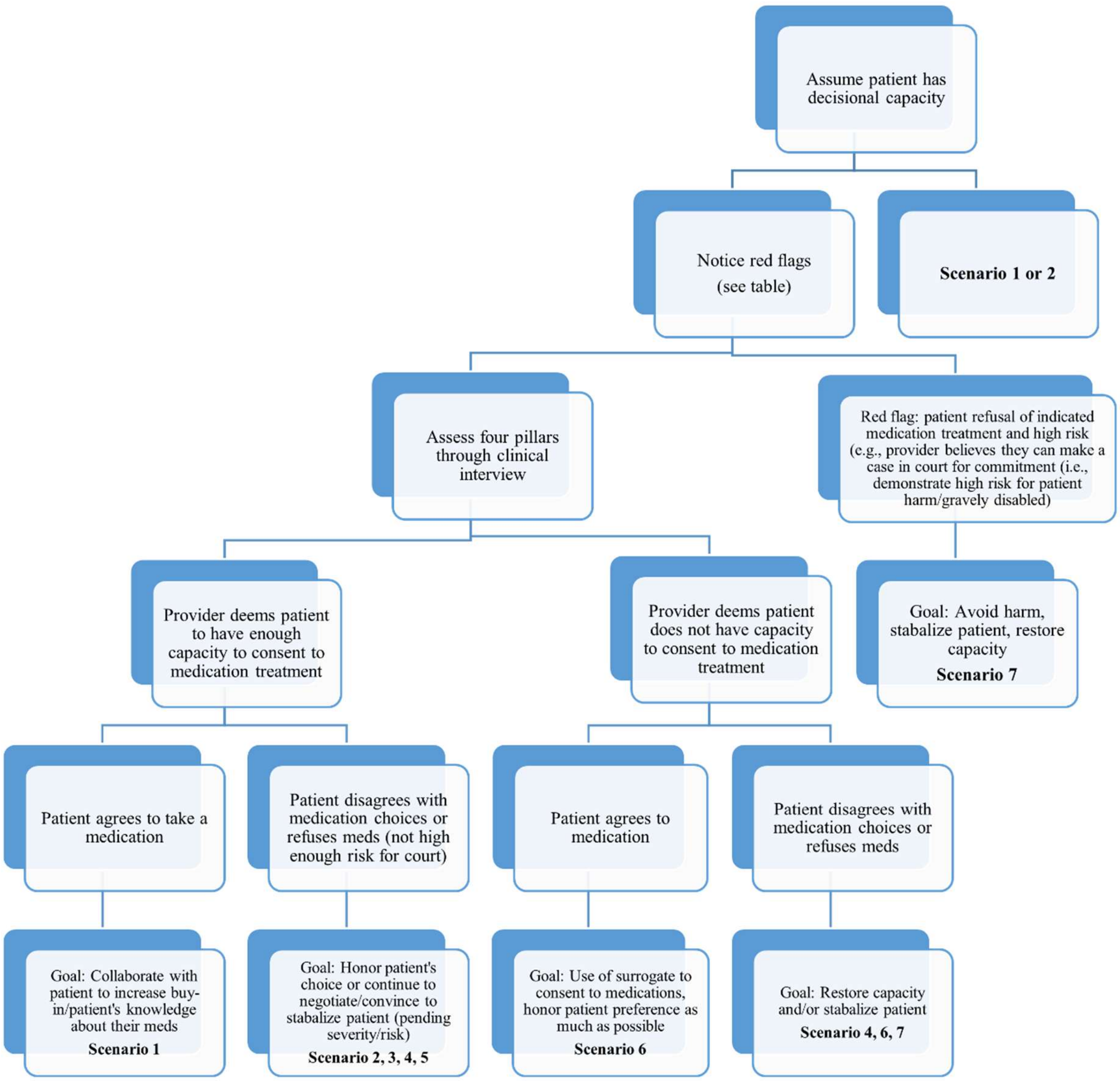


Figure 2. Level of Capacity for Consent Depends on Risks Associated with Medication Treatment

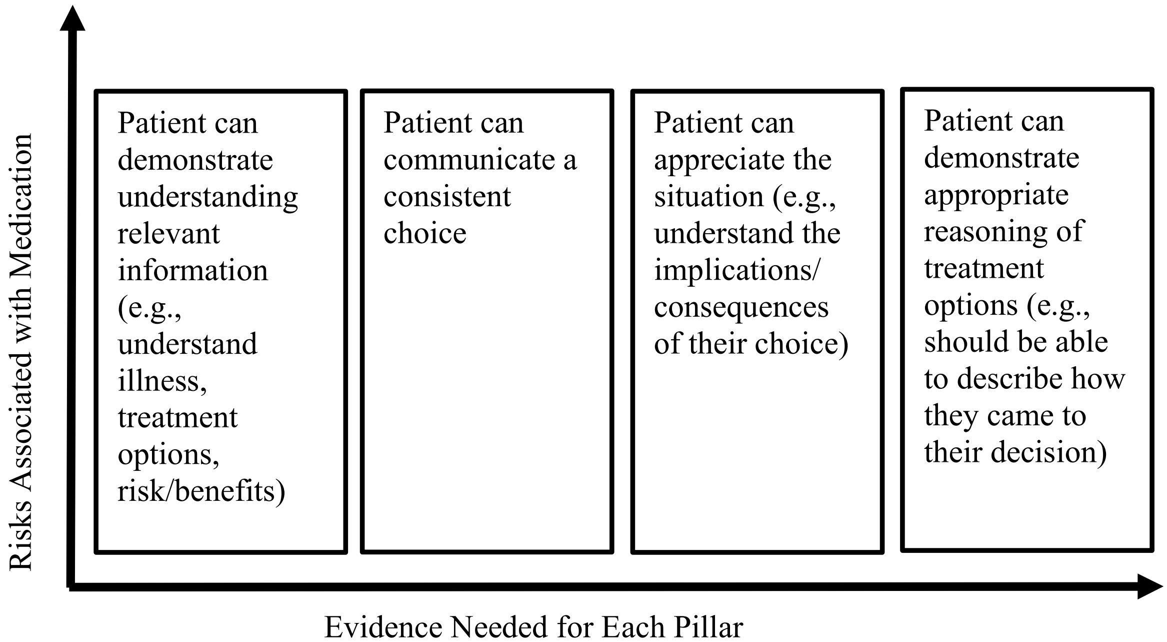


Figure 3. Suggestions for Future SDM Intervention Based on Study Results

<u>Educate Providers on Core Components of SDM (i.e., core elements for adherence to SDM)</u>
Example Core Components:
Clarifying problem, reviewing options (including non-pharmacological options), discussing pros/cons of each option (including how they align with patient's goals), providing recommendations (if needed), eliciting patient preferences/questions

Discuss with providers the importance of common factors in delivering core components + additional skills (e.g., doing so with empathy and warmth)

<u>Discuss with Providers Connection Between Capacity and SDM:</u>

- Emphasize importance of understanding the patients' perspective on treatment (e.g., what is their reasoning for wanting or refusing a particular treatment?)
- Emphasize that capacity assessment is time and decision-specific
- Red flags may be "risk factors" but should not be taken as complete indications
- Discuss the connection between risk/acuity and capacity concerns

<u>Additional Intervention Considerations:</u>

- Discuss role of residents/IDT in SDM on unit (possibly incorporating entire treatment team into training)
- On-site provider coaching and feedback related to skills

<u>Educate Providers on Additional Skills to Consider when Reduced Capacity is a Barrier to Completing Core Components</u>
These skills are meant to be considered based on providers' clinical judgement/capacity assessment. Additional guidance may be provided during training on when these skills may be most appropriate based on Scenarios presented in Table 2
Example Skills Informed/Modified based on Study Results:

- Supported Decision Making (including role of peer support) to facilitate capacity-adjusted sliding scale approach to SDM
- Psychiatric Advance Directives
- Joint Reflection on Shared Risk and Patients Goals
  a) includes use of scaffolding to patient's current cognitive abilities through integration of techniques from psychotherapy for individuals with SMI (e.g., accessing "adaptive mode" from CT-R)
- MI skills (e.g., exploring common ground, listening reflectively, evoking change talk, etc.)
  a) Specify these skills are to be used for coming to an agreement and not to "convince" patient of providers preferred approach

<u>Future Research Needed to Better Address Capacity as a Barrier to SDM:</u>

- Clarify the relationship between patients' capacity (as assessed using providers clinical judgement and formal capacity measures) and patients' ability to participate in SDM
- Development of formal measures assessing capacity for SDM specifically
- Understanding additional factors that may influence the relationship between providers' assessment of patients' capacity and provider SDM implementation (e.g., pressure to discharge quickly, views about patient autonomy, beliefs about capacity restoration while on inpatient)

APPENDICES

Appendix A

Subject ID: ___________________ Interviewer: ____________________________

Date: ________________________

Emily's Dissertation Interview Guide

Briefly review study purpose, potential risks, confidentiality from Informed Consent
Ask if interviewee has any questions and answer as appropriate

Thanks for talking with me today! The main goal of this interview is to learn more about how you make decisions with patients about their medications on the unit. I will be asking you questions about your typical medication decision-making process with patients on the unit and how you might determine patients' ability to contribute to these decisions across different scenarios. I have questions to guide us, but the idea is to have a conversation, so I learn about your experiences in your own words. Let me know if you have any questions. I will begin recording now.

BEGIN RECORDING

1. Before we begin, can you briefly tell me about your unit?
[Probe if not answered]:
How many beds are on the unit?
What is the average census?
What is the average length of stay?

2. What types of patients do you see on the unit?
[Probe if not answered]:
Does the unit have a specialty focus?
What are the most frequent mental health diagnoses on the unit?
What is the level of acuity?

3. Can you tell me about your role on the unit and what a typical day might be like?

General Decision-Making Process

4. When you work with patients, how are medication management decisions typically made?
[Probe if not answered]:
Who is involved in the decision (e.g., IDT, caregivers, etc.)?
What typically happens during this process?
When and where are these decisions made (e.g., on ward during ward rounds, during IDT meetings)?

5. How involved do you think patients should be in medication management decisions?

[Probe if not answered]:

What circumstances might change your view on how involved patients should be?

<u>Decision-Making Process: Reduced Decisional Capacity; Acute Symptoms; Reduced Insight</u>

4. How do you determine patients' decision-making capacity for medication management decisions?

[Probe if not answered]:

Do you ever use formal assessment to make this determination? If so, which ones? Who does it?

Are there certain symptoms (e.g., acuity level or specific symptoms in general) that are "red flags" where you are automatically concerned about patient's decision-making ability?

<u>Acceptability and Adaptability of Suggested Solutions</u>

Script:

Clinician concerns surrounding patients' decisional capacity, including patient symptom acuity and reduced insight, is an identified barrier to patient involvement in medication management decisions in psychiatric inpatient care within the literature. The literature also suggests some possible approaches to address this barrier to increase patient involvement in psychiatric inpatient medication management decisions. I am going to describe three different approaches and ask you questions about what you think about those approaches and how they may be adapted to work within your specific unit.

<u>Surrogate Decision-Makers</u>

Script:

One suggested solution is to use a sliding scale approach to how involved surrogate decision-makers are based on the patient's determined decisional capacity. Specifically, you would go over all the treatment options with the patient, elicit preferences, and discuss pros/con of the options, regardless of capacity concerns. If the patient can make simple decisions such as whether to take medications or not, but struggles to make more nuanced decisions such as which medication might be best, then you may bring in a surrogate to play the role of patient advocate and support the patient in decision-making. However, if the patient lacks decision-making capacity completely for the treatment decision, then you may bring a surrogate decision-maker in to make the decision on the patient's behalf, ideally based on the patient's best interest (including the patients' perceived preferences/values.

[Share this model on the screen]

Acceptability:
What do you like about this approach?
What do you dislike?
How comfortable would you be implementing this approach? (why, e.g., what about it would be uncomfortable…)
How much do you think this would improve patient participation in medication management in acute mental health care? (Why or why not?)

Adaptability:
Under what circumstances would you consider using this approach?
What are the facilitators that would make it easier to adapt this approach in your setting?
What are the barriers that would make it harder to adapt this approach in your setting?
What kinds of changes or alterations do you think would need to be made to this approach so it would work well in your setting?

<u>SDM-PLUS Methods</u>

Script
Another suggested solution describes approaches you could take across three types of decisions. Let's walk through the diagram together.

First, in "life or death" decisions, you would take a more directive approach to decision making with the patient to avoid harm.

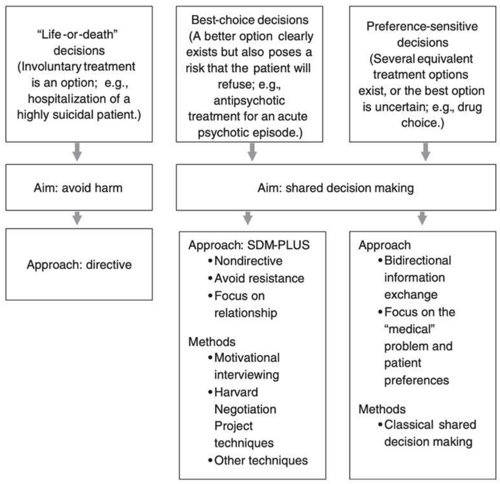
The second type of decision is "best choice decisions" such as when a better treatment option clearly exists for the patient, but there is a risk that the patient may refuse this option (e.g., refusing antipsychotic medication when someone is acutely psychotic). During these types of decisions, authors suggest using motivational interviewing and negotiation techniques. Motivational interviewing facilitates behavior change through increasing patient motivation and commitment to change, for example, encouraging the patient to say why and how they might make a behavior change for themselves rather than simply giving them advice on what they should be doing. A negotiation tactic might be having a second treatment option "in your back pocket" or ready to offer if the patient refuses the "best choice."

The third type of decision is called "preference-sensitive decisions" where there are multiple treatment options that may be equally effective and the best choice is unclear. In these types of decisions, you would engage in more traditional shared decision-making steps.

[Share this model on the screen]

Figure 1

Approaches to shared decision making in three prototypical clinical situations



Acceptability:

What do you like about this approach?
What do you dislike?
How comfortable would you be implementing this approach? (why, e.g., what about it would be uncomfortable…)
How much do you think this would improve patient participation in medication management in acute mental health care? (Why or why not?)

Adaptability:

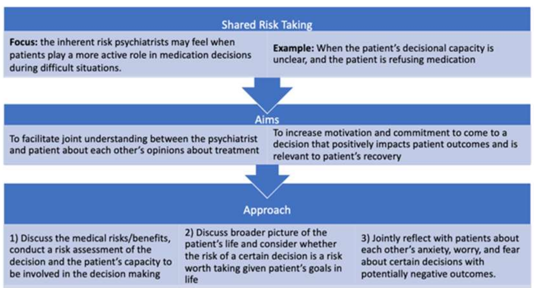
Under what circumstances would you consider using this approach?
What are the facilitators that would make it easier to adapt this approach in your setting?
What are the barriers that would make it harder to adapt this approach in your setting?
What kinds of changes or alterations do you think would need to be made to this approach so it would work well in your setting?

<u>Perceived and Shared Risk Taking</u>

The last suggested solution focuses on the inherent risk psychiatrists may feel when patients play a more active role in medication decisions during difficult situations, such as when the patient's decisional capacity is unclear, and the patient is refusing medication. Authors suggest engaging in something they call "shared risk-taking."
In this approach, the psychiatrists should still discuss the medical risks/benefits to medication decisions as well as conduct a risk assessment of the decision, its safety implications, and the patient's capacity to be involved in the decision making. However, the patient and psychiatrist should also take into account the broader picture of the patient's life and consider whether the risk of a certain decision is a risk worth taking given patient's goals in life. For example, the patient and psychiatrist may consider how the patient came to their beliefs about taking medication and whether being on no medication is a risk worth taking given the patient's recovery goals.

Additionally, psychiatrists should jointly reflect with patients about each other's anxiety, worry, and fear about certain decisions with potentially negative outcomes. For example, a psychiatrist may openly reflect on their fear that patient may not be able to maintain housing if they decide to not take medication. The goal of this approach is to facilitate joint understanding between the psychiatrist and patient about each other's opinions about treatment and increase motivation and commitment to come to a decision that positively impacts patient outcomes and is relevant to patient's recovery.

[Share this model on screen]



Acceptability:
What do you like about this approach?
What do you dislike?
How comfortable would you be implementing this approach? (why, e.g., what about it would be uncomfortable…)
How much do you think this would improve patient participation in medication management in acute mental health care? (Why or why not?)

Adaptability:
Under what circumstances would you consider using this approach?
What are the facilitators that would make it easier to adapt this approach in your setting?
What are the barriers that would make it harder to adapt this approach in your setting?
What kinds of changes or alterations do you think would need to be made to this approach so it would work well in your setting?

5. Out of these three models, which model would you prefer to use on your unit? Which do you feel would be most effective in increasing patient involvement in medication management in psychiatric inpatient care on your unit?

6. What other things have we not discussed in this interview that you think is important to share about determining patients' ability to participate in inpatient medication decision-making?
END RECORDING

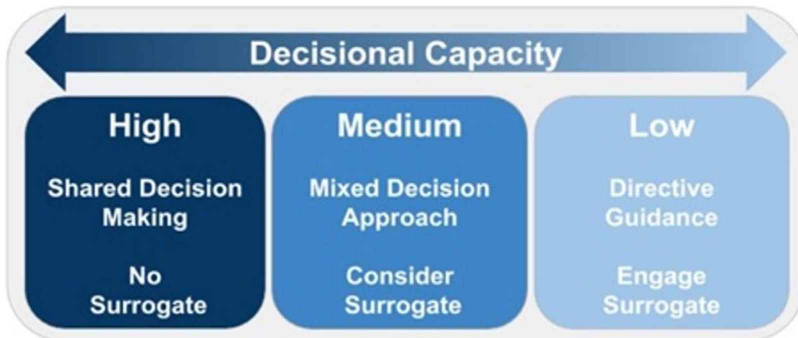
Thank participant and ask if it would be okay to follow-up with them via phone or email if we have any questions about their responses during data analysis.

If some of the interview was not done, please explain: ____________

Appendix B

Infographics Used During Interview for Each Approach

Sliding Scale Shared Decision Making

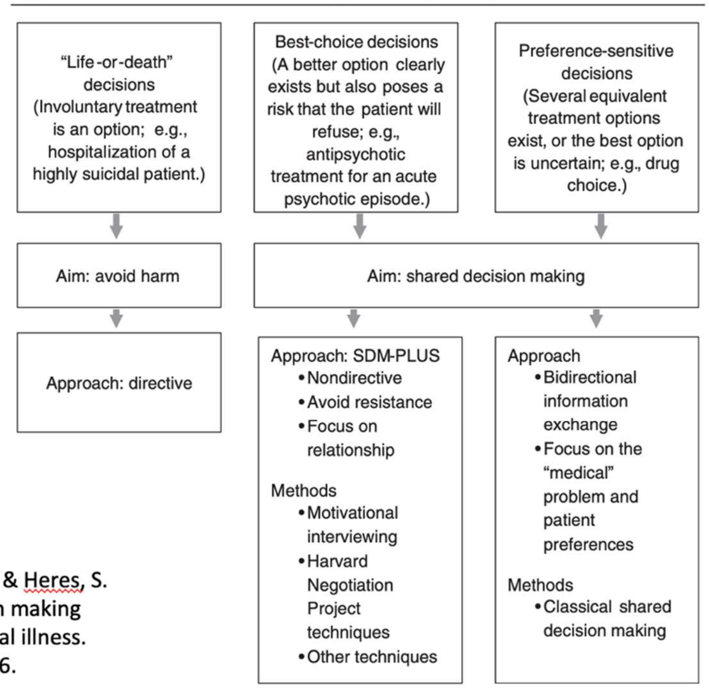


Graphic taken from: Lahey, T., & Elwyn, G. (2020). Sliding-scale shared decision making for patients with reduced capacity. *AMA Journal of Ethics*, *22*(5), E358-364.

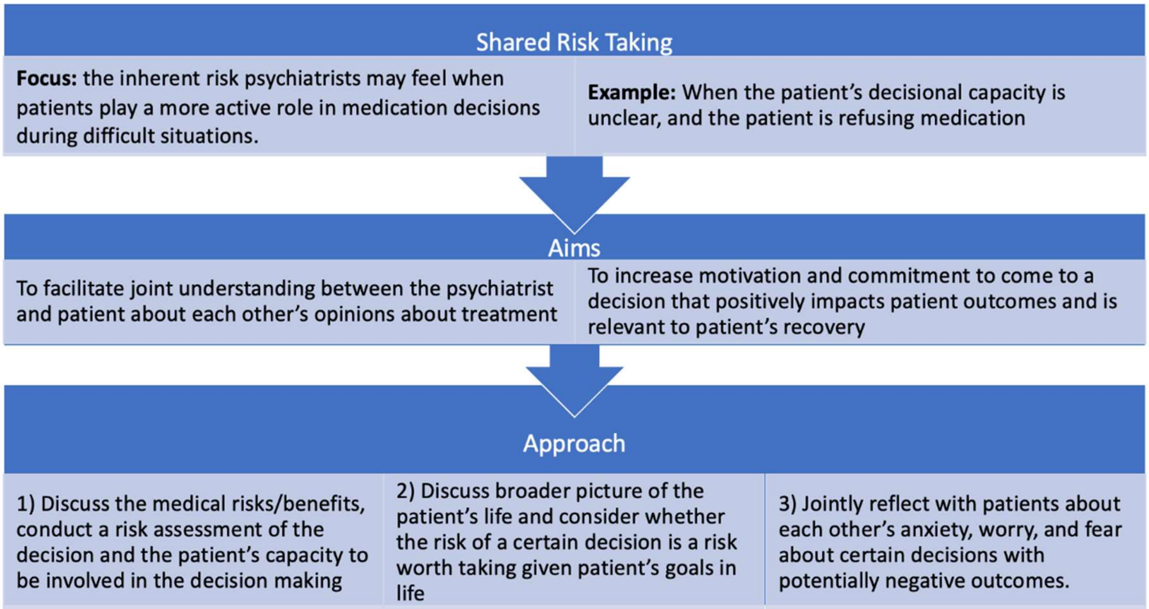
SDM-PLUS Method

Figure 1

Approaches to shared decision making in three prototypical clinical situations



Graphic taken from: Hamann, J., & Heres, S. (2014). Adapting shared decision making for individuals with severe mental illness. *Psychiatr Serv*, *65*(12), 1483-1486.


Shared Risk Taking
Focus: the inherent risk psychiatrists may feel when patients play a more active role in medication decisions during difficult situations.
Example: When the patient's decisional capacity is unclear, and the patient is refusing medication
Aims
To facilitate joint understanding between the psychiatrist and patient about each other's opinions about treatment
To increase motivation and commitment to come to a decision that positively impacts patient outcomes and is relevant to patient's recovery
Approach
1) Discuss the medical risks/benefits, conduct a risk assessment of the decision and the patient's capacity to be involved in the decision making
2) Discuss broader picture of the patient's life and consider whether the risk of a certain decision is a risk worth taking given patient's goals in life
3) Jointly reflect with patients about each other's anxiety, worry, and fear about certain decisions with potentially negative outcomes.

Appendix C

Final Codebook

Code	Definition
Structural Codes by Model: Code in combo with descriptive code to distinguish between models	
SS	Sliding Scale
SP	SDM-PLUS
SRT	Shared Risk Taking
Descriptive Codes	
Barriers	Anytime a barrier is mentioned (specify which model e.g., SRT Barriers), could overlap with dislikes if dislike is also a barrier but primarily used in response to the barriers question (Barrier = something that prevents the unit from being able to implement the model)
Facilitators	Anytime a facilitator is mentioned, particularly in response to the facilitators question). Specify which model (e.g., "SP Facilitator") (Facilitator: something that aids the unit in implementing the model).
Likes	When doctors discuss what they like about the model
Dislikes	When doctors discuss what they dislike about the model (including mentioning they have no dislikes)
Changes	Code anytime a provider suggests any changes or alterations to the model that could/should be made. Specify which model (e.g., "SS Changes"). Also use if they suggest doing something completely different from the model
Applications/Use	Code when doctors discuss doing the model. Any description of when/how/what types of patients they would use this model for (e.g., for patients who disagree with providers), or the purpose of this model. For example, mentioning a model could be used as an educational tool. Sometimes doctors begin with talking about application/use when discussing likes/dislikes. For example, some may mention it is what they already use or for SS, when people discuss issue of surrogate as the term and the application to their own unit (e.g., can't use surrogates) Sometimes in response to how they might do parts of the model on their unit

Improvement	Doctor's response to whether the model would improve patient participation in medication decision making
Comfort	When the doctor discusses how comfortable they would be using this model and why. Specify which model
Preference (SS, SP, SRT, or Mix)	Code when they answer the question about which model they prefer to use and specify what their preference was ("Preference SS"). If they like more than one or a combo use "Preference Mix"
Process Codes	
General Decision-Making Process	
Offering Options	When doctors discuss offering different treatment options to patients, including offering multiple types of meds, the option of no meds, and/or other types of treatments
Consulting the IDT	When doctors mention consulting with IDT about medication decisions
Considering their Role/Patient's Role	When doctors discuss their role in the decision/the patient's role. For example, some doctors may view themselves as the "recommending medical expert" while the patient makes the ultimate decision, others may view themselves as an equal partner in the decision, others may consider themselves as having the final say. Also use this code if they say they are patient-centered. Also use when doctors give their opinion on how involved patients should be in the decision (in an ideal scenario) and their reasoning behind that. Also use code when discussing shared decision making as their general decision-making process.
Relying on Students	When doctors mention the role of residents/med students
How are psychiatrists determining patients' ability to make decisions about medications?	
Defaulting to Autonomy	When doctors mention assuming capacity unless proven otherwise or trying to give as much autonomy as possible until proven otherwise
Considering Patient's History	When doctors mention factoring in patient's history into their ability to participate (e.g., knowing a patient's previous history with medication compliance, patients are admitted to the unit frequently). This does not include simply reviewing the chart to get an idea of the patient's problem before talking with the patient. Can be coded if they mention reviewing the

	chart to see how compliant they have been in the past. Coded when discussing patient compliance/if they are able to participate, not coded if having discussion with patient about what tx has worked in the past.
Considering Symptoms/Diagnosis	When doctors mention differences in patients’ ability to participate based on symptoms, symptom acuity, or diagnosis (things that get in the way of participating)
Patient willingness to engage	When doctors mention considering whether patients want to participate in the treatment decision or not.
Judging Acuity of Decision	When doctors say they consider how acute the decision (i.e., is this an emergency or not? is when determining degree of patient participation.
Considering Mental Health Law/VA Policy	When doctors mention factoring in mental health law (e.g., do they need to file for commitment based on law, voluntary vs. involuntary regulations by state) and VA policy (e.g., policies regarding forced meds) into the decision about patient's decision-making ability/autonomy. Do not code in discussion of the different models (what the term "surrogate" could be used for), only when they are discussing how they involve patients in their own practice.
Four Pillars	Use code when doctors mention considering the patient's level of insight (i.e., understanding and awareness of their illness and what it entails) into determining patient's degree of participation in the decision. When doctors consider whether patients can comprehend treatment options being offered to them and be able to repeat back the pros/cons. When doctors assess patient's ability to communicate their choice effectively/consistently
Considering Patient's Tx Preference/Reasoning	If the doctor's preference and patient's preference don’t align, doctors assess why the patient is choosing a particular treatment and assessing whether the patient's reasoning is acceptable.
Considering Family/Caretaker Involvement	When doctors mention that they use family/caregivers/legal guardians in decisions about medications for certain patients. Do not code when they are referencing the model and not their own practice.
Factoring in Time	Considering whether or not time will solve the problem (e.g., perhaps they just need time, even if they don't have capacity to participate, not being too hasty in providing meds

	immediately, considering capacity in each point in time, factoring in time to make decision about meds - mentioning an amount of time), mentioning use of PRNs that may help over time
Factoring in the type of Tx	When doctors consider the type of medications into the decision of whether the patient can make the final decision (e.g., antidepressants vs. ECT, level of invasiveness, harmful side effects). Also Factoring in whether patients' capacity is limited to a specific tx decision
Versus Codes: Conflicting values that may influence Psychiatrist's Determinations about patients' ability to participate	
Convincing vs. Compromising	when doctors mention trying to convince patients or get them to agree to what the doctor's view is best and/or when they discuss accepting patient's decision/refusal for medications or negotiating to a less ideal tx.
Formal Assessment vs. Clinical Judgement	When doctors mention consulting neuropsych in assessing capacity or when doctors say they don't really have a formal assessment (just use 4 criteria/Applebaum's criteria and clinical judgement)
Stabilization vs. recovery	When doctors make comments related to the overall purpose of the inpatient unit. Some doctors may feel that the overall purpose is to stabilize the patient or to restore capacity and recovery begins once they are outpatient. This should also be coded as the opposite - some doctors may mention recovery as a focus on inpatient. This may also come up in the context of not having enough time to do certain things like understand the patient's reasoning for not taking meds due to the ultimate goal of stabilize and discharge
People have the right to be mentally ill vs. some mental illness is too damaging	When doctors discuss their beliefs about people's autonomy in being mentally ill or the opposite - when doctors mention beliefs about needing to heal people's brains to prevent longer term damage (e.g., psychosis damages the brain therefore we need to break their psychosis as soon as possible). This does not include instance where doctors believe they should immediately treat people who are inherently in danger of hurting themselves/others as this is an ethical obligation and mental health law
Ambiguity vs. Black/White	Discussions around doctors recognizing there are grey areas in determining patients' ability to participate in medication decisions vs. when doctors view ability to participate more as yes/no or In "black and white" terms

Determining informed consent vs. Agreement	Discussion in the transcripts surrounding differences that exist between capacity in medical terms (e.g., capacity to provide informed consent) and the degree to which a person agree/disagrees with "best choice" tx.
Other	Use this code to capture things that are important but not captured by current codes/at the end of the interview if they mention additional things they think are important that we haven’t talked about (e.g., cultural considerations, patient education level)

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Thomas, E. C., Ben-David, S., Treichler, E., Roth, S., Dixon, L. B., Salzer, M., & Zisman-Ilani, Y. (2021). A systematic review of shared decision–making interventions for service users with serious mental illnesses: State of the science and future directions. *Psychiatric Services*, *72*(11), 1288-1300. https://doi.org/10.1176/appi.ps.202000429

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Zisman-Ilani, Y., Barnett, E., Harik, J., Pavlo, A., & O'Connell, M. (2017). Expanding the concept of shared decision making for mental health: systematic search and scoping review of interventions. *Mental Health Review Journal*, *22*(3), 191-213. https://doi.org/10.1108/mhrj-01-2017-0002

Zisman-Ilani, Y., & Byrne, L. (2023). Shared decision making and peer support: New directions for research and practice. *Psychiatric Services*, *74*(4), 427-428.

Zisman-Ilani, Y., Lysaker, P. H., & Hasson-Ohayon, I. (2021a). Shared risk taking: Shared decision making in serious mental illness. *Psychiatr Serv*, *72*(4), 461-463. https://doi.org/10.1176/appi.ps.202000156

Zisman-Ilani, Y., Roth, R. M., & Mistler, L. A. (2021b). Time to support extensive implementation of shared decision making in psychiatry. *JAMA Psychiatry, 78*(2), 133–134. https://doi.org/10.1001/jamapsychiatry.2020.3695

Curriculum Vitae

Emily Logan Bass

Education

August 2025 Indianapolis, IN	**Doctor of Philosophy, Clinical Psychology** Indiana University Chair: Kyle Minor, Ph.D. Dissertation: *Decisional Capacity in Psychiatric Inpatient Settings: Understanding and Addressing Key Barriers to Shared Decision-Making*
August, 2021 Indianapolis, IN	**Master of Science, Clinical Psychology** Purdue University (IUPUI) Chair: Michelle Salyers, Ph.D. Thesis: *The Relationship Between Working Alliance, Patient Activation, Hope, and Depression in Community Mental Health Care*
May 2017 Chapel Hill, NC	**Bachelor of Arts, Psychology; General Anthropology Minor** The University of North Carolina at Chapel Hill Chair: David L. Penn, Ph.D. Honors Thesis: *Client Predictors of the Therapeutic Alliance in Individual Resiliency Training*

Honors, Awards, & Scholarships

2024	North Carolina Psychological Association John Daniel Searcy Fellowship (Total: $5000) Awarded to individuals who have demonstrated superior academic achievement and are committed to a career focused on working with individuals with severe and persistent mental illness (SPMI)
2022-2023	IUPUI Graduate and Professional Education Grant (Total: $1000) Awarded twice to support registration and travel to the annual meeting of the Society for Research in Psychopathology
2019, 2022	IUPUI Clinical Psychology Program Research Funding Award (Total: $1,311). Awarded twice to support registration and travel to the annual meeting of the Society for Research in Psychopathology
2017	Graduated with highest honors in Psychology and Neuroscience

2016-2017	Phi Beta Kappa
2014-2016	Jim and Jane Wells Scholarship Recipient
2014-2017	UNC's Dean's List, College of Arts & Sciences

Membership in Professional Organizations

Society for Research in Psychopathology (SRP)
Associate Member since 2018

North Carolina Psychological Association (NCPA)
Student Member since 2024

Certifications

Certified Metacognitive Reflection and Insight Therapist
The MERIT Institute, Exp. 5/26/2029

Peer-Reviewed Publications

Fan, L., **Bass, E.**, Klein, H., Springfield, C., Vanneste, S., & Pinkham, A. E. (2025). Potential delayed positive effects of tDCS on improving introspective accuracy in social cognition in schizophrenia. *Schizophrenia Bulletin*, sbaf014.

Fukui S., Wu W., Garabrant J., Salyers M., Dell N., **Bass E**., Greenfield, J., Morse, G. (2025). Testing job wellbeing indicators among community behavioral health workers: Community-based participatory research. *PLoS ONE*, *20*(4), e0321351. https://doi.org/10.1371/journal.pone.0321351

Fukui, S., Garabrant, J., Greenfield, J., Salyers, M.P., Morse, G., **Bass, E.** (2025). Using exit surveys to elicit turnover reasons among behavioral health employees for organizational interventions. *Psychiatric Rehabilitation Journal*, https://doi.org/10.1037/prj0000638

Bass, E., Salyers, M., Hall, A., Garabrant, J., Morse, G., Kyere, E., Dell, N., Greenfield, J., Fukui, S. (2024). Why do stayers stay? Perceptions of White and Black long-term employees in a community mental health center. *Administration and Policy in Mental Health Services Research*, 1-18

Russell, M. T., Hajdúk, M., Springfield, C. R., Klein, H. S., **Bass, E. L.**, Mittal, V. A., Williams, T. F., O'Toole, A. J., Pinkham, A. E. (2024). Identity recognition from faces and bodies in schizophrenia spectrum disorders. *Schizophrenia Research: Cognition, 36*, 1-7.

Fukui, S., Wu, W., Greenfield, J., Salyers, M. P., Morse, G., Garabrant, J., **Bass, E.**, Kyere, E., & Dell, N. (2023). Machine learning with human resources data: Predicting turnover among community mental health center employees. *The Journal of Mental Health Policy and Economics*, *26*(2), 63-76.

Bass, E., Garabrant, J., Salyers, M. P., Patterson, S., Iwamasa, G. Y., & McGuire, A. B. (2023). eHealth use on acute inpatient mental health units: Implementation processes, common practices, and barriers to use. *Administration and Policy in Mental Health and Mental Health Services Research*, *50*, 603-615.

Eliacin, J., Carter, J., **Bass, E**., Flanagan, M., Salyers, M. P., & McGuire, A. (2022). Implementation and staff understanding of shared decision-making in the context of recovery-oriented care across US Veterans Health Administration (VHA) inpatient mental healthcare units: a mixed-methods evaluation. *BMJ open*, *12*(5), e057300.

Fan, L., **Bass, E.**, Klein, H., Springfield, C., Pinkham, A. (2022). A preliminary investigation of paranoia variability and its association with social functioning. *Schizophrenia Research: Cognition*, 29, 100258.

Pinkham, A., **Bass, E**., Klein, H., Springfield, C., Kent, J., & Aslan, S. (2022). Inducing paranoia is linked to increased resting amygdala cerebral blood flow in healthy individuals. *Journal of Experimental Psychopathology, 13*(3), 1-10.

McGuire, A., Flanagan, M., Kukla, M., Rollins, A., Myers, L., **Bass, E.,** Garabrant, J., Salyers, M. (2021). Inpatient mental healthcare before and during the COVID-19 pandemic. *Healthcare, 9*(12), 1613.

Fan, L., Klein, H., **Bass, E.**, Springfield, C., Pinkham, A. (2021). Amygdala hyperconnectivity in the paranoid state: A transdiagnostic study. *Journal of Psychiatric Research, 138*, 117.

Springfield, C., Isa. R., **Bass, E**., Vanneste, S., Pinkham, A. (2021). Preliminary evidence for the efficacy of single-session transcranial direct current stimulation to the ventrolateral prefrontal cortex for reducing subclinical paranoia in healthy individuals. *British Journal of Clinical Psychology, 60*(3), 333-338.

Klein, H., Springfield, C., **Bass, E.**, Ludwig, K., Penn, D. L., Harvey, P. D., Pinkham, A. E. (2020). Measuring mentalizing: A comparison of scoring methods for the hinting task. *International Journal of Methods in Psychiatric Research.* https://doi-org.proxy.ulib.uits.iu.edu/10.1002/mpr.1827

Hajdúk, M, Klein, H., **Bass, E**., Springfield, C., Pinkham, A. (2020). Implicit and explicit processing of bodily emotions in schizophrenia. *Cognitive Neuropsychiatry, 25*(2), 139-153.

Klein, H., **Bass, E.**, & Pinkham, A. (2019). F47. Experimentally inducing paranoia in a health population. *Schizophrenia Bulletin*, *45*(Suppl 2), S273. https://doi.org/10.1093/schbul/sbz018.459

Pinkham, A., **Bass, E.,** Klein, H., & Vanneste, S. (2019). O8.7. Stimulating the brain to improve introspective accuracy in schizophrenia. *Schizophrenia Bulletin, 45*(Suppl 2), S185–S186. https://doi.org/10.1093/schbul/sbz021.239

Browne, J., **Bass, E.**, Mueser, K. T., Meyer-Kalos, P., Gottlieb, J.D., Estroff, S. E., & Penn, D. L. (2019). Client predictors of the therapeutic alliance in Individual Resiliency Training for first episode psychosis. *Schizophrenia Research, 204*, 375-380.

Presentations

Bass, E., Salyers, M., Minor, K., Hirsh, A., McGuire, A. (September, 2023). *Shared decision-making in psychiatric inpatient care: A scoping review*. [Poster presentation]. 2023 Society for Research in Psychopathology, St. Louis, MO.

Bass, E. Salyers, M., Minor, K., Rand, K. (September, 2022). *The relationship between working alliance, patient activation, hope, and depression in community mental health care.* [Poster presentation]. 2022 Society for Research in Psychopathology, Philadelphia, PA.

Bass, E. (August, 2022). *Why do stayers stay? A qualitative analysis of long-term employees in a community mental health center.* [Oral presentation]. 2022 Washentaw Opioid Summit (virtual). https://www.whiopioidproject.org/video-library

Salyers M., & **Bass E.** (August, 2022). *Inpatient care and the road to recovery: Retooling station, pitstop, or a wrong turn?* [Oral presentation]. Southeast Mental Health Technology Transfer Center (MHTTC, virtual).

Bass, E., Wu, W., Kyere, E., Dell, N., & Fukui, S. (August, 2022). *Why do stayers stay? A qualitative analysis of long-term employees in a community mental health center - Strengthening a diverse mental health workforce symposium* [Oral presentation]. NIH's 25th National Conference on Mental Health Services Research (MHSR) (virtual). https://www.youtube.com/watch?v=S6rr8YTLIS4

Bass, E., Klein, H., Pinkham, A. (September 2019). *Stability in paranoia across time and the effect on social functioning.* [Poster presentation]. 2019 Society for Research in Psychopathology, Buffalo, NY.

Bass, E., Klein, H., Springfield, C., & Pinkham, A. (September 2018). *Effects of transcranial direct current stimulation (tDCS) to the ventral lateral prefrontal* *cortex in sub-clinical paranoia.* [Poster presentation]. 2018 Society for Research in Psychopathology, Indianapolis, IN.

Bass, E., Browne, J., Merritt, C. C., Gragson, A., & Garrison, B. (November 2017). *Client predictors of the therapeutic alliance in Individual Resiliency Training*. [Poster presentation]. 51st annual convention of the Association for Behavioral and Cognitive Therapies, San Diego, CA.

Bass, E., Browne, J., & Penn, D. L. (April 2017) *Client predictors of the therapeutic alliance in Individual Resiliency Training.* [Poster presentation]. 2017 Celebration of Undergraduate Research at the University of North Carolina – Chapel Hill, Chapel Hill, NC.

Research Experience

Fall 2020- Summer 2023	**Graduate Research Assistant** IU School of Social Work Study: *Developing a Data-Driven Management System Using Machine Learning and Mixed-Methods Research to Predict Job Turnover Among Mental Health Professional (NIMH - R34)* Supervisor/Principle Investigator: Sadaaki Fukui, Ph.D., MSW
Spring 2020- Summer 2022	**Graduate Research Assistant** Health Services Research & Development (HSR&D) Richard L. Roudebush Veteran's Affairs Medical Center Supervisor: Alan B. McGuire, Ph.D., HSPP
Fall 2021- Spring 2022	**Graduate Research Assistant** IUPUI department of Clinical Psychology and Sandra Eskenazi Mental Health Center, Adult Outpatient Program Study: *Goal Elicitation, Treatment Prioritization, & Electronically-Practiced Discussion (GET PrEPD) for Psychiatric Care* Principle Investigators: Michelle Salyers, Ph.D., Adam Hirsh, Ph.D.
Summer 2021- Fall 2021	**Graduate Research Assistant** IUPUI Department of Clinical Psychology and the Ezkenazi Health Prevention and Recovery Center for the Early Psychosis (PARC) Study: *Nutritional Enhancement in Early Psychosis (NEEP): Feasibility trial of enhanced nutrition messaging and a dietary tracking mobile application* Principle Investigator: Michelle Salyers, Ph.D.

Supervisor: Melanie Fischer, Ph.D.

Summer 2017- Summer 2019	**Post-Bac, Full-Time Research Assistant** The Schizophrenia and Social Cognition Lab Dept. of Brain and Behavioral Science, University of Texas at Dallas Supervisor: Amy Pinkham, Ph.D.
Spring 2015- Summer 2017	**Undergraduate Research Assistant** The Penn Lab Dept. of Psychology and Neuroscience at University of North Carolina – Chapel Hill Supervisor: David Penn, Ph.D.

Clinical Experience

July 2024- Present	**Psychology Internship** Internship Director: Dr. Jay Gregg, Ph.D. Rotations: Trauma Recovery Program (TRP; Supervisor: Dr. C. Beth Ready); Psychosocial Rehabilitation and Recovery Center (PRRC; Supervisor: Dr. C. Sloan Alday); Substance Use Disorder Clinic (Supervisor: Dr. Sam Peter); GMH-Raleigh (Supervisor: Dr. Pallavi Aurora) Durham VA Medical Center
June 2023- May 2024	**Psychology Practicum Student** Psychosocial Rehabilitation and Recovery Center (PRRC) Richard L. Roudebush Veteran's Affairs Medical Center Supervisor(s): Paul Lysaker, Ph.D., HSPP (June-July 2023); Marina Kukla, Ph.D., HSPP (July 2023-May 2024)
June 2022- July 2023	**Neuropsychology Practicum Student** Indiana Neuropsychology Group (formerly known as Neuropsychology Associates) Supervisor: Summer Ibarra, Ph.D., ABPP-RP, HSPP
August 2021- June 2022	**Psychology Practicum Student** Acute Mental Health Inpatient Unit (5 East) Richard L. Roudebush Veteran's Affairs Medical Center Supervisor: Sarah Horine, Psy.D., HSPP
May 2021- March 2022	**Trial Therapist** Sandra Eskenazi Mental Health Center, Adult Outpatient Program

	<u>Study</u>: *Goal Elicitation, Treatment Prioritization, & Electronically-Practiced Discussion (GET PrEPD) for Psychiatric Care* <u>Principle Investigators:</u> Michelle Salyers, Ph.D., Adam Hirsh, Ph.D. <u>Intervention Supervisor</u>: Kevin Rand, PhD, HSPP
August 2020- May 2021	**Psychology Practicum Student** IU Health Primary Care and Sports Medicine – Artistry <u>Supervisor</u>: Shelley Johns, Psy.D., HSPP, ABPP
2016	**Undergraduate Role-Play Volunteer** OASIS Clinic, UNC-Chapel Hill Department of Psychiatry <u>Supervisor:</u> David Penn, Ph.D.

Teaching Experience

Spring 2022	**Teaching Assistant** I643/681 Field Methods and Experimentation
Fall 2019 and Fall 2022	**Instructor of Record** B312: Research Methods in Psychology Laboratory
Summer 2020	**Teaching Assistant** B310: Life Span Development
Spring 2020	**Teaching Assistant** B433: Capstone Laboratory in Psychology; Course Theme: Serious Mental Illness

Specialized Trainings

2024	Durham VA Prolonged Exposure Training (4 days), Dr. Kelly Caron, Ph.D., Dr. Kate Berlin, Ph.D., Durham VA Medical Center
2024	Durham VA DBT Virtual DBT Training (2 days), Dr. Beth Ready, Ph.D., Dr. Melanie Roys, Ph.D., Dr. Jessica Kinsaul, Ph.D., Durham VA Medical Center
2024	Durham VA Virtual CPT Training (2 days), Dr. Carolina Clancy, PhD, Dr. Sara Tiegreen, Ph.D., Durham VA Medical Center

2023	Introduction to Metacognitive Reflection and Insight Therapy (MERIT) (1 day), Dr. Bethany Leonhardt, Psy.D., HSPP; Dr. Jacqueline F. Abate, Psy.D., HSPP; Dr. Jay Hamm, Psy.D., HSPP; Dr. Marina Kukla, Ph.D., HSPP, Eskenazi Health and Richard L. Roudebush Veteran's Affairs Medical Center
2023	Introduction to Dialectical Behavior Therapy (1 day) Workshop, Dr. Tamika C. B. Zapolski, Ph.D., IUPUI Department of Psychology/IU School of Medicine, Department of Psychiatry
2023	Structured Interview for Psychosis-risk Syndromes (SIPS) Rater Certification Training Workshop (2 days), Dr. Barbara Walsh, Ph.D., Yale University
2022	Increasing Therapist Wellbeing and Reducing Burnout Workshop, Dr. Gary Morse, Ph.D.
2021	Working with Suicidal People (2 days), Dr. Thomas E. Ellis, Psy.D., ABPP, Baylor College of Medicine
2021	Systematic Reviewing & Meta-Analysis with R (4 days), Dr. Ekin Secinti, Ph.D., Indiana University – Purdue University Indianapolis
2020	Multi-cultural Seminar: Spiritual and Religious Competency in Mental Health (6 sessions), Indiana University Purdue University- Indianapolis
2019	Categorical & Survival Data Analysis Workshop (1 day), Dr. Jaehoon Lee, Ph.D. Texas Tech University