Theory and behaviour change techniques (BCTs) for SDM interventions in child and youth mental health

Daniel Hayes[1,2], Rosa Town[1], Julian Edbrooke-Childs[1], Miranda Wolpert[1], Nick Midgley[2]

[1]Evidence Based Practice Unit: Anna Freud National Centre for Children and Families and University College London

[2]Child Attachment and Psychological Therapies Research Unit, University College London

Correspondence: daniel.hayes@annafreud.org

Background:

- The application of shared decision making to child and youth health is relatively new. A scoping review identified a number of approaches being used to facilitate shared decision making (SDM)[1]. However, these approaches showed mixed results on outcomes.
- Behaviour change techniques (BCTs) are the active components of an intervention designed to change behaviour[2]. These have yet to be investigated in child and youth mental health.
- Applying appropriate theory is recommended when designing interventions[3].
- Previous research suggests a lack of theory used when designing SDM interventions in other healthcare settings[4].

Aim:

1) What behaviour change theories and/or frameworks are being used for SDM in child and youth mental health?
2) Are there certain BCTs associated with better outcomes when using SDM in child and youth mental health?

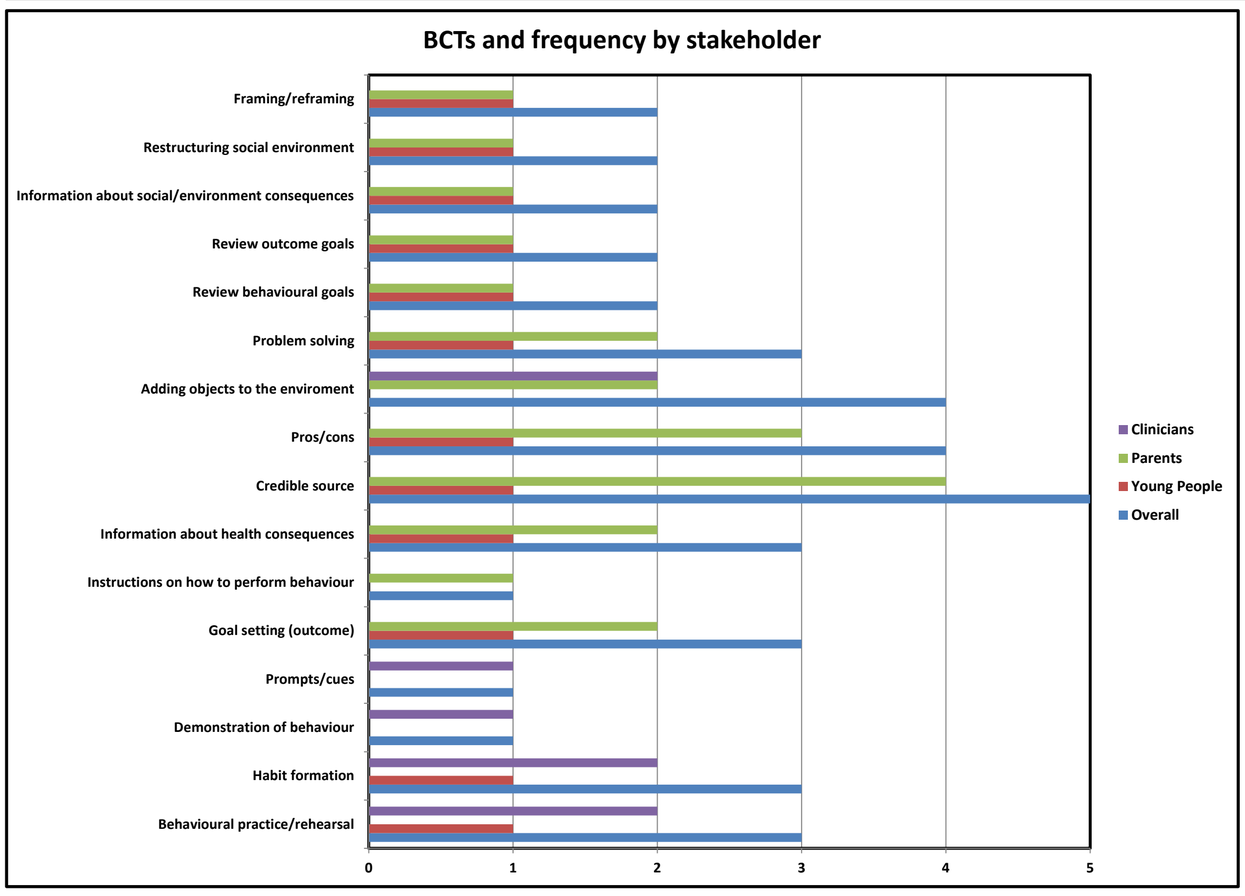
Method:

Inclusion criteria

Studies that 1) described an SDM approach, 2) took place in child and youth mental health, 3) included parents or young people, 4) included a comparison group to examine effectiveness, 5) included a measure of SDM, involvement or participation, and 6) had at least one outcome measure.

Data was independently extracted by two researchers.

Results:



Five studies met inclusion criteria. Three were aimed for parents[5,6,7], one for young people and parents[8], and one for young people only[9].

BCTs

Sixteen different BCTs were used across interventions. These ranged from one to nine BCTs per intervention with a mean of 4.80 (SD = 3.35) BCTs. Overall, the most frequent BCT was "credible source". This was followed by "adding objects to the environment" and then "pros/cons".

BCTs and outcome

Only two of the studies had common metrics which could be compared; these were: if a prescription was written for ADHD and parent decisional conflict (DC).

For DC, contradictory results were found in two studies, with one study showing a significant decrease in DC and another showing no difference[6,7]. The study that demonstrated a significant decrease in DC[7] employed the BCTs "behavioural practice and rehearsal" and "habit formation" with clinicians, and "problem solving" with parents. These BCTs could have been directly related to this decrease as they were not employed in the other study.

For ADHD prescriptions written, contradictory results were also found in two studies[6,8]. The same BCTs described above were employed with clinicians. For parents and young people, the BCTs "problem solving", "reviewing goals (behaviour and outcome)", "information about social consequences", "restructuring social environment" and "framing/reframing" were employed only in the study which showed an increase in ADHD prescriptions written.

Theory used when designing interventions:

Three of the five studies did not use any explicit behaviour change theory. One[6] reported using the International Patient Decision Aid Standards, and the other[7] used the Ottawa Decision Support Framework.

Implications:

- The small number of high quality rigorous studies, combined with the different populations and outcome measures, means no firm conclusions can be drawn on which BCTs may lead to better outcomes.
- There is a lack of theory being used when designing SDM interventions. This may be due to developers not knowing which to choose[2] or the gap between theory and practice[10].

References:

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