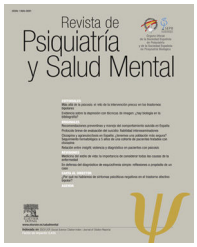
Rev Psiquiatr Salud Ment (Barc.). 2017;10(3):179–181

Revista de Psiquiatría y Salud Mental

www.elsevier.es/saludmental



LETTERS TO THE EDITOR

Person centered-care and recovery: Could it be used for obtaining a humanized health care?☆

Person centered-care y *recovery*: ¿pueden servir para alcanzar una asistencia sanitaria más humana?

Dear Editor,

Modern psychiatry seems to focus more on objective data than it does on patient experiences and circumstances. Sometimes it centres on symptoms, forgetting that we are dealing with people who have problems. This is why there is a constant demand for a paradigm shift from ''patient'' to ''person''. The aim is not to ignore or discredit the reductionist biomedical model, but rather to include additional areas to better understand individuals who have mental health problems. We will analyse 2 concepts; person centred care and recovery.

Thus due to this demand for a change of paradigm, approaches that centre on the individual are now wanted, in the form of person centred-care, thereby emphasising the needs and desires of the person more than medical or clinical questions. Although this concept is hard to define, and it is complicated to specify which variables it should cover, some authors have tried to delimit and define it so that it can be included in medical praxis[1–3] and even in the field of mental health. Certain fundamentals have been suggested for this.[4]

1. It has to be a multidimensional construct.
2. It has to be person-focussed.
3. It has to be controlled by the person him- or herself, so that informed consent is indispensible for any clinical act.
4. The person must have the right to decide beforehand in questions about their health.
5. This has to be seen as an approach which is contextualised in a personal history and circumstances.

A good example of its applicability, with good clinical results, can be found in people with dementia, as is the case for the *VIPS* model–values, individualised, perspective and social–proposed by Brooker[5]:

- Values that claim the absolute value of all human lives.
- An individualised approach that recognises personal singularity.
- Interpreting the world from the person's point of view.
- Providing a social framework that satisfies psychological needs.

Nevertheless, we should know that if we centre our attention on the person, we have to reflect on the nature of the final aim of psychiatric praxis, given that biomedical variables are now not the only factors to be taken into account, as also and very importantly the patient's desires and values, etc. in connection with their clinical situation have to be taken into account. This will allow us to respect the person more and understand the situation better.

Given that some patients with mental disorders have multiple pathologies and that they are vulnerable and dependent people with biological, psychological and social needs, with limited functioning (difficulties in their everyday life and interpersonal relationships, etc.), it may be worthwhile to include the concept of recovery in care plans, to consider what these patients appreciate the most.[6] The aim is therefore to discover and appreciate how people with mental diseases understand life, as they have to live with their own disease.[7]

Leamy et al.[6] proposed a theoretical–practical framework that covers this concept and expresses it in 5 categories: 1) satisfaction (in interpersonal relationships and their role in the community); 2) hope and optimism about the future; 3) identity (reconstruction of the self and overcoming stigma); 4) meaning in their life (quality of life and roles, etc.), and 5) empowerment.

All of these components express the demand that we centre more on personal re-insertion and self-esteem than we do on simply reducing psychiatric symptoms. We have to ensure they have a good quality life that is worth living, in which their treatment will be based on their personal values. It has to be said that to gain greater knowledge of this concept it is necessary to ask the patients themselves what they understand by *recovery*.[8] This may occur by adopting person-centred models, by reaching shared decisions[9] or even by patients expressing their decisions about any health-related matter in advance.[10]

☆ Please cite this article as: Ramos Pozón S. *Person centered-care* y *recovery*: ¿pueden servir para alcanzar una asistencia sanitaria más humana? Rev Psiquiatr Salud Ment (Barc). 2017;10:179–180.

This is therefore about aspiring to more humane and higher quality healthcare, basing ourselves on ethical questions too which guide the treatment process. While including biomedical questions, it will not forget personal values and wishes. It will cure–or try to cure–individuals, but will also care for them.

References

1. Jakovljević M, Ostojić L. Person-centered medicine and good clinical practice: disease has to be cured, but the patient has to be healed. Psychiatr Danub. 2015;27 Suppl. 2:S546–9.
2. Lusk J, Fater K. A concept analysis of patient-centered care. Nurs Forum. 2013;48:89–98.
3. The American Geriatrics Society Expert Panel on Person-Centered Care. Person-centered care: a definition and essential elements. J Am Geriatr Soc. 2016;64:15–8.
4. Rudnick A, David R. Foundations and ethics of person-centered approaches to serious mental illness. In: Rudnick A, Roe D, editors. Serious mental illness: person-centered approaches. London: Radcliffe Publishing; 2011. p. 8–18.
5. Brooker D. Atención centrada en la persona con demencia. Mejorando recursos. Barcelona: Ediciones Octaedro; 2013.
6. Leamy M, Bird V, Boutillier C, Williams J, Slade M. Conceptual framework for personal recovery in mental health: systematic review and narrative synthesis. Br J Psychiatry. 2011;199:445–52.
7. Turner J, Wallcraft J. The recovery vision for mental health services and research: a British perspective. Psychiatr Rehabil J. 2002;25:245–54.
8. Drake R, Whitley R. Recovery and severe mental illness: description and analysis. Can J Psychiatry. 2014;59:236–42.
9. Ramos S. Las decisiones compartidas en salud mental: mitos, barreras y beneficios. Rev Psiquiatr Salud Ment. 2016;9:175–6.
10. Ramos S. Las voluntades anticipadas en salud mental: hechos y valores. Rev Psiquiatr Salud Ment. 2015;8:244–5.

Sergio Ramos Pozón

Departamento de Filología Hispánica, Facultad de Filología, Universidad de Barcelona, Barcelona, Spain
E-mail address: sergioramos@ub.edu

2173-5050/
© 2017 SEP y SEPB. Published by Elsevier España, S.L.U. All rights reserved.

Assessment of decision-making capacity for research participation: When, how and why to do it☆

Valoración de la capacidad de toma de decisiones en investigación: cuándo, cómo y por qué realizarla

Dear Editor,

Informed consent (IC) in research is the process by means of which an individual, in a free and informed manner, takes the decision whether or not to take part in a study. For the consent to be valid the subject must have the capacity to take the decision, receive sufficient information adapted to their level of comprehension and take the decision voluntarily. National and international law states that IC is a basic requisite and guarantee for the exercise of independence in personal decision-making and to protect vulnerable subjects who may require special guarantees to protect their rights.[1] There are no clear guidelines in Spain about who should evaluate the decision-making capacity of patients or how any such evaluation should take place. Spanish laws on IC for biomedical research cover decision-making capacity and indicate the situations in which this is limited, without specifying how it should be evaluated.[2] The law underlines the need to justify the inclusion of ''vulnerable populations'' in research studies, without clearly specifying who they are.[3] Although there are populations that could potentially be considered to be vulnerable because their decision-making capacity varies during the course of their disease, the difference between vulnerable populations and non-vulnerable ones is not clear. Most research has centred on individuals with mental or cognitive pathology without reaching conclusive results.[4] According to several studies up to 5%–10% of individuals without a psychiatric or cognitive disorder may have a restricted decision-making capacity, and within the population with a mental disorder there is a high level of heterogeneity in their levels of decision-making capacity.[5]

These questions should be weighed up to prevent the inappropriate recruitment of individuals in high risk clinical trials, when they do not properly understand the nature of the procedures they are consenting to. On the other hand, there is also a risk of assuming that the decision-making capacity of certain patients is always reduced due to their diagnosis. This may has major consequences in limiting research into their diseases and it would be a stereotyped way of considering their decision-making capacity.

Another point is that the growing importance of regulatory procedures, together with increasingly complex research techniques, has led to longer and longer IC documents which are often very technical and hard to understand. The available bibliography suggests that a percentage of possible participants in research lack a suitable level of decision-making capacity, and that even those who do have such capacity will not comprehend the information contained in an IC as well as would be desirable.[4]

These difficulties emphasize the need to individually evaluate individuals' decision-making capacity. Over the past 20 years and due to the interest in this subject, several instruments have been developed to evaluate capacity to take part in research.[6] There is broad agreement on

☆ Please cite this article as: Morán Sánchez I, Luna A, Pérez Cárceles MD. Valoración de la capacidad de toma de decisiones en investigación: cuándo, cómo y por qué realizarla. Rev Psiquiatr Salud Ment (Barc). 2017;10:180–181.