

Towards preference-based and person-centered child and adolescent psychiatric service provision

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Perceptions of high quality service provision in child and adolescent mental health are changing. A recent editorial in the *British Medical Journal* (BMJ) called for high integrity health care (1) through challenging conventional assumptions regarding service provision, arguing that: (i) more services will not necessarily result in more health, (ii) evidence alone should not determine treatment, and (iii) optimal health care must include non-health professionals (1). As a response, Wolpert and colleagues (2), in an intriguing paper published earlier this year in BMJ, extended this line of non-conventional thinking about improvements of service provision to the field of mental health services for children and adolescents more specifically. In brief, they argue that our field should change from being led by professionals who focus primarily on problems (or diagnoses) towards person-centered care focused on progress and service user preferences.

Whilst we are sympathetic towards the evidence and arguments supporting this “new way” of thinking (or re-thinking) about child and adolescent mental health care services, we also would stress that though it might be non-conventional to the extent that it runs contrary to current traditional thinking about service provision, it is not entirely new. Indeed, many of these ideas are also more or less explicitly contained within the World Psychiatric Association’s Institutional Program on Psychiatry for the Person (also called Person-Centered Psychiatry) (3-4), the American Psychological Association’s program on Evidence-Based Practice in Psychology (5), Evidence-Based Medicine (6), as well as in recovery, empowerment and resilience focused movements (7-8).

Overall, we believe that a change of the provision of child and adolescent mental health care services towards a more person-centered and preference-based model is indicated. That said, ideas and movements, be they unconventional or ahead of

their time, are also always a product of the time and context in which they evolved and were formulated. Historically, the freedom of the individual combined with disbelief in institutionalized sanctioned authority has been steadfastly growing at least from medieval times and onwards (9-10). More recently, the fall of the Nazi regime in World War II spurred widespread research on the authoritarian personality and also ignited even more widespread disbelief in authority (11-12). In general, historically we seem to have moved towards more and more disbelief in institutionalized authority and focusing more and more on the individual and his/her own choices/preferences.

Perhaps somewhat ironically, despite this general trend towards heightened individualism and disbelief in socially sanctioned authority, many of us, including politicians and decision makers, have remained committed to an evidence-based paradigm for service delivery and development. No doubt, we agree that service delivery and developments within our field ought to be evidence-based. Yet, the fact remains that the available evidence (for example Cochrane reviews and NICE guidelines) to guide service provisions and interventions in child and adolescent psychiatry and psychology remains scarce, leaving little actual evidence to guide clinical practice and service developments (2, 13). As Wolpert and colleagues emphasize, “Supporting shared decision making is imperative when the best approach is uncertain or untested, as is the case for much of child mental health input” (2).

Currently, much of child and adolescent psychiatry is dominated by biological psychiatry. However, before the rise of biological psychiatry, attachment and family factors were viewed as the most important components in the theoretical foundations of child and adolescent psychiatry. Biological psychiatry is common in Scandinavia, but the focus on psychological processes (or the child behind the

diagnosis) is returning (14). In our region of Denmark, for example, the whole department of child and adolescent psychiatry has decided that mentalization-based theory (15-18) is the common frame of reference across all clinics, providing them with a shared theory, language, and generic model for approaching the children and families under their care. Mentalizing is a social cognitive construct referring to the very core human capacity of being able and inclined to interpret and understand one's own and others' minds (19). To quote the founders of mentalization-based treatment (MBT), Bateman and Fonagy, mentalizing can be defined as "our ability to attend to mental states in ourselves and in others as we attempt to understand our own actions and those of others on the basis of intentional mental states" (p. xv) (20).

Shared decision making is important because it allows for the children and adolescents to become more involved in their own treatment, for example through negotiating choice of treatment and its goals. Couched in the language of psychotherapy research, we could say that preference-based service and shared decision making most probably allow for a better treatment or working alliance, which has been found to be a very robust and global predictor of psychotherapy outcomes (21-23). Of course, shared decision making is by no means an easy task, not only due to the developmental age and cognitive capacities of the children accessing our services, but also because it requires clinicians to change their general approach to meeting their patients. To help the children and young people in making choices regarding their treatment, various web-based resources and apps have recently been developed (2). However, when it comes to actual clinical practice and negotiating shared decision-making, most of it will first and foremost rely on the clinician's ability to mentalize – to mind and keep in mind the mind or subjectivity of the child and their parents. As we see it, one of the biggest threats to implementation of shared decision-making and a mentalizing approach is the traditional and conservative expert role of the clinicians. Of course, clinicians have experience and a privileged insight into the available evidence. Nevertheless, whether or not there may be good evidence for various treatment choices, clinicians need to engage in shared decision-making, and take a humble and curious stance (a mentalizing stance) when dealing with the patients and families, always keeping the whole person in mind (17).

Challenging as it may be for clinicians to relinquish some of their authority — or perhaps more accurately, to share some of the responsibility for

treatment choice and goals with their patients — we would conjecture that it will have the favorable outcome of enhancing treatment alliance and adherence through stimulating agency (sense of subjectivity and self-efficacy) on behalf of the children and adolescents. Seeing the person behind the problem or diagnosis is much more than a slogan. Basically, it means meeting our patients as persons, recognizing their subjectivity and affirming it in every stage of treatment. This again rests first and foremost on the clinician's ability to mentalize, and keep on mentalizing even amidst emotional turmoil, in times of crisis or when the children and their caregivers appear dismissive. Children and young people presenting to psychiatric services, more often than not, have had their mind undermined through various forms of developmental trauma and neglect, including negative experiences in various contexts (e.g. schools) and in their peer groups (24). Hence, they are often not used to being mentalized by other minds, nor have they had many positive experiences with being so. Still the clinician must adopt a mentalizing stance from the outset, and stimulate the mentalizing capacities of the child and their family throughout the entire treatment process and in the shared decision-making.

To conclude, we wish to note that a shift towards preference-based and person-centered treatment in child and adolescent psychiatry can be seen as bringing the "psyche" back into our field (25). Though there certainly is a place for biological research and treatment in child and adolescent psychiatry together with evidence-based practice, in the "real world" of the clinics we do not primarily deal with brains, abstract cases or diagnoses, but rather try to mentalize and help real persons based on their experience of their own life, health, problems and situations.

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