Person-Centered Planning in Mental Health: A Transatlantic Collaboration to Tackle Implementation Barriers

Collaborative, person-centered approaches to care planning are increasingly recognized as instrumental in supporting attainment of personal recovery outcomes. Yet, while much is known about factors which support person-centered planning, successful implementation often remains an elusive goal. This paper reviews international efforts to promote Person-Centered Care Planning (PCCP) in the context of a randomized clinical trial in the United States and in the "Meaningful and Measurable" initiative, a collaborative action research project involving diverse provider organizations in Scotland. The authors review the history of international efforts to implement PCCP and offer preliminary evidence regarding its positive impact on both process outcomes (i.e., the nature of the primary therapeutic relationship and the service-user's experience) and personal recovery outcomes (e.g., quality of life, community belonging, and valued roles). PCCP will be defined through description of key principles and practices as they relate to both relational aspects (i.e., shifts in stakeholder roles and conversations) and documentation/recording aspects (i.e., how person-centered relationships are captured in written or electronic records). Similarities and differences across the US and Scottish experience of person-centered care planning will be highlighted and a series of recommendations offered to further implementation of this essential recovery-oriented practice.

Key words: person-centered care, person-centered planning, recovery, mental health, outcomes

Introduction

For some time now collaborative and person-centered approaches to care planning have been recognized as instrumental in supporting attainment of personal outcomes for all people receiving care including people with severe mental illnesses. Person-centered care matters because when people are actively involved in their care, they have improved clinical outcomes, which include being less likely to use emergency hospital services (de Silva 2011), being better able to manage complex chronic conditions, seeking appropriate assistance, having reduced anxiety and stress and having shorter lengths of stay in hospital (Balik et al., 2011). People are also more likely to adhere to their treatment plans and choose less invasive and costly treatments if they receive person-centered care (De Silva 2012, Stanhope et al 2013).

To put this concept in historical context, at the turn of this century, person-centered care was included as one of the six aims of general healthcare quality established by the U.S Institute of Medicine, who defined it as "providing care that is respectful of and responsive to individual patient preferences, needs, and cultural values and ensuring that patient values guide all clinical decisions" (IOM, 2001 p6). The six principles are intended to promote quality across health services and emphasize that quality care should be safe, timely, person-centered, effective, efficient and equitable. While the person-centered dimension has been increasingly promoted in health and social care services for many years, there is still no universally agreed definition (de Silva 2014, 2). This is perhaps unsurprising, given that being person-centered means being able to adapt to the circumstances and priorities of each individual, rather than viewing people as subjects of medical treatment in the context of services. Therefore, it could be argued that the quest is to agree on shared principles about ways of being with people, rather than producing standardized guidelines for universal application.

One example of an approach which does seek to promote a set of principles comes from the Health Foundation, a third sector organization in the UK committed to promoting improved health care. Instead of offering a concise but inevitably limited definition, the Health Foundation has identified a framework comprising four principles of person-centered care:

- Affording people dignity, compassion and respect.
- Offering coordinated care, support or treatment.
- Offering personalized care, support or treatment.
- Supporting people to recognize and develop their own strengths and abilities to enable them to live an independent and fulfilling life
  (Health Foundation 2014, 6)

While all of these principles are important, and should be viewed in tandem, the final enabling principle in this list is of particular importance and raises specific challenges which will be discussed in further detail below. The enabling principle also moves beyond the ethical rationale for person-centered practice. Other benefits include improving the sustainability of services. As identified in the opening paragraph, it is through supporting people to become active agents in their own care and lives that opportunities for a good quality of life improve and they become less reliant on services.

In an effort to advance understanding of the key principles and practice of person-centered programs in the context of mental health, international partners from Europe and the USA have been brought together through an EU funded (Horizon 2020) project entitled Citizenship, Recovery and Inclusive Society Partnership (CRISP). Collaborators from Scotland and the U.S. found significant parallels in the challenges encountered in person-centered planning implementation, and recognized potential for mutual learning around implementation strategies and continuing research. This paper provides an overview of the evolution of Person-Centered Care Planning (PCCP) within the U.S and the U.K. with emphasis on Scotland, and presents tools and approaches to overcoming implementation challenges while considering continuing barriers to be addressed.

Person-centered Care, Mental Health and Recovery

Alongside challenges faced by people with physical illnesses, many people using psychiatric services experience additional barriers. Building on the Quality Chasm report of 2001, the Institute of Medicine (2006) produced a report describing a strategy for ensuring that individual preferences and values could prevail in the face of stigma, discrimination, and treatment coercion in psychiatric services. It is against this background that the concept of recovery in mental health has increasingly come to mean a life beyond mental illness (le Boutillier 2015). In the US, the voices of the recovery movement were formally recognized in 2003 when the Freedom Commission declared that recovery be integrated into all aspects of mental health policy (DHHS, 2003). Person-centeredness was included as a fundamental component of recovery as defined by the United States Substance Abuse and Mental Health Services Administration (SAMSHA). While recovery oriented policy has the longest established history in the US, it began to feature in drug policies in Scotland in 2008, soon followed by similar developments in the rest of the UK (Humphreys and Lembke 2013). It is suggested that the first UK policy action to fund recovery may have been the awarding of a grant from the National Treatment Agency for Substance Misuse (NTA) to expand the SMART Recovery organisation in 2008 (Humphreys and Lembke 2013).

However, as person-centered care has to varying extents been embraced at policy level, the complex realities of translation into practice in systems of care underpinned by a biomedical view of health, with associated financial and legal constraints, have also

become apparent. Although in the U.S. the President's New Freedom Commission Report (2003) stated that customized plans should be developed in full partnership with people, funding systems can present barriers. The majority of services for people with severe mental illnesses are funded by Medicaid, which requires that all services meet "medical necessity" criteria. The documentation of care, particularly the need to demonstrate "medical necessity" often leads practitioners to view the collection of information as an administrative rather than a person-centered process. As funds diminish and health care reform drives increased accountability tied to measured outcomes, this creates constant tension with simultaneous mandates for individualized flexible person-centered care (Clossey et al., 2013).

Meantime in the UK, evidence shows that while staff identify with the notion of recovery, its implementation in practice is patchy, at least partly due to competing priorities within and between different layers of the health system. While the nationalized health care system is not subject to the same pressures to seek reimbursement, the health infrastructure is still shaped by traditional forces. The focus on hierarchy, clinical tasks, professional language, medicalization and psychiatric power, all present barriers to a life beyond mental illness (le Boutillier et al 2015).

Despite system based barriers to recovery-oriented person-centred planning, there have been instances of progress in both the US and UK, and the focus here is to explore supportive factors whilst acknowledging the need to address longstanding challenges.

Person-Centred Care Planning (PCCP)

The broader philosophy and principles of person-centered *care* inform new ways in which practitioners and persons with mental illnesses can partner in the practice of person-centered care *planning.* PCCP has been defined as an ongoing process of collaboration between an individual and his or her care team members (including their own community based or natural supports) that results in the co-creation of an action plan to assist the person in achieving his or her unique goals. Rather than viewing people as consumers of health and social care, they are involved as co-producers of collaborative plans (Epstein and Street 2011, Tondora et al 2014), where decision-making is shared between providers, people in recovery and their families. This is especially important for individuals from diverse cultural backgrounds who value family involvement.

In mental health contexts, tailoring service planning to people's personal life goals, or personal outcomes, has emerged as a recovery-oriented practice (Adams & Greider 2014, Tondora et al 2014). Engaging people in care that is relevant and responsive to their life goals improves the chances that they will adhere to and benefit from treatment. However, such decision-making can be challenging for people who may have had limited control over their lives. Active engagement in support planning can help people develop the confidence and skills needed to re-establish identity and regain a sense of control (Adam & Greider 2014, Tondora et al 2014). In some cases, a person's experience of symptoms may interfere with their ability to engage and make informed choices, but often, capacity to engage in shared-decision making is questioned even when they do not (Beitinger et al 2014, Ehrlich et al 2017). Thus, what may appear, at first, to be a lack of motivation, may be discomfort with the significant role shift for individuals who have been socialized into a passive role within health and care systems.

Promoting recovery for people experiencing mental ill health also requires tackling the discrimination and stigma identified by the Institute of Medicine. If individuals with serious mental illnesses are first and foremost people, then it follows that PCCP

principles should be the same for everyone. A focus on valued goals or outcomes in such plans offers opportunities to promote person-centered practice, while also generating possibilities for tracking or measuring outcomes for individuals and services over time.

The Effectiveness and Measurement of Person-Centered Care Planning

Early findings on PCCP in the United States emerged from the field of developmental disabilities, whereby PCCP led to increased articulation of preferences and positive outcomes with regard to expanding social networks and increasing community integration (Claes et al 2010). In the health care system overall, a systematic review found PCCP for people with chronic illnesses improved self-management capabilities, reduced depression and had a moderate positive effect on physical health outcomes (Coulter et al., 2015). Within community mental health settings, two randomized controlled trials demonstrated positive outcomes. The first study examined PCCP among low income adults of Hispanic and/or African origin in a peer-run community integration program, showing that PCCP was effective in increasing participants' active involvement in the care planning process and in increasing inclusion in the planning process for housing, employment, and education (Tondora et al., 2014). In the second study, five community health clinics were randomized to receive training in PCCP while five community mental health clinics were randomized to treatment as usual. The experimental condition showed a significant increase in medication adherence over time compared to the control condition and demonstrated a positive impact on engagement with a significant decrease in "no shows" (Stanhope et al 2013).

With regards to measuring person-centered care, Da Silva (2014) found that relevant studies tend to focus on four main issues; definitional measures, preferences of patients, experiences of patients and outcomes. Limited studies were identified on how clinical teams or health organizations routinely measure person-centered care as part of clinical practice (de Silva 2014, p2). While the latter review tended to focus on person-centered care in health services, a distinct stream of work on personal outcomes focused on practice and planning in social services has been in place for some time in the UK. Earlier work on personal outcomes at York University (Qureshi, 2001) has influenced a long-term research, practice and policy programme of work in Scotland (Cook and Miller 2012, Miller and Barrie 2016).

This shift to an outcomes based approach signals a move away from a limited focus on inputs, processes and short-term targets towards the impact that policy and service delivery have on people and communities (OSCPA 2016). It can be helpful to consider different types of outcomes and to distinguish between process outcomes (e.g. the experience individuals have of using services) change outcomes (e.g. improvements in symptoms and skills) and quality of life (e.g. feeling safe and being involved in meaningful activities and relationships). While the focus on *personal* outcomes can promote person-centered and enabling practice, there are significant continued risks associated with more managerialist interpretations of life goals/outcomes (Miller 2014), as identified both in the UK and the US.

Smull and Lakin (2002) identified how good intentions with person-centered planning were derailed by a greater concern to pass inspection in quality assurance reviews, driven by external criteria. Requirements for goals to be measurable and for data to document progress resulted in the recording of goals that were 'measurable, but not meaningful' (Smull & Lakin, 2002, 383). More recently in the US, Taylor and Taylor (2013) highlight the limitations of identifying pre-determined outcomes as being contradictory to the principles of person-centered planning, when some might become apparent during the planning process itself. The need to include qualitative data and

create plans which detail personal outcomes or goals are features of both the US and Scottish and US programmes described here. Against this background we now turn to consideration of some of the key challenges and strategies in both contexts.

Challenges and strategies in implementing person-centered and outcomes focused recovery planning in the US and Scotland

We identified three areas key to focusing efforts in implementing collaborative PCCP in both countries. These are the need for a person-centered recovery orientation among staff; the need to develop a plan that meets both the needs of the person and the requirements of funding systems; and the need for evaluation approaches that capture both the process and outcomes of PCCP..

1) Promoting a Recovery-Oriented Culture

Implementation of the *practice* of person-centered planning requires an organizational or staff culture committed to recovery oriented, person-centered care and *values.* While skepticism regarding the prospect of recovery and the benefits of recovery oriented care can manifest in a multitude of ways, we briefly discuss two common concerns and propose alternate ways of framing them in order to build consensus and enthusiasm for person-centered care planning.

Just as PCCP may require the development of new skills among persons in recovery, there can also be a learning curve for practitioners striving to adopt this practice. Successful adoption of PCCP begins with a provider's orientation toward recovery. They must believe that people can, and do, recover; believe that people can, and should, self-determine to the maximum extent possible; and believe that a life worth living in the community is a fundamental right for all people no matter their disability or cultural background. When these values and beliefs are in place the conditions can emerge for developing the commensurate skills (Tondora et al 2014). Notably, practitioners can be skeptical about their clients' readiness to engage in PCCP and their ability to set life goals (Zubkoff et al, 2016). In order to implement PCCP practices, and overcome such barriers, recovery-oriented values need to be nurtured within practitioners to enable them to embrace strength-based assessment, increase hope for the future, respect cultural differences and partner successfully with the individual.

One of the challenges for implementation is the tendency in many services towards standardised approaches to engaging with people who use them. Being person-centered requires flexibility and adaptability, to meet people wherever they are in their recovery process. There can be significant differences both between individuals and within individuals at different stages of their recovery journey, in terms of their motivation, cognitive capacity and ability to recognize and articulate their views. But even in challenging circumstances, practitioners can be highly creative in terms of how they elicit individual preferences and priorities, sometimes using non-verbal and other subtle cues to help identify goals. While in Scotland some practitioners have initially raised a concern that opening up conversations beyond clinical or service oriented goals might 'raise expectations' beyond what is achievable, in practice the challenge is often more to instill hope and support people to envisage what a better life might look like (Cook and Miller 2012). As alluded to earlier, this is likely to be exacerbated where there is learned helplessness and institutionalized dependence, common amongst people who have resided in long-term, intensive service settings.

Secondly, there can be a concern for practitioners that implementing PCCP might lead to individuals making choices that are deemed not to be in their own 'best interests,' from

a professional perspective. This may include a concern about poor health and wellbeing outcomes resulting from choices that increase risks to the individuals concerned. In response to such concerns, the use of the Exchange Model of assessment (adapted from Smale and Tuson 1993) has been identified in the Scottish context as supportive of achieving a balance in negotiating and agreeing outcomes whilst acknowledging risks. This model, originating in social work, has repeatedly proven useful in refocusing attention on the importance of including all perspectives in PCCP. This includes not least of course, the perspective of the person in recovery, but also the family member(s) where appropriate, the practitioner(s) and the agency perspective, which includes a duty of care and the need to effectively and equitably distribute resources. This model is relevant to the concept of shared decision-making underpinning person-centered care, and is compatible with the principle of co-production rather than consumerist approaches. It responds to a concern identified by practitioners in both the US and Scotland about not losing sight of professional knowledge (Cook and Miller 2012, Tondora et al 2012) while including the expertise of each party in negotiating outcomes.

Practitioners working to support people in identifying their goals and choices are often also concerned about risks and their own sense of responsibility to manage risk. However it is not possible for anyone to live a risk free life. In keeping with best practice in recovery-oriented care (Drake et al 2010), the role of the practitioner in such situations is to remain consistently engaged with the person to explore what a given choice means; to identify potential pros and cons; to consider alternatives; and to ensure the person is supported to make informed decisions. However, in the context of working with individuals with fluctuating symptoms and at times reduced capacity to engage in complex negotiation, it may be necessary to refer back to previously agreed and set outcomes, identified through exchange of perspectives, as outlined in the model.

Our experiences in PCCP implementation efforts have taught us that it is equally important to align with providers and acknowledge systemic constraints because practitioners can experience a sense of helplessness and conflict of values in face of such barriers. It is to these broader systemic and organizational factors we turn next.

 2) System based barriers to developing a Person-Centered Care Plan

Rather than focusing only on treatment, services and symptom relief, person-centered planning's unifying vision is for providers to collaborate with clients and natural supports to develop customized plans focused on life goals or outcomes. Although PCCP follows the usual trajectory of service planning from assessment to evaluation, it is informed by the principles of strengths-based approaches, of adhering to person-

centered principles, and of recognizing the range of interventions and contributors (family and community based supports) in the planning process. This includes positive risk enablement and a right to 'failure', and demonstrating a commitment to both outcomes and process evaluation.

A key system based barrier to achieving strengths based recovery plans centers around funding systems designed to contain budgets. Influenced by a still prevalent biomedical orientation, the unintended consequence of such systems can be a tendency to encourage the identification of individual deficits and link these to service and treatment solutions. We will consider the US and UK in turn in illustrating relevant barriers and attempts to overcome them. In the United States, Medicaid will only pay for services deemed medically necessary. Violations of this regulatory requirement can result in financial penalties for providers, which understandably creates concern.

In the U.S., we have explored ways of navigating perceived tensions between PCCP and medical necessity in ways that both 'honor the person and satisfy the chart.' The belief that funders will not pay for non-clinical life goals is actually a correct one, but not because of the nature of the goal itself. Technically, funders do not pay for goals at all. Rather, funders pay for interventions and professional services provided to help people overcome the mental health barriers to functioning and attainment of valued recovery goals. Furthermore, we have found that these expectations are often applied inconsistently in the field during site visits or accreditation surveys, depending on the training and orientation of the reviewer or auditor.

A key means of tackling some of these barriers is through virtual facilitation, which has been shown to increase implementation and aid sustainment of new clinical practices (Kauth et al, 2017). This method has been effectively employed within the US model to build staff competency and skills in co-creating person-centred plans. Consistent with evidence-based adult-learning strategies, the U.S. team incorporates a diverse array of teaching methods (including experiential, skills-based training, ongoing technical assistance, repeated behavioral rehearsal/practice, and a provider training manual) to promote the uptake of PCCP. A two-day intensive skills course launches the implementation effort. To strengthen learning transfer to participants' daily work, they are also provided with two follow-up technical assistance sessions per month. The first session is a case-based consultation where providers have the opportunity to present a completed plan and receive coaching and feedback from facilitators. The second monthly session is dedicated to supporting staff with implementation barriers.

This follow-up is tailored to be responsive to the provider's unique implementation situation, and may include the following types of activities: attendance at actual PCCP planning meetings to provide in-vivo coaching and mentoring, consultation to administrators regarding the balance of patient-centered documentation with "medical necessity" and other regulatory expectations, development of practical workbooks and "tips sheets" for use by staff, and feedback regarding the design of treatment planning software and electronic health records to facilitate patient-centered practice. Follow-up group-based formats allows for cross-fertilization of knowledge of, and building enthusiasm for PCCP.

In the UK, research by le Boutillier et al (2015) found that business priorities such as funding and contractual objectives of the NHS were a predominant feature preventing recovery-oriented practice. Typically, services are measured on increased activity and contact time targets, referral demands rather than personal experience (le Boutillier et al 2015). On the social services side in the UK, the requirement to meet Fair Access to Care Services (FACS) eligibility criteria which include four bands - critical, substantial,

moderate and low, can present an issue of conflict for practitioners. Evidence shows that while FACS criteria may support standardization, they are likely to lead to people not receiving the support they need (CSCI, 2009). They encourage a focus on what the person is unable to do, to focus on deficits and commensurate risks, to establish a sufficiently high band to access services, at odds with outcomes focused, preventative and enabling practice (Miller 2010).

The approach adopted to outcomes-focused practice development in Scotland has included experiential staff development opportunities, training based on solutions focused brief therapy principles and a website including a wide range of tools and resources to support implementation. Where possible, opportunities for shared learning and exchange are provided, as exemplified in the Meaningful and Measurable project which is discussed below (Barrie and Miller 2016), and a network which meets quarterly, to which anyone involved in implementation is invited to participate.

Collaboration is one of the approaches shared in both contexts, supported by research showing that collaboration accelerates the use of clinically relevant research and helps to bridge the knowledge practice gap in client-centered care initiatives (McCay et al 2015).

3) Capturing the Process and Outcomes of PCCP

While a widely mandated and clearly ethical practice, there are still challenges in capturing the effectiveness of PCCP, both in how the practice can transform the process of care and most importantly, the way in which it enhances the lives of people with severe mental illnesses. As the climate of accountability both in the United Kingdom and the United States demands quantifiable outcomes, the quest is to find means of capturing the relational and values based aspects of PCCP and its measurable impact on engagement and attainment of life goals or outcomes. Also, it is important to take account of those implementation factors, such as leadership and organizational culture that can mean the success or failure of the practice in real world settings.

A recent review of outcomes based approaches identified that the issue receiving most attention is measurement (Cook 2017). The review identified that two perspectives incorporating different sets of assumptions are in operation about the relationship between cause and effect. The first perspective views the system as closed and not influenced by external factors, so that interventions lead to outcomes in predictable ways. The second views interventions as occurring in complex and dynamic systems in which outcomes may be influenced by a range of factors, in unpredictable ways. The work in Scotland tends towards the second conceptualization, leading to a focus on contribution rather than attribution in identifying and tracking personal outcomes. Contribution means that it can reasonably be inferred that a particular activity (or service or person) might have a role to play in achieving an outcome, and in reviewing progress it is possible to tease out which factors have contributed. Attribution on the other hand suggests that clear cause and effect can be established between an activity (or alternative) and an outcome. Some have argued that this is an unrealistic endeavor (Mayne 2001). Importantly, the shift from attribution to contribution allows for recognition of the role of the individual in achieving their outcomes, consistent with strengths based practice. It also supports a partnership approach in that different agencies can contribute towards the same outcomes (Cook and Miller 2012).

In Scotland, the Meaningful and Measurable research project concluded in 2015, involving diverse providers engaged in outcomes focused PCCP. All providers reviewed a sample of records to check whether outcomes had been clearly identified, and the

extent to which people had been involved in development of their plans. This review was in most cases undertaken alongside interviews and/or focus groups with practitioners, to investigate their understanding of outcomes and decision-making about what to include and exclude from the record. A strong theme to emerge from the data generated was that recording needed a separate focus in its own right and that pragmatic and clear guidance was needed to support the shift from deficit led recording systems. Five simple criteria were identified to support implementation of outcomes focused recording which were:

- that outcomes (or clear purpose) should be identified and not just outputs (services)
- the outcomes should be personalised rather than general to all
- there should be a role for the person (and the family if appropriate)
- the person's own words should be included
- the plan should be action-oriented (Miller and Barrie 2016).

In the United States, we are conducting a randomized controlled trial of PCCP using mixed methods, which explore the process of care and implementation factors in addition to testing the effectiveness of the intervention (Stanhope et al, 2015). Randomizing seven community health clinics to experimental conditions and seven to control conditions, the aim is to assess both the provider's fidelity to PCCP and the influence of organizational factors. To assess fidelity to PCCP, providers were surveyed using the Person-Centered Care Questionnaire (cite) and the Recovery Knowledge Inventory (cite). To capture organizational factors, providers' perceptions of leadership were surveyed, as well as organizational readiness and recovery orientation using the Bass' Multilevel Leadership Quality scale (Cite), Organizational Readiness Climate scale (Cite) and the Recovery Self-Assessment scale (Cite). While there are increasing quantitative measures of implementation, capturing uptake of a new practice is greatly enhanced by the use of qualitative methods to give an in-depth understanding from both provider and service user perspectives. In this study, focus groups and leadership interviews were undertaken to understand how providers understood PCCP and its value and how the implementation process unfolded in their agencies. We also conducted focus groups with service users to explore their experience of person-centered planning and its relationship with their recovery goals.

Preliminary findings from the baseline quantitative survey completed by leaders, supervisors and direct care staff (N=273) indicated that more transformational leadership did predict a more recovery-oriented organization but that that effect was mediated by a positive organizational climate (Cite SSWR) supporting the notion that leadership and climate play an important role in implementation of person-centered care planning. Interestingly, in terms of fidelity to PCCP, at baseline we found a negative relationship between recovery knowledge and reported PCCP practice (cite SSWR). This points to the challenge of persons assessing their practice before they are trained, particularly in the case of a practice not reducible to technical skills. Sometimes referred to as "the Dunning Kruger" effect, it is the problem of people not knowing what they do not know. This may explain why a common barrier to implementing PCCP is that people believe they are already engaged in the practice (Tondora et al 2012). In terms of measurement, the finding demonstrates the importance of assessing fidelity with objective measures, which will be done in this study by reviewing provider's service plans to assess the extent to which they are person-centered.

Discussion

This article brings together learning from person-centered care programmes which have developed independently in the US and Scotland. The EU funded CRISP project has provided an opportunity to identify common challenges, offering opportunities for improved implementation strategies. A key strength of the emerging partnership is the blend of research, policy engagement and practice development. This article has focused in the main on the research and implementation aspects, with the intention of addressing policy engagement in future. For present purposes, it is worth noting that reimbursement requirements and approaches to budgetary constraint remain a core concern with regard to policy engagement. It appears that in both contexts, attempts to limit spending and support an equitable approach through standardization can lead to the opposite results of those intended. While health and care systems internationally are currently struggling to manage increasing demand with lower budgets, it is imperative that people who need support from mental health services are treated with dignity, compassion and respect, and supported to live independent and fulfilling lives (da Silva 2014). This is not supported by systems prioritizing standardization at the expense of personalization and enablement.

Whilst as noted previously, there is as yet no single definition of person-centered practice, key themes have emerged in the literature over many years. These core principles include the development of respectful relationships between practitioners and people experiencing mental ill health; the involvement of the person in identifying personal goals or outcomes, which relate to their whole life rather than being restricted to service led treatment options; the importance of inclusion of personal, family and community based resources in achieving those outcomes, a recognition of responsible risk taking as a necessary part of growth and recovery, and a focus on acknowledging the strengths and capacities of the person as an essential step to recovery. Funding systems that unintentionally encourage a focus on deficits, symptoms and traditional approaches to treatment do not support the practice development required to achieve the long sought after goal of person-centeredness in mental health services. Whilst, largely due to the efforts of people using services, practitioners, and in some cases the organizations involved, progress is being made in pockets in achieving PCCP, renewed efforts are required in ensuring that all perspectives are included in developing more sustainable policy solutions to overcoming systemic barriers. It is hoped that the collaboration described here, through drawing together experiences and evidence from different contexts, might make a contribution. There is much scope and optimism for building on strategies which have found to be successful and continued vital collaboration between research, policy and practice in diverse constituencies.

References

Adams, N. and Grieder, D. (2014) Treatment Planning for Person-Centered Care, Second Edition: Shared Decision Making for Whole Health (Practical Resources for the Mental Health Professional) 2nd Edition.

Balik B, Conway J, Zipperer L, Watson J. (2011) *Achieving an Exceptional Patient and Family Experience of Inpatient Hospital Care,* IHI Innovation Series white paper, Cambridge, Massachusetts: Institute for Healthcare Improvement.

Beitinger R, Kissling W, Hamann J. Trends and perspectives of shared decision-making in schizophrenia and related disorders. Current Opinion in Psychiatry. 2014;27(3):222-9; PMID24613981

Boswell, J.F., Constantino, M.J. & Kraus, D.R. Adm Policy Ment Health (2017). doi:10.1007/s10488-016-0789-3

Claes, Van Hove, Vandevelde, van Loon, & Schalock, 2010

Clossey, L., Rowlett, A., & Walker, J. (2014). Leadership, Budget Restrictions, and the Recovery Model. *Human Service Organizations: Management, Leadership & Governance, 38*(2), 178-192.

Cook, E. and Miller, E. (2012) *Talking Points personal outcomes approach: a practical guide,* Edinburgh: Joint Improvement Team

Cook, A. (2017) *What Works Scotland position paper: Outcomes based approaches in Public Service Reform*, Edinburgh: WWS

Coulter, A. (2014) Collecting data on patient experience is not enough: they must be used to improve care, BMJ 348:g2225 doi: 10.1136/bmj.g2225

Cribb, A., (2011) Involvement, shared decision-making and medicines, London: Royal Pharmaceutical Society (UK)

De Silva D. (2011) *Helping people help themselves*. London: The Health Foundation, www.health.org.uk/publications/evidence- helping-people-help-themselves

De Silva D. *Helping people share decision making*. London: The Health Foundation, July 2012. www.health.org.uk/publications/ helping-people-share-decision-making

De Silva, D. (2014) Helping measure person-centred care, London: The Health Foundation

Drake, R., Deegan, P.E., Rapp, C. (2010). The promise of shared decision making in mental health. Psychiatric Rehabilitation Journal, 34 (1) 7-13.

Ehrlich C, Dannapfel P. Shared decision making: People with severe mental illness experiences of involvement in the care of their physical health. Mental Health & Prevention. 2017;5:21-6.

Epstein, R.M. and Street, R.L. (2011) The Values and Value of Patient-Centered Care, *Ann Fam Med* 2011;9:100-103.

Health Foundation (2014) Person centred care made simple, London: The Health Foundation

Humphreys, K. and Lembke, A. (2013) Recovery-oriented policy and care systems in the UK and USA, *Drug and Alcohol Review,* 33(1), 13-18

Institute of Medicine (IOM) (2001) Crossing the Quality Chasm: A New Health System for the 21st Century. National Academy of Sciences. National Academy Press: Washington, DC.

Institute of Medicine (IOM). (2006). Improving the Quality of Health Care for Mental and Substance-Use Conditions: Quality Chasm Series. National Academy of Sciences. National Academy Press: Washington, DC.

Kaufman, L. & Stevens-Manser, S. (2013). Person-Centered Recovery Planning Initiative: Evaluation Report. Texas Institute for Excellence in Mental Health, Center for Social Work Research, School of Social Work, University of Texas at Austin

Michael R. Kauth, Geri Adler, Stephen J. McCandless, Wendy S. Leopolous, (2017) "Embedding new clinical practices: the role of facilitation in enhancing web-based training for mental health providers", The Journal of Mental Health Training, Education and Practice, Vol. 12 Iss: 1, pp.24 – 32

Klein, K.J. and Knight, A.P. (2005) Innovation Implementation: Overcoming the **s** Challenge, *Current Directions in Psychological Science*, 14 (5) 243-246

Mayne, J. (2001) 'Addressing Attribution through Contribution Analysis: Using Performance Measures Sensibly'. Canadian Journal of Program Evaluation, 18 (1): 1-24

Elizabeth McCay , Kristin Cleverley , Audrey Danaher and Naomi Mudachi , (2015) "Collaborative partnerships: bridging the knowledge practice gap in client-centred care in mental health", The Journal of Mental Health Training, Education and Practice, Vol. 10 Iss: 1, pp.51 – 60

Miller, E. (2014) Considering two outcomes paradigms: the improving (person-centred) and the proving (managerialist) agendas, Chapter 5 in Human Rights and Social Equality: Challenges for Social Work, Surrey, Ashgate

Miller (2015) Measuring personal outcomes: Challenges and strategies, IRISS Insights, No 12

Miller, E. and Barrie, K. (2016) *Learning from the Meaningful and Measurable project: Strengthening links between identity, action and decision-making*, Glasgow: Health Improvement Scotland

New Freedom Commission on Mental Health: Achieving the Promise: Transforming Mental Health Care in America. Final Report. DHHS pub no SMA-03–3832. Rockville Md, Department of Health and Human Services, 2003.

Office of the Chief Social Policy Advisor (OCSPA) (2016) The Scottish Approach to Government: How do we measure and evaluate impact? Edinburgh: OCSPA

Petch, A., Cook, A. and Miller, E. (2005) Focusing on outcomes: Their Role in Partnership Policy and Practice *Journal of Integrated Care,* 13 (6) 3-12

Richards, T., Coulter, A., and Wicks, P. (2015) Time to deliver patient centred care, *BMJ* 350:h530

Sanderson, H. (2002). A plan is not enough: Exploring the development of person-centered teams. In S. Holburn & P. M. Vietze (Eds.), *Person-centered planning: Research, practice and future directions* (pp. 97–126). Baltimore, MD: Brookes.

Scottish Government (2008) *Independent Review of Free Personal and Nursing Care In Scotland*, April 2008. Retrieved January 17, 2017 from http://www.gov.scot/resource/doc/221214/0059486.pdf

Shepherd, G., Boardman, J., Rinaldi, M. and Roberts, G. (2014) *Supporting recovery in mental health services, quality and outcomes* London: NHS Confederation

Smale, G., Tuson, G., Biehal, N. and Marsh, P. (1993) *Empowerment, Assessment, Care Management and the Skilled Worker*, National Institute for Social Work Practice and Development Exchange, London: HMSO

Smull, M., & Lakin, K. C. (2002). Public policy and person-centered planning. In S. Holburn & P. M. Vietze (Eds.), *Person-centered planning: Research*, *practice and future directions* (pp. 379–398). Baltimore, MD: Brookes.

Stanhope, V., Ingoglia, C., Schmelter, B., and Marcus, S.C., (2013) Impact of Person-Centered Planning and Collaborative Documentationon Treatment Adherence, *Psychiatric Services,* 64(1) 76-9

Tondora, J. Miller, R. and Davidson, L. (2012) The top ten concerns about person-centered care planning in mental health systems, *The International Journal of Person Centred Medicine,* 2(3) 410-420

Tondora J, Miller R, Slade M, Davidson L. (2014) Partnering for recovery in mental health: A practical guide to person-centered planning: John Wiley & Sons

Zubkoff, L., Carpenter-Song, E., Shiner, B. et al. (2016) Clinicians' Perception of Patient Readiness for Treatment: An Emerging Theme in Implementation Science? *Adm Policy Ment Health* 43: 250. doi:10.1007/s10488-015-0635-z

.