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The top ten concerns about person-centered care planning in mental health systems

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Abstract
Person-centered approaches to mental healthcare are at the forefront of behavioral healthcare transformation, yet how to implement this approach raises questions for practitioners. Based on extensive consultation and systems transformation work, the following paper describes the top ten concerns frequently raised by those providing services and addresses these concerns in the context of the provision of recovery-oriented care.

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Introduction

"It's amazing what you can do when you set your mind to it ... especially when you're no longer supposed to have one!"
(Woman with a mental illness describing her participation in person-centered care planning)

Person-centered care planning (PCCP) has been identified as a cornerstone of a recovery-oriented system of mental healthcare [1], with well-developed PCCP models used within the developmental field for over three decades [2-6] and person-centered care itself recently accepted as standard practice for all of medicine [7]. Implementation of person-centered care planning in mental health represents a relatively new and relatively controversial challenge. The introduction of person-centered care planning has provoked an array of contradictory responses in the mental health community, with concerns focused on risk management and professional liability, meeting documentation standards required by fiscal and accrediting bodies, practitioners' self-image as caring and compassionate people, as well as the priority democratic societies place on autonomy and self-determination and the long history of stigma associated with serious mental illness.

The convergence of these various factors presents a unique challenge to a mental health system that is in the process of transforming to a recovery orientation, but a challenge that we cannot afford to avoid. Given that person-centered care planning is one of the core and perhaps most basic components of recovery-oriented care [8], we felt compelled to take up this challenge and to stimulate a dialogue regarding this particularly complex, but also especially important, aspect of transformation. The following discussion of the top 10 concerns about person-centered care planning is drawn from extensive work carried out over the past 5 years in developing and evaluating a culturally responsive approach to psychiatric care [9-11].

Based on training and technical assistance provided to direct care staff, program managers and administrators who are working to implement such a model of person-centered care within the public mental health system in the U.S., we identified the 10 most common concerns raised in relation to this work. We describe these concerns below, ranging from the practical (e.g., How do I write a measurable objective?), to the fiscal (e.g., How will we get paid for person-centered care?) and clinical (e.g., Should people with serious mental illnesses be allowed to make their own treatment and life choices?), to the ultimately philosophical questions (e.g., How do I work with someone who has no goals?). The answers we offer are the beginning of responses to address these and other

frequently asked questions for systems engaged in transformation to recovery-oriented and, therefore, by necessity, person-centered, mental healthcare. We hope that others will join the dialogue.

What is person-centered care?

We define person-centered care planning as involving a collaborative process between the person and his or her supporters (including the clinical practitioner) that results in the development and implementation of an action plan to assist the person in achieving his or her unique, personal goals along the journey of recovery. We suggest that this plan can meet the rigorous documentation elements required by accrediting and funding bodies (such as CMS) and can be attentive to the specific mental health and/or substance use barriers interfering with goal achievement. In addition, for the plan to be considered person-centered it needs to: 1) be oriented toward promoting recovery rather than only minimizing illness; 2) be based on the person's own goals and aspirations; 3) articulate the person's own role and the role of both paid and natural supports in assisting the person to achieve his or her own goals; 4) focus and build on the person's capacities, strengths, and interests; 5) emphasize the use of natural community settings rather than segregated program settings and 6) allow for uncertainty, setbacks and disagreements as inevitable steps on the path to greater self-determination [6]. To expand on this definition, we offer the following table that contrasts person-centered care from traditional practitioner-driven models of care.

The top ten concerns about person-centered care planning

Below we address the top 10 concerns that have been raised by direct care staff, program managers and administrators as we have worked with them to implement the model of person-centered care planning described above. We discuss each in turn.

Concern 10. Emphasizing patient choice inevitably devalues clinical knowledge and expertise

"Why did I go to school for all these years if I'm just going to do whatever the patient wants? When a person is mentally ill, his judgment is impaired. How could he know what he needs?"

Person-centered care planning for mental illness no more requires practitioners to do whatever the patient wants than does person-centered care for any other medical condition. Ideally, person-centered care planning evolves within a collaborative relationship in which decision-making is viewed as shared between healthcare practitioners, patients and their supporters. Within the context of such a partnership, each party has its respective role to play.

Practitioners assess, evaluate, diagnose, educate, inform and advise the patient and his or her supporters about the possible courses of treatment and rehabilitation available for whatever ails the person, including the relative benefits and drawbacks of each approach. Practitioners then deliver whatever treatments and rehabilitation strategies they are competent to provide based on the nature of the ailment and the person's informed consent. The person, in conjunction with his or her supporters (to whatever degree he or she wishes) makes decisions about what treatments, interventions, services and supports make the most sense within his or her life context, given his or her values, needs, preferences and goals. It is no more appropriate for the person to assume the role of practitioner than it is for the practitioner to assume the authority to make the person's decisions for him or her.

While it is not appropriate for patients to tell practitioners what to do, it also is not appropriate for practitioners to tell patients what to do. It is the right and ethical responsibility of practitioners to offer the best mental healthcare that they can. Yet it is also the patient's right, except in few exceptional circumstances (see Concern 1 below), to make his or her own decisions about what treatment recommendations, interventions, services or supports he or she will use in his or her recovery [12].

Concern 9. Person-centered care planning is important, but it is the responsibility of non-clinical practitioners

"Personal goals are best served at the clubhouse, with the rehab' staff or at the peer-run program. My role is to provide treatment to reduce symptoms. That is what I was trained to do. Other practitioners have responsibility for helping people to find housing or jobs or hobbies."

It is certainly true that not every mental health practitioner can or should be proficient in every aspect of the care of persons with serious mental illnesses. Some practitioners were trained to diagnose disease and treat illness, while others may have been trained in job and community resource development or in cognitive-behavioral psychotherapy. The question is not so much one of what any given practitioner was trained in, however, as much as what the person receiving care needs, wants and can benefit from. Person-centered care planning provides the overarching framework within which any of these specific interventions or treatments becomes relevant to the person's life. Otherwise, the practitioner is trying to provide services to someone who may have no interest in or reason for, receiving them.

Offering people services they do not want has often occurred in mental health where the attainment of "clinical stability" has been framed as the ultimate goal rather than as a means to an end. For example, a man living with bipolar disorder may wish to be the best father he can be, yet symptoms of mania may have led him to behave in a manner that frightened his children and alienated his wife.

Table 1 Comparison of Traditional and Person-Centered Approaches to Care

Traditional Approaches	Person-Centered Approaches
Self-determination comes *after* individuals have successfully used treatment to achieve clinical stability	Self-determination and community inclusion are viewed as fundamental civil rights of all people
Compliance with practitioner's instructions and recommendations is valued	Active participation and empowerment is vital
Only professionals have access to information (e.g., plans, assessments, records, etc.)	All parties have access to the same information and information is shared readily between them
Disabilities, deficits, dysfunction and problems drive treatment. Focus is on illness.	Interests, abilities and personal choices define supports. Focus is on promoting health.
Lower expectations of patient.	High expectations of person.
Clinical stability is valued	Quality of life is valued
Linear progress and movement through an established continuum of services is expected	Person chooses from a flexible array of supports and/or creates new support options with team
Primary emphasis is on professional services	Diverse supports (professional services, non-traditional services and natural supports)
Facility-based settings and professional supporters	Integrated settings and natural supporters are also valued
Avoidance of risk; protection of person and community	Responsible risk-taking and growth

A traditional care plan might focus exclusively on the clinical goal (e.g., compliance with medications and reduction of mania) with little, or no, mention of the man's ultimate goal of reunification with his family. We suggest that this lack of connection between treatment and personally valued life goals is one reason why attrition and drop out rates are so high in outpatient mental healthcare [13-15].

For mental health practitioners to offer more responsive and individualized care, the care planning process needs to be shaped by the person's life goals rather than by the practitioner's specific training or professional discipline. Simply put, in a person-centered system, we no longer have a clinical or treatment goal that exists independent of a meaningful outcome in a person's life. The goal on the treatment plan – whether one is a supported employment specialist or a psychiatrist – is the same, for example, Nathan wants to get a job. Each professional then assists Nathan based on his or her unique skills and training, with a supported employment specialist offering job development and coaching and the psychiatrist prescribing effective medications at a suitable dosage to control the psychotic symptoms that interfere with Nathan's job performance without making it impossible for him to get out of bed in the morning [16].

In order to create these types of person-centered care plans, clinical and medical professionals will need to know more about the person's overall life context and everyday experiences and will need to place treatment and other interventions within this context [17]. For a psychiatrist, for example, to expect a patient to accept being diagnosed with a psychotic disorder, it will be incumbent upon the psychiatrist to explain how this diagnosis helps the person to make sense of his or her own experience and how it accounts for some of what has gone wrong in the person's life. Similarly, to expect a patient to take prescribed medication, it will be useful for the prescriber to connect the taking of these medications to potential improvements in his or her daily life. Failing to address the person's everyday life concerns and continuing to treat the illness as if it took place in a vacuum, perpetuates the narrowly defined, practitioner-driven model of care that people with mental illnesses routinely identify as a major barrier in their recovery and their ability to benefit from the services being offered [18].

Concern 8. We do it already; our care is already person-centered

"Are you suggesting that we don't take the person into consideration?"

We readily agree that caring and compassionate practitioners do already make concerted efforts to take the person into consideration. This is not the same, however, as offering person-centered care planning. In addition to listening empathically to the person and tailoring the care one provides to each individual, person-centered care planning involves the use of new tools and strategies that practitioners may have some familiarity with, but which generally are not employed routinely in practice. These include comprehensive and structured interests and strengths assessments; the inclusion of the person's natural supporters and legal advocates in the care planning process; articulation of clearly defined short- and long-term personal goals with measurable objectives; assignment of responsibility for different tasks and action steps to different members of the care team, including the person in recovery; prioritization of natural, integrated settings over those designed solely for persons labeled with serious mental illnesses; and the use of tools such as psychiatric advanced directives, shared decision-making aids and supported employment, housing, socialization and education coaches.

Thus, while many practitioners strive to attend to each person as a unique individual, there are many strategies

and tools (some new, some long-standing) that are under-utilized and whose consistent use in practice could significantly advance the implementation of a more person-centered model of care planning. Examples of this model are implied in such questions as: How do you determine what interests the person has that he or she might like to pursue? Does the person have the option of running the care planning meeting? Do you automatically offer a copy of the plan to the person you're working with? How often are natural supporters included in the meeting when desired by the person in recovery? How often are the person's roles and responsibilities articulated in the plan along with the services to be provided by mental health practitioners? [10,19].

Concern 7. The care plan is not that important and does not really drive care. It is more for accreditation and reimbursement purposes

"Why are you focusing on a piece of paper that has little to do with the quality of care I provide? It is for the chart... not the person. Does it really matter?"

Often in practice, the treatment plan is a technical document that has to be completed to satisfy accrediting or reimbursement bodies and is useful neither to the practitioner nor to the person receiving services. In such cases, the plan is completed and filed in the medical record and plays little, if any, role in actually guiding care. It is doubtful whether anyone involved would argue that this is an ideal way of providing care or occupying the time and talents of dedicated mental health practitioners. While we recognize this is the unfortunate reality of most treatment plans written in today's mental health systems, we propose that the truly person-centered plan - one created through a process of partnership and shared discovery - has the potential to be a powerful transformative tool. Rather than being a bureaucratic document that takes time away from the real work of direct patient care, creation of the person-centered care plan is an intervention in and of itself, as it becomes the very heart of the work and the therapeutic process.

Person-centered care planning emphasizes the need for the practitioner and patient to enter into a collaborative process of exploring and identifying the goals and objectives that will promote the person's recovery and increase his or her quality of life. The person-centered care plan is a road-map for pursuing valued life goals and the milestones which are achieved along the way (i.e., short-term objectives) serve to give both the practitioner and the individual the critical experiences of success and forward momentum needed to continue on the road ahead. In this sense, the plan becomes a useful tool that has direct relevance in guiding the work of the team over time. It can be consulted as needed in order to ensure that all parties stay on course and revised as often as needed if the person encounters roadblocks along the way or reaches certain landmarks and wants to set a new destination. An example of such a plan is depicted in Figure 1 below.

As depicted below, a quality person-centered plan not only depicts the short and long-term destinations, but also explicitly identifies the role of all team members in contributing to the process. Interventions are thought of broadly and include specific action steps for the practitioners involved as well as for the person in recovery and his or her natural supports. Thus, the person-centered plan is an important tool that promotes accountability among all stakeholders as both tasks and timelines are clearly spelled out. The potential impact and value of the written planning document is further magnified when this document is offered in hard copy to the person in recovery (an essential practice in person-centered planning). This is not only an important symbolic gesture offered in the spirit of partnership and transparency; it also serves to activate the person in the day-to-day work of his or her recovery process. The written care plan, while a valuable tool for setting a course and reflecting on progress, is only one piece of the picture. Equally, if not more, important is the process behind the development of the plan, which we discuss in other sections of this paper.

Concern 6. Person-centered care planning is based on people's own goals, but people with serious mental illnesses sometimes give up on life goals. They are doing their best just to get through each day, to survive and may not want to make changes

"What if my patients don't have goals? When I ask them what their goals are, they give me a blank stare. What if they are just comfortable with where they are at?"

Most people do not live their lives explicitly in terms of "goals". We may have dreams and aspirations, but often we do not take the time to break these down into the various steps that will be required for us to pursue them. So, while many people with serious mental illnesses similarly will not have explicit goals and may well not know how to answer questions that ask them about goals, they nonetheless will have ideas about what could make their lives better. Do they, for example, want to work and make money? Would they perhaps like to have a better place to live? How would they prefer to spend their time on a day-to-day basis? What gives them pleasure or a sense of success? This type of dialogue differs significantly from the more restrictive conversation in which the patient is expected to merely report on symptoms and side effects or patterns of eating, sleeping and taking medications. Using strength-based inquiry to inspire hope and to support people in goal-setting is a process that requires both clinical skill and perhaps a willingness to step outside the comfort zone of our inherited professional discourse.

For many people receiving public mental health services, it may also at first feel dangerous to allow themselves to dream once again - with so many of their previous dreams having been abruptly interrupted by illness or dashed by the legacy of the low expectations we

Figure 1 A person-centered Care Plan

Adapted from Adams & Greider (2004) [33]
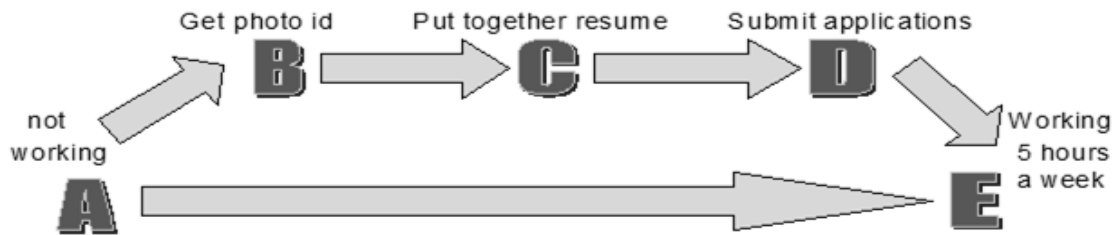
have had for persons with serious mental illnesses. Based on these experiences, individuals living with prolonged conditions may initially report that they have no goals or aspirations. Such a response should not be taken at face value, but rather to represent the years of difficulties and failures they may have endured and the degree of demoralization which has resulted. Over time, it is not uncommon for people to lose touch with the healthier and more positive aspects of themselves and become unable to see a future beyond the "patient" role. When facing such circumstances, practitioners need to conceptualize one of their first steps as assisting the person to get back in touch with his or her previous interests and talents and to draw upon these to imagine a brighter tomorrow.

This goal-setting dimension of person-centered care planning may benefit from incorporating the Stages of Change model developed by Prochaska and Diclemente [20], which breaks down behavioral changes into several incremental stages beginning with pre-contemplation and progressing through contemplation and persuasion to action. This model offers a useful framework for thinking through what the planning process might look like for a particular person at a particular point in his or her life, given such issues as apathy, an apparent lack of motivation, overwhelming symptoms, learned helplessness or demoralization. For some people in the pre-contemplative stage in relation to treatment adherence or medication use, for example, goals might at first be oriented toward addressing basic needs such as housing and income [21-23]. It is important to remember in this regard that someone may be *pre-contemplative* in one part of his or her life, such as the use of medications or

abstinence from substance use, for example, but in the *action* stage in another area, such as getting a job or having a girlfriend. Helping people to figure out what is possible in relation to these different areas of life at any given time and how to negotiate or make compromises among various goals, is another task for which clinical skill and experience can be extremely useful.

Concern 5. Does not the emphasis on using evidence-based practices contradict the principles of person-centered care?

"Am I supposed to follow evidence-based guidelines and provide evidence-based practices or am I supposed to do what the patient wants? I can't do both."

As already noted in Concern 10 above, person-centered care planning does not mean simply giving a patient whatever he or she wants. Instead, it requires practitioners to take into account and to base the services they provide, on a collaborative decision-making process in which the person plays a central role. Rather than being in conflict with evidence-based practice, this emphasis on the person's own values, goals and preferences is perfectly in accordance with the principles of evidence-based medicine, that all adults have the right to make their own healthcare decisions. It is for this reason that evidence-based medicine explicitly includes the person's role as decision-maker (including his or her needs, cultural values and preferences, including the right to defer decision-making to others) as one of the three components that the practitioner has to consider (the other two being the available scientific evidence and the practitioner's accumulated knowledge base and clinical experience; see [24]). Since the person is free to (and in one way or another, will, except in very limited situations) ultimately make his or her own decisions, it behooves healthcare practitioners to accept this fact and to communicate with the person and his or her family in as accurate, informative, culturally and personally responsive and perhaps even persuasive, a way as possible so as to maximize outcomes.

The apparent contradiction between person-centered care and evidence-based practice is due to a confusion, currently prevalent in the field, between evidence-based medicine or practice on the one hand and evidence-based practices on the other. As described above, evidence-based medicine or practice is based on the available scientific evidence, the practitioner's accumulated knowledge and experience and the patient's choice [25]. Evidence-based practices, on the other hand, are those interventions for which scientific evidence exists attesting to their effectiveness for certain conditions or patient populations. Evidence-based practices may (or may not) be used within the context of evidence-based medicine, depending on the practitioner's clinical judgment, the patient's particular conditions and circumstances and the patient's informed choice. Somewhere along the way, evidence-based practice (i.e., what *practitioners do*) became confused with evidence-based practices (those *interventions* which have been shown to be effective), leading some in the field to suggest broad-scale and indiscriminate adoption of evidence-based practices for everyone with a select condition (regardless of other evidence and other relevant factors). This has led to criticisms of evidence-based practice as "cookbook" medicine, to which Sackett, one of the foremost developers and proponents of evidence-based medicine and his colleagues have responded:

"Evidence-based medicine is not 'cookbook' medicine. Because it requires a bottom up approach that integrates the best external evidence with individual clinical expertise and patients' choice, it cannot result in slavish, cookbook approaches to individual patient care" [26].

Within this context, person-centered care planning can be viewed as a technology and strategy for maximizing the effectiveness of the role of patient choice in this "bottom up approach."

Concern 4. Person-centered care makes sense once the person is in recovery, once active treatment has been administered and been effective. But most patients seen in public sector settings have severe illnesses and are too disabled to pursue recovery goals. The first step is getting their clinical issues under control

"Person-centered care sounds great for people who are well on their way to recovery, but the people I serve are so ill, they are not ready for that. First, they need to be stabilized, then we can revisit the job, the classes and the new apartment."

There are undoubtedly times when people with serious mental illnesses want to be taken care of, just as there are times when people who do not have serious mental illnesses want to be taken care of. In the case of individuals with serious mental illnesses, such times may likely be when they are experiencing acute episodes of illness and/or when they are in extreme distress. Based on first-person accounts of people in recovery and on the wisdom of various accrediting bodies and laws, however, we are not to take this preference for being taken care of during acute episodes to generalize to the remainder of the person's life. The majority of individuals with serious mental illnesses will spend only about 5% of their adult lives in acute episodes, the remaining 95% of the time being spent in periods of relative symptomatic and functional stability [27]. It is during this 95% of the time that person-centered care planning is best carried out, including planning, through the use of a psychiatric advance directive, for how the person would like to be treated and supported during that 5% of the time that he or she may be too disabled to make his or her own decisions.

For those patients who appear to violate the 95% rule and/or who may appear to be too disabled to make their own decisions on an ongoing basis, we suggest that there remains a significant amount of latitude for practitioners to elicit and be guided by the person's own values, needs and preferences. It is equally important for persons with significant disabilities to *live* with as much choice as possible, even if that choice is based on a restricted range of options due to the individual circumstances. Simple examples of how this principle can be honored in practice are in asking people in institutional settings how they would like to spend their time, what and with whom they would like to eat and what activities would give them some degree of pleasure, rather than insisting they first participate in treatment and other activities which have proven not to be effective for them in the past. Even if these core treatment activities did have a proven effectiveness, to expect all patients to rigidly move through a pre-determined continuum of care is, we suggest, a subtle yet pernicious form of coercion.

Unfortunately, despite the positive changes brought about by recovery-oriented system transformation, it is still not uncommon for individuals to be expected to jump through "clinical hoops" and demonstrate stability before moving on to pursue broader life goals (e.g., requiring 6 months of medication compliance as a pre-requisite for referral to supported employment or dictating a certain compliance level with unit groups before a patient is allowed to participate in a hospital's treatment mall rehabilitation programming). Ironically, engagement in these personally preferred activities is often the factor that ultimately increases individuals' desire to acknowledge and begin to work on, the core clinical issues that interfere with progress.

Finally, the consumer/survivor literature has argued that much of what practitioners view as apathy, passivity or a lack of motivation to engage in person-centered planning is actually due to "learned helplessness" [28] stemming from years of having other people take over one's control and decision-making authority for one's own life. Just as the process of sharing power and responsibility in care planning is a sometimes disconcerting role-shift among mental health practitioners, many persons with serious mental illnesses may truly want to exert greater control over their lives but feel unprepared to do so. To the degree that this is a contributor to a person not wanting to make his or her own decisions or to take a backseat in care planning, the process of re-instilling a sense of control, competence and confidence in one's own decision-making capacity will require time, incremental successes and the provision of mentoring and skill-building opportunities specific to the process of person-centered planning.

Regardless of how long such a process takes, however, it is most likely true that such a process will not even begin as long as people continue to have others make their decisions for them in the context of a professional-knows-best model of service planning. For more on the importance of assisting people to make their own decisions so that they can get better at making their own decisions and on the failure of good intentions alone to foster autonomy, the reader is referred to the work of Nobel Prize winning political economist Amartya Sen [29-30]; see also [31].

Concern 3. Person-centered care planning is time and labor intensive and practitioners have case loads that are too high to allow them the time needed

"I have to complete paperwork on a timeline and we don't have the luxury of discussing everything first – especially when the client doesn't show up half the time! How can I satisfy my supervisor and still do person-centered care planning?"

Mental health practice in today's fiscal climate balances on razor-thin margins. Budget deficits around the country often lead to stretching of resources, making this seem like an ill-advised moment to advocate for the expansion of person-centered planning which further taxes the time of practitioners. While we acknowledge that conversations regarding goals, dreams, strengths and aspirations may take more time up front, these conversations are an investment in a collaboration that stands to be timesaving in the long run. With the focus on patient responsibility and action, practitioners can shift from a "do for" the person perspective to a "do with," fostering increased independence on the part of the patient and a shift toward maximizing natural community connections rather than relying on institutional ones.

Program evaluation findings on person-centered planning models suggest that this approach to care may also serve to interrupt the reactive cycle of crisis response, leading to reductions in hospitalizations, incarcerations and assaultive or self-injurious behavior [32]. One could argue that the management of these crisis-oriented situations stretches systems and practitioners far more than the additional time needed to engage in collaborative person-centered planning. Ultimately, person-centered planning may take more time to create than the cookie-cutter documents that still populate many charts in mental health systems around the country. However, we view this as time well spent and suggest it is a prudent investment in improving the quality of the partnership and, ultimately, the quality of life among persons in recovery.

Concern 2. Person-centered care is not consistent with the concept of "medical necessity" and therefore won't be reimbursed. Also, it doesn't fit with the regulations of the Joint Commission, CARF and other accrediting bodies

"We can't lose our accreditation and our income. Our funders and regulators don't allow us to focus on recovery goals. We have to focus on treatment issues."

The response to this concern builds directly on the response given above to Concern 9 about person-centered care planning violating professional roles and identities. Here, the concern is that person-centered care planning is not consistent with the traditional medical model and the regulatory, accrediting and reimbursing bodies that govern mental healthcare. Our response to this concern is complex, as the issues involved are themselves complex.

In the first place, such regulatory and accrediting bodies as the Joint Commission and CARF (Commission on Accreditation of Rehabilitation Facilities) are actually ahead of everyday clinical practice regarding the importance placed on person-centered and goal-directed care. Individually responsive care oriented to the achievement of each person's unique situation and goals has been the mandate for many years, prior to the advent of person-centered care in mental health *per se*. Care is expected to be strength-based, culturally competent and responsive to each individual's life context and that all of this be documented adequately in the person's medical record. Funding for work on which this article is in part based was awarded by the U.S. Centers for Medicare and Medicaid, the bastion of American healthcare that is responsible for the very notion of "medical necessity."

These consistencies do not negate the fact, however, that person-centered care planning principles do not translate readily into the categories and concepts of conventional care plans. Were they to do so, it would be questionable how much their introduction actually effects change in the way we provide care. Efforts must therefore be made to reconceptualize care plans and documentation tools to become person-centered, strength-based and goal-directed. Doing so does not minimize the importance of illness, deficits and problems, but does reframe them within the context of the person's overall life. That said, it is still true that Medicaid, for instance, currently will not provide reimbursement for certain services or supports that people with serious mental illnesses desire and will find useful. For the time being - until, that is, these regulatory and funding bodies move further in the direction of self-directed care and flexible funding - other sources of funding will need to be identified for these kinds of services (e.g., transportation or job coaching) or they will need to be secured beyond the parameters of the formal mental health system in the community at large - a solution that may ultimately be both cost-effective and consistent with the desire of persons in recovery

Even at the current time, it is common for practitioners to view regulatory and funding bodies as more formidable barriers to providing person-centered care than they in fact need to be. We believe this derives from two fundamental misconceptions. First is the belief that person-centered planning is somehow "soft." Second is the belief that funders will not pay for life goals such as helping someone to finish school or return to work.

Contrary to the common myth that person-centered planning is "soft," emerging practice guidelines explicitly call for the documentation of a) comprehensive clinical formulations; b) mental health-related barriers that interfere with functioning; c) strengths and resources; d) short-term, measurable objectives and e) clearly articulated

interventions which spell out who is doing what on what timeline and for what purpose [33]. Based on hundreds of chart reviews done by the authors and our colleagues, we suggest that these standards for person-centered care planning documentation are on par with, if not superior to, the level of rigor which actually exists in most treatment plans around the country.

Second, 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 but the fact that funders do not pay for *goals* at all. Rather, funders pay mental health practitioners for the *interventions/professional services* we provide to help people overcome the mental health barriers that are interfering with their functioning and the attainment of valued recovery goals. This is admittedly a broad-brush review and the authors acknowledge that each state and locality is subject to its own unique funding and regulatory expectations, a full discussion of which is beyond the scope of this paper. However, we maintain that medical necessity and person-centered care are not incompatible constructs and service plans can be created in partnership with persons in recovery while also maintaining rigorous standards around treatment planning and documentation.

Concern 1. Allowing people to set their own goals and make their own decisions increases risk and exposes the practitioner to increased liability

"Isn't impaired judgment one of the core characteristics of serious mental illness? If given choices, and people make bad ones, will I be the one held responsible?"

Person-centered care planning does not override a practitioner's ethical and societal obligation to intervene on a person's or the community's behalf should someone pose a serious and imminent threat to self or others. In such cases, just as in the case of an automobile accident or traumatic brain injury, healthcare practitioners are sanctioned to intervene on the person's behalf without getting prior consent. In psychiatry, as in most other branches of medicine, however, such cases are the extremes and the exceptions, not the norm. Consistent with our response to Concern 4 above, the literature suggests that most people with most mental illnesses pose few if any risks most of the time. Risk can be exacerbated by substance use and by non-adherence to medication, but even then the risk posed by people with serious mental illnesses pales in comparison to the risks they face from others, as it is much more common for a person with a serious mental illness to be the victim of a crime than to be a perpetrator [34,35].

What this suggests is that heightened concerns about increased risk and liability are misplaced when applied to most people most of the time. In the circumstances in which they are warranted, prudent risk assessment and management are central and crucial aspects of effective care. When not warranted, though, they place undue

restrictions on the liberty of persons with serious mental illnesses.

Issues of risk and liability put aside for the moment, how do we respond to the concern that people with serious mental illnesses will still make bad decisions if left up to their own devices? Initial studies in shared decision-making in fact point to the opposite and indicate that people with schizophrenia, for example, make decisions in similar ways as those with other medical disorders. Simply put, some people with mental illnesses make good decisions most of the time, some make good decisions some of the time and some make good decisions only rarely; but the same is true of the general population [36]. At this time, the only legal or statutorily-justified way to interfere with an individual's personal sovereignty (other than based on serious and imminent risk) is when the person has been determined to be incapable of making his or her own decisions by a judge and therefore has been assigned a legal guardian or conservator of person. Even in these cases, in many states a judge's decision needs to outline those *specific* areas in which the person is unable to make his or her own decisions. Short of this, the vast majority of individuals with serious mental illnesses have both the right and the responsibility of making their own decisions and of dealing with and learning from the consequences of these decisions.

Where then does all this leave the compassionate practitioner who wishes to support someone in his or her personal choice but fears the person is making potentially detrimental decisions that will jeopardize his or her recovery and wellbeing; for example, a person is choosing not to take medications that seem to be helpful or is spending time with someone who has physically abused them or provided them drugs? In these situations, we would not suggest that practitioners sit silently on the sidelines in the name of being person-centered or in the hope the individual will ultimately learn from suffering the "natural consequences" of an apparent self-defeating choice. Rather, in keeping with emerging best-practices in recovery-oriented care [37], we suggest that the role of the practitioner in such situations is to remain fully engaged with the person to explore what the choice means and why it is important to him or her; to identify potential pros and cons; to brainstorm alternative choices and to ensure the person has all the information necessary in order to make an informed decision. But, in the end, barring any immediate safety concerns, it is the person's decision to make, just as it is in any other healthcare arena.

Following the type of collaborative dialogue described above, the person, in fact, might arrive at a different decision that both parties are comfortable with. However, there also will be circumstances in which the person and the practitioner may need to "agree to disagree" moving forward. In these circumstances, some practitioners have expressed concern that they are exposing themselves to liability or failing to meet their clinical obligations, if the issue at hand is not identified in writing as an active problem area or treatment goal on the recovery plan. Rather than putting oneself at odds with the service user by insisting the issue become the focus of the planning process (e.g., Problem 1, substance abuse, Problem 2

medication non-compliance, etc.), the practitioner is encouraged to document fully the conversation in the medical record, capturing both perspectives in writing in the plan, making clear the service user's position as well as the practitioner's own efforts to communicate these concerns and to provide necessary support and information. While each and every situation must be evaluated on a case-by-case basis, we believe that this represents a balanced approach which both respects the individual's right to make decisions and practitioners' desires to ensure they have done their due diligence and upheld their professional obligations.

Conclusion

We hope that this discussion has helped to clarify some of the more confusing aspects of person-centered care planning for persons with serious mental illnesses. For readers who find general principles easier to follow than specific examples, we suggest that there is one general principle at the heart of person-centered care planning from which the responses offered above can all be derived. This principle is itself derived from the fundamental assumption of the mental health recovery movement, which is that people with serious mental illnesses have been, are and will remain people first and foremost, just like everyone else [28].

If people with serious mental illnesses are first and foremost people, then it follows that person-centered care planning for people with serious mental illnesses is first and foremost similar to, if not exactly the same as, person-centered care planning for other people. We need only depart from this approach when required by specific challenges posed by the illness or by other aspects of the person's life history, such as a history of demoralization and despair. Any adaptations or additions that need to be made to the basic process of identifying the person's goals, the barriers to those goals and an action plan to pursue the goals and overcome the barriers, need not fundamentally alter the nature of the approach itself. Rather, we suggest beginning with an approach to person-centered care planning that would be relevant and applicable to anyone at all and then make the adaptations and additions required by the nature of the specific mental illness this specific person is experiencing and its specific impact on his or her ability to participate fully in the process. Developing strategies and tools that can assist people in these specific tasks of identifying and setting goals and making their decisions remains an important area for development in the future.

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