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Person-centered planning in mental health: A transatlantic collaboration to tackle implementation barriers

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Abstract

Collaborative, person-centered approaches to care planning are increasingly recognized as instrumental in supporting attainment of personal recovery outcomes. Yet, though much is known about factors that support person-centered planning, successful implementation often remains an elusive goal. This article 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 (e.g., 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 descriptions of key principles and practices as they relate to both relational aspects (e.g., shifts in stakeholder roles and conversations) and documentation/recording aspects (e.g., how person-centered relationships are captured in written or electronic records). Similarities and differences between the United States and Scottish experiences of PCCP are highlighted and a series of recommendations offered to further implementation of this essential recovery-oriented practice.

Keywords

mental health; outcomes; person-centered care; person-centered planning; recovery

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 those with severe mental illnesses. Person-centered care is uniquely beneficial because when people are actively involved in their care, they experience

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improved clinical outcomes; these include being less likely to use emergency hospital services (de Silva, 2011), being better able to manage complex chronic conditions, seeking appropriate assistance, experiencing reduced anxiety and stress, and having shorter hospitalizations (Balik, Conway, Zipperer, & Watson, 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, Ingoglia, Schmelter, & Marcus, 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 health care quality established by the U.S. Institute of Medicine (2001), which 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" (p. 6). 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. Although the person-centered dimension has been increasingly promoted within health and social care services for many years, there is still no universally agreed-upon definition (de Silva, 2014). This is perhaps unsurprising, given that being person-centered means adapting to the circumstances and priorities of each individual, as opposed to the typical approach of viewing service users as subjects of medical treatment in the context of the health care system. Therefore, it could be argued that the quest is not to produce standardized guidelines for universal application, but to agree on shared principles about ways of being with people.

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

- affording people dignity, compassion, and respect;
- offering coordinated care, support, and/or treatment;
- offering personalized care, support, and/or treatment; and.
- supporting people to recognize and develop their own strengths and abilities, enabling them to live independent and fulfilling lives (de Silva, 2014, p. 6).

Although 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 is discussed in further detail below. The enabling principle also moves beyond the ethical rationale for person-centered practice; additional benefits include improving the sustainability of services. As identified in the opening paragraph, supporting someone to become an active agent in his or her own care and life encourages less reliance on services and gives way to more opportunities for a good quality of life.

In an effort to advance understanding of the key principles and practices of person-centered programs within the context of mental health, international partners from Europe and the United States have been brought together through an European Union (EU)-funded (Horizon 2020 program) project titled Citizenship, Recovery, and Inclusive Society Partnership

(CRISP). Collaborators from Scotland and the United States found significant parallels in the challenges they encountered during person-centered planning implementation and recognized the potential for mutual learning around implementation strategies and continuing research. This article provides an overview of the evolution of person-centered care planning (PCCP) within the United States and the United Kingdom, particularly 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 the 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) published an additional report that describes a strategy for ensuring that individual preferences and values prevail in the face of stigma, discrimination, and treatment coercion within 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, Chevalier, Lawrence, Leamy, Bird, Macpherson, Williams, & Slade, 2015). In the United States, the voices of the recovery movement were formally recognized in 2003 when the New Freedom Commission on Mental Health (2003) mandated that recovery be integrated into all aspects of mental health policy. Person centeredness was included as a fundamental component of recovery, as defined by the U.S. Substance Abuse and Mental Health Services Administration (Department of Health and Human Services, 2004). Although recovery-oriented policy was first established in the United States, it began to feature in drug policies in Scotland in 2008 and was soon followed by similar developments in the rest of the United Kingdom (Humphreys & Lembke, 2013). It is suggested that the first U.K. 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 Self Management and Recovery Training (SMART) Recovery organization in 2008 (Humphreys & Lembke, 2013).

However, as recovery oriented, person-centered care has been embraced at the policy level, the complex realities of translation into practice within systems of care underpinned by a biomedical view of health—with associated financial and legal constraints—have also become apparent (Tondora, Miller, & Davidson, 2012). Although the U.S. 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 required demonstration of “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, a constant tension emerges with simultaneous mandates for individualized, flexible, person-centered care (Clossey, Rowlett, & Walker, 2014).

Meanwhile, in the United Kingdom, evidence shows that though staff identify with the notion of recovery, its implementation in practice is patchy; this is at least partly due to competing priorities within and between different layers of the health care system. Although the nationalized health care system is not subject to the same pressures to seek reimbursement, the health care 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 systems-based barriers to recovery-oriented person-centered planning, there have been instances of progress in both the United States and the United Kingdom; the focus here is to explore supportive factors while acknowledging the need to address longstanding challenges.

Person-centered care planning

The broader philosophy and principles of person-centered care inform new ways in which practitioners and people with mental illnesses can partner in the practice of person-centered care planning (PCCP). *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), which results in the cocreation 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 coproducers of collaborative plans (Epstein & Street, 2011; Tondora, Miller, Slade, & Davidson, 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.

Within mental health care contexts, tailoring service planning to people’s personal life goals, or personal outcomes, has emerged as a recovery-oriented practice (Adams & Grieder, 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 have typically had limited control over their lives. Active engagement in support planning can help someone develop the confidence and skills needed to reestablish his or her identity and regain control (Adams & Grieder, 2014; Tondora et al., 2014). In some cases, a person’s experience of symptoms may interfere with his or her ability to engage and make informed choices; however, even when it does not, his or her capacity to engage in shared decision making is often questioned (Beitinger, Kissling, & Hamann, 2014; Ehrlich & Dannapfel, 2017). Thus, what may appear at first to be a lack of motivation may actually be discomfort with the significant role shift for individuals who have been socialized into passive roles within health and care systems.

Promoting recovery for people experiencing mental illness also requires tackling the discrimination and stigma identified by the Institute of Medicine. Because individuals with serious mental illnesses are first and foremost people, it necessarily 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, Van Hove, Vandevelde, van Loon, & Schalock, 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 (Richards, Coulter, & Wicks, 2015). Within community mental health settings, two randomized controlled trials demonstrated positive outcomes. The first study examined PCCP among adults with low incomes, and histories of psychosis, who identified as Hispanic and Black/African American in a peer-run community integration intervention. This showed that PCCP was effective in increasing participants’ active involvement in the care planning process and 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, de Silva (2014) found that relevant studies tend to focus on four main issues: definitional measures, preferences of service users, experiences of service users, 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, p. 2). Although 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 United Kingdom. Earlier work on personal outcomes at York University (Qureshi, 2001) has influenced a long-term research, practice, and policy program of work in Scotland (Cook & Miller, 2012; Miller & Barrie, 2016).

This shift to an outcomes-based approach signals a move away from a limited focus on inputs, processes, and short-term targets and toward the impact that policy and service delivery have on people and communities (Office of the Chief Social Policy Advisor, 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 outcomes (e.g., feeling safe and being involved in meaningful activities and relationships). Although 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 in the United Kingdom and the United States.

Smull and Lakin (2002) identified how good intentions with person-centered planning can be 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, p. 383). More recently, in the United States, Taylor and Taylor (2013) highlighted that identifying predetermined outcomes could potentially be contradictory to the principles of person-centered planning, because some outcomes may become apparent during the planning process itself. The need to include qualitative data and create plans that detail personal outcomes or goals are features of the United States and Scottish programs described here. Against this background, we now consider some of the key challenges and strategies within both contexts.

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

We identified three areas that are key to focusing efforts in implementing collaborative PCCP in both countries: 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.

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. Although 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. Our purpose here is to build consensus and enthusiasm for person-centered care planning.

Just as PCCP may require the development of new skills among people 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 emerge for developing the commensurate skills (Tondora et al., 2014). Notably, practitioners can be skeptical about their clients’ readiness to engage in PCCP and ability to set life goals (Zubkoff, Carpenter-Song, Shiner, Ronconi, & Watts, 2016). To implement PCCP practices, and overcome such barriers, recovery-oriented values need to be nurtured within health care settings to enable practitioners to embrace strengths-based assessment, increase hope for the future, respect cultural differences, and partner successfully with the individual.

One of the challenges for implementation in many services is the use of standardized approaches to engage with the people who use those services. Being person centered requires flexibility and adaptability to meet people wherever they are in their recovery process. There can be significant differences between individuals and within individuals at different points on their recovery journeys, 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 nonverbal and other subtle cues to help identify goals. In Scotland, some practitioners have expressed their 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 someone to envisage what a better life might look like (Cook & Miller, 2012). As alluded to earlier, this is likely to be exacerbated where there is learned helplessness and institutionalized dependence, common among 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 well-being 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, Tuson, Biehal, & Marsh, 1993) has been identified in Scotland as supporting a balance in negotiating and agreeing on outcomes, while also acknowledging risks. This model, which originated in social work, has repeatedly proven useful for refocusing attention on the importance of including all perspectives in PCCP. This includes, not least of course, the perspective of the person in recovery, as well as the perspectives of the family member(s) where appropriate, the practitioner(s), and the agency, 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 coproduction rather than consumerist approaches. It responds to a concern identified by practitioners in the United States and Scotland about not losing sight of professional knowledge (Cook & 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 professional responsibility to manage those risks. However, it is not possible for anyone to live a risk-free life. In keeping with best practice in recovery-oriented care (Drake, Deegan, & Rapp, 2010), the role of the practitioner in such situations is to remain consistently engaged with the person to explore what a given choice means, identify potential pros and cons, consider alternatives, and 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-upon and set outcomes, identified through the exchange of perspectives as illustrated in Figure 1.

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 the face of such barriers. It is to these broader systemic and organizational factors we turn next.

Systems-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, the adherence to person-centered principles, and the recognition of the range of interventions and contributors (family and community-based supports) involved in the planning process (Tondora et al., 2014). This includes positive risk enablement, a right to "failure," and a commitment to outcomes and process evaluation.

A key systems-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 consider the United States and the United Kingdom, in turn, to illustrate 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.

The U.S. researchers have explored ways of navigating perceived tensions between PCCP and medical necessity in ways that honor the person and satisfy the documentation requirements. The belief that funders will not pay for nonclinical 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 their mental health barriers to a higher level of functioning and the attainment of valued recovery goals. Furthermore, 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, Adler, McCandless, & Leopolous, 2017). This method has been effectively employed within the U.S. model to build staff competency and skills in cocreating person-centered plans. Consistent with evidence-based adult-learning strategies, the U.S. team incorporates a diverse array of teaching methods to promote the uptake of PCCP (e.g., experiential approaches, skills-based training, ongoing technical assistance, repeated behavioral rehearsal/practice, and a provider training manual). A 2-day intensive skills course launches the implementation effort. To reinforce the incorporation of this learning in the 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 then receive coaching and feedback from the 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 with administrators regarding the balance of person-centered documentation with “medical necessity” and other regulatory expectations, development of practical workbooks and “tips sheets” for use by staff, and feedback regarding the ability of treatment planning software and electronic health records to facilitate person-centered practice. Follow-up group-based formats allow for cross-fertilization of knowledge of, and building enthusiasm for PCCP.

In the United Kingdom, research by Le Boutillier et al. (2015) found that business priorities such as funding and contractual objectives of the National Health Service 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 United Kingdom, the requirement to meet the four bands of the Fair Access to Care Services (FACS) eligibility criteria—critical, substantial, moderate, and low—can present an issue of conflict for practitioners. Evidence shows that though FACS criteria may support standardization, they are likely to lead to people not receiving the support they need (Commission for Social Care Inspection, 2009). They encourage a focus on what the person is unable to do, emphasize deficits and commensurate risks, and 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 discussed below (Miller & Barrie, 2016). A network, which meets quarterly, is also available to anyone involved in implementation, to exchange learning from diverse perspectives and progress some of the challenges identified.

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 to practice gap in client-centered care initiatives (McCay, Cleverley, Danaher, & Mudachi, 2015).

Capturing the process and outcomes of PCCP

Although a widely mandated and clearly ethical practice, there are still challenges in capturing the effectiveness of PCCP, regarding how the practice can transform the process of care and—more importantly—the way in which it enhances the lives of people with severe mental illnesses. As the climate of accountability in the United Kingdom and the United States demands quantifiable outcomes, the quest is to find a 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 determine the success or failure of the practice in real-world settings.

A recent review of outcomes-based approaches identified that the issue receiving the 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, 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 a clear cause-and-effect relationship 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 the recognition of the individual’s role 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 & 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, as well as the extent to which people had been involved in developing 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 regarding what to include and exclude from the record. A strong theme that emerged from the data was that recording needed a separate focus in its own right and that pragmatic and clear guidance was needed to support the shift away from deficit-led recording systems. Five simple criteria were identified to support the implementation of outcomes-focused recording:

- outcomes (or clear purposes) should be identified, not just outputs (services).
- outcomes should be personalized 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 & Barrie, 2016).

The U.S. researchers are conducting a randomized controlled trial of PCCP using mixed methods, which will explore the process of care and implementation factors in addition to testing the effectiveness of the intervention (Stanhope, Tondora, Davidson, Choy-Brown, & Marcus, 2015). Randomizing seven community health clinics to experimental conditions and seven to control conditions, the aim is to assess the providers’ fidelity to PCCP and the influence of organizational factors. To assess fidelity to PCCP, providers were surveyed using the Person-Centered Care Questionnaire (Tondora et al., 2014) and the Recovery Knowledge Inventory (Meehan & Glover, 2009). 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 (Avolio, Bass, Walumbra, & Zhu, 2004), Organizational Readiness Climate Scale (Glisson & Schoenwald, 2005), and the Recovery Self-Assessment Scale (O'Connell, Tondora, Croog, Evans, & Davidson, 2005). Although there is an increasing number of 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 provider and service user perspectives. In this study, focus groups and leadership interviews were undertaken to investigate how providers understood PCCP and its value, and how the implementation process unfolded in their agencies. Focus groups undertaken with service users explored their experiences of person-centered planning and its relationship with their recovery goals.

Preliminary findings from the baseline quantitative surveys completed by leaders, supervisors, and direct care staff ($N = 273$) indicated that more transformational leadership predicted a more recovery-oriented organization, but that effect was mediated by a positive organizational climate (Stanhope, Matthews, Choy-Brown, & Doherty, 2017). This supports the notion that leadership and climate play important roles in the 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 (Stanhope et al., 2017). This points to the challenge of people 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 objective assessment, which will be done in this study by reviewing providers' service plans to assess the extent to which they are, in fact, person centered.

There are some significant distinctions between the methodologies employed by the studies in each country. However, the purpose of the collaboration at this stage is to review the findings of the existing research and implementation programs and their implications for practice, policy and further research. Given the concern to advance knowledge in this area, the difference areas of inquiry and associated methods are a strength. A more comparative approach might be considered as part of the next stage.

Discussion

This article brings together learning from multiple person-centered care programs, which have been developed independently in the United States and Scotland. The EU-funded CRISP project has provided an opportunity to identify common challenges, paving the way for improved implementation strategies. A key strength of the emerging partnership is the blend of research, policy engagement, and practice development. This article mainly focused 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 constraints remain core concerns 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. Although 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 encouraged to live independent and fulfilling lives (de Silva, 2014). This is not supported by systems prioritizing standardization at the expense of personalization and enablement.

As previously noted, there is as yet no single definition of person-centered practice; there are however common themes that have emerged in the literature over many years. These core principles include the development of respectful relationships between practitioners and people experiencing mental illness; the involvement of the person in identifying personal goals or outcomes, which relate to his or her whole life rather than being restricted to service-led treatment options; the importance of including personal, family, and community-based resources to achieve 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 emphasize deficits, focus on symptoms, and encourage 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. Although progress is being made in pockets to achieve PCCP—largely due to the efforts of people using services, practitioners, and, in some cases, the organizations involved—renewed efforts are required in ensuring that all perspectives are included in the development of 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 that have been found to be successful, as well as continued vital collaboration between research, policy, and practice in diverse constituencies.

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Figure 1.

The exchange model of assessment (adapted from Smale et al., 1993).