

**Implementation of Person-Centered Care and Planning:
How Philosophy Can Inform Practice**

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“You keep talking about getting me in the ‘driver’s seat’ of my treatment and my life... when half the time I’m not even in the damn car!”

—woman in recovery¹ on her experiences of treatment planning

As the above quote illustrates, mental health services in this country—including the potentially pivotal process of recovery planning—continue to be oriented primarily to the requirements of bureaucracies rather than to the goal of providing individuals² (and, in the case of youth and their families) real and meaningful opportunities for choice and self-determination. The recently released *Federal Action Agenda* makes a clear and compelling case for the fundamental and profound transformation necessary to revolutionize a system of care which currently holds people, and their dreams for recovery, “hostage to outmoded and contradictory regulations that dictate the services individuals receive and the funding that is available to support them” (DHHS, 2005). Transformation efforts must occur simultaneously at all levels of the system if it is to be fully re-oriented to the needs, priorities, and personally-defined goals of people in recovery (Osher, Osher, & Blau, 2005a).

Person-centered planning (PCP) has increasingly been recognized as one promising tool in the process of transforming the current system and restoring certain elementary freedoms (e.g., self-determination, community inclusion, etc.) to American citizens with psychiatric diagnoses and the loved ones who support them (Institute of Medicine, 2001). Consumers demand it, public service systems endorse it, medical and professional programs are encouraged to teach it, and researchers investigate it. Yet, people struggle to understand exactly what “*It*” is and what “*It*” might look in practice. To some extent, this challenge holds true for the implementation of any new approach or strategy. However, it is particularly formidable when implementing a practice such as PCP that is based on a moral/values imperative—a practice whose adoption forces the system and all of its stakeholders to address the conflict between two diametrically opposed paradigms: the long-dominant medical/illness paradigm and the emerging recovery paradigm. Successful implementation of person-centered planning warrants changes not only in professionals’ behaviors and in agencies’ policies but, more importantly, dramatic shifts in individual beliefs and organizational culture (Osher & Osher, 2001; Osher, Osher, & Blau, 2005b).

These complexities of implementation are not unique to the context of mental health systems. Person-centered planning has been employed for more than a quarter of a century in the broader disability arena in a variety of models such as lifestyle planning (O'Brien, 1987), whole-life planning (Butterworth et al., 1993), the McGill Action Planning System (Vandercook, York & Forest, 1989), and personal futures planning (Mount & Zwernik, 1988). It is widely respected as a best practice to design effective networks of services and supports that enable people to have a higher quality of life and to achieve full citizenship and integration into their communities (Burns & Goldman, 1999; Kendziora, Bruns, Osher, Pacchiano, & Mejia, 2001.) Despite its relative longevity and recognition as a best practice, PCP in the disability arena continues to be “used and misused, complicated and simplified, lengthened and shortened, trivialized, legalized and lionized” (O'Brien & O'Brien, 2000, p. 2) by those who misunderstand it as well as those who feel challenged by it.

The Case for the “Nuts and Bolts”

How, then, can we avoid the trap of misapplication and trivialization as we struggle to build consensus in the mental health field in relation to person centered planning—as we struggle to define what *It* is and struggle to figure out how we will know when we are making good on our promise to deliver *It*? There are real and valid concerns that in its “importation” to the mental health system, the hallmarks of person-centered planning will be diluted and compromised to the extent that the process is no longer recognizable or worthy of being called “person-centered.” One response is to address the dire need to move beyond the rhetoric of “person-centered care” and its associated abstractions to which no system or individual provider can, in the end, be held accountable (O'Connell et al., 2005). Indeed, articulating the “nuts-and-bolts” of the practice and its effective implementation is the main purpose to which the remainder of this paper will be devoted. While not an exhaustive review of program innovations around the country, our hope is that the presentation of practice guidelines will add a dimension of clarity to the consensus-building process and further advance the dialogue regarding person-centered planning strategies.

A few cautionary notes are necessary before moving on to this topic; first: what our intention is and what it is **not**. Person-centered planning cannot be implemented as though it were some simple thing like inserting “Tab A” into “Slot B.” Our emphasis on “nuts and bolts” should by no means be taken to suggest this. In fact, such a rigid adherence to a single model or

set of standards would be antithetical to the core premises of person-centered planning! Nonetheless, there are underlying principles that suggest what it is, and what it is not, and we will articulate these to offer guidance (not directives) for well-intentioned providers who ask the question—as they so often do—“What can we do differently *today* when we sit down with Tisha to do her treatment plan?” We will review reflective practices and innovative programs in an effort, in the words of O’Brien (2002), to “encourage the flowering of diverse methods...that express the many different gifts of those people who accept responsibility for the work” and the responsibility to walk beside people on their unique paths to recovery, wellness, and better lives.

Second, it is imperative to note that carrying out the “nuts and bolts” of PCP will be meaningless unless it is accompanied by profound change—“not at the margins of the system, but at its very core” (DHHS, 2005). A dramatic paradigm shift which fundamentally alters the ways in which professionals, individuals, families, and the community behave and interact is necessary to achieve person-centered planning and the true partnership it is based on (Osher & Osher, 2001). We must work together to move away from “medical necessity” toward “human need,” away from managing illness to promoting recovery, away from deficit-oriented to strengths-based, and away from symptom relief to personally-defined quality of life. Perhaps most critical is the fundamental shift in power involved in realigning systems to promote person and/or family-centered planning—the shift away from prioritizing “expert” knowledge over respect for individual autonomy and self-determination (Osher & Osher, 2001; WNYCCP, 2005). The *practice* of PCP can only grow out of a *culture* that fully embraces the principles embodied in these types of changes. As such, for the remainder of this paper, we assume as the foundation for the practices we describe a system which reflects this major paradigm shift toward recovery-oriented, person-centered care.

Finally, there are many critical topics that cannot be adequately addressed in a paper of this scope and length. These include the unique issues of children and families, the impact of culture on planning processes and preferences, and the challenges posed by questions concerning the person’s capacity for self-determination. We consider these issues to be crucial to the successful implementation of person-centered planning, but will defer their elaboration to our colleagues who have prepared additional papers as a part of this consensus-building process.

Review of Promising Programs

The practice guidelines which follow derive from the experiences of people in recovery, providers, administrators, and “family” members from around the country who have taken on the challenge of implementing person-centered planning in one form or another. For the readers’ reference, Table 1 attached summarizes select programs and/or state initiatives involved in this effort and notes web-based resources where more detailed information is available.

Review of Person-Centered Practice Guidelines

The guidelines themselves reflect a range of criteria from those that would be considered “minimal threshold” to those that would be considered “standards of excellence.” The former are not included so as to suggest that the “bare minimum” (e.g., a signature on a planning document) is at all an acceptable alternative to a more lofty vision³³ of person-centered care. Rather, it is put forth simply as an honest appraisal and acknowledgement of where the system is starting and how very far we have to go to actualize the principles of person-centered planning. While this may seem at times inadequate, incremental change, which can set the stage for more extensive systems transformation, is better than no change at all, or change that is limited to symbolic gestures or “talking the talk.” We suggest that incremental change can be achieved while still maintaining a rigorous pursuit of excellence in the provision of person-centered care.

Finally, just as starting where the system is now is necessary, so too is engaging in the process of PCP beginning where each person is as well. No matter how person-centered a practice is in theory, it ceases to be person-centered if it does not respect the individual’s preferences as well as his/her existing capacities and resources. This means tapping into the expertise of the individual and seeking to complement what he or she already has working for him or her. While the “package” of strategies will look different across systems and individuals, select practices which exemplify person-centered principles include those which:

Make continuous use of strengths-based assessment strategies:

- A discussion of strengths is a central focus of every assessment, care plan, and case management summary. Assessments begin with the assumption that individuals are the experts on their own recovery, and that they have learned much in the process of living with and working through their struggles.

- Initial assessments recognize the power of simple, yet powerful questions such as “What happened? And what do you think would be helpful? And what are your goals in life?” Self-assessment tools rating level of satisfaction in various life areas can be useful ways to identify diverse goal areas around which supports can then be designed.
- The concepts of stages of change or developmental readiness is valued as helpful in understanding a person’s ability or preference for engaging in the PCP process (Adams & Grieder, 2005; Osher, Osher, & Blau, 2005b).
- Assessment of strengths is conceptualized broadly to include skills, talents, personal virtues and traits, interpersonal skills, community and environmental resources, cultural knowledge and lore, family stories and narratives, knowledge gained from struggling with adversity knowledge gained from occupational or parental , spirituality and faith, and hopes and dreams (Kendziora et al., 2001; Saleeby, 2001). A diverse assessment of individual and environmental strengths is consistent with the view that treatment and recovery is not seen as a solitary process but rather as a journey toward interdependence with one’s community of choice.
- In addition to the assessment of individual capacities, it is beneficial to explore other areas not traditionally considered “strengths,” e.g., an individual’s most significant or most valued accomplishment, what motivates them, educational achievements, ways of relaxing and having fun, ways of calming down when upset, preferred living environment, personal heroes, most meaningful compliment ever received, etc.
- Efforts are made to record the individual’s responses verbatim, including his or her unique goals, rather than translating the information into professional language. This helps to ensure that the assessment remains narrative-based and person-centered. If technical language must be used, it is translated appropriately and presented in a person-first, non-offensive manner, e.g., avoiding the language of “dysfunction, disorder” etc.
- Illness self-management strategies and daily wellness approaches such as WRAP (Copeland, 2002) are respected as highly effective, person-directed recovery tools, and are fully explored in the strengths-based assessment process. When a WRAP is already in place, it serves as the foundation of the PCP process.
- A written protocol for a strengths-based assessment follows an in-depth discussion with the individual (or in the case of children and youth, the individual and his or her family) as well

as attempts to solicit collateral information regarding strengths from the individual's family and natural supporters.

- Strengths-based assessment is conducted as a collaborative process and all assessments in written form are shared with the individual and with natural supporters at the discretion of the individual. .
- Diagnostic “catch-all” labels are not used as a means of describing an individual (e.g., “she’s a borderline”), as such labels (in addition to generating negative emotions and reinforcing stigma) often yield minimal information regarding the person’s actual experience or manifestation of the difficulties they may be struggling with. Alternatively, an individual’s needs are best captured by an accurate description of his or her functional strengths and areas identified for growth.
- The language used is neither stigmatizing nor objectifying. At all times “person first” language is used to acknowledge that the diagnosis is not as important as the person’s individuality and humanity, e.g., “a person diagnosed with schizophrenia” versus “a schizophrenic” or a “person with an addiction” versus “an addict.” Employing person-first language does not mean that a person’s diagnosis is hidden or seen as irrelevant; however, it also is not be the sole focus of any description about that person. To make it the sole focus is depersonalizing and derogatory, and is no longer considered acceptable practice.
- The language used also is empowering, avoiding the eliciting of pity or sympathy, as this can cast people with diagnoses in a passive, victim role and reinforce negative stereotypes (Osher, 1996). For example, just as we have learned to refer to “people who use wheelchairs” as opposed to “the wheelchair-bound” we should refer to “individuals who use medication as a recovery tool” as opposed to people who are “dependent on medication for clinical stability.” Words such as “hope” and “recovery” are used frequently in documentation and delivery of services. Professionals are mindful of the power of language and carefully avoid the subtle (and sometimes not so subtle) messages that professional language has historically conveyed to people with psychiatric diagnoses and their loved ones.

Adhere to person-centered principles in the process of building person-centered plans:

- Consistent with the “nothing about us, without us” dictum, providers actively partner with the individual in all planning meetings and/or case conferences regarding his or her recovery

services and supports.

- The individual has reasonable control as to the location and time of planning meetings, as well as to who is involved. Planning meetings are conducted and services are delivered at a time that does not conflict with other activities that support recovery such as employment. The individual can extend invitations to any person she or he believes will be supportive of his or her efforts toward recovery. Invitations extended are documented in the recovery plan. If necessary, the person (and family as relevant) are provided with support before the meeting so that they can be prepared and participate as equals (e.g., Osher & Keenan, 2001).
- The language of the plan is understandable to all participants, including the focus person and his or her non-professional, natural supporters. Where professional terminology is necessary, this is explained to all participants in the planning process.
- Where individuals are engaged in rehabilitation services (e.g., in housing, social, or educational/employment areas), these rehabilitation providers are involved in all planning meetings (at the discretion of the individual) and are given copies of the resulting plan.
- Within the planning process, a diverse, flexible range of options must be available so that people can access and choose those supports that will best assist them in their recovery. These choices and service options are clearly explained to the individual. Where preferred supports do not exist, the recovery team works collaboratively with the individual to develop the support or to secure an acceptable alternative. Goals are based on the individual's unique interests, preferences, and strengths, and objectives and interventions are clearly related to the attainment of these stated goals. In the case of children and youth, the unique goals of family are also considered with the youth increasingly driving the process as he or she approaches the age of maturity.
- Planning focuses on the identification of concrete next steps, along with specific timelines, that will allow the person to draw upon existing areas of strength to move toward recovery and his or her vision for the future. Individuals, including non-paid, natural supporters who are part of the planning process, commit to assist the individual in taking those next steps. The individual takes responsibility for his or her part in making the plan work. Effective recovery plans help people rise to this challenge.
- Information on rights and responsibilities of receiving services is provided at all recovery planning meetings. This information should include a copy of the mechanisms through which

the individual can provide feedback to the provider and/or agency, e.g., protocol for filing a complaint or compliments regarding the provision of services.

- In the spirit of true partnership and transparency, all parties must have access to the same information if people are to embrace and effectively carry out responsibilities associated with the recovery plan (Osher & Osher, 2001). All individuals are automatically offered a copy of their written plans and assessments. A simple but powerful strategy, knowing ahead of time that a copy will be shared can dramatically impact both the language of the plan and the content of its goals and objectives.
- The team reconvenes as necessary to address life goals, accomplishments, and barriers. Planning is characterized by celebrations of successes, and meetings can occur beyond regular, established parameters (e.g., 6-month reviews) and crises (e.g., “all-treaters” meetings to address hospitalization or relapse).

Recognize the range of interventions and contributors to the planning and care process:

- Providers acknowledge the value of the individual’s existing relationships and connections. If it is the person’s preference, significant effort is made to include these “natural supporters” and unpaid participants as they often have critical input and support to offer to the team. Treatment should complement, not interfere with, what people are already doing to keep themselves well, e.g., drawing support from friends and loved ones (Osher & Webb, 1994).
- The plan identifies a wide range of both professional supports and alternative strategies to support the person’s recovery, particularly those which have been helpful to others with similar struggles. Information about medications and other treatments are mingled with information about self-help, peer-support, exercise, nutrition, daily maintenance activities, spiritual practices and affiliations, homeopathic and naturopathic remedies, etc.
- Individuals are not required to attain, and maintain, clinical stability or abstinence before they are supported by the planning team in pursuing such goals as employment. For example, in some systems access and referral to vocational rehabilitation programs may be controlled by a clinical provider, and individuals are often required to demonstrate “work readiness” or “symptomatic stability” as a prerequisite to entry. In addition to an abundant body of research which has shown that such screening procedures and criteria have limited predictive validity, this structure also neglects that fact that activities such as working are often the path

through which people become clinically stable and recover their lives.

Value community inclusion as a commonly identified and desired outcome:

- The focus of planning and care is on how to create pathways to meaningful and successful community life and not just on how to maintain “clinical stability” or abstinence. Person-centered recovery plans document areas as physical health, family and social relationships, employment/education, spiritual life, housing satisfaction, community connections, recreation, community service and civic participation, etc., unless such areas are designated by the person as not-of-interest.
- Achieving interdependence with natural community supports is a valued goal for many people in recovery who express a strong preference to live in typical housing, to have friendships and intimate relationships with a wide range of people, to work in regular employment settings, and to participate in school, worship, recreation, and other pursuits alongside other community members (Reidy, 1992). Such preferences often speak to the need to help reduce time spent in segregated settings designed solely to support people labeled with a mental illness.
- Recovery plans respect the fact that services and professionals should not remain central to a persons’ life over time, and exiting criteria from formal services are clearly defined.
- Given its focus on life context, one tool required for effective recovery planning is adequate knowledge of the person’s local community, including its opportunities, resources, and potential barriers. This knowledge is to be obtained and updated regularly at a community-wide level for the areas in which a program’s service recipients live, but also is to be generated on an individual basis contingent on each person’s interests, talents, and needs. *Asset-based community development* is one strategy for developing this comprehensive understanding of local resources and supports. Based on the pioneering work of and Kretzmann and McKnight (“Building Communities from the Inside Out”), asset-based community development (ABCD) is a widely recognized capacity-focused approach to community development that can help open doors into communities for persons who have been labeled or otherwise marginalized and through which people in recovery can build social capital and participate in community life as citizens rather than as clients.
- A focus on community is consistent not only with person-centered principles but with the

need for fiscal efficiency. Professionals and service recipients should be mindful of the limited resources available for specialized services and should focus on community solutions and resources first by asking “*Am I about to recommend or replicate a service or support that is already available in the broader community?*” At times this has direct implications for the development of service interventions within recovery plans, e.g., creating on-site health and fitness opportunities such as exercise classes without first exploring to what extent that same opportunity might be available in the broader community through public recreational departments, YMCAs, etc. If natural alternatives are available in the community, the individual should be informed of this opportunity and the extent to which it is offered in a culturally competent, and effective manner, and then supported in pursuing his or her choice.

Support the “dignity of risk” and the “right to fail” (Deegan, 1996):

- Prior to any acts of imposing power, providers relentlessly try different ways of engaging and persuading the individual (or in the case of children and youth, individual and family) which respects their ability to make active choices.
- The individual is presumed competent and entitled to make his or her own decisions. She or he is encouraged and supported to take risks and try new things. Only in cases involving imminent risk of harm to self or others is a clinical professional allowed to override the decisions of the individual and his or her support team. Person-centered care does not take away the provider’s right, and responsibility, to take action to protect the person or the public in the event of emergency or crisis situations, but limits the authority of providers to narrowly defined circumstances as defined by statutory laws.
- In all other cases, providers are encouraged to offer their expertise and suggestions respectfully within the context of a collaborative relationship, clearly outlining for the person his or her range of options and their respective (potential) consequences. The professional supports the dignity of risk and sits with his/her own discomfort as the person tries out new choices and experiences that are necessary for growth and recovery.
- In keeping with this stance, providers encourage individuals to write their own crisis and contingency plan (such as psychiatric advanced directives or the crisis plans of the WRAP model). Ideally, such plans are directed by the individual but developed in collaboration with the entire team so as to share responsibility and resources in preventing or addressing crises

(Kendziora et al., 2001). Such plans provide detailed instructions regarding preferred interventions and responses in the event of crisis, and maximize an individual's ability to retain some degree of autonomy and self-determination at a time when he or she is most likely to have these rights taken away. This plan is kept in an accessible location and can be made available for staff providing emergency care.

Demonstrate a commitment to both outcomes and process evaluation:

- Outcomes evaluation in a provider-driven paradigm is typically limited to change in specific agency functions (e.g., length of hospital stays) as well as by the need to protect the image of the agency (e.g., consumer satisfaction) (Osher & Osher, 2001). In contrast, evaluation in a consumer or family-driven paradigm is a continuous process and expectations for successful outcomes in a broad range of quality of life dimensions (e.g., in areas such as employment, social connections, community membership, etc.) are high. The maintenance of “clinical stability” alone is not accepted as a treatment outcome as the experience of recovery is about much more than the absence of symptoms or distress.
- There is concern that efforts to identify the “nuts and bolts” (i.e., the key process elements) of PCP will obscure the moral and values foundation that is so essential in its quality implementation—concern that adoption of a formula without adoption of its associated ideals often leads to a practice which is clumsy, artificial, and even patronizing (Evans, 2002). Despite such concerns, cogent arguments have been made regarding the need for flexible application of process tools such as the *Assessment of Person-Centered Planning Facilitation Integrity* Questionnaire (Holburn, 2001) to promote quality service delivery. Assuming attention is paid to the larger organizational culture, process tools can be helpful in defining the practice and then monitoring its effective implementation (Osher, Osher, & Blau, 2005b).

Lessons Learned Regarding Implementation Barriers and Solutions

This leads us to a brief discussion of lessons learned regarding barriers and solutions in the implementation of PCP. These lessons are derived from our own work in the States of Connecticut and New York, from our provision of technical assistance to grantees funded under the Comprehensive Mental Health Services for Children and their Families Program, and from experiences of the promising programs reviewed in Table 1.

- First and foremost, **the medical/illness-based paradigm** from which our mental health system has historically operated is perhaps *the* single-most overarching barrier impeding both consensus and implementation of person-centered planning. A recovery-oriented paradigm can not, and will not, be realized simply by changing what people *do* (i.e., their behavior). It also requires changing the way that people *feel* and *think* (i.e., their hearts and minds). As individuals and as a system, we must look inward and address the obstacles that linger in our own perspectives and worldview, and then we must talk with each other honestly and openly about what we see. Even in the process of writing this paper, while we as co-authors largely agreed on a vision of person-centered planning and the type of system needed to support it, we sometimes disagreed on how this particular paper might best serve that vision. We each brought differing perspectives to the table, and it was necessary for us to share those perspectives without reservation, to listen to others without judgment, and to negotiate a shared “voice” which we could contribute to this consensus-building dialogue. In some ways, this reflects the same type of listening, challenging, and partnering that is necessary in the system as a whole as it strives to achieve transformation and the paradigm shift it entails.
- **A lack of clarity** regarding what we are actually talking about and what the practice might look like in action has been a primary barrier to implementation. We hope that the previous pages begin to address this issue and help to generate further dialogue regarding promising practices and programs.
- The failure to date of the mental health system to deliver person-centered care cannot, and should not, fall, solely, on the shoulders of individual practitioners. Resistance to change on the individual level may be a very real and formidable barrier. Yet practitioners are frustrated by the fact that they are overwhelmed by a constant stream of **change mandates for which they receive little or no training or support**. Add to this the fact that that direct-care providers can be almost as devalued a group as the people they serve, and what results is a parallel process in which practitioner resistance is directly analogous to the resistance of service recipients when they get told what they *have* to do. As consensus emerges regarding the knowledge and skills needed to implement person-centered care, this information must lead to the development of competency models, and these models must be disseminated broadly as guidance for training programs and licensing bodies which prepare and accredit future and current providers of mental health care. Close collaboration with organizations

such as the Annapolis Coalition on Behavioral Health Workforce Development and the National Wraparound Initiative is necessary to ensure the competency of practitioners to engage in person-centered planning and to develop genuine partnerships with the people they serve.

- Even the most competent, well-prepared practitioners will be unable to implement PCP if they are not operating in an organizational context that promotes and values adherence to recovery-oriented, person-centered ideals (Walker, Koroloff, Schutte, & Bruns, 2004). As Rummeler, a leader in the human performance technology field, has so cogently stated, “When you pit a good performer against a bad system, the system will win almost every time” (1995). Exploration of the science-to-service gap has taught us that the adoption of best practices is significantly influenced by the level of institutional resources, the attitudes of program leaders, and organizational climate. These factors must be attended to as we strive to create cultures in which person-centered planning can take hold and thrive. Such **culture change** requires supervision focused on implementing Person Centered Planning one case at a time, case conferences which focus on the individual’s preferences and choices, and training of Directors of Clinical Services and Directors of Quality Improvement, who will have primary responsibility for assuring that resources are made available for implementing these changes in orientation and attitudes.
- **Assessment of organizational readiness** to adopt PCP may be one potential tool for illuminating and addressing critical contextual issues. A promising tool for this purpose in the mental health arena is the Recovery-Oriented System Indicators measure or ROSI (Onken et al., 2004). The ROSI is currently undergoing pilot testing and will be used to inform the development of a “report card” to assess recovery-oriented supports across state mental health systems. In addition, there are efforts underway in general medicine that have potential utility for application in mental health. For example, the Institute for Family-Centered Care has developed a toolkit for patient-centered medicine that includes a self-assessment instrument which pays particular attention to the organizational leadership necessary to involve patients and families as active partners in development of their plans (See: http://www.aha.org/aha/key_issues/patient_safety/contents/assessment.pdf).
- Intrinsic to any dialogue regarding systemic barriers to person-centered planning is the need to address **funding structures** that recognize a limited range of clinical interactions as

reimbursable services, and **documentation requirements** that hinder creative formulation of person-centered goals and objectives. This topic is widely recognized as a barrier of such magnitude that it is addressed in an additional paper in this series (Selleck, 2005) to which the reader can turn for additional information. Based on emerging best practices employing self-directed budgets and “flexible-funding” pools, we maintain that this barrier, though complicating, is not insurmountable. For example, in some cases, braiding funds, may enable collaborations to move beyond funding silos (Osher, Dwyer, & Jackson, 2004; Poirier, Osher, & Tierney, In Press). While ongoing fiscal and health care reform, at the federal level will greatly facilitate the adoption of PCP, there is much that systems, providers, and individuals can do *today* to improve the planning process so that it is carried out in partnership with people in recovery.

- Finally, no matter how competent the workforce, no matter how ripe the organizational context, and no matter how compatible the funding mechanisms, PCP will not become a reality unless people in recovery and their families understand it, are supported in using it, and come to demand it as a basic expectation of quality care. It is imperative that **training initiatives regarding PCP not neglect the needs of people in recovery and families to develop their own capacity** to self-direct their treatment and life decisions. Some may already do this with great skill and acumen. Others may be reluctant to assume the seat of power having been socialized by their culture (Harry, Kalyanpur & Day, 1999) or taught by professionals and agencies that their preferred role is one of deferential compliance (Katz & Danet, 1973). Ideally, training initiatives put all stakeholders, including consumers, families, and providers together at the same table. Doing so represents both a challenge and an opportunity. It sets a powerful precedent regarding the expectation to forge partnerships in which we can discuss even the most difficult of issues, and in which we can collectively celebrate the transformation of the mental health system and the realization of truly person-centered care.

In conclusion, we offer the guidelines and discussion above in the hope that states will begin to experiment with various approaches to person- and family-centered planning and care as core components of their system transformation efforts. Consistent with the emerging recovery philosophy, we suggest that self-determination and community inclusion provide the foundation upon which processes of resilience and recovery can be promoted. If mental health systems are

to promote these processes, then self-determination and community inclusion will need to be embraced as the prerequisites for recovery rather than continue to be indefinitely delayed as its eventual reward. Person- and family-centered planning offer one valuable tool for making this extremely important, and long overdue, shift in practice.

Notes

¹ The notion of recovery has become a dominant force in mental health policy, evident in both the Surgeon General and President's New Freedom Commission reports. In both reports, recovery is stipulated as the overarching goal of care and foundation for reforms at state and local levels. Little consensus exists regarding the nature of recovery in mental illness, however, or about the most effective ways to promote it. For the purpose of this paper, we endorse a broad vision of recovery that can include such things as developing a positive sense of identity apart from one's condition, establishing a meaningful sense of belonging and membership in the broader community, experiencing joy, and attaining "a life worth living" as defined by the person's interests, preferences, and dreams including partaking in valued and respected roles and the rights, freedoms, and responsibilities of any member of society (WNYCCP, 2005).

² There are many terms that have been used to refer to individuals who experience mental illness including person in recovery, individual with a mental illness, person labeled with a psychiatric disorder, mental health consumer, person with a psychiatric disability, etc. With the exception of adherence to "person-first" language principles, there is little conceptual agreement regarding the preferred or most appropriate terminology. Given the focus of this paper, we have opted to speak simply to the "person," and to use terms such as individual, person in recovery, person seeking services, etc.

³ The vision of person centered planning and self-determination is, and should remain, the pursuit of an ambitious ideal but one that is, ironically, based simply on the attainment of goals that are universal to typical human experiences – goals which appreciate our common humanity, our common aspirations and dreams, and our common sense of responsibility to become contributing members of society (Nerney, 2005, p. 4). However, the *reality* of the moment is more aptly reflected in the opening quote of this paper, i.e., the consumer who is not even in the "car," let alone the "driver's seat." Basic criteria such as "physically being present to participate in all planning meetings" must therefore be put forth simply because even these bare minimum expectations are not yet routinely being met in many mental health systems.

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Table 1. Summary of Select Programs, Initiatives, and Regulatory Efforts Regarding Person-Centered Planning

Description of Program & Practices Reflecting Person-Centered Innovation	For more info:
<p>The National Research and Training Center (NRTC) on Psychiatric Disability at the University of Illinois at Chicago is a program of research, training, technical assistance and dissemination activities designed to promote self-determination. This website contains a collection of papers devoted to the topic of person-centered care and self-determination. Of particular relevance to the implementation of person-centered planning is the Center’s person centered-planning guide, “his Is Your Life! Creating Your Self-Directed Life Plan.” It is an easy-to-use workbook that helps people think about, choose, plan for, and act on a life goal, with supports of their own choosing.</p>	<p>http://www.psych.uic.edu/UICNRTC/self-determination.htm</p>
<p>Wellness Recovery Action Planning. WRAP is a wholly self-directed recovery plan that is developed during a group learning process that is focused on recovery and tapping into one’s own expertise about what has been helpful and what has not, as well as learning from others about what has been effective in their journeys of recovery. Broad recovery education combined with concrete action planning empowers individuals to harness an expanding array of “wellness” tools—ranging from diet, exercise and peer support to primary health care and mental health treatment—that contribute to critical self awareness and lifestyles that are intentionally wellness-oriented.</p>	<p>http://www.mentalhealthrecovery.com/index.php</p>
<p>Network of Care for Mental Health, Trilogy Integrated Resources, LLC.: In the Final Report of the President's New Freedom Commission on Mental Health, Goal 6 reads: “Technology Is Used to Access Mental Health Care and Information.” Consistent with this goal, the Network of Care was a program developed in California and piloted as a joint public/private venture between the state, county governments, and Trilogy Integrated Resources. This highly innovative program empowers consumers and their caregivers directly with a wide range of information about local agencies; a worldwide knowledge base; evidence-based practices; individual and group support; recovery; policy advocacy; personal recordkeeping and much more. It represents a state-of-the-art use of high technology for mental health services at the local level. The integration of Person-Centered Treatment Plans into the Network of Care consists of four specific components: 1- Offer online training for consumers, families and the providers' network. 2- Provide an outline of the Person-Centered Treatment Planning process and informational materials for clients and family members. 3- make available a providers' interface for Person-Centered Treatment Planning. 4- Fully integrate a "Personal Folder" and providers' case management software.</p>	<p>http://networkofcare.org/index2.cfm?productid=2&stateid=6</p>

Description of Program & Practices Reflecting Person-Centered Innovation	For more info:
<p>Connecticut PCP Initiative. The CT Department of Mental Health and Addiction Services PCP Initiative incorporates policy formulation, program development, state-wide training efforts, and research and evaluation all in the area of person-centered planning. In collaboration with the Yale Program for Recovery and Community Health, DMHAS is currently carrying out a 5-year NIH study titled <i>Culturally Responsive Person-Centered Care for Psychosis</i>. This study incorporates much of what has been learned in recent years regarding the effectiveness of interventions such as self-directed wellness strategies, community integration programs, peer-support services, and collaborative treatment planning. For example, the study employs “Peer Facilitators” who conduct “pre-planning” meetings in which they assist individuals to articulate their personal vision for a positive future, and provide mentoring in the use of person-centered planning to move toward that vision. Finally, facilitators are available to attend actual treatment planning meetings to support the participant in his/her recovery efforts and to promote participant-provider partnership.</p>	<p>http://www.dmhas.state.ct.us/recovery.htm or contact: janis.tondora@yale.edu</p>
<p>Florida Self-Directed Care (SDC Program). The Florida Self-Directed Care program provides independent brokerage and coaching services to adults who have psychiatric diagnoses who use public funding to access mental health care. Program provides fiscal intermediary services so that participants have the opportunity to manage the state funds allocated for their mental health care services; Participants choose from a variety of community-based providers that may or may not already be a part of the current community mental health system; An independent community advisory board comprised of program participants, their significant others, and advocates guides the program.</p>	<p>http://www.psych.uic.edu/UICNRTC/sdsa/mhsaconfsentver3.pdf</p>
<p>Michigan PCP Initiative. The Michigan Mental Health Code establishes the right for all individuals to have their Individual Plan of Service developed through a person-centered planning process regardless of age, disability or residential setting. All individuals are informed of their right to person-centered planning; “Pre-planning” activities are utilized to determine and identify the persons and information that need to be assembled for successful planning to take place; Individuals are encouraged to include natural supporters in the process; Individuals have input regarding the time and location of planning meetings; Individuals have choice in the selection of treatment or support services and staff; Emphasis is placed on the utilization of natural and community supports rather than professional supports designed specifically for individuals with behavioral health conditions</p>	<p>http://www.michigan.gov/documents/PCPgud02_83966_7.pdf</p>

Description of Program & Practices Reflecting Person-Centered Innovation	For more info:
<p>The Western New York Care Coordination Program. WNYCCP is a unique multi-county collaboration among six (6) County governments, the New York State Office of Mental Health, consumers and family members, and mental health provider agencies to transform the mental health system in line with their commitment to provide recovery-focused, person-centered care. This initiative has involved extensive policy development, consensus building, provider training, organizational realignment, peer education, and outcomes evaluation regarding emerging person-centered planning practices. Of particular note is the WNYCCP's incorporation of a "flexible funding" tool wherein state and county funds are pooled to create resources to support individualized recovery goals that are not reimbursable within the limits of other existing funding mechanisms. Examples of goals offered support include: tuition assistance or books for educational goals; expenses related to helping people start cottage industries; and partial payment of art studio space.</p>	<p>http://www.carecoordination.org/care_coord.shtm</p>
<p>Rhode Island Training School (RITS) Family Service Coordinators Project. RITS, the only secure juvenile detention and correctional facility in Rhode Island, is one example of a program which exemplifies elements of the shift to person-centered care for youth and families. To ensure youth and family-centered service planning, the RITS makes use of family service coordinators and transition coordinators, who are themselves family members, trained specifically to meet with students and families and help them prepare to effectively participate in formal IEP and transition planning meetings. These family service and transition coordinators are hired by Project REACH, one of the grant communities funded under the Center for Mental Health Services' Comprehensive Community Mental Health Service for Children and Their Families Program, and continue providing support in accordance with the wishes of the youth and family. As such, family service and transition coordinators provide essential facilitation and advocacy functions as necessary.</p>	<p>http://www.ncmhjj.com/resource_kit/pdfs/Related%20Topics/References/Paradigm.pdf</p>
<p>JCAHO Standards for Services that Promote Recovery and Resiliency. These newly developed standards will be effective for survey January 1, 2006, and will be integrated into existing standards and published in the <i>2006-2007 Comprehensive Accreditation Manual for Behavioral Health Care (CAMBHC)</i>. Standards in the areas of "Case Management/Care Coordination" and "Community Integration" articulate multiple performance expectations relevant to person centered planning and recovery-oriented care. Standards expand upon previous JCAHO expectations regarding individualized care planning.</p>	<p>http://www.jcaho.org</p>

Description of Program & Practices Reflecting Person-Centered Innovation	For more info:
<p>CARF. Commission on the Accreditation of Rehabilitation Facilities accredits rehabilitation and human service organizations nationally and internationally. CARF incorporates extensive provider standards regarding individualized recovery planning that is consistent with the overarching CARF priority of actively involving consumers in all aspects of service planning, selection, and evaluation.</p>	<p>www.carf.org</p>
<p>Council on Accreditation (COA) of Services for Families and Children. COA partners with human service organizations worldwide to improve service delivery outcomes by developing, applying, and promoting accreditation standards. Service planning includes and involves family members and significant others when the person served makes such a request or if the person served is a minor or is under the care of a legal guardian. Individuals and families participate in service planning; are kept advised of ongoing progress; and are invited to all case conferences.</p>	<p>http://www.coanet.org/front3/page.cfm?sect=4&cont=2796</p>
<p>National Wraparound Initiative for Children, Youth, and Families. The National Wraparound Initiative (NWI) is a collaborative effort that seeks to promote the implementation of high quality Wraparound. The NWI seeks to accomplish this work through the creation of a learning community that includes a range of stakeholders with a high level of expertise in Wraparound. Participants have collaboratively defined a series of needs that are a priority for the Initiative’s work. These needs include: Clear definitions of the terms used to describe the wraparound philosophy and practice; Specification of the theory of change for wraparound; Minimum standards for wraparound practice and for supporting families, teams, and practitioners; Specific strategies on how to achieve high quality wraparound at the family/team level; Descriptions of the organizational supports and the system-level policies and funding arrangements that are necessary for high quality wraparound; Implementation and fidelity tools aligned with the strategies and standards for wraparound that can inform quality improvement and be used in more rigorous evaluation; and Handbooks for youth, caregivers, practitioners, and team members that explain wraparound and what should be expected during a wraparound team’s work.</p>	<p>http://www.rtc.pdx.edu/nwi/</p>
<p>Wraparound Milwaukee. Wraparound Milwaukee is a publicly operated care management organization developed to service children and youth up to age eighteen who have serious emotional, behavioral, or mental health needs and who have been identified by the child welfare or juvenile justice system as being at immediate risk of placement in a residential treatment center or a psychiatric hospital. Wraparound Milwaukee does not provide direct services; instead, it provides leadership, training, administrative organization. All principal supports are weaved into a seamless system providing the full range of services to the youth and family.</p>	<p>http://cecp.air.org/teams/prospectors/wrap_around_milwaukee.asp</p>

Description of Program & Practices Reflecting Person-Centered Innovation	For more info:
<p>The Technical Assistance Partnership for Child and Family Mental Health. The Technical Assistance Partnership for Child and Family Mental Health (TA Partnership) operates under contract with the federal Center for Mental Health Services to provide technical assistance to system of care communities funded by the <i>Comprehensive Community Mental Health Services for Children and Their Families Program</i>. The TA Partnership is a collaboration between the American Institutes for Research and the Federation of Families for Children's Mental Health. Through this partnership, we model the family-professional relationship that is an essential value in our work. Families must share a leadership role in planning, implementing, and evaluating systems of care in their community. We provide a staff of family members and professionals with extensive practice experience, grounded in an organization with vast research experience.</p>	<p>http://www.tapartnership.org/</p>
<p><i>Treatment Planning for Person-Centered Care</i> (Neal Adams and Diane M. Grieder, 2005). This groundbreaking text challenges treatment professionals to evaluate the effectiveness of their current way of working with consumers against the person-centered approach which Adams and Grieder support. Testimonials from consumers who have benefited from a person-centered approach are provided along with a Prologue by Wilma Townsend, former chief of the Office of Consumer Services for the Ohio Department of Mental Health. Four case studies are detailed in the Appendices, with examples of assessment tools, social histories, cultural considerations, consumer needs and preferences, and 90-day follow-up observations. These documents and reports move the book from theory to concrete implementation strategies for behavioral health professionals and administrators who wish to continually improve their service effectiveness. Many of the programs, practice guidelines, and concepts discussed in this paper are reviewed in greater detail in the Adams & Grieder text.</p>	<p>nadamsmd@pacbell.net and alipar@charter.net or www.nccbh.org</p>