Module 1: What is mental health recovery and how does it relate to person-centered care planning?

Goal

This module introduces the key concepts in mental health recovery and recovery-oriented practice. It reviews the history and development of "person-centered" care planning and places it within the broader context of recovery-oriented efforts that are transforming the mental health system as a whole.

Learning Objectives

After completing this module, you will be better able to:

- define mental health recovery;
- describe the difference between traditional practices and recovery-oriented approaches;
- define person-centered care planning;
- understand how person-centered planning differs from past practice.

Learning Assessment

A learning assessment is included at the end of the module. If you are already familiar with mental health recovery and its implications for care planning, you can go to the end of this module to take the assessment section to test your understanding.

Recovery is about living a fulfilling and rewarding life in the context of mental health challenges. While some people recover in the sense that they no longer experience psychiatric symptoms, recovery is not necessarily about becoming symptom- or problem-free. A large part of recovery for many people is moving beyond being labeled as a "mental patient,"

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"client," or even "consumer" to find new meaning, purpose, and possibility in life. For many people, recovery means [1]:

- No longer defining oneself by the experience of mental illness.
- Being a full participant in the community with valued roles such as worker, parent, student, neighbor, friend, artist, tenant, lover, and citizen.
- Running one's own life and making one's own decisions.
- Having a rich network of personal and social support outside of the mental health system.
- Celebrating the newfound strength and skills gained from living with, and recovering from, mental illness.
- Having hope and optimism for the future.

> Recovery is a journey of healing and transformation enabling a person with a mental health problem to live a meaningful life in a community of his or her choice while striving to achieve his or her full potential.
>
> —*SAMHSA National Consensus Statement on Mental Health Recovery* [2]

All around the world people have been demonstrating the possibility, and reality, of mental health recovery. Their stories of lived experience are supported by a mounting evidence base that suggests that recovery is more the norm than the exception in serious mental illness. Beginning with the World Health Organization's (WHO) International Pilot Study of Schizophrenia launched in 1967, there have been a series of long-term, longitudinal studies conducted that have produced a consistent picture of broad heterogeneity in outcome for persons with serious mental illnesses. For example, with respect to schizophrenia, the WHO study documented partial to full recovery in between 45% and 65% of each sample, even when recovery was defined in a clinical fashion as a remission in symptoms, while an even larger percentage of people were able to live independently despite continued symptoms [3].

Similarly, the Vermont Longitudinal Study conducted by Courtney Harding and colleagues found recovery or significant improvement in 62%–68% of the people studied—a finding that was all the more important given that the research was carried out on individuals discharged from a state hospital who were considered to have the most severe and persistent of conditions [4]. Since then, eight more long-term studies (e.g., 22–37 years) have been completed around the world, yielding comparable—and at times, better—results [5].

The evidence for the prevalence of recovery and the potential for recovery-oriented care to help people live full lives has recently been gathered in two landmark texts published by the Boston University Center for Psychiatric Rehabilitation [6]. These books present a summary of over 30 years of experience that challenges the long-held view that serious mental illnesses typically follow a deteriorating course, and explore the range of interventions that have been employed to promote recovery for persons with these conditions.[1] Readers seeking a briefer overview of the

> *Recovery is a process, a way of life, an attitude, and a way of approaching the day's challenges… The need is to meet the challenge of the disability and to re-establish a new and valued sense of integrity and purpose within and beyond the limits of the disability; the aspiration is to live, work, and love in a community in which one makes a significant contribution.*
>
> —*Deegan* [7]

[1] For more information, see: www.bu.edu/cpr/products/books/titles/rsmi-2.html.

empirical evidence for recovery in serious mental illness are referred to an essay on this topic by Ed Knight, Vice President of Recovery, Rehabilitation, and Mutual Support for Value Options.[2]

Where Did the Idea of Mental Health Recovery Come From?

The idea that people can—and do—actually recover from serious mental illnesses grew in large part from the personal experiences and stories of people who experienced recovery in their own lives. Their voices and perspectives were diverse and were from people who were receiving mental health services ("users" of services); individuals who believed they had survived despite the treatment they received ("psychiatric survivors"); and people who had once been patients receiving services, but who felt they had moved beyond that status in their lives and were now "ex-patients." These voices provide the most powerful, and persuasive, testament to recovery, and readers who are interested in reading such stories can find them in websites such as www.SAMHSA.gov/Recoverytopractice (from the United States), www.recoverydevon.co.uk (from England) and www.scottishrecovery.net (from Scotland), to name a few.

> *Recovery is a process by which an individual with a disability recovers self-esteem, dreams, self worth, pride, choice, dignity, and meaning.*
>
> —*Townsend & Glassner* [9]

These voices and perspectives merged to form a movement that has not only survived, but has also grown and emerged as a powerful force for change in mental health policy and services around the world. Drawing on personal experiences, social justice values, civil and human rights, and a passion for changing the mental health system, users/survivors have been the driving force behind the recovery movement that promises to significantly impact both public policy and treatment practices around the globe [8].

Is Mental Health Recovery the Same as Recovery from Addiction?

A variety of self-help and 12-step programs in the addictions arena has influenced the recovery movement and the value it places on mutual support and shared experience. However, there are some unique differences between the actual experience of recovery in mental illness as compared to recovery from addiction. For example, there are core differences related to issues of power. A common requirement in 12-step programs is to admit powerlessness and turn one's self and life over to a "Higher Power." While respecting the importance spirituality plays in many people's lives, mental health recovery emphasizes empowerment and

[2] This document is available at: http://csipmh.rfmh.org/Knight_recovery.htm.

self-determination as well; helping individuals to find their own voice and to take personal responsibility for their own lives. This is based on the belief that people need to reclaim, not turn over, their power as one of the first steps of recovery.

This distinction between mental health and addiction recovery impacts both the process of self-identification and the use of preferred language and terms. For example, traditional 12-step programs encourage individuals to introduce themselves as: "My name is X and I am an alcoholic." This is consistent with the 12-step focus on acknowledging one's powerlessness over a substance, and self-identification in this manner is respected as a part of the individual's unique recovery process. In contrast, in the mental health recovery community, there is an emphasis on helping individuals to move beyond the diagnostic labels that have been applied to them by others. Therefore, individuals are encouraged to use "person-first" language and thereby NOT to identify themselves, or allow themselves to be identified by others, in any way that makes a psychiatric diagnosis their most salient or defining characteristic: for example, "My name is X and I am schizophrenic." In both the addiction and mental health contexts, it is important to note that individual preferences around language and self-identification vary widely, and additional guidance on this topic is offered in Module 2.

Despite these differences in the process of recovery in mental illness and addiction, there are numerous areas of overlap and commonality [10]. The important thing to remember is that no matter what an individual's particular label or diagnosis, people with mental illnesses and addictions are first and foremost people, and people who know best what kind of life they will find worth living in the wake of a behavioral health condition. This is the hallmark of the recovery movement in both mental health and addiction.

Getting Beyond Us versus Them

When we say that "people with mental illnesses and addictions are first and foremost people," we mean that "they" are fundamentally the same as "us" (i.e., those persons who do not have a mental illness or addiction). Though we may be stating the obvious when we say that people with mental illnesses are still people, the reality and experiences in the past have suggested otherwise. Consider Table 1.1. On the left are the things we typically consider to be important in leading a satisfying life, while on the right are the things that have traditionally been identified in care plans as important for persons with serious mental illnesses. 1) What differences do you see in the lists below? 2) What are the similarities? and 3) Are there differences in tone and language between the two lists?

People receiving mental health services want essentially the same things out of life that practitioners do—a home, family, faith, a sense of purpose, health, and other such things. As a result, "recovery" for mental health service users should involve pretty much the same things that mental health service practitioners see as being a part of their own well-being and quality of life. Yet systems are structured in such a way that practitioners are seldom prompted to think of it in this manner. This is particularly true in the context of service planning where "compliance" (with treatment, administering of medications, program rules, etc.) is by far the most commonly identified desired outcome in the "what we expect for them" list reflected in written treatment plans. Recovery-oriented and person-centered care is, at its core, about getting past this "us/them" dynamic to truly partner with people in recovery in their efforts to attain their personally defined and valued goals.

Table 1.1 "Us and Them"

What We Expect for "Us"	What We Expect for "Them"
✓ A life worth living	✓ Attends program, groups, clubhouses
✓ A home to call my own	✓ Residential stability
✓ Faith, spiritual connections	✓ Better judgment
✓ A real job, financial independence	✓ Decreased symptoms/stability
✓ Being a good spouse … parent	✓ Increased insight … accepts illness
✓ Friends	✓ Decreased hospitalization
✓ Joy, fun	✓ Compliance
✓ Nature	✓ Abstinence
✓ Music	✓ Increased functioning
✓ Love … intimacy … sex	✓ Cognitive functioning
✓ Learning, growing	✓ Realistic expectations

Recovery as an Emerging Global Paradigm

A number of prominent reports reflect the emergence of recovery and recovery-oriented care as the driving force behind mental health systems across the globe. For example, a 2012 issue of the *International Review of Psychiatry* contained papers outlining the current stage of recovery research and practice from Austria, Australia, Canada, England, Hong Kong, Israel, New Zealand, Scotland, and the United States [11], while a 2011 review of policy developments identified 30 government documents mandating recovery-oriented care from English-speaking countries around the globe [12]. The following are a few examples from these English-speaking nations:

Achieving the Promise: Transforming Mental Health Care in America, US Department of Health and Human Services [13]. This report called for recovery to be the "common, recognized outcome of mental health services" and recommended "fundamentally reforming how mental health care is delivered in America" to be reoriented to the goal of recovery. This report strongly criticized the nation's current mental health system as one that, too often, "simply manages symptoms and accepts long-term disability."

Improving the Quality of Health Care for Mental and Substance Use Conditions, Institute of Medicine [14]. This report speaks specifically of the decision-making abilities of individuals who have a mental illness as well as those who do not. One harmful stereotype that is referenced in the report is "incompetent decision making." One key recommendation notes that "to promote patient-centered care, all parties involved in health care for mental or substance use conditions should support the decision-making abilities and preferences for treatment and recovery of persons with mental and substance use problems and illnesses."

No Health without Mental Health, UK Department of Health [15]. This national policy framework for England identifies six priorities for the mental health system, including "more people will have good mental health," "more people with mental health

problems will recover," and "fewer people will experience stigma and discrimination." One national initiative being carried out as part of this policy is the Implementing Recovery–Organisational Change (ImROC) program, which is working with 33 of the 55 mental health trusts (provider organizations) in England to support their transformation to a recovery orientation [16]. This initiative includes the recommendation that the mental health workforce comprise 50% people with lived experience of mental illness [17] and introduce Recovery Colleges to provide support to people with mental illnesses through an educational approach [18].

Changing Directions, Changing Lives, Mental Health Commission of Canada [19]. An emerging vehicle of change in several countries has been the establishment of influential Mental Health Commissions. The Canadian commission was established in 2007, and in developing its national mental health strategy, it has taken testimony from thousands of people living with mental health conditions. An important stepping stone was the 2009 discussion document *Toward Recovery and Well-Being* [20], which defined mental health as "*a state of well-being in which the individual realizes his or her own potential, can cope with the normal stresses of life, can work productively and fruitfully, and is able to make a contribution to her or his own community*." In this report, a mental health framework is developed as a blueprint for change, with the strategic direction to "*foster recovery and well-being for people of all ages living with mental health problems and illnesses, and to uphold their rights*." The emphasis on well-being in the context of mental illness is consistent with empirical research [21] and the links between well-being research and recovery are becoming clearer [22].

A Recovery Approach within the Irish Mental Health Services—A Framework for Development, Mental Health Commission of Ireland [23]. The Mental Health Commission in Ireland has created a framework for developing services across the island of Ireland, which involves a focus on the strengths and opportunities rather than the limitations and symptoms of illness. The contribution of mental health systems is understood to involve "*enabling and empowering the person to access their inner strengths and resources to build a meaningful, valued, and satisfying life*." One transformation component that is highlighted is that of dynamic leadership because "*if the predominant ethos is one of benign paternalism and illness orientation, or one that ignores the input of service users at management and service development level, then a culture that ignores the principles of recovery is likely to be fostered throughout the organization. Equally, without a stated commitment to the principle of individualism and choice, people may simply re-title current practice as recovery-oriented*." This focus on the role of organizational commitment is consistent with best practices internationally [11].

Blueprint II: Improving Mental Health and Well-Being for All New Zealanders, Mental Health Commission of New Zealand [24]. In 1998, New Zealand developed the first national blueprint for transformation toward recovery. In 2012, it issued a new 10-year national strategy based on the learning from Blueprint I, and addressed specifically the impact of the global economic downturn. It adopted the "Triple Aim" model as a framework for sustainable service development: 1) improving quality, safety, and experience of care; 2) improving health and equity for all populations; and 3) ensuring the best value in public health system resources. In identifying eight priority areas for service development, a shift from Blueprint 1 was evident, involving a greater focus on well-being and a more explicit reference to issues of risk and safety.

Framework for Recovery-Oriented Practice, Department of Health, Victoria [25]. Although a state-based policy rather than a national policy, this framework draws on the best available evidence internationally to identify the key domains of recovery-oriented practice:

promoting a culture of hope; encouraging autonomy and self-determination; fostering collaborative partnerships and meaningful engagement; focusing on strengths; striving for holistic and personalized care; involving family, carers, supporting people, and significant others; maximizing community participation and citizenship; showing responsiveness to diversity; and committing to ongoing reflection and learning. For each domain, the key capabilities and examples of both good practice and good leadership are provided. This is a brief and easily accessible document that informs the development of a recovery orientation as mandated in the fourth National Mental Health Plan (2009–2014) in Australia.

Cross-Cutting Principles, US Substance Abuse and Mental Health Services Administration (SAMHSA) [26]. This report establishes a set of cross-cutting principles to guide the program, policy, and resource allocation based on the belief that people of all ages, with or at risk for mental health or substance use disorders, should have the opportunity for a fulfilling life that includes an education, a job, a home, and meaningful relationships with family and friends. To further this agenda, SAMHSA put forth a *Consensus Statement* that outlines 10 fundamental components of mental health recovery as guideposts for recovery-oriented service providers, policymakers, and advocates. The consensus definition was developed through deliberations at a conference in December 2004 of over 110 expert panelists representing mental health consumers, families, providers, advocates, researchers, managed care organizations, state and local public officials, and others. These fundamental components are summarized in Table 1.2.

A Common Misconception: Is Recovery = Cure?

> *"The goal of the recovery process is not to become 'normal.' The goal is to embrace our human vocation of becoming more deeply, more fully human.*
> *The goal is not normalization.*
> *The goal is to become the unique, awesome, never to be repeated human being that we are called to be."*
>
> *—Deegan* [27]

The widespread misinterpretation that "recovery equals cure" has generated concerns among service users, practitioners, family members, and policymakers alike who fear that recovery-oriented care will "leave certain people behind." However, the notion of mental health recovery, as defined by SAMHSA and presented in these modules, does not advocate complete symptom remission. Rather, it is personally defined and accessible to all. It involves a redefinition of one's illness as only one aspect of a multidimensional sense of self who is capable of identifying, choosing, and pursuing meaningful goals despite the effects of the illness or possible side effects of treatment or stigma.

In this sense, the notion of recovery borrows from the disability rights movement that argues that the elimination of the disability is not the ultimate goal. The goal is to live life to its fullest even in the face of continued limitations, for example, a person with paraplegia does not have to regain his or her mobility to have a satisfying life in the community, nor does an individual with schizophrenia have to stop hearing voices to work, worship, or volunteer. Recovery restores a positive sense of identity despite one's disability and its limitations, and it is a lifelong process that involves an indefinite number of incremental steps in various life domains.

Table 1.2 Ten Core Components of Mental Health Recovery

Self-Direction: Individuals lead, control, exercise choice over, and determine their own path of recovery by optimizing autonomy, independence, and control of resources to achieve a self-determined life. Individualized and Person-Centered: There are multiple pathways to recovery based on an individual's unique strengths and resiliencies as well as his or her needs, preferences, experiences (including past trauma), and cultural background in all of its diverse representations. Empowerment: Individuals have the authority to choose from a range of options and to participate in all decisions—including the allocation of resources—that will affect their lives, and are educated and supported in so doing. Holistic: Recovery encompasses an individual's whole life, including mind, body, spirit, and community. Nonlinear: Recovery is not a step-by-step process but one based on continual growth, occasional setbacks, and learning from experience.	Strengths-Based: Recovery focuses on valuing and building on the multiple capacities, resiliencies, talents, coping abilities, and inherent worth of individuals. Peer Support: Mutual support—including the sharing of experiential knowledge and skills and social learning—can play an invaluable role in recovery. Respect: Community, systems, and societal acceptance and appreciation of individuals with mental illnesses—including protecting their rights and eliminating discrimination and stigma—are crucial in achieving recovery. Responsibility: Individuals with mental illnesses have a personal responsibility for their own self-care and journey of recovery. Hope: Recovery provides the essential and motivating message of a better future—that individuals can and do overcome the barriers and obstacles that confront them.

(Adapted from U.S. Department of Health and Human Services, 2006).

How Does the Concept of Recovery Transform Care?

The concept of recovery is increasingly recognized as stimulating a new way to think about serious mental health problems, treatment, and outcomes, and it is gradually being accepted and incorporated by traditional mental health programs. Many practitioners are looking for new ways to relate to, and work with, people who receive services in the hope that they can transform their programs to be more recovery focused in meaningful and significant ways [7]. Often, the first step in this process is acknowledging the core differences between traditional models of care and recovery-oriented approaches.

Until fairly recently, most mental health services have been organized around a deficit-based model that perceives mental illness as a disease that must be "cured" [28] through the remission or elimination of symptoms. Because they are trained to focus on

treating deficits and symptoms—the things that are wrong with people—practitioners and service delivery organizations have had a tendency to overlook the things that are right with people, such as strengths and competencies [29]. A recovery orientation shifts the focus to "the glass as half full." It is a perspective that allows us to see that no matter how disabled, "all people have existing strengths and capabilities as well as the capacity to become more competent" [30].

With all this attention on strengths, how then, does a recovery-oriented system view the very real, and sometimes serious, difficulties experienced by people living with mental illnesses? Furthermore, with its emphasis on self-determination, what does the recovery model say about the role of practitioners and clinical care?

"Both/And" rather than "Either/Or"

The notion of recovery-oriented care presented throughout this manual does not imply that exclusive power is turned over to the service user with disregard for the knowledge and value of practitioners. Rather, recovery-oriented care, and the representative practice of person-centered care planning, is based on a foundation of partnership in which there is mutual respect between the practitioner and the individual service user. While the emphasis is on maximizing the person's autonomy, the recovery paradigm also respects the expertise of the caregiver and recognizes the important role of the practitioner in the person-centered partnership.

> *Hope is a frame of mind that colors every perception. By expanding the realm of the possible, hope lays the groundwork for healing to begin.*
>
> *—Jacobson & Greenley* [31]

It is equally important to acknowledge that there have been major advances made within the context of traditional clinical and rehabilitative care. Now more than ever, the mental health field has the ability to offer individuals a wider range of evidence-based practices, diagnostically based treatment modalities, and diverse medication options, and these advances have had a significant impact on the treatment of symptoms for persons with serious mental illnesses. However, no matter how skilled the professional community has become in treating the *illness*, the voice of the recovery community suggests that doing so is not sufficient in and of itself to recover the *person*—or more accurately, for the person *to recover*. The interventions of traditional clinical models will definitely continue to play an important role in transformed mental health systems, and recovery-oriented care is based on an understanding that the field can, and must, do better to reframe the goal of treatment as helping people to move beyond achieving clinical stability to recovering lives worth living. This is the essence both of recovery-oriented care planning and of recovery-oriented practice.

Hope as the Foundation

So, how will the field get there? Self-determination, freedom of choice, control over one's own life, personal responsibility, and meaningful community belonging—this is the recovery vision of a transformed mental health system. Throughout the remainder of these modules, the reader will be introduced to a wide range of strategies and tools that will assist him or her in implementing the potential recovery-oriented practice of "person-centered care

planning." Yet the most essential tool that a direct care provider has at his or her disposal is the belief in the possibility of recovery for all people.

Hope is at the heart of recovery. Just as the person must hold onto hope in the journey of recovery, the practitioner must hold onto hope that recovery-oriented systems change is both possible and powerful. This belief is at the foundation of each of the modules that follow.

How Does Person-Centered Care Planning Relate to Recovery?

Person-centered care planning (PCCP) and recovery-oriented care are inherently interwoven. One cannot exist without the other. A recovery-oriented system cannot be fully realized in the absence of PCCP. PCCP is one tool that systems can use to move away from an illness-based model of diagnosis and treatment delivered by experts toward a recovery-based model of growth and achievement in which every person involved has an important role to play.

Similarly, PCCP cannot be fully implemented in the absence of a recovery-oriented culture. PCCP must be embedded in a system that is committed to changing not only what people *do* (e.g., in the practice of PCCP) but also how people *think* and *believe* about recovery and their obligation to partner with people to achieve it. PCCP is best thought of as one essential tool that should be combined with other efforts to promote system change, including such things as the expansion of peer-operated services or the modification of outcomes-monitoring plans. PCCP represents a window of opportunity to move from theory to practice and to apply the concepts and values of recovery-oriented care to prompt real and meaningful changes in care planning.

In understanding this relationship between PCCP and recovery-oriented care, it can be helpful to think of PCCP as requiring attention to the four essential "Ps" (see Figure 1.1), which are philosophy, process, plan, and product.

- **Philosophy:** the overall philosophy of the organization and the extent to which it is recovery-oriented and supports PCCP.
- **Process:** the typical planning process and whether it involves the type of collaborative interactions that are consistent with PCCP.
- **Plan:** the design of the plan itself, that is, the paper (or electronic) document, and whether it reflects a meaningful roadmap to support the person's recovery.
- **Product:** the expected outcomes associated with PCCP, that is, how an agency determines if the plan has been successful in terms that are meaningful to the persons being served and their loved ones.

> *In a transformed mental health system, a diagnosis of a serious mental illness… will set in motion a well-planned, coordinated array of services and treatments defined in a single plan of care…*
> *The plan will include treatment, supports, and other assistance to enable consumers to better integrate into their communities and to allow consumers to realize improved mental health and quality of life.*
>
> —*Final Report of the US New Freedom Commission on Mental Health* [12]

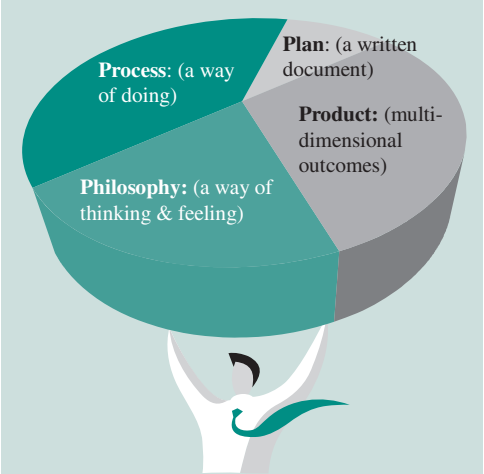

Figure 1.1 The "4 Ps" of Person-Centered Care Planning

What Does Person-Centered Care Planning Mean and Why Is It Important?

For people receiving mental health services, person-centered care means they have choices in the services they use. It means they can be an active partner in selecting their recovery support team and in inviting family members and other "natural supporters" (such as employers, tutors, neighbors) to be involved. It means realizing—or being helped to realize—that they have the power to change their lives and can partner with their recovery team in doing so. For practitioners, PCCP means partnering with people receiving services to help them achieve goals that are personally meaningful to them, even when such goals extend beyond those areas traditionally addressed by clinical care. Such goals may include returning to work, finishing school, making friends, having a girlfriend/boyfriend, or developing a hobby.

PCCP as presented in these modules is informed by many sources, particularly the experiences of people who have "survived" the limitations of traditional models of care to call for radical change toward more person-centered planning. In addition, the vision of PCCP in the mental health field is informed by similar efforts in other disability fields. For example, some of the earliest and most prominent "person-centered planning" models were developed in the 1980s by professionals and advocates in the developmental disabilities field. These include

- Whole-life planning [32]
- Lifestyle planning [33]
- McGill Action Planning System [34]
- Personal futures planning [35]

Although each of these approaches in the developmental disabilities field varies somewhat, they all share the following characteristics [36]:

- The primary direction in the planning process comes from the individual, or his or her family or designated other when the person is under age or incapacitated and the family or other is empowered to speak on his or her behalf.
- Maximum involvement of significant others and a reliance on personal relationships as a primary source of support.
- A focus on capacities and assets rather than on just limitations and deficits.
- An emphasis on promoting the use of community resources and nonsegregated settings outside the formal health and social service systems.
- An acceptance of uncertainty, setbacks, and disagreements as natural steps on the path to self-determination.

Is This Really any Different from Traditional Approaches to Care Planning?

Traditional models of care planning are often referred to as deficit or illness-based models. These models differ across setting and service providers but can generally be characterized as follows:

- Attention is paid primarily to illnesses, symptoms, or impairments.
- Emphasis is on eradicating or managing illness rather than specifically promoting recovery.
- Role of person with mental illness is often passive and limited to following the practitioner's recommendations or suggestions, such as taking medications and "avoiding stress".
- Perhaps most importantly, community inclusion and personal choice are viewed as rewards that follow from successful treatment (i.e., you will be able to live by yourself and return to school once you take your medication consistently and your symptoms are stable), rather than as basic human and civil rights that provide the foundation for the person's efforts toward recovery.

Some of the limitations of these traditional models include the following:

- Power is allocated largely (or only) to the service provider to determine diagnosis and to develop treatment goals.
- People receiving services are not commonly encouraged to take an active or self-directed role, which fosters both short-term disengagement and long-term institutional dependency.
- Service agencies focus on systemically defined outcomes (e.g., hospitalization rates) and are held less accountable for other outcomes that hold real value for those they serve (e.g., employment, relationships, community activities).
- Success is most often determined by system standards and is gauged on narrowly defined goals such as treatment compliance or symptom reduction.

- Services are typically fragmented and disconnected from other important parts of a person's life. For example, mental health services are typically provided separate and apart from primary health care. Another example of service fragmentation is the lack of connection between the mental health system and a spiritual or faith community.

Treatment planning practices delivered within more traditional models are heavily influenced by these limitations:

- Traditional treatment planning is seen as more of a peripheral and bureaucratic paperwork task rather than as a central focus of the recovery-oriented relationship.
- Planning meetings are still sometimes carried out in the absence of the person served. When individuals receiving services are present, their role is generally limited and often involves simply signing the plan to acknowledge that he or she "participated" in the process, with little or no attention paid to whether or not that "participation" was substantive or meaningful.
- Treatment "teams" typically consist of a variety of paid mental health service providers with minimal, if any, direct involvement of natural supporters such as family and friends (assuming such involvement is desired by the individual).
- Traditional treatment plans respond to individuals' needs largely through a reliance on specialized services designed for persons with a label of mental illness rather than through a focus on community inclusion and resources. For example, a service user who identified bowling or reading as a desired activity might be encouraged to initiate bowling outings from the local psychosocial clubhouse or start a reading group there rather than join a bowling league or a neighborhood book club that is already taking place in the community.
- Treatment goals are often based on the person receiving services demonstrating an expected level of engagement in treatment, for example, medication or treatment compliance. Failure to meet such goals may then be attributed to the person's lack of "motivation" rather than the system's failure to deliver person-centered services or other factors such as a person's choice, or lack of resources.

Status of PCCP Implementation

Despite the limitations of traditional treatment planning models, person-centered care planning (PCCP) has not yet been widely accepted or adopted by the mental health system—particularly in contrast to person-centered planning as implemented in the developmental disabilities service system [37]. There are many reasons for this, but some can be found in understanding that PCCP is:

- Not widely taught in professional or graduate training programs.
- Viewed as an administrative burden and an exercise in paperwork.
- Not valued as a clinical intervention or as a means to build a therapeutic alliance.
- Seen as a "risky business" because of a belief that allowing service users choices and self-determination in their own care could lead to poor decision making and disastrous consequences.

- Viewed as not something that people in the process of recovery are interested in.
- Viewed as somehow inconsistent with the clinical rigor expected in the process and documentation by funders (e.g., Centers for Medicare and Medicaid Services) and accreditors (e.g., Joint Commission on Accreditation of Healthcare Organizations).

But for those mental health practitioners and organizations that have fully embraced recovery and person-centered practices, the co-created care plan becomes:

- An essential part of services.
- A strategy for managing complexity.
- An opportunity for collaborative and creative thinking.
- An opportunity to thoughtfully support individuals in taking next steps, trying new activities, and expanding natural support networks.
- Something that is valued, by service user and practitioner alike, as a meaningful roadmap to recovery.
- A tool for gauging progress toward valued short and long-term recovery goals.

Table 1.3. summarizes the contrasts between a recovery-oriented and a person-centered approach as compared with a more traditional treatment approach. Module 2 will provide greater detail regarding the translation of each of these principles into the *practices* of person-centered care planning.

What Does PCCP *Actually Look Like* in Practice?

While much greater detail regarding both the *process* and *documentation* of PCCP will be shared in subsequent modules, we conclude this module with an example that previews how a person-centered plan might look very different in practice. This scenario is based on an actual case consultation with a treatment team that requested support in developing a rigorous person-centered plan for someone we will call "Mr. Gonzalez." Mr. Gonzalez was initially described by the team as having "limited insight regarding his mental health and addictions issues," which led to "frequent refusal to take meds and to participate in treatment." Below is a snapshot of his story.

> *Mr. Gonzalez, a 31-year-old married Puerto Rican man, is living with bipolar disorder and a co-occurring addiction to alcohol that he often uses to manage distressing symptoms. During a recent period of acute mania, Mr. Gonzalez had increasingly volatile arguments with his wife in the presence of his two young sons. On one such occasion, he pushed his wife across the room that prompted her to call the police. When the police arrived, Mr. Gonzalez was initially uncooperative and upset. After he calmed down, Mrs. Gonzalez agreed not to press charges, but insisted her husband leave the house and meet with his clinician the following morning.*

Table 1.3 Summary of Contrast between Traditional and Person-Centered Approaches to Service Planning

Traditional Approaches	Person-Centered Approach
Self-determination comes after individuals have successfully achieved clinical stability	Self-determination and community inclusion are viewed as fundamental human rights of all people
Compliance is valued	Active participation and empowerment are valued
Largely one-directional; clearly delineated professional boundaries	Reciprocity in relationship; engaged, collaborative relationship
Jargon and reductionist terms and labels common	Strengths and respect-based communication in written/spoken language
Only professionals have access to information (e.g., plans, assessments, records)	All parties have full access to the same information—often referred to as "transparency."
Symptoms, disabilities, and deficits drive treatment; targeted professional solutions	Plans capitalize on strengths and the value of life experiences
Lower expectations	Higher expectations
Facility-based settings and professional supporters	Integrated settings and natural/ community supports are seen as crucial
Avoidance of risk; protection of person and community	Acceptance of the dignity of risk and a focus on growth
Clinical stability or managing illness	Achievement of broad-based life goals
Lack of individualization; "cookie-cutter" service design	Cultural preferences and values more actively incorporated in individualized care
Assumptions regarding readiness/desire for active treatment	Sensitivity to stage of change; meeting people "where they are at"

Mr. Gonzalez's wife is actively involved in his recovery and treatment, and she is open to reconciliation. However, she made it clear that he would not be allowed to live at home, or visit with his sons, until he "gets control of himself." Upon visiting the Community Mental Health Center the following morning, Mr. Gonzalez tells his clinician repeatedly that his love for his family and his faith in God are the only things that keep him going when things are rough and he does not know what he will do without them. More than anything, he wants to be able to reunite with his family and be a good role model for his sons. He feels that the only person who understands this is the Center Peer Specialist with whom he has a close relationship.

A few weeks after the incidents described here, the treatment team contacted us and requested consultation, as they were clearly frustrated with Mr. Gonzalez. They noted that he had "great potential" but was "refusing to meet them half way." Prior to meeting with

the team and Mr. Gonzalez, we requested that a copy of the working treatment plan be shared with us so that we could get familiar with the story. A look at the treatment plan made it clear that the plan had been drafted with limited, if any, substantive input from Mr. Gonzalez, with a focus on four narrowly defined clinical problem areas.

The numbered goals on "his" treatment plan included achieving and maintaining clinical stability; reducing assaultive behavior; complying with medications; and achieving abstinence. These goals were then followed by objectives related to such things as attending scheduled groups; taking meds as prescribed; demonstrating insight into illness; submitting to urine toxicology screens, and so on. This is not to say that all these things are necessarily negative or undesirable. However, they do not, in and of themselves, equate with the realization of Mr. Gonzalez's valued long-term recovery goals! Nor do they reflect any respect for Mr. Gonzalez as a *unique* human being. Mr. Gonzalez's working treatment plan could have just as easily been for Mr. Smith, Mr. Reyes, or Mr. Martino as there was virtually NO mention of his personal recovery goals. It is critical that the treatment plan not be completely divorced from that which is most valued by, and motivating to, the individual—in the case of Mr. Gonzalez, his love for his family, his desire for reconciliation, and his wish to be "a better role model" to his boys.

When presented with this feedback, the treatment team began to see that their style of working with Mr. Gonzalez might, in fact, have been one of the factors leading to the very disengagement and "noncompliance" that had generated their request for consultation in the first place. To what extent could they really expect him to actively work a recovery plan that he had no part in creating—a plan that had little, if any, connection to his most valued goals and priorities? Given this, it is not surprising that Mr. Gonzalez was reluctant to talk to the doctor about his lithium, to attend the "anger-management" group, or to show up for his toxicology screens. What had been attributed initially to the "patient's noncompliance and denial" was, in fact, far more complicated and driven, at least in part, by the team's inability to really listen to, and understand, Mr. Gonzalez, and to reflect that in a collaboratively developed recovery plan.

Now let us shift to a discussion on how Mr. Gonalez's care plan might look different through the lens of recovery-oriented, person-centered care. First and foremost, the plan should begin with, and be driven by, the priority goals as stated by Mr. Gonzalez. Next, it should reflect the strengths and resources that may be particularly significant in achieving his current goals. This is then balanced by a clear statement of the clinical and/or psychosocial issues that may be interfering with progress. These barriers should be acknowledged alongside his assets and strengths, as this is essential in maintaining clinical rigor in the documentation, providing targeted and effective interventions, and justifying the "medical necessity" of treatment. Next, the plan should include short-term objectives that reflect desired concrete changes in behavior or functioning that are meaningful to Mr. Gonzalez. And, finally, a quality person-centered care plan should conclude with a mix of services and action steps (carried out by practitioners, natural supporters, and the person him/herself) that help Mr. Gonzalez to overcome barriers and move forward in his personal recovery journey.

Each of these points is discussed in greater detail in subsequent modules, but for now we leave you with a graphic representation that illustrates how PCCP departs from traditional practice by integrating Mr. Gonzalez's strengths, preferences, and valued goals in a

A Traditional Treatment Plan

- **Goal(s):**
  - *Achieve and maintain clinical stability*
  - *Reduce assultive behavior*
  - *Comply with medications*
  - *Achieve abstinence*
- **Objective(s):**
  - Pt will attend all scheduled groups; pt will meet with psychiatrist and take all meds as prescribed; pt will complete anger management program; pt will demonstrate increased insight re: clinical symptoms; pt will recognize role of substances in exacerbating aggressive behavior.
- **Services:**
  - Psychiatrist will provide medication management 1x/mos. for 3 mos. to stabilize symptoms; Rehab specialist will provide Anger Management Group 1x/wk for 6 weeks; Nursing staff will monitor medication compliance; Psychologist will provide individual therapy 2x/mo for purpose of increasing insight into bipolar illness; Addictions Counselor will conduct random tox screens to monitor abstinence.

Toward Person-Centered Planning

Life Goal:

I want to get my family back and be a good father to my boys.

Strengths to Draw Upon:	**Barriers Which Interfere:**
Devoted father; motivated for change; supportive wife; faith & prayer are source of strength/comfort; connected to Peer Specialist	Acute symptoms led to arguments/aggression in the home; lack of coping strategies; abuse of alcohol escalates behavioral problems

Sample Short-Term Objective

Within 30 days, Mr. Gonzalez will use learned coping strategies to have a minimum of two successful visits with wife & children as reported by Mrs. Gonzalez in family therapy session.

Services & Supports

-M.D. to provide med management 2x/mo for 3 mos. to reduce irritability & distressing symptoms.

-Clinician to provide weekly family therapy sessions for one mos. for purpose of discussing Mrs. Gonzalez's expectations and to negotiate a possible family reunification plan.

-Rehab Specialist to provide Communication and Coping Skills Training 1x/wk. for 1 mos. to coach/practice skills which will support successful visits with wife and children.

-Center Chaplain will meet with Mr. Gonzalez 2x/mo. to promote use of faith/daily prayer as positive coping strategy to manage distress.

-Center Peer Specialist will provide weekly Wellness Recovery Action Plan group to promote daily wellness through use of self-directed strategies.

Figure 1.2 From Traditional Planning to Person-Centered Care Planning

person-centered care plan that simultaneously respects the role of high quality mental health services. More than simply a rewritten treatment plan, this process represented a dramatic shift in the very nature of the relationship between Mr. Gonzalez and his treatment team. They shared a commitment to co-create a more hopeful recovery vision for the future and a practical plan for how all would work together to achieve it. No longer feeling excluded and depersonalized, Mr. Gonzalez (the formerly labeled "noncompliant patient") gradually developed a sense of trust in his team and began to actively participate in, and benefit from, the care he had previously rejected as he worked toward reuniting with his family. Together, Mr. Gonzalez and his team learned that person-centered planning was both possible and powerful (Figure 1.2).

Exercises

Exercise 1. Consider the following questions

1. How are the 10 components of recovery described above reflected in your agency and the services you deliver?
2. What are your strengths as an agency?
3. What are the areas in need of improvement?
4. How do you think service users would respond to this question?
5. How do you think they experience getting help?
6. In what ways are the services in your agency organized around symptoms? In what ways are they organized to promote recovery?
7. What changes in the provision of service does your organization need to make to move toward a person-directed, recovery-oriented system?
8. How might the quote "The goal of the recovery process is not to become 'normal' … " impact the clinical policy and practice within your organization?
9. How might the international reports in this module help you as an administrator or supervisor to change mental health care practices within your organization?
10. What would your biggest fears be regarding reorganizing your service delivery system to become recovery-oriented?
11. Looking into the future, if the vision of recovery-oriented care is realized, how will your organization be different? What will services look like when a person walks through the front door?
12. Do most of the direct care staff in your organization think that recovery is possible for everyone with a mental illness? Have you assessed recovery attitudes and beliefs among the staff members? If so, how?
13. What can be done to help support team members to be more comfortable with the idea that recovery is possible for everyone no matter what s/he looks like today?
14. Do the individuals you support believe recovery is possible for them? How can you and/or your staff engage service users to "believe" in their own recovery? How can this be built into care on a practical level?
15. The implementation of person-centered planning requires attention to each of the four "Ps". Which areas are the most challenging for you/your organization? Which areas represent strengths to build upon?

Exercise 2. *What If…?*

1. Write down three things that are important to you in your life, the things that give you meaning, keep you happy or healthy, or are reasons that you get up in the morning.
   - Now count up and down each item until you reach 7, and cross off that item.
2. How did it feel to cross off that item? How did that feel to imagine your life without those things?
3. How does this relate to the experience of treatment planning? Can you think of examples in traditional treatment planning where important things are "crossed off" of peoples' lists?

Take home message:

Traditional treatment has involved other people having the power to decide the focus of a service user's care over the next 3–6 months—what makes it on the list and what doesn't. Think of situations in which people are told they cannot be supported in moving out of the group home until they have been medication compliant for six months, or cannot be referred to a supported employment program to get a job until they have done "90 meetings in 90 days." People in recovery report that this experience feels like others "crossing off" deeply valued goals from their personal list, such as moving into a home of one's own or securing a job to feel proud of.

- Some service users are excluded completely from these decisions, others are told it is "not in their best interest" or the "timing is not right" to … go back to school or to work … to move out of the group home … to regain custody of their children, and so on.
- Most treatment plans continue to identify the goals of clinical stability, compliance with medications, and abstinence from drugs and alcohol as the highest priorities—to the exclusion of other life domains that are critical elements of anyone's sense of well-being.
- In developing a plan for recovery, remember this exercise and how it feels to have something important to you crossed off your list … said it was not a priority … said you needed to wait….

Now imagine what your attitude and response to this kind of treatment would be if this were not just an exercise … What if?

Learning Assessment

Module 1: What is mental health recovery and how does it relate to person-centered care planning?		
Statement	True	False
1. Recovery requires the reduction or remission of symptoms of mental illness.		
2. The pursuit of community activities and valued roles is important for recovery.		
3. Traditional mental health care is mainly focused on identifying and addressing deficits.		
4. Adherence to psychiatric medications is a necessary prerequisite for recovery.		
5. The goal of recovery is to become normal.		
See the Answer Key at the end of the chapter for correct answers. **Number Correct**		
0 to 2: Don't be discouraged. Learning is an ongoing process! You can review the Module for greater knowledge. 3 to 4: You have a solid foundation. Use this Module to enhance your skills. 5: You are ahead of the game! Use this Module to teach others and strive for excellence!		

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Answers to the Learning Assessment:

1. F
2. T
3. T
4. F
5. F