CHAPTER 2

Person-Centered Care

... everything can be taken from a man but one thing: the last of the human freedoms—to choose one’s attitude in any given set of circumstances, to choose one’s one way.

Viktor E. Frankl

Live your life, not your diagnoses.
Anonymous

I. STATING THE CASE

Multiple reports in the last 5 years have stressed the need to rethink how mental health and addictive disorders services are planned for and provided to individuals and families. These include the Report of the US Surgeon General on Mental Health, the Institute of Medicine’s (IOM’s) Crossing the Quality Chasm: A New Health System for the 21st Century, the Center for Substance Abuse Treatment’s Changing the Conversation: The National Treatment Plan Initiative, the IOM’s report on Unequal Treatment: Confronting Racial and Ethnic Disparities in Health Care, the World Health Organization’s 2001 Report on Mental Health, and the 2003 report of the President’s New Freedom Mental Health Commission. The consensus emerging from these reports is that recovery and person-centered care are two tightly linked concepts.

Recovery

Recovery, a term and concept frequently used in the alcohol and drug self-help and treatment fields, does not have any single definition. Rather, it is
viewed as a process, a new way to live one’s life beyond mere abstinence from alcohol and/or other drugs. Recovery defines how one lives life today, implying hope, healing, and restoration.

The mental health consumer/survivor movement, which began in the early 1970s, has truly championed the notion of mental health recovery with an emphasis on self-determination and empowerment. By the early 1990s, professionals began to take notice of the change in attitudes and expectations. In 1993, Anthony\(^1\) endorsed the concept of recovery as a guiding vision for the mental health system after reading and listening to consumers’ personal accounts of their struggles through and recoveries from mental illness. A recovery advisory group at a Virginia community mental health center describes recovery in the following way:

A process of re-emergence, awakening, or working towards the full life that you want and deserve to have, a life that includes the vision and dreams that you long for. A life in which each person is treated with complete respect at every moment. A life in which you have meaningful choices and you continuously move towards wholeness and healing from hurts, trauma, and/or darkness. A life in which you feel completely hopeful, completely empowered, and completely connected to the community.

Another definition of a recovery-oriented system, and of recovery itself, in the mental health field, can be found in the National Technical Assistance Center for State Mental Health Planning’s report *Mental Health Recovery: What Helps and What Hinders*\(^2\):

Recovery can be construed as a paradigm, an organizing construct that can guide the planning and implementation of services and supports for people with severe mental illness. The outlines of a new paradigm recovery-enhancing system are emerging. Such a system is person-oriented, and respects people’s lived experience and expertise. It promotes decision-making and self-responsibility. It addresses people’s needs holistically and contends with more than their symptoms. Such a system meets basic needs and addresses problems in living. It empowers people to move toward self-management of their condition. The orientation is one of hope with an emphasis on positive mental health and wellness. A recovery-oriented system assists people to connect through mutual self-help. It focuses on positive functioning in a variety of roles, and building or rebuilding positive relationships.

Recovery is an ongoing dynamic interactional process that occurs between a person’s strengths, vulnerabilities, resources, and the environment. It involves a personal journey of actively self-managing psychiatric disorder while reclaiming, gaining, and maintaining a positive sense of self, roles, and life beyond the mental health system, in spite of the challenge of psychiatric disability. Recovery involves learning
to approach each day's challenges, to overcome disabilities, to live independently, and to contribute to society. Recovery is supported by a foundation based on hope, belief, personal power, respect, connections, and self-determination.

On July 22, 2003, President Bush's New Freedom Commission on Mental Health released its final report, *Achieving the Promise: Transforming Mental Health Care in America.* It stated the following:

A goal of a transformed system is recovery. Recovery refers to the process in which people are able to live, work, learn, and participate fully in their communities. For some individuals, recovery is the ability to live a fulfilling and productive life despite a disability. For others, recovery implies the reduction or complete remission of symptoms. Science has shown that having hope plays an integral role in an individual’s recovery. Successfully transforming the mental health service delivery system rests on two principles:

1. Services and treatments must be consumer- and family-centered, set to provide consumers real and meaningful choices about treatment options and providers—not oriented to the requirements of bureaucracies.
2. Care must focus on increasing consumers’ ability to successfully cope with life’s challenges, on facilitating recovery, and on building resilience, not just on managing symptoms.

Out of the six goals put forth by the Commission to transform the mental health system of care, Goal Two is the one that addresses the issues related to individual planning for services. Simply stated, the report calls for mental health care that is consumer- and family-driven.

When a serious mental illness or a serious emotional disturbance is first diagnosed, the health care provider—in full partnership with consumers and families—will develop an individualized plan of care for managing the illness. This partnership of personalized care means basically choosing who, what, and how appropriate health care will be provided:

- choosing which mental health care professionals are on the team;
- sharing in decision-making; and
- having the option to agree or disagree with the treatment plan.

The Mental Health Commissioner of Ohio and chairman of the President’s Mental Health Commission, Michael Hogan, PhD, fostered the development of his state’s Department of Mental Health emphasis on a recovery-oriented approach to services. The Ohio model can be described by its emphasis on determining the recovery status of the individual and its process for developing a responsive individual recovery-management plan. The individual plan is clearly identified as central to a
person-centered and recovery-oriented approach to services. “Nothing about me without me” has become a central theme and often-repeated refrain for many advocates of recovery-oriented person-centered systems change.

**Person-Centered Care**

The link between recovery and person-centered care is evident. The essential role of the individual plan in supporting both is explicit. The ideas of recovery, wellness, and resiliency embody a functional model of what it means to be person-centered; they simultaneously address both process and outcome. The concern is not only with the impact of services but also with the importance of the experience for the individual and family receiving services. The creation and implementation of an individual plan are the points at which these values should be most evident in practice. If service planning is not itself a person-centered process, then the entire service-delivery system cannot likely succeed. Planning is the foundation upon which the provision of person-centered services is built. Creating the plan is all about ensuring that our response to individuals is true to the vision and values of person-centeredness.

**Re-Designing Health Care**

Recently, the California Department of Mental Health’s Statewide Quality Improvement Committee adapted the IOM’s six aims for health care quality in response to the concerns of mental health and addictive disorders systems stakeholders. Their translation of the aims is as follows.

Mental health and addiction services should be experienced as:

1. **Equitable**
   Access and quality of care do not vary because of client or family characteristics such as race ethnicity, age, gender, religion, sexual orientation, disability, diagnosis, geographic location, socioeconomic status, or legal status.

2. **Safe**
   Services are provided in an emotionally and physically safe, compassionate, trusting, and caring treatment/working environment for all clients, family members, and staff.
3. Timely
   Goal-directed services are promptly provided in order to restore and sustain the integration of clients and families into the community.

4. Effective
   Up-to-date evidence-based services are provided in response to and respectful of individual choice and preference.

5. Efficient
   Human and physical resources are managed in ways that minimize waste and optimize access to appropriate treatment.

6. Person-centered
   A highly individualized comprehensive approach to assessment and services is used to understand each individual’s and family’s history, strengths, needs, and vision of their own recovery including attention to the issues of culture, spirituality, trauma, and other factors. Service plans and outcomes are built upon respect for the unique preferences, strengths, and dignity of each person.

These six aims are inter-related and complimentary; it is difficult to achieve one without attending to the others. Together they articulate a vision of a system that is both recovery-oriented and person-centered.

The IOM also posited 10 new rules or guidelines for directing health care systems and service-delivery reform. Several of the rules suggest how person-centered care can be achieved. Table I includes 5 of the 10 rules that especially illustrate this point by comparing existing practices, values, and assumptions with a vision of a new and different approach. The concepts described within the “new paradigm” portion of the table are the guiding principles for this book.

These rules help breathe life into the notion of person-centered services and to make them less of an abstraction and more of a reality. Clearly, there is a need to involve individuals receiving services in decision-making and planning in a new and different way.

If these rules are followed, the provider should no longer solely determine outcomes for individuals and families. Treatment goals such as symptom reduction, decreased hospitalization, treatment compliance, or the elimination of behavior problems are for the most part generic and provider driven. Instead, the outcomes of services should be those changes identified and valued by the individual. Typically they will address personal and specific concerns about psychosocial functioning, improved clinical status, quality of life, and satisfaction with services. Outcomes should be
person-centered and empowerment-oriented: all involve some degree of self-determination, self-esteem, and self-efficacy, and together lead to maximizing one’s life and minimizing one’s illness.⁵

TABLE 2.1 Changing Practice Guidelines

<table>
<thead>
<tr>
<th>Current approach</th>
<th>New paradigm</th>
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<tr>
<td>Care is based primarily on visits</td>
<td>Services are provided in the context of continuous healing relationships</td>
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<tr>
<td>Professional autonomy drives care</td>
<td>Services are customized according to the needs and values of the individual</td>
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<tr>
<td>Decision making is based on training and experience</td>
<td>Decision making is based on evidence when possible</td>
</tr>
<tr>
<td>Information is a record</td>
<td>Knowledge is shared and information flows freely</td>
</tr>
<tr>
<td>Professionals control care</td>
<td>The individual is the source of control</td>
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Which Direction to Travel?

Donald Berwick, MD, was a member of the IOM’s Committee on the Quality of Health Care in America and has subsequently attempted his own explanation of person-centeredness. In a groundbreaking article from Health Affairs,⁶ Berwick describes four levels of organization in the health care system (Fig. 2.1). Beginning with the experience of “patients and communities,” Berwick argues that health care should “honor the individual patient, respecting the patient’s choices, culture, social context, and specific needs.” Berwick goes on to describe this as True North: “like a compass guiding our journey, individuals and their experiences should be the ‘defining force in health care delivery’. This is what orients the very basics of a service-delivery system.”

Returning to the metaphor of individual planning as a journey, a compass is an invaluable tool for the traveler and explorer—without its guidance, it is easy to get lost. Without a fixed point of reference, setting and staying the course can be exceedingly difficult. In the same way that the magnetic pull of the North Pole has long helped direct human expeditions, the needs and experience of individuals and families seeking services should always be our point of reference and direction in organizing the resources required to address their needs.
The other points of the compass are equally important. To the West are the “microsystems of care,” providers and small clinical units that provide direct service. They in turn are supported by the East, which are “macro-systems of care” that include large provider organizations, HMOs, health care-delivery systems, and the like. The South points to the general, political, social, and economic environment in which health care systems function. In order for the experience of care for the individual to change to True North, it is often times necessary for change to occur at all points of the health care compass.

If we are to succeed in becoming person-centered, the entire system may need to re-examine its bearings. Those in the West, who have immediate responsibility for effecting change and the quality of care at True North, are also dependent upon support, influence, and factors that we cannot always control in the East and South. None of this, however, should minimize the importance of good practice at the level of microsystems where care is provided. Individual planning is all about ensuring that the needs of the individual and family at True North are identified, understood, and addressed.

Diversity

Nowhere is both the importance and the challenge of assuring a person-centered approach more evident than in considering the needs of an increasingly diverse American population and the disparities in access and quality of care for cultural, racial, and ethnic minorities in this country. The 2000 Surgeon General’s report, Mental Health: Culture, Race, and Ethni-
city—A Supplement to Mental Health: A Report of the Surgeon General established that in the U.S. today, many members of minority groups:

- have less access to, and availability of, mental health services
- are less likely to receive needed mental health services
- often receive a poorer quality of mental health care
- are under-represented in mental health research

There are many barriers—both real and perceived, both physical and psychological—that contribute to these disparities. The chief barriers are mistrust and fear of treatment, racism and discrimination, and differences in culture, language, and communication. The ability of persons receiving services to clearly and openly communicate with providers carries special significance in the area of mental health and addictive disorders service. These emotional and addictive problems impact and affect thought, mood, cognition, and the highest integrative aspects of behavior. The effective diagnosis and treatment of mental health and addictive disorders greatly depends on the quality of verbal communication as well as trust and understanding between individuals, families, and providers.

Attention to the role of culture in understanding the needs of each individual in the process of assessment and individual planning must be an essential part of the solution to these problems. The Diagnostic and Statistical Manual of Mental Disorders IV-Text Revision (DSM IV-TR)\(^8\) includes often-overlooked guidelines for a cultural formulation in its Appendix I. There has been considerable controversy and frustration with the placement of this important component of diagnosis in an appendix, which has, for many, called into question the field's real commitment to cultural competence. Regardless, the outline specifically requires that the following items and considerations be included as part of each assessment and diagnosis:

- an inquiry about the individual's cultural identity (including issues of race, ethnicity, gender, sexual orientation, religion, spirituality, disability status, and other self-defining characteristics)
- the exploration of possible cultural explanations of problems
- consideration of cultural factors related to psychosocial environment and levels of functioning
- examination of cultural elements in the client-provider relationship
- an overall cultural assessment in establishing a diagnosis and development of an individual plan
In essence, both the Surgeon General’s report and the Diagnostic and Statistical Manual of Mental Disorders—Fourth Edition—Text Revision (DSM-IV-TR) link a person-centered approach to understanding the unique needs of each individual and culturally competent service planning. Similar to the relationship between recovery- and person-centered approaches, the values and practice of culturally competent and person-centered mental health and addictive disorders service are also closely linked.

**Self-Determination**

The roots of a person-centered approach to care and planning can also be found in the mental retardation and developmental disabilities system of care. For over 20 years, clients and their family members in that system, along with practitioners and programs, have been actively involved in the process of developing individual plans. The focus has been on promoting the individual’s right to self-determination and providing the necessary supports for the individual’s highest level of participation in the community. In most cases, these practices would still be far from the norm in the mental health and addictive disorders service field.

Many of the ideas now spreading through the mental health and addictive disorders field about choice, self-determination, and self-directed care derive from the experience and knowledge developed in related human-service systems. The changes there have been accomplished not only by redefining the role of providers, but also most importantly by assuring the meaningful participation of the individual and their family in the individual planning process. This practice is in alignment with funding, licensing, and accrediting standards in the developmental disabilities field throughout the U.S. The behavioral health field has much to learn from developmental disabilities service systems where individual plans are rich, relevant, and meaningful tools for the consumers and their families as well as for the providers.

**Professional Partnerships**

One of the barriers to a person-centered approach in the fields of mental health and addiction services are the notions of transference and counter-transference, which remain a dominant framework. This strongly influences a provider’s understanding of the dynamics and the relationship with
the individual seeking services and shapes their interactions accordingly. While there may be some relatively tacit acknowledgment of the importance of a “therapeutic alliance,” this is often given little attention in routine practice. Clearly it is a model based upon professional autonomy, professional control of services, and the presumed if not expected relative passivity of the individual receiving services. The idea of viewing the person as an active participant and partner—a member of the team—is relatively alien.

Many providers do not know how to establish a professional partnership with the individual receiving services. Nor are they especially comfortable with the idea and question its appropriateness. Many are threatened by the perceived loss of control and its multiple implications. Many providers voice the concern that empowering the individual and family-seeking services is tantamount to relinquishing their professional roles and responsibility. They have had difficulty in redefining their essential contribution in a realigned therapeutic relationship. It is easy to understand why for many providers the idea of being person-centered represents a difficult set of changes in practice that all too often are not achieved.

Somewhat in contrast to the prevailing practice in the mental health field, the idea of partnership has long been central to the addictive disorders field. Twelve-step programs are based upon peer-to-peer support and Alcoholics Anonymous is often described as a fellowship. This tradition, and recognition of the value and effectiveness of a helping alliance, should inform all of health care as we decide how to better help individuals articulate and achieve their own vision of wellness and recovery.

Historically, multidisciplinary team-based care was a distinguishing feature of psychosocial rehabilitation. Increasingly, multidisciplinary teams are now seen as an optimal service delivery model for health care services in general. The individual plan has always had an important function in multidisciplinary teams: the coordination of a range of services to address complex needs. But perhaps even more important has been the notion that the individual receiving services must be included as a vital member of the team if the desired goals and objectives are to be achieved. Whether or not it is a team of two—the individual and the provider—or a diverse team involving a range of mental health and addiction services providers, the idea of a team-based model can help to reinforce a person-centered approach.

Many providers have been trained in guild-based academic and clinical traditions. This approach has often focused on individual/provider dyads. As a result, many providers are not familiar or necessarily comfortable with multidisciplinary team-based approaches. Authority and secrecy have been the prevalent mode as compared to the need for cooperation, openness, and
transparency among team members. The challenge now and into the future is to train the existing workforce, many of whom are experienced with a different model, in how to work effectively with the individual receiving services and family members in creating plans responsive to each individual’s needs.

Clearly, there is compelling evidence that a person-centered approach to planning and services is the emerging new standard of care. Yet there is also substantial evidence that in daily mental health and addictive disorders practice, this is not what occurs. While we can see the future, we remain rooted in the past.

II. CREATING THE SOLUTION

Ultimately, the assurance of person-centered mental health and addictive disorders service lies in the process of individual planning. Based upon an individual and culturally competent assessment, the plan is in essence a contract between the provider and the individual, an agreement detailing who is to do what and when to help the individual and family realize their hopes and dreams. The individual plan belongs to the individual receiving services and is the written record of the agreed upon strategies and course. Individual planning is the essence of being person-centered.

Experience of Individuals and Families

Respect for the individual and family by the provider is an important component of a person-centered approach and an essential ingredient in planning. Although it is generally a well-understood concept, it can be difficult to explain. Responding precisely to the wants, needs, and preferences of each individual and family is the essence of respect. This implies that there are abundant opportunities for the provider to be informed about each person’s unique attributes and perspectives. Another aspect of respect is the genuine inclusion of the individual and family in clinical decision-making consistent with his or her level of comfort, preference, and functional status.

While active participation is valued, it must be balanced with individual choice, preference, and comfort. This is often impacted by a whole host of factors ranging from age and gender to culture, ethnicity, and tradition. Past experience with seeking services—both positive and negative—may impact their ability to understand the process. Education and orientation,
along with creating opportunity, can often go a long way towards facilitating meaningful participation and is in and of itself both healing and empowering.

**Communication**

Communication is another critical component of a person-centered approach to planning and providing services. Providers must assure the free flow of information, particularly about matters such as diagnosis, prognosis, services, and alternatives, as well as the attendant risks and benefits. It is essential that all information provided is accurate, perceived as trustworthy and credible, understandable, and tailored to the individual’s preferences for involvement and participation. As much as possible, information must be communicated in a compassionate and empathic manner and should not compromise the comfort and safety of the individual.

Language is obviously core to communication. It is not enough to simply know the fluency and literacy of the individual and family; language preference may be even more important. It is not unusual to find that at times of distress, some people may find it easier and more comforting to communicate in their “mother tongue” rather than a second or third language.

Another key aspect of communication is sensitivity to the use of language. ‘Person-first’ language in and of itself goes a long way towards expressing respect and consideration. People are not diagnostic labels: a person may be diagnosed with schizophrenia but they are not “a schizophrenic.” This awareness extends to providers and staff as well. Referring to those providing compassionate care as *direct-care staff* as compared to “front-line staff” who are “in the trenches” has its own connotations and implications. We are not at war with the individuals and families that we serve! Our use of language is an opportunity to focus on strengths and talents, identify successes, respect the individual’s right to self-determination, and build an alliance between provider and individual.

Another component of language is the differences in terms between the traditional model of care and the person-centered approach. Table II provides a comparison of terms and preferred person-centered language.

The traditional approach keeps the focus on what is wrong, what is not working, and problems/abnormalities. In contrast, the person-centered approach is oriented to developing the resources of the individual, building solutions, and identifying possibilities.
Family

The appropriate involvement of family and friends is yet another facet of a person-centered approach. Family is a vital source of information and knowledge about the individual, their history and needs, the role of culture in their lives, and other important details. At the same time, the physical and emotional support of family can be a critical component of each individual’s recovery. If one component of successful rehabilitation and recovery is the individual’s increasing reliance on natural supports and a decreasing dependence on professional services, the importance of family as a primary source of support cannot be underestimated. For most people, family includes the most important and significant relationships of our lives.

The role of family is often influenced by cultural factors, this makes an accurate understanding of the individual in the context of culture essential. Definitions of family should not be restricted to traditional notions; instead, the right of individuals (certainly each adult) to self-define their family and support system should be respected.

The Role of the Provider

Attention to the process of developing, documenting, and implementing an individual plan is part of a commitment to person-centered care. Actively

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TABLE 2.2 Comparison of Terms

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<thead>
<tr>
<th>Person-Centered</th>
<th>Traditional</th>
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<td>Person-centered</td>
<td>Practitioner-based</td>
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<tr>
<td>Strengths-based</td>
<td>Problem-based</td>
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<tr>
<td>Skill acquisition</td>
<td>Deficit focus</td>
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<tr>
<td>Collaboration</td>
<td>Professional dominance</td>
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<tr>
<td>Community integration</td>
<td>Acute treatment</td>
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<tr>
<td>Quality of life</td>
<td>Cure/amelioration</td>
</tr>
<tr>
<td>Community-based</td>
<td>Facility-based</td>
</tr>
<tr>
<td>Empowerment/choices</td>
<td>Dependence</td>
</tr>
<tr>
<td>Least restrictive</td>
<td>Episodic</td>
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<tr>
<td>Preventative</td>
<td>Reactive</td>
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involving the individual seeking services in the process of identifying goals, specifying objectives, and selecting services is the essence of being person-centered. For many providers this will be a shift in roles. The days of the provider as the source of expert knowledge and professional experience, knowing what is “best” for the individual, not sharing the assessment/diagnosis results, not openly communicating, or not encouraging shared decisions are gone. Dismissing an individual’s preferences and goals as being “unrealistic,” or not soliciting them at all, ultimately fosters dependence rather than independence, and is the antithesis of recovery, wellness, and resiliency.

The concept of person-centered service does not suggest, however, that the provider no longer has any role to play in the recovery process. Simply put, the provider’s role has changed from that of all-knowing, all-doing caretaker to that of coach, architect, cheerleader, facilitator, and/or shepherd. The provider builds a partnership with the individual, resulting in the individual plan that serves as the roadmap for service delivery and recovery. The provider uses the plan in four ways: to maintain focus on the individual’s progress toward goal attainment, to track changes in needs or challenges, as a framework for identifying and organizing needed resources, and to measure growth and change.

**The Plan**

The individual plan should be a practical, understandable tool that the individual and the provider can utilize together to steer the course in the journey of recovery. It is not a document written by the provider in isolation without the participation of the individual. The plan is created by “meeting the person where they are” at any moment in time and not superimposing the provider’s own goals and directions.

In order to be meaningful and effective, a plan must truly be the individual’s road map. It is the focal point of each session with the individual. It needs to include personally defined goals along with realistic objectives that address relevant and immediate barriers and impediments. Plans need to be practical and reasonable in identifying specific services and interventions consistent with the individual’s preferences and values. The plan should be sensitive to language choices and written in “plain English” or the individual’s preferred language. The plan must be culturally relevant and outcome-oriented.
In contrast, it is worthwhile to be clear about what the plan is not. It is not written in jargon typically understood only by the professional provider. It is not disconnected from the assessment data and formulation, and does not stand alone with goals and objectives unrelated to assessment data. A plan is not merely a completed form that follows a computerized treatment-planning module with predetermined menus of goals and objectives that match diagnostic criteria. It is not solely based on the individual’s deficits, disabilities, and problems. It is not written simply to satisfy funding and regulatory requirements, waved under the individual’s nose for their signature, and then filed in their record never to be used again.

Ultimately, the plan is a communication tool for the provider, for the individual, for family and others involved in the individual’s life, for payers, and for accreditation or regulatory reviewers. A written copy of the plan should be given to the individual and family to take with them and use. In this way the plan can help to evaluate the recovery progress of the individual and family.

### III. MAKING IT HAPPEN

In a recovery-oriented, person-centered care system, the following conditions exist:

- individuals are encouraged and assisted in identifying their own goal(s)
- services are provided in the context of the individual’s culture and community
- services facilitate an individual’s and family’s culturally appropriate interdependence with their community and are responsive to their expressed needs and desires
- the therapeutic alliance is directed by the expectation of the individual
- reaching goals for each person is facilitated by understanding their:
  - hopes and dreams
  - life roles
  - valued role functions
  - interest in work and other activities
  - spirituality and religious affiliation
  - culture and acculturation
  - educational needs
- individual differences across the lifespan are valued and considered
- there is a holistic approach in which assessment and intervention models are merged
mutual reciprocity in a trusting hopeful relationship with providers is considered essential
- providers work from a strengths/assets model
- there is collaborative development of an individual service plan which identifies needed resources and supports
- the individual receiving services defines the family unit and their level of involvement

Much of this is realized through the process of developing, documenting, and implementing an individual plan.

**Evaluation**

Current practice should be evaluated against these criteria for person-centered care. There will no doubt be many examples of success and fidelity to the values and principles of this approach. It is equally likely that there will be opportunities for change and improvements that are identified at all levels within the service delivery system. The compass in Figure 2.1 is a useful framework not only for thinking about change for individuals and families but also for providers and care systems. Evaluating current performance at each of the four levels or points, and identifying strategies for change, is key to “making it happen.”

Figure 2.2 reflects the interdependent relationship between the levels of system hierarchy and the elements of the IOM Quality Chasm framework. At the level of microsystems of care, providers are focused on assuring that the six core quality aims are satisfied; person-centered care is one of those core aims. This builds on the responsibilities of organized systems to employ and support the rules or guidelines for quality-oriented systems. Many of these rules are intended to assure person-centered approaches to providing services. Lastly is the importance of values, reflected and elaborated in policy, providing the basic structure and foundation of the service-delivery system. Each component of quality—values, rules, and aims—becomes an essential part of the individual’s experience of a person-centered approach.

The four levels are inter-related, do not exist or function independently, and must be considered together. That is the essence of a system. Neither policymakers, health care organizations, direct-care providers, or individuals alone can assure that the systems and services they provide are person-centered. Success requires an alignment of values, policies and procedures,
and principles and practice throughout the system in order to achieve this goal.

At the level of the individual and family, there are two important considerations. Knowing about the current (and future) experience of the care and service process is a key component of evaluating both provider and systems performance. There are several well-accepted surveys geared towards measuring the experience of care of the individual and family including the MHSIP (Mental Health Statistics Improvement Program) Consumer Oriented Survey\(^9\) and the Experience of Care and Health Outcomes Survey (ECHO\(^{TM}\)) survey\(^{10}\) which is part of the NCQA’s (National Council on Quality Assurance’s) HEDIS dataset as well as others. Other methods of understanding and evaluating the perspective of those seeking services include the use of individual interviews and focus groups. Every provider and organized system of care should have some mechanism in place to evaluate how service recipients experience the process and allow for suggestions for improvement and change. This is discussed further in Chapter 9.

**Alternatives**

Another approach to changing and improving current practice at the level of the individual and family is to create “demand-side” change. It may well be that while individuals and families may be dissatisfied with a more provider-centered approach, they do not know what the alternative is or how it might be changed. In all too many settings, service recipients are not aware of the role of the individual plan—how it is created and how it directs services. In some cases, they may not even be aware of the goals and
objectives that are supposedly determining the services they receive. By increasing awareness among individuals and families about the importance of the individual plan—and their essential role in its creation—a powerful ally in the process of systems change can be created.

Some of this can and should be part of the basic orientation to services that each individual and family should receive as they enter into the process of assessment and service planning. By making expectations and opportunities clear, the likelihood of meaningful participation and a truly person-centered plan is enhanced. This also provides an opportunity to understand the education or support an individual or family might need in order to meaningfully participate in his or her own plan and recovery.

Evaluating Providers

At the level of the provider and “microsystems of care,” there should be multiple opportunities to evaluate and improve current practice. This can include self-assessment, peer-review, evaluation by a supervisor, or review by an external oversight authority. There are three key points of performance that can be considered:

1. Attitudes
   - How does the provider feel about the values and principles of person-centered care?
   - In what ways are they threatened or enthused by these ideas?
   - How does the provider regard the process and value of creating individual plans?

2. Knowledge
   - Does the provider understand the principles of a person-centered approach?
   - Has the provider received appropriate education and training in person-centered approaches to assessment, planning, and service delivery?
   - Can the provider identify the elements and phases of the planning process?

3. Skills and Abilities
   - Can the provider conduct a person-centered assessment that leads to a formulation?
   - Can the provider develop an effective alliance with the individual seeking services that supports their participation in planning and recovery?
Can the provider work to develop, organize, document, and implement a plan that is responsive to the identified goals and objectives and is sensitive to the unique preferences and needs of the individual?

Do individuals and families report feeling like they were treated with dignity and respect and supported in their own personal vision of recovery, wellness, and resilience?

Core competencies for providers need to be established and providers need to be evaluated as to their attitude, knowledge, and skills. The ability of a provider to develop person-centered individual plans should be one of those competencies. The IOM's *Crossing the Quality Chasm* report notes: “All health professionals should be educated to deliver patient-centered care as members of an interdisciplinary team, emphasizing evidence-based practice, quality improvement approaches, and informatics.” If we are to achieve the reality of a consistent person-centered approach to providing mental health and addictive disorders service, this is an essential part of “Making It Happen.”

In many cases this will necessitate additional education and training for the existing workforce as these represent a new set of expectations and skills from what has been the prevailing standard of care. There is also a pressing need to evaluate and change the curriculum in current pre-degree professional programs as well as consideration of the post-degree pre-licensure training for those who are preparing to enter the mental health and addictive disorders service workforce. Lastly, we must recognize the important role in today’s service-delivery system of para-professionals and peers—many of whom sorely lack adequate education and training to meet their substantial responsibilities. Hopefully this book can make a contribution to this education and training agenda.

**Systems Change**

Providing person-centered services requires endorsement and support at the level of organized systems of care. The expectations of quality care need to be aligned with the resources and supports required by providers in order to realize a person-centered approach. Structural barriers—including regulations, licensure standards, and payment requirements—are potential impediments to providing person-centered care and at this level need to be examined and removed. It is unfair to expect providers to change how they work without recognizing their dependence on these requirements and its impact on their meeting core quality aims. If person-centered approaches
are to succeed, they must become part of the expectations and norms of organized systems and the resources necessary to meet this objective need to be available. This should be most clearly reflected in the requirements and expectations related to the development and use of individual plans in the service-delivery process.

Lastly, person-centered care must be clearly and unequivocally endorsed as a core value of our policy-making processes. The goals of the President’s New Freedom Commission report begin to accomplish that clarification at a national level. It is quite significant that the need for proper service planning is identified as one of the six major goals and objectives of the report. There can be no clearer statement at the national policy level of the critical role of the individual plan in providing quality effective care. Only time will tell if the Commission’s recommendations truly become an anchor point of policy and practice across the country. However, policy for mental health and addictive disorders services should not only be determined in Washington; it should also be elaborated on within states, counties, and commercial health plans. Our ability to provide a person-centered approach is inevitably dependent on the explicit endorsement and support at this level. Commitment to a person-centered approach must be made at the highest level of authority and influence in our care systems if organizations and providers together are to succeed in meeting the expectations of individuals and families.

In our endeavor to help individuals bring about positive changes in their lives, we need to recognize and accept the obligation to effect changes in values, policy, and practice within our own work and systems of care.

REFERENCES

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