Strengthening **Person-Centered Recovery Planning** in State Behavioral Health Systems

A Technical Guide

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Executive Summary

Person-centered practices—promoting choice and self-determination, community inclusion, and full access to services and supports—are endorsed as a goal for most state behavioral health systems, and person-centered recovery planning (PCRP) is a required element of community mental health and substance use services.

Nationwide, there is an urgent need for system leaders to issue bold and clear directives to their agencies and partners. It is our hope that the guidance provided here will support those efforts.

To facilitate and accelerate PCRP, behavioral health system leaders should advance implementation across four areas (listed in teal box). This brief presents guidance for strengthening Person-Centered Recovery Planning (PCRP) in state behavioral health systems. It is based on the authors' collective experience providing decades of PCRP technical assistance as well as a recent review of policies and practices and interviews with staff and community partners in one state behavioral health system.

Person-Centered Recovery Planning (PCRP): Recommended Definition

PCRP is a collaborative process between the person and their supporters. This process results in the development and implementation of an action plan to assist the person in achieving their unique, personal goals along the journey of recovery. PCRP is rooted in person-centered thinking, which focuses language, values, and actions on respecting the views of the person and their supporters and emphasizes quality of life, well-being, and informed choice.

1. Create technical guidance for PCRP process and documentation.
2. Establish ongoing quality monitoring, technical assistance, and training to support the technical guidance.
3. Develop and distribute billing guidance to support providers in more uniformly capturing PCRP-related services while abiding by state and federal regulations.
4. Expand innovation and investment in peer support to directly and indirectly support PCRP implementation.

Background

Person-centered practices—promoting choice and self-determination, community inclusion, and full access to services and supports—are endorsed as a goal for most state behavioral health systems, and person-centered recovery planning (PCRP) is a required element of community mental health and substance use services. This endorsement aligns with the quality expectations outlined by the Centers for Medicare & Medicaid Services in the Home and Community-Based Services (HCBS) Final Rule and Quality Measure Set, the Substance Abuse and Mental Health Services Administration,[1] state and federal Certified Community Behavioral Health Clinic criteria, and Department of Justice Olmstead standards. While these existing and emerging mandates, along with growing consensus on the rationale for PCRP, serve as a catalyst for change, implementation efforts across the country largely remain stalled. This is not due to a lack of understanding of the "why" behind PCRP, but rather because of ongoing confusion about the "how."

Nationwide, there is an urgent need for system leaders to issue bold and clear directives to their agencies and partners. It is our hope that the guidance provided here will support those efforts. To facilitate and accelerate PCRP adoption, behavioral health system leaders should advance implementation across four areas:

1. Create technical specifications for PCRP process and documentation.
2. Establish ongoing quality monitoring, technical assistance, and training to support the technical specifications.
3. Develop and distribute billing guidance to support providers in more uniformly capturing PCRP-related services while abiding by state and federal regulations.
4. Expand innovation and investment in peer support to directly and indirectly support PCRP implementation.

To ensure systems-change efforts remain true to the "nothing about us without us" adage, it is imperative that people with lived experience and their supporters be involved in all four change areas in meaningful and authentic ways. This type of engagement results in innovative ideas for improvement, pressure for positive change, and accountability to systems' person-centered mission, vision, and values.

This brief presents guidance for strengthening PCRP in state behavioral health systems. It is based on the authors' collective experience providing decades of PCRP technical assistance as well as a recent review of policies and practices and interviews with staff and community partners in one state behavioral health system.

[1] See Substance Abuse and Mental Health Services Administration (SAMHSA). Person-Centered Planning. Publication No. PEP24-01-002 Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, 2024. https://library.samhsa.gov/product/issue-brief-person-centered-planning/pep24-01-002

Priority Actions to Facilitate & Accelerate PCRP Adoption

1. *Create technical specifications for PCRP process and documentation*

A. **Crosswalk existing policy and training materials to identify and resolve inconsistencies that hinder the use of PCRP.** Documents should include program manuals, assessment and utilization management guidelines, quality assurance tools, and training curricula. State materials should be reviewed against national best practice and federal standards for PCRP (e.g., the requirements for person-centered planning in the Centers for Medicare & Medicaid Services Final Rule and SAMHSA CCBHC criteria).

B. **Develop, disseminate, and monitor adherence to a set of minimum specifications that the state requires across all programs responsible for PCRP.** The specifications should be based on national and local best practice and promote resolution of the inconsistencies identified in the crosswalk. Best practice should:

- **Define the purpose and function of core documentation elements including goals, objectives, and action steps.**
    i. The *goal* is the cornerstone of the plan and should reflect meaningful quality of life changes that motivate the person in their recovery.
    ii. The *objectives* are measurable, short-term outcomes or changes that incrementally move a person closer to their goal.
    iii. And *action steps* are interventions offered through the delivery of professional and supportive services as well as actions taken by the person and their supporters outside of professional services.
- **Define key indicators of quality PCRP facilitation.** To be meaningful, the plan (whether on paper (or in the electronic health record) must be authentically founded on a quality facilitation process. Practitioners as well as people who use services need clear guidelines on quality PCRP meeting facilitation (e.g., who is involved, how the meeting is organized, what constitutes respectful communication, and how power and decision-making are shared).
- **Emphasize that the plan is fluid and evolves over time in accordance with the person's priorities.** It is appropriate for initial plans to be streamlined and narrowly focused on the specific issue that brought the person to seek support. Initial plans are often related to immediate basic needs and the alleviation of distress (i.e., around the "presenting problem"). This early focus on the resolution of problems and immediate

distress represents a responsive approach during a person's initial engagement in care. Aspirational and long-term quality-of-life goals often associated with person-centered planning may not be a priority at the initial point of contact. Over time, a more holistic and comprehensive person-centered plan tends to unfold as the person develops a sense of trust and mutual respect with their care partner. This type of relationship is the foundation on which a skilled provider authentically engages a person in the process of person-centered goal discovery.

- **Keep the scope of plans limited to only necessary information and eliminate internal redundancies (i.e., "overlap") in plan fields or documentation.** A focused, concise, and meaningful plan cuts down on unnecessary staff time developing lengthy plans that are less likely to be used. Areas of assessed need that directly interfere with the person's most valued goal(s) should be prioritized for inclusion in the plan. Other areas of functioning identified in the assessment process that are not interfering with the person's life or causing them distress do not need to be included in the plan and may be deferred and revisited as needed. This type of prioritization focuses the plan on what is most important to the individual and what they can reasonably address at any one time.
- **Outline effective practices in goal discovery.** Goal discovery is a process in which the person—with support as needed and desired— identifies their vision of a good life. Goals should be elicited through deep reflection and in dialogue with supporters. There are numerous goal discovery tools and exercises freely available, and several widely used training resources incorporate such tools.[2] States should vet existing tools for alignment with PCRP principles and standards and incorporate selected tools into policies and trainings.
- **Clarify how data from standardized needs assessments should and should not inform the PCRP.** As noted above, goals should be identified by the person through a process of understanding what matters most to them in their *life,* not just in their *treatment.* Deriving PCRP goals directly from the needs, deficits, or problems listed in an assessment detracts from the meaningful, life-oriented recovery goals that are the hallmark of PCRP. Needs identified in an assessment process may feed into short-term objectives if they are interfering with a person's goals and their desire to work on them. Or, an identified need may be deferred if the person is not interested in working on it and it does not present an immediate safety concern. This clarification would allow providers to create plans that remain responsive to the needs assessment while allowing the long-term goals to be developed through a meaningful process of goal discovery.

[2] For example, see Crisp, Suzanne and Lawrence, Jane (2019). Person-Centered Thinking, Planning, and Practice: A National Environmental Scan of Foundational Resources and Approaches. Cambridge, MA: NCAPPS. Available at: https://ncapps.acl.gov/docs/NCAPPS_ResourcesApproaches_NationalEnvironmentalScan_December2019.pdf

- **Offer strategies for soliciting input from supporters without reliance on a single formal meeting**. The "big meeting around the table" with a person's entire circle of support is a concept that was developed out of person-centered planning models practiced in other disability populations (e.g., intellectual and developmental disabilities) often outside of a structured service environment. As such, it does not readily translate into modern behavioral health system contexts. While the "big meeting" can be a powerful intervention, it is often not feasible/compatible within a fee-for-service environment where one-to-one planning is the norm. In circumstances where a meeting of the circle of support is not feasible, the expectation remains to creatively include the input of the person's chosen natural supporters as well as the input of other staff and providers. Minimum expectations and best practices for staff coordination should be clarified. Ideally the staff member responsible for co-developing the PCRP with the person is also the one with the most direct contact with them and is the most well-situated to coordinate effectively with other professional and natural supporters.
- **Ensure the person is maximally involved in the planning process.** Plans should be written in language that the person understands. The plan facilitator (i.e., the person responsible for co-developing the PCRP with the person receiving services, often a primary clinician or care coordinator) should work with the person to determine what supports they need to participate in the process and provide those supports—in advance of, during, and after the meeting/planning process. When a person is reluctant or unwilling to participate, there should be a designated staff person to help them to explore why they are reluctant and then remove barriers and adjust the process as needed. The inclusion of peer support staff can be a highly efficient and effective strategy to help maximize a person's voice and choice throughout the PCRP process. However, this should be implemented with caution to avoid co-optation of peers into roles that are not aligned with their core professional ethics (see Section 4.C. below).
- **Ensure provision of self-advocacy skills training for people who use services**. A self-advocacy skills training curriculum should include support for goal discovery as well as tools and practices to understand what to expect from services and from the PCRP process. It should also include robust information regarding the rights to: direct the planning process, refuse services, and request changes in the PCRP. All training materials should be cognitively and linguistically accessible and culturally responsive. Self-advocacy skills training and support is particularly important for people returning to community after long-term institutional stays who may not have had opportunities to exercise choice and control over services. Self-advocacy skills training can be incorporated into existing psychiatric rehabilitation programs but may also be effectively

provided by peer supporters through one-to-one or group-based coaching (See section 4.C. below)

- **Clarify expectations for the use of PCRP to facilitate transitions across service levels (e.g., inpatient to community), service areas (e.g., mental health and substance use programs), or life stages (e.g., youth to adult).** This includes clarification about expectations around coordination of plan implementation when a person has multiple plans across different service areas. For example, if a person has a service plan with a primary clinical therapist, an employment specialist, and a care manager, how and when does coordination and communication occur across these three providers? If differences arise in priorities, how are these mediated and resolved in a way that ensures all parties are aligned in support of the person's most valued goals? It is also important to include clarifications about expectations around continuity of PCRP through life transitions and transitions across levels of care. For example, if a person has developed a person-centered plan with a transition coordinator to move from an institutional setting to the community, what mechanisms are in place to ensure that the service plan developed by the community provider stays true to that person's original vision?

C. **Develop guidance related to PCRP considerations when choosing and customizing electronic health record (EHR) platforms.** EHRs and PCRP forms can either enhance or hinder the planning process. State behavioral health system decisionmakers and provider agencies need to be aware of this when choosing vendors, developing processes, and researching/negotiating customization options. Practical guidance on the development EHR platforms that facilitate the uptake of PCRP is available in the resource *The Promise and Pitfalls of Electronic Health Records and Person-Centered Care Planning*.[3]

2. *Establish ongoing quality monitoring, technical assistance, and training to support the technical specifications*

A. **Enhance quality management functions to monitor and improve PCRP processes.** Traditionally, state quality management processes are limited in their capacity to measure PCRP quality. This is due to ongoing conceptual confusion around PCRP operationalization, as well quality management's heavy orientation toward regulatory compliance—at times to the exclusion of other aspects of quality. Quality data to inform ongoing PCRP implementation should be derived from diverse sources and incorporate service user experience data. Ongoing

[3] Tondora J., Stanhope V., Grieder D., Wartenberg D. The Promise and Pitfalls of Electronic Health Records and Person-Centered Care Planning. J Behav Health Serv Res. 2021 Jul; 48(3):487-496. doi: 10.1007/s11414-020-09743-z. Epub 2021 Jan 4. PMID: 33398591; PMCID: PMC8254826. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC8254826/

mechanisms should solicit feedback using diverse methods of data collection including individual surveys, focus groups, and routine input from peer-based advocacy organizations. There are multiple ways quality management processes can be enhanced to better monitor and improve PCRP processes:

- **Establish a feasible, yet meaningful, set of key indicators to reinforce PCRP implementation across the behavioral health system**. Such indicators can be drawn directly from existing technical specifications as well as national standards.[4]
- **With lived experience leadership at the state and community levels, develop and institute metrics of experience with the PCRP process, and incorporate these into quality management processes.** Perhaps most essential to systemic accountability around PCRP is the routine solicitation of direct feedback from people who use services through diverse methods of data collection including individual surveys, focus groups, and ongoing input from peer-run advocacy organizations. Quality measures should include whether the person's priorities, cultural values, and self-defined wants and needs are reflected in their plan. Ideally, these efforts are carried out as a partnership between quality management personnel and lived experience leadership such as the state's office of engagement, recovery, peer services, or consumer affairs. These same participatory processes should be mirrored at the community level to maximize lived experience input in the change efforts of local programs.
- **Provide a sample chart review tool based on minimum specifications in the technical specifications.** A targeted and reliable chart review tool is necessary to assess a manageable number of specifications in PCRP documentation. However, chart review should not be taken as a proxy for the experience of persons served and those who serve them.
- **Incorporate additional data sources such as observational audits.** In addition to plan reviews, monitoring in PCRP implementation should include service user feedback surveys as well as observational audits of one-to-one or group-based planning meetings to ensure they are facilitated in accordance with person-centered principles.

B. **Develop mechanisms to provide ongoing technical assistance to providers to facilitate implementation of PCRP specifications as outlined above.** To be effective, training must be accompanied by complementary technical assistance. Technical assistance is essential to support and sustain PCRP implementation over time, particularly in systems where legacy practices may weaken PCRP.

[4] See Human Services Research Institute (2019). Person-Centered Thinking, Planning, and Practice: A National Environmental Scan of Indicators. Cambridge, MA: National Center on Advancing Person-Centered Practices and Systems. Available at: https://ncapps.acl.gov/docs/NCAPPS_Indicators%20Scan%20_191202_Accessible.pdf

C. **Establish feedback channels that allow systemic implementation challenges identified through technical assistance to be communicated to leadership, enabling them to address these issues in good faith.** The advancement of PCRP is frequently weakened when behavioral health systems focus primarily on provider workforce development without attending to the policies, procedures, and infrastructure that must be in alignment to support robust implementation.

D. **Establish expectations for staff training including who needs it and what it should look like.** Best practice in PCRP training dictates the following:
   - **Staff at all levels (including and especially leadership) receive role-relevant PCRP training.** Knowledge of PCRP should never be limited to the primary clinician or plan facilitator (i.e., the person with responsibility for co-developing the PCRP with the person receiving services).
   - **Training and technical assistance are provided to partners both within and outside the system who have the power to either support or hinder the adoption of PCRP, particularly due to their control over funding.** Specifically, local and state-level oversight bodies responsible for plan audits, service authorizations, and provider payments—such as managed care organizations—must be actively involved in PCRP system change efforts to ensure consistent messaging that supports quality implementation.
   - **Training content includes the "why" of PCRP alongside the "how," including the technical aspects of PCRP development and implementation.** Training should first ensure that learners understand the rationale for person-centered approaches before addressing mechanics or "how-to's" of PCRP (particularly with regard to forms and documentation).
   - **Training builds core competencies for person-centered planning.** Five competency domains for person-centered planning—a resource from NCAPPS—can guide the selection and development of trainings. These include interpersonal skills related to engagement, communication strategies, recognition of personal bias, and methods for responding to dissatisfaction and beliefs that may seem to be disconnected from reality.
   - **Training incorporates lived experience perspectives.** People with lived experience should have active involvement in the development or selection of training materials. Trainings should be facilitated or co-facilitated by people who have lived experience of receiving publicly funded behavioral health services. This can be accomplished through collaboration with state's office of engagement, recovery, peer services, or consumer affairs and peer-run organizations.

3. *Develop and distribute billing guidance to support providers in more uniformly capturing PCRP-related services while abiding by state and federal regulations*

A. **Create billing guidance for maximizing billable time spent on PCRP.** In some state payment structures, "planning" is not able to be billed as a distinct service. Goal discovery, supporting the person to identify needs and preferences, and ensuring services are supportive of and responsive to the person's culture and values are part of the service delivery process and should be reimbursed accordingly. Guidance should specify appropriate billing strategies to more uniformly support agencies in capturing valuable services while abiding by state regulations. Billing guidance should include the following:

- **Develop an initial brief plan during the intake encounter to facilitate swift access to services and to allow for billing and reimbursement.** Per the technical guidelines, this plan can include simple goals based on the reasons the person sought help and the issues causing them immediate distress. As distress is alleviated and the person's relationship with their provider is established, the breadth and depth of the PCRP should evolve to reflect a more holistic appreciation for a person's long-term goals and recovery aspirations.
- **Provide guidelines to bill for time spent engaged in goal discovery activities and the identification of best supports to meet needs and preferences.** Time spent on administrative aspects of the plan may not be billable, but in many systems, case management, outreach, and engagement can be billed for the essential activities to gather input to inform the plan. These conversations and activities represent valuable, therapeutic services in their own right (e.g., goal discovery, decision-making regarding the involvement of natural supporters, and exploring barriers to day-to-day functioning). All these activities can, and should, inform the PCRP, and they should not be categorized merely as "planning" and thereby automatically excluded as billable, reimbursable services. This includes time spent revisiting and updating goals as a person's needs, preferences, and life circumstances change.

4. *Expand innovation and investment in peer support to directly and indirectly support PCRP implementation*

A. **Promote the availability of peer support throughout the system.** Peer support and PCRP are inherently linked, and both help to foster a deepening of recovery culture and enhanced outcomes. Even when agencies do not carve out an explicit role for peers within PCRP, any agency that is committed to, and advanced with, their peer specialist implementation will be better positioned to also implement PCRP. For this reason, states should invest in peer support

services and elevate lived experience leadership roles as guiding forces in promoting a recovery-oriented system.

B. **Promote wellness planning programs and psychiatric advance directives as complementary to PCRP.** Because PCRP is tied to clinical, regulatory functions, it will always have limitations in its capacity to support person-directed wellness and recovery. Person-centeredness can be optimized when PCRP is complemented by self-directed wellness tools. These tools, such as Wellness Recovery Action Planning (WRAP)® have unique value to support well-being regardless of a person's engagement in clinical services. And a well-implemented Psychiatric Advance Directive is a powerful person-centered tool to maximize a person's self-determination when they are in distress and engaged with the crisis services system.

C. **With lived experience leadership, specify best practice for the role of peers in developing, supporting, and implementing PCRP.** Best practice should be based on local exemplars and should be in full alignment with national standards for peer support and the peer support code of ethics. The foundation of PCRP rests on authentic processes of person-centered goal discovery and the promotion of choice and control. Given this alignment, peer specialists represent natural leaders in PCRP implementation. However, it is also true that peers can be incorporated in PCRP in a way that runs counter to their ethics and values if they are co-opted into more "clinical" as opposed to peer-based roles. The development of complementary roles for peers in the PCRP process needs to be done thoughtfully, and ideally with a certain organizational stage of readiness as it relates to an agency's current recovery culture and values. PCRP can be a complex practice, and the risk of co-optation of the peer into roles that are not aligned with the values of peer support is extremely high. While the added value of a peer presence in PCRP is substantial, this risk must be guarded against, as poor or premature organizational changes can serve to diminish the integrity of both PCRP and peer support. Understanding of best practice is not necessary only for peer supporters themselves; it is just as important that state and provider agency staff understand and appreciate the uniqueness of peer roles to safeguard against confusion and co-optation.

D. **Incorporate PCRP content into the peer certification curriculum based on best practice.** Peer certification curricula should include content specific to PCRP and the ways in which peers should (and should not) be involved in PCRP. Offering PCRP content in continuing education for peers can also deepen learning in the practice.

E. **Create separate new employee orientations for peer and non-peer staff to reinforce the peer role in general and in PCRP specifically.** In some agencies, peers participate in the exact same new employee orientation training as their clinical colleagues, contributing to role confusion and the risk of co-optation. A new employee training specifically for peers could reinforce role-specific PCRP training in ongoing supervision.

Conclusion

Transformational leadership in systems change efforts demands not only the knowledge to act, but also the will to act. In this regard, lived experience partnership (between people who use services and those who serve them) holds a critical lesson for any agency engaging in PCRP implementation. Leaders must be authentically committed to doing business differently. In the absence of that commitment, continued discussion of PCRP is not only ineffective but detrimental as it weakens a state's credibility and erodes trust. Providers are left burdened with a set of expectations without adequate leadership and support to meet those expectations, and people who use services are left disillusioned by the disconnect between rhetoric and reality. This document offers behavioral health leadership strategies and resources to address this and to harness the transformative power of quality Person-Centered Recovery Planning.

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Resources

The following documents informed our review and recommendations.

- Recovery Roadmap Tip Sheets. Yale Program for Recovery and Community Health. Recovery Roadmap Tip Sheets. Yale Program for Recovery and Community Health
- Certified Community Behavioral Health Clinic Criteria: https://www.samhsa.gov/sites/default/files/ccbhc-criteria-2023.pdf
- Centers for Medicare and Medicaid Services Home & Community-Based Services Final Regulation: https://www.medicaid.gov/medicaid/home-community-based-services/guidance/home-community-based-services-final-regulation/index.html
- 2024 Home and Community-Based Services (HCBS) Quality Measure Set (QMS): www.medicaid.gov/federal-policy-guidance/downloads/cib041124.pdf
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