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EDITORIAL

Person-centred mental health care: the challenge of implementation

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Within mental health care, 'person-centredness' has been generally interpreted to convey a holistic approach with an attitude of respect for the individual and his/her unique experience and needs. Although it has been possible to demonstrate that professionals can acquire such skills through training, the impact on clinical outcomes has been more difficult to demonstrate in randomized controlled trials. Indeed what is becoming increasingly apparent in the literature is the need to acknowledge and address the degree of complexity that exists within the health care system that militates against achieving satisfactory implementation and outcomes from person-centred mental health care. In addressing this, we must develop and work with more sophisticated and three-dimensional models of 'patient-centredness' that engage with not only what happens in the consulting room (the relationship between individual service users and healthcare professionals), but also addresses the problems involved in achieving person-centredness through modifying the way that services and organizations work, and finally by engaging families and communities in the delivery of health care. A truly meaningful concept of 'people-centredness' encompasses how the views of the population are taken into consideration not only in healthcare but also in health and social care policy, and wider society too.

Key words: Communication, implementation, mental-health, patient-centred.

What do we understand by 'person-centred mental health care'?

Greater participation by patients in healthcare consultations and decision making is central to current health policy in the UK and other high-income countries that have seen increasing demand for healthcare, aging of populations and a shift in focus from acute to chronic conditions. Increasingly people must become co-producers of their care alongside health professionals through greater engagement in health protective behaviours and shared decision-making. This movement for public and patient participation in health is in part built on political notions of citizens as responsible consumers, less dependent on the State and paternalistic models of healthcare – here choice and plurality of service provision are key policy directives (Thompson, 2007).

In line with these more global epidemiological and political trends, the last three decades have also witnessed a considerable shift in the way in which power relationships between doctor and patient are both understood and enacted in practice. Indeed the word 'patient' has been variously replaced in different traditions by other terms, notably in mental health by the terms 'client' (from the counselling and therapy tradition) and more recently by 'service-user' in the context of adult mental health services (see e.g. NICE, 2011).

A key concept in understanding this shift has been the concept of 'patient-centred' practice, which evolved within primary care and has more recently become influential in thinking about mental healthcare delivery in both primary and specialist settings. According to Mead & Bower (2000), who extensively reviewed the concept, 'patient-centredness' (the word 'patient' remains more acceptable in British primary care than alternative more consumerist terminology) has five key dimensions: a bio-psychosocial perspective; an acknowledgement of the patient as a *person*, by understanding the personal meaning for the illness for each individual patient; sharing power and responsibility – sensitivity to patients' preferences for shared decision-making (which has also developed an extensive literature of its own, for example, see Edwards & Elwyn, 2009); development of a therapeutic alliance and the 'doctor as person', echoing the key influence of Balint (1957) in overt acknowledgement of the influence of the personal qualities and subjectivity of the doctor on the practice of medicine. As a clinical method, 'patient-centred care' therefore means a change in the style of interaction between patient and professional from a paternalistic consultation

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style with a traditionally 'authoritarian and controlling doctor', to one of more shared decision-making and empowerment of the patient. At the heart of this lies the idea of striving to understand the 'whole person'. By listening to what the patient says, and following up key cues that indicate what the nature of their problems might be, and responding empathically to their distress, the health professional seeks to communicate through a 'patient-centred' consultation. 'Person' and 'patient-centred' services espouse to offer patients more of a say in how they are delivered through patient surveys and patient and public involvement in planning.

However, within mental health care, 'person-centredness' has been generally interpreted to convey a holistic approach with an 'attitude of respect for the individual and his or her unique experience and needs' (Freeth, 2007, p. 13). More recently, the psychiatric literature appeared to have 'rediscovered' the concept of person-centredness in the guise of 'psychiatry for the person' (Mezzich, 2006). However, this not only failed to note the developments that had been going on in primary care and mental health nursing literature over the previous quarter century, but also the parallel debate in the mental health literature. Here, there has been growing support for more service-user engagement in the design, delivery and evaluation of mental health care, most obviously manifest in the growth of the recovery movement (Anthony, 1993), which has had a considerable impact on health care policy. Crucial tensions nevertheless remain for the delivery and implementation of true person-centred care within formal mental health settings. Freeth (2007), a psychiatrist influenced by the person-centred philosophy of Carl Rogers, has written with clarity about the complex ethical dilemmas that must be acknowledged in the delivery of true personal centred mental health care. For example, managing the conflicts between 'risk management' and 'self-determination' for the potentially suicidal person and the dilemma between delivering 'evidence-based medicine' in the form of cost-effective care and delivering patient choice in the use of psychotropic medication remain daily challenges.

Lessons from research

Given that the majority of research that has been carried out in this field has taken place within primary care settings, and this is where most people in the community with mental health problems receive care, we will focus much of our discussion on this domain of care. Even here, the impact of 'patient-centred' consulting is not uncontested. Stewart *et al.* in Canada, reviewing a wide range of studies carried out in many different settings, not only primary care, have no doubt that a patient-centred style of consulting improves a wide range of patient outcomes (Stewart *et al.* 1995). And in the context of chronic disease it is well established that patients who actively share in making healthcare decisions have better health outcomes compared with those denied such opportunities (Kaplan *et al.* 1989). However, Mead and Bower also reviewing the literature questioned the quality of the published literature and argued that the case had not been made definitively (Mead & Bower, 2002); a conclusion that they supported with empirical work (Mead *et al.* 2002). Furthermore, there is evidence from both primary and specialist care settings that implementing core facets of person-centred care such as shared decision-making is problematic due to time constraints and lack of agreement among professionals about the applicability of engaging patients in healthcare owing to either patient characteristics and/or the clinical situation (Légaré *et al.* 2008). Nevertheless, this debate has not diminished the view that improving how professionals and patients communicate is morally a 'good thing' to do, and there is plentiful evidence that mental health service users do want to participate in decisions about their healthcare, especially if they have been treated involuntarily (Hamann *et al.* 2005).

Over the last 30 years we have learned a great deal about the methods that seem to be effective in helping health professionals to change the way in which they communicate with patients. Two particular areas of clinical practice led the way in developing methods for doing this. In specialist care, Maguire *et al.* developed interview skills training for professionals working with people with a diagnosis of cancer which proved to be enormously influential in the field. He was also a key pioneer in the drive towards routinely providing such teaching to medical students. However, within primary care, such active methods of teaching such as those promoted by Maguire *et al.* (1996), specifically involving participants in role-play and providing them with audio and video feedback of their consultations with either real or role-played patients, developed during the 1980s and was adapted by pioneers such as Goldberg *et al.* (1980) and Lesser (1985) to specifically address the mental health aspects of patient care.

However, what has become apparent over the last decade in specifically trying to address the issues of patient-centred communication in mental health care within the primary care setting is that the early findings from before–after studies of improved clinical outcome in care following training have not been confirmed in higher-quality randomized controlled trials of educational interventions.

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For example, in a series of studies (see Gask *et al.* 2011) in which one of us was a major collaborator, British general practitioners were able to acquire a range of skills for the assessment and management of people presenting with medically unexplained symptoms which would, if applied, result in a more patient-centred consultation. These included learning how to pick up on cues relating to emotional distress, explore family and social issues with sensitivity and enquire about the meaning of particular physical symptoms to patients. However, these did not translate into improved clinical outcomes for patients (Morriss *et al.* 2007). What became apparent from conversational analysis of the consultations was that trained GPs made an initial foray into emotionally important topics with the patient but did not necessarily develop this into a broader and more meaningful conversation about the patient's concerns and worries (Morriss *et al.* 2010). However, further qualitative studies revealed an even more complex scenario.

From a nested qualitative study with the patients (Peters *et al.* 2009) it became apparent that they continued to be uncertain about sharing emotional concerns with doctors, and felt that the complexity of their problems could not be done appropriate justice in the short time available in primary care. They were worried that doctors would not take their physical concerns seriously and sometimes chose not to reveal their suspicions that emotional factors might be playing a part as a consequence of this concern. Doctors who had received the training pinpointed potential barriers to the implementation of what they had learned in routine clinical practise: at the level of the patient, the doctor, the consultation, diagnosis and the healthcare context (Dowrick *et al*. 2008). Of particular note here, they talked about patients choosing not to consult with a regular doctor or being unwilling to share private information, and their own negative emotional or cognitive responses to particular patients. Barriers in the healthcare context included organizational requirements of which the commonest problem, as expected, was lack of time. Indeed, this finding echoes previous work by Rogers *et al.* who were among the first to identify that the specific organizational context of primary care can place limits on healthcare professionals' ability and time to respond to patients' psychological problems – logistical constraints and the need to 'dispose' or move patients on through the care pathway figure large in clinicians' accounts about their experiences of managing depression in primary care (Rogers *et al.* 2001). In a related study (Salmon *et al.* 2007), doctors who declined training for managing patients with medically unexplained symptoms were found to be characterized in their communication style by devaluing, not patients with medically unexplained symptoms, but their own psychological skills, putting very little value on the importance of 'just talking'.

We have particularly focused here on findings from one particular series of studies, but other researchers in this field have reported remarkably similar barriers (Edwards *et al.* 2005).

What becomes clear is that there are probably limits to what can be achieved in terms of improved outcomes for patients simply by providing educational interventions for experienced doctors in patient-centred consulting, certainly in respect of mental health care in the setting of a high-income country such as the United Kingdom where doctors already have some degree of training in consultation skills and mental health care both at undergraduate and postgraduate levels. There are numerous complexities relating to patient and doctor attitudes and views, organizational factors and contextual issues. As Bower and Gilbody (2005) commented in a review of the field:

> "the training model may be limited by the paradox that training that is feasible within current educational structures (such as guidelines and short training courses) is not effective, whereas more intensive training is effective but may not be feasible. The role of training models cannot be dismissed, however. Educational interventions might need to be delivered in the context of other effective mechanisms, such as financial incentives."

Addressing complexity

What is becoming increasingly apparent in the literature is the need to acknowledge and address the degree of complexity that exists within the health care system that militates against achieving satisfactory implementation and outcomes from person-centred mental health care.

At the level of the person, we are developing a greater understanding of the issues that govern where, how and whether people are able to gain access to mental health care. Undoubtedly much of our research in the UK has focused on the needs of a mostly white, literate, middle-aged, middle income, indigenous population. We have largely failed to address the needs of those who often have difficulty accessing appropriate care such as those from ethnic minorities, and older people who maybe housebound with multiple chronic physical conditions and related mental health problems for whom there appears in many ways to be a mismatch between what services provide and what they perceive their particular needs to be. Engaging people from 'hard-to-reach' communities involves not only ensuring that they

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have explicit knowledge about the provision of care that they perceive to be appropriate, but specifically being able to understand and address the barriers that they face. These can be found at the level of their communities, families, the health service and the consultation and relate not only to the stigma associated with mental health care, and lack of information and communication difficulties relating to language, but also the material, social and psychological 'costs' to patients of engaging in such care (Kovandžić *et al.* 2011; Lamb *et al.* 2012). We have found the work of Dixon-Woods *et al.* (2006), which considers how persons achieve 'candidacy' to be in receipt of health care, particularly useful in understanding the numerous barriers that need to be navigated through and overcome for people from 'hard-to-reach' groups to achieve truly person-centred care.

People also rarely have a single problem, and physical and mental health problems commonly co-exist. Delivering person-centred care in the presence of complex comorbidity is a challenge and qualitative research reveals once again barriers to delivering such care, at different levels. Mismatch again exists between patient and professional narratives about vulnerability and awareness of depression in the presence of long-term conditions and both may tend to normalize distress and move the focus of the consultation onto more comfortable issues of physical health. Echoing the issues of stigma mentioned earlier there is also uncertainty about how patients and professionals find ways of negotiating acceptable terms for emotional distress (Coventry *et al.* 2011). Delivering person-centred care for people with co-morbidities becomes even more complicated as different professionals are involved in the care of particular problems, both within primary care as care becomes increasingly delivered by teams rather than individual practitioners (doctor, practice nurse and mental health worker), and across the primary – specialist interface.

Future directions

We therefore need to find ways of implementing person-centred care that can address not only the interface between patient and practitioner, but will take into consideration the broader context in which this dyad is situated. This means not only what goes on in the consultation (the 'patient-centred' aspect of care) but also what happens in the broader communities of healthcare, the organization in which the doctor practices and the community in which the person lives. The work carried out by Wagner *et al.* (1996) in developing the Chronic Care Model is instructive here. Not only is the Chronic Care Model a platform for improving the quality of care for people with long-term conditions, it also provides a useful framework for reviewing how to implement changes in wider systems that will support a more equal and active interaction between persons and professionals for people with long-term conditions – which includes many of those with mental health problems. One of the key aspects of this approach is the recognition that professionals should work as a team and that high-quality health care involves improving relationships between staff and between patients and their families. Other central elements to successful chronic disease management and supported self-care programmes include collaborative approaches to problem definition and goal setting, and pro-active case management of patients – approaches that are common in cognitive and behavioural therapy traditions.

The Chronic Care Model has since been adapted to address delivery of care for depression (Katon *et al.* 2011), and more recently for serious and enduring mental illness (Bauer *et al.* 2006), and has also been adapted by the World Health Organization to address the key role played by families and local communities, an aspect that was lacking in the original American model (Epping-Jordan *et al.* 2004). Patients' accounts about the benefits of collaborative care attest to the positive role person-centred approaches such as case management can play in improving communication between patients and professionals, especially when delivered in trustworthy and empathetic ways (Gensichen *et al.* 2012). Taking their lead from the work in the United States, quality improvement interventions using the collaborative model developed by the Institute for Healthcare Improvement (see http://www.improvingchroniccare.org) are increasingly used across the world for mental health care. For example, in the UK, a nationally funded programme is dedicated to improving quality of care for people with depression and long-term conditions through partnership working between mental health professionals, primary care nurses, patients and their advocates, to overcome known barriers to access for this vulnerable patient population (Coventry *et al.* 2011).

There is, however, much work still to be done. Complex problems require multifaceted solutions. In addressing the difficult and complicated issues implementation of person-centred mental care, we need to think not only of 'patient-centredness' – what happens in the consulting room, but the problems involved in achieving person-centredness in our organizations, families and communities; and 'people-centredness' (WHO, 2007), how the views of the population are taken into consideration not only in health

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care but also in health and social care policy and the wider society.

Declaration of Interest

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