# Ideal and Real Treatment Planning Processes for People With Serious Mental Illness in Public Mental Health Care

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# Ideal and Real Treatment Planning Processes for

# People with Serious Mental Illness in Public Mental Health Care

Emily B. H. Treichler, PhD[a,b], Eric A. Evans, PhD[c,d], & William D. Spaulding, PhD[c]

[a]Desert Pacific MIRECC, VA San Diego; San Diego, CA

[b]University of California, San Diego: San Diego, CA

[c]University of Nebraska-Lincoln; 1400 R Street, Lincoln, NE, USA, 68588.

[d]Disability Rights Nebraska; 134 S 13th St #600, Lincoln, NE, USA, 68508

Author Note:

All correspondence should be addressed to Emily Treichler. Email: emily.treichler@gmail.com; telephone: +1 (360) 951-4166; fax: +1 (619) 543-2493; mail: 3350 La Jolla Village Drive, San Diego, CA, USA, 92161.

Abstract

Treatment planning processes are a fundamental component of evidence-based practice in mental health for people with serious mental illness (SMI), who often present with complex concerns and require an interdisciplinary treatment team. It is unclear how well treatment planning practices in usual care settings for SMI adhere to best practices guidelines. In this study, we used qualitative methods to increase understanding of typical treatment planning practices. Twelve mental health providers completed a participatory dialogue focused on discussing perceptions of ideal and real treatment planning processes. Content analysis of the transcription from the dialogue was used to identify major themes and subthemes. Analysis revealed six primary themes with 23 subthemes. Providers described the *ideal* treatment planning process as dynamic and collaborative, including thorough assessment and inclusion of all stakeholders including the consumer, providers, and family members. *Real* treatment planning was described as directed by institutional and regulatory needs, resulting in treatment plans that were not personalized and not communicated to frontline *staff* or the consumer. These results indicate that providers have a strong understanding of evidence-based principles of treatment decision-making. However, actual treatment planning processes rarely live up to those principles. Providers identified several obstacles to enacting best practices. Although many obstacles were system-level, providers themselves also contributed to the gap between ideal and real treatment planning. Additional training and education may help to close this gap. Consumer self-advocacy is also important, given that providers often see themselves as lacking agency to make changes.

Keywords: serious mental illness; treatment planning; provider perspectives; shared decision making; qualitative research

Impact Statement: Although mental health professionals who work with adults with serious mental illnesses understand what research-supported treatment planning practice looks like, their typical treatment planning processes do not follow these practices. Regulatory processes, stigma, lack of training, and other issues create barriers to engaging in research-support treatment planning. Administrative support, provider training, anti-stigma campaigns, and advocacy from people receiving services may help improve treatment planning practices.

**Ideal and Real Treatment Planning Processes for**

**People with Serious Mental Illness in Public Mental Health Care**

Treatment planning is a core component of evidence-based mental health care (Antony & Barlow, 2010; Hurt, Reznikoff, & Clarkin, 1991). Treatment planning is particularly important for people with serious mental illness (SMI), given the complexity and chronicity of presenting problems, and typical duration of care (Johnson, 2018). Evidence-based treatment planning processes like multimodal assessment, consumer engagement, and interdisciplinary coordination are fundamental to effective SMI treatment (Galletly et al., 2016; Lehman et al., 2004; Treichler & Spaulding, 2017). In particular, the advance of consumer-engaged treatment processes requires that treatment planning processes not only be founded in the literature, but also tailored to the preferences, needs, and values of individual consumers (Stanhope et al., 2013; Treichler & Spaulding, 2017). A number of treatment planning recommendations and interventions have been developed, many of which take into account SMI-specific issues like advanced directives and guardianship (e.g., Hamann et al., 2011; Johnson, 2018; Stanhope et al., 2013; Swanson et al., 2006; Treichler et al., 2018). Concurrently, precision medicine aims to customize healthcare by identifying which treatments are most likely to be successful for a given individual using biomarkers (Insel, 2014). In this approach, strategies like phenotyping and machine learning may be used to match interventions to individuals (Vicini et al., 2016; Wei & Denny, 2015). All of these approaches intend to improve outcomes by effectively personalizing treatment plan decisions based on individual factors.

Despite the range of literature on methods of treatment planning, implementation in community practice is often difficult and nebulous (Briand et al., 2014; Tondora et al., 2010). Although there are a number of evidence-based treatment approaches for people with SMI, the appropriateness of each intervention varies depending on individual needs and characteristics (Dixon et al., 2010). Once an approach is selected, they must often be tailored to individuals based on cultural needs, consumer preferences, comorbidities, and resource availability, but clear guidelines for such modification are still in process (Lau, 2006; McHugh et al., 2009; Tondora et al., 2010). In the future, precision medicine strategies might facilitate making these complex decisions, but these strategies are not yet ready for broad implementation.

Given the difficulty of implementing effective and recovery-oriented treatment planning strategies, it is perhaps unsurprising that treatment decisions often run counter to clinical guidelines (Addington et al., 2012; Lehman et al., 1998), and to consumer preference (Cohen et al., 2013). Treatment for SMI in usual care settings often includes overutilization of non-evidence-based practices like polypharmacy alongside underutilization of evidence-based practices like supported employment (Gilmer et al., 2007; Hortiz-Lennon et al., 2009). For example, one study found that zero unemployed people with SMI were receiving vocational rehabilitation (West et al., 2005), while another found that only 16.3% of first admission patients with schizophrenia received consistent medication management and therapy (Mojtabai et al., 2009). Consumers with SMI report that one of the primary reasons for disengagement from care is lack of appropriate services (Thomas et al., 2013), so it may be that in the face of suboptimal care, consumers choose no care at all. More appropriate treatment planning- combined,

of course, with follow-through on those plans –may not only facilitate better care for those currently engaged in treatment, but also prevent disengagement due to dissatisfaction with treatment offerings.

The prototypical treatment planning approach is paternalism, which positions the provider as the expert and primary decision-maker, and the consumer as the recipient but not an agent in the decision-making process. Paternalism limits consumer voice during treatment planning, and so is not an optimal strategy. Alternatively, shared decision-making is a person-centered approach to decision-making that acknowledges the unique expertise of the provider and consumer, and supports reaching a mutual decision based on integration of consumer preferences and values with provider judgment and research-identified best practices (Charles et al., 1997; Deegan et al., 2007; Drake et al., 2010; Joosten et al., 2008). Recent work has emphasized equal power and responsibility between consumers and providers within a collaborative process (Treichler & Spaulding, 2017). Although shared decision-making is valued by consumers with SMI and associated with a range of positive outcomes, consumers report being unsatisfied with their current levels of involvement in decision-making (Adams et al., 2007; Park et al., 2014).

Better understanding of treatment planning processes in public mental health may elucidate gaps that lead to suboptimal treatment decisions in typical care practices. To increase understanding of these issues, we collected qualitative data from mental health providers regarding their perspectives of real treatment planning processes and ideal treatment planning processes. Specifically, we aimed to understand a) providers' perspectives on treatment planning in their day-to-day practice, including specific

processes and persons involved; b) providers' perspectives on what treatment planning should ideally include; and c) providers' understanding of shared decision-making within this context and their overall view of consumer engagement in treatment planning. Our primary hypothesis was that providers would define these real and ideal processes as distinct and currently unaligned.

**Methods**

This study was approved by the Internal Review Board at the University of Nebraska-Lincoln.

**Participants**

Twelve providers of mental health services in a small city in the Midwest participated in this study. Inclusion criteria was being any type of mental health provider as long as the majority of consumers they worked with had a schizophrenia spectrum disorder, psychotic disorder, and/or neurodevelopmental disorder. *There were no exclusion criteria.* All of the participants were white. There were eight women and four men. Seven participants were front line staff including case managers and program specialists, two were registered nurses, one was a licensed clinical social worker, one was a psychologist, and one was a peer specialist. All providers were currently working *in* or had previously worked in publicly funded services for adults with SMI, including outpatient, day programming, psychosocial rehabilitation, and long-stay inpatient programs. Providers identified eight individual programs from four larger agencies as their current or most recent SMI program affiliation. These programs included day

programs, residential rehabilitation, supported housing, peer-run respite, and community mental health.

**Procedure**

Participants were recruited using snowball convenience sampling. Study investigators contacted three local treatment programs specializing in SMI, and posted information about the study on a local disability advocacy website and a local mental health advocacy listserv. Interested providers contacted the study investigators. All providers who expressed interest *met inclusion criteria*. No compensation was provided, but study investigators collaborated with treatment programs to ensure that providers could attend during work hours without loss of compensation or taking leave time.

The first author (ET) moderated a two-hour participatory dialogue (Bluebird et al., 2000) that included all of the participants. The participatory dialogue model brings together people from diverse backgrounds (in this case, diverse training backgrounds and roles) to discuss and explore their perceptions, beliefs, and experiences in relationship to specific mental health processes. The participatory dialogue model relies on significant participant-to-participant interaction to facilitate connection and understanding among participants. Participatory dialogues can include large numbers of participants. We elected to use the roundtable model, a relatively small dialogue structure, to ensure that each participant's voice would be heard within the constraints of the dialogue.

Participants introduced themselves at the beginning of the dialogue, after which the moderator introduced the first of five discussion topics (Table 1). These topics were

based upon our overarching questions integrated with our literature review, and so aimed to capture overall perceptions of treatment planning and its components; typical treatment planning approaches used by providers, juxtaposed by providers' ideal vision of treatment planning; and provider understanding and perceptions of shared decision-making and consumer involvement in treatment planning. The questions were formulated to be open-ended and promote discussion between providers.

The moderator minimized her own role in the discussion to promote collaborative interaction between participants, as prioritized by the participatory dialogue model. To support this goal, the moderator did not offer her own perceptions or 'correct' answers to questions, but rather used motivational interviewing techniques to encourage discussion. She did offer clarification when needed (e.g., regarding the structure of the dialogue). There was a short break after an hour of discussion. Following completion of the five topics, each participant was given the opportunity to share any last thoughts. The dialogue was audio-recorded and professionally transcribed by a non-research staff member with transcription training, with the consent of all participants.

**Analysis plan**

We used a structured approach integrating the inductive method (Elo & Kyngäs, 2008) and conventional method (Hseih & Shannon, 2005) within the general content analysis approach. Both of these approaches are used to create initial description of phenomena when *pre*-existing data are limited. Themes are derived based on the qualitative data rather than developed a priori. The conventional method emphasizes immersion with the data, and the inductive method prioritizes using structured steps to

accomplish deep understanding. These methods allowed the content analysis to be structured and yet still create themes and subthemes based upon the content of the data, as opposed to forming themes prior to analyzing the data. We used the qualitative analysis software NVivo (QSR International Pty Ltd, 2012) to organize and analyze data. Based on these approaches, we created a five step analytic plan. The first author (ET) completed these analyses, which facilitated our ability to integrate the tone of the dialogue and other non-verbal communication dynamics into the analysis. The second and third authors (EE and WS) conducted reliability checks. All authors are experienced in qualitative theory and analysis.

The first step was a word frequency analysis using NVivo to identify most commonly used words. We used a 10 occurrence minimum for a 2 hour long transcription set. Words with the same stems (e.g., you, yours) were coupled together. This allowed us to start with a reliable foundation and verifiable process with which create themes.

The second step, initial theme construction, created themes based on words identified in the word frequency analysis. Each word identified in the word frequency analysis was examined in the original context to determine words that *were* relevant to a theme as opposed to words that were relevant to the speaker's manner of speaking (e.g., "you know"), relevant to the research process (e.g., moderator's name), or a highly used word without thematic relevance (e.g., "the"). All words not clearly irrelevant to the content of the study due to one of these reasons were included in theme construction. Construction of a theme based on a word used the context around the word's appearance throughout the dataset to attribute typical meaning. Words could be

used to construct multiple themes if it was highly used in multiple contexts. Multiple words could contribute to the same theme node if relevant to the same theme. Themes could be organized as sub-themes if theorized to be contained within another theme.

The third step is aggregate data review. The entire transcription set was thoroughly reviewed for theme-relevant content not identified during initial theme construction. Newly identified theme-relevant content could be added to one or more existing themes, or used to add or revise themes.

The fourth step is thematic review. Each theme and subtheme was reviewed to determine whether the theme or subtheme meets the following criteria: 1) contained content relevant to that theme, indicating that the theme should remain as it is rather than being revised, combined, or deleted; 2) contained a significant amount of relevant content, indicating that it should remain as it is rather than being revised, combined, or deleted; 3) that the theme was placed in a relevant and logical spot within the thematic web. Upon thematic review, themes could be moved to another spot in the web, deleted, combined with another theme, or revised by changing the theme name or adding a new theme. In general, we expected that a minimum of three references were needed to effectively understand the meaning of a theme, but themes with three or more references could be deleted if the references contained within them did not align clearly enough to support that theme.

The final step is a reliability check. At this stage, all three authors reviewed all decisions made during the analysis and had full access to the data in all stages. Any disagreements were reviewed until 100% agreement among all researchers was reached. The combination of this reliability check, the NVivo-constructed frequency

analysis, and the multi-step analysis plan supports the reliability and validity of our results.

**Description of researchers' background.**

At the time of data collection, the first author (ET) was a doctoral candidate in clinical psychology at a large public institution in the Midwest. She is now a clinical psychologist employed as a clinical research fellow at a VA and large public university in Southern California. At the time of data collection, the second author (EE) was the COO of the local disability advocacy organization in the Midwest used to recruit providers. He is now the CEO of that organization. He holds a PhD in Philosophy and an MA in Anthropology. The third author (WS) is a clinical psychologist and professor of psychology at a large public institution in the Midwest.

**Description of relationship between researchers and participants.**

The researchers all lived in the same community as the participants. Three of the participants had previously worked with one or more of the authors in a clinical or research capacity. The authors knew a fourth participant through a social connection. These relationships did not appear to impact the participants or the content or their contributions, as the authors did not hold power over the participants in these relationships. The rest of the participants were unknown to the first author (the moderator) prior to data collection. The other authors did not directly interact with the participants and so we are unaware of any other connections, although they are possible given the small size of the mental health community.

**Results**

**Word frequency analysis.** The transcription was 27 pages long and included 15,620 words. NVivo identified 101 words with at least 10 occurrences.

**Initial theme construction.** Fifty-four words were considered thematically relevant and used to either form a new theme or contribute to an already formed theme. For example, "person" was used in reference to consumers as well as to other members of the treatment team, and so it contributed to two themes: Consumers and Treatment Teams. Forty-seven words were considered thematically irrelevant and excluded. For example, "kind" was frequently said within the phrase "kind of," used as a placeholder rather than contributing specific content to the discussion, and so it was excluded. Following the initial theme construction, six primary themes with 36 subthemes were hypothesized to exist within the transcriptions.

**Transcription analysis.** During the transcription analysis, five subthemes were added and two subthemes were removed. First, the subtheme Consumer Strengths was added to the Consumer theme. Second, the subtheme Empathy was removed from the Employment as a Mental Health Professional theme, and four subthemes, Clinical Judgment, Expertise, Peer Providers, and Therapeutic Relationship, were added to this theme. Last, the subtheme Recovery Model was removed from the Treatment theme. These subthemes were added or removed in response to new understandings of the providers' perspectives based on reading the transcription in full. For example, provider comments originally theorize to capture Empathy coalesced around the importance of a good therapeutic relationship ("letting them know that you as their treatment provider … that you are very supportive, that you try to understand where they are coming from and

that they have as much involvement as they can- as they will allow themselves to [have] in their treatment,") indicating that a Therapeutic Relationship subtheme would be more appropriate.

**Thematic analysis.** During thematic analysis, two themes and 11 subthemes were removed. All of these themes contained two or fewer transcription sections. Neither of the deleted primary themes contained any transcription sections. Transcription sections from removed subthemes were retained in the primary theme and so still contributed to overall analysis and interpretation. An additional four subthemes were collapsed into their primary theme. These subthemes contained three or fewer transcription sections. Retained themes contained between 4-97 transcription sections and retained subthemes contained between 3-29 transcription sections. As a result of these deletions, the subthemes Family and Mental Health System became primary themes and the subtheme Assessment was moved into the primary theme Treatment Planning. The subtheme Clinical Judgment was integrated into the Expertise subtheme within the Employment as a Mental Health Professional theme because these two themes were highly related and the Clinical Judgment subtheme contained only one reference. The three subthemes Negative Treatment Processes & Outcomes, Gaps in the MH System, and Systemic Problems & Obstacles were combined into one Systemic Problems & Obstacles subtheme within the Mental Health System theme due to redundancy.

**Reliability check.** The two reviewers received and examined all of the data from each stage of analysis. After examination, the reviewers approved all themes in the their

current form. There were no disagreements about themes or their content, and so there were no changes made to the themes.

After analysis was completed, there were six primary themes: Treatment; Mental Health System; Decision Making; Employment as a Mental Health Professional; Consumers; and Family (listed in descending order of size of attributed transcription sets). There were 23 subthemes. In general, providers agreed with each other regarding their perspectives on real treatment planning and ideal treatment planning.

**Theme 1: Treatment**

**Treatment planning.** Providers described the complexity of treatment planning, noting that treatment plans should include assessing multiple areas, creating a case conceptualization, understanding socioenvironmental context and available resources, and identifying signs of relapse.

> *"Does the treatment plan include everything from very specific to very broad? You know, are you looking at, 'Okay it is a mental illness; we are going to manage the symptoms'? [Or,] are you looking at the socioeconomic aspect? Are you looking at the environmental aspects? You know, those types of things [need] to be all-inclusive in that treatment plan because in any one of those areas if they're not looked at as a whole, then that is going to affect the other areas involved. You know- you can't take your meds if you can't afford to buy them. You can't get to go to a blood draw if you don't have a way to get there with a bus pass."*

They reported that although treatment planning should include the consumer, a broad range of providers and potentially family or friends, in practice treatment planning was often limited to a small number of clinicians and often did not include the consumer in any substantial role.

> *"One thing that I have found in developing a treatment plan is that…there are so many times when decisions are made by one member of the team. And the other members don't even know that it happened."*

**Ideal versus real treatment planning processes.** There were marked differences between the ideal treatment planning process described by the providers, and the typical process they participated in. Although providers prioritized a team-based, holistic, and consumer-driven approach founded on thorough assessment and case conceptualization, typical treatment planning often involved only a subset of providers or a single provider based on immediate impressions, a medical model approach, and occasionally, legal requirements. Treatment plans were often not communicated to other staff members or the consumer.

> *"Obviously in an ideal situation a team approach with heavy involvement from the client is always desirable. However, as many of [the other providers] have stated, [providers] are not all in that position to be able to do that type of thing."*

**Assessment.** Providers universally agreed that ongoing and thorough assessment is needed in order to provide appropriate care. In contrast, current practices rarely involve any structured assessment protocol.

*"A thorough assessment with the person driving that assessment is critical. Sometimes that requires psychological testing."*

**Communication.** Although providers prioritized communication in treatment and treatment planning, they reported two areas where significant obstacles often occurred. First, that often, a small number of providers create the treatment plan without involving other providers or even communicating the results to them. During the dialogue, a nurse practitioner listened to front line staff who worked at the same agency describe that due to inadequate case coordination (a further subtheme), they were often unaware of treatment plan changes and therefore unable to congruently adjust their own approach with consumers.

*"It would be nice to know what their goals are that they set. Otherwise we are just walking around in the dark. Someone wants to get their GED and unless, you know, they tell me directly, it can go for a couple years [before I find out]."*

The nurse practitioner responded by acknowledging this issue, and indicating openness to reconsider their current protocol.

*"We don't provide treatment plan copies to day center staff. I don't know if that would be something you guys would want from us?"*

The second obstacle to effective communication was between providers and consumers, with providers noting that "doctors" and other more senior providers were often unwilling to talk to consumers or respond to consumer questions or concerns, leading case managers to intervene on the consumer's behalf.

*"The power relationship between a doctor and a patient or a client… it's kind of an unnatural relationship. There's a professional relationship but there is a power dynamic there that the individual can't challenge the doctor and that's where, I think as case workers, we can help with that and help advocate in that situation."*

**Treatment teams.** Providers agreed that treatment teams were essential aspect of best practices, but that effective collaboration between treatment team members was rare. Two providers discussed their positive experiences with two collaborative public mental health programs (both now closed), both of which invited all providers associated with each case within and without the program to treatment team meetings. Other providers agreed that this sort of model was ideal, but that typically, a small subset of providers made most decisions without consultation.

*"A lot of [the] time you don't even know there was a med change until you start making phone calls and say, 'what happened?'"*

**Treatment goals.** Treatment goals were a key component of an effective treatment plan. Providers reported prioritizing consumers' opinions when creating these goals, and using a range of techniques to help consumers identify goals, including by starting with smaller goals.

*"[For] a lot of clients that I have worked with over the 18 years, small successes lead to bigger successes."*

**Community resources.** Providers noted that although utilizing community resources and tools was also important to effective treatment planning, identification and coordination of these resources was difficult, leading to isolation among consumers.

*"I have one individual that I work with now. I meet with him at Starbucks, and we see his psych doctor once every three months, and then there's me, and that's it. That's all the only human [contact he has] … other than, you know, walking down the street to get to the bus."*

**Theme 2: Mental Health System**

*"[The mental health system is] a system that is so broken that it's very disheartening to most of the people who work in the field."*

**Systematic problems and obstacles.** Providers reported a large range of systemic problems and obstacles, often tying these issues into poor care models described in Theme 1. For example, providers reported that due to lack of funding and the prevalence of one-size-fits-all treatment models, it was difficult for providers to work closely with each other or to provide comprehensive and community-based treatment. Providers experience widespread burnout and cynicism due to these obstacles.

*"I think what's being done to the mental health system is pretty criminal, with the closures of the mental health centers and the other programs. I see people trying to do more and more with less and less and it's not a good situation. I really admire everybody here with what they [are dealing with]."*

They also noted that consumers' perspectives also seemed impacted; for example, that consumers came to expect that providers would set treatment goals without their input, and were "lost" and overwhelmed when asked to participate.

*"You get [a consumer] who is 50 or 60 and they have been told they can't [participate] – they're lost. They don't know how to set goals. They've never thought about setting goals before."*

**Changes in the mental health system.** Providers discussed changes in the mental health system both locally (i.e., publicly funded programs in the community that recently closed) and globally (i.e., consumer-driven movements towards shared decision making). Views on changes were mixed; with some providers reporting that the system was improving overall, and others reported it was deteriorating.

*"Unless we keep evolving then if we grow stagnant so do our clients, so do our consumers. We look back at how things were done five years ago and we shake our heads, you know what I mean? We look back six months ago and we shake our heads."*

**Regulations.** Providers universally saw regulatory bodies and specific regulations, including insurance companies, state and federal regulations, and provider caseload size expectations as obstacles preventing appropriate care. They noted that regulatory bodies are often both implicitly and explicitly opposed to dynamic and personalized care, and may make treatment decisions without ever meeting a consumer. One provider noted that she sometimes ignored regulations, including HIPAA, if she felt it would improve consumer outcomes.

*"[Administrators] have criteria that they are supposed to work for that is mandated by law. Or by courts or whatever. And if you come back at them and*

*say, 'hey this is the goal they're supposed to be working on. But for this client*

*that is not going to work.' They don't want to hear it."*

**Theme 3: Decision-Making**

**Consumer involvement in treatment decision-making.** Providers were

ambivalent about consumer involvement in decision-making. Although the majority

reported that consumer involvement is important and improves care, they also reported

struggling to adequately engage consumers.

*"I think it is difficult to keep in mind that the treatment plan should be driven by*

*the consumer."*

This was due to a number of explanations, including systemic obstacles, perceived lack

of interest or ability by consumers, and perceived faults among providers as a group.

These provider faults included lack of training, difficulty acting in congruence with

shared decision-making due to past experiences or bias, and frustration with the

process of encouraging involvement. Providers tended to describe provider faults in a

generalized and detached way, attributing faults to providers as a group but not

explicitly including themselves.

*"Having a consumer having accurate information is really critical, because a lot*

*of times I have seen mental health professionals tell people one things and then*

*they write a letter that's totally opposite, you know, to the court and being*

*dishonest, essentially."*

Providers reported encouraging consumers to be more engaged, and advocating on their behalf to other providers, but despite this, continuing to see low involvement among most consumers.

*"I think that is a big part of it – letting them know that you as their treatment provider in whatever capacity that you are in … that you are very supportive, that you try to understand where they are coming from and that they have as much involvement as they …will allow themselves to do in their treatment."*

**Shared decision-making.** Although shared decision-making was a primary avenue identified by providers to increase consumer involvement, many providers' understanding of shared decision-making was vague and incomplete. For example, three providers identified shared decision-making as primarily a method to increase access to information, like one's diagnosis, rather than encompassing engagement in decision-making.

*"What I consider shared decision making is trust [in] that goal with you, and that consumers have data, good information to operate on. That includes in many respects the person having information about themselves."*

Two providers had a strong understanding of shared decision-making, and they focused on how it can be used to facilitate consumer empowerment and engagement in treatment.

*"If you have shared decision making and if people have a voice in the process, they own the process, so your chances of moving the process forward I think are increased. And if you let clients, you know, be involved in decisions rather than*

*have the decision made for them, if nothing else it has the value of*

*[communicating that providers] value [the client] as an individual. It gives them*

*some dignity and respect [that] I think [is] totally important."*

**Paternalistic decision-making.** Ambivalence towards consumer roles in treatment continued as providers reported both engaging in paternalistic approaches as well as trying to decrease paternalism by other providers and in the mental health system more broadly. Providers reported that although they'd prefer consumers lead treatment planning, consumers are disengaged, forcing providers to take a paternalistic role.

*"We are doing quarterly evaluations right now where [clients] are supposed [to*

*identify] what [they] want to do for future goals. [But clients say] 'I don't have any*

*goals.' They would just want to stay their rut…to try to come to a goal, even one*

*or two is a quantum leap, it really is. And you almost [think] 'okay I'm going to*

*decide [for you if] you don't!' [laughter from other participants] But you are almost*

*kind of thinking that."*

## Theme 4: Employment as a Mental Health Professional

**The therapeutic relationship.** Providers agreed that a strong therapeutic relationship is key to success during treatment planning, and to ultimate treatment outcomes. Trust was most important to providers; they felt that trust was necessary for honest communication and consumer confidence in providers' judgment. Perspectives on ideal balance between providers and consumers varied, with many providers reporting that they take a directive or managerial role, for example providing direct

advice or feedback about limitations, and intervening on the consumers' behalf with other providers. However, another provider reported that it was common for providers to take too much responsibility within the relationship, doing more than the consumer or more than is helpful to the consumer.

> *"I think [the therapeutic relationship is] very, very important. Without the trust of the client, without that safety, and that security you're not going to see them for who they really are."*

**Expertise.** Providers highlighted understanding one's own strengths and limitations. Extent of formal training varied, with one provider noting that she had no training before entering her role as a front line staff member. Providers noted the importance of quality training, and continuing to learn and gather information while on the job. Providers reported using informal self-assessment to identify what appropriate roles they could fill given their skill set.

> *"I think part of this process is we need to know our own limitations very often with case management- not the clients' limits but what your own limits are. What you can't provide and being willing to spell that out very clearly because I think in terms of learned helplessness a lot of people go to providers thinking 'you've got the answers,' and we don't actually."*

**Responsibilities as a mental health professional.** Alongside assessing their own expertise, providers also prioritized understanding their own role as well as other providers' role within the treatment team. They reported that although they tried to delineate a specific role, separate to that of other providers, boundaries between roles

often blurred. Providers agreed that all roles included supporting consumers to be involved and active in treatment, advocating for consumers, and facilitating increased independence.

>*"I think that's an important thing to is to know what is your role and what are the edges? Sometimes the edges are really blurry as far as that can be concerned. You may be put in situations where it's not ordinarily something that you would do, but because there is no one else around to do it at the time, you end up doing it."*

**The helping role.** Although specific responsibilities varied, providers consistently endorsed seeing themselves as in a helping role. Providers reported striving to provide person-centered, recovery-oriented care, for example by imbuing hope and helping consumers identify feasible steps towards achieving goals.

>*"Your job is to teach that there is hope.  You can go and try this out. This might be something that's worthwhile."*

**Psychoeducation.** Psychoeducation was identified as important for consumers as well as their families and the general public. For consumers, psychoeducation regarding diagnosis, cognitive abilities, and limitations were highlighted. For others, providers reported that by increasing general knowledge among families and the public, stigma would decrease, facilitating better care.

>*"That is our job to help that person understand what these symptoms are. I think the large part of is sort of understanding and education. It is also education of the family. Many people have attention deficit disorder. Family members usually*

*blame the person for being lazy or all sorts of things when in fact it is a*

*neurocognitive impairment and it is something that the person is born with [and]*

*didn't ask for. Because people have to understand that you can, in fact, recover*

*from mental illnesses in large measure."*

**Theme 5: Consumers**

There were only two comments regarding consumer strengths, and so a specific subtheme was not supported. However, these two comments were coded within the overall Consumer theme, and both came from providers who used a strengths-based approach to help consumers reach attainable goals.

**Learned helplessness.** Providers agreed that learned helplessness was a chronic issue within the SMI population. Many providers acknowledged the impact of the larger system including the medical model approach in teaching this pattern. Although providers desired increased self-efficacy among consumers, they noted that other providers often reinforced this pattern by ignoring or resisting consumer attempts to become more active in treatment. Providers reported a meta-level of learned helplessness: that attempting to decrease their consumers' learned helplessness was fruitless and disheartening, decreasing their likelihood of taking on the task.

*"A demon we all deal with is learned helplessness. You [can tell consumers] 'you*

*can do this you can do this' but these are people that have been told for years-*

*the way the system was 20 years ago, I mean, it has changed a lot -but these are*

*people that have been told 'you can't you can't you can't.' People get into a*

*progressive program and they have no idea what to do because they have been*

*told they can't."*

**Consumer limitations.** Providers viewed consumers as limited in general (i.e., "there's also limitations as far as the individuals that we work with,") and specifically in regards to cognitive ability, communication skills, and motivation levels. They noted that consumer abilities often impacted their own ability to effectively engage with consumers and facilitate effective treatment planning.

*"You may have [clients] who have very little ideas themselves of what they want*

*to do other than smoke cigarettes and sit in a corner someplace."*

**Treatment adherence.** Poor treatment adherence among consumers was common, and providers reported struggling to enhance adherence. They reported feeling that consumers were often disinterested in treatment engagement of any kind, and often disagreed with goals set for them by providers or regulatory bodies. Providers reported trying to advocate for consumers so that goals would be desirable and appropriate, but rate of success was unclear.

*"Now, granted there are a number of folks and clientele that have gotten out in*

*the community and of course, they -so to speak- played the game when they*

*were in treatment and when they got out they said, 'I'm don't with that crap, I'm*

*not doing it anymore.' You know? 'I'm going to do what I damn well please and*

*nobody's going to tell me different.'"*

**Theme 6: Family**

The last theme, Family, included no subthemes. Providers valued the involvement of families and other loved ones broadly, noting that often non-provider support is key to creating an effective support system. One provider noted that talking to families can sometimes reveal information that the consumer themself would not disclose. However, families could also have a negative impact on care:

> *"If we had a supportive family or whatever, that was great… Sometimes [families] thought they were a real good support but they really weren't … Sometimes it was almost better off that we didn't have family involvement."*

## Discussion

As expected, real treatment planning processes fell short in comparison to ideal processes in the eyes of mental health providers. Providers described the ideal treatment planning process as dynamic and collaborative, with significant consumer engagement, assessment using a biopsychosocial conceptualization model, inclusion of all staff members associated with the consumer, and inclusion of family or other relevant non-providers if appropriate. This description of ideal treatment planning largely mirrored both literature on this subject (Simpson et al., 2015) and patient perspectives (Chinman et al., 2009; Livingston et al., 2013; Wonders et al., 2018), indicating that these elements are supported by the evidence and valued across stakeholder groups.

In marked contrast, real treatment planning was described as disjointed and lacking appropriate personalization. Providers or other authorities (e.g., administrators for insurance companies) with no therapeutic relationship with the consumer often create

treatment plans without consultation with other providers or the consumer themselves. As a result, treatment plans frequently remain unknown to frontline staff and consumers. The current treatment planning process therefore creates two problems that obstruct quality care. First, treatment plans are created using inadequate information and do not take into account consumer preferences and values, impairing ability to tailor treatment effectively. Second, treatment plans are not communicated to those in charge of day-to-day implementation of treatment plans, including consumers and frontline staff, limiting likelihood of implementation. Therefore, both the development and the implementation of treatment plans in public mental health are in need of significant improvement.

The providers in this study attributed the gap between real and ideal treatment planning to a number of factors, including policy- and insurance-level barriers, poor provider communication, inadequate provider training, and impaired consumer motivation and engagement. Many of these issues are well documented in the literature; for example, past work has suggested that institutional factors obstruct consumer and family participation in treatment planning (Bee et al., 2015; Linhorst et al., 2002; Todd et al., 2002). Additionally, providers are often undertrained for their roles and given impossibly high caseloads and duty lists, leading to inadequate care and provider burnout (Ballenger-Browning et al., 2011; Lasalvia et al., 2009; Todd et al., 2002). However, understanding lack of engagement by consumers requires consideration of systemic factors. Although disengagement is high among people with SMI (Dixon et al., 2016), literature indicates that a majority of consumers are interested in being involved in treatment planning (Treichler & Spaulding, 2017). Consumers report that providers underestimate their interest in treatment planning, and tend to blame the consumer

when there are difficulties in engagement (Chinman et al., 2009). Although providers often encourage engagement, typical processes are often disempowering (e.g., asking consumers to approve an already developed treatment plan; Livingston et al., 2013).

Providers endorsed a number of provider-level concerns, including lack of communication among staff, overly paternalistic and even rejecting responses to consumers, and lack of training. Despite their largely negative description of other providers, participants saw themselves as consumer advocates, describing their interventions with physicians who were reluctant to engage with consumers. Providers simultaneously reported that proactive behavior like this was a part of their essential role and that it often felt unseen and unwanted by consumers and providers alike. In only one interaction, a provider took personal responsibility for provider-level issues, when responding to discussion about the lack of dissemination of treatment plans to frontline staff with openness about changing current protocol. In all other cases, providers attributed responsibility to other providers or to the system at large without acknowledging that they are a part of that system. This demonstrates the actor-observer bias (Nisbett & Marecek, 1973); providers perceive flaws in their own actions as a result of an ineffective system, while flaws in behavior of other providers are due to their own incompetency or apathy. When combined with the widespread disenfranchisement reported by providers due to poor funding, restrictive regulations, high caseloads, and disengaged consumers, providers see themselves as a casualty of the system rather than a contributor to it. This disempowered perspective may inhibit providers from attempting individual-level or system-level change, limiting ability to improve treatment planning processes.

However, provider-level interventions still show promise to improve treatment planning processes. The providers in this study demonstrated knowledge and training gaps, which, if filled, might increase their ability and motivation to improve these processes. For example, their understanding of shared decision-making was lacking. Their conceptualization of shared decision-making was primarily comprised of sharing information with consumers; most commonly, explaining diagnosis or cognitive deficits. This highlights the need to adjust language from 'shared decision-making' to 'collaborative decision-making' to clearly emphasize consumers' and providers' equal responsibility and power in decision-making processes (Treichler & Spaulding, 2017).

Providers may also benefit from training in recovery-oriented and strengths-based approaches to treatments. Providers generally described consumers within the context of their help-seeking behaviors, their limitations, and their disengagement from treatment. After discovering that all of the subthemes under the Consumer primary theme were clusters of negative perceptions of consumers, we coded the transcript for positive perceptions and found only two comments about consumer strengths. This indicates that providers continue to conceptualize consumers from a medical model, focusing on problems and impairments, rather than a strengths-based model like the recovery model. Consumer-led interventions can improve provider competencies needed to provide recovery-oriented care (Young et al., 2005). Given the provider's report of significant burnout, and the impact of burnout on provider care quality (Salyers et al., 2015), implementing interventions that target provider burnout may also cause downstream improvements in care quality (Wood et al., 2017).

Still, focusing solely on provider-level interventions may be inhibited by provider disempowerment. Improving treatment planning effectively may require macro level (systemic), and micro level (consumer-focused) approaches. A provider noted that he believed that consumers would change the status quo in public mental health by embodying that change themselves and demanding change from the system. System-level consumer empowerment efforts may illustrate one path forward. Results from studies of consumer leadership initiatives (O'Connell et al., 2018; Scholz et al., 2017) and skills training interventions (Alegría et al., 2008; Steinwachs et al., 2011; Treichler et al., 2018) show promise in this strategy.

Our study included providers from a variety of training backgrounds and current positions, which enabled us to promote dialogue between these diverse groups and gather multidisciplinary perspectives. Overall, the providers agreed with each other on most points, and there rarely seemed to be clear division based on training background or position. There were some instances where these factors appeared to impact provider perspectives; for example, the psychologist was most familiar with assessment strategies, and an unlicensed support staff person acknowledged that her lack of formal training left her with knowledge gaps. These instances are congruent with expectation; psychologists receive the most training in assessment among mental health professionals, for example.

**Limitations**

This study is limited by the scope of the sample; all of the providers worked in the same small Midwestern city. However, the difficulties providers identified are common in the United States and elsewhere: service systems for complex mental health

populations are inadequately funded and providers working in systems are asked to move mountains with a garden shovel (Green et al., 2014). Although the United States government has prioritized recovery-oriented and personalized care, these approaches are slow to reach the SMI population (Farkas et al., 2005; Le Boutillier et al., 2015). Given that the broad context is applicable nationally and beyond, it's reasonable to consider that these perspectives would have generalizable value.

We did not collect demographic data in order to preserve anonymity within the small local mental health community where the data was collected. Future studies should consider variability within providers based on factors like position, years of experience, and education background.  Although we developed our analytic plan using peer-reviewed literature and built-in processes to support validity of the findings, having two independent reviewers complete all steps of the analysis would have maximized rigor. Future work in this area should consider ways to increase rigor and validity through reliability facilitation mechanisms like this.

**Conclusions**

This study used a participatory dialogue among 12 mental health providers to understand the ideal treatment planning processes, real treatment planning processes, and the space between them. It is clear that providers have a general understanding of what should occur during treatment planning, as their vision is very similar to what research supports as best practices: significant interdisciplinary collaboration, consumer engagement, use of comprehensive assessment, and personalized goals. It is also clear that system-wide regulations prevent providers from fully engaging in this kind of treatment planning, leading to treatment plans that are not appropriate for specific

consumers, and often end up filed away to fulfill regulations rather than being

adequately integrated into treatment. Although many of the obstacles come from the

system-level, providers themselves also contributed to the gap between ideal and real

treatment planning. Additional training and education may help to close this gap.

Consumer self-advocacy is likely to also be an important player, given that providers

often see themselves as lacking agency to make changes.

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