
Person-centred care: implications for training in psychiatry

Person-Centred Training and Curriculum
(PCTC) Scoping Group

Special Committee on Professional Practice
and Ethics

Acknowledgements

Compiling this report has been an eventful journey for members of the PCTC Scoping Group, who have all contributed to the writing. We would like to thank Dr Gwen Adshead, Professor Wendy Burn, Dr Louise Byrne, Diane Goslar, Dr Adrian James, Masood Khan, Dr Kate Lovett, Professor David Morris and Dr Vuokko Wallace.

College Report CR215

September 2018

Approved by: The Policy and Public Affairs Committee (PPAC)

© 2018 The Royal College of Psychiatrists

College Reports constitute College policy. They have been sanctioned by the College via the Policy and Public Affairs Committee (PPAC).

The Royal College of Psychiatrists is a charity registered in England and Wales (228636) and in Scotland (SC038369).

Contents

Working group	2
Executive summary and recommendations	4
Introduction	7
Background	8
What is person-centred care?	10
What is the value of person-centred care?	16
Person-centred care: training and assessment	25
Background surveys	34
Appendix	37
References	40

Working group

Working group members

This report has been written by the Person-Centred Training and Curriculum (PCTC) Scoping Group, which consisted of members and non-members of the College, including consultants and trainees. The mixed membership reflected the collaborative and co-productive ethos of both person-centred care and of the RCPsych. Together, the members brought expertise in psychiatric education, clinical psychiatry and lived experience to the scoping group, with many having combined experiences. The group consulted with stakeholders, including RCPsych groups advocating reflective practice, recovery, compassion, philosophy, ethics, kindness and values in psychiatric training and practice. The PCTC liaised with the Specialty Advisory Committees, the Curriculum Project Implementation Group and reported to the Curriculum Committee.

Chairs

Dr Jed Boardman

Dr Subodh Dave

Members

Dr Dave Baillie

Dr William Burbridge-James

Professor Chris Cook

Professor Bill Fulford

Dr Annette Gensale

Dr Rosemary Lethem

Dr Anna Ludvigsen

Dr Louise Murphy

Dr Norman Poole

Veryan Richards

Dr Glenn Roberts

Waldo Roeg

Sue Williams

Work on the report

The PCTC scoping group was set up to assist in moving training in person-centred care from ideas to action. Its key objectives were:

- To examine the existing literature on person-centred care and practice and related concepts (including reflective practice, recovery, compassion, kindness and values)
- To examine, with reference to current training, the implications of person-centred care for the training and work of core trainee psychiatrists
- To liaise and consult with other experts and stakeholder groups to ensure that groups within and outside the Royal College of Psychiatrists contesting for the same conceptual space in the curriculum (related to whole-person care and collaborative working) work jointly under a common umbrella
- To produce recommendations to ensure that the core curriculum is in line with national standards, current legislation and contemporary practice with respect to person-centred care
- To collate examples of good practice in the teaching and assessment of person-centred care
- To produce recommendations on promoting and implementing best practice for training
- To produce a report for the Royal College of Psychiatrists on person-centred curriculum and training

The Royal College of Psychiatrists has been awarded a Wellcome and Gatsby Foundation grant to enhance the element of neurosciences in the curriculum for its core trainees. The Neurosciences Commission has been set up to oversee this task. The College has also been mandated by the General Medical Council (GMC) to ensure that its curricula for basic and higher specialist training are outcomes-based and focus on key capabilities required of trainees. The Curriculum Project Implementation Group has commenced the task of reviewing the current core curriculum.

The PCTC scoping group has worked closely with the Curriculum Project Implementation Group to ensure that first, any proposed amendments to the curriculum are reviewed to ensure compliance with the core purpose of the RCPsych (www.rcpsych.ac.uk/about-the-college/what-dowe-do.aspx) and with other RCPsych and national standards where relevant, for example, the *Generic Professional Capabilities Framework* (General Medical Council, 2017). Second, to ensure that the demand for adequate representation for the relational aspects of care and whole-person care is realised in the new curriculum.

Executive summary and recommendations

The practice of medicine has changed over the past 50 years. One notable change has been a move away from the traditional deference of the patient to medical authority towards a more active role for the patient, who is now becoming ‘person’ rather than ‘patient’. Medicine as a whole is becoming more person-centred. Psychiatry is focused on the person; it is impossible to practise psychiatry well without listening carefully to a person’s concerns and making them the focus of clinical attention. A collaborative approach to care is fundamental. Nevertheless, there are concerns that care in the UK National Health Service (NHS) has become commodified and impersonal as was, for example, demonstrated in the Mid-Staffordshire scandal (Francis, 2013). Parity of esteem between physical and mental health services is still lacking. Psychiatry has received criticism for its sometimes remote approach to individuals, ignoring their broader subjective and cultural experiences. A person-centred and recovery-oriented approach is now explicitly part of health service policy in the UK. Other medical specialties and professional bodies are taking active steps towards a more person-centred approach. Psychiatry, with its background in a holistic approach to care, can lead in this area.

However, at present there is no explicit reference to person-centred practice in the curriculum for psychiatrists in training. This topic is often neglected in training programmes and person-centred care is sometimes discussed only in the context of a peripheral approach to practice, rather than as a professional frame of reference.

Aims

This report reviews the case for strengthening the focus on the person in clinical practice and giving person-centred approaches a central position in the practice and training of psychiatrists. It aims to:

- outline the rationale for embedding person-centred practice in postgraduate training and assessment
- provide recommendations to enable the delivery of person-centred care through postgraduate psychiatric training and assessment.

In setting out a case for reinforcing and prioritising person-centred care, this report does not suggest a new or different approach to that already supported by the guiding values of our profession. Rather, it offers guidance to bridging the gap between values and experience, principles and practice, and intention and achievement.

Information sources

The scoping group reviewed the literature on person-centred approaches and took evidence from people who have used services, patient representatives and members of the Royal College of Psychiatrists (RCPsych). It has used data sources including the Core Curriculum Survey 2013, content analysis of the core curriculum and a person-centred training survey of trainees and MRCPsych course organisers 2015–2016.

Key findings

- 1 There is an extensive literature that supports the benefits of person-centred approaches for clinicians, patients and service delivery.
- 2 The adoption of a person-centred approach is supported by other medical Royal Colleges and health professional bodies, UK government's health and social policies, and international bodies such as the World Health Organization and the World Psychiatric Association.
- 3 The core curriculum survey showed overall satisfaction with the curriculum but identified gaps in learning objectives related to therapeutic relationship-building. A survey of MRCPsych courses showed patchy availability of person-centred training across the country, despite an overwhelming wish for its inclusion in psychiatric training on the part of both trainers and trainees.
- 4 The current RCPsych core curriculum signals the importance of respect towards people who use services but it makes no reference to 'co-production', 'values', 'personalisation', 'personal budgets', 'ethics', 'human rights', the community context of people's lives, 'self-care' or 'self-directed care'.

Recommendations

1 Revising the curriculum

The revised curriculum should reflect the need to create a curriculum that is 'person-centred'.

- a The language of the curriculum should reflect its 'person-centred' nature. This should bear in mind the need to:
 - recognise that patients are people first and people's lived experience of mental health challenges occurs in the lived experience of their life 'as a whole'
 - afford people dignity, compassion and respect
 - provide a collaborative or co-productive approach to decision-making
 - offer coordinated care, support or treatment
 - offer personalised care, support or treatment
 - support people to recognise and develop their own strengths and abilities, discovered collaboratively, so as to enable them to live an independent and fulfilling life
- b Relational competences related to person-centred care (e.g. shared decision-making, self-directed support, co-production, collaborative care, support-planning) should be included in the curriculum.
- c Competences related to broader aspects of person-centred care should be included in the curriculum (e.g. ethics, human rights, community engagement, social inclusion).

2 Postgraduate psychiatric training

- a Postgraduate psychiatric training (delivered largely through MRCPsych courses) should deliver the key learning objectives identified in the core curriculum and ensure that the psychiatrists of tomorrow have embraced the core values for psychiatrists.
- b Strengthen the role of service users, carers and patient representatives in planning and delivering MRCPsych courses and supplementary skills training.

- c Create guidelines and standards for course organisers for working inclusively, mindfully and continuously with people who use services and patient representatives in the teaching for the MRCPsych courses.
- d Promote the involvement of trainees in Recovery Education Colleges or related opportunities in their local areas.
- e Increase the opportunities for psychiatric trainees to have joint training sessions with other medical professionals and with other professional groups working in mental health services.
- f Support training programme organisers to help embed person-centred care in training placements.¹

3 Assessment: assess and examine competences related to person-centred care

- a Assessment drives learning. The RCPsych must ensure that person-centred training-related competences are adequately and appropriately assessed in both summative (MRCPsych papers and CASC examination) and formative assessments (e.g. workplace-based assessments).
- b Review the current formative assessment tools to ensure consonance with the revised curriculum, with explicit criteria to assess person-centred care.
- c Ensure that person-centred care domains (see 2b) are given appropriate weight in summative exams.

4 Quality assurance

- a Health Education England (HEE) and its counterparts in the devolved nations must ensure that benchmarks and quality assurance criteria for MRCPsych courses and other postgraduate psychiatric training include reference to competences related to person-centred practice.
- b RCPsych is the main body responsible for setting professional standards for psychiatric training and practice in the UK. It must develop mechanisms to assure and demonstrate that postgraduate training and assessments in psychiatry across the nation are able to consistently deliver core values and objectives outlined in the curriculum consistently.

5 Values: reinforce the importance of the set of core values for psychiatrists

- a All RCPsych publications and documents should demonstrate consistency with the document *Core Values for Psychiatrists* (College report; Richards & Lloyd, 2017).
- b Incorporate relevant aspects of values-based skills training into the curriculum.
- c Amend the core curriculum to explicitly demonstrate its consistency with these core values, including the core value of person-centred practice.

1. A range of programmes/training experiences are available to enhance the person-centred elements of a training placement. For example: Experience-based co-design; Hello, my name is...; House of Care; Person and family-centred care; Personal health budgets and individual budgets; Balint Groups; Schwartz Rounds; Open Dialogue.

Introduction

The practice of medicine has changed radically over recent years. There is a greater emphasis on individualised care, more attention is paid to the needs and values of people who use health services and there is an emphasis on developing a partnership between those people who use health services and those who deliver them. These notions can be summarised under the umbrella term of person-centred care. Responses to these developments mean changes in the way clinicians act and imply a need to modify training.

In common with other medical Royal Colleges, the Royal College of Psychiatrists is currently revising its core curriculum. This offers the opportunity to update the basic postgraduate training of psychiatrists to bring it in line with current developments.

This report examines the nature of person-centred care and associated concepts and provides suggestions to revise the curriculum to build a training for psychiatrists that is truly centred on the person. It sets out a case for reinforcing and prioritising person-centred care in psychiatry and it offers guidance about how to bridge the gap between the values of our profession (Richards & Lloyd, 2017) and the inevitable challenges that practitioners face in their practice between values and experience, principles and practice, and intention and achievement. We explore how person-centred care enables psychiatrists to embody and articulate the values of psychiatry in the personal encounter with the person seeking our help; we have used a variety of sources of data in this exploratory process.

Person-centred care focuses on the patient as a person, with 'personhood' being its superordinate principle. This forms the central message of this report and means that the language we use is of crucial importance (Richards, 2018). To emphasise these points, we have used the terms such as 'person', 'individual' and 'people who use mental health services' in preference to 'patient'. Of course, in writing such a detailed report we cannot avoid the term 'patient', but we have tried to limit this to quotes from other sources or when we wish to emphasise the relationship of people to health services. We have also used the term 'people with lived experience' to highlight that not all individuals with mental health conditions have contact with mental health services.

Background

Persons and people are the subjects of human life experience. The term 'person' comes from the Greek word for 'persona' or 'mask', and gives rise to the English word 'personality'. In Greek drama, the mask or persona conferred identity; and the narrative approach to personal experience tells us that people experience themselves as persons who take decisions and make choices that reflect their identities as the authors of their own story (McAdams, 2015). Other areas of discourse also invoke persons and personhood: in moral philosophy, persons have agency and are the owners of rights and the subjects of duties; in law, only legal persons have legal rights and legal existence.

The practice of psychiatry is inherently person centred, because it must focus on lived personal identity and the ways that experience can change this, including the experience of mental distress and disorder (Glover, 2003). It is arguable that good quality psychiatric practice is impossible unless the people who need our help are *seen* as people with concerns that need careful attention and focus. Commentators such as Michael Balint and S. Kay Toombs have long argued that a collaborative and person-centred approach is fundamental to good medical practice, and the RCPsych makes this explicit in its professional practice document, *Good Psychiatric Practice* (Balint, 1957; Kay Toombs, 1987; Royal College of Psychiatrists, 2009).

Why, then, the need for an RCPsych report on person-centred care in psychiatry? First, because of general concerns that routine healthcare has become commodified and impersonal, with a focus on profits, not persons (Ballatt & Campling, 2011; Mezzich *et al*, 2009). The findings of the Francis report into care at Mid Staffordshire exemplify this (Francis, 2013; Royal College of Psychiatrists, 2013a).

Second, there is evidence that there is lack of parity of esteem between physical and mental health services, in terms of commissioning and funding both clinical services and research (Royal College of Psychiatrists, 2013b). This lack of respect means that financial considerations, rather than clinical need, become the dominant priority for mental health service providers, and an accompanying tendency to see clinical work as 'completed episodes of activity', not care of people in need. Only in mental health services do we see bald statements about lack of service provision set out as if it was obvious, justifiable and acceptable, and with a complete lack of shame or concern.

Finally, psychiatry has a long history of being criticised for its focus on categories and classes of disorders that are seen as dehumanising people and labelling them as deviant while ignoring key aspects of

subjective experiences of culture, ethnicity, political oppression and trauma. What people who use mental health services want to hear from their psychiatrists is 'What is your story?', not 'What is wrong with you?' (Roberts, 2000).

The importance of developing a person-centred practice is recognised by clinicians across all medical specialties. However, this topic has thus far often been neglected in training programmes, and person-centred care is sometimes discussed only as a peripheral approach to practice, rather than a professional frame of reference. As other medical specialties and bodies are taking active steps towards a more person-centred approach, psychiatry is now reclaiming its role in this process (Future Hospital Commission, 2013; Ahmad *et al*, 2014; Royal College of General Practitioners, 2014; Royal College of Physicians, 2014, 2015; Health Education England *et al*, 2017; Leng *et al*, 2017). Given that psychiatric practice is based on a holistic approach to care, its traditions provide a firm basis for developing an approach to person-centred practice fit for the modern context. The revision of the curriculum provides an opportunity to examine the person-centred nature of our training.

What is person-centred care?

The years since the 1940s have seen a shift in focus from the patient as an acquiescent subject to a participatory agent. The development of medical ethics has provided a system of moral principles that applies values to the practice of clinical medicine and outlines a familiar common framework of the four principles of respect for autonomy, beneficence, non-maleficence and justice (Beauchamp & Childress, 2001). Of particular relevance here is the principle of respect for autonomy, which gained importance after the Second World War as a result of the trials of Nazi physicians and the development of the Nuremberg Code (Weindling, 2004). Initially focusing on informed consent, autonomy emerged as an important aspect of the doctor-patient relationship (Bergsma & Thomasma, 2000). The civil rights movements of the 1960s and early 1970s increasingly questioned the power of the medical profession and the growing dominance of medical technology, reinforcing the need for a stronger patient voice and the duty of the doctor to foster independent decision-making. Patients no longer wished to be acquiescent subjects and their role as experts by experience was being increasingly recognised (Byrne *et al*, 2018). These developments were paralleled in medical sociology and anthropology, with the growing interest in the doctor-patient relationship, the power of the medical profession, a focus on the patient narrative and the expert patient (Parsons, 1951; Cartwright, 1967; Freidson, 1975; Fitzpatrick *et al*, 1984; Tuckett *et al*, 1985; Kleinman, 1988). Person-centred care is now explicitly embedded in UK health policy (Coalition for Collaborative Care, 2015; Welsh Government, 2015).

We recognise that modern medicine is moving towards a more personalised approach, not only because of technical advances in immunology and gene therapy, but also because of an increasing demand for a more 'human' approach to healthcare. The human aspects of practice such as communication skills, cultural sensitivity and the creation of effective alliances will remain central (Lancet Psychiatry Commission, 2017).

There is a considerable international literature on person-centred care (sometimes referred to as patient-centred care). This literature offers a range of definitions, which has sometimes obscured as well as illuminated the nature of the approach (Gerteis *et al*, 1993; Leplege *et al*, 2007; Entwistle & Watt, 2013; Kitson *et al*, 2013; Ahmad *et al*, 2014; Sidani & Fox, 2014) (Box 1). While there may be many definitions,

Box 1 Some definitions and components of person-centred care

The good physician treats the disease; the great physician treats the patient with the disease. *Osler (1849–1919), quoted in Harding et al (2015, p. 14)*

[Patient-centred medicine means] understanding the patient as a unique human being. *Balint (1969)*

[Patient-centred medicine] represents a style of consulting where the doctor uses the patient's knowledge and experience to guide the interaction. *Byrne & Long (1976)*

[Patient-centred care is when] the physician tries to enter the patient's world, to see the illness through the patient's eyes. *McWhinney (1989)*

[There are] 8 principles of patient-centred care: (1) Respect for patients' values, preferences and expressed needs; (2) Coordination and integration of care; (3) Information, communication and education; (4) Physical comfort; (5) Emotional support and alleviation of fear and anxiety; (6) Involvement of family and friends; (7) Transition and continuity; (8) Access to care. *Gerteis et al (1993)*

[The] model of the patient-centred clinical method has six interconnecting components: (1) exploring both the disease and the illness experience; (2) understanding the whole person; (3) finding common ground regarding management; (4) incorporating prevention and health promotion; (5) enhancing the doctor–patient relationship; (6) 'being realistic' about personal limitations and issues such as the availability of time and resources. *Stewart et al (1995)*

Patient-centred care [is] closely congruent with, and responsive to patients' wants, needs and preferences'. *Laine & Davidoff (1996)*

Patient-centred medicine has five distinctive dimensions: (1) a biopsychosocial perspective; (2) patient as person; (3) having power and responsibility; (4) therapeutic alliance; and (5) doctor as person. *Mead & Bower (2000)*

Patient-centred care (a) explores the patients' main reason for the visit, concerns, and need for information; (b) seeks an integrated understanding of the patient's world – that is, their whole person, emotional needs, and life issues; (c) finds common ground on what the problem is and mutually agrees on management; (d) enhances prevention and health promotion; and (e) enhances the continuing relationships between the patient and the doctor. *Stewart (2001)*

[Patient-centred care means] providing care that is respectful of and responsive to individual patient preferences, needs, and values and ensuring that patient values guide all clinical decisions. *Institute of Medicine (2001, p. 6)*

Continued on next page

Box 1 Some definitions and components of person-centred care

To achieve patient-centred healthcare, healthcare must be based on five principles: (1) respect; (2) choice and empowerment; (3) patient involvement in health policy; (4) access and support; and (5) information. *International Alliance of Patients' Organizations (2007)*

Person centeredness has four main meanings: addressing the person's specific and holistic properties; addressing the person's difficulties in everyday life; regarding the person as an expert who should participate actively in their rehabilitation; respecting the person behind the impairment or disease. *Leploge et al (2007)*

Person-centred medicine is dedicated to the promotion of health as a state of physical, mental, sociocultural, and spiritual well-being, as well as to the reduction of disease, and founded on mutual respect for the dignity and responsibility of each individual person. *Mezzich et al (2009)*

[Patient-centred care is] the experience (to the extent the informed, individual patient desires it) of transparency, individualisation, recognition, respect, dignity, and choice in all matters, without exception, related to one's person, circumstances, and relationships in healthcare. *Berwick (2009)*

Person-centred care: (1) Affording people dignity compassion and respect; (2) Offering coordinated care, support or treatment; (3) Offering personalised care, support or treatment; (4) Supporting people to recognise and develop their own strengths and abilities to enable them to live an independent and fulfilling life. *The Health Foundation (2014)*

what runs through them is a series of constant themes, including the provision of holistic, biopsychosocial or integrative care that is responsive to people's needs and values and that treats people with dignity, respect and compassion; that empowers them and offers choice, involvement and a partnership approach. The obvious overarching theme here is ethical: the idea that patients should be 'treated as persons' (Entwistle & Watt, 2013).

This change of terminology from patient to person is not a linguistic sleight of hand, but represents a shift from a perspective of a person living the role of a patient, to a more complete focus on a person as a fellow human being. The focus is, first and foremost, on people, not patients.

At this stage it is worth introducing a social dimension to the person-centred approach. Given the central importance of identity, it is necessary to consider the importance of social and community connections, not only to understand the individual in his or her social and cultural context, but to appreciate how these reflect on care interventions and the choice of clinical intervention. This means considering the person as a fellow human being or citizen whose social connectivity or interdependence is equally valued as an aspect of a fulfilling life.

Recently in the UK, guidance on translating these person-centred principles into action has been provided by the Health Foundation in *Person Centred Care: From Ideas to Action* (Ahmad *et al*, 2014). Their report views person-centred care as an attempt to support people in developing the knowledge, skills and confidence they need to more effectively manage, and make informed decisions about, their own health and healthcare. Importantly, this approach challenges professionals to employ a 'partnership' approach with people focusing on the following four elements:

- 1 Affording people dignity, compassion and respect
- 2 Offering coordinated care, support or treatment
- 3 Offering personalised care, support or treatment
- 4 Supporting people to recognise and develop their own strengths and abilities to enable them to live an independent and fulfilling life

Person-centred care in the NHS

The ideas behind person-centred care have significantly influenced both physical and mental health policy in the UK. For example, the NHS Plan in 2000 highlighted the need for personalisation and coordination (HM Government, 2000), and the Wanless report in 2002 focused on enablement and empowerment and seeing patients as 'partners in care' (Wanless, 2002). In 2002 the Department of Health developed the Expert Patients Programme and in 2012 the government's response to a public consultation, *Liberating the NHS: No Decision about Me, without Me*, said:

'We consider that greater patient involvement and greater patient choice are all part of the same goal: to ensure that "no decision about me, without me" becomes the norm' (Department of Health, 2012, p. 1).

In its mental health outcomes strategy, *No Health without Mental Health*, the government emphasised that people with mental health conditions should have

'...a greater ability to manage their own lives, stronger social relationships, a greater sense of purpose, the skills they need for living and working, improved chances in education, better employment rates and a suitable and stable place to live' (Department of Health, 2011, p. 6).

Person-centredness can also be viewed as a dimension of healthcare quality in its own right (Berwick, 2009).

In the *Health and Care Standards for Wales*, person-centred care is referred to as

'... a process that is people focused, that promotes independence and autonomy, provides choice and control and is based on a collaborative team philosophy. It takes into account people's needs and views and builds relationships with family members. It recognises that care should be holistic and so includes a spiritual, pastoral and religious dimension. The delivery of person centred care requires both safe and effective care and should result in a good experience for people. This responds

to the need expressed by NHS Wales to be able to describe the key determinants of a “good” experience to help both users and providers in assessing how people feel and achieve improved outcomes as a result of the care and services they receive’ (Welsh Government, 2015, p. 8).

Person-centred care is now a part of UK health policy (Coalition for Collaborative Care, 2015; NHS England, 2014) and the concepts of clinical governance and principles of safety, clinical effectiveness and ensuring dignity and compassion in patient care have become ingrained in the NHS (Scally & Donaldson, 1998). This vision of delivering care that is personalised, coordinated and compassionate is enshrined in the NHS Constitution itself (Department of Health, 2015). In psychiatry, with its strong biopsychosocial ethos and whole-person focus, there has been a particular urgency in ensuring that services are person-centred and that care is enabling, engaging and empowering for patients. This focus is also reflected in the College’s stated core purpose to ‘set standards and promote excellence in psychiatry and to work with patients and carers and other relevant organisations’ (www.rcpsych.ac.uk/aboutthecollege/whatdowedo.aspx). Recent advances in genomics have furthered the concept of personalised medicine and the idea that care, whether medical, social or psychological, needs to be person-centred is now becoming mainstream (Lancet Psychiatry Commission, 2017).

Person-centred care and psychiatry

The ideas behind person-centred care are familiar to mental health professionals. We know that there has been a plethora of concepts such as compassionate care, intelligent kindness, values-based practice, recovery movement, human rights and spirituality, which can all be seen as key elements within the conceptual space of person-centred care. As psychiatrists, we place great emphasis on the therapeutic relationship and, not surprisingly, people rate relationships as the most important component of psychiatric care (Johansson & Eklund, 2003).

Psychiatrists mainly operate as physicians who pay attention to both the physiological reality of experience and the psychodynamics of the person and their broader interpersonal relationships, experiences and abilities (i.e. the sociodynamics). For many psychiatrists, their core approach to mental health has been influenced by Carl Rogers and his description of ‘person-centred’ therapy as an intervention that allowed the patient (not the doctor) to be the ‘expert’ in the process of recovery from illness. The psychiatric literature commonly cites George Engel’s notion of a biopsychosocial model of health as applying to our core approach to mental health. Psychiatrists have had to take on many of the criticisms aimed at the practice of psychiatry since the 1950s and have supported legal and policy frameworks that protect the rights of people with mental health conditions and intellectual disabilities. In

the context of the increasing move towards community-based care, psychiatrists need to develop relationships with people who use mental health services that are mutually satisfying, socially reflective and clinically effective. Future generations of psychiatrists need the skills and capacities that enable us to listen to people who seek our help, understand and support the social context of their lives, and to place an increased emphasis on the active roles that they can play as citizens and partners in care processes. They need a knowledge of both biological and social sciences, as well as the ability to adapt to changing social trends and the way in which services are delivered (Lancet Psychiatry Commission, 2017).

Perhaps more importantly, psychiatry needs to embrace the central principle of 'personhood', described by Bill Anthony as simply 'people with severe mental illness are people' (Anthony, 2004). For our purposes, this simple description should apply to all people, of all ages, with mental health conditions and with intellectual disabilities. Personhood then becomes the superordinate principle from which other principles arise. In embracing this principle, we may view the individual's experience of illness and the challenges of mental illness and engagement with services not *through the patient's eyes* but *through the eyes of a person*, thus shifting a preoccupation with *patienthood* to a new focus on *personhood*.

We should remember that the lived experience of mental health challenges occurs in the lived experience of a person's life 'as a whole'. This means that we need to give a central emphasis to developing an understanding and response to people in the social, community and individual dimensions of their life, which can enrich the four elements of the partnership approach listed earlier (p. 13). This refocusing not only becomes important for the practice of psychiatry, but it should form the basis of psychiatric training. At present, a patient's history, strengths, goals, social circumstances, activities, values, beliefs, etc. are regarded as informing decisions about diagnosis, treatment and support. The shift in focus forces us to consider diagnosis, treatment and support in terms of the extent to which they help the person to do the things they want to do and live the life they wish to lead. One responsibility of psychiatrists is to play a role in the active enablement and co-design of the forms of support identified by individuals as being key to fulfilment.

Person-centred approaches are supported internationally by the World Health Organization and the World Psychiatric Association (World Health Organization, 2007; Mezzich *et al*, 2009). A recent RCPsych report, *Core Values for Psychiatrists* (Richards & Lloyd, 2017), put the ability to work as person-centred practitioners at the heart of their identity as psychiatrists.

This emphasis on humanistic and person-focused practice is common across all mental health professionals and represents an opportunity to provide a focus for inter-professional training and to improve interdisciplinary working.

What is the value of person-centred care?

We have already stressed the importance of shifting our emphasis from patient to person and focusing on the person in the context of their life. The whole-person stance takes in a personal perspective to assessment and draws upon the many strengths and preferences salient to an individual in planning care and treatment.

A case can be made for supporting person-centred care based on a number of perspectives, which we will discuss next.

Ethical case

This is a values-based argument, which sees person-centred care as respecting autonomy and being a good in its own right. The Health Foundation (2016) illustrate this using their four principles. They suggest that we turn these on their heads and ask whether it is acceptable for healthcare to:

- fail to offer people dignity, compassion or respect?
- be poorly coordinated?
- treat people as a set of diagnoses or symptoms, without taking into account their wider emotional, social and practical needs or those of their carers?
- maintain dependency, so that people fail to recognise and develop their own strengths and abilities and live an independent and fulfilling life?

When put across in this manner, the answers to these questions become self-evident.

Consumer case

People want to be treated with dignity and respect, to be listened to and to be actively involved in their healthcare. There has been a steady change in societal expectations as we move from a paternalistic model of care to a more collaborative model, with a significant increase in the number of people expressing a preference for greater involvement in

clinical decision-making (Chewning *et al*, 2012). In psychiatric care, out-patients view the quality of the relationship they have with the clinical staff, and being understood by staff, as the central aspect of good care (Johannsson and Eklund, 2003). Important components of quality in the helping relationship included feeling that staff gave patients enough time to talk and open-up, to disclose their thoughts and explain their situation and for the staff not to intervene too quickly. In addition, people did not want to be pre-judged and wanted staff to listen and to base their actions on the uniqueness of the person's situation. It was important for people to see that staff had a similar explanation for and understanding of their problems as they themselves had. The final component was the development of a helping relationship that was experienced as warm, supportive, interested and engaging. As one of the service users interviewed said, 'I was so afraid of his generalized, standardized therapy. I wanted treatment for my own person, for my own problems' (p. 342). Studies in primary care have revealed similar notable components of person-centred care to be valued by people using services (Little *et al*, 2001; Stewart, 2001).

People who encounter problems with their care express a range of feelings, beliefs and values and common to these is a 'personal identity threat' (Coyle, 1999). This threat includes the feeling of not being treated as a human being; being treated as an object or in some way as non-human; being taken for granted; being stereotyped; feeling disempowered and devalued. Many said that they wanted more power to make choices, to participate in their treatment, assert their identity and perform their social roles.

Professional case

Person-centred care not only improves the experience of people who use health services, but can also result in greater work satisfaction and reduced stress for professionals delivering healthcare (South London and Maudsley NHS Foundation Trust & South West London and St George's Mental Health NHS Trust, 2010; van den Pol-Grevelink *et al*, 2012; Brownie & Nancarrow, 2013). The refocusing of the core interaction of the clinical encounter to 'people working with people' upholds the value and reality that practitioners are people too, and highlights that the experience and well-being of practitioners are major determinants of the quality of care – burnt out and depersonalised practitioners cannot offer person-centred care (Roberts, 1997). This approach may also encourage recruitment into psychiatry (Choudry & Farooq, 2017). The health and well-being of professionals remains key to practising well. [#choosepsychiatry](#), a major recruitment campaign by the RCPsych, has highlighted the holistic bio-psychosocial, person-focused nature of psychiatry (www.rcpsych.ac.uk/discoverpsychiatry/acareerinpsychiatry/choosepsychiatry.aspx).

Instrumental case

This view sees person-centred care as a means to achieving better outcomes, arguing that people who are more engaged and informed are likely to experience improvements in health behaviours, health and wellbeing outcomes. While there is an obvious and self-evident justification for treating patients first and foremost as people, there is also research evidence to show how such practice is associated with better patient outcomes.

A wide range of studies show beneficial effects of the components of person-centred care on patient outcomes across a range of conditions, including arthritis, asthma, diabetes, hypertension, heart disease, heart failure, stroke and cancer (Health Foundation, 2016). Similar improvements in outcomes have been reported for people with mental health conditions (Priebe *et al*, 2011a). ‘Patient-centred communication’ is associated with improved patient satisfaction, adherence, and better health outcomes (Stewart *et al*, 1995).

The ‘therapist–client relationship’ and the ‘therapeutic alliance’ have played a central role in counselling and psychotherapy and are considered pivotal in producing successful outcomes. These concepts have influenced psychiatric as well as general medical practice and are central to the success of the clinical encounter (Priebe *et al*, 2011a). These ‘doctor–patient’ relationships are relevant to all staff working in health and social services, and the interpersonal processes that make up the therapeutic relationship are not just a vehicle for the delivery of an evidence-based treatment, but are part of the therapy itself (Priebe & McCabe, 2008).

A systematic review of the effects of the clinician–patient alliance and communication in mental health settings showed that both factors were associated with treatment adherence (Thompson & McCabe, 2012). The clinician’s ability to elicit the patient’s perspective was found to be particularly important, in line with studies in general medical settings (Arthbutnott & Sharpe, 2008; Ahmad *et al*, 2014). The quality of the relationship of the clinician and the person with a psychosis is associated with better treatment adherence, fewer severe symptoms, better social functioning and fewer hospital admissions (McCabe *et al*, 2016). A shared understanding of the person’s problems is an important component in developing successful relations (McCabe *et al*, 2016). Several aspects of communication between clinicians and patients are important: a focus on the patient’s concerns; positive regard and personal respect; appropriate involvement of patients in decision-making; genuineness and a personal touch; and the use of a psychological treatment model (Priebe *et al*, 2011b). In the treatment of psychosis, a good therapeutic relationship is predictive of better treatment adherence, lower severity of symptoms, better social functioning and fewer hospital admissions (McCabe *et al*, 2016).

A meta-analysis of 127 studies found that overall a good therapeutic relationship is associated with better treatment adherence, and

training physicians in communication skills improves adherence by 12% (Zolnieriek & DiMatteo, 2009). Important elements of communication included: patient-centred interviewing, demonstrations of support, empathy and understanding, development of collaborative partnerships and joint decision-making.

In a study of outpatients with HIV, the perception of being treated as a person was the strongest factor in predicting engagement with the clinic (Flickinger *et al*, 2013). Those attending the clinic kept more appointments if the staff treated them with dignity and respect, listened to them, explained matters in ways that they could understand and knew them as persons. Respecting patients as people is a recognition by clinicians of the unconditional value of patient as a person (Beach *et al*, 2007).

Economic case

With most health systems facing a limiting of resources, efficiency in healthcare delivery is vital. This is usually achieved through reduction of health costs through less (or less costly) service utilisation. Person-centred care leads to better self-management and less service utilisation while better engagement in one's care allows for more cost-effective and efficient treatment choices. A Cochrane review of 36 self-management trials of people with asthma found that self-monitoring and agenda-setting reduced hospital stays, emergency department visits, unscheduled visits to the doctor and days off work or school. Moreover, when people are fully informed about care and treatment they choose less invasive and less costly treatments (Gibson *et al*, 2003). In mental health, co-production and peer support in particular have been associated with economic efficiency through early discharge, reduced in-patient bed usage (Lawn *et al*, 2008) and reduced readmissions (Min *et al*, 2007).

Legal case

The Health and Social Care Act 2012 imposes a legal duty on NHS England and Clinical Commissioning Groups (CCGs) to involve individuals in their own care. The Care Act 2014 puts the individual first and at the heart of care decision-making. In this context, we also need to consider that doctors may be patients too (Rippere & Williams, 1985).

A further legal imperative comes from the recent UK Supreme Court judgment in the matter of *Montgomery v Lanarkshire Health Board* (UK Supreme Court, 2015; Herring *et al*, 2017). This judgment makes shared decision-making based on the individual's values the basis of consent to treatment. It requires doctors to:

- engage in dialogue with their patients to the point that,
- the patient concerned has sufficient understanding of the benefits

as well as risks of the options available for treatment, so that,

- a shared decision can be made that ‘takes into account’ the values of that particular patient.

Following this relatively new legal judgment, the requirement to foster a person-centred approach becomes important for all members of the medical profession. It reflects and gives legal force to guidance on shared decision-making provided by the GMC (2008) and corresponding guidance from the Royal College of Psychiatrists in *Good Psychiatric Practice* (2009).

A host of other policy documents from medical Royal Colleges, the NHS and other healthcare and healthcare educational organisations support the embedding of person-centred care in medical and healthcare education.

Concepts related to person-centred care

In planning the content of training schemes, it is important to consider what components of person-centred care might be included in the curriculum. Person-centred care may be seen as an umbrella term encompassing a range of different but related factors: shared decision-making, self-management support, co-production, personal recovery, values-based practice, human rights, ethics and philosophy, social inclusion, compassion, empathy and kindness, spirituality, reflective practice, patient narratives, and finally, formulation skills. They will be discussed here in detail.

Shared decision-making

This is a collaborative process through which a healthcare professional supports a person to reach a decision about their treatment. It brings together the clinician’s expertise (e.g. treatment options, risks and benefits) and the expertise of the individual person (e.g. their preferences, personal circumstances, goals, values and beliefs) and may help improve collaboration between clinicians and people with lived experience (Ahmad *et al*, 2014; Morgan *et al*, 2015; Ramon *et al*, 2017). One of the policy drivers for shared decision-making has been the need to reduce health costs and this may give rise to a narrow understanding of the process (Entwistle *et al*, 2012b). A broader understanding, one which incorporates flexibility, allows for greater influence by clinicians and adaptation to diverse situations is important, particularly for excluded groups. This is akin to the interactional approach to decision-making outlined by Epstein and Street (2011), which ‘promotes knowing the patient as a person, tailoring information, constructing preferences, achieving consensus, and promoting relational autonomy’ (p. 454). The implementation of shared decision-making remains a challenge (Coulter, 2017; Slade, 2017).

Self-management support

This aims to enable people with long-term conditions to manage their health and well-being, day by day, as effectively as possible. This is an aspect of social models of health and is based upon coaching and supporting incremental achievements towards life goals (Ahmad *et al*, 2014).

Co-production

This has been defined as 'A relationship where professionals and citizens share power to plan and deliver support together, recognising that both partners have vital contributions to make in order to improve quality of life for people and communities' (New Economics Foundation, 2013, p. 3). It has six principles (Boyle *et al*, 2010):

- 1 Recognising people as assets
- 2 Building on people's existing capabilities
- 3 Promoting mutuality and reciprocity
- 4 Developing peer support networks
- 5 Breaking down barriers between professionals and recipients
- 6 Facilitating rather than delivering.

Personal recovery

In mental health, 'personal recovery' relates to the process through which people find ways of living meaningful lives with or without ongoing symptoms of their condition (Shepherd *et al*, 2008; Slade, 2009). People who use mental health services have identified three key factors that are important their recovery journey (Leamy *et al*, 2011):

- **Hope**, for example, the continuing presence of hope that it is possible to pursue one's personal goals and ambitions.
- **Agency**, for example, the need to maintain a sense of control over one's life and one's symptoms and to build a sense of identity.
- **Opportunity**, for example, the importance of opportunities to help build a life 'beyond illness'.

Many of the ideas underpinning personal recovery are not new (Davidson *et al*, 2010). They have emerged from the service user movement, for example, the consumer/survivor movement in the 1980s and 1990s, based on self-help, empowerment and advocacy. These ideas themselves had their roots in the Civil Rights movements of the 1960s and 1970s in the USA and in self-help groups, such as Alcoholics Anonymous, where the concept of being 'in recovery' remains a central tenet. These values are generally supported by service users (Centre for Mental Health, 2012), but are seen by some as representing a colonisation by professionals or a move to reduce service provision (Rose, 2014).

Values-based practice

Values-based practice is a clinical skills-based approach to working with complex and conflicting values in healthcare (Morgan *et al*, 2015). It can be considered as a twin framework to complement evidence-based practice. For the practice of person-centred care it is important to know what the values of others are and to promote partnership in decision-making. Training in values-based practice can contribute to the skills needed to deliver person-centred care (Richards & Lloyd, 2017).

Human rights

Knowledge of human rights legislation and of other relevant legislation, the ability to consider proportionality in applying legislation that restricts individual freedom, along with an attitude that demonstrates respect for a person's wishes and human rights are critical to psychiatric practice (Department of Health, 2007). There is international support for improved knowledge in this area from the World Health Organization and the World Psychiatric Association (Bhugra, 2016; Funk and Drew, 2017).

Ethics and philosophy

The growth of medical ethics over the past 70 years has provided a framework for making difficult decisions and is an example of the enrichment that can flow from disciplines currently tangential rather than central to education in psychiatry (Beauchamp & Childress, 2001; Fulford & Thornton, 2006). Related to this is an understanding of the capabilities approach (Sen, 2009; Entwistle & Watt, 2013).

Social inclusion

Social exclusion refers to the extent to which individuals are unable to participate in key areas of economic, social and cultural life. The emphasis here is on non-participation arising from constraint, rather than choice. In relation to people with mental health problems, the impetus toward a socially inclusive clinical practice is clearly related to drivers that include legislation on anti-discrimination, equality and human rights, policy on health equalities, social justice and citizenship, and practical approaches that help to address the impact on individuals of discrimination in the areas of employment, housing, poverty and debt (Boardman *et al*, 2010). Moreover, clinical practice for social inclusion will need to look to both individual and community levels in assessing and supporting a person's social and community connectivity and their roles as contributors to civic life. In a whole-person oriented clinical practice based on the objectives of enabling effective recovery as well as good clinical outcomes, it is important to actively attend to the value of (often hidden) social and community networks. As evidenced in studies on connected communities (Parsfield *et al*, 2015), these networks may represent a form of 'community capital'

in a number of dimensions, such as well-being, citizenship, capacity, cost. A 'literacy of community' within clinical practice will help to ensure that the current and potential value of these networks for support, participation and inclusion can be actively realised.

Exploring and identifying alongside the individual the community connections which they may have or want to have, may be key to mobilising their assets, fulfilling their recovery ambitions and honouring their right to feel included. Understood at community level, the nature and value of connected communities is likely to be key to tapping their beneficial potential.

Compassion, empathy, kindness

These terms are used widely in the health and social care literature and perhaps come together most satisfactorily under the term 'intelligent kindness' (Ballatt & Camping, 2011). For the purposes of training, there is a need to promote compassionate activity and to consider:

- How to promote and sustain compassionate bearing of the person in mind
- How to generate imaginative understanding of the contribution a person's tasks can make to others' well-being
- How to promote and sustain respect for the person's wishes
- How to instil in people and support a confident belief in their own value and freedom to act
- How to ensure that they have the knowledge and repertoire to act skilfully and compassionately to fit the circumstances.

Many people give high importance to factors such as respectful listening, the sharing of understanding, and the development of a mutual understanding of goals. They see this as central to the interaction with clinicians. Extending this to leadership can assist in improving the working environment for healthcare staff (West *et al*, 2017).

Spirituality

Spirituality is concerned with human experiences of relatedness, meaning and purpose in life (Cook, 2004). This may or may not include religious beliefs – many people now identify as 'spiritual but not religious'. There is a growing evidence base supporting the relevance of spirituality to clinical assessment and treatment planning. In clinical practice, it is important to show sensitivity and respect for the spiritual/religious beliefs and practices of people who use services as well as their families and carers (Royal College of Psychiatrists, 2013c).

Spirituality is fundamentally person-centred. Imposition of the beliefs of the clinician upon the other, whether by ignoring or demeaning faith, proselytising or avoiding the topic is a failure to demonstrate a person-centred approach.

Reflective practice

The ability to reflect, i.e. the ability to think about and critically analyse one's actions with the aim of improving/understanding one's practice, is critical to person-centred practice. Following the amendment to the core curriculum in 2013, it has been included as an intended learning outcome (ILO 19).

Patient narratives

In clinical encounters between doctors and patients, the narratives of illness, life and recovery that are shared offer the potential to provide meaning and hope (Cook *et al*, 2016, Greenhalgh & Hurwitz, 1998). These narratives are constructed, negotiated, and reconstructed – for good or ill – during the course of an illness. A good clinician is able to assist the person in the process of undertaking this work in such a way that the narrative is supportive of recovery. However, narratives also have the potential to hinder recovery, particularly when they primarily serve the agenda of the medical professional rather than being person-centred; in other words, when they are imposed rather than received. The primary focus of clinical work is not the doctor's narrative. A good clinician has sufficient empathy to see the story from the other person's perspective, and to facilitate the process of telling it well.

Formulation skills

The process of formulating involves an attempt to explain how a situation is developed, maintained or resolved. Often taught narrowly as an understanding of the contribution of predisposing, precipitating and perpetuating factors involved in a person's current problems, formulation is in fact a more comprehensive understanding or making sense of what has happened to the person (Baird *et al*, 2017). This takes into account the person's protective factors and strengths as well as their difficulties, and always has at its centre the need to seek and welcome new information from the person and their carers, as experts by experience, and to expect to adjust clinical views accordingly. Maintaining the person-centred belief that everyone can change is central to effective and reflective formulation. By definition, formulation is based on a shared exploration of the issues concerned by the professional and a person and is inherently person-centred. The RCPsych has produced a useful guide to using formulation in general psychiatric care (Royal College of Psychiatrists, 2017).

Person-centred care: training and assessment

The need for training in person-centred care

Person-centred care, much like the bio-psychosocial approach in psychiatry, runs the risk of being the 'obvious' concept that is assumed to be practised implicitly. One of the most common responses to questions about the practice of person-centred care is 'Aren't we already doing this?' The Care Quality Commission's (CQC's) report on care in mental health services highlights that the vast majority of staff genuinely care for their patients (Care Quality Commission, 2017). However, the report highlights collaborative care as an area that needs further improvement, with professionals criticised for doing 'to' or 'for' people rather than 'with' them. Another recent survey found that only 60% of patients report definite involvement in making decisions about their care (Fisher *et al*, 2016).

An earlier report from the CQC suggested that adults and children with long-term psychiatric illnesses are less likely to be involved in their own care (Care Quality Commission, 2016). The CQC has also highlighted the fact that there has been very little improvement in the involvement in their own care of people compulsorily treated under the Mental Health Act. This report, as well as other patient-reported survey measures, provides evidence for the need to ensure that person-centred care is embedded as standard practice for all staff.

Barriers to the implementation of person-centred care

Implementation of genuine person-centred care can be particularly difficult in psychiatric practice. People with mental illness often have complex care needs, and a small but significant minority of people are treated under the provisions of the Mental Health Act or the Mental Capacity Act, adding another layer of complexity. Aspects of forensic practice, risk management and working with organic brain disorders also present challenges (see 'Clinicians' attitudes' on p. 26).

Researchers have looked at the factors that act as barriers to the implementation of person-centred care and identified several main areas, broadly grouped into clinician- and organisation-related (Harding *et al*, 2015; Health Foundation, 2016; Moore *et al*, 2016; Quality Watch, 2016). These key barriers are: clinicians' attitudes, knowledge and skills, resource constraints, organisational culture and leadership.

Clinicians' attitudes

Attitudes of clinicians have been identified as a key barrier to successful implementation of person-centred care. Psychiatrists in particular may bristle at being asked to pay attention to person-centred care, believing that their practice is already patient-centred (and indeed it is the experience of the authors of this report that some do react so). However, data show that psychiatrists' own assessment of their person-centredness may not always be accurate (Goossensen *et al*, 2007). Moreover, psychiatrists vary in their ability to involve people in shared decision-making (McCabe *et al*, 2016).

While there is an acknowledgement that people's experience of care is largely quite positive, there remains a concern that psychiatric care retains a degree of paternalism, not least in the care of those who are compulsorily treated. Clinicians may also worry about person-centredness leading to 'demanding patients' rather than independent and empowered people.

Even when psychiatrists are motivated to practise in a person-centred manner, they may be faced with conflicting values such as organisational targets or risk management, which may prevent a full implementation of person-centred care (Boardman & Roberts, 2013). In addition, psychiatrists working in certain circumstances may encounter difficulties practising in a person-centred way. For example, they must face the contradictions embedded in their power to contribute to the compulsory treatment of citizens on mental health grounds and to be directly involved in their involuntary treatment (Roberts *et al*, 2008). Forensic psychiatrists working with offenders encounter not only the challenges of risk-management, but the people's antisocial values and beliefs (Dorkins & Adshead, 2011; Roberts, 2011). Those working with older adults with dementia face problems of capacity (Hill *et al*, 2010). These circumstances require adaptations of the person-centred approach to retain its humanistic core.

An additional element affecting clinician attitudes is the strain on retention of clinician empathy and compassion in the face of increasing workload and greater regulatory scrutiny. Burnout and compassion fatigue in medical and healthcare staff has been extensively reported and has been linked to erosion of professionalism, deterioration in the quality of care, increase in the risk of medical errors and early retirement (Roberts, 1997; Shanafelt *et al*, 2012).

Clinicians' knowledge

Lack of awareness of human rights law, provisions and code of practice/principles of the Mental Capacity Act and the Mental Health Act and of the evidence linking person-centred care and patient outcomes are all relevant. Clinicians often mistakenly believe that person-centred care will be more time-consuming and adversely affect patient outcomes, when in fact the evidence points to the contrary (Berwick, 2009). Awareness of various clinical decision-/shared decision-making tools is not widespread. Learning outcomes based on philosophical concepts underpinning psychiatric practice or of arguments put forth by critical psychiatry or anti-psychiatry movements are absent from the core curriculum (Royal College of Psychiatrists, 2016). Many will not be aware of the latest research on interventions of relevance to support whole-person practice (Webber *et al*, 2015, 2018).

Clinicians' skills

While clinicians seem keen to learn more about shared decision-making and its implementation (Stead *et al*, 2017), currently there is significant variation in its use in clinical practice (Royal College of Psychiatrists, 2014). The core curriculum does not explicitly signpost learning outcomes relevant to shared decision-making, for example, motivational interviewing skills or the ability to choose and use clinical decision aids (Royal College of Psychiatrists, 2016). Managing value conflicts is a key element of clinical practice and one for which training seems limited. Medical education has tended to focus on communication skills training but person-centred care involves the ability to take into account a person's individual values, beliefs, concerns and expectations along with relevant evidence to arrive collaboratively at a clinical decision. The skills required to identify and negotiate such value conflicts are not often part of formal medical and psychiatric training.

Resource constraints

Psychiatric services are significantly underfunded, both in the UK and globally. When faced with reduced capacity and limited time, clinicians may choose to prioritise what they see as being in the best interest of the person. Loh *et al* (2006) have shown that in primary care consultations with people who are depressed, clinicians spent 80% of the time in determining the medical problem, with very little time in engaging the person in shared decision-making. Conversely, research on clinical decision-making in the USA shows that payment incentives can overshadow the values of people who use health services (Lee & Emanuel, 2013).

Organisational culture and leadership

This has been highlighted as being a critical element in the successful implementation of person-centred care. Successful organisations are able to provide a clear vision of person-centred care to their workforce

and help translate this vision to a mission statement relevant to the work of the individual staff member. One barrier has been the multiple definitions of person-centred care and multiple initiatives that contest for the same conceptual space. For example, within the Royal College of Psychiatrists there have been many special interest groups (SIGs) and faculties attempting to address issues relevant to person-centred practice from their niche perspective:

- Medical Psychotherapy Faculty promotes reflective practice
- Spirituality and Psychiatry SIG promotes better understanding of people's spiritual needs
- Philosophy SIG promotes values-based practice
- Rehabilitation and Social Psychiatry Faculty promotes strengths-based practice
- Liaison Psychiatry Faculty focuses on the need for collaborative care-planning in personality disorder
- General Adult Psychiatry and Medical Psychotherapy faculties promulgate the importance of formulations in individual care-planning.

All are examples of efforts aimed at improving the implementation of person-centred care.

In addition, the College has run campaigns and publications to promote compassionate care or intelligent kindness. The absence of explicit labelling of these efforts as person-centred care creates the risk of duplication of effort and dilution of the link between stated intention and action.

We are aware that even ardent devotees of person-centred care may have individual clinical encounters that are not person centred. This is hardly surprising, and indeed it is to be expected, given the very human nature of our clinical interaction. An organisational culture that promotes mindfulness of one's own practice supported by reflective practice and peer supervision is critical in ensuring that person-centred care is facilitated at both the individual and systemic level. Appropriate changes in training and assessment can aid this process. The following section provides examples of how this may be achieved in practice.

Training in person-centred care

While resource scarcity or other operational issues may partly explain the widespread lack of implementation of person-centred care, in part it is also the product of inadequate training (Moore *et al*, 2016). A review of medical education in the UK revealed that while assessment of a person's perspective was being encouraged, particularly in general practice, the focus of medical education remained on diseases rather than on people. Communications skills training was extensively

available but tended to focus on specific tasks, such as breaking bad news, rather than on learning the skills of exploring a person's values, preferences and strengths (Hasman *et al*, 2006). Aligning professional training with the mission objective of person-centred care has been shown to be effective in a study of leading healthcare organisations in the USA. Typically, such training has addressed the knowledge, skills and attitudinal learning outcomes discussed earlier and included training in communication skills, person-centred care values, customer service and leadership skills as well as use of specific patient feedback in individual staff development (Luxford *et al*, 2011).

A recent review of current education and training policy encompassing person-centred care revealed that some UK medical Royal Colleges (including the Royal College of General Practitioners and the Royal College of Physicians) were moving towards the integration of person-centred care in their postgraduate curricula. The RCPsych does have an active tradition of involving patients and carers in all its committees, including those involved in the design and review of its curricula. Moreover, compared with other medical specialties, psychiatric practice is arguably inherently people focused rather than disease focused. However, there is a lack of both a central policy document and an educational framework specific to person-centred care in the core curriculum, as evidenced by the explicit lack of developed competences. This contrasts with the College's own Centre for Quality Improvement (CCQI) which promotes joint working and co-production as standards of good quality care for service delivery in several of its published reports (e.g. acute care, crisis care, community care, all available at www.rcpsych.ac.uk/workinpsychiatry/qualityimprovement.aspx). This lack of alignment between the stated aims and mission objectives of the College and its curriculum is demonstrated through the data analysis covered in the next section.

There are a number of programmes that have attempted to embed person-centred care in clinical practice. The training of clinicians in the relevant skills and attitudes is often a key element of such programmes. Evidence from the evaluation of these programmes shows that such training is best delivered in clinical teams, though it is acknowledged that specific members of the team may have individualised learning needs (Ahmad *et al*, 2014). This has particular relevance to trainees, who may be attached to clinical teams for only a short period of time.

Another barrier relates to the design and delivery of such training interventions. Training in person-centred care, while being focused on the correct learning outcomes, may fail to deliver on actual behaviour or attitude change (Stead *et al*, 2017). This outlines the importance of ensuring that training interventions are embedded in day-to-day clinical practice. The content of training need not be complicated, but it does require being mindful of using a complex model of mind that is open to:

- the possibility that the doctor does not know everything
- consideration of the fact that the doctor is not always right and thus it is accepted that one may not know what is going on, and
- acceptance that what you see on the surface may not be all there is (Kahneman, 2011).

In particular, training needs to instil in future clinicians the need to remain continuously mindful of people's own inherent capacity to heal and change, and to see the continual facilitation of the unique abilities and wishes of the person as central to ongoing diagnosis, treatment and care. Heeding this reflection will limit the potential for 'best interests' decisions to be wrongly influenced or guided by the pressures caused by a reduced capacity for funding that clinicians will inevitably experience.

Assessment of person-centred care

Given the breadth of the concepts underlying the umbrella term person-centred care, it is not surprising that a number of assessment tools have been devised to measure it. These involve both process and outcome measures, individual, service/organisational and population-level measures and both quantitative and qualitative measures. Examples include outcome measures such as symptom or side-effect scales, process measures such as medication usage, patient-reported outcome measures and patient-reported experience measures.

However, despite the availability of a large number of measures their usage in the training environment is limited, though there are some signs of change (Ahmad *et al*, 2014). Undergraduate medical students are now routinely assessed on their ability to explore people's ideas, concerns and expectations. The Royal College of Physicians has introduced a domain-based marking for its membership examination (MRCP) that provides explicit scores for 'managing patient concerns' and 'maintaining patient welfare' apart from 'clinical communication' and 'clinical judgement' (Royal Colleges of Physicians of the UK, 2018). The MRCPsych examination summative skills assessment, the Clinical Assessment of Skills and Competences (CASC), appraises components of clinical skills such as history-taking, mental state examination, risk assessment, cognitive examination, physical examination, case discussion and management. Elements such as rapport-building, empathy and advanced communication skills relevant to psychiatric practice are routinely assessed and the domains of assessment include 'develops an appropriate professional relationship' that makes explicit reference to 'patient-centred consulting'. However, given the nature of the summative exam which comprises the assessment of competences in the context of 16 discrete scenarios, questions have been raised.

In formative assessment, however, the pace of change is slow. The current core curriculum offers mainly case-based discussion (CbD) as an assessment tool in the workplace to provide feedback to trainees about their skills in delivering person-centred care. The standardised CbD template does not feature any domains to *explicitly* assess person-centred care. The list of domains includes: clinical record-keeping, clinical assessment and diagnosis, risk assessment/management, medical treatment, investigation and referral, follow-up/care planning, professionalism, clinical decision-making and overall clinical care. Other formative tools, such as Assessment of Clinical Expertise (ACE) and mini-Assessed Clinical Encounter (min-ACE) also do not feature any explicit criteria to assess collaborative care or shared clinical decision-making. The absence of indicators of person-centred care or collaborative working which are critical to psychiatric practice may seem glaring, but it has usually been explained by the suggestion that person-centred care is ‘so obviously important’ that it does not need to be explicitly highlighted in assessment measures. It may be the case that clinical supervisors are using these domains to assess person-centred care, but the current formative assessment tools have not been designed to consistently deliver a robust assessment and feedback on a candidate’s ability to practise in a person-centred way.

Generally, assessment drives learning, so the absence of formal assessment tools (both formative and summative) to evaluate trainees’ person-centredness is puzzling, especially as some tools are already being used for consultant appraisals or for service accreditation. 360-degree appraisals for consultants include feedback from users of services, but for trainees there is no opportunity to learn through formal feedback in the same way. The CCQI has devised a range of standards for psychiatric services to help them benchmark themselves to their peer services and to help drive up the quality of their care. These standards have been co-produced with active involvement of psychiatrists, users of services, carers and service line managers. Person-centred measures are quite routinely included in all of these service standards. For example, the Accreditation for In-patient Mental Health Services – Working Age (AIMS-WA) (College Centre for Quality Improvement, 2017) includes standards such as:

- **Standard U8.27:** Staff who undertake assessment and care planning have received training in: How to involve patients and carers in all aspects of care.
- **Standard 16.4:** The aims of admission are agreed among the referring team, the ward/unit team and the patient and carers.
- **Standard 20.1:** Care plans are negotiated with the patient as far as possible, and are based on a comprehensive physical, psychological, social, cultural and spiritual assessment. They include a comprehensive risk and strengths assessment, taking into account patient’s preferences and goals.

Training in person-centred care at an early stage can acculturate trainees to this concept. As assessment drives learning, being assessed

on tasks such as written formulations, shared care plans, shared written communication between professionals and patient wherever possible and therapeutic letters to patients will promote person-centred behaviours not just among trainees but also for supervisors.

Co-production has brought significant success to the accreditation standard development work of CCQI. In the training field, while there is patient and carer representation in the Curriculum Committee, their role as Committee members is to provide oversight rather than to (co-)produce learning outcomes, learning materials or assessment tools. Certainly, some of the CCQI standards could be adapted to produce effective person-centred workplace-based assessments. For example, ACE focusing on trainees' skills in collaborative working, shared decision-making and joint care-planning; CbD focusing on evaluation of clinic letters or discharge summaries as therapeutic tools; and even the introduction of patient-feedback in 360-degree appraisals for trainees.

Two further points deserve consideration in the discussion of using assessments as tools to drive improvements in person-centred care. First, psychiatric services have changed significantly over the past two decades. The introduction of a large number of specialist services, such as early intervention, liaison, assertive outreach, eating disorders, perinatal, and the splitting of in-patient and community services, have led to service improvements, but it has also resulted in increased fragmentation and lack of continuity of care. This impact is not confined to services, but it has also affected the training environment. A good example is the impact of enhanced crisis and liaison services on out-of-hours training experience available to trainees. The Psychiatric Trainees' Committee (PTC) of the College reported concerns from core trainees that they are not getting sufficient experience of emergency psychiatry to allow them to practise safely and confidently as they progress to higher training. As services fragment, ensuring that individuals remain at the centre of service planning and training provision will guard against the unintended consequences that ultimately adversely impact on the care of people. The PTC's Emergency Psychiatry Training Taskforce report highlights this point while making recommendations about emergency psychiatry training (Royal College of Psychiatrists, 2015).

The second point relates to clinical situations where evidence suggests that shared decision-making is less likely. Work by Quirk (2008) provides ethnographic data of people's experience of being compulsorily treated under the Mental Health Act, their experience of being an in-patient and an analysis of the conversation between service users and clinicians as they discussed the prescription of long-acting antipsychotic depot medication. His work is particularly informative as current psychiatric practice (and training) involves very little direct observation of peer practice. Encouragingly, the study shows that out-patient negotiations of medication prescriptions are typically 'democratic' and involve considerable amount of shared decision-making.

However, crisis admissions often under the Mental Health Act pose a real exception to the ideal of shared decision-making. For many people, an admission under compulsion is often the defining point of their care pathway, which contrasts with the defining point that psychiatrists identify, namely when they establish trust with a person. Training for young psychiatrists needs to take into account such defining points and prepare them to deal with such situations adeptly. Formative assessments in such crisis situations offer a critical learning tool but given the current workplace-based assessment structures and the paucity of emergency training experience, it is not possible to assure that all trainees have had such formative assessments.

Background surveys

In addition to the literature on person-centred care, we also examined the content of the current core curriculum and a core curriculum survey we conducted in 2013 on trainees and course organisers, as well as relevant RCPsych committees, including the Patients and Carers Committee.

Core curriculum survey 2013

The core curriculum survey was commissioned to assess trainer and trainee response to the new MRCPsych core curriculum introduced in 2010. The survey focused on the 18 ILOs of the curriculum which covered the domains of medical expert, communicator, collaborator, leader, health advocate, scholar and professional. A total of 780 responses were received.

Overall, while there was a broad level of satisfaction with the core curriculum, gaps were identified in areas related to person-centred care such as empathy, caring skills and the ability to work collaboratively with the person.

Almost two-thirds of the respondents expressed satisfaction with the curriculum. A third expressed dissatisfaction with the coverage of a number of subject areas:

- neurology
- psychopharmacology
- perinatal psychiatry
- out-of-hours and emergency psychiatry
- treatment outcomes
- values-based practice
- ethics, compassion and person-centred care.

While 77% of the respondents thought that the core curriculum adequately prepared trainees for higher specialist training, over 1 in 5 believed that it failed to impart effective training in empathy and caring skills, and in leadership.

By a significant margin, respondents preferred training on the job, in clinical settings such as wards or out-patient clinics. Teaching in MRCPsych courses or in postgraduate education meetings was

reported as being the least preferable setting for learning of all ILOs, except for ILO 16 – research. On a positive note, there was a high level of satisfaction with the teaching of almost all ILOs barring medical psychotherapy, leadership and governance.

ILO 14 – the ability to ‘inform and educate patients effectively’ – received many free-text comments. Respondents identified this as an essential skill but commented that training in this skill was not adequately prioritised and was seldom assessed.

Core curriculum content analysis

The core curriculum (revised in 2013 and again in 2016; see www.rcpsych.ac.uk/pdf/Core_Psychiatry_Curriculum_August_2016.pdf) was analysed to assess the person-centredness of its language. Each ILO and the knowledge, skills and attitude competencies underpinning each ILO were examined to assess their person-centredness, using appropriate key words or phrases (e.g. shared decision-making, collaborative working, co-production, recovery). The key findings were:

- person-centred care was not mentioned explicitly
- there were references to ‘recovery’, ‘co-operation’ ‘respect’ and ‘peers’
- there was no reference to ‘co-production’, ‘values’, ‘personalisation’, ‘personal budgets’, ‘ethics’, ‘human rights’, ‘self-care’, ‘self-directed care’, ‘shared decision-making’, ‘partnership working’, ‘peer support’, the ‘value of learning from lived experience’.

PCSC survey of trainees and MRCPsych course organisers

The Person-Centred Scoping Group conducted a survey of MRCPsych course organisers and trainees to examine the current provision of teaching in person-centred care. The survey aimed to identify the attitudes towards concepts of person-centred care in formal teaching and establish what was already taking place in this context. The survey was disseminated opportunistically to trainees through the PTC representative and to all the MRCPsych course organisers; a total of 74 trainees and 15 course organisers responded.

The results showed that both course organisers and trainees thought that it was important or very important to include concepts of person-centred care in formal training, but that these were frequently not being taught. Thematic analysis of free-text responses showed that barriers were, perhaps understandably, a desire from trainees to focus teaching on activities that would help them pass the MRCPsych exams and a lack of knowledge on the part of course organisers about how best to deliver teaching on person-centred care. Suggestions from trainees and course organisers on how to include training in

person-centred care included involving more experts by experience in delivering teaching. However, this recommendation came with a warning that any involvement of experts by experience must always be done in a collaborative way that enabled co-production and avoided tokenism. The survey suggested that almost a third of MRCPsych courses did not involve people with lived experience in the delivery of the course and only a quarter involved experts by experience when designing the course teaching programme.

Recommendations

We have submitted a set of detailed recommendations to the RCPsych curriculum committee. These are given in the [Executive summary](#) (pp. 5–6).

| Appendix

Examples of good practice in training psychiatrists in person-centred care

Open Dialogue

Open Dialogue is a way of structuring mental health services that draws heavily on systemic and family therapy approaches. It originated in the north-west of Finland.

Open Dialogue is a wholly person-centred approach to mental healthcare, both on the direct clinical level and on the wider service operational level. Care is organised around network meetings that bring the service users together with their significant network – family and friends – and the practitioners involved in care. The person is at the centre of the network, so they determine network membership and together the members decide, as much as possible, on the length and frequency of the meetings. The staff who attend undergo intensive training in systemic and dialogical ways of working, which means that their primary aim is to promote dialogue, ensure all voices are heard and increase the agency of the network members. A great deal of skill is involved in holding back from interpretations and determinations and tolerating uncertainty for long enough to enable a space to emerge in which the network can start to develop their own understanding of the experience and map out their own way forward.

Other core skills include reflections, which the practitioners make in front of the network. By expressing their thoughts and anxieties openly, a sense of trust is gradually instilled and a more open approach modelled. Practitioners are generally expected – unless risk issues dictate otherwise – to conduct all discussions about the person in front of them and not in separate meetings.

Given the intense work that goes on in network meetings, continuity of care becomes fundamental to the model. Over time, practitioners themselves become integral members of the network, which operates in a less hierarchical way than traditional service models. In the UK, peer support workers are integral to every service that is being developed and are recognised as equal team members, and this helps facilitate a more open, mindful and democratic service culture.

This approach has spread across a number of countries, including Germany, Italy, the Netherlands and the USA (Stockmann, 2015). In New York City, the Parachute Project now integrates peer support workers into the service. The model has been used across all demographics and all psychiatric presentations. A national multicentre randomised controlled trial is currently under way in the UK, bringing seven trusts together to pilot the model, with a number of psychiatrists completing the training as part of the project. Anecdotal reports to date suggest colleagues experience a substantial improvement in job satisfaction due to the new skills they are utilising and the rewarding nature of this more relational way of working. A university-based training is now open to all, and an online network currently runs within the RCPsych's Faculty of General Adult Psychiatry (www.rcpsych.ac.uk/workinpsychiatry/faculties/generaladultpsychiatry/aboutthefaculty/networks/opendialoguenetwork.aspx).

Co-production at the Recovery College

Recovery Colleges have been set up in many mental health trusts in England (Perkins *et al*, 2018). They adopt an educational approach and are open to people with lived experience, their families and carers as well as staff to learn together. They operate on a set of principles with an educational paradigm, where the person with lived experience is a student and can attend discussions, talks and courses that focus on developing their strengths, helping them to understand their own challenges and how they can best manage these. Importantly, their central approach is based on co-production, bringing together the expertise of lived and professional experience on equal terms. Recovery Colleges offer trainees the opportunity to assist in the delivery and co-production of courses.

Recovery-oriented care in US psychiatry curriculum

As part of a larger initiative of the Substance Abuse and Mental Health Services Administration (SAMHSA), the American Psychiatric Association and the American Association of Community Psychiatrists undertook a 5-year effort to develop and implement a curriculum for psychiatrists on recovery-oriented care (www.samhsa.gov/recovery-to-practice).

The Expert Patient Programme

The Expert Patient Programme at the Psychiatric Teaching Unit in Derby has won accolades for involving patients in the teaching and training of undergraduate medical students at the University of Nottingham. Based on the principle that learning occurs best when it is set in the context of practice and when it creates an emotional resonance, the expert patient involvement is not limited to sharing the personal experience but includes direct feedback to students on their skills and attitudes from a patient perspective. Two lived experience development workers coordinate the programme and also contribute to the design and delivery of the undergraduate curriculum in psychiatry. Working with over 40 expert patients trained in providing feedback, the co-produced programme consistently receives over 90% satisfaction ratings and is the highest-rated element in students' training. The programme has now been expanded to provide students with the experience of interacting with 'patients as people' away from hospital/clinical settings in community-based social inclusion programmes.

References

- Ahmad N, Ellins J, Krelle H, Lawrie M (2014) *Person-Centred Care, From Ideas to Action: Bringing Together the Evidence on Shared Decision Making and Self-Management Support*. Health Foundation.
- Anthony WA (2004) The principle of personhood: the field's transcendent principle. *Psychiatric Rehabilitation Journal*, **27**: 205.
- Arthbutnott A, Sharpe D (2008) The effect of physician-patient collaboration on patient adherence in non-psychiatric medicine. *Patient Education and Counselling*, **1**: 60–7.
- Balint E (1969) The possibilities of patient-centred medicine. *Journal of the Royal College of General Practitioners*, **17**: 269–76.
- Balint M (1957) *The Doctor, his Patient and the Illness*. Pitman Medical Publishing.
- Baird J, Hyslop A, Macfie M, Stocks R, Van der Kleij T (2017) Clinical formulation: where it came from, what it is and why it matters. *BJPsych Advances*, **23**: 95–103.
- Ballatt J, Campling P (2011) *Intelligent Kindness: Reforming the Culture of Healthcare*. RCPsych Publications.
- Beach MC, Duggan PS, Cassel CK, Geller G (2007) What does 'respect' mean? Exploring the moral obligation of health professionals to respect patients. *Journal of General Internal Medicine*, **22**: 692–5.
- Beauchamp TL, Childress JF (2001) *Principles of Biomedical Ethics*. Oxford University Press.
- Bergsma J, Thomasma DC (2000) *Autonomy and Clinical Medicine Renewing the Health Professional Relation with the Patient*. Kluwer Academic Publishers.
- Berwick D (2009) What 'patient-centered' should mean: Confessions of an extremist. *Health Affairs*, **28**: w555–65.
- Bhugra D (2016) Bill of Rights for Persons with Mental Illness. *International Review of Psychiatry*, **28**: 335.
- Boardman J, Roberts G (2013) *Risk Safety and Recovery*. NHS Confederation Centre for Mental Health.
- Boardman J, Currie A, Killaspy H, Mezey G (2010) *Social Inclusion and Mental Health*. RCPsych Publications.
- Boyle D, Coote A, Sherwood C, Slay J (2010) *Right Here Right Now: Taking co-production into the Mainstream*. NESTA.
- Brownie S, Nancarrow S (2013) Effects of person-centered care on residents and staff in aged-care facilities: a systematic review. *Clinical Interventions in Ageing*, **8**: 1–10.
- Byrne P, Long B (1976) *Doctors Talking to Patients*. HMSO.
- Byrne L, Stratford A, Davidson L (2018) The global need for lived experience leadership. *Psychiatric Rehabilitation Journal*, **41**: 76–9.
- Care Quality Commission (2016) *Better Care in My Hands*. CQC.
- Care Quality Commission (2017) *The State of Care in Mental Health Services 2014 to 2017*. CQC.
- Cartwright A (1967) *Patients and Their Doctors: A Study of General Practice*. Routledge Keegan Paul.
- Centre for Mental Health (2012) *Implementing Recovery through Organisational Change: Continuing the Journey...* Centre for Mental Health.

- Chewning B, Bylund CL, Shah B, Arora NK, Gueguen JA, Makoul G (2012) Patient preferences for shared decisions: a systematic review. *Patient Education and Counselling*, **86**: 9–18.
- Choudry A, Farooq S (2017) Systematic review into factors associated with the recruitment crisis in psychiatry in the UK: students' trainees' and consultants' views. *BJPsych Bulletin*, **41**: 345–52.
- Coalition for Collaborative Care (2015) *Our View for the Future*. NHS England.
- College Centre for Quality Improvement (2017) *Standards for Acute Inpatient Services: Working-Age Adults (AIMS-WA)*. 6th edn. Royal College of Psychiatrists.
- Cook CCH (2004) Addiction and spirituality. *Addiction*, **99**: 539–51.
- Cook CCH, Powell A, Sims A (2016) *Spirituality and Narrative in Psychiatric Practice: Stories of Mind and Soul*. RCPsych Publications.
- Coulter A (2017) Shared decision making: everyone wants it so why isn't it happening? *World Psychiatry*, **16**: 117–18.
- Coyle J (1999) Exploring the meaning of 'dissatisfaction': The importance of 'personal identity threat'. *Sociology of Health and Illness*, **21**: 95–124.
- Davidson L, Rakfeldt J, Strauss J (2010) *The Roots of the Recovery Movement in Psychiatry: Lessons Learned*. Wiley–Blackwell.
- Department of Health (2001) *The Expert Patient: A New Approach to Chronic Disease Management for the 21st Century*. Department of Health.
- Department of Health (2007) *Human Rights in Health – A Framework for Local Action*. Department of Health.
- Department of Health (2011) *No Health without Mental Health: A Cross-Government Mental Health Outcomes Strategy for People of All Ages*. Department of Health.
- Department of Health (2012) *Liberating the NHS: No Decision about Me without Me*. Department of Health.
- Department of Health (2015) *The NHS Constitution*. Department of Health.
- Dorkins E, Adshead G (2011) Working with offenders: challenges to the recovery agenda. *Advances in Psychiatric Treatment*, **17**: 178–87.
- Entwistle VA, Cribb A, Watt IS (2012) Shared decision making: enhance the clinical relevance. *Journal of the Royal Society of Medicine*, **105**: 416–21.
- Entwistle VA, Watt IS (2013) Treating patients as persons: a capabilities approach to support delivery of person-centered care. *American Journal of Bioethics*, **13**: 29–39.
- Epstein RM, Street RL (2011) Shared mind: communication decision-making and autonomy in serious illness. *Annals of Family Medicine*, **9**: 454–61.
- Fisher E, O'Dowd NC, Dorning H, Keeble E, Kossarova L (2016) *Quality Watch Annual Statement 2016*. Health Foundation Nuffield Trust.
- Fitzpatrick R, Hinton J, Newman S, Scambler G, Thompson J (1984) *The Experience of Illness*. Routledge.
- Flickinger TE, Saha S, Moore RD, Beach MC (2013) Higher quality communication and relationships are associated with improved patient engagement in HIV care. *Journal of Acquired Immune Deficiency Syndrome*, **63**: 362–6.
- Francis R (2013) *Report of the Mid Staffordshire NHS Foundation Trust Public Inquiry*. TSO (The Stationery Office).
- Freidson E (1975) *Profession of Medicine: A Study of the Sociology of Applied Knowledge*. Dodd Mead.
- Fulford W, Thornton T (2006) *Oxford Textbook of Philosophy and Psychiatry*. Oxford University Press.
- Funk M, Drew N (2017) WHO Quality Rights: transforming mental health services. *Lancet Psychiatry* ([http://dx.doi.org/10.1016/S2215-0366\(17\)30271-7](http://dx.doi.org/10.1016/S2215-0366(17)30271-7)).

Future Hospital Commission (2013) *Future Hospital: Caring for Medical Patients – A Report from the Future Hospital Commission to the Royal College of Physicians*. Royal College of Physicians.

General Medical Council (2008) *Consent: Patients and Doctors Making Decisions Together*. GMC (<https://www.gmc-uk.org/ethical-guidance/ethical-guidance-for-doctors/consent>).

General Medical Council (2017) *Generic Professional Capabilities Framework*. GMC.

Gerteis M, Edman-Levitan S, Daley J, Delbanco TL (1993) Medicine and health from the patients perspective. In *Through the Patient's Eyes: Understanding and Promoting Patient-Centered Care* (eds M Gerteis, S Edman-Levitan, J Daley, et al). Jossey-Bass, pp. 1–18.

Gibson PG, Powell H, Coughlan J, Wilson AJ, Abramson M, Haywood P, et al (2003) Self management education and regular practitioner review for adults with asthma. *Cochrane Database of Systematic Reviews*, **1**: CD001117.

Glover J (2003) *Towards Humanism in Psychiatry*. The Tanner Lectures on Human Values. Delivered at Princeton University February 12–14 2003 (http://tannerlectures.utah.edu/_documents/a-to-z/g/glover_2003.pdf).

Greenhalgh T, Hurwitz B (1998) *Narrative Based Medicine: Dialogue and Discourse in Clinical Practice*. BMJ Books.

Goossensen A, Zijlstra P, Koopmanschap M (2007) Measuring shared decision making processes in psychiatry: skills versus patient satisfaction. *Patient Education and Counseling*, **67**: 50–6.

Harding E, Wait S, Scrutton J (2015) *The State of Play on Person-Centred Care: A Pragmatic Review of How Person-Centred Care is Defined Applied and Measured*. Health Foundation.

Health Education England, Skills for Health Skill for Care (2017) *Person-Centred Approaches: Empowering People in Their Lives and Communities to Enable an Upgrade in Prevention Wellbeing Health Care and Support*. Skills for Health.

Health Foundation (2014) *Person-Centred Care Made Simple – What Everyone Should Know about Person-Centred Care*. Health Foundation.

Health Foundation (2016) Why person-centred care is important (<http://personcentredcare.health.org.uk/person-centred-care/overview-of-person-centred-care/why-person-centred-care-important>).

Hasman A, Coulter A, Askham J (2006) *Education for Partnership: Developments in Medical Education*. Picker Institute Europe.

Herring J, Fulford KWM, Dunn D, Handa A (2017) Elbow room for best practice? Montgomery patients' values and balanced decision-making in person-centred care. *Medical Law Review* (in press).

Hill L, Roberts G, Wildgoose J, Perkins R, Hahn S (2010) Recovery and person-centred care in dementia: common purpose common practice? *Advances in Psychiatric Treatment*, **16**: 288–98.

HM Government (2000) *The NHS Plan: A Plan for Investment, a Plan for Reform*. HMSO.

Institute of Medicine (2001) *Crossing the Quality Chasm: A New Health System for the 21st Century*. National Academy Press.

International Alliance of Patients' Organizations (2007) *What is patient-centred healthcare? A review of definitions and principles, 2nd ed*. IAPO.

Johansson H, Eklund M (2003) Patients' opinion on what constitutes good psychiatric care. *Scandinavian Journal of Caring Sciences*, **17**: 339–46.

Kahneman D (2011) *Thinking Fast and Slow*. Allen Lane.

Kay Toombs S (1987) The meaning of illness: a phenomenological account of the different perspectives of physician and patient. *Journal of Medicine and Philosophy*, **12**: 219–40.

- Kitson A, Marshall A, Bassett K, Zeitz K (2013) What are the core elements of patient-centered care? A narrative review and synthesis of the literature from health policy medicine and nursing. *Journal of Advanced Nursing*, **69**: 4–15.
- Kleinman A (1988) *The Illness Narratives*. Suffering Healing and the Human Condition. Basic Books.
- Laine C, Davidoff F (1996) Patient-centered medicine: a professional evolution. *Journal of the American Medical Association*, **275**: 152–6.
- Lancet Psychiatry Commission (2017) The WPA–Lancet Psychiatry Commission on the Future of Psychiatry. *Lancet Psychiatry*, **4**: 775–818.
- Lawn S, Smith A, Hunter K (2008) Mental health peer support for hospital avoidance and early discharge: An Australian example of consumer driven and operated service. *Journal of Mental Health*, **17**: 498–508.
- Leamy M, Bird V, Le Boutillier C, Williams J, Slade M (2011) Conceptual framework for personal recovery in mental health: systematic review and narrative synthesis. *British Journal of Psychiatry*, **199**: 445–52.
- Lee EO, Emanuel EJ (2013) Shared decision making to improve care and reduce costs. *New England Journal of Medicine*, **368**: 6–8.
- Leng G, Clark CI, Brian K, Partridge G (2017) National commitment to shared decision making. *The only way to achieve truly person centred care*. *BMJ*, **359**: j4746.
- Leplege AF, Gzil M, Cammelli C, Lefevre B, Pachou, Ville I (2007) Person-centredness: Conceptual and historical perspectives. *Disability and Rehabilitation*, **29**: 1555–65.
- Little P, Everitt H, Williamson I, Warner G, Moore M, Gould C, *et al* (2001) Preferences of patients for patient centred approach to consultation in primary care: observational study. *BMJ*, **322**: 46872.
- Loh A, Simon D, Wills CE, Kriston L, Niebling W, Härter M (2006) The effects of a shared decision-making intervention in primary care of depression: a cluster-randomized controlled trial. *Patient Education and Counselling*, **67**: 324–32.
- Luxford K, Safran DG, Delbanco T (2011) Promoting patient-centered care: a qualitative study of facilitators and barriers in healthcare organizations with a reputation for improving the patient experience. *International Journal for Quality in Healthcare*, **23**: 510–15.
- McCabe R, John P, Dooley J, Healey P, Cushing ADK, *et al* (2016) Training to enhance psychiatrist communication with patients with psychosis (TEMPO): cluster randomised controlled trial. *British Journal of Psychiatry*, **209**: 517–24.
- McWhinney I (1989) The need for a transformed clinical method. In *Communicating with Medical Patients* (M Roter, D Stewart, eds). Sage.
- Mead N, Bower P (2000) Patient-centredness: A conceptual framework and review of the empirical literature. *Social Science and Medicine*, **51**: 1087–110.
- Mezzich J, Snaedal J, van Weel C, Heath I (2009) The international network for person-centered medicine: Background and first steps. *World Medical Journal*, **55**: 104–107.
- McAdams DP (2015) *The Art and Science of Personality Development*. Guilford Press.
- Min SY, Whitecraft J, Rothbard AB, Salzer MS (2007) Peer support for persons with co-occurring disorders and community tenure: A survival analysis. *Psychiatric Rehabilitation Journal*, **30**: 207–13.
- Moore L, Britten N, Lydahl D, Naldemirci O, Elam M, Wolf A (2016) Barriers and facilitators to the implementation of person-centred care in different healthcare contexts. *Scandinavian Journal of Caring Sciences*, doi: <http://dx.doi.org/10.1111/scs.12376>.
- Morgan A, Felton A, Fulford B, Kalathil J, Stacey G (2015) *Values and Ethics in Mental Health: An Exploration for Practice*. Palgrave.

- New Economics Foundation (2013) *Co-Production in Mental Health: A Literature Review*. New Economics Foundation.
- NHS England (2014) A narrative for person-centred coordinated care (<http://www.nationalvoices.org.uk/sites/default/files/public/publications/narrative-for-person-centred-coordinated-care.pdf>).
- Parsfield M, Morris D, Bola M, Knapp M, Park AL, Yoshioka M, et al (2015) *Community Capital*. The Value of Connected Communities. RSA.
- Parsons T (1951) *The Social System*. The Free Press.
- Perkins R, Meddings S, Williams S, Repper J (2018) *Recovery Colleges 10 Years On*. ImROC.
- Priebe S, McCabe R (2008) Therapeutic relationships in psychiatry: The basis of therapy or therapy in itself? *International Review of Psychiatry*, **20**: 521–6.
- Priebe S, Richardson M, Cooney M, Adedjei O, McCabe R (2011a) Does the therapeutic relationship predict outcomes of psychiatric treatment in patients with psychosis? A systematic review. *Psychotherapy and Psychosomatics*, **80**: 70–7.
- Priebe S, Dimic S, Wildgrube C, Jankovic J, Cushing A, McCabe R (2011b) *Good communication in psychiatry – a conceptual review*. *European Psychiatry*, **26**: 403–407.
- Quality Watch (Health Foundation and Nuffield Trust) (2016) Do people feel involved in decisions about their care? (<http://www.qualitywatch.org.uk/indicator/do-people-feel-involved-decisions-about-their-care>).
- Quirk A (2008) *Obstacles to shared decision making in psychiatric practice: findings from three observational studies* (DPhil thesis). School of Social Sciences (Sociology), Brunel University.
- Ramon S, Zisman-Ilani Y, Kaminskiy E (2017) Shared decision making in mental health. *Mental Health Review Journal*, **22**: 149–51.
- Richards V (2018) The importance of language in mental health care. *Lancet Psychiatry*, **5**: 460–1.
- Richards V, Lloyd K (2017) *Core Values for Psychiatrists* (College Report CR204). Royal College of Psychiatrists.
- Rippere V, Williams R (1985) *Wounded Healers: Mental Health Workers' Experiences of Depression*. Wiley.
- Roberts GA (1997) Prevention of burn-out. *Advances in Psychiatric Treatment*, **3**: 282–9.
- Roberts G (2000) Narrative and severe mental illness: what place do stories have in an evidence-based world? *Advances in Psychiatric Treatment*, **6**: 432–41.
- Roberts G (2011) 'Forensic service user': transitional identity or life sentence? *Advances in Psychiatric Treatment*, **17**: 188–90.
- Roberts G, Boardman J (2014) Becoming a 'recovery-oriented' practitioner: putting principles into practice. *Advances in Psychiatric Treatment*, **20**: 37–47.
- Roberts G, Dorkins E, Wooldridge J, Hewis E (2008) Detained – what's my choice? *Part 1: Discussion*. *Advances in Psychiatric Treatment*, **14**: 172–80.
- Rose D (2014) The mainstreaming of recovery. *Journal of Mental Health*, **23**: 217–18.
- Royal College of General Practitioners (2014) *An Inquiry into Patient Centred Care in the 21st Century: Implications for General Practice and Primary Care*. RCGP.
- Royal College of Physicians (2014) *Personalising Healthcare: The role of Shared Decision Making and Support for Self-Management*. RCP.
- Royal College of Physicians (2015) *Person-centred care – working with patients as partners* (webinar). (<https://www.rcplondon.ac.uk/news/person-centred-care-working-patients-partners-webinar>).

- Royal Colleges of Physicians of the UK (2018) *PACES examination format* (<https://www.mrcpuk.org/mrcpuk-examinations/paces/paces-examination-format>).
- Royal College of Psychiatrists (2009) *Good Psychiatric Practice, 3rd edn* (College Report CR154). RCPsych.
- Royal College of Psychiatrists (2013a) *Driving Quality Implementation in the Context of the Francis Report* (Occasional Paper OP92). RCPsych.
- Royal College of Psychiatrists (2013b) *Whole-Person Care: From Rhetoric to Reality Achieving Parity between Mental and Physical Health*. RCPsych.
- Royal College of Psychiatrists (2013c) *Recommendations for Psychiatrists on Spirituality and Religion* (Position Statement PS03). RCPsych.
- Royal College of Psychiatrists (2014) *Report of the Second Round of the National Audit of Schizophrenia (NAS) 2014*. Healthcare Quality Improvement Partnership.
- Royal College of Psychiatrists (2016) *A Competency Based Curriculum for Specialist Core Training in Psychiatry: Core Training in Psychiatry CT1 – CT3*. RCPsych.
- Royal College of Psychiatrists (2017) *Using Formulation in General Psychiatric Care: Good Practice* (Occasional Paper OP103). RCPsych.
- Sally G, Donaldson LJ (1998) Clinical governance and the drive for quality improvement in the new NHS in England. *BMJ*, **317**: 61.
- Sen A (2009) *The Idea of Justice*. Belknap Press.
- Shanafelt TD, Boone S, Tan L, Dyrbye LN, Sotile W, Satele D, *et al* (2012) Burnout and satisfaction with work–life balance among US physicians relative to the general US population. *Archives Internal Medicine*, **172**: 1377–85.
- Shepherd G, Boardman J, Slade M (2008) *Making Recovery a Reality*. Sainsbury Centre for Mental Health.
- Sidani S, Fox M (2014) Patient-centered care: clarification of its specific elements to facilitate interprofessional care. *Journal of Interprofessional Care*, **28**: 134–41.
- Slade M (2009) *Personal Recovery and Mental Illness: A Guide for Mental Health Professionals*. Cambridge University Press.
- Slade M (2017) Implementing shared decision making in routine mental healthcare. *World Psychiatry*, **16**: 146–53.
- South London and Maudsley NHS Foundation Trust, South West London and St George's Mental Health NHS Trust (2010) *Recovery is for All. Hope Agency and Opportunity in Psychiatry* (A Position Statement by Consultant Psychiatrists). SLAM/SWLSTG.
- Stead U, Morant N, Ramon S (2017) Shared decision-making in medication management: development of a training intervention. *BJPsych Bulletin*: 1–7 (doi: 10.1192/pb.bp.116.053819).
- Stewart M (2001) Towards a global definition of patient centred care. *BMJ*, **322**: 444–5.
- Stewart M, Brown J, Weston W, McWhinney I, McWilliam C, Freeman T (1995) *Patient-Centred Medicine: Transforming the Clinical Method*. Sage.
- Stockmann T (2015) The UK National Health Service Peer-Supported Open Dialogue Project [blog] (<https://tomstockmann.wordpress.com/2015/11/07/uk-peer-supported-open-dialogue-project/>).
- Thompson L, McCabe R (2012) The effect of clinician–patient alliance and communication on treatment adherence in mental healthcare: a systematic review. *BMC Psychiatry*, **12**: 87.
- Tuckett D, Boulton M, Olson C, Williams A (1985) *Meeting Between Experts: An Approach to Sharing Ideas in Medical Consultations*. Tavistock Publications.

- UK Supreme Court (2015) *Judgement: Montgomery (Appellant) v Lanarkshire Health Board (Respondent)* (Scotland) (https://www.supremecourt.uk/decided-cases/docs/UKSC_2013_0136_Judgment.pdf).
- van den Pol-Grevelink A, Jukema JS, Smits CH (2012) Person-centred care and job satisfaction of caregivers in nursing homes: a systematic review of the impact of different forms of person-centred care on various dimensions of job satisfaction. *International Journal of Geriatric Psychiatry*, **27**: 219–29.
- Wanless D (2002) *Securing our Future Health: Taking a Long-term View* (Final Report). HM Treasury.
- Webber M, Morris D, Howarth S, Fendt-Newlin M, Treacy S, McCrone P (2018) Effect of the connecting people intervention on social capital. *Research on Social Work Practice* (doi: 10.1177/1049731517753685).
- Webber M, Reidy H, Ansari D, Stevens M, Morris D (2015) Enhancing social networks: a qualitative study of health and social care practice in UK mental health services. *Health Social Care in the Community*, **23**: 180–9.
- Weindling P (2004) *Nazi Medicine and the Nuremberg Trials*. Palgrave.
- Welsh Government (2015) *Health and Care Standards*. NHS Wales.
- West M, Eckert R, Collins B, Chowla R (2017) *Caring to Change: How Compassionate Leadership can Stimulate Innovation in Healthcare*. The King's Fund.
- World Health Organization (2007) *People Centred Healthcare: A Policy Framework*. WHO Western Pacific Region.
- Zolnierok KBH, DiMatteo MR (2009) Physician communication and patient adherence to treatment: a meta-analysis. *Medical Care*, **47**: 826–34.

