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Barriers to Implementing Person-Centered Recovery Planning in Public Mental Health Organizations in Texas: Results from Nine Focus Groups

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Abstract Despite being an established practice in the disabilities service systems, person-centered planning is a relatively new practice in the behavioral health system. As a result, little is known about the barriers that mental health organizations face in implementing person-centered recovery planning (PCRP). To fill this gap, results are presented from a qualitative analysis of nine focus groups at three public mental health organizations in Texas that have been implementing PCRP for at least 2 years. Findings suggest that organizations experienced 12 distinct barriers to PCRP implementation which were categorized into the Consolidated Framework for Implementation Research domains of intervention characteristics, the outer setting, the inner setting, characteristics of individuals, and the implementation process. Half of these 12 barriers fell within the inner setting domain, suggesting that implementation efforts should be flexible and adaptable to organizational culture and context. One-quarter of the barriers fell into the domain of characteristics of individuals involved in the intervention, which further suggests implementation efforts should assess the impact that both staff and consumers have on implementation success.

Introduction

Person-centered care is one of the six aims of healthcare quality established by the Institute of Medicine (2001) and a large body of research links person-centered planning to better outcomes for individuals (Claes et al. 2010; Everson and Zhang 2000; Holburn et al. 2004; Parley 2001; Robertson et al. 2006; Sanderson et al. 2006; Stanhope et al. 2013; Tondora et al. 2014; Wigham et al. 2008) while greater individual engagement is linked to lower health care delivery costs (Dentzer 2013; Hibbard and Greene 2013; Hibbard et al. 2013). Person-centered recovery planning (PCRP) or person-centered care planning (PCCP) is a foundational element of recovery-oriented care (Tondora et al. 2012; Tondora et al. 2005). PCRP—defined as "a collaborative process between the person and his or her supporters (including the clinical practitioner) that results in the development and implementation of an action plan to assist the person in achieving his or her unique, personal goals along the journey of recovery" (Tondora et al. 2012, p. 411)—originated from the disability rights movement, but has more recently expanded to the behavioral health system. PCRP provides a framework for individuals to partner with mental health providers to select services that meet their needs in moving towards a life goal. In doing so, it responds to critiques of the system, particularly that people are expected to fit passively into existing services with no role in the organization or planning of their treatment (Dowling et al. 2007; Sanderson 2000).

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As a relatively new behavioral health initiative, however, most existing work focuses on the practical aspects of writing person-centered recovery plans (e.g., Adams and Grieder 2005; Tondora et al. 2014). Little research has empirically examined efforts to implement PCRP in the behavioral health system generally, or the barriers to implementing PCRP in the public mental health system, specifically. Although research on barriers to implementing person-centered planning with individuals with intellectual and developmental disabilities is somewhat more developed, it is unclear whether similar barriers are faced in the public mental health system.

To fill these gaps in knowledge, the current study utilizes an implementation science framework to present findings from analyses of nine focus groups at three public mental health organizations in Texas that have been implementing PCRP for at least 2 years to address the following question: What barriers do public mental health organizations face in implementing PCRP? In order to gain varied stakeholder perspectives, three separate focus groups were conducted at each organization: one focus group with leadership; one focus group with practitioners; and one focus group with peer specialists (i.e., individuals in recovery who are employed to share their experiences and assist others in recovery).

Background

At first blush, it might seem counter-intuitive to focus on barriers to implementing a relatively new behavioral health initiative, rather than focusing on strategies to successfully implement PCRP. There are, however, several important reasons to focus on barriers to PCRP implementation. First, at an organizational level, a recognition of barriers facilitates constructive change and is an essential aspect of collaboration and consensus-building (Holburn and Vietze 1999; Schalock 1997). When staff are able to participate in open discussions that allow them to voice their concerns and suggest solutions, they are more likely to support person-centered care (Holburn and Vietze 1999). Research that examines barriers that other public mental health organizations have faced in implementing PCRP can be used to structure and inform such discussions. Second, as researchers in the disabilities arena have noted, there may be substantial dangers in ignoring barriers to implementing person-centered planning: "there are considerable difficulties encountered in such planning systems and that if these difficulties go unaddressed, skepticism and resistance to PCP may ensue" (Robertson et al. 2007, p. 298). Third, implementing PCRP in the behavioral health system—which has long been characterized by a medical/illness paradigm that runs directly counter to a person-centered

approach (Tondora et al. 2005)—requires careful and well thought-out implementation plans (van Dam et al. 2008). A greater understanding of barriers to PCRP implementation that public mental health organizations have faced can and should be used to assess readiness and inform future program design and implementation efforts.

To guide the examination of barriers to PCRP the current study uses the Consolidated Framework for Implementation Research (CFIR; Damschroder et al. 2009) which offers a comprehensive conceptual scheme to assess context and progress when implementing an intervention in the field. The framework is considered a meta-theory in that it consolidates a number of concepts and domains from existing implementation science frameworks into five major domains, namely, characteristics of the intervention, the inner setting (i.e., features of the structural, political, and cultural contexts through which the implementation process will proceed), the outer setting (e.g., the economic, political, and social context that organizations reside within), characteristics of the individuals involved in the intervention, and characteristics of the implementation process (Damschroder et al. 2009).

Previous Research on Barriers to Person-Centered Care

Although no empirical research exists on barriers to implementing PCRP in the public mental health system, Tondora et al. (2005; 2012) note some possibilities based on their provision of consultative and systems transformation work with public mental health organizations. For example, Tondora et al. (2005) note the following institutional or system-level barriers: a medical/illness-based service paradigm; a lack of clarity about what PCRP is and looks like in action; direct care providers are overwhelmed by a constant stream of change mandates for which they receive little training or support (and are consequently resistant to PCRP); a lack of institutional resources; program leaders' attitudes and organizational climate; funding structures and documentation requirements; and a lack of training initiatives that include persons in recovery and their families to develop self-directed capacities. In addition to these institutional or system-level barriers, Tondora et al. (2012) also describe ten attitudinal concerns that individuals providing services frequently raise, including: PCRP devalues clinical expertise; PCRP is the responsibility of non-clinical practitioners; practitioners already provide person-centered care; the plan itself is not that important beyond accreditation and reimbursement purposes; individuals with serious mental illness often give up on life goals; PCRP contradicts evidence-based practices; clinical issues must be addressed before PCRP can commence; PCRP is time and labor intensive; PCRP is not

consistent with medical necessity and will not be reimbursed; and PCRP exposes clinicians to greater risk and liability. While Tondora et al. (2012) demonstrate that these concerns are erroneous, to the extent that they are widely held by service providers, they are barriers to successfully implementing PCRP.

Person-centered planning has been successfully implemented in the intellectual and developmental disabilities services systems for several decades (O'Brien and O'Brien 2002) and research from these implementation efforts suggest several individual- and institutional-level barriers or limitations to person-centered planning. In particular, this research points to the following individual-level barriers: the difficulty of serving some individuals; family and other natural supports participating in the planning process (who may have unrealistic expectations) (Everson and Zhang 2000; O'Brien and Lovett 1992; Rasheed et al. 2006); and unhelpful service providers (O'Brien and Lovett 1992; Rasheed et al. 2006). In terms of institutional-level barriers, research points to the following factors: service culture based on the medical model; resource constraints; rigid funding structures; staff turnover; a lack of staff training and service management experience; inadequate supervision (Dowling et al. 2007); limited choices due to the fact that funds are tied to programs rather than individuals; a lack of advocacy training for individuals and families (Anderson and Factor 1993; Rasheed et al. 2006; van Dam et al. 2008); high caseloads and a lack of time (Anderson and Factor 1993; Parley 2001; Rasheed et al. 2006); staff shortages; and a lack of supporting documentation for person-centered planning (Parley 2001).

Despite this important research in the intellectual and developmental disabilities service systems, it remains unclear if similar barriers exist to person-centered planning in the public mental health system. Further, although Tondora et al. (2005; 2012) provide some indication of the factors that mental health organizations experience in attempting to implement PCRP, it remains unclear if these are the most salient barriers around PCRP implementation for service providers and moreover, if perceived barriers differ among various service providers (e.g., peer specialists versus practitioners). Assessing the perspectives of various stakeholders is important from a CFIR perspective for evaluating the effectiveness of implementation efforts (Damschroder et al. 2009) and, thus, for gaining a more complete understanding of barriers to PCRP implementation because different stakeholders bring distinctive clinical perspectives and experiences that researchers might overlook (Aarons et al. 2009). Therefore, to fill these gaps this paper provides an empirical examination of barriers to implementing PCRP in public mental health organizations by presenting the perspectives of three distinct groups of mental health service providers: leadership (i.e., individuals who are particularly instrumental in implementing PCRP), practitioners (primarily case managers at the community centers and treatment team members at a state hospital), and peer specialists.

PCRP Implementation Efforts in Texas

Four public mental health organizations in the state of Texas participated in a PCRP initiative, funded by the Texas Department of State Health Services (DSHS). As of 2016, these are the only four organizations in the state to have participated in this particular initiative. These organizations are all funded by DSHS. Two organizations (one state psychiatric hospital and one community mental health center [CMHC]) began participating in state fiscal year 2012; the remaining two organizations (both CMHCs) began participating the following year in state fiscal year 2013. PCRP implementation efforts at the hospital were directed at units serving adults and adolescents. Implementation efforts at the three CMHCs were directed at teams serving Level of Care 3 (LOC3) individuals, who are described as "individuals who enter the system of care with moderate to severe levels of need …[and] require intensive rehabilitation to increase community tenure, establish support networks, increase community awareness, and develop coping strategies in order to function effectively in their social environment (family, peers, school)" (Texas Department of State Health Services 2015, p. 16).

The state hospital is located in an urban city in Texas and covers a catchment area of 38 counties, admitting approximately 1500 individuals a year and maintaining an average daily client population of 257 (Texas Department of State Health Services 2016). The state hospital is comprised of 14 units serving adults and adolescents with serious mental illness (including individuals on forensic commitments), substance use issues, and/or developmental disorders. The CMHC that began participating in state fiscal year 2012 operates in eight rural and urban counties and serves approximately 5200 adults and 1600 children and adolescents annually (Texas Department of State Health Services 2016). They provide services to adults with serious mental illness and chemical dependency; children and adolescents with serious mental illness, chemical dependency, autism or developmental disorders; and persons with intellectual disabilities.

Of the two CMHCs that began participating in 2013, one CMHC operates 16 clinics in one urban county, including a newly formed integrated care clinic. Annually, this CMHC serves approximately 8500 adults and 2300 children who experience persistent mental illness, developmental disabilities, and/or substance use (Texas Department of State Health Services 2016). The second CMHC that began participating in 2013 operates 10 clinics that serve 18

largely rural counties. Annually, this CMHC serves approximately 4300 adults and 1000 children who experience persistent mental illness, developmental disabilities, and/or substance use issues (Texas Department of State Health Services 2016).

The aim of this initiative was to facilitate implementation of the practice of person-centered recovery planning at each of the sites. Participation was intensive with organizations receiving training (Introduction to PCRP, Two Day Skills-Based Training, Supervisor's Training, Coach Workshop, and Training for PCRP Trainers), expert coaching (bi-monthly calls to review and offer feedback on a plan written by a practitioner), and technical assistance (monthly calls with a leadership team from each site and individualized discipline-specific technical assistance with peer specialists and psychiatrists). In the first 2 years, coaching was provided by three experts in the field; in the third year, an additional coach replaced one of the former three coaches and the initiative began utilizing a "Coach-the-Coach" model in which the experts provided feedback to organization-based coaches who were providing feedback to practitioners; in the fourth year, the organization-based trained coaches assumed all coaching duties with no assistance from external experts.

Data and Methods

Data Collection

In the fourth year, all four organizations were invited to participate in focus groups to reflect on organizational efforts to implement PCRP over the past 2 or 3 years. All but one organization (the CMHC that began participating in state fiscal year 2012) accepted the invitation to participate. This organization declined to participate due to uncertainty regarding future PCRP implementation efforts. Researchers conducted nine focus groups with 71 staff members at the three public mental health provider organizations in fall 2014. Qualitative methods were deemed appropriate for this research given the exploratory nature of the topic. At each organization, focus groups were conducted with (1) leadership (i.e., individuals who had been particularly instrumental in implementing PCRP and served in a leadership position at the organization) (2) practitioners at the community centers (e.g., case managers, rehabilitation specialists, or qualified mental health practitioners) and treatment team members at the state hospital (e.g., social workers, psychologists, rehabilitation specialists, nurses, and treatment plan coordinators), and (3) peer specialists. See Table 1 for a description of how many participants were in each focus group.

Prior to the focus groups, researchers emailed a contact person at each organization to explain the purpose of and ask for their assistance in coordinating focus group participation. In an attempt to engage in purposive sampling, a list of suggested attendees was sent to the contact person at each site based on knowledge of who had actively participated in PCRP implementation in order to gain a wide-variety of information-rich respondents (Palinkas et al. 2015). For peer specialist groups, all peer specialists at the organization were invited to participate and 89 % of peer specialist participants had received PCRP training while 26 % had received PCRP coaching. Practitioners who had participated in PCRP coaching and/or training were invited to participate and 100 % of participants met this requirement. Suggested attendees for the leadership focus groups were more specific and included individuals known to the researchers to have been particularly instrumental in PCRP implementation. At the state hospital, we suggested 17 individuals and 8 of those attended while 9 did not (although an additional 2 individuals did participate). At one community center 11 leadership individuals were invited to participate and 8 of those 11 did so. At the second community center, 11 leadership individuals were invited to participate and 7 did so while 4 did not (although an additional 4 individuals did participate). These lists were meant to be suggestive; for example, we did not expect all 17 leadership invitees from the state hospital to be able to attend. High workloads and turnover at public mental health organizations also meant that our suggested attendees did not match perfectly with actual attendees. Researchers requested that organizations limit focus groups to 6–12 participants (ideally 8–10) based on best practices (Krueger and Casey 2008); however, actual group size varied between 3 and 13 participants. In terms of demographics, focus group participants were predominately female (70 %) and white (74.6 %), followed by Hispanic (11.3 %), Asian American (8.5 %), and black (5.6 %).

Focus groups were jointly moderated by two researchers. For each question, one researcher was responsible for moderating the group while the other researcher captured key points on a flip chart. To facilitate conversation, focus group participants were asked to first write down their responses to Questions 1, 2, 4, and 5 (see below) before sharing their responses with the group. Researchers decided to limit prompting unless discussions got off topic, one person dominated the group, if conversations hit a lull or if clarifying questions were necessary to understand what was being said. Focus groups lasted between one and one and half hours and, with participants' permission, were recorded with a digital recorder and later transcribed. This project was approved by the Institutional Review Board at The University of Texas at Austin and participants received no financial compensation for their participation.

Table 1 Number of focus group participants

	State hospital	Community center 1	Community center 2	Total
Leadership	10	11	8	29
Peer specialist	12	4	3	19
Practitioner	13	4	6	23
Total	35	19	17	71

Focus group questions were developed by the researchers to gather data from participants on three PCRP implementation areas: PCRP implementation accomplishments, PCRP implementation facilitators, and PCRP implementation barriers. Focus group participants were asked to reflect on: (1) accomplishments related to PCRP implementation; (2) factors contributing to those accomplishments; (3) resources they found helpful in implementing PCRP; (4) barriers to implementing PCRP; (5) factors contributing to those barriers; and (6) future needs related to PCRP implementation. This paper focuses primarily on barriers to implementing PCRP (items 4 and 5), although in the "Discussion" section we provide recommendations that were informed by these data (item 6).

Data Analysis

Analysis was guided by a grounded theory approach to qualitative data analysis whereby codes emerged directly from the data and were not pre-determined prior to analysis (Charmaz 2006) and was completed using NVIVO qualitative data analysis software Version 10 (QSR International 2012). Codes were developed iteratively and constantly refined—that is some codes were merged while others were disaggregated as more data were analyzed. All analytic decisions were recorded in analytic memos in line with best practices for establishing credibility and validity in qualitative research (Groenewald 2008). First, one researcher engaged in the process of "line-by-line open coding" by reading through all transcripts line-by-line to develop initial codes (Charmaz 2006). For example, the initial code "consumers are not invested in PCRP because they don't trust the traditional system" was developed directly from a transcript that read: "Sometimes the clients just aren't as invested because they don't believe we're invested and …it's gonna take a while…for them to understand that …we've switched over to a client-centered model instead of being so medical-centered." Once an initial coding scheme was developed by one researcher, in the process of "axial coding" (Charmaz 2006) two researchers independently categorized the codes to develop categories. For example, in this process the codes "consumers are not invested in PCRP because they don't trust the traditional system" and "consumers are stunted or frustrated because of the traditional system" were combined into the category

of "Consumer Skepticism/Lack of Engagement." The researchers then met and refined the categories until consensus was reached—a process in line with best practices for establishing inter-coder reliability (Campbell et al. 2013). Further, in order to establish theoretical saturation, categories were refined until no new categories emerged and existing categories had sufficient data (Charmaz 2006; Padgett 2008). This coding scheme was recorded in a shared codebook with precise and concrete code definitions. Finally, in a process called "theoretical coding," we developed theoretical propositions about what perceived barriers exist to PCRP implementation in the public mental health system and found that perceived barriers differ across organizations and stakeholder groups (i.e., practitioner, leadership, or peer specialist) (Charmaz 2006). Although these theoretical propositions emerged directly from the data, we interpret them through the lens of CFIR domains.

Findings

Qualitative analyses revealed 104 unique initial codes about barriers to PCRP implementation. These initial codes were then developed into 12 categories, which we present in relation to the CFIR domains of intervention, outer setting, inner setting, characteristics of individuals, and process. Tables 2, 3, 4, 5 and 6 present CFIR domains and corresponding categories and codes within each domain. Within the CFIR domain of intervention characteristics the category of lack of clarity in applying PCRP to different consumers emerged (6 unique codes). Within the CFIR domain of the outer setting the category of state and policy barriers emerged (6 unique codes). Within the CFIR domain of the inner setting the following categories emerged: time and resource barriers (15 unique codes), non-collaborative planning (6 unique codes), software and plan structure barriers (7 unique codes), leadership barriers (6 unique codes), change is hard (10 unique codes), and dissemination barriers (10 unique codes). Within the CFIR domain of characteristics of individuals the following categories emerged: consumer skepticism/lack of engagement (8 unique codes), lack of staff buy-in (8 unique codes), and staff lack knowledge, training, and confidence (16 unique codes). Lastly, within the CFIR domain of process the

Table 2 CFIR domain 1: intervention characteristics

Category	Codes
Lack of clarity in applying PCRP to different consumers	A lack of clarity about how to apply PCRP to consumers with a limited ability to communicate
	A lack of clarity about how to apply PCRP consumers experiencing psychotic symptoms
	Children and adolescents are not involved in their recovery planning
	PCRP does not address the needs of consumers who require fewer services
	Difficulty of implementing interventions in an acute unit
	Difficulty creating dynamic plans for consumers who have been readmitted to the hospital multiple times

Table 3 CFIR domain 2: the outer setting

Category	Codes
State and policy barriers	State policymakers do not understand or value PCRP
	Medicaid does not reimburse for PCRP
	PCRP is not considered an "encounter" by the Texas Department of State Health Services unless it is called an "engagement"
	Organizations are not able to bill for peer support or other services until a treatment plan is in place
	There is a lack of funding for peer specialist positions
	Mental health funding is dismal in the state

category of problems with coaching, training, and technical assistance emerged (6 unique codes). It is important to note that these categories could fall within multiple domains as the boundaries between CFIR domains are often precarious and contextual (Damschroder et al. 2009).

Domain 1: Intervention Characteristics

The domain intervention characteristics includes one category—lack of clarity in applying PCRP to different consumers (see Table 2). One of the sub-domains within intervention characteristics is adaptability, which refers to an intervention's ability to be modified to the organization's specific needs. A lack of clarity on how to apply PCRP to different consumers suggests that organizations need more direction on how to adapt PCRP to populations with varying needs.

Lack of Clarity in Applying PCRP to Different Consumers

Leadership, peer specialist, and practitioner focus group participants at two organizations (the state hospital and one community center) noted that they lacked knowledge or clarity about how to implement PCRP with different consumers. This barrier appeared to be particularly salient for practitioners, with most of the unique barriers within this theme coming from focus groups with practitioners (Table 7 presents which categories were particularly

salient for different stakeholders). For example, practitioners at one organization discussed the challenges of implementing PCRP with consumers who have difficulty communicating or with those who are experiencing psychotic symptoms:

Practitioner 1: Unless they can't talk…like our unit…in which case [laughter]. I feel like sometimes the word-smithing involved to meet the expectations of coaching…you're making stuff up 'cause you don't know…
Practitioner 2: Very similar to dealing with psychotic patients… they're actively hallucinating and you're asking them 'What is your life goal?'
Practitioner 1: At least they can say *something*.
Practitioner 3: But it's going to be outlandish…like they want a tiger.
Practitioner 1: I would be very excited about wanting a tiger [laughter from a few]. I could then at least get them a stuffed tiger. But that's I think one of the things was really lacking is that there was no definitive way to adapt that to that population and so sometimes having them in meetings is actually a disservice because it isn't respecting that that isn't an appropriate place for them to be. It can be really confusing.

Similarly, practitioners at two organizations discussed the difficulty of implementing PCRP in an acute unit or in a crisis situation. For example one practitioner explained:

Table 4 CFIR domain 3: the inner setting

Category	Codes
Time and resource barriers	Difficulty coordinating treatment team members' schedules for planning and coaching
	Difficulty finding the time to complete DLA 20s [the Daily Living Activities functional assessment] with consumers
	Not having a printer in the field
	High caseloads/workloads
	Lack of resources make it difficult to implement interventions
	Lack of resources
	Turnover and having to retrain staff on PCRP
	Lack of time
	PCRP is more time-consuming than old treatment plans
	Not enough PCRP coaches/coaches are stretched too thin
	Fatigue
	Key positions are vacant
	Competing initiatives
	Perception that PCRP is time-consuming
	A lack of efficiency in gathering information from consumers
Non-collaborative planning	Consumers are often not involved in the planning process
	Practitioners often lack rapport with consumers
	Peer specialists are not as involved in the planning process as they could be
	The difficulty of working together as a multi-disciplinary team
	Treatment team often isn't collaborative or cooperative
	[Hospital] units are not asked for their input or feedback
Software and plan structure barriers	Electronic Health Record (EHR) software
	Drop-down menu in EHR software doesn't allow practitioners to individualize strengths
	EHR software prevents practitioners from seeing which objective progress notes link to
	Treatment plan information is not easily accessible in EHR software
	Staff find revisions and reviews difficult because of EHR software
	Plans are unreadable and not user-friendly
	Consumers often do not want a copy of their plan because they are not user-friendly and reveal personal information
Leadership barriers	Leadership overestimate or exaggerate the extent to which the organization is actually person-centered
	Leadership overcomplicate PCRP
	Leadership fail to hold staff accountable to being person-centered
	Lack of support from leadership
	Leadership overemphasize the person-centered plan as an indicator of being person-centered
	Direct care staff [at the hospital] receive conflicting messages about their role
Change is hard	A punitive, command-and-control model has historically been dominant
	It is difficult to maintain a sustained vision over time/stagnation around roll-out
	A culture of autonomy among physicians
	Falling back into old model
	Difficulty of changing a large, complex organization
	Medical model difficult to shift away from, particularly for older practitioners
	Doctors do not let peer specialists come to appointments with consumers
	Case managers often do not invite peer specialists to planning meetings
	A failure to document if plans are being implemented
	Plans are not revised or looked at after they are written

Table 4 continued

Category	Codes
Dissemination barriers	Dissemination is difficult and time-consuming
	Dissemination across [hospital] shifts is difficult
	Dissemination varies across caseworkers
	PCRP is difficult to implement in community Level of Care 1
	Difficulty maintaining continuity of care
	Intake form does not align with PCRP
	Difficulty getting person-centered recovery plan information to front-line staff
	[Hospital] direct care staff are usually not involved in the PCRP process
	Translating recovery concepts to the ground floor is difficult
	PCRP is not prioritized across disciplines

Table 5 CFIR domain 4: characteristics of individuals

Category	Codes
Consumer skepticism/lack of engagement	Consumers are stunted or frustrated because of the traditional system
	Consumers are not invested in PCRP because they don't trust the traditional system
	Paradigm shift to recovery-oriented care is difficult for consumers because of their previous experiences in the traditional system
	Some consumers do not believe that they can recover
	Practitioners believe consumers have unrealistic goals or their goals are not meaningful
	Consumers may not identify barriers
	Consumers may not be ready to open up yet
	Some consumers are not engaged
Lack of staff buy-in	Lack of staff buy-in
	Lack of medical staff buy-in
	Staff resentment about training and coaching
	Staff resistance to change
	Staff apathy
	Staff disrespect and make fun of consumers
	"It's not my job" barrier
	Consumers continue to lack access to their social workers
Staff lack knowledge, training, and confidence	Admissions/intake staff are not trained on PCRP
	Clinicians lack confidence
	Trainers lack confidence
	Confusion and lack of training on how to bill for peer support
	Clinic directors believe that they are at the same level of knowledge in terms of PCRP as staff
	Caseworkers fear (of receiving negative consultant feedback on) technical assistance calls
	Staff lack cultural competency
	Staff find learning specific PCRP terminology difficult
	Understanding recovery-oriented language is difficult for clinicians
	Staff lack an understanding of how to document or establish a process for PCRP
	PCRP is perceived as being harder and less clear and comfortable than traditional treatment planning
	Out in the field caseworkers are on their own without team or supervisor support
	Staff struggle to integrate the narrative summary and hypothesis
	Staff lack clarity on how to make objectives achievable reasonable
	Staff lack clarity on how to link goals and specific objectives
	Collaborative documentation is difficult to implement in groups due to a lack of training

Table 6 CFIR domain 5: process

Category	Codes
Problems with coaching, training, and technical assistance	Coaches at the organizational level do not do direct care and were selected without much thought
	Coaches do not provide concrete feedback
	Coaches are too critical
	Practitioners receive conflicting messages about how to write PCRPs
	Purpose of technical assistance calls are unclear
	Coaches often suggest that practitioners use clinical jargon that alters the meaning of consumers' goals, ultimately reducing the person-centeredness of plans

Table 7 Categories important to different stakeholder groups

Category	Leadership	Practitioner	Peer specialist
Lack of clarity in applying PCRP to different consumers		X	
State and policy barriers	X		X
Time and resource barriers	X	X	
Non-collaborative planning		X	
Software and plan structure barriers	X	X	
Leadership barriers		X	X
Change is hard	X		X
Dissemination barriers	X	X	X
Consumer skepticism/lack of engagement		X	
Lack of staff buy-in		X	X
Staff lack knowledge, training, and confidence	X	X	X
Problems with coaching, training, and TA		X	

As a [Mobile Crisis Outreach Team] person we're striving to do more treatment plans for our transitional folks and I have a hard time doing the PCRP with that population because we're so short-term. We only keep consumers about 3 months, so it's really hard to…I wish there was…maybe more of a streamlined version for crisis or even it would work better for crisis and probably the lower level of care.

Domain 2: The Outer Setting

The domain the outer setting includes one category—state and policy barriers (see Table 3). A sub-domain within the outer setting is external policy and incentives to implement an intervention. State and policy barriers suggest that particular external policies and structures could be more supportive of PCRP implementation.

State and Policy Barriers

Leadership and peer specialist focus group participants at all three organizations discussed state-level barriers. For

example, a peer specialist participant explained that consumers must have a PCRP in place before peer services can be billed:

Well especially when somebody's new, like we may engage them in peer support, they don't have a PCRP done yet, but they're coming to peer [support] group because we've engaged them to come, but we can't bill because they don't have a treatment plan and all that yet.

Similarly, a leadership participant described PCRP as not being a reimbursable service:

We don't get reimbursement for recovery planning from Medicaid. And kinda tied along with it, is that it's not considered an encounter by DSHS unless we call it engagement or something. Which I think makes it difficult for staff because they get mixed messages at times about, 'This is really important, you need to invest the time upfront in doing this' and yet their director is also always saying 'But you gotta provide services that we get paid for. That doesn't count unless you call it something else. It doesn't count towards an encounter.' So I guess a barrier is

the Medicaid rule and how they [DSHS] perceive maybe this activity, the time spent.

Domain 3: The Inner Setting

Six of the twelve categories fell into the domain of the inner setting, suggesting organizational characteristics are particularly salient to focus group respondents (see Table 4).

Time and Resource Barriers

Focus group participants at all three organizations discussed the difficulty of implementing PCRP given a lack of time and resources; this was particularly common with leadership and practitioner participants, compared to peer specialist participants who only discussed one of these barriers. For example, one leadership participant noted:

I put time and resources [as a barrier]. And the cause was just we had a number of projects and changes going on all at once. We really had to work…I think we did a pretty good job of keeping this at the forefront but there were a lot of things that wanted to get in the way.

Similarly, practitioners discussed the difficulty of implementing individualized interventions due to a lack of resources in the hospital setting:

Practitioner 1: What we offer is sort of to everybody that comes in with that…my intervention is going to have some standard-ness to that because…that is the standard that we offer here, you know what I'm saying? [laughs] Practitioner 2: And even in Adult Psychiatric Services, we have less variety of programming than Specialty [Services] has or Child and Adolescent Psychiatric Services has…
Practitioner 1: Okay. We do with less, yeah.
Practitioner 2: It would be great…I actually could come up with lots of really incredible objectives that would be much more helpful, but we can't even do it.
Practitioner 1: Can't even do it. Yeah, then I go write a discharge summary and it's like, 'Oh, we didn't do any of the interventions cause we couldn't.'

Non-Collaborative Planning

Practitioner and peer specialist focus group participants at two organizations also noted that the PCRP process was often not collaborative, with this concern particularly salient among practitioners. For example, a hospital practitioner discussed the difficulty of collaboratively working together as a multi-disciplinary treatment team:

I think that when a team actually functions as a team it works out you know, I shouldn't have to write a social work intervention, social work shouldn't have to write one of mine…but it doesn't always happen that way, right? But I think when it does and you have a very cooperative and collaborative team environment that that really helps the process. Unfortunately, that seems to be rare here from what I've seen. But I think one of the barriers is still team dynamics and kind of shifting away from…you know before I was here it was primarily the psychologists' role to write the treatment plans from start to finish. And then it was just the treatment plan coordinator's and so I still think that there's some of this…'not my job description' kind of thing…so I think that shifting some of that so that people are really acting as a team and sharing the responsibility for that document and that meeting and kind of this whole process I think is a really big thing that's going to continue to need to be worked on.

Similarly, a peer specialist discussed the fact that peer specialists are not as involved in the planning process as they could be:

We have…two peers who are attempting to engage clients prior to their person-centered care plan new review…I was hoping that this was going to really take off and their schedules would fill…and this would be a really meaningful prelude to the clinicians' 'Hurry up, let's get this done.' But we've had so far only limited success. And…I haven't quite figured out what the factors are. Is it the scheduling? The support staff? The peer staff themselves ability to engage? Their belief in the effectiveness of it…? I haven't quite figured that out but I've been disappointed by it.

Software and Plan Structure Barriers

Another set of barriers around implementing PCRP that participants reported were plan software and structure issues. These barriers more commonly emerged in focus groups with practitioners and leadership as well as participants from CMHCs compared to the state hospital. For example, practitioners from a CMHC discussed some of the difficulty they experienced working with the EHR software:

Practitioner 1: With the system you can't toggle back and forth [between the original plan and the plan being reviewed and updated] to see like 'Ok, well this person did this on this plan.' Once anything is open, that's all you have. You can't pull up anything.

Practitioner 2: When you do the review you almost have to write down all the goals and then go into it 'cause you don't know what each goal is, to refer back.

Researcher: So when you're doing your 90 day review you don't see the plan that you originally wrote that you're reviewing?

Practitioner 3: No! [laughter from all] You have to copy and paste each section.

Practitioner 4: I'll be honest, what I normally do is I just do a revision instead of a review cause when you do a revision it starts the clock all over again for how long you have to do a review.

Similarly, practitioners at the same organization described why consumers often do not want a copy of their PCRP:

Practitioner 1: And then the treatment plans we print out are like completely unintelligible to our clients so it'd be awesome if we could just print out like 'Here's your goal. Here are the steps you're going to take to do it.'

Practitioner 2: Especially because a lot of my clients choose not to get a copy of their treatment plan because they live in situations where chances are they're gonna lose it or someone's going to find it and it's…relatively personal information on there. Like they don't want people knowing about that sort of stuff. And so if there's a way…for them to have access to a form that was less revealing, more basic…that would be nice for them and a way for us to ensure that they have a physical copy of it.

Leadership Barriers

Focus group participants also discussed several barriers related to organizational leadership. These concerns were more salient for practitioner and peer specialist focus group participants at the state hospital than they were for other groups. For example, hospital practitioners discussed the fact that leadership does not hold staff accountable for being person-centered:

Practitioner 1: The hospital is making this shift…to person-centered…and I can only speak for the [discipline name redacted] department…within our department it is presented as 'This is the direction the hospital is going in. This is now part of your job.' I do not get the impression across other departments that it is presented as 'This is now part of your job. This is an expectation of your job.'

Practitioner 2: And even when it is, there's no follow-up.

Practitioner 1: Accountability.

Practitioner 2: Exactly. Like if I see someone being clearly disrespectful [to a consumer] on my unit, there's no follow-up.

Leadership participants at a CMHC also discussed the lack of support for PCRP from other key leadership in the organization:

Leadership 1: Just not enough support from key leadership. We had some, it wasn't like when we started…

Leadership 2: We certainly have more than we used to [laughs]. This is great!

Leadership 1: Yeah. Oh yeah! But especially getting started it was really just [Level of Care] 3, you know? And other people were offered in and declined. And even within that upper leadership was supposed to be more involved and wasn't…I don't really know the reasons for that. So with that…dissemination then has been a separate process when it's…supposed to just go hand-in-hand…I think that's just kind of made the dissemination process all that more difficult and lengthy.

Change is Hard

Leadership, peer, and practitioner participants at all three organizations also described several barriers related to the difficulty of implementing and sustaining cultural and organizational change. These concerns seemed to be particularly salient for leadership and peer specialist participants as well as participants from the state hospital. For example, a leadership participant from the state hospital noted:

It's just like the reality of having a sustained push in a public institution for several years. You know we had our particular challenges that I think we worked through wonderfully but I think that is a huge barrier. I mean if you look at how do you keep retention? And, you know, being able to have a continued vision for that amount of time. I think all of our challenges become a barrier to being able to do that.

A leadership participant at a CMHC shared a similar sentiment:

One of the things I talked about is just sustaining this 'cause I think there is an opportunity to get stagnant in this, to go back to the thinking of 'Ok, now we have this. We know what we're doing.' And this is really kind of an ongoing learning process, right?

Dissemination Barriers

Leadership, peer, and practitioner participants at all three organizations also discussed barriers related to disseminating PCRP across the organization. These barriers appeared to be equally salient across stakeholder and organizational groups.

For example, hospital practitioners discussed the difficulty of involving direct care staff in the PCRP process:

Practitioner 1: Because a lot of the times we have to do a lot direct care interventions on my unit, being the population that we have. And so if they [nursing staff] don't know what that is because we weren't able to get any nursing at the meeting well then I can write something that maybe all of them disagree with and won't do or that they don't think it's their job to do or that just isn't plausible to do, so.
Researcher: Do the direct care staff get invited to the planning meetings?
Practitioner 1: …it's not so much whether or not they're invited, it's whether or not they have enough staff to be able to come.
Practitioner 2: When it comes to nursing and the psychiatric nurse assistants (PNAs) it really does kind of depend on are they short staffed, is the unit having a complete meltdown kind of thing? So…they come when they can.
Practitioner 3: …obviously immediate safety of the patients is…it's difficult to pull like specific staff…usually somebody has a preference…we've been able to do it in the past but …we don't always get a PNA into the meeting which would be good…so yeah, getting people to be able to attend is a very difficult thing.

Similarly, several CMHC focus group participants discussed the difficulty of implementing PCRP in Level of Care 1, which is the lowest level of care (primarily medication management) with minimum monthly service hours and high caseloads. For example, one leadership participant noted:

In Level of Care 1, clients may not get seen quite as often or there might be more time constraints so I think it can be more challenging to keep the plan current or to keep it relevant when each time people come in maybe there's other assessments to do and it's hard to maybe pay as much attention or keep the client…keep everybody accountable to what the goal was or…just due to high caseloads and time constraints.

Domain 4: Characteristics of Individuals

Three of the twelve categories fell into the domain of the characteristics of individuals, suggesting focus group respondents are particularly aware of staff and consumer barriers to PCRP implementation (see Table 5).

Consumer Skepticism/Lack of Engagement

Barriers related to consumer skepticism or a lack of engagement emerged in all three organizations'

practitioner focus groups, but did not emerge in any of the focus groups with leadership or peer specialists. For example, one practitioner explained:

Sometimes the clients just aren't as invested because they don't believe we're invested and …it's gonna take a while…for them to understand that …we've switched over to a client-centered model instead of being so medical-centered. But they've had all of those years of it being one way and it's hard for them to believe just some random stranger is willing to come out of nowhere and focus on them so I think sometimes they just really don't want to work on stuff or have the energy to work on things' cause they just maybe don't trust us as the system anymore.

Similarly, another practitioner noted:

The whole paradigm shift of 'you matter and we're going to listen to…what you have to say,' it's just foreign to our clients….like the PCCP is great but it's like for so long the system has handicapped people to not be able to make those decisions.

While some of the consumer-related barriers that practitioners discussed stemmed from the ways that a medical or traditional approach to mental health care had limited consumers, other consumer-related barriers placed the onus on consumers themselves—suggesting practitioners may benefit from additional PCRP training, coaching, and clinical supervision. For example, practitioners in one focus group discussed the difficulty of writing a plan for an individual with "unrealistic goals":

Practitioner 1: One more thing and I know that y'all have heard this too…writing the treatment plan for somebody that has a goal that is obviously…I don't want to…
Practitioner 2: It's not realistic.
Practitioner 1: Not realistic. I didn't want to use that word, but that's it. And there are ways to go around and to teach towards that…I get that. But then again how do you implement that in the plan…and blah…it goes on and on. I'm gonna be there a long, long time getting that done.
Practitioner 3: I agree. I agree.
Practitioner 4: Yeah I had one a couple weeks ago that said her goal was to be one with Jesus and it's just kinda like, 'Well is that more community service? Is that more..?' It's difficult sometimes to try to…fish I guess, for the perfect goal for them, so.

Lack of Staff Buy-in

Leadership, peer specialist, and practitioner focus group participants at all three organizations noted barriers related

to a lack of staff buy-in. This barrier seemed to be most salient for peer specialists and practitioners and less salient for leadership focus group participants and this theme was particularly salient for participants from the state hospital, as indicated by the number of unique barriers concerning this theme within each group. For example, a peer specialist at the state hospital expressed the difficulty of getting other staff to buy-into the client's role in the planning process:

> When…the powers that be are at a treatment team meeting…they [the consumer] get the dog and pony show…everybody's acting all nice and then I've seen the client leave that and break down crying, ok? Because the [practitioners] were laughing and stuff like that …all of them just joking around [sarcastic tone] 'Oh, he's in this stage.' 'Oh no, haha, he's in this stage.' You know, I'm tired of them laughing at the client and after the client leaves. Our treatment team coordinator told us that she could care less about PCRP.

Across all organizations, focus group participants were particularly likely to note a lack of buy-in from medical staff, as noted by leadership participants at one organization:

> Leadership 1: I think one thing that is still kind of a barrier too is that like case managers and rehab specialists and everyone use it but I think as far as the medical side…like more of the psychiatrists, the nurses may not have as deep of an understanding, or any understanding maybe about the actual plans or goals that are in place or know how to look at them or kind of understand maybe what that person is working on…
> Leadership 2: I would agree with that…some aspects of the organization…have more buy-in than others…I feel like it's usually clinicians who do the heavy lifting…and I don't know how we make that buy-in happen, but that would certainly be helpful.

Staff Lack Knowledge, Training, and Confidence

Another set of barriers concerned staff's lack of knowledge or training around PCRP or their confidence in implementing PCRP. Leadership, peer specialist, and practitioner participants at all three organizations discussed barriers related to a lack of staff knowledge and confidence and this barrier seemed to be equally salient to different stakeholders but was less salient for participants at the state hospital. For example, one peer specialist explained how low levels of organizational support for PCRP led to low levels of confidence:

> And actually I hear a lot from people that work here that they're not supported. They don't feel comfortable or confident. They don't feel trained…and this is from clinicians all around. And I think that when people feel supported, they're able to present that better.

Similarly, leadership participants at one organization noted that PCRP is less comfortable or more challenging than a traditional treatment planning approach for some staff:

> Leadership 1: I also think that this requires work… I think the med[ication] stabilization model…is a little bit easier. Like, it is just easier for people to do…I mean, that's a challenge. This is harder for people, the expectations are harder.
> Leadership 2: Well more work up front, it's harder.
> Leadership 1: Well really we're trying to sell it when we're saying that because honestly it just requires people to do their jobs in a real nuanced way…you know the relational focus. But I think when people have been coming and the expectation was lower you don't have to do as much work.
> Leadership 3: Well the perception is it's easier…to do it the old way.
> Leadership 1: Well you know it's like if you go all the way back to how easy it was then to…just drop down libraries [in the electronic health record]…you get into a routine and that's also comfortable.

Domain 5: Process

The process domain includes one category—problems with coaching, training, and technical assistance (see Table 6). A sub-domain within the process domain is engaging— which refers to the provision of training, role modeling, and education to the appropriate individuals.

Problems with Coaching, Training, and Technical Assistance

Practitioner and peer specialist participants at all three organizations discussed several problems with coaching, training, and technical assistance (with this concern being particularly salient for practitioners at the state hospital). For example, practitioners discussed the fact that the clinical jargon coaches suggested they use to meet medical necessity and billing requirements reduces the person-centeredness of plans:

> Practitioner 1: The question becomes, 'Is it really person-centered when we have to change the

terminology around so much?' because it's like, 'Well that's not what my client said when I'm sitting down doing that with them.' But when we're doing, like the technical assistance calls, and it's like: 'Well if you could word it like this.' And it's fine, but that's not what they said. [laughs] So is it really person-centered!? Not only is that not what they said, but my client has no idea what that means when I'm sending it back to them! [laughs] So…the complexity of how it's needing to be worded does take away from it really being theirs and they don't have that ownership of it because that's not what my client said how I've gone back and edited those words.
Practitioner 2: Yeah…it's the jargon of a clinician…if it's truly theirs then let them say …how they want to get there.

Similarly, practitioners discussed the issue of receiving conflicting information about how to write quality PCRPs from different coaches and trainers. For example, practitioners at one organization noted:

Practitioner 1: Maybe it was someone different that would do the next technical assistance call, but what was told then it would be something different on how to do this, so I'm like 'Ok, what is the correct way to do it!?' [laughs] You know what I mean? So there was…some confusion with that because whether it was one person's way of saying, 'This is how you do the objectives.' And then it's someone different the next time. So I will be honest…it was always kind of different!
Practitioner 2: Yeah, I think a lot of the trainers are actually still trying to get on the same page.
Several: Uh huh!
Practitioner 3: Cause we've had a few times when there's been some conflict on the critique we get back from different trainers.
Practitioner 1: Yeah!

Discussion

As health care systems move toward achieving healthcare quality aims established by the Institute of Medicine (2001) and even more evidence for person-centered care in mental health care is established (Claes et al. 2010; Everson and Zhang 2000; Holburn et al. 2004; Parley 2001; Robertson et al. 2006; Sanderson et al. 2006; Stanhope et al. 2013; Tondora et al. 2014; Wigham et al. 2008), it will be important to understand and address individual, organizational, and systemic barriers to person-centered planning implementation. Although little is known about barriers to the successful implementation of person-centered planning

in the behavioral health system, this is an important endeavor given the likelihood that only when barriers are understood and addressed can PCRP improve consumer outcomes and reduce healthcare costs. A greater understanding of barriers to PCRP implementation is therefore important for the facilitation of constructive change, creative solutions, and greater staff buy-in (Holburn and Vietze 1999; Robertson et al. 2007).

Our analysis revealed twelve key barriers to PCRP implementation in public mental health organizations in Texas. Although some of these barriers have been noted in previous research (e.g., Tondora et al. 2012), the current study extends and clarifies our understanding of barriers to PCRP by applying an implementation framework. Examining these barriers through a CFIR lens reveals that half of the barriers to PCRP implementation fell within the inner setting domain, that is, barriers within the organization. This suggests that implementation efforts should focus primarily on aspects of the inner setting which are unique to the organizational context and culture and should provide more flexible approaches to intervention implementation. Further, one-quarter of the barriers fell into the domain of characteristics of individuals involved in the intervention, which suggests implementation efforts should also assess the impact that both staff and consumers have on implementation success. Additionally, it is worth noting that only one barrier emerged within the CFIR domain of intervention characteristics, suggesting there are few problems with the practice of PCRP itself.

In addition to being the first empirical study to examine barriers to the implementation of PCRP in the public mental health system, another strength of the current study is the inclusion and analysis of various stakeholder perspectives (Cabral et al. 2014). The findings suggest that perceived barriers to PCRP vary across stakeholder groups; for example, practitioners named the most barriers of all three stakeholder groups and were more likely to discuss barriers related to direct care service provision (e.g., non-collaborative planning, consumer skepticism). A complete understanding of organizational barriers—and ultimately developing interventions to overcome barriers—requires examining multiple perspectives in an organization given that different stakeholders bring different experiences and clinical lens to the table (Le Boutillier et al. 2015). Further, assessing practitioner and leadership perspectives prior to and throughout implementation may be particularly central to understanding how to effectively implement new practices given that "they are the vehicle bridging the gap between policy rhetoric and clinical practice" (Le Boutillier et al. 2015, p. 430). Findings also suggest that there are some differences between the state hospital and CMHCs. For example, the categories of change is hard, leadership

barriers, and problems with coaching, training, and technical assistance were more salient for staff at the state hospital compared to staff at the CMHCs. However, it is unclear the extent to which these differences can be attributed to organizational type versus length of time since implementation commenced (given that the state hospital began implementation efforts a year before the two CMHCs).

Although this research is important for gaining a greater understanding of barriers to PCRP implementation and some differences emerged among different focus groups, a key limitation of this study is the inability to make definitive statements about the extent to which different staff see these barriers as more or less important for PCRP implementation. It is also unclear the extent to which focus group participants' opinions on PCRP are representative of the organization, although the fact that categories were triangulated across organizations and stakeholder groups suggests that the results presented here are valid (Creswell and Miller 2000). Further, given the nature of qualitative research it is unclear if these findings are statistically generalizable, although to the extent that they are valid, they should be theoretically generalizable. Thus, they can be used to develop implementation readiness and other instruments that can aid in implementation and assessing the progress of implementation in each of the CFIR domains. Another limitation of the study is a misunderstanding of PCRP amongst focus group participants; this is, however, not surprising given our findings that staff reported a lack of knowledge and confidence in executing PCRP despite receiving extensive training and coaching and identified problems with coaching, training, and technical assistance. Future data collection efforts should address different stakeholders' knowledge and understanding of PCRP concepts and how PCRP is translated into practice. Data were also at times hindered by the size of our focus groups which depended on various organizational factors outside of the researchers' control; specifically in larger focus groups not all of the participants provided their perspectives, while in smaller focus groups dead air was not uncommon. Another limitation of this study is that due to manuscript length concerns our analysis does not address facilitators to PCRP implementation, although respondents did discuss strategies for overcoming barriers which we discuss in the recommendations section below. Finally, we were unable to conduct focus groups with consumers; future research should examine consumers' perspectives on barriers to and facilitators of PCRP implementation in public mental health organizations.

Recommendations

Although the results of this study suggest that there are individual, organizational, and system-level barriers to implementing PCRP in the public mental health system in Texas, focus group participants also provided several practical recommendations for overcoming these barriers, which can be classified into the CFIR domains of the outer setting, inner setting, and process domain. Within the outer setting domain, participants suggested that organizations should be able to bill for certain aspects of PCRP, specifically the planning process and development of the plan. Recommendations that fall within the inner domain include: aligning EHR software with PCRP; hiring more peer specialists (through enhanced funding for peer support positions); including peer specialists in planning and intake; and sharing plans with front-line/direct care staff. Within the process domain, participants suggested several ways that PCRP coaching and training could be improved including: incorporating PCRP training into New Employee Orientation training; providing training for all employees; training and designating more coaches at the organization – including coaches from multi-disciplinary backgrounds and specifically in hospitals, from both long- and short-term units; providing staff with more concrete examples of plans that reflect person-centered values and principles; providing more frequent refresher trainings; and offering trainings on how to expand PCRP in different populations (e.g., crisis populations, children and families). Another recommendation that falls within the process domain is to create an organizational-level PCRP taskforce. These recommendations may not address all of the barriers that participants named nor can there be assumed to be complete alignment between these recommendations and the barriers discussed in this paper. Future research should examine other additional ways of directly overcoming these barriers.

These findings suggest the importance of cultivating supportive leadership and organizational climates; in fact previous research indicates that the perceived burden of adopting and implementing evidence-based practices depends heavily on leadership and organizational climate (Brimall et al. 2015). Findings also highlight the importance of utilizing implementation frameworks to more effectively implement complex practices such as PCRP that require the involvement of entire systems to be successful. A clear understanding of—and proposed solutions to—these barriers may enable other mental health organizations implementing PCRP to develop creative solutions to these barriers via open and collaborative discussions among staff.

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