GUIDANCE FOR COLLABORATION ABOUT PEOPLE RESIDING IN LICENSED ADULT FOSTER CARE FACILITIES
Final: 6/21/11

The purpose of this guidance is to suggest pathways for local collaboration among community mental health services programs (CMHSPs), Department of Human Services (DHS) licensing consultants, and providers who operate licensed adult foster care settings (AFCs) where people with developmental disabilities or serious mental illness reside in order to:

- Assure that residents receive excellent care in environments that promote a culture of gentleness no matter what their disability or presenting behaviors or geographic location.
- Encourage all entities to take pro-active and preventative measures to prevent adverse licensing action
- Reduce the frequency of inappropriate transfers of individuals from one facility to another
- Reduce the inappropriate use of law enforcement response as an intervention to address harmful behaviors of residents of AFCs
- Reduce complaints filed by neighbors of AFCs to DHS or law enforcement
- Avoid adverse action taken by DHS against the licensee of the AFCs because of residents' behaviors

Issues:

1. By the time DHS licensing consultants get involved in a case or with a home, there have been enough reported incidents that the consultant may have no choice, according to law, but to begin the adverse licensing action process.
2. Many people served by CMHSPs are placed out-of-county into an AFC that may be better equipped to support them than local AFCs. Sometimes it is because the receiving AFC has a specialty focus (e.g., Prader Willi syndrome, sexual predators) that is not available in the counties of the sending CMHSPs. Out-of-county placements should not incur suspicion from the DHS licensing consultant or the local law enforcement entities.
3. Some people are placed out-of-county and are not followed by the placing CMHSP case management, clinical support or recipient rights.
4. Licensing consultants, providers and CMHSPs tend not to share information until a case reaches a crisis.
5. Training is a significant and logistical nightmare. AFCs that serve people from a number of CMHSPs find that they must train staff using training programs from each CMHSP. [Note: this issue is being addressed in another MDCH workgroup]
6. Failure of CMHSP and provider to give proper supports to the AFC home staff
7. Conflicts between the Mental Health Code and Licensing rules
8. Who will pay for extra staffing or staff training when a behavior treatment plan is to be followed.
9. Mismatch of resident with home (staff and other residents), or community – often the result of having to make the placement in a crisis situation

Solutions:

A. Community Integration

- For AFCs who serve people who are vulnerable, or who are likely to have behaviors that could be harmful, CMHSPs (including their ORRs), providers, group home manager, and licensing consultant should meet to discuss the purpose of the home, the nature of the residents and what can be expected, the goals for them, and how staff are being trained and supported to care for them. The culture of the neighborhood and community should be discussed to make sure that all are sensitive to the community "norms."
- Outreach to neighbors or other community members and discuss what they might expect to see (e.g., shift staff, vehicles); that there will be supervision of the residents; what kinds of actions [that are okay] that direct care workers might take. After people move in to the home, accompany them out to meet the neighbors.
- Give community officials and neighbors or neighborhood associations the home manager's and provider's contact numbers so they may call when they have a concern. Indicate how they can make a formal complaint to DHS Licensing, law enforcement, or the CMHSP if concerns are not resolved at the home level.
- AFCs who serve people from out-of-county, should get assurance from the placing CMHSP that it will continue to provide the necessary supports to the individual and the home staff. AFCs should discuss with licensing consultants why individuals from other counties are being served there – often because the AFC supports people with special conditions (e.g., Prader Willi, sexual predator) that cannot be served in other CMHSP areas.
- To the extent possible, the CMHSP and provider should reach out to law enforcement, fire departments and EMS entities who might respond to emergencies at the home to talk about the residents, what constitutes an emergency, etc.

B. Transition planning:

- Placing CMHSP must develop a transition plan prior to an individual moving into a home. If there is likelihood of behaviors that threaten to harm self or others, the CMHSP needs to develop a behavior plan and assure that staff are trained to implement it. CMHSP must involve the provider, home staff, licensing consultant in a discussion about each individual's transition and behavior plans. Consideration should also be made about involving local law enforcement, and communicating with neighbors.
- CMHSP and provider must reach agreement on the amount and type (mentoring, reinforcements, clinical) of initial and ongoing support the group home staff will be given from CMHSP and provider in the implementation of the transition and behavior plans.

B. Plan and Support for Behavior Challenges

- Use of informal behavior plan imbedded in Individual Plan of Service (IPOS) training of direct care staff

- Formal behavior plan with training, or the necessary resources to the facility for implementing it.
- There must be access to an expedited review and approval of formal behavior plans that is within 2 days (per MDCH/PIHP & CMHSP contracts, Attachment 1.4.1.).
- Non-emergent or urgent changes to behavior plans are reviewed and approved within 30 days.
- Identify under what circumstances law enforcement should be used.

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D. Early Warning System

- CMHSP and provider, with consultation from licensing consultant, should develop an "early warning system" that is collaborative and based on data tracking of (minimally) incidents listed below. The system should include who will be notified, when, and what action will be taken by CMHSP, provider, and other relevant parties
    - Law enforcement involvement – 911 called, and/or individual taken to police station
    - Use of physical management in the home
    - Hospitalization of an individual due to injury (by self, other resident, staff)
    - Unauthorized Leave of absence (to be defined)
    - Complaint by neighbors, other community citizens to law enforcement or DHS
    - High turnover rate of direct care staff or home manager (or absence of home manager for extended period)
    - Substantiated abuse, including use of unreasonable force
    - Substantiated Licensing investigations
    - Other
- Licensing consultant should alert the provider and the placing CMHSP that complaints have been received from law enforcement or other community members.