23. Person Centered Planning

Policy and Practice Guideline (FY20 contract attachment C3.3.1)
Behavior Treatment Plan Review Committee (FY20 contract attachment C6.8.3.1)
Guide to Prevention and Positive Behavior Supports (companion guide)
How Person-Centered Planning Works for You
Advance Directive for Mental Health in Michigan
Advance Directive Guideline (required components in a standard DPOA)

MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES
BEHAVIORAL HEALTH AND DEVELOPMENTAL DISABILITIES ADMINISTRATION
PERSON-CENTERED PLANNING POLICY

April, 2018

"Person-centered planning" means a process for planning and supporting the individual receiving services that builds upon the individual's capacity to engage in activities that promote community life and that honors the individual's preferences, choices, and abilities. **MCL 330.1700(g)**

I. WHAT IS THE PURPOSE OF THE MICHIGAN MENTAL HEALTH SYSTEM?

The purpose of the community mental health system is to support adults and children with intellectual and developmental disabilities, adults with serious mental illness and co-occurring disorders (including co-occurring substance abuse disorders), and children with serious emotional disturbance to live successfully in their communities—achieving community inclusion and participation, independence, and productivity. Person-Centered Planning (PCP) enables individuals to identify and achieve their personal goals. As described below, PCP for minors (family-driven and youth-guided practice) involves the whole family.

PCP is a way for people to plan their lives in their communities, set the goals that they want to achieve, and develop a plan for how to accomplish them. PCP is required by state law[the Michigan Mental Health Code (the Code)] and federal law [the Home and Community Based Services (HCBS) Final Rule and the Medicaid Managed Care Rules] as the way that people receiving services and supports from the community mental health system plan how those supports are going to enable them to achieve their life goals. The process is used to plan the life that the person aspires to have, considering various options—taking the individual's goals, hopes, strengths, and preferences and weaving them into plans for the future. Through PCP, a person is engaged in decision making, problem solving, monitoring progress, and making needed adjustments to goals and supports and services provided in a timely manner. PCP is a process that involves support and input from those people who care about the person doing the planning. The PCP process is used any time an individual's goals, desires, circumstances, choices, or needs change. While PCP is the required planning approach for mental health and I/DD services provided by the CMHSP system, PCP can include planning for other public supports and privately-funded services chosen by the person.

The HCBS Final Rule requires that Medicaid-funded services and supports be integrated in and support full access to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community to the same degree

of access as individuals not receiving such services and supports. 42 CFR 441.700 et. seq. The HCBS Final Rule also requires that PCP be used to identify and reflect of services and supports funded by the mental health system.
Through the PCP process, a person and those he or she has selected to support him or her:

a. Focus on the person's life goals, interests, desires, choices, strengths and abilities as the foundation for the PCP process.

b. Identify outcomes based on the person's life goals, interests, strengths, abilities, desires and choices.

c. Make plans for the person to achieve identified outcomes.

d. Determine the services and supports the person needs to work toward or achieve outcomes including, but not limited to, services and supports available through the community mental health system.

e. After the PCP process, develop an Individual Plan of Services (IPOS) that directs the provision of supports and services to be provided through the community mental health services program (CMHSP).

PCP focuses on the person's goals, while still meeting the person's basic needs [the need for food, shelter, clothing, health care, employment opportunities, educational opportunities, legal services, transportation, and recreation as identified in the Code]. As appropriate for the person, the PCP process may address Recovery, Self-Determination, Positive Behavior Supports, Treatment of Substance Abuse or other Co-Occurring Disorders, and Transition Planning as described in the relevant MDHHS policies and initiatives.

PCP focuses on services and supports needed (including medically necessary services and supports funded by the CMHSP) for the person to work toward and achieve their personal goals.

For minor children, the concept of PCP is incorporated into a family-driven, youth-guided approach (see the MDHHS Family-Driven and Youth-Guided Policy and Practice Guideline). The needs of the child are interwoven with the needs of the family, and therefore supports and services impact the entire family. As the child ages, services and supports should become more youth-guided especially during transition into adulthood. When the person reaches adulthood, his or her needs and goals become primary.

There are a few circumstances where the involvement of a minor's family may be not appropriate:

a. The minor is 14 years of age or older and has requested services without the knowledge or consent of parents, guardian or person in loco parentis within the restrictions stated in the Code.

b. The minor is emancipated.

c. The inclusion of the parent(s) or significant family members would constitute a substantial risk of physical or emotional harm to the minor or substantial disruption of the planning process. Justification of the exclusion of parents shall be documented in the clinical record.

II. HOW IS PCP DEFINED IN LAW?

PCP, as defined by the Code, "means a process for planning and supporting the person receiving services that builds upon his or her capacity to engage in activities that promote community life and that honors the person's choices, and abilities. The PCP process involves families, friends, and professionals as the person desires or requires." MCL 330.1700(g).

The Code also requires use of PCP for development of an Individual Plan of Services:

> "(1) The responsible mental health agency for each recipient shall ensure that a PCP process is used to develop a written individual plan of services in partnership with the recipient. A preliminary plan shall be developed within 7 days of the commencement of services or, if an individual is hospitalized for less than 7 days, before discharge or release. The individual plan of services shall consist of a treatment plan, a support plan, or both. A treatment plan shall establish meaningful and measurable goals with the recipient. The individual plan of services shall address, as either desired or required by the recipient, the recipient's need for food, shelter, clothing, health care, employment opportunities, educational opportunities, legal services, transportation, and recreation. The plan shall be kept current and shall be modified when indicated. The person in charge of implementing the plan of services shall be designated in the plan." MCL 330.1712.

The HCBS Final Rule does not define PCP, but does require that the process be used to plan for Medicaid-funded services and supports. 42 CFR 441.725. The HCBS Final Rule also sets forth the requirements for using the process. These requirements are included in the PCP Values and Principles and Essential Elements below.

III. WHAT ARE THE VALUES AND PRINCIPLES THAT GUIDE THE PCP PROCESS?

PCP is an individualized process designed to respond to the unique needs and desires of each person. The following values and principles guide the PCP process whenever it is used.

a. Every person is presumed competent to direct the planning process, achieve his or her goals and outcomes, and build a meaningful life in the community. PCP should not be constrained by any preconceived limits on the person's ability to make choices.

b. Every person has strengths, can express preferences, and can make choices. The PCP approach identifies the person's strengths, goals, choices, medical and support needs and desired outcomes. In order to be strength-based, the positive attributes of the person are documented and used as the foundation for building the person's goals and plans for community life as well as strategies or interventions used to support the person's success.

c. The person's choices and preferences are honored. Choices may include: the family and friends involved in his or her life and PCP process, housing, employment, culture, social activities, recreation, vocational training, relationships and friendships, and transportation. Individual choice must be used to develop goals and to meet the person's needs and preferences for supports and services and how they are provided.

d. The person's choices are implemented unless there is a documented health and safety reason that they cannot be implemented. In that situation, the PCP process should include strategies to support the person to implement their choices or preferences over time.

e. Every person contributes to his or her community, and has the right to choose how supports and services enable him or her to meaningfully participate and contribute to his or her community.

f. Through the PCP process, a person maximizes independence, creates connections and works towards achieving his or her chosen outcomes.

g. A person's cultural background is recognized and valued in the PCP process. Cultural background may include language, religion, values, beliefs, customs, dietary choices and other things chosen by the person. Linguistic needs, including ASL interpretation, are also recognized, valued and accommodated.

IV. WHAT ARE THE ESSENTIAL ELEMENTS OF THE PERSON-CENTERED PLANNING PROCESS?

The following elements are essential to the successful use of the PCP process with a person and the people invited by the person to participate.

a. **Person-Directed.** The person directs the planning process (with necessary supports and accommodations) and decides when and where planning meetings are held, what is discussed, and who is invited.

b. **Person-Centered.** The planning process focuses on the person, not the system or the person's family, guardian, or friends. The person's goals, interests, desires, and choices are identified with a positive view of the future and plans for a meaningful life in the community. The planning process is used whenever there are changes to the person's needs or choices, rather than viewed as an annual event.

c. **Outcome-Based.** The person identifies outcomes to achieve in pursuing his or her goals. The way that progress is measured toward achievement of outcomes is identified.

d. **Information, Support and Accommodations.** As needed, the person receives complete and unbiased information on services and supports available, community resources, and options for providers, which are documented in the IPOS. Support and accommodations to assist the person to participate in the process are provided. The person is offered information on the full range of services available in an easy-to-understand format.

e. **Independent Facilitation.** Individuals have the information and support to choose an independent facilitator to assist them in the planning process.

f. **Pre-Planning.** The purpose of pre-planning is for the person to gather the information and resources necessary for effective PCP and set the agenda for the PCP process. Each person must use pre-planning to ensure successful PCP. Pre-planning, as individualized for the person's needs, is used anytime the PCP process is used.

The following items are addressed through pre-planning with sufficient time to take all needed actions (e.g. invite desired participants):

1. When and where the meeting will be held.

2. Who will be invited (including whether the person has allies who can provide desired meaningful support or if actions need to be taken to cultivate such support).

3. Identify any potential conflicts of interest or potential disagreements that may arise during the PCP for participants in the planning process and making a plan for how to deal with them. (What will be discussed and not discussed.

4. The specific PCP format or tool chosen by the person to be used for PCP.

5. What accommodations the person may need to meaningfully participate in the meeting (including assistance for individuals who use behavior as communication).

6. Who will facilitate the meeting.

7. Who will take notes about what is discussed at the meeting.

g. **Wellness and Well-Being**. Issues of wellness, well-being, health and primary care coordination support needed for the person to live the way he or she want to live are discussed and plans to address them are developed. People are allowed the dignity of risk to make health choices just like anyone else in the community (such as, but not limited to, smoking, drinking soda pop, eating candy or other sweets). If the person chooses, issues of wellness and well-being can be addressed outside of the PCP meeting.

PCP highlights personal responsibility including taking appropriate risks. The plan must identify risks and risk factors and measures in place to minimize them, while considering the person's right to assume some degree of personal risk. The plan must assure the health and safety of the person. When necessary, an emergency and/or back-up plan must be documented and encompass a range of circumstances (e.g. weather, housing, support staff).

h. **Participation of Allies**. Through the pre-planning process, the person selects allies (friends, family members and others) to support him or her through the PCP process. Pre-planning and planning help the person explore who is currently in his or her life and what needs to be done to cultivate and strengthen desired relationships.

V. WHAT IS INDEPENDENT FACILITATION?

An Independent Facilitator is a person who facilitates the person-centered planning process in collaboration with the person. In Michigan, individuals receiving support through the community mental health system have a right to choose an independent or external facilitator for their person-centered planning process. The terms independent and external mean that the facilitator is independent of or external to the community mental health system. It means that the person has no financial interest in the outcome of the

supports and services outlined in the person-centered plan. Using an independent facilitator is valuable in many different circumstances, not just situations involving disagreement or conflict.

The PIHP/CMHSP must contract with a sufficient number of independent facilitators to ensure availability and choice of independent facilitators to meet their needs. The independent facilitator is chosen by the individual and serves as the individual's guide (and for some individuals, assisting and representing their voice) throughout the process, making sure that his or her hopes, interests, desires, preferences and concerns are heard and addressed. The independent facilitator must not have any other role within the PIHP/CMHSP. The role of the independent facilitator is to:

a. Personally know or get to know the individual who is the focus of the planning, including what he or she likes and dislikes, personal preferences, goals, methods of communication, and who supports and/or is important to the person.

b. Help the person with all pre-planning activities and assist in inviting participants chosen by the person to the meeting(s).

c. Assist the person to choose planning tool(s) to use in the PCP process.

d. Facilitate the PCP meeting(s) or support the individual to facilitate his or her own PCP meeting(s).

e. Provide needed information and support to ensure that the person directs the process.

f. Make sure the person is heard and understood.

g. Keep the focus on the person.

h. Keep all planning participants on track.

i. Develop an individual plan of service (IPOS) in partnership with the person that expresses the person's goals, is written in plain language understandable by the person, and provides for services and supports to help the person achieve their goals.

The Medicaid Provider Manual (MPM) permits independent facilitation to be provided to Medicaid beneficiaries as one aspect of the coverage called "Treatment Planning" (MPM MH&SAA Chapter, Section 3.25.) If the independent facilitator is paid for the provision of these activities, the PIHP/CMHSP may report the service under the code H0032.

An individual may use anyone he or she chooses to help or assist in the person-centered planning process, including facilitation of the meeting. If the person does not meet

the requirements of an Independent Facilitator, he or she cannot be paid, and responsibility for the Independent Facilitator duties described above falls to the Supports Coordinator/Case Manager. A person may choose to facilitate his or her planning process with the assistance of an Independent Facilitator.

VI. HOW IS PERSON-CENTERED PLANNING USED TO WRITE AND CHANGE THE INDIVIDUAL PLAN OF SERVICE?

The Code establishes the right for all people to develop Individual Plans of Services (IPOS) through the PCP process. The PCP process must be used at any time the person wants or needs to use the process, but must be used at least annually to review the IPOS. The agenda for each PCP meeting should be set by the person through the pre- planning process, not by agency or by the fields or categories in a form or an electronic medical record

Assessments may be used to inform the PCP process, but is not a substitute for the process. Functional assessments must be undertaken using a person-centered approach. The functional assessment and the PCP process together should be used as a basis for identifying goals, risks, and needs; authorizing services, utilization management and review. No assessment scale or tool should be utilized to set a dollar figure or budget that limits the person-centered planning process.

While the Code requires that PCP be used to develop an Individual Plan of Services (IPOS) for approved community mental health services and supports, the purpose of the PCP process is for the person to identify life goals and decide what medically necessary services and supports need to be in place for the person to have, work toward or achieve those life goals. The person or representative chooses what services and supports are needed. Depending on the person, community mental health services and supports may play a small or large role in supporting him or her in having the life he or she wants. When a person is in a crisis situation, that situation should be stabilized before the PCP process is used to plan the life that he or she desires to have.

People are often at different points in the process of achieving their life goals. The PCP process should be individualized to meet each person's needs of the person for whom planning is done, i.e. meeting a person where he or she is. Some people may be just beginning to define the life they want and initially the PCP process may be lengthy as the person's goals, hopes, strengths, and preferences are defined and documented and a plan for achieving them is developed. Once an IPOS is developed, subsequent use of the PCP process, discussions, meetings, and reviews will work from the existing IPOS to amend or update it as circumstances and preferences change. The extent to which an IPOS is updated will be determined by the needs and desires of the person. If and when necessary, the IPOS can be completely redeveloped. The emphasis in using PCP should be on meeting the needs of the person as they arise.

An IPOS must be prepared in person-first singular language and be understandable by the person with a minimum of clinical jargon or language. The person must agree to the IPOS in writing. The IPOS must include all of the components described below:

a. A description of the individual's strengths, abilities, plans, hopes, interests, preferences and natural supports.

b. The goals and outcomes identified by the person and how progress toward achieving those outcomes will be measured.

c. The services and supports needed by the person to work toward or achieve his or her outcomes including those available through the CMHSP, other publicly funded programs (such as Home Help, Michigan Rehabilitation Services (MRS)), community resources, and natural supports.

d. The setting in which the person lives was chosen by the person and what alternative living settings were considered by the person. The chosen setting must be integrated in and support full access to the greater community, including opportunities to seek employment and work in competitive integrated settings, engage in community life, control personal resources, and receive services in the community to the same degree of access as individuals not receiving services and sup- ports from the mental health system. The PIHP/CMHSP is responsible for ensuring it meets these requirements of the HCBS Final Rule.

e. The amount, scope, and duration of medically necessary services and supports authorized by and obtained through the community mental health system.

f. Documentation that the IPOS prevents the provision of unnecessary supports or inappropriate services and supports.

g. Documentation of any restriction or modification of additional conditions must meet the standards.

h. The services which the person chooses to obtain through arrangements that support self-determination.

i. The estimated/prospective cost of services and supports authorized by the community mental health system pursuant to Contract Attachment P.6.3.2.1B.ii.

j. The roles and responsibilities of the person, the supports coordinator or case manager, the allies, and providers in implementing the IPOS.

k. The person or entity responsible for monitoring the plan.

l. The signatures of the person and/or representative, his or her case manager or support coordinator, and the support broker/agent (if one is involved).

m. The plan for sharing the IPOS with family/friends/caregivers with the permission of the person.

n. A timeline for review.

o. Any other documentation required by Section R 330.7199 Written plan of services of the Michigan Administrative Code.

Once a person has developed an IPOS through the PCP process, the IPOS shall be kept current and modified when needed (reflecting changes in the intensity of the person's needs, changes in the person's condition as determined through the process or changes in the personal preferences for support).

The person and his or her case manager or supports coordinator should work on and review the IPOS on a routine basis as part of their regular conversations. A person or his/her guardian or authorized representative may request and review the IPOS at any time. A formal review of the IPOS with the person and his/her guardian or authorized representative, if any, shall occur not less than annually. Reviews will work from the existing IPOS to review progress on goals, assess personal satisfaction and to amend or update the IPOS as circumstances, needs, preferences or goals change or to develop a completely new plan, if the person desires to do so. The review of the IPOS at least annually is done through the PCP process.

The PCP process often results in personal goals that aren't necessarily supported by the CMHSP services and supports. Therefore, the PCP process must not be limited by program specific functional assessments. The plan must describe the services and supports that will be necessary and specify what HCBS are to be provided through various resources including natural supports, to meet the goals in the IPOS. The specific person or persons, and/or provider agency or other entity providing services and supports must be documented. Non-paid supports, chosen by the person and agreed to by the unpaid provider, needed to achieve the goals must be documented. With the permission of the person, the IPOS should be discussed with family/friends/caregivers chosen by the person so that they fully understand it and their role(s).

The person must be provided with a written copy of his or her IPOS within 15 business days of conclusion of the PCP process. This timeframe gives the case manager/ supports coordinator a sufficient amount of time to complete the documentation described above.

VII. HOW MUST RESTRICTIONS ON A PERSON'S RIGHTS AND FREEDOMS BE DOCUMENTED IN THE IPOS?

Any effort to restrict the certain rights and freedoms listed in the HCBS Final Rule must be justified by a specific and individualized assessed health or safety need and must be addressed through the PCP process and documented in the IPOS.

The rights and freedoms listed in the HCBS Final Rule are:

a. A lease or residency agreement with comparable responsibilities and protection from eviction that tenants have under Michigan landlord/tenant law.

b. Sleeping or living units lockable by the individual with only appropriate staff having keys.

c. Individuals sharing units have a choice of roommate in that setting.

d. Individuals have the freedom to furnish and decorate their sleeping or living unites within the lease or other agreement.

e. Individuals have the freedom and support to control their own schedules and activities and have access to food at any time.

f. Individuals are able to have visitors of their choosing at any time.

The following requirements must be documented in the IPOS when a specific health or safety need warrants such a restriction:

1. The specific and individualized assessed health or safety need.

2. The positive interventions and supports used prior to any modifications or additions to the IPOS regarding health or safety needs.

3. Documentation of less intrusive methods of meeting the needs, that have been tried, but were not successful.

4. A clear description of the condition that is directly proportionate to the specific assessed health or safety need.

5. A regular collection and review of data to measure the ongoing effectiveness of the modification.

6. Established time limits for periodic reviews to determine if the modification is still necessary or can be terminated.

7. Informed consent of the person to the proposed modification.

8. An assurance that the modification itself will not cause harm to the person.

VIII. WHAT DO PIHPS, CMHSPS AND OTHER ORGANIZATIONS NEED TO DO TO ENSURE SUCCESSFUL USE OF THE PERSON-CENTERED PLANNING PROCESS?

Successful implementation of the PCP Process requires that agency policy, mission/ vision statements, and procedures incorporate PCP standards. A process for monitoring PCP should be implemented by both the PIHPs and CMHSP, along with the monitoring process through the MDHHS site review.

The following elements are essential for organizations responsible implementing the PCP process:

a. **Person-Centered Culture**. The organization provides leadership, policy direction, and activities for implementing PCP at all levels of the organization. Organizational language, values, allocation of resources, and behavior reflect a person-centered orientation.

b. **Individual Awareness and Knowledge.** The organization provides easily understood information, support and when necessary, training, to people using services and supports, and those who assist them, so that they understand their right to and the benefits of PCP, know the essential elements of PCP, the benefits of this approach and the support available to help them succeed (including, but not limited, pre-planning and independent facilitation).

c. **Conflict of Interest.** The organization ensures that the conflict of interest requirements of the HCBS Final Rule are met and that the person responsible for the PCP process is separate from the eligibility determination, assessment, and service provision responsibilities.

d. **Training.** All Staff receive competency-based training in PCP so that they have consistent understanding of the process. Staff who are directly involved in IPOS services or supports implementation are provided with specific training.

e. **Roles and Responsibilities.** As an individualized process, PCP allows each person to identify and work with chosen allies and other supports. Roles and responsibilities for facilitation, pre-planning, and developing the IPOS are identified; the IPOS describes who is responsible for implementing and monitoring each component of the IPOS.

f. **System wide Monitoring.** The Quality Assurance/Quality Management (QA/QM) System includes a systemic approach for measuring the effectiveness of PCP and identifying barriers to successful use of the PCP process. The best practices for supporting individuals through PCP are identified and implemented (what is working and what is not working in supporting individuals). Organizational expectations and

standards are in place to assure that the person directs the PCP process and ensures that PCP is consistently followed.

IX. WHAT DISPUTE RESOLUTION OPTIONS ARE AVAILABLE?

Individuals who have a dispute about the PCP process or the IPOS that results from the process have the rights to grievance, appeals and recipient rights as set forth in detail in the Contract Attachment 6.4.1.1 Grievance and Appeal Technical Requirement/PIHP Grievance System for Medicaid Beneficiaries. As described in this Contract Attachment, some of the dispute resolution options are limited to Medicaid beneficiaries and limited in the scope of the grievance (such as a denial, reduction, suspension or termination of services). When a person is receiving services and no agreement on IPOS can be made through the person-centered planning process during the annual review, services shall continue until a notice of a denial, reduction, suspension, or termination is given in which case the rights and procedures for grievance and appeals take over. Other options are available to all recipients of Michigan mental health services and supports. Supports Coordinators, Case Managers and Customer Services at PIHP/CMHSPs must be prepared to help people understand and negotiate the dispute resolution processes.

MICHIGAN DEPARTMENT OF HEALTH AND HUMAN SERVICES (MDHHS)
BEHAVIORAL HEALTH & DEVELOPMENTAL DISABILITIES ADMINISTRATION
Standards for Behavior Treatment Plan Review Committees
Revision FY'17

Application:

Prepaid Inpatient Health Plans (PIHPs)
Community Mental Health Services Programs (CMHSPs)
Public mental health service providers

Exception: State operated or licensed psychiatric hospitals or units when the individual's challenging behavior is due to an active substantiated Axis I diagnosis listed in the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition or successor edition published by the American Psychiatric Association.

Preamble:

It is the expectation of the Michigan Department of Health and Human Services (MDHHS) that all public mental health agencies protect and promote the dignity and respect of all individuals receiving public mental health services. All public mental health agencies shall have policies and procedures for intervening with an individual receiving public mental health services who exhibits seriously aggressive, self-injurious or other challenging behaviors that place the individual or others at imminent risk of physical harm. These policies and procedures shall include protocols for using the least intrusive and restrictive interventions for unprecedented and unpredicted crisis or emergency occurrences of such behaviors. For all other non-emergent or continuing occurrences of these behaviors, the public mental health service agency will first conduct appropriate assessments and evaluations to rule out physical, medical, and environmental (e.g., trauma, interpersonal relationships) conditions that might be the cause of the behaviors.

MDHHS will not tolerate violence perpetrated on the individuals served by the public mental health system in the name of intervening when individuals exhibit certain potentially harmful behaviors. If and when interventions are to be used for the purpose of treating, managing, controlling or extinguishing predictable or continuing behaviors that are seriously aggressive, self-injurious, or that place the individual or others at risk of harm, the public mental health agency shall develop an individual behavior treatment plan to ameliorate or eliminate the need for the restrictive or intrusive interventions in the future (R. 330.7199[2]][g]) and that:

- Adheres to any legal psychiatric advance directive that is present for an adult with serious mental illness;
- Employs positive behavior supports and interventions, including specific interventions designed to develop functional abilities in major life activities, as the first and preferred approaches;
- Considers other kinds of behavior treatment or interventions that are supported by peer-reviewed literature or practice guidelines in conjunction with behavior supports and interventions, if positive behavior supports and interventions are documented to be unsuccessful; or

- As a last resort, when there is documentation that neither positive behavior supports nor other kinds of less restrictive interventions were successful, proposes restrictive or intrusive techniques, described herein, that shall be reviewed and approved by the Behavior Treatment Plan Review Committee.

MDHHS requires that any individual receiving public mental health services has the right to be free from any form of restraint or seclusion used as a means of coercion discipline, convenience or retaliation, as required by the 1997 federal Balanced Budget Act at 42 CFR 438.100 and Sections 740 and 742 of the Michigan Mental Health Code.

I. POLICY

It is the policy of MDHHS that all publicly-supported mental health agencies shall use a specially-constituted committee, often referred to as a "behavior treatment plan review committee" called for the purposes of this policy the "Committee." The purpose of the Committee is to review and approve or disapprove any plans that propose to use restrictive or intrusive interventions, as defined here in section IV, with individuals served by the public mental health system who exhibit seriously aggressive, self-injurious or other challenging behaviors that place the individual or others at imminent risk of physical harm. The Committee shall substantially incorporate the standards herein, including those for its appointment, duties, and functions.

II. COMMITTEE STANDARDS

A. Each CMHSP shall have a Committee to review and approve or disapprove any plans that propose to use restrictive or intrusive interventions. A psychiatric hospital, psychiatric unit or psychiatric partial hospitalization program licensed under 1974 PA 258, MCL 330.1137, that receives public funds under contract with the CMHSP and does not have its own Committee must also have access to and use of the services of the CMHSP Committee regarding a behavior treatment plan for an individual receiving services from that CMHSP. If the CMHSP delegates the functions of the Committee to a contracted mental health service provider, the CMHSP must monitor that Committee to assure compliance with these standards.

B. The Committee shall be comprised of at least three individuals, one of whom shall be a board certified behavior analyst or licensed behavior analyst, and/or licensed psychologist as defined in Section 2.4, Staff Provider Qualifications, in the Medicaid Provider Manual, Behavioral Health and Intellectual and Developmental Disabilities Chapter, with the specified training; and at least one member shall be a licensed physician/psychiatrist as defined in the Mental Health Code at MCL 330.1100c(10). A representative of the Office of Recipient Rights shall participate on the Committee as an ex-officio, non-voting member in order to provide consultation and technical assistance to the Committee. Other non-voting members may be added at the Committee's discretion and with the

consent of the individual whose behavior treatment plan is being reviewed, such as an advocate or Certified Peer Support Specialist.

C. The Committee, and Committee chair, shall be appointed by the agency for a term of not more than two years. Members may be re-appointed to consecutive terms.

D. The Committee shall meet as often as needed.

E. Expedited Review of Proposed Behavior Treatment Plans:

Each Committee must establish a mechanism for the expedited review of proposed behavior treatment plans in emergent situations. “Expedited” means the plan is reviewed and approved in a short time frame such as 24 or 48 hours.

The most frequently-occurring example of the need for expedited review of a proposed plan in emergent situations occurs as a result of the following AFC Licensing Rule:

Adult Foster Care Licensing R 400.14309 Crisis intervention
(1) Crisis intervention procedures may be utilized only when a person has not previously exhibited the behavior creating the crisis or there has been insufficient time to develop a specialized intervention plan to reduce the behavior causing the crisis. <u>If the [individual] requires the repeated or prolonged use of crisis intervention procedures, the licensee must contact the [individual’s] designated representative and the responsible agency … to initiate a review process to evaluate positive alternatives or the need for a specialized intervention plan</u>. (Emphasis added)

Expedited plan reviews may be requested when, based on data presented by the professional staff (Psychologist, RN, Supports Coordinator, Case Manager), the plan requires immediate implementation. The Committee Chair may receive, review and approve such plans on behalf of the Committee. The Recipient Rights Office must be informed of the proposed plan to assure that any potential rights issues are addressed prior to implementation of the plan. Upon approval, the plan may be implemented. All plans approved in this manner must be subject to full review at the next regular meeting of the Committee.

F. The Committee shall keep all its meeting minutes, and clearly delineate the actions of the Committee.

G. A Committee member who has prepared a behavior treatment plan to be reviewed by the Committee shall recuse themselves from the final decision-making.

H. The functions of the Committee shall be to:

1. Disapprove any behavior treatment plan that proposes to use aversive techniques, physical management, or seclusion or restraint in a setting where it is prohibited by law or regulations.
2. Expeditiously review, in light of current peer reviewed literature or practice guidelines, all behavior treatment plans proposing to utilize intrusive or restrictive techniques [see definitions].
3. Determine whether causal analysis of the behavior has been performed; whether positive behavioral supports and interventions have been adequately pursued; and, where these have not occurred, disapprove any proposed plan for utilizing intrusive or restrictive techniques.
4. For each approved plan, set and document a date to re-examine the continuing need for the approved procedures. This review shall occur at a frequency that is clinically indicated for the individual's condition, or when the individual requests the review as determined through the person-centered planning process. Plans with intrusive or restrictive techniques require minimally a quarterly review. The committee may require behavior treatment plans that utilize more frequent implementation of intrusive or restrictive interventions to be reviewed more often than the minimal quarterly review if deemed necessary.
5. Assure that inquiry has been made about any known medical, psychological or other factors that the individual has, which might put him/her at high risk of death, injury or trauma if subjected to intrusive or restrictive techniques.
6. As part of the PIHP's Quality Assessment and Performance Improvement Program (QAPIP), or the CMHSP's Quality Improvement Program (QIP), arrange for an evaluation of the committee's effectiveness by stakeholders, including individuals who had approved plans, as well as family members and advocates. De-identified data shall be used to protect the privacy of the individuals served.

   Once a decision to approve a behavior treatment plan has been made by the Committee and written special consent to the plan (see limitations in definition of special consent) has been obtained from the individual, the legal guardian, the parent with legal custody of a minor or a designated patient advocate, it becomes part of the person's written IPOS. The individual, legal guardian, parent with legal custody of a minor child, or designated patient advocate has the right to request a review of the written IPOS, including the right to request that person-centered planning be re-convened, in order to revisit the behavior treatment plan. (MCL 330.1712 [2])

I. On a quarterly basis track and analyze the use of all physical management and involvement of law enforcement for emergencies, and the use of intrusive and restrictive techniques by each individual receiving the intervention, as well as:
   1. Dates and numbers of interventions used.
   2. The settings (e.g., individual's home or work) where behaviors and interventions occurred

3. Observations about any events, settings, or factors that may have triggered the behavior.
4. Behaviors that initiated the techniques.
5. Documentation of the analysis performed to determine the cause of the behaviors that precipitated the intervention.
6. Description of positive behavioral supports used.
7. Behaviors that resulted in termination of the interventions.
8. Length of time of each intervention.
9. Staff development and training and supervisory guidance to reduce the use of these interventions.
10. Review and modification or development, if needed, of the individual's behavior plan.

The data on the use of intrusive and restrictive techniques must be evaluated by the PIHP's QAPIP or the CMHSP's QIP, and be available for MDHHS review. Physical management and/or involvement of law enforcement, permitted for intervention in emergencies only, are considered critical incidents that must be managed and reported according to the QAPIP standards. Any injury or death that occurs from the use of any behavior intervention is considered a sentinel event.

J. In addition, the Committee may:
   1. Advise and recommend to the agency the need for specific staff or home-specific training in positive behavioral supports, other evidence based and strength based models, and other individual-specific non-violent interventions.
   2. Advise and recommend to the agency acceptable interventions to be used in emergency or crisis situations when a behavior treatment plan does not exist for an individual who has never displayed or been predicted to display seriously aggressive, self-injurious or other behaviors that place the individual or others at risk or harm.
   3. At its discretion, review other formally developed behavior treatment plans, including positive behavioral supports and interventions, if such reviews are consistent with the agency's needs and approved in advance by the agency.
   4. Advise the agency regarding administrative and other policies affecting behavior treatment and modification practices.
   5. Provide specific case consultation as requested by professional staff of the agency.
   6. Assist in assuring that other related standards are met, e.g., positive behavioral supports.
   7. Serve another service entity (e.g., subcontractor) if agreeable between the involved parties.

III. BEHAVIOR TREATMENT PLAN STANDARDS

A. The person-centered planning process used in the development of an individualized written plan of services will identify when a behavior treatment plan

needs to be developed and where there is documentation that functional behavioral assessments have been conducted to rule out physical, medical or environmental causes of the target behavior; and that there have been unsuccessful attempts, using positive behavioral supports and interventions, to prevent or address the target behavior.

B. Behavior treatment plans must be developed through the person-centered planning process and written special consent must be given by the individual, or his/her guardian on his/her behalf if one has been appointed, or the parent with legal custody of a minor prior to the implementation of the behavior treatment plan that includes intrusive or restrictive interventions. .

C. Behavior treatment plans that propose to use physical management and/or involvement of law enforcement in a non-emergent situation; aversive techniques; or seclusion or restraint in a setting where it is prohibited by law shall be disapproved by the Committee.

   Utilization of physical management or requesting law enforcement may be evidence of treatment/supports failure. Should use occur more than 3 times within a 30 day period the individual's written individual plan of service must be revisited through the person-centered planning process and modified accordingly, if needed. MDHHS Administrative Rules prohibit emergency interventions from inclusion as a component or step in any behavior plan. The plan may note, however, that should interventions outlined in the plan fail to reduce the imminent risk of serious or non-serious physical harm to the individual or others, approved emergency interventions may be implemented.

D. Behavior treatment plans that propose to use restrictive or intrusive techniques as defined by this policy shall be reviewed and approved (or disapproved) by the Committee.

E. Plans that are forwarded to the Committee for review shall be accompanied by:
   1. Results of assessments performed to rule out relevant physical, medical and environmental causes of the challenging behavior.
   2. A functional behavioral assessment.
   3. Results of inquiries about any medical, psychological or other factors that might put the individual subjected to intrusive or restrictive techniques at high risk of death, injury or trauma.
   4. Evidence of the kinds of positive behavioral supports or interventions, including their amount, scope and duration that have been used to ameliorate the behavior and have proved to be unsuccessful.
   5. Evidence of continued efforts to find other options.
   6. Peer reviewed literature or practice guidelines that support the proposed restrictive or intrusive intervention.
   7. References to the literature should be included on new procedures, and where the intervention has limited or no support in the literature, why the plan

is the best option available. Citing of common procedures that are well researched and utilized within most behavior treatment plans is not required.

8. The plan for monitoring and staff training to assure consistent implementation and documentation of the intervention(s).

IV. DEFINITIONS

Term	Definition
Anatomical support	Body positioning or a physical support ordered by a physical or occupational therapist for the purpose of maintaining or improving a recipient's physical functioning.
Aversive techniques	Techniques that require the deliberate infliction of unpleasant stimulus (a stimulus that would be unpleasant and may often generate physically painful responses in the average person or would have a specific unpleasant effect on a particular person) by staff to a recipient to achieve the management, control of the target behavior. Examples of such techniques include electric shock, foul odors, loud noises, mouthwash, water mist or other noxious substance to cons equate target behavior or to accomplish a negative association with a target behavior. Note: Clinical techniques and practices established in the peer reviewed literature that are prescribed in the behavior treatment plan and that are voluntary and self-administered (e.g. exposure therapy for anxiety, taking a prescription medication to help quit smoking) are not considered aversive techniques for the purposed of this technical requirement.
Bodily function	The usual action of any region or organ of the body.
Emotional harm	Impaired psychological functioning, growth, or development of a significant nature as evidenced by observable physical symptomatology or as determined by a mental health professional.
Consent	A written agreement signed by the individual, the parent of a minor, or an individual's legal representative with authority to execute consent, or a verbal agreement of an individual that is witnessed and documented by someone other than the service provider.
Functional Behavioral Assessment (FBA)	An approach that incorporates a variety of techniques and strategies to determine the pattern and purpose, or "function" of a particular behavior and guide the development of an effective and efficient behavior treatment plan. The focus of an FBA is to identify social, affective, environmental, and trauma-based factors or events that initiate, sustain, or end a target behavior. A physical examination must be done by a MD or DO to identify biological or medical factors related to the target behavior. The FBA should integrate medical conclusions and recommendations. This assessment provides insight into the function of a behavior, rather than just focusing on the target behavior itself so that a new behavior or skill will be developed to provide the same function or meet the identified need of the recipient. Functional assessments should also identify situations and events that precede positive adaptive behavior to provide more information for a positive behavior support plan.
Emergency Interventions	There are only two emergency interventions approved by MDHHS for implementation in crisis situations when all other supports and interventions fail to reduce the imminent risk of harm: physical management and the request for law

	enforcement intervention. Each agency shall have protocols specifying what physical management techniques are approved for use.
Imminent Risk	An event/action that is about to occur that will likely result in the serious physical harm of one's self or others.
Intrusive Techniques	Those techniques that encroach upon the bodily integrity or the personal space of the individual for the purpose of achieving management or control, of a seriously aggressive, self-injurious or other behavior that places the individual or others at risk of physical harm. Examples of such techniques include the use of a medication or drug when it is used to manage or control an individual's behavior or restrict the individual's freedom of movement and is not a standard treatment or dosage for the individual's condition. Use of intrusive techniques as defined here requires the review and approval by the Committee.
Medical and dental procedures restraints	The use of mechanical restraint or drug-induced restraint ordered by a physician or dentist to render the individual quiescent for medical or dental procedures. Medical restraint shall only be used as specified in the individual written plan of service for medical or dental procedures.
Physical management	A technique used by staff as an emergency intervention to restrict the movement of a recipient by direct physical contact to prevent the recipient from seriously harming himself, herself, or others. Note: Physical management shall only be used on an emergency basis when the situation places the individual or others at imminent risk of serious physical harm. To ensure the safety of each consumer and staff each agency shall designate emergency physical management techniques to be utilized during emergency situations.
Practice or Treatment Guidelines	Guidelines published by professional organizations such as the American Psychiatric Association (APA), or the federal government.
Prone immobilization	Extended physical restraint of an individual in a face down (prone) position, usually on the floor, where force is applied to his or her body in a manner that prevents him or her from moving out of the prone position for the purpose of control. Note: **PRONE IMMOBILIZATION IS PROHIBITED UNDER ANY CIRCUMSTANCES**
Positive Behavior Support (PBS)	A set of research-based strategies used to increase opportunities for an enhanced quality of life and decrease seriously aggressive, self-injurious or other targeted behaviors that place the individual or others at risk of physical harm by conducting a functional assessment, and teaching new skills and making changes in a person's environment. Positive behavior support combines valued outcomes, behavioral, and biomedical science, validated procedures; and systems change to enhance quality of life and reduce behaviors such as self-injury, aggression, and property destruction Positive Behavior Supports are most effective when they are implemented across all environments, such as home, school, work, and in the community.
Protective device	A device or physical barrier to prevent the recipient from causing serious self-injury associated with documented and frequent incidents of the behavior. A protective devices as defined in this subdivision and incorporated in written individual plan of service shall not be considered a restraint as defined in below.
Provider	The department, each community mental health service program, each licensed hospital, each psychiatric unit, and each psychiatric partial hospitalization program licensed under section 137 of the act, their employees, volunteers, and contractual agents.

Psychotropic drug	Any medication administered for the treatment or amelioration of disorders of thought, mood, or behavior.
Request for Law Enforcement Intervention	Calling 911 and requesting law enforcement assistance as a result of an individual exhibiting seriously aggressive, self-injurious or other behavior that places the individual or others at risk of physical harm. Law enforcement should be called for assistance **only when**: caregivers are unable to remove other individuals from the hazardous situation to assure their safety and protection, safe implementation of physical management is impractical, and/or approved physical management techniques have been attempted but have been unsuccessful in reducing or eliminating the imminent risk of harm to the individual or others
Restraint	The use of physical devise to restrict an individual's movement. Restraint does not include the use of a device primarily intended to provide anatomical support
Restrictive Techniques	Those techniques which, when implemented, will result in the limitation of the individual's rights as specified in the Michigan Mental Health Code and the federal Balanced Budget Act. Examples of such techniques as limiting or prohibiting communication with others when that communication would be harmful to the individual; prohibiting unlimited access to food when that access would be harmful to the individual (excluding dietary restrictions for weight control or medical purposes); using the Craig (or veiled) bed, or any other limitation of the freedom of movement of an individual. Use of restrictive techniques requires the review and approval of the Committee.
Serious physical harm	Physical damage suffered by a recipient that a physician or registered nurse determines caused or could have caused the death of a recipient, caused the impairment of his or her bodily functions, or caused the permanent disfigurement of a recipient.
Special Consent	Obtaining the written consent of the individual, the legal guardian, or parent with legal custody of a minor child, or a designated patient advocate prior to the implementation of any behavior treatment intervention that includes the use of intrusive or restrictive interventions or those which would otherwise entail violating the individual's rights. The general consent to the individualized plan of services and/or supports is not sufficient to authorize implementation of such a behavior treatment intervention. Implementation of a behavior treatment intervention without the special consent of the individual, guardian or parent of a minor may only occur when the individual has been adjudicated pursuant to the provisions of section 469a, 472a, 473, 515, 518, or 519 of the Mental Health Code.
Therapeutic de-escalation	An intervention, the implementation of which is incorporated in the individualized written plan of service, wherein the re3cipient is placed in an area or room, accompanied by staff who shall therapeutically engage the recipient in behavioral de-escalation techniques and debriefing as to the cause and future prevention of the target behavior.
Time out	A voluntary response to the therapeutic suggestion to a recipient to remove himself or herself from a stressful situation in order to prevent a potentially hazardous outcome.
Unreasonable force	Physical management or force that is applied by an employee, volunteer, or agent of a provider to a recipient in one or more of the following circumstances: 1. There is no imminent risk of serious or non-serious physical harm to the recipient, staff or others. 2. The physical management used is not in compliance with techniques approved by the provider and the responsible mental health agency.

	3. The physical management used is not in compliance with the emergency interventions authorized in the recipient's individual plan of service. The physical management or force is used when other less restrictive measures were possible but not attempted immediately before the use of physical management or force.
Person-centered planning	A process for planning and supporting the individual receiving services that builds upon the individual's capacity to engage in activities that promote community life and that honors the individual's preferences, choices, and abilities. The person-centered planning process involves families, friends, and professionals as the individual desires or requires.
Seclusion	The temporary placement of a recipient in a room, alone, where egress is prevented by any means. Note: Seclusion is prohibited except in a hospital or unit operated by the department, a hospital licensed by the department, or a licensed child caring institution licensed under 1973 PA 116, MCL 722.111 to 722.128.
Support Plan	A written plan that specifies the personal support services or any other supports that are to be developed with and provided for a recipient.
Treatment Plan	A written plan that specifies the goal-oriented treatment or training services, including rehabilitation or habilitation services, which are to be developed with and provided for a recipient.

V. LEGAL REFERENCES

1973 PA 116, MCL 722.111 to 722.128.
1997 federal Balanced Budget Act at 42 CFR 438.100
MCL 330.1700, Michigan Mental Health Code
MCL 330.1704, Michigan Mental Health Code
MCL 330.1712, Michigan Mental Health Code
MCL 330.1740, Michigan Mental Health Code
MCL 330.1742, Michigan Mental Health Code
MCL 330.1744, Michigan Mental Health Code
MDHHS Administrative Rule 7001(l)
MDHHS Administrative Rule 7001(r)
Department of Health and Human Services Administrative Rule 330.7199(2)(g)

MICHGAN DEPARTMENT OF COMMUNITY HEALTH
BEHAVIORAL HEALTH AND DEVELOPMENTAL DISABILITIES ADMINISTRATION

Guide to Prevention and Positive Behavior Supports in a Culture of Gentleness

June 27, 2011

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I. Introduction

The Michigan Department of Community Health (MDCH) promotes the use of positive supports in a "culture of gentleness" as a means to interact with the people served in the public mental health system. People who exhibit behaviors that put themselves or others at risk of harm especially must be helped to feel safe and valued in the environments where they receive services. For such individuals, MDCH encourages the system to develop behavior plans that include positive behavior supports and non-restrictive and non-intrusive behavioral interventions. However, when the implementation of positive supports or a less restrictive behavior plan is not successful in keeping the individual safe, there may be a need to include more intrusive and/or restrictive measures. The Technical Requirement for Behavior Treatment Plan Review Committees (TR), which became effective October 1, 2007, was added as an attachment to the fiscal year (FY) 2008 contract between MDCH and Michigan's Pre-paid Inpatient Health Plans (PIHPs) and Community Mental Health Services Programs (CMHSPs). The TR requires that Behavior Treatment Plans that include restrictive and/or intrusive techniques be submitted to the local Behavior Treatment Plan Review Committees (the Committees) for review and approval, and provides guidance to the Committees for reviewing and approving or disapproving these plans. The Committees are responsible for ensuring that a thorough assessment of needs has been conducted looking for how and what positive supports have been and will be used before intrusive or restrictive interventions are considered and approved.

This guide provides information and assistance to the Committees, behavior plan[1] developers, program directors, providers, group home supervisors, and caregivers of adults and children in all settings. This informational document is intended to provide examples and definitions of prevention and positive behavior supports and techniques in a culture of gentleness and to encourage the use of these approaches before implementing intrusive or restrictive interventions outlined in a Behavior Treatment Plan to address challenging behaviors[2]. Although behavior plans have traditionally been used in working with individuals with developmental disabilities, these prevention and positive approaches have been proven to be effective with other populations. Therefore, this guide is intended to apply to adults and children with developmental disabilities, adults with serious mental illness, and children with serious emotional disturbance.

II. Prevention

The Michigan public mental health system has learned through various experiences of the last three years, including the Mt. Pleasant Center transition, Center for Positive Living Supports activities, and meeting with the Michigan Department of Human Services' Adult Foster Care Licensing Division, that having supportive and safe

[1] For purposes of this guide, "behavior plan" is a generic term for any plan that addresses challenging behaviors. This would include both a Positive Behavior Support Plan and a Behavior Treatment Plan.
[2] The term "challenging behaviors" is used in this guide to describe seriously aggressive, self-injurious, or other behaviors that place the individual or others at imminent risk of harm.

environments and taking certain preventive measures are the greatest deterrents to challenging behaviors, and the resulting need to employ intrusive and/or restrictive interventions. Thus, it is the responsibility of all entities to promote and model positive supports in a culture of gentleness for all people served by the public mental health system.

A. Feelings of Safety and Value

It is important that the culture of the person's home and other places where he/she receives public mental health services, as well as the organization(s) affiliated with those places, are supportive of, and safe for, him/her. Many of the people served by the public mental health system have suffered trauma, in many cases repeated, in the past. Their clinical records contain reports of abuse, neglect, sexual assault, over-medication, abandonment by family, and frequent moves among foster care settings, institutional settings, and jail. These adverse experiences have forced many of the people to be fearful of others and to develop "defense mechanisms" aimed at protecting themselves. When the fear and distrust are coupled with an individual's inability to verbally communicate, we often see challenging behaviors. When caregivers and professionals interpret these behaviors as manifestations of "disobedience" and "non-compliance" with "rules" and react with force, it can lead to more fear and distrust, and often cause the individual to be re-traumatized. It should be noted that in some instances, individuals who are part of loving and caring families may still, at times, exhibit challenging behaviors.

All individuals served by the public mental health system must feel valued, understood, and safe in the places where they are supported. Regardless of whether an individual lives in a place of his/her own or a licensed facility, it <u>is</u> his/her home and should be a safe haven. This place must be treated as the individual's home by all who may work there or who come to it. What happens in this place needs to center around what works for the person or people who live there, i.e., person-centered, not around the tasks that the caregivers need to complete on their shift, i.e., task-oriented, nor centered around maintaining compliance with "house rules."

A supportive and safe environment promotes helping the individual to establish and maintain meaningful relationships with caregivers in the home and people outside the home; supporting and assisting the individual to get involved in activities in the home and in the community that have value to him/her; shifting more choice and control to the individual; valuing and supporting caregivers; and providing continuous on-site support and training to home staff. Each of these areas will be further discussed in the pages that follow.

B. Establishment of Meaningful Relationships

Caregivers are in the position to help people create the foundations they need to be able to establish and maintain relationships. Relationships with others are crucial to a quality life and good mental and physical health, yet many of the individuals supported by the public mental health system, have few or no meaningful relationships. Good relationships are based on making individuals feel safe and unconditionally valued. Caregiver interactions, especially in the beginning stage of relationships or when the individual is feeling especially vulnerable, must focus on nurturing and valuing him/her. Once the foundation has been established, the circle of relationships can be more easily expanded.

C. Meaningful Activities

Individuals who have things to do during the day that are meaningful to them, in the home and out in the community, are less likely to exhibit the behaviors that result in the need for reactive interventions. In fact, there are many individuals who exhibit challenging behaviors at home, but exhibit none when they are out in the community. It is through a person's involvement in and completion of a task, game or routine that he/she can receive the positive affirmation, encouragement and support that leads to trusting others, feeling valued and gaining self-worth. Having meaningful activities also reduces boredom, both at home and in the community.

While it is important that each individual has the opportunity to choose the things he/she wants to do, he/she should also be assisted in performing the tasks that are part of everyone's life. These typical routines of daily life, and assisting the individual to perform them, should be the foci around which the operation of the home revolves, rather than a set of tasks that need to be accomplished solely by caregivers while they are on their shift, such as meal preparation, cleaning, laundry, and grocery shopping.

Meaningful activities in the "community" are things that any person would do during his/her day, such as going to sporting events, plays or music events, volunteering, paying bills, going to the bank, buying a lottery ticket, going to the salon for a hair cut, getting a membership at the gym, buying greeting cards at the store and mailing them at the post office to friends and family, picking up a newspaper at the same place every day, having coffee with a friend, and visiting a family member. The act of engaging in these activities of life brings with it not only multiple opportunities to make choices and to perform transactions that lead to self-confidence and self-worth, but also to interact with other human beings. Receiving a friendly welcome at the door of Meijer every week will be much more significant to the individual who goes there to buy a few personal items, than to the caregiver who ran to the store to pick up the items for him/her. Looking at all the goods available in the store, including colors, textures, funny pictures, sweet words, and even sounds, is also an activity in and of itself, and provides a low-risk opportunity to make a selection.

D. Opportunities for Making Choices

Every person has the right to choice and control in his/her own life. Arrangements that support Self-Determination give an individual true choice and control to self-direct his or her own life. As an individual has more and more frequent community activities in his/her life, he/she will have more and more opportunities to make choices. However, caution should be taken that individuals who are not used to having choice and control are not overwhelmed with too many choices or too many open-ended choices too soon. The more vulnerable the individual, the more consideration should be given for the level of support for their choice-making.

E. Identification of Precursors

Conducting a functional assessment of the precursors to challenging behaviors can serve to identify "triggers" that set off an action, process, or series of events and interactions that make individuals feel unsafe, insecure, anxious, panicked, or agitated. There is often a reason, situation, or person that is causing a particular reaction from the individual. In order to prevent such a reaction and promote a calm, safe, and positive environment, it is important to identify, then remove or reduce exposure to, the potential precursors that may initiate, sustain, or end a particular behavior.

The following are precursors that could contribute to a challenging behavior:

Transitions between Activities and/or Caregivers

It is possible that an individual may not like to do certain activities, such as family visits, going to bed, or taking a shower. Therefore, when he/she knows it is time for this activity, he/she may become frustrated. Similarly, the individual may not like or feel comfortable with a specific person living in the home, or a caregiver or other staff person working in the home. When he/she is around this person, he/she may exhibit a challenging behavior. There are also certain situations that could be a trigger for the individual, such as being isolated, feeling pressured, people being too close, people yelling, being in the dark, or people being too close.

Sensory Integration

Difficulties with sensory integration processing create anxiety in some people due to over- or under-stimulation. It is important to have this assessed if it is suspected to be a precursor to challenging behavior. Sensory integration processing issues are often associated with individuals who have autism; however, they can also affect other individuals. People identified as having sensory integration processing issues should receive necessary interventions, many of which need to be included as part of their daily routines.

Physical Health

Chronic health conditions and acute episodes of illness can heighten sensitivity and trigger challenging behavior. An annual physical examination and a medical history record are important to identify and track conditions, and should be used as a basis for a care plan that calls for caregivers to pay attention to early signs that a condition is reoccurring or intensifying.

The medications individuals take can cause reactions, some paradoxical to the purpose of the medication. Some medications may make an individual feel "different" but have no physical signs, and the individual may communicate these subtle feelings through exhibiting a challenging behavior. Other individuals may be overmedicated and experience medication interactions.

Many individuals who exhibit challenging behaviors also receive psychiatric services. It is critical that psychiatrists are making recommendations regarding diagnosis and treatment on sound objective information.

Another type of "precursor" is the cues, or early warning signs, the individual gives that they are beginning to feel unsafe, insecure, anxious, or frustrated. By becoming sensitive to these cues, we can change our interactions to be more supportive and less demanding before the situation escalates into more dangerous behaviors. Some examples of these cues are restlessness, shortness of breath, pacing, sweating, shaking, rocking, crying, and clenching teeth.

There are numerous strategies that can be used to calm an individual when he/she shows signs of no longer feeling safe. Strategies will vary from person to person. Some individuals may prefer to talk to someone, including peers, family, or maybe staff. Others may want to lie down or listen to peaceful music or look at a magazine. Taking a walk or exercising may also help. It is important to remember to ask the individual what helps him/her calm down. Be creative, and if a strategy does not work, try something else.

F. Transition Planning

Transitions can be very stressful for individuals. Transitions include changing homes or jobs, changes in caregivers at shift change, or may be something as simple as getting up in the morning or ending one activity and beginning another.

Changes in Homes

Whether the individual is moving because of his/her choice or because of the decision of others, it is one of the biggest changes he/she will make in life. The public mental health system needs to become better at matching individuals with the places they will live, people who will live with them, and people who will support them, regardless whether he or she moves to a family home, own home,

or group home. The CMHSP, provider, and home staff should have frank discussions about whether an individual would be successful in a particular home or conversely, whether the home can successfully support the individual; develop together and implement a very detailed transition plan; make sure caregivers are trained and supported; and provide on-going on-site assistance and support to the home.

In-Home Transitions

Small transitions made on a daily basis can make a person feel anxious and insecure. Some examples of daily transitions include: getting out of bed in the morning, brushing teeth after breakfast, leaving for work/school, changing tasks at work/school, moving from one location to another at work/school, coming home from work/school, getting ready for dinner, and getting ready for bed. For those who have multiple caregivers, the change of shift can also be disconcerting.

It is important to make transitional events as predictable as possible and to be encouraging and less demanding during these times. Reviewing with the individual visual cues and/or schedules can also assist during transitions.

G. Caregiver Interactions

Interactions with individuals need to promote a sense of companionship, connectedness and community. Caregivers need to be very self-aware of how they are perceived by the individual they support. The vulnerabilities a person brings to an interaction determine how interactions are perceived. In some cases, a caregiver's presence alone can trigger memories of demands and trauma in the individual being supported. Caregivers need to be aware of what their body posture, facial expression, tone and volume of voice, and hand gestures communicate. Smiles and expressions of warmth are needed at all times. Words need to be soft, slow and uplifting. Touch needs to be respectful and purposeful in making the individual feel safe and valued.

H. Communication

Behavior is a form of communication. Behaviors identified as challenges are often expressions of unmet needs. Caregivers should not only identify the unmet need and try to meet it, but also attempt to teach the individual other ways to communicate his/her needs, such as needing to take a break, not feeling well, or needing affection. As with any attempt to build a skill, this can only be done successfully if the individual is taught by someone who truly understands and cares about him/her.

I. Staff Training and Support

Only the most skilled caregivers should be supporting individuals who have a history of challenging behavior. The CMHSP and provider need to assure that caregivers are properly trained to best support the individual. Using temporary or rotating/floating staff that has not been trained to support the specific individual should be avoided entirely. Caregivers should receive basic direct care staff training, training specific to the individual, transitional training, and knowledge of preventive strategies related to the issues that lead to the individual's anxiety or frustration. All home staff, provider staff, and CMHSP staff should be trained in approaches that support a culture of gentleness.

The provider needs to ensure that caregivers are valued and supported, but also have clear directions on what is expected of them. It is consistently reported across the state that direct caregivers who feel valued and supported by their supervisors, the provider, and the CMHSP are more satisfied with their jobs and are less likely to leave. Staff turnover can have devastating effects on the individuals they support. If the relationships were positive, staff departure is another loss to the individual. The costs associated with turnover cannot be minimized either. Home staff should hold regular staff meetings that focus on support, improving morale, coaching and reinforcement of training, and problem-solving.

Direct caregivers, who view the place where they work as an individual's home, and perceive the individual as a peer, will be less likely to treat him/her as a less-valued person. Individuals who feel safe in the presence of caregivers, who feel valued, and who are receiving positive and undivided attention from caregivers are less likely to exhibit challenging behaviors. However, some caregivers may need to be coached and supported in making the transition from viewing their job as custodial and relating solely with other caregivers, to interacting and connecting with the people they serve. Helping to build and strengthen the relationships between individuals and caregivers should be a primary goal of managers and supervisors. Another goal should be clearly communicating expectations about caregiver behavior on the job (e.g., texting and taking personal calls need to be confined to staff break periods).

CMHSPs should provide on-going, on-site clinical, case management/supports coordination involvement and support to the home staff for situations that are challenging. Clinicians and case managers/supports coordinators need to be trained in positive behavioral support techniques, in addition to the providers and home staff. Clinical support staff should also commit to and have the skills to be able to work along-side the direct caregivers to assist in modeling, coaching and troubleshooting.

If there is potential (i.e., based on recent history) that a challenging behavior may occur, then there should be a written behavior plan for what home staff are to do. If the action caregivers are to take requires a behavior plan, then the plan should go to the setting with the individual; caregivers should be trained in the implementation of

the plan; and the plan should be continually evaluated, modified and updated as needed. The CMHSP should provide ongoing and on-site support and mentoring to the provider and home staff as necessary to assist in the implementation of the behavior plan. Also, the provider should have leadership present during all waking shifts: a manager, assistant manager, a lead direct care worker, or a shift leader who has experience in implementing behavior plans that focus on helping the individual feel safe and valued. The home should also be cognizant of the organization of staff resources, and schedule new caregivers with more experienced caregivers.

III. Positive Behavior Support Plan

MDCH encourages the development of a Positive Behavior Support Plan that includes positive approaches to preventing and decreasing challenging behaviors, as well as focusing on improving the individual's quality of life. All behavior plans must be developed with the individual during the person-centered planning process.

The TR requires that the Behavior Treatment Plan Review Committee (the Committee) review any Behavior Treatment Plan that includes intrusive and/or restrictive techniques. However, it is suggested that all behavior plans developed by the CMHSP be reviewed by the Committee or by other available resources, such as clinical or interdisciplinary peer review or case consultation. Members of the Committee and other available resources provide valuable expertise that may assist the plan developer in improving the behavior plan.

A. Key Ingredients to an Effective Positive Behavior Support Plan

The following guidelines are useful to assist the plan developer in creating a Positive Behavior Support Plan:

1. Involving the individual in the development and implementation of the plan during the person-centered planning process allows him/her to achieve goals that he/she has chosen.
2. A functional behavioral assessment looking at the situational and motivational variables affecting the presence of a challenging behavior helps the person and everyone involved to understand why the behaviors occur and develop workable ways to achieve better alternatives.
3. Everyone who relates to the individual in any important way should receive training on how to participate in his/her plan.
4. Data collection and analysis of the plan will allow the individual to track his/her progress over time, as well as identify problems early.
5. Celebrate progress in meeting goals.

B. Positive Behavior Supports in a Culture of Gentleness

The MDCH preferred approach when addressing aggressive, self-injurious, or other challenging behaviors is to use Positive Behavior Support strategies within the

framework of a Culture of Gentleness. Positive Behavior Support is a set of research-based strategies used to increase opportunities for an enhanced quality of life while decreasing challenging behaviors by teaching new skills and making needed changes in a person's environment (Association for Positive Behavioral Supports [APBS]). Positive Behavior Supports are most effective when they are implemented across all environments, such as home, school or work, and in the community. Positive Behavior Supports include, but are not limited to, the following:

1. Provision of a sense of safety
2. Teaching the individual that engagement with others is good
3. Teaching the individual to value others and provide opportunities to establish meaningful relationships
4. Enhancement of the individual's sense of self-value
5. Assurance of consistency through structure
6. Provision of opportunities to express autonomy while receiving necessary supports
7. An environment that is conducive to optimal learning
8. Teaching skills that promote companionship, esteem building, problem solving and coping abilities
9. Community inclusion

C. Proactive Strategies in a Culture of Gentleness

Supporting individuals in a Culture of Gentleness is an ongoing process that requires patience and consistency. As such, no precise strategy can be applied to all situations. The following are some general strategies to consider when trying to prevent challenging behaviors from occurring in the first place, or for reducing their frequency, intensity, or duration:

1. Unconditional Valuing – through the actions (words, touch, eyes, presence) of the caregivers, the individual must feel that they are valued for who they are, not for what they have done or not done.
2. Precursor Behaviors – look for indicators that the individual is starting to feel unsafe or anxious and immediately drop demands and increase rewarding or positive interactions.
3. Environmental Management – items that could be distracting or used as weapons should be placed out of sight; how caregivers position themselves can prevent possible injury.
4. Stimulus Control - set up the materials for activities before the person arrives so as to ensure success through the consideration of factors such as the arrangement and control of materials, concreteness of the task, teaching methods, location, etc.
5. Errorless Learning (Chaining) - break learning skills into a sequence which facilitates their acquisition, and provide adequate support in order to avoid errors (so that structured tasks can serve as vehicles to teach that the interaction is more important than the task itself).
6. Teach Quietly - initially using minimal verbal instruction maximizes the power of verbal reward, and prevents on-task confusion. Gradually use more

language as the strength of the relationship allows the ability to "stretch" the individual.

7. Shaping and Fading - use the caregiver's initial intense presence, necessary support and valuing teaching as a way to ensure as much as possible the person's on-task attention (shaping), and then as rapidly as possible remove the external support so that the person will remain on-task and be able to receive sufficient reward from the task itself (fading).
8. Assistance (Prompting) - initiate learning with a sufficiently high degree of assistance to ensure success and systematically and rapidly decreasing the degree of assistance, but ready at any given point in time to offer higher degrees of assistance as needed for the purpose of redirection or valuing.
9. Using the Task as a Vehicle, Not an End in Itself – each part of the day needs structuring so that there are opportunities to create valuing interactions - we cannot wait for these opportunities to present themselves; the task of learning is secondary to teaching that interactions are rewarding in and of themselves.
10. Redirection - the redirection of an individual to a more positive interaction/activity through minimal verbal or gestural guidance; redirecting to a break or away from anxiety-provoking situations; if capable, redirecting to utilize previously learned coping skills.
11. Reinforced Practice – providing many opportunities to practice and receive validation for performing newly learned behavior in order to ensure its retention.
12. Validating Feelings – verbally acknowledging what the individual may be feeling
13. Reinterpreting or Reframing Antecedent Events – helping the individual get a different perspective on the precipitating event.

D. Reactive Strategies in a Culture of Gentleness

Positive Behavior Support Plans should give caregivers direction in how to respond when individuals begin feeling unsafe, insecure, anxious or frustrated. The following are examples of those strategies:

1. Be Aware of Precursors – Be aware of the behavioral precursors that the individual expresses so caregivers can provide support before the situation escalates. Also, identify precursors to *positive* behaviors and apply these to increase the likelihood for positive behavior to occur.
2. Reduce Demanding Interactions – Being told to "stop" or "calm down" can be perceived by the individual as demanding. Additionally, common forms of redirection can also be demanding depending upon the individuals. The functional assessment should be helpful in determining what is demanding to that individual.
3. Increase Valuing/Supportive/Warm Interactions – At all times, and particularly when an individual is having a difficult time, it is important that the people around him/her create a warm and supported atmosphere where he/she feels valued. This could include validating the individual's feelings.

4. Redirect – Redirect to an alternative activity if it is determined that it is not too demanding. The undesirable behavior will not be reinforced if that is the only time the individual is able to engage in it.
5. Modeling the Activity – Model or show the individual how to do the activity, then assist with the activity, providing active support as needed, encouraging but not demanding the individual complete it. Then, eventually reduce support.
6. Give Space – Be ready to help the individual as described above, or at times, give him/her some space (both in time and/or physical distance). However, be cautious that the individual is not left alone for extended periods of time.
7. Focus on the Relationship – Continue to focus on the power of the relationship between the caregiver and the individual. The task or activity is not important at this point.
8. Maintain a Calm, Relaxed Manner – It is important for the caregiver to remain calm and relaxed.
9. Use Blocking techniques –Use arms, hands, pillows, etc. to block an individual from exhibited a behavior, such as hitting himself/herself or others. For example, if someone is hitting himself/herself in the face, with an open palm, the caregiver should place his/her hand or arm over the person's arm to block attempts to get to his/her face. If someone is attempting to hit another person, the caregiver should hold hands with the person and attempt to keep his/her hands away from the caregiver.
10. Environmental Manipulations – Use environmental manipulations to keep individuals safe – e.g., keeping furniture between the individual and others; move others out of the area.
11. Focus on Safety – The focus and priority should be on safety, not teaching a lesson. Not only should the person be in a safe environment, they must also *feel* safe and valued.

V. References

General Introduction to Positive Behavior Support. *Association for Positive Behavior Support*. (2007). Retrieved July 2010, from http://www.apbs.org/new_apbs/genIntro.aspx

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How Person-Centered Planning Works for You

August 9, 2011

Behavioral Health and Developmental Disabilities Administration
Bureau of Community Mental Health Services
Division of Quality Management and Planning

How Person-Centered Planning Works for You

Note: Words in italics are defined in the Glossary at the end of the booklet.

Person-centered planning is a way for you to plan the life you want. It builds upon your capacity to engage in community life and honors your preferences, choices, and abilities.

1. Person-Centered Planning

Why Is Person-Centered Planning Required?
Person-centered planning (PCP) has been required by the Michigan Mental Health Code (Code) since 1996 to ensure that individuals can direct the process of planning for their mental health services and supports.

However, PCP is much more than just creating your plan. It is a way for you to make sure you live your life the way that you want. Instead of focusing on what you cannot do, PCP focuses on what you can do.

How Will I Benefit From Person-Centered Planning?
Through PCP, you identify your goals, hopes, interests and preferences for your life. You also will plan how you will work toward and achieve them, including the services and supports you need.

Who Is Involved in the Person-Centered Planning Process?
You choose the people you want involved in your planning process. Some ideas of people involved are: friends, family or anyone else important to you. Involve people who you know well, who care about you, and who believe in you. Think of them as your *allies*.

How Can My Allies Help?
Your allies (sometimes, they are called a circle of support or a support network) can help in a number of ways. They can brainstorm creative ideas or solutions to problems, work with you to explore your options, assist you in achieving your goals and support you in making choices.

Can I Use Person-Centered Planning if I Have a Guardian?
Yes, everyone who receives services and supports through a public mental health agency uses PCP. Your guardian will work with you to talk about your choices and options when developing your plan.

How Is Person-Centered Planning Different Than Self-Determination?
PCP is the way you decide what your goals are and the way you develop a plan to achieve them including what services and supports you need from the community

mental health system. *Self-Determination* is a way to have more control over how those services and supports are provided. In arrangements that support self-determination, you have control over your individual budget for the services and supports in your plan and you can directly choose and manage the people or agencies that provide your services and supports. Ask your supports coordinator or case manager for more information and a copy of the booklet, "How Self-Determination Works".

How Does My Mental Health Agency Help?
A *supports coordinator* or *case manager* from your mental health agency supports, guides, informs and assists you in learning about PCP and assures that you control the planning process. Through the process, you set the agenda for your meeting. You can use an independent facilitator to assist you (see Section 2 below).

Under a new federal rule, you can also choose not to have a supports coordinator or case manager. If you choose not to have a supports coordinator or case manager, someone at your mental health agency will be responsible for obtaining authorization for your services and supports. You can also choose to have a supports coordinator assistant or an independent supports coordinator. You can also get information and help from the Customer Services Department at your mental health agency.

2. Independent Facilitation

What Does the Independent Facilitator Do?
The *independent facilitator* serves as your guide during the PCP process, making sure that your hopes, interests and goals are the focus. Your independent facilitator helps you with the planning activities (see Section 3 below) and may also lead the PCP meeting if you choose.

Can I Use an Independent Facilitator?
Yes, you have the right to independent facilitation of the PCP process. It is your choice whether or not to use an independent facilitator.

Who Can Be My Independent Facilitator?
An independent facilitator does not work for your mental health agency. He or she is trained in PCP. He or she must know or get to know you, including:

- What you like and dislike
- Your hopes, interests and goals
- How you communicate
- Who supports and/or is important to you

How Does My Independent Facilitator Work With My Mental Health Agency?
Your supports coordinator or case manager is responsible for developing your plan with you. Your independent facilitator works with you and your supports coordinator or case manager to ensure that your plan reflects what you want and need.

3. Pre-Planning

Through pre-planning, you prepare for the PCP process (which you may think of as your PCP meeting or just your meeting). **Pre-planning is done before your meeting.**

What Is Pre-Planning?
Pre-planning is preparing for the planning meeting and important for successful planning. When you pre-plan, you decide who will be involved in your PCP process, what you will talk about, and where your meeting or meetings will be held.

Who Is Involved in Pre-Planning?
You can choose to do pre-planning with your supports coordinator, an independent facilitator, and/or your trusted ally or allies.

What Decisions Do I Make Through Pre-Planning?
With the person or persons helping you in pre-planning, you decide:

- What things you want to and do not want to talk about at your meeting
- What things you want to talk about outside of your meeting
- Who you want to invite to your meeting
- Where and when your meeting will be held
- Who will lead your meeting (You may want to lead your meeting, or you may want your supports coordinator or independent facilitator to run your meeting)
- Who will write down what happens at your meeting

4. The Process (or Meeting)

What Can I Talk About at a Person-Centered Planning Meeting?
You can talk about anything that is important to you—everything from your hopes, interests, goals and desires for life to your preferences about what you do every day and how your support is provided. You may also talk about what may get in the way of your goals. You and your allies work together to decide what services and supports you need to work toward and achieve your goals.

What If I Want to Use Community and other Resources Outside of my Mental Health Agency?
PCP is not limited to planning the services and supports from your public mental health agency. If you identify other resources, services and supports, you, your supports coordinator or your case manager, and your allies can look for opportunities and ways to achieve your goals. For example, other agencies may help you obtain employment skills you want and need.

How Often Do I Have a Meeting?
PCP is not a single meeting. It is a process. The process may take lots of time in the beginning as you gather information about you, your hopes, interests, goals and needs. After this work is done, you will review and update your plan as your goals or needs change. You can use PCP any time your wants or needs change. Sometimes, you will need to have a meeting; other times, you will work with your supports coordinator or case manager to make the changes you need.

5. Your Individual Plan of Service (often called an IPOS or Plan)

The Code requires that you develop your plan through the PCP process. That plan includes information about you, your goals and outcomes and the services and supports that you need to achieve those goals and outcomes.

What Is an Individual Plan of Service (Plan)?
The plan is for you and includes your vision of what you would like to be and do. The plan focuses not just on activities, but also on results. The plan includes your goals and outcomes as well as the services and supports paid for by your mental health agency that will enable you to work toward and achieve your goals and outcomes. The services and supports included in your plan are intended to support you to:

- Achieve your goals
- Meet your needs
- Assist you to connect with people in your community
- Help you participate in activities you choose
- Support you in taking on a valued role in your community

What Is in a Plan?
Services and supports in the plan must be based upon the desired goals and outcomes that you defined through PCP. Your services and supports must be *medically necessary* and defined in terms of *amount*, *scope* and *duration*. In addition, you should be given a list of the estimated cost of the services and supports in your plan.

Who Approves My Plan?
Your mental health agency approves your plan.

When Do I See the Written Plan?
You have a right to a written copy of your plan within 15 days after your plan is done.

6. Ways to Make Changes and Solve Problems

How Can I Make Changes or Solve Problems?
You have a PCP meeting any time you want to change your plan. PCP is often the best way to make changes or solve problems because your allies can work together to help you come up with creative solutions.

What If I Do Not Agree With My Plan?
If you are not satisfied with your PCP process or your plan developed through that process, there are several things that you can do. You can:

- Start over the PCP process, perhaps using an independent facilitator
- Request a review of your plan in writing. Once your request is made, the mental health agency has 30 days to review the plan.
- Use the dispute resolution process at the mental health agency
- Appeal any actions the mental health agency takes to change, reduce, or terminate your Medicaid services or an issue related to the PCP through the *Medicaid Fair Hearings Process*

Your supports coordinator must inform you about these rights.

Glossary –Words Used in This Booklet and What They Mean

Allies: Friends, family members and others who you choose to assist you in PCP.

Amount: The number of times or frequency of service identified in your plan of service or treatment plan to be provided.

Case Manager: Someone who works for your mental health agency and helps you develop and monitor your plan.

Duration: The length of time (e.g. three weeks, six months) it is expected that a service identified in the plan will be provided.

Individual Plan of Service (IPOS or Plan): The list of services and supports that is approved and funded by your mental health agency.

Independent Facilitator: A person you choose to assist and guide you through the PCP process.

Medicaid: A federal/state program that pays for the services and supports in your plan.

Medicaid Fair Hearing Process: The legal process, conducted by the state Administrative Law Judge (ALJ), for review of an action taken by your mental health agency to change, reduce or terminate your Medicaid services.

Medically Necessary: Mental health, developmental disabilities and substance abuse services are supports, services and treatment:

- Necessary for screening and assessing the presence of a mental illness, developmental disability or substance use disorder; **and/or**
- Required to identify and evaluate a mental illness, developmental disability or substance use disorder; **and/or**
- Intended to treat, ameliorate, diminish or stabilize the symptoms of mental illness, developmental disability or substance use disorder; **and/or**
- Expected to arrest or delay the progression of a mental illness, developmental disability or substance use disorder; **and/or**
- Designed to assist the beneficiary to attain or maintain a sufficient level of functioning in order to achieve goals of community inclusion and participation, independence, recovery or productivity.

Mental Health Agency: The mental health agency that approves your plan and pays for your supports and services.

Person-Centered Planning: The way that you, with the support of your allies and supports coordinator or case manager, identify what you want to do in your life and what services and supports you need to accomplish what you want to do.

Self-Determination: Arrangements where you control the individual budget for your plan. You choose who supports you, when they support you and how that support is provided.

Scope: The way the service will be provided, including:

- Who (e.g., professional, paraprofessional, aide supervised by a professional)
- How (e.g., face-to-face, telephone, taxi or bus, group or individual)
- Where (e.g., community setting, office, your home)

Supports Coordinator: Someone who works for your mental health agency and helps you develop and monitor your plan.

MICHIGAN
ADVANCE DIRECTIVE
FOR MENTAL HEALTH CARE

I, _____, am of sound mind and I
(Print or type your full name)
voluntarily make this designation.

APPOINTMENT OF PATIENT ADVOCATE

I designate _____, my _____,
(Insert name of patient advocate) (Spouse, child, friend …)

living at _____,
(Address of patient advocate)

telephone number _____, as my patient advocate.

If my first choice cannot serve, I designate _____,
(Insert name of patient advocate)
my_____, living at_____
(Spouse, child, friend …) (Address of patient advocate)
_____, telephone number _____, as my patient advocate.

GENERAL POWERS

My patient advocate can only make decisions for me if a physician and a mental health professional determine I cannot give informed consent for mental health care.

My patient advocate must sign an acceptance before he or she can act. I have talked over this appointment with the individuals I have chosen as patient advocate.

In making decisions, my patient advocate shall try to follow my wishes, whether I have talked about them or written them in this document or any other document.

I give my patient advocate power to agree to or refuse treatment as set forth below, and to pay for such services with my funds.

SPECIFIC POWERS

Following is a list of types of treatment. I can choose one or more, by writing my initials on the line. By my initialing a line, I give my patient advocate power to consent to or refuse that type of treatment. On the following pages, I can indicate my specific wishes concerning each type of treatment I initial here.

_____ The individual I have chosen as my patient advocate shall have access to any of my medical and mental health records to which I have a right, immediately upon signing an Acceptance. To grant such access, I appoint this individual as my "personal representative" as defined in the privacy provisions of the Health Insurance Portability and Accountability Act, and as my "authorized representative" as defined in the Michigan Medical Records Access Act.

_____ outpatient therapy

_____ my admission as a formal voluntary patient to a hospital to receive inpatient mental health services. I have the right to give three days notice of my intent to leave the hospital.

_____ my admission to a hospital to receive inpatient mental health services

_____ psychotropic medication (psychiatric medicine)

_____ electro-convulsive therapy (ECT)

_____ placement in a group residence

_____ seclusion and restraints

STATEMENT OF PREFERENCES

(optional)

1. The doctor and mental health professional I want to make the decision if I am not able to give informed consent are:

_____

2. If I need outpatient therapy, I prefer it to be provided by _____, in the following setting: _____

3. If I need to be hospitalized for inpatient treatment, I prefer the following hospital:

_____.

4. If I need to be hospitalized, I prefer _____
to take me to the hospital.

5. If I need medication, I prefer to receive _____
at the following dose(s) _____. I **do not** want to receive the following medication or medications: _____, because _____

6. If I have given my patient advocate authority concerning ECT treatments, I want the maximum number of treatments to be _____.

(Write " O" if you do not want ECT)

7. Additional wishes:

REVOCATION

(Initial one statement)

_____ I may change my mind at any time by communicating in any manner that this designation does not reflect my wishes.

_____ I give up my right to have a revocation effective immediately. If I revoke my designation, the revocation is effective 30 days from the date I communicate my intent to revoke. Even if I choose this option, I still have the right to give three days notice of my intent to leave a hospital if I am a formal voluntary patient.

LIABILITY

It is my intent that no one involved in my care shall be liable for honoring my wishes as expressed in this designation or for following the directions of my patient advocate.

Photocopies of this document can be relied upon as though they were originals.

SIGNATURE

I sign this document voluntarily, and I understand its purpose.

Dated: _____

Signed: _____
(Your signature)

_____
(Address)

STATEMENT REGARDING WITNESSES

I have chosen two adult witnesses who are not named in my will; who are not my spouse, child, grandchild, brother or sister; who are not my physician or my patient advocate; who are not an employee of my life or health insurance company, an employee of a home for the aged where I reside, an employee of community mental health program providing me services or an employee at the health care facility where I am now.

STATEMENT AND SIGNATURE OF WITNESSES

We sign below as witnesses. This declaration was signed in our presence. The declarant appears to be of sound mind, and to be making this designation voluntarily, without duress, fraud or undue influence.

_____

(Print name) (Signature of witness)

_____

(Address)

_____ _____

(Print name) (Signature of witness)

_____

(Address)

I, _____, understand the above
(Name of patient advocate)
conditions and I accept the designation as patient advocate or successor patient advocate for _____, who signed an
(Name of patient)
advance directive for mental health care on the following date: _____.

Dated: _____

Signed: _____
(Signature of patient advocate or successor patient advocate)

ACCEPTANCE BY PATIENT ADVOCATE

(1) This designation shall not become effective unless the patient is unable to participate in decisions regarding the patient's mental health.

(2) A patient advocate shall not exercise powers concerning the patient's care, custody and medical or mental health treatment that the patient, if the patient were able to participate in the decision, could not have exercised in his or her own behalf.

(3) A patient advocate shall not receive compensation for the performance of his or her authority, rights, and responsibilities, but a patient advocate may be reimbursed for actual and necessary expenses incurred in the performance of his or her authority, rights, and responsibilities.

(4) A patient advocate shall act in accordance with the standards of care applicable to fiduciaries when acting for the patient and shall act consistent with the patient's best interests.

(5) The known desires of the patient expressed or evidenced while the patient is able to participate in medical or mental heath treatment decisions are presumed to be in the patient's best interests.

(6) A patient may revoke his or her designation at any time or in any manner sufficient to communicate an intent to revoke.

(7) A patient may waive his or her right to revoke the patient advocate designation as to the power to make mental health treatment decisions, and if such waiver is made, his or her ability to revoke as to certain treatment will be delayed for 30 days after the patient communicates his or her intent to revoke.

(8) A patient advocate may revoke his or her acceptance to the designation at any time and in any manner sufficient to communicate an intent to revoke.

(9) A patient admitted to a health facility or agency has the rights enumerated in Section 20201 of the Public Health Code, Act No. 368 of the Public Acts of 1978, being Section 333.20201 of the Michigan Compiled Laws.

ADVANCE DIRECTICE GUIDELINE
MDCH/BHS/L&C
(DESIGNATED PATIENT ADVOCATE AUTHORITY TO ADMIT A PATIENT TO A PSYCHIATRIC INPATIENT UNIT)

MCL 330.1415 (Section 415 of the Michigan Mental Health Code) in part provides that "an individual 18 years of age or over may be hospitalized as a formal voluntary patient if … the individual assents…(and) a patient advocate authorized by the individual to make mental health treatment decisions under the estates and protected individuals code, 1998 PA 386, MCL 700.1101 to 700.8102, executes an application for hospitalization and if the hospital director considers the individual to be clinically suitable for that form of hospitalization."

This DRAFT GUIDELINE is designed to assist psychiatric inpatient program admission personnel in determining whether an individual representing him/herself as patient's designated patient advocate (DPA) named in a Patient Advocate Designation Instrument (PADI) such as a Durable Power of Attorney for Health Care (DPOA-HC) has authority to admit the patient to a psychiatric unit as provided in MCL 330.1415.

Based on discussions with DCH-ORR, a DPA has standing to execute an application for the hospitalization of a patient in a psychiatric inpatient unit only if the following 4 key elements are present in the patient's PADI or DPOA-HC and the applicable required documentation is presented for review to the admitting hospital:

1. As provided by MCL 700.5509(1)(h), the PADI or DPOA-HC conveys to the DPA the authority to exercise mental health treatment decisions.

   If the PADI or DPOA-HC does not reference authority to exercise mental health treatment decisions, the DPA may NOT execute an application for the hospitalization of the patient in a psychiatric inpatient unit as provided by MCL 330.1415.

   NOTE that unless specifically authorized in the patient's PADI or DPOA-HC, the DPA can NOT:

   a. Consent to forced administration of medication [MCL 700.5509(1)(h)],

   b. Consent to hospitalization other than as a formal voluntary patient under the provisions of MCL 330.1415 [MCL 700.5509(1)(h)],

   c. Consent to Electro-convulsive Treatment [MCL 330.1717(1)(d)].

   d. Delegate his or her powers to another individual [MCL 700.5509(1)(g)].

2. As provided by MCL 700.5515(2), the DPA may exercise the power to make mental health treatment decisions for the patient only after a physician and a mental health practitioner have examined the patient and both certify in writing that the patient is unable to give informed consent [see Rule 330.7003(1)(b)(c)(d)] to mental health treatment.

   The psychiatric inpatient unit admission officer should ask the DPA for a copy of the written certification completed by the examining physician and mental health practitioner documenting that the patient is unable to give informed consent to mental health treatment.

3. The PADI or DPOA-HC includes one of the following provisions regarding revocation of the patient advocate designation:

   A. Pursuant to MCL 700.5510(1)(d), a patient may revoke a patient advocate designation at any time and in any manner by which he or she is able to to communicate his/her intent to revoke the patient advocate designation. The patient's revocation shall be effective immediately.

   B. Pursuant to MCL 700.5515(1) the patient may waive the immediate right to revoke a patient advocate designation. In such circumstances, if the patient does revoke the patient advocate designation, the revocation becomes effective 30 days from the date that the notice of revocation is provided.

      NOTE that MCL 700.5515(1) provides that if the patient elects to waive his her/her right to revoke a patient advocate designation, the patient shall still have the right to give three days notice of his/her intent to leave the hospital under the provisions of MCL 330.1419

4. As required by MCL 700.5507(3), the individual designated to be the patient's DPA has signed an acceptance to be the designated patient advocate.

<u>Note that a properly credentialed DPA may only execute an application for hospitalization of a patient if the above 4 conditions are met and the patient ASSENTS to the admission as provided in MCL 330.1415.</u>

The statutory provisions regarding the authority, duties responsibilities of a designated personal advocate, and mechanism for dispute resolution regarding the authority or actions of the personal advocate are found at MCL 700.5506 to MCL 700.5515.

While not an exhaustive listing of applicable requirements, DCH-ORR notes that hospital staff need to be aware of the following other additional legal requirements specified in the Acceptance by Patient Advocate section of the Michigan Advance Directive for Mental Health Care that can be down loaded from the DCH-ORR web site at http://www.michigan.gov/recipeient rights.

(1) A patient advocate shall not exercise powers concerning the patient's care, custody and medical or mental health treatment that the patient, if the patient were able to participate in the decision, could not have exercised in his or her own behalf .

(2) A patient advocate shall act in accordance with the standards of care applicable to fiduciaries when acting for the patient and shall act consistent with the patient's best interests.

(3) The known desires of the patient expressed or evidenced while the patient is able to participate in medical or mental heath treatment decisions are presumed to be in the patient's best interests.

(4) A patient advocate may revoke his or her acceptance to the designation at any time and in any manner sufficient to communicate an intent to revoke.

(5) The patient advocate will have the right to the patient's medical records, as soon as the patient advocate signs for acceptance if the patients DPOA-HC includes the provisions that "The individual I have chosen as my patient advocate shall have access to any of my medical and mental health records to which I have a right, immediately upon signing an Acceptance…"

If the above provision is not noted or authorized in the patient's DPOA-HC, the patient advocate will have access to the patients medical records only after a physician and a mental health professional have determined that the patient cannot give informed consent for mental health treatment.