

## **Connecticut Implementation of Person-Centered Care**

### **What is Person-Centered Care and How Can it Be Designed for Application in Connecticut?**

Commissioner's Policy Statement #83 formally designates the concept of "recovery" as the overarching goal of the service system operated and funded by the Department of Mental Health and Addiction Services. DMHAS' mission to provide recovery-oriented care requires that services be maximally responsive to each individual's unique needs, values, and preferences. The Department has used the terms "person centered care" and "person centered planning" to refer to a body of principles and practices which, together, constitute an exciting and innovative approach that will allow DMHAS to advance in this mission and to create a recovery-oriented system where consumers take greater control over their treatment and life decisions.

This emphasis on person-centered care occurs at a particularly opportune time as it is consistent with major advances that have already occurred throughout the DMHAS system, e.g., greater collaboration with consumer advocacy and advisory groups, increased recognition of, and funding for, peer-run services, and the promotion of tools which promote consumer self-determination, e.g., advance directives. In addition, person-centered care promises to be a particularly effective means of promoting DMHAS' efforts to provide culturally responsive care, in that it goes beyond an appreciation of culture and ethnicity as group phenomenon to appreciate the specific influence each may have on the individual's unique sense of identity, values, needs, and preferences.

This document draws upon lessons learned in these DMHAS advances/efforts and upon established person-centered care models (e.g., from the developmental disabilities field), to begin to articulate and derive a Connecticut-specific model of person-centered care that has maximum relevance to behavioral health and to the Department's mission to provide recovery-oriented care. Within the context of the Recovery Institute, we have begun to conceptualize a model which allows for both: a) the system-wide enhancement of person-centered practices, and b) smaller, systematic pilots of specific PCP interventions that can subsequently be evaluated and considered for broader implementation (categories are detailed below).

### **Model for Connecticut Implementation and Issues of Transferability within the DMHAS System**

This strategy for implementation is consistent with the recommendations of national experts in person-centered care who caution large state agencies not to underestimate the organizational tensions and barriers that must be addressed in system-wide adoptions of PCP (Butkus et al., 2002). For example, Holburn & Vietze (1999) recommend "focusing initially on a small number of people for person-centered planning while simultaneously working on system changes that can affect all consumers" (Holburn & Vietze, 1999). While some flexibility and compromise in practices will be inevitable in the latter, it is critical that there be a high degree of fidelity in the former, i.e., in the pilot or demonstration sites. Pilot projects should be thoughtfully designed with careful attention to the site's ability to maintain integrity to the core features of PCP. If too much of the process is compromised, the result becomes something other than person-centered planning and it is a misrepresentation to call it that (Holburn & Vietze, 1998) – at which point the task of "transferability" becomes a moot point because there may be no intervention worth transferring.

In consideration of these factors, it is imperative that we select sites for the Connecticut PCP pilot that will have the highest likelihood of successfully carrying out the steps needed for an effective person-centered intervention. These steps include such things as building staff consensus, removing procedural barriers, and enacting significant practice changes which would: decrease the reliance on clinical professionals, shift authority to the individual, enhance the role of natural supporters, and focus the team on community-building efforts. Given these factors, the selection of an inpatient psychiatric setting (where many individuals are treated as a result of emergency orders and where the focus of care is on acute symptomatic stabilization) as an initial implementation site would appear to be inappropriate as the nature of the setting could significantly undermine the intervention. As such, the selection of one or two outpatient settings, preferably with strong evidence of effective community collaborations, are recommended as initial pilot implementation sites. However, as noted above, the Department can take a dual approach that can simultaneously shift practices in all service settings, including inpatient units. For the purpose of clarity, state-wide shifts in philosophy and practice are referred to below as Person-Centered

Care (PCC), while the smaller-scale, systematic pilot intervention is referred to as Person-Centered Planning (PCP).

### ***PCC: PERSON-CENTERED CARE***

**A). The state-wide transfer of multiple key person-centered practices which require minimal resources or policy changes.** These practices can, and should, be universally applied for all individuals and in all settings. They include things such as the following:

1. The planning process solicits the individual's unique goals and these are documented in the plan in the individual's own words.
2. The individual has input as to the location and time of planning meetings, as well as who is involved.
3. Significant effort is made to include "natural supports" and unpaid participants. The individual extends invitations to ANY person s/he believes will be supportive of their efforts toward recovery. Invitations extended are documented in the treatment plan.
4. To the extent possible, the individual has the ability to select his/her service providers.
5. Where rehabilitation providers are involved in housing, employment, or social goals, such providers participate in all planning meetings and are given copies of the resulting plan. The coordinating provider is held accountable for assuring that these steps occur.
6. Planning meetings and services can be delivered at a time that does not conflict with other recovery-supporting activities, e.g., employment.
7. All choices and service options are clearly explained to the individual. Where the options presented are not amenable to the individual, reasonable efforts are made to secure appropriate services elsewhere and these efforts are documented.
8. Assessment and treatment goals focus on areas of strength and capacity rather than deficits or dysfunction.
9. Planning focuses on the identification of concrete next steps (with timelines) that will allow the focus person to draw upon existing areas of strength to move toward recovery and their vision for the future. Individuals, including non-paid, natural supporters, who are part of the planning process commit to assist the individual in taking those next steps.
10. The focus of planning and care is on how to create pathways to community life and NOT just on how to maintain clinical stability or abstinence. All treatment plans document areas as physical health, social relationships, employment/education, spiritual life, housing satisfaction, community connections, etc., unless such areas are designated by the individual as not-of-interest.
11. The individual is presumed competent and allowed to make his/her own decisions. S/he is encouraged to take risks and try new things. Only in cases involving imminent risk of harm to self or others is a clinical professional allowed to override the decisions of the individual and his/her support team. Person-centered care does NOT take away the provider's right to take action to protect the individual or the public in the event of emergency/crisis situations. However, providers do have an obligation to be familiar with, and supportive of, the use of consumer-directed recovery-tools that allow for advance crisis planning, e.g., advance directives for health care and Wellness-Recovery-Action-Planning. It should also be noted that it has NOT been the experience of individuals implementing PCP (locally or nationally) that people use the process to make requests that dramatically increase risk. Rather, individuals tend to request support with areas that are not traditionally incorporated into their care, e.g., expanding recreational activities, finding a partner, getting a pet, etc.
12. The individual is automatically offered a copy of his/her service plan.

## ***PCP: PERSON-CENTERED PLANNING***

**B) Smaller scale, “pilot” implementations of person-centered care which more rigorously adhere to select practices previously identified in systematic applications of established PCP models.** These pilot applications of PCP and their select practices will require additional resources, organizational restructuring, policy changes, and significant training and technical assistance. As such, they should be reserved for those clients who stand to derive the most benefit from a high-fidelity implementation of PCP. Upon demonstrating the potential outcomes of these pilot projects, the Department can then determine the feasibility of broader-scale application given the costs/benefits involved. More systematic PCP approaches might first be targeted toward those DMHAS consumers with the most severe functional impairments as such individuals (and the providers who serve them) are often unable to see beyond the “patient role” and their community lives frequently involve minimal meaningful activities or natural supporters. Given the intended outcomes of the systematic PCP models, a more intensive application in this manner might allow such individuals to rediscover themselves as healthy persons with a history, a future, and with strengths and interests beyond their deficits or functional impairments. Proposed elements of a more intensive, systematic application of a PCP approach might include (in addition to those features noted above) the following elements:

1. **The support of a “facilitator” or “advocate”** to assist with conducting initial and follow-up planning meetings. A facilitator is someone who has been trained in the principles and practices of PCP, including the role of culture and ethnicity in planning and care. The facilitator is generally NOT the individual’s direct provider – as the idea is to shift the control of the interaction from professional providers toward the individual. The role of the facilitator is to support the focus person in voicing his/her aspirations, hopes, and dreams and to ensure that these remain the focal point of all planning efforts. Ultimately, the focus person becomes more capable of performing the advocacy function for him/herself. While providing the facilitator as an initial support might appear to require extensive resources, it may be possible to re-organize existing resources within the system to fill the need for facilitators, e.g., making use of current outpatient rehabilitation staff, or of staff within the PNP social rehabilitation agencies. In addition, given what we know about the power of peer support for individuals with behavioral health disorders, it might be a more optimal plan to train facilitators via the major consumer advocacy and recovery organizations (AU, CCAR, FOR-U) or through advocacy/empowerment training tracks which are increasingly visible in local clubhouses and other social rehabilitation agencies. The Department is already committed to expanding the employment of persons in recovery, and functioning as a PCP facilitator would be one natural role for such employees to fill. One state-operated facility has apparently re-organized resources to place consumer-providers on all clinical treatment teams – reflecting the fact that some agencies may already be postured to carry out this intervention with minimal effort. Finally, given the critical role that “giving-back” plays in the recovery process for many individuals, it is also likely that a substantial number of people in recovery could be trained as volunteer PCP facilitators - reflecting a potential resource that would be of no cost to the Department
2. **Use of a pre-planning meeting** between the facilitator and the focus person. The purpose of such a meeting is to identify: who should/should not be involved; when and where the meeting should happen; what the person’s top priority areas; and what is “off-limits.” Also, within the context of the pre-planning meeting, some formal measure should be incorporated which comprehensively (but simply) assesses the individual’s strengths and interests. Samples include those instruments developed at SMHA and used within their PCP initiative, i.e., The Personal and Environmental Strengths Questionnaire and the Comprehensive Interest Inventory. The pre-planning meeting may also include the use of additional planning tools known as expanded “life profiles” or “MAPS.” In addition to uncovering the individual’s resources and assets, these tools often review the following type of information: background and history (what works/doesn’t work); relationships, where/how person spends time; what types of choices the person does/does/not make; what is the dream/nightmare for the future; what are the trends in the environment that promote/hinder independence; exploring the ideal day; community connections; cultural concerns; spirituality and faith resources; and overall health and medical conditions.

3. **Use of “flexible funding” pools.** In systems where PCP is firmly embedded as the core means of delivering services this translates into self-determined funding structures where the individual actually has control over his/her own budget, e.g., the widely successful national DMR/Robert Wood Johnson Self-Determination Project. While the funding structures within DMHAS are not currently organized in a manner to allow for such self-determination, there is a “flexible-funding” pool within the current DMHAS PCP pilot for each individual to have access to funding which will facilitate their unique recovery goals, e.g., money for new clothes for an employment interview, tuition for adult education or recreation classes, money to contribute to car pools that will allow individuals to attend faith services on weekends, start-up funds for individual businesses, etc. The most essential requirement regarding this resource is that the funding be applied to goals which are valued by the individual and not simply his/her professional treatment team.

**Applicability Regarding Individuals with Substance Use Disorders.** The principles and practices of person-centered care are designed to enhance the care of individuals who are often disenfranchised within traditional service delivery models. Whether one has experienced a loss of power or meaningful community inclusion as a result of a mental health condition or a substance use disorder has less relevance to the process as a whole. The principles and practices should be universally available as necessary and desired by the individual. Given that PCP has largely NOT been systematically introduced within the behavioral health field (in addictions OR mental health), we will need to rely upon the pilot implementation to determine whether differential applications might be indicated. However, there is sufficient reason to believe that PCP will be a relevant intervention for ALL DMHAS consumers, including those with addictions, as its basic premises are consistent with several other addictions focused initiatives currently underway within the Department, e.g., elements of training (MET via the Recovery Institute) and recommended best-practices (as identified by the Outreach and Engagement Planning Team of the Preferred Practices Initiative, e.g., focusing on the building of “recovery capital”).