



**Promoting Community Integration:
Increasing the Presence and Participation of People with
Psychiatric and Developmental Disabilities
in Community Life**

**Results of a Two-Day Workshop Sponsored by Polk County Health
Services**

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Introduction

Strengthening the community integration of people with mental illnesses, mental retardation, and developmental disabilities will require a collaborative effort bringing together individuals with disabilities, provider programs, MH/MR/DD systems decision-makers, and the broader community to address the barriers that keep people with serious disabilities from effectively pursuing the opportunities in life that are available to others.

Polk County Health Services, in Des Moines (IA), has pursued community integration and recovery goals for these disabled groups for many years, gradually transforming their policies, programs, and practices so that more consumer-centered and community-based services were available to individuals struggling to move beyond the everyday limits placed on their lives within more traditional service networks. Recently, the county program, in coordination with local providers, determined to re-vitalize these efforts by exploring in greater depth the barriers that still remained in realizing the goals of a community integration approach.

Working with the UPENN Collaborative on Community Integration – a Rehabilitation Research and Training Center funded by the National Institute on Disability and Rehabilitation Research (NIDRR) and based at the University of Pennsylvania’s Department of Psychiatry – county officials and program providers developed a two-day program (March 6 -7, 2006) that focused on several inter-related goals: first, they sought to more clearly define community integration and the barriers that remained to its genuine realization; second, they framed a series of recommendations for addressing those barriers that were designed to help direct service staff with ideas on how to work with consumers to develop a plan that would help each individual become more involved in his or her community; and, third, they examined the risks – to clients, counselors, and communities – associated with realizing community integration goals and then looked at the best strategies for managing those risks responsibly.

The group that gathered in March consisted of county officials and program executives, case managers, service coordinators, program line staff, families and consumers, and the recommendations that emerged reflected their varying perspectives. The two-day session was coordinated by Mark Salzer, Ph.D., the Director of the UPENN Collaborative (based in Philadelphia) and John Rose, a Vice President of Risk Management for the Irwin Siegel Agency, an insurance provider active in the field.

The group focused on a set of ten critical barriers that were seen as emerging from quite different sources – from the clients themselves, from program staff and program design, from the MH, MR, and DD systems and their preconceptions and procedures, and from the community itself – and then struggled to define a range of strategies that could effectively help clients and staff to move forward. Just as importantly, the group looked at barriers and strategies in each of eight different ‘dimensions,’ with each dimension describing a specific arena of community life: employment, education, civic responsibility, recreational activities, etc. While not entirely comprehensive, the eight dimensions in which they discussed barriers and strategies convey the scope of the challenge and the likely complexity of the response required.

This report provides an overview of the group’s deliberations. At several points those who participated divided into separate groups, with each group identifying barriers and making

responsive recommendations within the framework of one of the eight specific life dimensions: each group took careful notes, and their deliberations have been closely examined and synthesized to provide this overview of the two-day program's results. This report begins with a summary of the major barriers identified across several dimensions and then reports on recommended community integration strategies in each dimension, identifying several dozen specific approaches that might provide a framework for Polk County – or, potentially, for other county systems or other agencies – to determine priorities as they move toward greater levels of community integration.

Each of the individual strategies noted here would require far greater detail prior to implementation, of course, but the richness of this variety suggests that there is considerable potential for progress. Finally, this report provides a brief overview of three over-arching issues: first, the need for an action agenda that would prioritize these strategies for implementation; second, the importance of transforming policies, programs, and practices with a more complete awareness of related risks and the risk management strategies that can be responsive to consumer, staff, and community concerns; and, third, the necessity of building into community integration plans a capacity to assess the success of its strategies for promoting more genuine community integration.

Barriers to Community Integration

The Iowa group's consideration of barriers ranged quite widely, from specific funding patterns that limited agency flexibility to a broad consideration of community attitudes that foreshortened the chance for clients to feel at home in their own neighborhoods. Here, we focus on the ten most frequent and most salient barriers identified, and they provide a portrait of a system of care in which everyone has a portion of the burden to shoulder in addressing the current limitations faced by those with disabilities in attempting to move from mere 'presence' in the community to a far more robust sense of 'participation' in community life.

Client Capacities. The group acknowledged the impact that mental illness, mental retardation, and developmental disabilities can have on the community integration of clients, as well as the varying ability of service systems to offer people the support they need to minimize those problems. The group noted the undeveloped social skills of many clients, their widespread anxiety when attempting greater connection to the community, and the sense of hopelessness that permeates many of their decisions about their lives, but argued that far more could be done to help clients develop both the skills they need and the recovery-based sense of hope for their own futures that is required if community integration is to be a realistic goal.

Client Knowledge Levels. More frequently, however, the group noted that clients were often very ill-informed about the opportunities available to them in the community: unaware of the opportunities for vocational training and/or job placement; unaware of housing options or recreational activities in their communities; unaware of their rights and responsibilities as citizens; and unaware of the range of everyday community resources – congregations, clubs, and civic associations – that they could readily join. Again, the group was clear that community integration could be vastly increased if provider agencies took greater responsibility for

providing clients with the information (as well as the skills and support) they need to make use of those resources.

Transportation. Still more frequently, and not surprisingly in this part of the country, the group focused on the lack of access to transportation to facilitate client engagement in community activities. Without adequate public transportation or driver's licenses, or the financial wherewithal to operate a car, clients were often unable to access those community opportunities in which they were interested – whether it was a job, a social event, a church service, or a course at a local community college. A number of strategies – for car ownership, agency-operated bus services, improved and targeted public transportation – spoke to the isolation that many of their clients experience and the frustration of both staff and clients with the limitations this imposed on their lives.

Agency Attitudes. The group was often blunt in its assessment of the attitudes of provider agency staff within the MH/MR/DD provider network: in nearly every dimension, the resistance of staff to support clients in their efforts to engage in community life was noted. Participants in this two-day program were aware that staff had too little confidence in client capacities and were too fearful of the consequences for clients of their community encounters, both reflecting and reinforcing the clients' own concerns and sense of hopelessness. Many suggestions focused on staff training within the MH/MR/DD agencies themselves, awakening staff not only to client capabilities but also to the wide range of opportunities – the varied dimensions of community life – that their clients could and should explore.

Risk Management. The group recognized that a significant aspect of negative agency attitudes – and of similar resistance to community integration initiatives among clients themselves, their families, and the community - lay in the perception that each effort to heighten client engagement in community life entailed risks, and that many risks – of de-stabilization or re-hospitalization, or rejection or ridicule, of financial strains or relationship losses – would be difficult for clients to sustain, and there was a good deal of discussion about how to identify, evaluate, and respond to those risks so that client progress was not derailed by preemptive decisions to avoid stress, risk, or everyday challenges by refusing the offer the support clients might need to move in new directions.

Agency Rules and Regulations. To be fair, the group also recognized that some aspects of staff resistance are based in the rules and regulations of the MH/MR/DD systems: the definitions of staff roles often limited staff innovations; the '9 to 5' workday was often at odds with the need for supportive programs on weekends and in the evenings; caseload size and paperwork requirements could set parameters for staff experimentation; and limited agency funds made it impossible to pursue many ventures or support more client-run initiatives. The group grappled with the combination of regulatory limitations and agency conventions that needed to be confronted if the opportunities for community integration are to be expanded.

Community Attitudes. The group was particularly concerned about the way in which community attitudes created substantial barriers: the negative effects of prejudice in the community were noted in every dimension, limiting job opportunities, social networks, family life, housing opportunities, and religious activity. People with almost any disability, the group

here reported, felt either invisible or unwelcome, and the group felt that little progress toward community integration could be made without significant educational programming in the community about mental illness, mental retardation, and developmental disabilities. Both large scale educational initiatives and more personal ones (e.g., promoting community members as mentors; supporting clients as volunteers) were among the suggestions repeated in each dimension as effective approaches.

Family Resistance. The group spoke frequently about the degree to which family members resisted community integration: parents fearful of the emotional consequences if their adult child experienced rejection; siblings concerned about whether a sister or a brother would lose their eligibility for SSI/SSDI if they successfully explored an interest in work; and a general sense of over-protectiveness that lead to unnecessary isolation. The group recommended a number of family education and family support programs that would make them partners – with clients and staff – in promoting greater community integration for their relatives, and – potentially – creating a new generation of public advocates within the families of those with serious mental illness.

The Challenge of Empowerment. One of the principles at the heart of community integration is the ‘empowerment’ of the individual with a serious psychiatric or developmental problem; that is, each individual’s inherent authority over his or her own life. The group felt that neither staff nor clients in their communities fully grasped the concept of empowerment or its implications: that clients had inalienable rights to life in the community; that clients could not only make judicious choices for themselves but also operate consumer-run programs for others; and that civil liberties were fully theirs. The group proposed a wide series of educational programs on empowerment – for clients, for staff, for family members, and for policy makers – to help bridge this knowledge gap.

Funding. Many of the participants in this exercise also understood each issue within a financial context: Were there funds available to support new programs and new training initiatives; Could the rules and regulations that managed public funds be made more flexible to insure that staff roles and program structures could respond to the community integration imperative? Could public support be generated to support new programming – such as new transportation approaches - that made community integration more possible? The group struggled to find ways to insure that community integration would not be short-changed, and participants were unambiguous about acknowledging that this remains among the most fundamental challenges to be resolved in the future.

Strategies

With these ten barriers identified, the group turned to specific suggestions – strategies – they felt were worthy of further exploration. Some are quite specific, others more general, and still others quite vague, but taken together they offer a portrait of a rich landscape of ideas and possibilities. We address them here within each of the eight dimensions because they offer quite specific proposals for addressing very particular barriers.

Citizenship and Civic Engagement. To help people with disabilities play a more robust role in the civic life of their communities, programs could:

- provide educational programming to clients to familiarize them with local, regional, state, and national issues, particularly those that may play a role in future elections;
- sponsor forums in which political candidates or civic groups could discuss both sides of controversial issues, particularly those in which groups of clients may have a special interest;
- create and use ‘practice voting booths’ before local and national elections to help familiarize clients with the procedures of voting, and to spur their interest in participating in the election process
- support clients as they volunteer in civic groups that address public issues, helping clients to determine their personal interests and matching clients to local interest and advocacy groups in the community;
- develop a ‘mentoring’ program in which volunteers from civic groups or political organizations agree to provide additional supports to the individual with an MH, MR or DD diagnosis who is interested in joining their group; and
- fund a series of programs to help clients better understand their rights, the organizations that exist to help protect their rights, and the best ways in which to utilize that support.

Education. To help people with MH, MR, or DD problems resume and complete their educations and to better prepare them for better-paid employment, programs could:

- work with local schools, community colleges, and universities to develop academic programs that provide supports people may require to successfully apply to and complete certification and/or degree programs;
- develop ‘educational guides’ for consumers that both encourage them to continue their educations and provide them with helpful hints with regard to applications, scholarships, course work, and degree/certification completion;
- identify existing scholarship funding for consumers who wish to continue their education, assist consumers in applying for those funds, and advocate for new funding to support these educational initiatives;
- develop ‘supported education’ programs – based on one of the existing and well documented successful supported education programs – in which service providers offer support to the consumer seeking to complete his or her education;
- design and advocate for a range of educational accommodations (e.g., more time to complete tests, more explicit instructions for assignments, etc.) that students with disabilities may require in order to succeed in school;
- provide or find funding for child care services for individuals with children who could not otherwise attend school, as well as provide transportation money for school attendance;
- develop a plan - to help students at every educational level – to: complete high school; enter and/or resume two-year or four-year college programs, work toward job certifications for employment; or pursue graduate education;

- establish a ‘school liaison’ position within their agency to help students explore educational opportunities and scholarship programs as well as help schools meet the needs of these new special students;
- establish a ‘buddy program’ in which volunteers, rather than staff, provide the support students need in resuming their educations, providing a mixture of academic and personal support; and
- develop a ‘student mentor’ program in which non-disabled students within educational programs – as volunteers or for a fee – provide ongoing support to those with mental illness, mental retardation, or developmental disabilities.

Employment. To increase the rate of employment and the pay and benefit levels among those who do work despite serious illness, programs could:

- initiate job coach / supported employment programs in which a staff member works closely with individual clients to determine their vocational interests and capacities, quickly helps to place them on a job, and provides ongoing support;
- develop educational programs to expose clients to the world of work, to the benefits and risks of re-entering the competitive labor market, and to the variety of rehabilitation resources available to them to assist them in going back to work;
- develop expertise in the ‘work incentive provisions’ of the Social Security Act to help clients make informed decisions about the financial risks associated with returning to work;
- work closely with area ‘temporary worker’ placement agencies to provide clients with short-term entry-level positions as a way to expose clients to the demands of the competitive labor market;
- invite former clients who have successfully returned to work to talk on a regular basis with current clients about the rewards of employment, the various challenges they may have faced, and the supports they received in the process;
- improve the relationship between their own rehabilitation staff and programs and the business community, inviting business persons to participate in advisory committees and responding to the needs of employers working with clients;
- develop a variety of transportation solutions for clients who need to get to work but do not own a personal car: volunteer drivers; vans with well established routes; an expansion of public transportation routes; utilization of cabs; etc.;
- develop a ‘co-worker as mentor’ program at job sites, in which a volunteer (or paid) co-worker would provide support, guidance, and ongoing critiques to the individual with mental illness, mental retardation, or developmental disabilities;
- develop ‘natural support systems’ (circles of support) composed of co-workers, family members and friends, as well as rehabilitation workers, to offer ongoing support to the individual who returns to work; and
- offer training to employers, their non-disabled staff, and others about disabilities, those with disabilities and their challenges in holding down a job, and the supports that business can (and sometimes have to) offer to such individuals.

Housing. To broaden the quality, range, and accessibility of housing for people with serious disabilities, programs could:

- design and implement landlord educational programs about mental illness, mental retardation, and developmental disabilities, and the challenges (and successes) in the lives of those individuals who live independently;
- insure that more of those living independently are engaged either in vocational rehabilitation programs leading to employment or are employed, at least half-time, as a way to stabilize, with their own incomes, their living arrangements;
- offer support and protections for landlords (rent guarantees, 24/7 availability in times of crises, payment of rent during hospitalizations, etc.) as a way to encourage the availability of housing and the support offered therein;
- explore the prospects for ‘home ownership’ for those with disabilities and work to change those policies that make clients ineligible for other supports if they have significant financial investments in their own homes;
- insure that those who have had success in living independently have a regular opportunity to share their stories with consumers who are doubtful about their own ability to do so;
- develop ‘loan programs’ that help consumers either to purchase their own homes or to meet security deposit arrangements, or to adequately furnish a home or apartment that they rent;
- develop new ways to link consumers with potential roommates, both other consumers and others without disabilities, in order to limit the sense of isolation among many consumers who live on their own;
- advocate for tax incentives to landlords who rent and/or provide additional personal supports to clients, as a way to recognize and reward their participation;
- work more closely with community development corporations developing low-income housing in depressed and/or minority communities to insure that some properties are set-aside for service consumers;
- develop a ‘volunteer representative payee’ programs to help those within the MH, MR, and DD populations who choose to live independently to manage their monies more effectively and for the long-term;
- work with public transportation authorities to insure that low-income housing that clients utilize has access to public transportation routes, helping clients to return to programs, employment, and friendships more readily; and
- expand the training they offer to residential staff to help staff develop effective relationships with clients, in order to provide necessary support and avoid overly dependent linkages.

Recreation. To help consumers participate in the social and recreational life of the community, programs could:

- provide regular information to clients about recreational and social opportunities in surrounding communities, as well as help small groups of clients to participate in community events together;

- provide access to community events through computer listings of social and recreational opportunities, and insure that computer access is available to clients, who may also need training in order to access the information they need;
- redefine staff roles so that personnel are available to help clients determine interests, contact social and recreational programs, and provide on-the-spot supports until clients are able and willing to participate on their own;
- develop mobile crisis teams to respond to emergencies in the community, and work with other social and recreational programs to better understand consumers and the social challenges they face;
- offer more weekend and evening programs and supports that make it more likely that staff will be able to provide social and recreational supports within community settings rather than just within the agencies;
- more aggressively seek donations (of tickets) to sports, cultural, and community events that could be provided to clients who might not otherwise attend, and develop a way for clients and their agency to 'pay back' this generosity;
- train staff to be more sensitive to the individual social and recreational needs of clients and to develop the skills to assist clients in participating in the social and recreational life of the community;
- develop an approach to transportation of clients to social and recreational opportunities that is less stigmatizing than the 'agency van' that now often provides access to many community events;
- establish a new staff position – access advocate – to work with both clients and social and recreational programs within the community to insure that clients are both welcomed and supported as they participate;
- initiate a broad-based public education program designed to make community members more aware, more comfortable with, and more supportive of the presence and participation of those with serious disabilities in community events;
- develop 'support groups' to help clients who do choose to participate independently in social and recreational events to talk about their feelings, experiences, and suggestions for the future with one another; and
- help clients to identify past social connections (family and friends, civic groups and sports clubs) and develop a plan to revive all or a portion of those relationships.

Peer Support and Self-Determination. To help consumers establish more control over their lives, programs could:

- provide a wide array of educational programs targeted to consumers and outlining the fundamentals of consumer empowerment, peer support, and consumer-run programming;
- provide intensive educational services for staff in order to familiarize them with consumer empowerment principles, peer support models, and consumer-run services, with an emphasis on the new roles required of staff;
- develop an ongoing public speaking programs – utilizing both consumers and staff – to talk about the principles of recovery and empowerment and the importance of 'hope' in the lives of consumers;

- fund ‘peer advocacy’ and ‘consumer-run’ programs within residential, vocational, and social rehabilitation programming, and provide training to consumer staff in their roles and responsibilities;
- offer additional training to staff in making treatment planning a more person-centered, rehabilitation-oriented, and consumer-run process that both clients and staff are committed to; and
- search for grant funding for new programming based on peer support and consumer-run principles, and open traditional agency staffing positions to current and past consumers.

Spirituality. To assist those with mental illness who wish to deepen their spiritual lives and religious affiliations, programs could:

- work with local religious groups – both pastoral and lay persons – to insure a welcoming response to new congregants and to offer whatever support congregations may require;
- develop ‘mentor’ programs within area congregations in which an individual in the congregation goes out of his or her way to welcome and support new congregants with MH, MR, or DD issues;
- develop staff training programs internally to help existing staff become more comfortable in working with clients around their spiritual needs and referring them to appropriate community resources; and
- research and contact existing programs of congregation/consumer programming to serve as a model for their own activities in this regard, and bring in the consumer and congregational leaders of such programs to provide technical assistance.

Social Roles. To help service consumers to develop an array of valued social roles for themselves, programs could:

- help consumers re-establish or repair past relationships – with family members, friends, employers, etc. – by identifying issues, providing personal support throughout the process, and recommending actions along the way;
- provide training in diversity to staff and clients in order to broaden each participants readiness to establish meaningful relationships across traditional social barriers; and
- help clients develop new social roles for themselves by exploring possibilities, develop new relationship skills, and initiate new relationships within the context of staff support.

Action, Risk Management, and Evaluation

It should be noted that the meeting also set aside time to talk about three over-arching issues in pursuing an action agenda.

Developing an Action Agenda: From Strategies to Support. These strategies that are recommended here – cutting across many key dimensions of consumer life – cannot be considered comprehensive, but do provide a way for programs to consider the variety of initiatives they can undertake (on their own, in alliance with other agencies, and with or without financial support, and in close cooperation with consumers and consumer groups) to strengthen the connections between their clients and their communities. However, the group felt strongly

that identification of strategies was not sufficient: at some point, they argued, both the alliance of agencies and the individual units of that alliance needed to develop an unambiguous ‘action agenda’ – including the development of a consumer/staff consensus on priority areas for development - that permitted real progress to be made in supporting community integration.

Acknowledging Risk and Building in Risk Management. Part of the overall program included a presentation by a consultant to the process – John Rose – who talked with the group about their perception of the risks entailed in encouraging consumers to pursue a greater degree of presence and participation in the community across several life domains: while the risks identified (e.g., de-stabilization or re-hospitalization; a loss of SSI/SSDI support for those who return to work; the challenge to supportive emotional relationships for consumers seeking a greater degree of independence from their families; etc.) are quite real and often profound, Mr. Rose argued that such risks were important opportunities for client growth – but only in those circumstances in which the risks could be identified and evaluated so that clients and staff together could plan and implement responsive support strategies to minimize the impacts of those risks. A more complete description of the Risk Management approach discussed by the group is attached to this report.

Assessing Community Integration Outcomes. Also attached to this report is a paper from the UPENN Collaborative on Community Integration that provides a helpful overview of potential strategies that can be used to measure community participation for mental health, mental retardation, and developmental disability populations. The group felt that additional work might be done in developing both baseline measures of the level of community participation at present – for both individual clients and client groups – and then periodically assessing the success of the strategies implemented in promoting still greater degrees of community integration. The UPENN materials approach the issues from the vantage point of several of the key dimensions in which the group developed strategy recommendations – providing a periodic opportunity to assess those individual areas in which substantial progress may have been made as well as those areas in which system efforts might profitably be increased.



Individual Risk Management Planning (IRMP)

**John Rose – Vice President for Risk Management
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In addition to the earlier mentioned barriers to community integration, there is an underlying concern from providers regarding liability should an individual being supported suffer harm while experiencing opportunities of greater interdependence.

Community participation requires active and meaningful engagement of the various community domains, which include citizenship, education, employment, housing, recreation, spirituality and social roles. There is an inherent risk in most everything we do in our lives, this should not exclude us from participating, but rather ensure that we properly plan to mitigate harm that can be associated with the various domains and life activities.

IRMP is a process that is solely based on an individual's abilities and goals; it is a balancing of risk and reward. IRMP is about finding the balance in keeping people safe while promoting personal independence and self-determination. It is essential to create an environment that provides effective and appropriate safeguards and support, distinguishing between reasonable and unreasonable risks. This will require professional judgment and the guidance of practice standards.

- ❖ No one should be in a potentially or blatantly risky, exploitative or abusive situation as a matter of “personal choice”.
- ❖ Developing a plan of support requires the individual and those who know him/her best, to be given the opportunity to provide input.

Guiding Principles for Risk Management

- Risk management should emphasize safeguards and strategies that will address issues and create situations where risk is managed and reasonable, whenever possible.
- A risk management system must be based upon a clear process for identifying unreasonable risk.
- The process of identifying and addressing unreasonable risk should be respectful of an individual’s right while responsibly addressing questions of competency and capacity to make choices.
- The determination of who is at risk should involve, among others, those who know the individual best. It should also be based on professional/clinical assessments, when indicated and an understanding of any cultural and linguistic issues. Risk management should be integrated with the ISP process.
- A risk management system must weigh the capacity of an individual to make informed choices and to learn from those choices with the necessity of assisting an individual to be safe.
- Those making determinations about responsive courses of action must have timely access to clinical, legal and administrative consultation and have access to individuals/groups with relevant training/expertise.
- The risk management system must include ongoing oversight and monitoring activities, based on accurate data and focused on promoting institutional learning.

The process is inclusive of *four components* (identifying, evaluation, treatment & monitoring) that are incorporated in the development of an individual’s support Plan (ISP, IEP, IHP, ICP, etc.).

Identification attempts to identify where risk exposure exists based on what the individual’s interest and activities may expose them to. There are assessment tools and checklists (ISA-Risk Analysis and Planning Tool and AAMR-SIS) that can help in identifying where needed supports are required in the development of the ISP. The next step is evaluation. Is the risk identified one of a frequent nature and what is the severity of the risk? Frequency includes looking at risks and whether they could be occurring rarely, reasonably, monthly, weekly or daily. Severity includes looking at the degree of risk either being an inconvenience or having an impact on placement, to health and safety or eminent and likely harm or even death. Treatment is the actual implementation of a specific practice or protocol that is intended to mitigate any risk potential. This may include but not be limited to, staff or consumer training, development of specific administrative action like policies and procedures or installation of some engineering controls. The final and critical component is monitoring. Monitoring evaluates the effectiveness of the plan and implemented treatments. It in effect is the QA of IRMP. It ensures

rights protection, reviews incidents that might indicate needed modification to the plan and verification that various ‘safety nets’ remain viable.

Finally, the goal of risk management planning is to identify potential risks and to implement practices that will either eliminate or minimize loss impact. Also, to ascertain appropriate interventions and to remain pro-active to crisis that could occur. Liability exposure typically occurs from either improperly identifying risk potential associated with an individual’s person-centered plan or the implementation of treatment options. Individuals supported should have the opportunities to experience various options to their selected goals in order to establish preference- a process each one of us goes through daily. However, while experience is the best teacher, it is usually from bad experience that we learn. The role of the provider and the individual’s team is to identify those potentially ‘bad experiences’ as far as reasonable and to implement an individualized risk management plan.

In regards to liability, it is not “choice” one should fear, but rather the failure to offer “informed choice” to those you support by not implementing an appropriate IRMP.

References for further reading: 1) *Choice and Responsibility*, New York State Commission on Quality of Care, 1994; 2) www.hsri.org/quality - a website of state outcomes resources in the field of developmental disabilities; and 3) *Risk Management and Quality in HCBS, Individual Risk Planning and Prevention*, Medstat, February, 2005.