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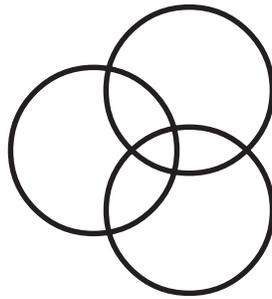
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*Department of Human Services*  
*Review Boards*

*An overview of their past, present,  
and possible future*

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Issued under the Authority of  
*Roberta Opheim*  
Ombudsman for Mental Health  
and Mental Retardation

**August, 1997**

**This information will be made available in alternative format,  
for example, large print, Braille, or cassette tape, upon request.**



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# Preface

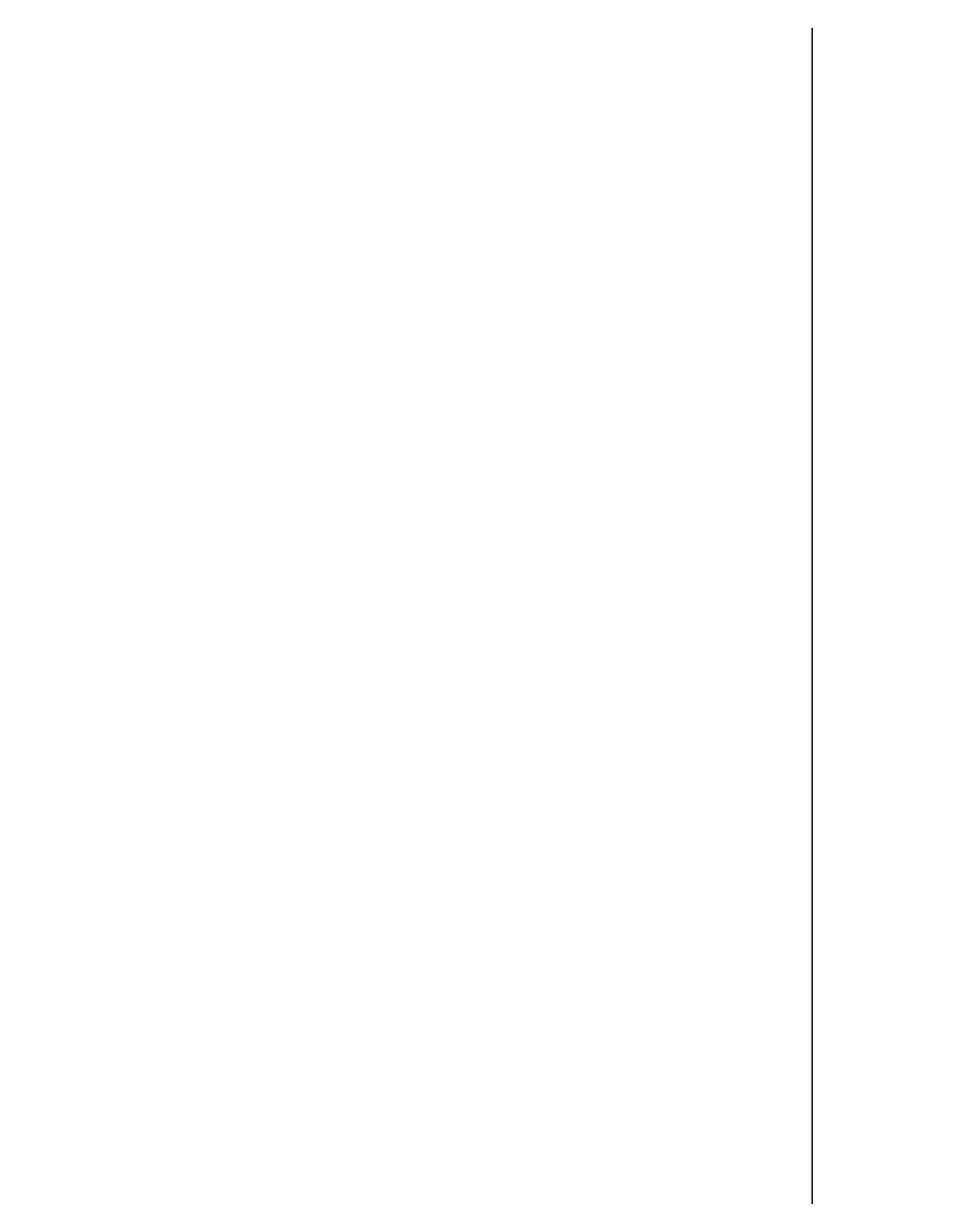
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The Office of the Ombudsman for Mental Health and Mental Retardation is charged under Minn. Stat. § 245.92 with promoting the “highest attainable standards of treatment, competence, efficiency, and justice for persons receiving services for mental health, developmental disabilities, chemical dependency, or emotional disturbance.” This review was conducted under the powers granted to the Office of the Ombudsman for Mental Health and Mental Retardation in Minn. Stat. § 245.94.

Discussion of Minnesota’s Department of Human Services State Hospital Review Boards (HRB) is a complex subject with many widely differing points of view. Not surprisingly, the points of view vary depending on the perspective of the person or agency which expresses the opinion. We wish to be quite clear that the Office of the Ombudsman for Mental Health and Mental Retardation’s perspective is to look at what is best for the client. When the Office considers the input it has received and weighs the options available, the essential question is: “What is the right thing to do?”

Civil commitment to a state regional center (formerly known as "state hospital") not only deprives a person of some of their rights, it transfers responsibility for maintaining and ensuring these rights to the government. When the government assumes responsibility for the life of a person, there is a greater level of accountability that must be maintained; else we are all diminished.



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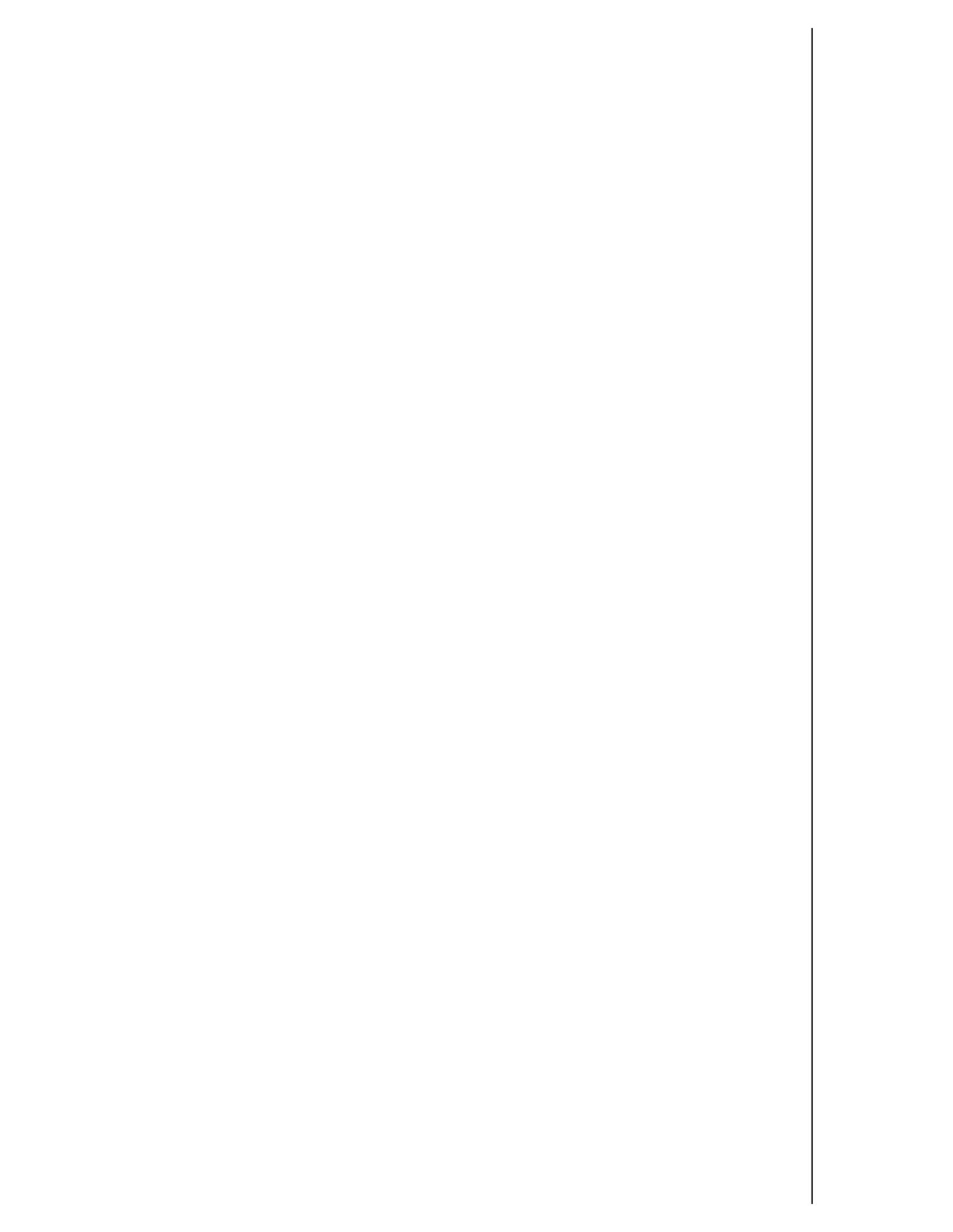
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# Staff Acknowledgments

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# Definition of Terms

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- "Hospital review boards", and "regional center review boards" (HRBs) are terms used by many who contributed to this report. As used in this report, these terms have essentially the same meaning.
- QA = quality assurance. QA refers to efforts and processes which monitor an agency's ability to provide quality services and to meet the needs and expectations of their customers.
- CEO = Chief Executive Officer. The CEO is the highest administrative person at each state regional center.



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# Executive Summary

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Since the creation of Minnesota's Office of the Ombudsman for Mental Health and Mental Retardation (hereinafter referred to as the "Ombudsman Office"), there have been several requests for the Ombudsman Office to participate in and assist with discussions regarding possible changes in the role, function, and administration of the HRBs. Additionally, the Ombudsman Office has taken note of changes in the way individual HRBs function, changes in the environment in which they operate, and changes in how their administrative agency views the HRBs and interacts with them. This report provides an overview of these issues and also offers some conclusions and recommendations.

This report includes the input of multiple individuals representing a variety of perspectives on the past, present, and possible future of HRBs. Great effort was taken to be sure the broadest possible spectrum of viewpoints and positions was considered. Those interviewed included administrative and professional staff from the Department of Human Services (DHS); current and former HRB members; professional, paraprofessional, and peer advocates from Advocacy and Disability services; former recipients of services at state regional centers, and staff from the Ombudsman Office. Documents offering the opinions and input from former statewide HRB coordinators and others involved with these issues were also considered and included.

In considering the wide variety of opinions and options identified in this report, the Ombudsman Office evaluates these factors from its primary perspective. This perspective can be summarized in two essential questions: 1) What is best for the client? 2) What is the right thing to do? In the case of Minnesota's institutionalized population, the government - through the civil commitment process - assumes responsibility for the life of a person while they are under the terms of the commitment order. When the government assumes this responsibility, there is a greater level of accountability that must be maintained.

With Minnesota's Civil Commitment Statute (including the HRB statute) scheduled for review during the

1997 legislative session, the Ombudsman Office presents this public report to assist with the full and careful consideration of proposals which could significantly impact some of the state's most vulnerable citizens.

This report includes six possible options for the future of HRBs and HRB type services in Minnesota. Virtually everyone who had input into the report identified one or more of these six options. Those options include:

- 1) Maintain the "status quo".
- 2) Restore prior status with some modifications to allow for current service patterns, improve/restore support from DHS, and transfer HRB responsibilities away from the DHS Licensing Division.
- 3) Transfer the HRB functions to another agency with the goal of providing the type and quality of services the HRBs have offered.
- 4) Continue with and augment current HRB services for DHS' mentally ill and dangerous and psychopathic personality populations, while developing a new model for clients in community based services and short-term institutional placements.
- 5) Transfer HRB functions to another agency with the goal of developing a new model of service.
- 6) Modify the existing statute and abolish the HRB.

Of the six options, the Ombudsman Office has identified three of them as having the most viability to be successfully implemented in the near future.

It is the recommendation of the Ombudsman Office that DHS pursue one of the following three options.

These three options are:

- Continue to augment current HRB services for DHS' mentally ill and dangerous and psychopathic personality population, while developing a new model for clients in community based services and short-term institutional placement.
- Restore prior status with some modifications to allow for current service patterns, improve/restore support from DHS, and transfer HRB responsibilities away from DHS Licensing Division.
- Transfer HRB functions to another agency with the goal of developing a new model of service.



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# Introduction

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Over the past decade, there have been periodic discussions suggesting that HRBs be either eliminated or their role modified. These suggestions have also been discussed during state legislative sessions. The assertions and assumptions which are cited in support of elimination of the HRBs include:

- The services of the HRBs are duplicative of those provided by other agencies and processes.
- It is a conflict of interest for DHS Licensing Division to both license a program and facilitate external review and criticism of that program.
- DHS has decreased and diminished the amount and kind of support, oversight, and responsiveness to issues and documents coming from the HRBs.
- As the level of support from DHS diminished, the apparent frequency of some HRB meetings also appeared to be reduced. Without an active statewide facilitator/coordinator, both the visibility of HRBs, as well as the effect and outcomes of their services, became less apparent in certain quarters.
- Increasing numbers of persons are receiving community based services and institutional populations have been getting smaller. HRBs provide services only to persons receiving institutional based services.

This report will comment on these assumptions. It will also address the questions:

- What are the barriers to HRBs becoming, or being seen as, a useful entity?
  
- What are the alternatives?

State Hospital Review Boards (HRBs) were established under the requirements and authority of Minnesota Statute 253B.22, a portion of the state's commitment law (A copy of MS 253B.22 is included with the attachments in this report.). It is anticipated that during the 1997 legislative session the entire state

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# A Brief History of Minnesota's State Hospital Review Boards

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commitment act, including the portion pertaining to HRBs, will be reviewed and significant changes will be proposed.

The law requiring the establishment of HRBs at state regional centers was one of several outcomes resulting from the identification and acknowledgment of substandard living conditions, inadequate monitoring of and response to complaints, and concerns about treatment issues. This statute was first enacted in 1967. Subsequent revisions were minor and did not substantially alter the law or the functions of the HRBs.

The HRB statute has always been slightly ambiguous regarding some of the duties and powers of the HRB. Subdivision 4 of the statute contains three “may” authorities or functions of the HRB. The “shall” powers and functions of the HRB are somewhat narrow in scope: “review the admissions and retention of patients institutionalized under this chapter” and “report its’ findings to the commissioner and the head of the treatment facility.” Additionally, while the HRB are required to review the admission and retention of patients, the authority to admit, retain, and discharge patients is completely separate from the HRB. The persons and agencies most directly involved in this part of the process (county agencies, case managers, support services, and community based service providers) seldom, if ever, have contact with the HRBs.

However, it is under the “may” powers and functions that HRBs have been most effective; for example “the board may also receive reports from patients, interested persons, and treatment facility employees, and investigate conditions affecting the care of patients.” Virtually every HRB member, from each state regional center, can recall issues and actions which significantly affected living conditions, treatment issues, and/or legal issues for the clients at state regional centers.

These issues and actions include matters affecting large groups of clients such as monitoring protective isolation, and leaky bathroom conditions which seemingly could not be resolved despite work order re-

quests and internal complaints to all levels of facility administration. These conditions remained unchanged until the HRB members personally escorted the facility CEO to observe the situation. Matters affecting individuals or smaller groups such as individual treatment issues not resolved through other means also were positively impacted by the HRBs.

Often, solution to the problem or issue appears obvious to outside observers, yet resolution seems out of reach until a certain amount of external review and pressure occurs. Examples of this include the bathroom plumbing problem and the clients' canteen at one state regional center being predominately open during hours when the clients were scheduled for treatment or programming and predominately closed during hours when clients had their free time. Despite repeated communications of concern and alternative proposals from both internal and external sources, the issue was not resolved until the HRB became involved. Now, the canteen is open during the times when clients can get there. Implementing this solution began after the HRB began commenting on this issue and reporting it to other concerned parties.

From their inception through the late 1980's, the HRBs received a fairly high and consistent level of support from DHS. Training and statewide meetings were arranged and concerns identified by the HRB were responded to. Good lines of communication between the HRBs and DHS were in place. Some of this still occurs, but inconsistently.

The persons who provided statewide coordination and facilitation services to the HRBs during this period (from the late 1960's through the late 1980's) are described as people who took this aspect of their work seriously and made it a priority. Both the statewide coordinators and their supervisors valued and respected the role and work of the HRBs. The HRBs were seen as tangible evidence of the commitment of both DHS and the State of Minnesota to improving the quality of services and the quality of life for persons receiving services at state regional centers. In effect, the HRBs provided

an internal quality assurance mechanism before quality assurance became a widely accepted process.

A good portion of the current status of HRBs can be traced back to previous discussions of changing the HRBs' function and role. The two primary participants in these discussions were DHS and the Ombudsman Office. Also included were some HRB members from the late 1980's.

In the late 1980's, staff changes at DHS resulted in the first of several changes in who served as the DHS statewide HRB coordinator. As this responsibility was changed first from one person, and then to another, the amount of personal and departmental investment in the HRBs also began to change. Gradually, DHS



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# Minnesota's State Hospital Review Boards - Their Current Status

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began supplying the HRBs with less support and guidance. There was no formal announcement of policy change. However, as evidenced by the absence of statewide meetings, training sessions, and overall pattern of diminishing communication with the HRBs, a changing environment for the HRBs had clearly begun.

The HRB at each state regional center was left on their own to define their role, the frequency of their meetings, and what they would do and how they would do it. This, over time, resulted in the current system: each state regional center's HRB became essentially a separate entity, relating primarily to their facility's CEO and local HRB coordinator. For example, at St. Peter RTC, the HRB focused on seclusion, restraint, and other legal and human rights issues specific to the local client population; at Fergus Falls the HRB continued to meet, but focused their working relationship on the local CEO and stopped sending their meeting minutes to the DHS central office; at Faribault the HRB focused almost exclusively on how they interpreted their role on reviewing admissions and discharges.

This is in contrast to the model that existed previously, where each HRB was an integral part of a greater whole; where the concept of HRBs was seen as a system-wide tool or process to monitor services, identify problems or concerns, and generally serve as an internal QA process that was able to achieve positive results. Through a combination of apparent decreasing investment in and support for the HRBs, changes in social services and public policy (including the Minnesota Vulnerable Adults Reporting Act, the trend towards community based services and the formation of the Ombudsman Office) DHS began to question the role of the HRBs. Staff turnover, combined with changes in agency administration and periodic review and refinement of their work, resulted in a climate where the HRBs became increasingly less

visible, their work became less valued, and their value and existence was no longer viewed as essential.

This situation resulted in a steadily increasing level of discussion at DHS which asks the same basic questions mentioned earlier in this report:

- Is it a conflict of interest for an organization which licenses a program to at the same time administer a process designed to identify and, at least in some cases, publicize problems in that program?
  
- Are the HRBs a duplicative service? The issues raised by DHS include assertions that in an era of the Vulnerable Adult Reporting Act, designated legal protection and advocacy services like the Mental Health Law Project and Legal Advocacy for Persons With Developmental Disabilities, and broader advocacy and monitoring services like the Ombudsman Office, HRBs are no longer needed because they are duplicating the services and results provided by other means and mechanisms.
  
- With public policy promoting community based services and the trend towards smaller institutional populations, should we continue to fund a service that only looks at the needs and problems of a small percentage of the citizens. Summarizing DHS' position are these factors:
  - 1) That public policy has forever moved away from greater use of institutions<sup>1</sup>;
  
  - 2) That the needs and problems of a small percentage of the population require less monitoring and fewer means to express concerns or complaints simply because they constitute a smaller percentage of our population than 15 to 20 plus years ago; and

- 3) That the funds and resources expended by DHS could better serve the citizens if applied to services other than the HRB's.
- 4) Also articulated by some interviewees, are the following comments: "Why should DHS pay for someone else to criticize us, when we already have all these other people and agencies doing that? Anything identified by the HRB would also be noted by one of these other groups."

As these discussions grew and these questions began to surface repeatedly, the Ombudsman Office was included in this process. The mandate and mission of the Ombudsman's Office includes the goal to "promote the highest attainable standards of treatment, competence, efficiency, and justice...", and "to investigate the quality of services provided to clients and determine the extent to which quality assurance mechanisms within state and county government work to promote the health, safety, and welfare of clients...".

In 1990 several meetings and discussions were held involving DHS staff, the current HRB members, staff from the Ombudsman's Office, and a former DHS statewide HRB coordinator. Some of the documents and letters generated from that time are included in the attachments portion of this report. They provide a good overview of the nature of these discussions.

No new questions or possible solutions came out of these meetings and discussions. The same questions and concerns identified at that time, continue to be raised today:

- If HRBs are to be viable and useful, they need more support and guidance than they currently receive from DHS. This was an accurate observation in 1990, and, it continues to remain so today.

<sup>1</sup> The question of housing people together in larger groups, the role and appropriateness of congregate and/or institutional based services, does get revisited from time to time; particularly during times of economic change or the perception of limited resources.

- It would be a positive step if we could provide the same type of service to clients in community based services as the HRBs provide to the state regional centers. However, to do such a process correctly, would be a huge, potentially unworkable, undertaking unless there was a commitment to fully fund and implement this process.
- The most solid finding of the 1990 process was the need to form a “work group” to “further examine the statute mandating HRBs and to then discuss the issues with DHS”.

Formal participation of the Ombudsman’s Office in these discussions essentially ended with a September 4, 1990, memo from the then Ombudsman to all HRB members. Included in this memo was the statement that the Ombudsman “believed future dialogue and decision making should be matters to be handled between DHS and the HRBs, the two parties most directly impacted at this point;” along with the offer that in the future “the Ombudsman Office would play a supportive role, if indicated.”

For unknown reasons, no further formal discussions were held between DHS central office staff and HRB members. Within the DHS central office, the discussions about the HRBs continued. Responsibility for HRB data, response to the HRB, and response for HRB concerns directed specifically to the Commissioner of DHS were divided between two or more persons. The perception by multiple stakeholders was that the HRBs were given a lower priority at DHS.

Publicly, mention of the future of HRBs occurred around the beginning of state legislative sessions. Over the past six years, a steadily increasing level of comment has been heard from DHS on possible legislative initiatives to abolish the HRBs. With Minnesota’s Commitment Act scheduled for extensive review and possible revision during the 1997 legislative session, some changes affecting the HRBs seem inevitable.

Some HRB members are more aware of and concerned about the possible changes than others. Many of the most active and concerned members met in the summer of 1996 to discuss the future of HRBs and what role HRB members could play in planning for the future. Action taken at this meeting included review of the many successful outcomes HRBs have played a part in and discussion of possible legislative or lobbying action with state legislators and the public.

In addition to HRB members themselves, there are several groups, agencies, and persons who are very much interested in DHS' plans for the future of HRBs. Over the summer and fall of 1996, the Ombudsman Office heard from many of these people and groups. A sampling of this input is included in the text of this report and in the attachments section. Also, many are interested in and willing to give public testimony on the value and importance of the HRBs, if DHS announces an intent to pursue abolishing the HRBs.

A representative sampling of responses from legal and consumer advocates, along with other non-DHS input, on the possible initiative to abolish the HRBs includes:

- “The hospital review boards provide a forum for patients to discuss issues that is more independent and neutral than a treatment team meeting. This quasi-external oversight of practices and procedures directly benefits clients.”
- “The Minnesota Security Hospital’s Review Board has an essential role in reviewing use of protective isolation pursuant to the Court Order. Over the years the hospital review board has done an excellent job overall of hearing these difficult cases. I am very troubled that serious discussions of eliminating the review boards may be taking place without reference to the ongoing Reome consent decree.”
- “The review boards provide a service to clients that is not provided by the few other resources available to clients. Both the Disability Law Center and the Ombudsman’s Office have limited resources. Both agencies need to determine if a person meets the definition of a "client". The review boards will

see and listen to anyone. They can do things and look at issues others will, or may, not.”

- “The Disability Law Center is a law office. They are sometimes unable to help people that have legitimate concerns that do not present a legal issue.”
- “Many of the other agencies and options mentioned as alternatives (which make review boards unnecessary) are not able to assume the full role of the review boards. The continued funding and existence of these agencies (Protection and Advocacy, Legal Advocacy, etc.) is uncertain. They may cease to exist. They barely survived efforts to eliminate them in the last session of Congress.”
- “The review board is often an appropriate and safe forum in which a patient can express dissatisfactions with treatment or with hospital administration or policy.”
- “Even if no definitive change occurs as a result of the complaint, the opportunity for venting to “outsiders”, the experience of being heard and taken seriously, are important to people who are confined in the closed settings of the state hospitals.”
- Despite the DHS’ deteriorating support for the HRBs, there continue to be instances of quality work and positive outcomes. This is directly due to the hard work of individual HRB members. For virtually all HRB members, the per diem they receive is only a fraction of what they would earn in a days work in their profession. Where else can the state receive this kind of value for its’ investment?
- As has been stated, the HRB members are essentially volunteers, working for minimal compensation. By being essentially volunteers who work for a cause and service they believe in, they are more independent. They can go outside of channels and contact those who can take action or respond. As one interviewee stated, “Review Boards don’t care whose feet they step on”.
- Each member of the HRB brings a valuable perspective and background to Review Board actions. By statute, "One member shall be qualified in the diagnosis of mental illness, mental retardation, or chemical

dependency, and one member shall be an attorney," and by tradition, with one member from the community served by the Regional Treatment Center, the HRB's provide an interdisciplinary makeup of a cross-section of community perspectives. The interdisciplinary makeup of the HRB's is a key component of the service they provide. It is not duplicated by the more narrow perspective of other agencies (Disability Law Center, Office of Health Facility Complaints, DHS Licensing Division, Health Department) who monitor and respond to only those complaints or issues which meet their criteria.

- “The review boards are a process that’s already in place. They provide a quality assurance service which benefits both the Commissioner and the entire Department. They provide good public relations for the RTC’s and DHS. Therefore, we all benefit.”
- Monitoring treatment and quality of life issues in closed environments like the state regional centers is an immense, complex task which requires a multifaceted process. It is a task well beyond the limited resources of one or two small agencies like the Disability Law Center or the Ombudsman Office, both of whom have broad mandates and service responsibilities. The HRBs mission is to focus specifically on the state regional centers. The HRBs have been, and should continue to be, an essential part of that process.
- An essential part of the DHS’ position on abolishing the HRBs seems to be the assumption that as a society we are imminently and irreversibly at the point where institutions will, at the most, serve only an extremely small residual population, and, on the whole, most institutions will cease to exist. Therefore, HRBs are simply not needed.

While the abolition of institutions would indeed be a laudable accomplishment, in reality, this is far from being accomplished. Our present circumstances require a monitoring process; we are at risk of losing many of the gains made over the past two decades of deinstitutionalization.

- 1) Maintain the “status quo”.

- 2) Restore prior status with some modifications to allow for current service patterns, improve/restore support from DHS, and transfer HRB responsibilities away from DHS Licensing Division.
- 3) Transfer the HRB functions to another agency with the goal of providing the type and quality of services the HRBs have offered.
- 4) Continue with and augment current HRB services for DHS' mentally ill and dangerous and psychopathic personality populations, while developing a new model for clients in community based services and short-term institutional placements.
- 5) Transfer HRB functions to another agency with the goal of developing a new model of service.
- 6) Modify the existing statute and abolish the HRBs.

**1) Maintain the “status quo”**

**Pro:**

- Current level of service does produce some positive outcomes.





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# Future Options for State Hospital Review Boards in Minnesota

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- Enforcement of the Reome consent decree will continue.
- Overall, the state continues to get good value for the amount of money spent.

**Con:**

- DHS' attitudes and actions promote a sense of uncertainty for many HRBs and their members.  
This results in a less productive atmosphere.
  - Without some type of reinvigoration, some HRBs and their members will see their uncertainty grow. This will result in fewer decisive actions.
  - A process that could, and once did, work better remains unchanged.
- 2) Restore prior status with some modifications to allow for current service patterns, improve/restore support from DHS, and transfer HRB responsibilities away from DHS Licensing**



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# Discussion of Options

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## **Division.**

### **Pro:**

- The HRBs history is one of good, cost effective service. It is far better to fix/restore it, than to cast it aside.
- The service delivery system has changed significantly since HRBs came into existence. At a minimum, some modifications in the HRBs services should be made to reflect this. This would include some expansion of their services to include persons receiving state regional center administered services in remote (remote = not located on-site at the regional centers) or community based sites.
- Restore HRB services to the institutional population at Moose Lake.
- Restore to the HRBs a consistent, dedicated, full-time coordinator/facilitator. Give this person, and the HRBs, the ability and authority to get results.

- Transferring HRB responsibilities away from DHS Licensing Division accomplishes two significant things:

- 1) It significantly reduces the weight of the “conflict of interest” assertion.
- 2) It provides an opportunity to “house” the HRBs in a division more compatible and directly in line with the mission and work of the HRBs:

A) The DHS Quality Initiatives Division, or

B) The DHS Quality Services Division

**Con:**

- This keeps the HRBs based out of an agency that has had conflict of interest problems. Even with a legislative mandate to support, work with, and respond to the HRBs, this may or may not be the best climate for the service to grow and become reinvigorated.
- It will cost more to return to the prior level of functioning and support than what is currently being spent.
- Growth to cover community based services would require a further increase in direct expenditures and human resources.

- 3) **Transfer the HRB functions to another agency with the goal of providing the type and quality of services the HRBs have offered.**

**Pro:**

- It gives the HRBs a fresh start.
- By transferring the HRBs to an agency with similar mission and goals as the HRBs, training, technical expertise, and consultation crossovers could occur naturally.
- If done and funded properly, it would augment and improve the monitoring of treatment and quality of life issues in state run institutions and collateral services.

**Con:**

- There is no way any agency could replicate even the current level of HRB service at the funding level currently dedicated to the HRBs. Any hope of improving or expanding HRB type services will require an increase in expenditures even greater than option #2.
- Transferring the HRBs, or HRB functions, to another agency runs the significant risk of much time and resources being spent to “recreate the wheel”. There once were people and processes within DHS and the HRBs that knew how to bring an issue to a conclusion. Some of those people and that knowledge are still present. Much of this would potentially be lost in a transfer to another agency requiring rediscovery of the knowledge and processes.

**4) Continue and augment current HRB services for DHS’ mentally ill and psychopathic personality populations while developing a new model for clients in community based services and short-term institutional placements.**

**Pro:**

- Effective HRB services would be provided to the clients most likely to experience long-term institutionalization.

- Enforcement of the Reome consent decree would continue.
- Significantly greater numbers of citizens would have access to third party review, advocacy, and grievance resources.
- What works from the current system could be maintained. Other aspects would either be improved on or discarded.

**Con:**

- Non-mentally ill and psychopathic personality institutionalized clients would be at risk of losing a currently existing resource during the time it takes to bring a new model up to speed.
- Wherever the new model was housed, funding and human resource expenditures would need to be significantly increased over current levels. Full and appropriate funding level would be a necessity.

**5) Transfer HRB functions to another agency with the goal of developing a new model of service.**

**Pro:**

- HRB type services would be available to more citizens.
- HRB type services would be completely independent from DHS.
- Potentially, HRB type services would be more powerful and effective than the current model.
- Effectiveness would be increased if housed in an agency with similar mission and goals.

- Looking at the big picture, such a model would provide broad, good quality, oversight for a reasonable cost.
- A new model could increase citizen and consumer involvement in government.
- Increased protection of vulnerable citizens could be achieved.
- In the long run, this model could lead to a decrease in the need for licensing as oversight and quality of service improve.

**Con:**

- This would require the greatest increase over current funding levels; roughly \$250 - \$300 thousand dollars to get up and running. New staff would need to be hired.
- This would be a new initiative without any existing models to build on or other indicators of success, except for the New York Board of Visitors model.
- This is a complex model. It requires a willingness to be open to and learn new methods.
- As old conflict of interest doors close, new ones may open. New conflicts of interest may develop if placed in an existing agency.

**6) Modify the existing statute and abolish the HRBs**

**Pro:**

- This would save some short term expenditures. Currently, DHS budgets \$24 to \$26 thousand dollars each biennium for HRB costs. Some hidden costs, such as facility staff and administration time could also be saved.

- State regional centers and DHS central office would have one less third party reviewer to spend time with. This could translate into more time for improving client services.

**Con:**

- The only way this proposal could be seen as appropriate would be to accept the assertion that other processes and resources are currently in place and functioning at a level so as to make the HRBs duplicative and unnecessary. This assertion is not proven and is contradicted by many knowledgeable and involved people.
- Implementing this proposal on the basis of an unproven assertion is experimental research on a vulnerable population which has not been offered or given informed consent.
- Whatever short term spending or resources might initially be saved would quickly be dwarfed by the costs of the first of many potential legal and/or court battles linked to the abolishment of HRBs. Admittedly, this statement is as much a hypothesis as the assertion this proposal is based on.

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# Conclusions

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- Minnesota has received good value for the money spent on the HRBs.
- Good outcomes for some of our most vulnerable citizens have been achieved through HRB action and involvement.
- The HRBs, as currently configured, are not as active or as effective as they once were.
- Through the efforts of some committed and motivated HRB members, some positive accomplishments continue. However, many of their positive accomplishments go unpublicized and unnoticed.
- Abolishment of the HRBs, without ensuring an equal or greater level of service, is a risk of the well-being of some of our most vulnerable citizens. It could potentially expose the State and its citizens to costly claims and challenges.
- The HRBs are part of a complex process working to promote quality care and service at state regional centers. They cannot be eliminated without diminishing the whole process.
- If HRBs continue, clear standards are needed for all the HRBs and their members.
- HRBs or their equivalent need the authority and ability:
  - a) to communicate directly with other persons and agencies including the Governor's Office and the Ombudsman Office.
  - b) to make unannounced visits as indicated.

- The HRB statute needs to be examined and improved.
- To be more effective, the HRBs would need a dedicated, possibly full-time coordinator/facilitator. They should be housed in a division or agency which is supportive of their work, responsive to their concerns, and which minimizes any conflict of interest claims.
- Consumer representation and input should be a part of the HRB process. Peer advocates should be identified.
- A 1-800 number should be developed and publicized so clients can directly contact their HRB.
- Many possible responses to the current status of HRBs exist. Any meaningful improvement or new model would cost more money, at least initially.
- In the long run, whether we restore the HRBs to their prior level of functioning, develop a hybrid concept which blends existing HRB services with a new model, or move towards a new model altogether, we should see an improvement in outcome.

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# Closing and Comments

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As identified in our preface statement, our perspective is to look at:

- What is best for the client?
- What is the right thing to do?

The Ombudsman Office took notice of the markedly different positions expressed depending on who one is listening to. If we only consider one side of the issue, we could be convinced that the HRBs are a totally outdated concept, and the service they provide is redundant and unnecessary. The underlying assumption is that anything that was identified by the HRB would surface through these other services. However, there is a question of whether or not sufficient resources exist.

If we listen to and consider the other side of the issue, we could be concerned that DHS is strongly considering abolishing HRBs while the court order mandating their review of certain key issues, like monitoring the possible excessive use of seclusion and restraint, is still in effect.

In summary, we have identified a number of possible options. Of the six “Future Options for State Hospital Review Boards in Minnesota” we identified, the Ombudsman Office feels numbers 2, 4, or 5 have the most viability to be successfully implemented in the near future. (2. Restore prior status with some modifications to allow for current service patterns, improve/restore support from DHS, and transfer HRB responsibilities away from DHS Licensing Division; 4. Continue and augment current HRB services for DHS’ mentally ill and psychopathic personality populations; while developing a new model for clients in community based services and short-term institutional placements; and 5. Transfer HRB functions to another agency with the goal of developing a new model of service.)

The Ombudsman Office feels that option numbers 1, 3, and 6 would not be appropriate or productive choices.

It is possible to develop a new model. Any new model should include the quality assurance programs at state run facilities and expand to include more access by community based citizens receiving services. At a minimum, this essential part of our quality assurance and treatment monitoring process should be re-stored.

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# Attachments

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## 253B.22 REVIEW BOARDS.

Subdivision 1. **Establishment.** The commissioner shall establish a review board of three or more persons for each regional center to review the admission and retention of patients institutionalized under this chapter. One member shall be qualified in the diagnosis of mental illness, mental retardation, or chemical dependency, and one member shall be an attorney. The commissioner may, upon written request from the appropriate federal authority, establish a review panel for any federal treatment facility within the state to review the admission and retention of patients hospitalized under this chapter. For any review board established for a federal treatment facility, one of the persons appointed by the commissioner shall be the commissioner of veterans affairs or the commissioner's designee.

Subd. 2. **Right to appear.** Each treatment facility shall be visited by the review board at least once every six months. Upon request each patient in the treatment facility shall have the right to appear before the review board during the visit.

Subd. 3. **Notice.** The head of the treatment facility shall notify each patient at the time of admission by a simple written statement of the patient's right to appear before the review board and the next date when the board will visit the treatment facility. A request to appear before the board need not be in writing. Any employee of the treatment facility receiving a patient's request to appear before the board shall notify the head of the treatment facility of the request.

Subd. 4. **Review.** The board shall review the admission and retention of patients at its respective treatment facility. The board may examine the records of all patients admitted and may examine personally at its own instigation all patients who from the records or otherwise appear to justify reasonable doubt as to continued need of confinement in a treatment facility. The review board shall report its findings to the commissioner and to the head of the treatment facility. The board may also receive reports from patients, interested persons, and treatment facility employees, and investigate conditions affecting the care of patients.

Subd. 5. **Compensation.** Each member of the review board shall receive compensation and reimbursement as established by the commissioner.

HIST: 1982 c 581 s 22; 1983 c 251 s 25; 1986 c 444



CLIENT ASSISTANCE PROJECT  
LEGAL ADVOCACY FOR PERSONS  
WITH DEVELOPMENTAL DISABILITIES  
MENTAL HEALTH LAW PROJECT  
PROTECTION AND ADVOCACY FOR  
INDIVIDUAL RIGHTS  
EXECUTIVE DIRECTOR  
Jeremy Lane  
MANAGING ATTORNEYS  
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PROGRAM COORDINATOR  
Lisa Cohen

## MINNESOTA DISABILITY LAW CENTER

THE PROTECTION & ADVOCACY  
SYSTEM FOR MINNESOTA

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Judith A. Sweeney

October 1, 1996

James E. Tausch, L.S.W.  
Office of the Ombudsman  
of Mental Health and Retardation  
1235 Highway 293S  
Cambridge, MN 55008-9003

**RE: Hospital Review Board Issue**

Dear Mr. Tausch:

This letter is to follow up on our meeting of September 24, 1996 regarding the value of the Hospital Review Boards. I understand that the Department of Human Services is considering eliminating the Hospital Review Boards. Our office would oppose this for a number of reasons. I hope you will note the following points in your report to the Ombudsman:

1. The Hospital Review Boards provide a forum for patients to discuss issues that is more independent and neutral than a treatment team meeting. This quasi-external oversight of practices and procedures directly benefits clients. For example, at Anoka-Metro Regional Treatment Center, a patient was forced to take neuroleptic medications without a court order, in a non-emergency by members of the treatment team. The patient brought these concerns to the Hospital Review Board. Consequently the Board recommended various policy and procedural changes at the hospital to safeguard against such an incident recurring. This result benefitted not only the particular individual who complained to the Board, but also the patient population as a whole.
2. The Minnesota Security Hospital's Hospital Review Board has an essential role in reviewing use of protective isolation pursuant to the Court Order in *Reome v. Gottlieb et al.*, (copy attached hereto). The Stipulation and Consent Decree embodied in the Order in that matter governs the use of protective isolation at Minnesota Security Hospital. Under the Court Order, the Hospital Review Board is responsible for reviewing the use of protected isolation that extends beyond 48 hours. Attorneys in our office, including myself, frequently appear before the Hospital Review Board to represent clients who are in protective isolation. I believe that the procedures set forth in the Consent Decree provide a workable mechanism for oversight and review of this extremely restrictive type



James E. Tausch, L.S.W.

October 1, 1996

Page 2

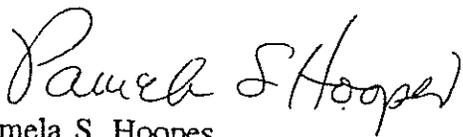
of seclusion. Over the years the Hospital Review Board has done an excellent job overall of hearing these difficult cases. I am very troubled that serious discussions of eliminating the Hospital Review Boards may be taking place without reference to the ongoing Consent Decree.

3. The Hospital Review Boards provide a service to clients that is not provided by the few other resources available to clients including the Minnesota Disability Law Center. As the designated Protection and Advocacy agency for people with disabilities in Minnesota, our office receives myriad calls from state hospital patients. Because we have limited resources and because we are a law office, we are sometimes unable to help people who have legitimate concerns that do not present a legal issue. The Hospital Review Board is often an appropriate forum in which a patient can express dissatisfactions with treatment or with hospital administration or policy. Even if no definitive change occurs as a result of a patient's complaint, the opportunity for venting to "outsiders," the experience of being heard and taken seriously, are important to people who are confined in the closed settings of the state hospitals.
4. To enhance community and consumer involvement in the Boards, the statute could require that the community member on the Board also be a consumer or family member.
5. In addition, the current system could be enhanced if consumer advocates from the Consumer Survivor Network or AMI were enlisted to accompany patients appearing before the Boards at their request.

I hope that these comments are useful to you. Please let me know if I can be of further assistance.

Sincerely,

Minnesota Disability Law Center



Pamela S. Hoopes  
Managing Attorney  
PSH:dld

Enc.

STATE OF MINNESOTA

DISTRICT COURT

MENTAL HEALTH DIVISION

COUNTY OF HENNEPIN

FOURTH JUDICIAL DISTRICT

Hyles Renee,

Plaintiff,

File No. <sup>MC</sup> 835507

v.

ORDER

-Brian Gottlieb, et al.,

Defendants.

The parties to the above matter have entered into a Stipulation for Consent Decree. The terms of that Stipulation fairly and adequately protect the interests of all parties and constitute a full and final settlement of all the issues before this Court except for the issues of damages, attorney's fees, and costs, if any, which may be awarded, and provided that the Court shall retain jurisdiction to enforce this Order.

NOW THEREFORE, IT IS HEREBY ORDERED that the following provisions shall govern the use of protective seclusion at Minnesota Security Hospital:

I. SCOPE OF ORDER

This Order shall govern all uses of protective seclusion (as defined below) which extend beyond 48 hours, except as provided below, for all patients at Minnesota Security Hospital. The rights and obligations enumerated herein are in addition to, and do not supercede any rights or obligations otherwise set forth in existing statutes. Nor do they supercede any rights or obligations otherwise set forth in existing rules or policies and guidelines which are not inconsistent with this order. The terms of this Order shall be superceded by any federal or state statutes or federal administrative or state administrative regulations promulgated pursuant to the Minnesota Administrative Procedures Act which contain provisions inconsistent with this Order which become

effective after the effective date of this Order. In the event that any or all of the terms of this Order are superceded by state administrative regulations, plaintiff reserves the right to challenge the legality of such regulations. In addition, the procedures set forth in the Minnesota Security Hospital's Aversive and Deprivation Procedure guidelines are unaffected by this Order. Nothing herein limits any existing rights of any patient to seek judicial review of seclusion or any other matter.

## II. DEFINITIONS

- A. "Hospital" means Minnesota Security Hospital, and does not include any other State-operated facility.
- B. "Commissioner" means the Commissioner of the Minnesota Department of Public Welfare, or a lawfully designated representative.
- C. "Medical Director" means the Medical Director of the Minnesota Security Hospital, or a lawfully designated representative.
- D. "Hospital Review Board" or "Board" means the review board appointed pursuant to Minn. Stat. § 253B.22 (1982).
- E. "Protective Seclusion" means placing a patient in a room from which he or she is not able or allowed to exit in order to protect the patient or other persons from the unreasonable risk of imminent serious physical harm, or prevent imminent serious property damage. Protective seclusion does not include the routine practice of locking patients in their sleeping rooms between the hours of 10 p.m. and 7 a.m.

Protective seclusion does not include programmatic seclusion, which shall be administered pursuant to the procedures of the Aversive and Deprivation Therapies Committee as set forth in M.S.H. Policy #701, or its successor.

The length of the period of seclusion includes any period(s) of time out of seclusion if the patient must return to seclusion at the end of the period(s) of time, irrespective of his or her behavior during the time out of seclusion.

## III. GENERAL STANDARDS

- A. Protective seclusion may not be used for convenience of staff or as a substitute for programming.

- B. Protective seclusion may be used only to protect the patient or other persons from the unreasonable risk of imminent serious physical harm, or to prevent imminent serious property damage.
- C. Protective seclusion may be used only if no less restrictive means exists to protect the patient or other persons from the unreasonable risk of imminent serious physical harm or to prevent imminent serious property damage.
- D. Treatment shall be provided to the patient during seclusion which meets statutory standards, and unless prohibited by the patient's behavior; shall include components which are designed to eliminate or reduce the specified behavior(s) which occasioned the need for seclusion.
- E. Protective seclusion may be used only if the requirements of this order are satisfied.

IV. PROTECTIVE SECLUSION MAY NOT EXTEND BEYOND 48 HOURS, EXCEPT AS PROVIDED BELOW, UNLESS PRIOR TO THE EXPIRATION OF THAT TIME, THE TREATMENT TEAM DEVELOPS, AND THE MEDICAL DIRECTOR APPROVES, A SECLUSION STATEMENT WHICH:

- A. States the reasons protective seclusion is necessary to protect the patient or other persons from the unreasonable risk of imminent serious physical harm or to prevent imminent serious property damage;
- B. Contains an objective description of the behavior which poses the danger;
- C. Sets forth the frequency of the behavior in the past;
- D. Contains an analysis of the causes or precipitating condition for the behavior, including, where appropriate, an analysis of the needs of the patient which the behavior fills;
- E. Contains a complete, non-conclusory discussion of the reasons that protective seclusion is necessary, including a statement of the facts and data from which it is concluded that less restrictive programming will not be sufficient to prevent the risk of harm;
- F. Describes the treatment plan which will be implemented during the period of protective seclusion;

- G. Specifies the maximum length of time for which protective seclusion is approved, and sets forth a plan for reviewing the seclusion, including the frequency of reviews and the criteria for judging that the risk of harm is no longer sufficient to justify seclusion;
- H. Is placed in the patient's medical records; and
- I. Is approved in writing by the Medical Director;
- J. If the 48 hour period would otherwise expire on a weekend or holiday, the time by which the requirements of this section must be met shall be extended to 4:30 p.m. on the next business day.

V. REVIEW BY HOSPITAL REVIEW BOARD

- A. On the business day that it is determined that protective seclusion is to extend beyond the period permitted by section IV, the patient shall receive written notice of that fact, and of his rights under this order, and shall be furnished with a copy of the Seclusion Statement;
- B. No patient may be kept in seclusion more than seven days unless:
  - (1) The Hospital Review Board, after a hearing, as described below, recommends that protective seclusion is necessary to protect the patient or other persons from the unreasonable risk of imminent serious physical harm or to prevent imminent serious property damage, and that no other less restrictive means of reducing that risk exists, and that the provisions of this order are satisfied; or
  - (2) The Commissioner approves, in accordance with K below, a request by the Medical Director to modify or reject the recommendation of the Hospital Review Board; or
  - (3) If all testimony and deliberations of the Board cannot be completed by the close of business on the date of the hearing, the Board may continue seclusion until the end of the next business day in order to allow for the completion of the hearing and the issuance of a final decision. The Board may not continue seclusion pending a decision beyond the end of the business day following the hearing except in exigent circumstances.

- C. The Hospital Review Board shall hold a hearing on or before the close of business on the seventh day of seclusion unless the seventh day falls on a weekend or holiday, in which case the Board shall meet on or before the close of business on the next business day. If it is not possible to timely convene the Hospital Review Board, an interim hearing shall be held before an ad hoc committee of three or more mental health professional persons, at least one of whom shall not be from the Hospital, appointed by the Chief Executive Officer of St. Peter Regional Treatment Center. The interim hearing shall be conducted pursuant to the standards set forth herein.
- D. The seclusion may continue for up to an additional seven days, if approved by the ad hoc committee, or the Commissioner, pursuant to K. The seclusion may not extend beyond the additional seven day period unless approved by the Hospital Review Board, or the Commissioner, as set forth herein.
- E. The patient shall have at least three days written notice of the hearing and the proposal to continue protective seclusion for more than seven days.
- F. (1) The hearing shall take place whether or not the patient requests it. The patient shall have the right to attend the hearing. The Board may require the removal of the patient if the patient's behavior is, after appropriate warning, so disruptive as to render completion of the hearing impractical. The hearing shall be held even if the patient chooses not to attend;
- (2) The Hospital shall make a good faith effort to assure that the patient has available to him or her an effective advocate. The Hospital shall not be required to pay for such advocate;
- (3) The patient may compel the attendance of any staff member who is not on leave because of sickness or vacation; the patient may also require the presence of any consenting patient to appear before the Hospital Review Board.
- G. Formal rules of evidence shall not apply, but the hearing shall be conducted in an orderly fashion. The Hospital shall proceed first, and all parties shall have the right to question any persons appearing before the Board. The patient, and not the patient's advocate, makes the final decision on whether the patient shall attend the hearing

and whether the patient shall testify. The Hospital may neither compel the attendance of the patient nor require the patient to testify.

- H. The Hospital Review Board shall issue a written recommendation to the Medical Director within two business days of the Board's decision, a copy of which shall be furnished to the patient, and the patient's advocate, which contains findings and conclusions, including:
- (1) The facts relevant to the behavior and other circumstances alleged to have justified seclusion;
  - (2) Whether, at the time seclusion was imposed, that behavior posed an unreasonable risk of imminent serious physical harm or imminent serious property damage, and the grounds for that conclusion;
  - (3) If the answer to #2 is in the affirmative, whether that risk continues at present, and the grounds for that conclusion;
  - (4) Whether there were or are alternatives less restrictive than the seclusion which is proposed, and if not, the reasons that less restrictive alternatives will not suffice;
  - (5) Whether the treatment plan proposed meets the standards of this order;
  - (6) The maximum length of time that the protective seclusion may continue and the length of time prior to the next review by the Hospital Review Board; and
  - (7) The criteria for release prior to the expiration date.
- I. The Hospital Review Board shall recommend that protective seclusion be continued, terminated, or continued only on specified conditions.
- J. In the case of review by the ad hoc committee pursuant to V.C. , the seclusion may not extend for more than seven days beyond the initial seven day period. The Hospital Review Board may recommend protective seclusion for a period of up to 30 days beyond the initial 7 day period.
- K. The Medical Director shall state in writing whether the recommendation of the Hospital Review Board is to be accepted, rejected, or modified. If the Medical Director wishes to reject or modify the recommendation, he or she

shall inform the Commissioner of the Board's recommendation and the Medical Director's reasons for wanting to reject or modify that recommendation. The matter shall be submitted to the Commissioner, who shall decide whether to accept, reject or modify the recommendation. The decision of the Commissioner shall be made and communicated orally to the patient and the patient's advocate within seven days of the initiation of seclusion, except as provided in V.B.(3) or V.C., in which case the decision shall be made and communicated orally to the patient and the patient's advocate no later than the end of the business day following the completion of the hearing. A written decision stating the reasons for rejecting or modifying the Board's recommendation shall be prepared and served by mail upon the patient and patient's advocate within two business days of the date of the decision.

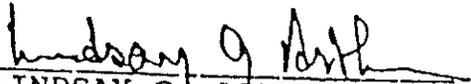
- L. The Medical Director shall once a week interview the secluded patient and the patient's treatment team to determine whether protective seclusion shall continue. If the Medical Director determines that protective seclusion shall continue, he or she shall set forth in writing the reasons for concluding that each of the requirements of section III is satisfied. The patient shall be notified of this decision, and provided a copy of the Medical Director's written decision and reasons.
- M. Protective seclusion may not extend beyond 30 days from the date of approval by the Hospital Review Board or Commissioner, or beyond the date, if any, set by the Hospital Review Board for its next review, whichever is earlier, unless, prior to that time:
- (1) The treatment team conducts a thorough and comprehensive review of the seclusion and the patient's treatment needs, and prepares an updated Seclusion Statement, including the items set forth in IV; and
  - (2) The continuation of seclusion is approved pursuant to the procedures set forth in V.
- N. The Medical Director, with the advice of the Hospital Review Board, shall be responsible for determining whether additional resources would render protective seclusion unnecessary. If so, the Medical Director shall notify the Commissioner in writing of the additional resources needed to render seclusion unnecessary, and the Commissioner may approve or disapprove such additional resources.

- O. The patient, the patient's advocate, relative, legal guardian, county social worker, Hospital staff member, or other adult person acting on behalf of the patient, shall have the right to request in writing that the Commissioner reconsider any final decision to continue protective seclusion beyond seven days. No individual may submit such a request more frequently than once every seven days.

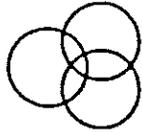
VI. MONITORING

- A. All uses of protective seclusion which extend beyond 48 hours and which are not otherwise submitted to the Hospital Review Board because they do not extend beyond 7 days, shall be reported to the Hospital Review Board, which shall review them for compliance with this order. The Hospital Review Board shall report, on or about January 1 of each year, to the Medical Director, Commissioner, and plaintiff's counsel, its conclusions and observations regarding the use of protective seclusion, compliance with the terms of this order, and recommendations for changes in the use of protective seclusion. The Hospital Review Board shall have complete access to patient and other records for purposes of conducting this review. The report to plaintiff's counsel shall not include any individually identifying information.
- B. The Medical Director shall keep records of the frequency and length of instances of protective seclusion for a three year period. These records shall be submitted, upon request, to plaintiff's counsel on a quarterly basis.

Dated:

  
LINDSAY G. ARTHUR  
Judge of District Court  
Mental Health Division

2/12/84



STATE OF MINNESOTA

OFFICE OF THE OMBUDSMAN FOR MENTAL HEALTH  
AND MENTAL RETARDATION

# 1996 LEGISLATIVE PRIORITIES

• **Parity** - Maintain parity in mental health care coverage in health care plans. Oppose any efforts to return to pre -1996 coverage

• **Supreme Court Task Force**- Support the recommendations of the Supreme Court Task Force including:

- Understanding of Advanced Psychiatric Directives
- New early intervention process
- New process to replace "Jarvis"
- Health Care reform that includes mental health under managed care

• **Ombudsman Roundtable Report** - Support for the work of the Ombudsman Roundtable and recommendations clarify and improve Ombudsman services in Minnesota

• **Hospital Review Boards** - Department of Human Services is proposing to eliminate hospital review boards in the Regional Treatment Centers. These review boards have not been as effective in recent years however, they provide the clients with an opportunity to be heard. This agency supports some modification of the function but not the total elimination unless they are replaced by a similar function in another state agency that is independent from the hospitals.



Roland M. Peek, Ph.D.  
Licensed Consulting Psychologist  
10559 Grey Cloud Island Drive South  
St. Paul Park, Minnesota 55071

April 3, 1990



Shirley Hokanson, Ombudsman  
Office of the Ombudsman for Mental Health and Mental Retardation  
Suite 202, Metro Square Building, Seventh and Robert Street  
St. Paul, Minnesota 55101

Dear Ms. Hokanson:

After your recent meeting about the Review Boards (RBs), I tried to summarize for myself my current views, and thought I might forward them to you for whatever they are worth. They are, of course, subject to change induced by future discussions and information.

1. RBs should be continued in some form, if:
  - a. They receive adequate administrative (local and departmental) support, and
  - b. There is some designated way to deal adequately with their recommendations.
  
2. Regional RBs sound like a good idea. It would be necessary, however, to structure this so that RBs could carry the additional load. To simply assign the additional responsibilities to existing RBs would probably not work out, and it would likely be harder to find appointees.
  
3. Wherever the RBs are assigned (DHS or Ombudsman), there should be at least one-half FTE (more if RBs go regional) designated in the relevant Central Office to coordinate RBs and serve as contact person to the other Department or Office (DHS or Ombudsman's Office). If RBs should be assigned to the Ombudsman, DHS should still designate someone to coordinate and follow-up recommendations concerning DHS facilities.
  
4. The RB coordinator should:
  - a. Establish training and orientation procedures for new and continuing RB members.
  - b. Establish procedures for timely coordination, follow-up and

- response concerning RB recommendations and findings.
- c. Establish records of types and locations of problems seen by RBs.
  - d. Provide for appointment of RB members as needed.
  - e. Serve as resource person to RBs concerning legislation, court decisions, policies, special problems, etc.
5. Some agreement should be worked out concerning how advocates can facilitate the functioning of RBs and vice versa.
  6. The implied language of the present statute should be changed so it is clearer that RBs may not only respond to patients' requests, but may also concern themselves with any patient, employee, program, location within facility, or any other matter related to commitment, hospitalization, treatment, programming, discharge, research, policies, procedures, etc., and to protect patients' rights and dignity. The language should also specify more clearly that the RBs role is advisory and that it should not be required to make treatment or administrative decisions.

The statute should also mention that RBs are established because it is state policy to protect patients' rights and thereby improve programs and help prevent adverse conditions; it should also state that the relevant commissioner must provide adequate resources for appointing, training, and coordinating the function and recommendations of RBs.

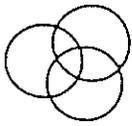
Perhaps the language should also clarify that RBs may deal with all patients for which the facility is responsible, not only committed patients.

7. Other questions:

- a. Should one or more RBs be established for patients committed to private hospitals or units? For persons committed on an out-patient basis? For persons in community facilities (this also relates to the regional RB concept)? Or should present RBs be beefed up somehow to handle these?
- b. Is the present membership of RBs appropriate and adequate to the task?

Sincerely,

*Roland M. Fisk*



STATE OF MINNESOTA

OFFICE OF THE OMBUDSMAN FOR MENTAL HEALTH  
AND MENTAL RETARDATION

Shirley Hokanson  
Ombudsman

Suite 202, Metro Square Building  
Seventh and Robert Street  
St. Paul, Minnesota 55101

612-296-3848  
Toll-free 1-800-652-9747

April 10, 1990

Roland M. Peek, Ph.D.  
Licensed Consulting Psychologist  
10559 Grey Cloud Island Drive South  
St. Paul Park, MN. 55071

Dear Dr. Peek:

Thank you for your thoughtful summary of views regarding the Review Boards. This letter will respond numerically to each of the views you expressed.

1. The Office of the Ombudsman is in full agreement with your opinion that Review Boards should be continued if they receive adequate administrative support and there is a mechanism developed to follow-up on recommendations made by the Review Boards.. A top-level meeting with DHS is needed to secure this commitment on the part of the Department.
2. The idea of Regional Review Boards, which originated in the Ombudsman Office, should be dropped. Regional Review Boards would be too unworkable and would involve too great of a time commitment due to travel time.
3. The Review Boards must continue to be housed within the domain of DHS to remain an internal advocacy vehicle. The Ombudsman Office agrees that the Review Boards need a contact person in DHS to coordinate the Boards and serve as a liaison with the Ombudsman Office.
4. The Ombudsman Office is in full agreement with the duties outlined for the Review Board Coordinator.



Roland M. Peek, Ph.D.  
Page Two  
April 10, 1990

5. The Ombudsman Office agrees that the relationship between the Review Boards and the Regional Client Advocates of the Ombudsman Office needs clarification.

6. We recommend that your suggestions concerning changes in the statute (Minn. Stat. §253B.22) be studied over the next three months. While we are of the opinion that the current statute is vague enough to allow the Review Boards to function in a broad manner, perhaps clarification would be in order. The Ombudsman Office is willing to work with Review Board members to review the statutory mandate of the Boards. DHS could be invited to participate in this review process or the suggestions could be taken to DHS after studying the statute.

7. a) Expanding the Review Boards to private hospitals and community facilities is not recommended, for the same reasons listed in #2 above.

b) Regarding the present membership and whether it is adequate to the task is a question that needs to be raised with DHS, once some of the other above issues are clarified.

Thank you again for taking the time to summarize your current views of the Review Boards. We look forward to working with you and other Review Board members to insure that the Review Board plays a vital internal advocacy role in the RTCs.

Sincerely,



Shirley Hokanson  
Ombudsman

SH:cs

**SUMMARY OF HOSPITAL REVIEW BOARD MEETING  
APRIL 17, 1990**

**PRESENT:** Randall Tigue-Brainerd RB; Jeffrey Boyd-Brainerd RB; Peter Thelen-Moose Lake RB; Michael Lynch-Willmar RB; Audrey Jones-Minnesota Security Hospital RB; Nicholas Long-M.S.H. RB; David Haley-Faribault RB; Roland Peek-Anoka RB; Norma Banks-St Peter RB; Michael Linder-Office of Ombudsman; Charlie Singer-Office of Ombudsman; Shirley Hokanson-Ombudsman.

**I. PREFACE**

The meeting began with a summary of recent discussions between some Review Board members and the Ombudsman. During those discussions it became apparent that there existed a lack of uniformity relative to the Review Boards' role and function. It was determined that an expanded meeting involving a greater number of Review Board members was needed.

**II. INTRODUCTORY STATEMENTS**

Each RB member described his/her perception of how his/her board functioned. The following represents a brief synopsis of concerns and comments expressed by those in attendance:

\*Significant diversity and inconsistency exists relative to the perceived relationships between RBs and the respective RTC administrations. For example, most members stated that they enjoyed a congenial relationship although some felt that their recommendations were ignored.

\*Members in attendance stated that they have had little or no contact with DHS.

\*Each member expressed the opinion that the Regional Client Advocate had been helpful in coordinating the functions of the RB. RB members were reminded that since the creation of the Ombudsman Office, Client Advocates are no longer employees of the Regional Treatment Center and as such are not responsible for staffing the Review Board. They now serve all clients within an assigned region, including but not limited to one RTC.

**III. DISCUSSION OF REVIEW BOARD ISSUES AND CONCERNS**

Using Roland Peek's letter of April 3, 1990 (attached) and Shirley Hokanson's letter of April 10, 1990 (attached) as a guide, the group discussed each area of concern.

A. The RB members assembled fully concurred with the view that the RBs should be continued. It was, furthermore, the opinion of the group that administrative support and coordination by DHS was needed. (See #1 of attached letter).

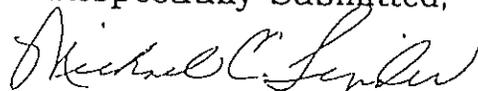
- B. The RB members agreed with Ombudsman Hokanson's assertion that Regional Review Boards would not be practical at the present time although some discussion occurred regarding the notion of tele-communication and whether grants might be available to fund the concept. (See #2 of attached letters).
- C. After considerable discussion, the group agreed that RBs, in order to provide internal advocacy, need to have a contact person in DHS for purposes of coordination. It was also agreed that the nature of the RB role requires a delicate blend of administrative support, while maintaining a posture of independence relative to client advocacy. (See #3 of attached letters).
- D. The RB members supported the recommended duties of a proposed Review Board Coordinator position as outlined in Mr. Peek's April 3, 1990 letter. (See #4 of attached letters).
- E. RB members agreed that there exists some confusion relative to the RBs relationship to the Regional Client Advocates and that clarification is needed. (See #5 of attached letters).
- F. It was the opinion of the group that the "work group" made up of RB members should be assembled to further examine the statute mandating Review Boards (Minn Statute §253B.22) and to then discuss the issues with DHS. (See #6 of attached letters).
- G. The RB members elected to table discussion relative to RB expansion to private hospitals and membership issues. (See #7 of attached letters).

## II. PLAN

The meeting concluded with the following plan:

1. A work group was formed composed of six RB members. The group will formulate a position statement which will include recommendations relative to the present and future operational needs of Review Boards. Work Group members are: Rollie Peek; Nick Long; Randy Tigue; Dave Haley; Jeff Boyd; Tom Williams; and Michael Linder (Office of Ombudsman), who will act as a coordinator for the group. (\*Note: Work Group meeting scheduled for 5/24/90)
2. Having developed recommendations, a delegation of RB members, in collaboration with the Ombudsman, will schedule a meeting with appropriate members of the DHS staff.

Respectfully Submitted,



Michael C. Linder,  
Ombudsman Office  
Suite 202 Metro Square Bldg

ML/sp

AGENCY: Office of the Ombudsman for Mental  
Health and Mental Retardation

STATE OF MINNESOTA  
Office Memorandum

TO: Hospital Review Board Members

DATE: September 4, 1990

FROM: Shirley Hokanson   
Ombudsman

PHONE: 6-0941

SUBJECT: Joint project with Hospital Review Boards

It was a pleasure to meet and work with you throughout the spring and summer. I sincerely hope that our joint effort will culminate in statutory and guideline changes that will enhance the rights of persons in the Regional Treatment Centers.

On August 21st, your representatives, Review Board members Rollie Peek and Nick Long; DHS Assistant Commissioner Julie Brunner, DHS Medical Director Tom Malueg, and Sue Allan also from DHS, and Charlie Singer (from the Ombudsman Office) and I held a very productive meeting. All issues that had been discussed at earlier meetings with the Review Board members were reviewed.

I indicated at the meeting that I believed future dialogue and decision-making should be matters to be handled between DHS and the Review Boards, the two parties most directly impacted at this point, and that the Ombudsman Office would play a supportive role, if indicated.

Again, it was a pleasure to work with you, and I look forward to doing so again in the future.

SH/sp

CC: Julie Brunner, Assistant Commissioner, DHS  
Dr. Tom Malueg, Medical Director, DHS



# Quality Assurance Resources

## Instruments, Publications and Organizations

The following pages contain a list and description of quality assurance instruments, publications and organizations to help you secure resources for monitoring services and supports for people with mental retardation. In assembling this guide, we attempted to include resources which are considered exemplary by experts or that were provided by chapters of The Arc and other organizations. No system was employed to guarantee that every resource listed is truly exemplary. However, each resource submitted for this list was reported by its author or agency to be useful in terms of assessing services or gaining a better understanding of quality.

Included in this guide are publications and organizations which directly or indirectly address quality of services and supports for people with mental retardation. Readers are encouraged to review the literature and contact different organizations to become familiar with exemplary quality standards and components of monitoring instruments.

The Arc of the United States  
Department of Research & Program Services  
P.O. Box 1047  
Arlington, Texas 76004  
(817)261-6003  
(817) 277-0553 TDD  
[hearc@metronet.com](mailto:hearc@metronet.com) (e-mail)

May 1996

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The Arc's Position Statement on Quality

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## Instruments

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### **A Guide to Program Quality Review of Day Programs. A Guide to Program Quality Review of Homes and Residences.**

A survey instrument to assess either day or residential programs for people with mental retardation. The instrument will assess if programs facilitate the use of community resources, encourage people to develop relationships, help people make plans and choices, respect people's rights and help develop skills and interests. Reviews are done by volunteer teams composed of a person with mental retardation, family member, staff and private provider, 1986. No cost.

Contact - Catherine Daly, Connecticut Dept. of Mental Retardation, 90 Pitkin St., E. Hartford, Conn. 06108 (203) 528-7141.

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### **Aim for Excellence**

The AIM (Advocates Involved in Monitoring) is an evaluation instrument to assess quality of life for individuals

characteristics of a person's living situation. It reviews quality of life in five areas: physical setting, staff, regard for the individual, personal growth and safety. 1989. \$10 plus postage.

Contact - The Arc of Oregon, 1745 State St., Salem, Ore. 97301 (503) 581-2726.

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### **Association for Retarded Citizens/Michigan Monitoring Tools**

These monitoring tools are used to create and/or maintain quality living in state run residential settings. The focus is on quality of life and normalization, always putting yourself (the monitor) in the place of the people in residential programs. Tools consist of Group Home Observation Forms, Nursing Home Observation Forms, and Regional Center Observation Forms. Tools are used in conjunction with 10 hours of training and a 75 page monitoring manual. Reproducible forms can be obtained free by sending SASE. \$20 for manual.

Contact - Sandy Orne-Adams, The Arc Michigan, 333 S. Washington Sq., Ste. 200, Lansing, Mich. 48933 (517) 487-5426.

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### **Association for Retarded Citizens Of Arizona Volunteer Monitoring Tool**

A checklist approach, designed by family members to determine whether the residential community homes for children and adults are quality programs. The monitoring project focuses on the "Would I want to live here?" approach. Volunteer family members and self-advocates applaud positive aspects of homes monitored as well as sharing constructive ideas for program enhancement. Tool and packet of information on full project is available. No cost.

Contact - The Arc of Arizona, Inc., 5610 S. Central Ave., Phoenix, Ariz. 85040 (602) 243-1787.

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### **Association for the Macomb Oakland Regional Center Monitoring Guidelines**

An outline of the AMORC Monitoring Committee to evaluate and report on residential services. Committee members go out in teams of two people to evaluate area group homes. The evaluation addresses the general areas of quality of life, health, nutrition, and client rights. Each general area lists a number of specific questions to evaluate the program. \$3.

Contact - Ruth M. Taylor, AMORC Monitoring Committee, P.O. Box 480471, New Haven, Mich. 48048-0471 (313) 749-3038.

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### **Association for the Rights of Citizens With Mental Retardation in Delaware Citizens Monitoring Instrument**

A checklist to monitor residential programs for individuals with mental retardation. Based on quality of life standards, the instrument assesses programs in terms of physical appearance/location, respect and dignity of client, integration, skill development, and personal relationships. Utilizes a three person monitoring team. No cost.

Contact - The Arc of Delaware, Tower Office Park, 240 N. James St., S-B2, Wilmington, Del. 19804 (302) 996-9400.

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## **Center-Based Preschool-Age Program Quality Review Instrument**

A rating tool for child development programs. The instrument can be used in a self-review, as a teaching tool, as a review of program quality, or for program improvement. The instrument rates the program's philosophy, goals and objectives; administration; assessment of child and family; developmental program; parent education and involvement; community resources and involvement; and evaluation. 1988. \$2.

Contact - Dept. of Education, Child Development Division, P.O. Box 944272, Sacramento, Calif. 94244-2720 (916) 323-1343.

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## **Child Development Program Evaluation**

The Child Development Program Evaluation is a licensing monitoring system that has identified key regulatory predictor indicators that have a positive impact on children's development. Its applicability in the mental retardation service area is in the identification of basic health and safety standards that apply to all human services. Developed under Richard Fiene, Ph.D. 1981. No cost.

Contact - Richard Fiene, Ph.D., Dept. of Public Welfare, P.O. Box 2675, Harrisburg, Pa. 17105-2675 (717) 772-2099.

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## **Client Outcome Formative Evaluation**

A client outcome-based formative evaluation system for adults with mental retardation. The system includes information regarding overall program goal, target population and services. It establishes client outcome objectives, measures for these objectives, and expected outcomes. It enables the collection of measurement data which allows comparison between expected and actual outcomes to assess performance. 1984. No cost.

Contact - Charles Lyle, Community Human Services Dept., 160 E. Kellogg Blvd., St. Paul, Minn. 55101 (612) 298-5351.

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## **Commonwealth of Pennsylvania Quality Assurance System**

A nationally recognized individual oriented and outcome oriented quality assurance model. In this system, the individual is visited annually and families are surveyed by mail. Both residential and day program/employment environments are measured in terms of behavioral progress, independence, productivity, and integration. The system allows for direct contact with the consumer and remedies for "red flag" situations. 1986. No cost.

Contact - Publications, Temple University, 927 Ritter Annex, Philadelphia, Pa. 19122 (215) 787-6560.

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## **Consumer Program Review**

The Consumer Program Review is an evaluation instrument which was designed to assist consumers who have a developmental disability, including those individuals who have a cognitive impairment, in the evaluation of the day programs in which they and others participate. The instrument utilizes information from the consumer and staff of the program to make an assessment. By Joanna Pierson and Nancy Norwood. 1985. Revised 1987. \$5.

## **Guidelines for Quality Individual Plans**

A brochure checklist to help families and individuals with disabilities assess whether the written individual plan meets state-of-the-art criteria. (Note: this brochure was reprinted by The Arc with permission from the Minnesota Governor's Planning Council on Developmental Disabilities. The brochure contains a list of national organizations to contact for assistance.) 1987. Minnesota: single copies free. Contact for bulk requests. The Arc: Single copies free with self-addressed, stamped envelope. \$13 per 100.

Contact: Minnesota Governor's Planning Council on Developmental Disabilities, 300 Centennial Bldg., 658 Cedar St., St. Paul, Minn. 55158 (612) 296-4018 or The Arc, National Headquarters, P.O. Box 1047, Arlington, Texas 76004 (817) 261-6003, (817) 277-0553 TDD.

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## **Partnership for Quality Services**

The Partnership for Quality Services Volunteer Handbook and videotape can be utilized as a guide for developing and implementing a volunteer monitoring system or for promoting quality assurance concepts in community programs. The handbook includes the monitoring tool, standards, reporting methods, and background information for volunteers. The video depicts quality of life issues and the monitoring process for training volunteers. 1987. \$15 per video tape. \$16 per handbook.

Contact - Jean Swanson, Arc Minnesota, 3225 Lyndale Ave. South, Minneapolis, Minn. 55408 (612) 827-5641.

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## **Passing**

Designed to help meet the demand for incisively measuring the quality of human services in relation to normalization in an insightful and concrete manner. PASSING can be learned and used by most citizens and service consumers as well as service staff. List of evaluation forms available. By Wolf Wolfensberger and Susan Thomas. NIMR. 1983. 510 pp. \$55 plus 15% postage (CANADIAN CURRENCY). Order #0-920121-65-9. Make checks payable to Fitzhenry & Whiteside.

Contact - The Roeher Institute/CACL, c/o Fitzhenry & Whiteside, 91 Granton Drive, Richmond Hill, Ontario, CANADA L4B 2N5.

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## **Personal Integration Inventory**

A survey approach to assessing the extent to which the individual is being integrated into the community. It focuses on the day-to-day experiences and interactions of people who live in community settings and should be completed by someone familiar with the person. The survey can be used every six or twelve months to assess the individual's growth and progress. By Hank Bersani and Rebecca Salon. 1988. \$2.10 each plus 10% shipping and handling.

Contact - Rachael A. Zubal, Publications Coordinator, Syracuse University, 200 Huntington Hall, 2nd Fl., Syracuse, N.Y. 13244-4230 (315) 443-3851, (315) 443-4338 FAX.

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## **Program Analysis Of Service Systems (PASS 3)**

PASS 3 is a method of assessing the quality of a wide variety of human services for any handicapped or disadvantaged group of people. By Wolf Wolfensberger and Linda Glenn. NIMR. 1975. Handbook - 91 pp. \$15. Order #0-919648-03-7. Field Manual - 81 pp. \$17. Order #0-919648-04-5. Both for \$30. Order #0-920121-80-2. Add 15% postage (CANADIAN CURRENCY).

Contact - The Roeher Institute/CACL, c/o Fitzhenry & Whiteside, 91 Granton Drive, Richmond Hill, Ontario, CANADA L4B 2N5.

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### **Program Quality Indicators (PQI)**

PQI is designed for use by school district personnel and consumer groups to evaluate and guide program development. The checklist monitoring tool is organized into six program components: (1) Program Philosophy; (2) Program Design and Student Opportunities for Learning; (3) Systematic Instruction and Performance Evaluation; (4) IEP Development and Parent Participation; (5) Staff Development and Team Collaborations and (6) Facilities and Resources. 1987. \$5.

Contact: TASH - Association for Persons with Severe Handicaps, 11201 Greenwood Ave. No., Seattle, Wash. 98133 (206) 361-8870.

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### **Residential Services Monitoring Project**

An evaluation instrument and companion handbook to monitor residential services. The instrument covers areas of community living. The handbook contains descriptions of residential alternatives, procedural guidelines, and other pertinent areas. Information on setting up or attending workshops is also available. 1984. \$15 per set for members of The Arc. \$25 per set for non-members.

Contact - The Arc of Ohio, 1335 Dublin Rd., Ste. 205-C, Columbus, Ohio 43215-1000 (614) 487-4720.

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### **Test Your IQ: Integration Quotient**

A brochure checklist to help families of persons with developmental disabilities determine the level of integration efforts provided by the programs and services they use. Single copies free. Contact for bulk requests.

Contact - Minnesota Governor's Planning Council on Developmental Disabilities, 300 Centennial Bldg., 658 Cedar St., St. Paul, Minn. 55155 (612) 296-4018.

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### **Test Your School's IQ: Integration Quotient**

A brochure checklist to help families of students with developmental disabilities determine the level of integration in their local schools. Contains a list of Minnesota organizations to contact for further information. (Note: this brochure was reprinted by The Arc with permission from the Minnesota Governor's Planning Council on Developmental Disabilities. The brochure contains a list of national organizations to contact for assistance.) 1987. Minnesota: single copies free. Contact for bulk requests. The Arc: single copies free with self-addressed, stamped envelope. \$13 per 100.

Contact - Minnesota Governor's Planning Council on Developmental Disabilities, 300 Centennial Bldg. 658 Cedar

## **The Arc of New Mexico Group Home Satisfaction Survey**

A 62 question rating instrument for parents or guardians of persons with mental retardation in group homes. The mail-out survey solicits the perceptions of parents/guardians on group home services using a one to five scale on 56 questions and asks for comments on six questions. 1988. No cost for single copies.

Contact - The Arc of New Mexico, 3500 G Comanche NE, #500, Albuquerque, N.M. 87107 (505) 883-4630.

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## **Publications**

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### **Assessing and Enhancing the Quality of Services**

A comprehensive overview of the purposes of quality assurance, the current state-of-the-art, the components and elements of a viable quality assurance system, methodological and measurement constraints, and model quality assurance approaches. This manual represents five years of work and analysis and is applicable to developmental and other human services. Project Director: Valerie J. Bradley. 1984. 268 pp. \$15 plus postage. Other publications also available.

Contact - Publications Coordinator, Human Services Research Institute, 2336 Massachusetts Ave., Cambridge, Mass. 02140 (617) 876-0426.

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### **Guidelines for Evaluators During a Pass, Passing, for Similar Assessment of Human Service Quality**

A guide for PASS or PASSING users for the preparation and conduct of an assessment. By Wolf Wolfensberger. NIMR. 1983. 180 pp. \$24 plus 15% postage (CANADIAN CURRENCY). Order #0-919648-36-3. Make checks payable to Fitzhenry & Whiteside.

Contact - The Roeher Institute/CACL, c/o Fitzhenry & Whiteside, 91 Granton Drive, Richmond Hill, Ontario, CANADA L4B 2N5.

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### **Mental Retardation, Vol. 30, No. 3, June 1992**

American Association on Mental Retardation's Mental Retardation dedicated to various areas on compliance and quality in residential life. Numerous articles and reaction papers on a wide scope of issues affecting quality in residential settings.

Contact - Back issues not available from AAMR. Journal is available in most major university settings or contact local mental retardation/developmental disability agency.

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## **Monitoring Educational Programs: A Guide for Parents**

A guide for parents to assist them in monitoring their child's educational experience. Although not an actual instrument, the booklet notes areas to observe and questions to ask regarding: (1) Program Philosophy and Characteristics; (2) Learning Opportunities; (3) Facility Resources; (4) Individual Education Plans; (5) Teaching Strategies; and, (6) Social/Recreational Opportunities. \$2.

Contact - The Arc of Ohio, 1335 Dublin Rd., S-205-C, Columbus, Ohio 43215-1000, (614) 487-4720.

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## **Quality: An Exploration of What Makes Quality Residential Services**

A report of The Arc of North Carolina Task Force on Quality. The report is the result of numerous meetings of professionals in the areas of residential care and quality assurance, an extensive research of the literature, and a public hearing on the issues. Areas addressed include the physical setting, the community, relationships, rights, management, program standards, funding, and other pertinent areas. 1988. 20 pp. \$3.

Contact - The Arc of North Carolina, 16 Rowan St., Suite 204, P.O. Box 20545, Raleigh, N.C. 27619 (919) 882-4632.

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## **Quality Assurance for Individuals With Developmental Disabilities**

A book addressing the subject of quality assurance from the perspectives of self-advocates, parents, service providers, evaluators, and scholars. The text is devoted to the many aspects of quality assurance including conceptual issues, varying perspectives, government's role, management, accreditation, research and the future of quality assurance. Edited by Valerie J. Bradley and Hank A. Bersani. 1990. 352 pp. \$29 plus approximately \$2.50 shipping and handling.

Contact - Paul H. Brookes Publishing Co., P.O. Box 10624, Baltimore, Md. 21285 1-800-638-3775; in Maryland call (410) 337-9580.

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## **Quality Evaluation Guidelines**

A publication of the International League of Societies for Persons with Mental Handicap. The book addresses the guidelines for quality services as established by 35 delegates from 18 countries who met for a three day symposium in 1986. Areas covered include principles, quality standards, evaluation methods, contexts for evaluation and basic premises, and implementation steps. 1988. 37 pp. Based on foreign currency exchange. Contact for price in U.S. dollars.

Contact - ILSMH Secretariat, 248 Avenue Louise - bte 17, B-1050 Brussels (BELGIUM).

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## **Quality of Life: Measurement and Programmatic Implications**

A manual summarizing the work to date regarding the development, standardization, and use of the Quality of Life Questionnaire. The authors have been involved in a three-year study on how to evaluate a person's quality of life. The manual addresses the concept of quality of life and its measurement, the development of the questionnaire, and its use and resulting data. By Kenneth Keith, Robert Schalock, and Karen Hoffman. 1986. 54 pp. \$10 plus postage.

### **Quality of Life: Perspectives And Issues**

Provides personal viewpoints, new strategies for service systems and guiding principles for application of the concept to practice and public policy. Timely information is given on an important, and often neglected, issue. By Robert L. Schalock, Ed. 1990. 256 pp. \$35 non-member, \$29.75 member. Add \$3 for shipping and handling.

Contact - American Association on Mental Retardation, Publications Center, P.O. Box 25, Annapolis, Md. 20701-0025 (301) 604-1340.

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### **Signs of Quality: Words to Serve By**

A collection of signs of quality developed by People on the Go, a self-advocacy advisory committee to The Arc of Maryland, Inc. The booklet provides ideas on how to tell if services and supports are passing the "litmus test" in the areas individual expression and opinion, safety, health, privacy, rights, choosing free time/friends, community involvement and services. 1992. 14 pp. No cost.

Contact - The Arc of Maryland, Inc., 6810 Deerpath Rd., Ste. 310, Baltimore, Md. 21227 (410) 379-0400.

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### **The Principle of Normalization in Human Services**

A book which looks at all aspects of normalization and its major implications. It examines normalization in relationship to specific problems and service areas. By Wolf Wolfensberger. NIMR. 1972. 259 pp. \$18 plus 15% postage (CANADIAN CURRENCY).

Order #0-9690438-48. Make checks payable to Fitzhenry & Whiteside.

Contact - The Roeher Institute/CACL, c/o Fitzhenry & Whiteside, 91 Granton Drive, Richmond Hill, Ontario, CANADA L4B 2N5.

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### **The Role of Voluntary Self-Assessment in Quality Assurance**

Describes current approaches to monitoring quality, two alternate proposals for self-monitoring, and a self-monitoring system based on a search of business practices and the National Association of Rehabilitation Facilities' (NARF) review of exemplary supported employment programs. Includes a suggested format for the Six Guiding Principles and a completed example of how to use the system. Designed for program managers and supervisors, state agency personnel, evaluators, and policymakers. 28 pp. \$4.50 NARF members/\$6 nonmembers.

Contact - NARF, P.O. Box 17675, Washington, D.C. 20041.

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### **Where's the Jello? The Continuing Saga of One Home's Experience With the ICF/MR (Small) Program**

The story of a six-bed group home, full of comic-tragic anecdotes from discussions with health facility evaluators. Includes suggestions as to how staff can maintain a sense of purpose, and their sanity. Calls for reform or

abandonment of ICF/MR (Small) Program. By John Shea. 1990. 37 pp. \$5 plus 10% shipping and handling.

Contact - John Shea, Allen, Shea & Associates, 1040 Main St., Napa, Calif. 94559.

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## Organizations

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### **Accreditation Council on Services for People With Disabilities**

A private, nonprofit agency sponsored by nine consumer advocacy, professional, and service provider organizations (including The Arc). The purpose of the organization is to improve the quality of services for persons with developmental disabilities through the development of standards, provision of accreditation surveys, in-service training/consultations, workshops and publication of educational materials. Publications and workshops available. Contact for list and prices.

Contact - The Accreditation Council, 8100 Professional Pl, Ste 204, Landover, Md. 20785 (301) 459-3191.

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### **American Speech-Language-Hearing Association**

A national organization that sets standards for accreditation of quality speech-language pathology and audiology services. The organization also sets standards for certification of professionals in the field. Information available includes Accreditation Manual, Interpretation of Standards, and Membership and Certification Handbook. No cost.

Contact - Professional Services Board, American S-L-H Association, 10801 Rockville Pike, Rockville, Md. 20852 (301) 897-5700.

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### **Commission on Accreditation of Rehabilitation Facilities**

A private, nonprofit organization established by and for the field of rehabilitation/habilitation to adopt and apply standards in organizations throughout the nation. CARF has standards for a variety of individual programs or services including employment programs, residential services, personal and social adjustment programs, etc. A Standards Manual addresses organization and program operations based on standards recommended by professionals and consumers. Publications available. Contact for list and prices.

Contact - CARF, 101 North Wilmot Rd., Ste. 500, Tucson, Ariz. 85711 (602) 748-1212.

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### **National Accreditation Council for Agencies Serving the Blind and Visually Handicapped**

A national organization that maintains standards and conducts an accreditation program for schools, programs and agencies serving children and adults who are blind or vision impaired. Publications include standards manuals and accreditation guidelines. Free Publications List is available.

Contact - National Accreditation Council, 232 Madison Ave. #907, New York, N.Y. 10016 (212) 779-8080.

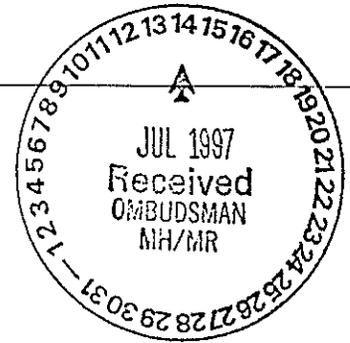
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Minnesota Department of **Human Services**



July 9, 1997

Roberta Opheim, Ombudsman  
Office of the Ombudsman for Mental Health  
and Mental Retardation  
Metro Square Building  
121 Seventh Place East, Suite 420  
St. Paul, MN 55101-2117

Dear Ms. Opheim:

Thank you for the opportunity to review an advance copy of your office's report regarding the Department of Human Services' Review Boards. It is apparent that a considerable amount of time and effort went into the preparation of this report.

The Department of Human Services places a high priority on the provision of quality services for persons who are served by state operated facilities as well as the ability of consumers to effectively voice any concerns they may have about the care they receive. As department staff examine and evaluate the review boards, they will carefully review and consider the thoughtful recommendations that are outlined in your report. You and your staff will be included in these discussions.

I appreciate your continued commitment to ensuring that consumers of state operated services have a voice in the manner in which these services are provided.

Sincerely,

David S. Doth  
Commissioner

