

A Description of Microboards

By John Shea*

What is a microboard? A microboard is a non-profit society of family and friends, committed to knowing a person, supporting that person, and having a volunteer (unpaid), reciprocal relationship with that person. Some microboards become the entity through which paid services and supports are provided. Involvement, caring, and standing by the person are valued over technical expertise.

Where can I learn more about microboards? Here are three sources:

<http://www.microboard.org/>-- This is the web site of the Vela Microboard Association, in British Columbia. Vela provides support (e.g., facilitators; developers) for about 120 microboards.

<http://members.tripod.co.uk/jmccarthysoc/>-- This is the homepage for Julie McCarthy Society of Family and Friends. Julie moved to the UK from British Columbia, and found a rather traditional service system (pre-existing programs; people slotted into existing services; funding of providers rather than service users; etc.), and pursued a direct payments scheme, a new option in the UK.

<http://www.allenshea.com/jrj.html>-- Here you will find a story about a group of people committed to three lives. NOTE: Options3, Inc., is generally considered a small agency rather than an incorporated circle-of-support around a single individual, the usual meaning of a microboard.

What factors underlie the microboard approach? - Here are a few developments underlying use of microboards in assisting people with developmental disabilities.

1. Public policy (both federal and state) emphasizes independence, empowerment, inclusion, choice, and regular lives. See President Bush's New Freedom Initiative; the Olmstead decision; and (in California) the Lanterman Developmental Services Act.
2. Disappointment with many conventional service practices (e.g., going to someone else's home to receive paid services; being asked to leave if the person has a falling out with the service provider; regulatory rules that get in the way of informed choice; residential service providers assuming 'ownership' of those they serve, thereby cutting off ordinary community relationships).
3. The emergence of real person-centered planning, which when done well covers everything important to the person and his/her circumstances (health and safety, activities, relationships, choice, freedom and control). Such planning involves the focus

person, those who know the person well, and generally requires 20 to 30 hours to do reasonably well. It can be contrasted with traditional program (or service) planning, with service users slotted into what exists.

4. The consumer movement, defining quality in terms of the extent to which each consumer's needs and expectations are met, rather than fidelity to a professionally-designed 'model.'
5. A belief that person-centered services will come only if power relationships (sustained by how the money flows) are fundamentally changed. Individual budgets, self-determination, and direct payment schemes, as opposed to the conventional way services are funded (dollars to agencies).
6. A change in role expectations away from "good residents or patients do what they are told" (or, parents turn over their children lock, stock, and barrel to a stand-in) to any number of ways individuals and families want to be involved in constructive, mutually beneficial ways.
7. A belief that what really keeps people safe is "being enmeshed in a web of caring relationships," rather than enforcement of service and facility standards.

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