CHAPTER 6201. COUNTY MENTAL RETARDATION SERVICES

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Authority

The provisions of this Chapter 6201 issued under section 201(2) of the Mental Health and Mental Retardation Act of 1966 (50 P. S. § 4201(2)), unless otherwise noted.

Source

The provisions of this Chapter 6201 amended through February 9, 1973, effective February 10, 1973, 3 Pa.B. 285, unless otherwise noted.

Cross References

This chapter cited in 55 Pa. Code § 6000.821 (relating to criteria for approval of new intermediate care facilities for people with mental retardation).

GENERAL PROVISIONS

§ 6201.1. Introduction.

(a) The county program is the means by which minimum services, as described in the Mental Health and Mental Retardation Act of 1966 (50 P. S. §§ 4101—4704), are available to promote the social, personal, physical and economical habilitation or rehabilitation of mental retarded persons with respect for the full human, social and legal rights of each person. This means that the health, social, educational, vocational, environmental and legal resources that serve the general population shall be marshalled and coordinated by the county program to meet the personal development goals of mentally retarded persons, in accordance with the principle of normalization. Normalization means to ensure for every mentally retarded person and his family the right to live a life as close as possible to that which is typical for the general population. The mandated services, the provision of service mechanisms and the fiscal support of the program shall

be used to secure for each person and his family the conditions and circumstances of day-to-day life that comes as close as possible to representing typical life patterns.

(b) In keeping with this principle of normalization, the county program shall serve as an advocate for persons who are mentally retarded and secure for them their full entitlement to existing and future human services available to the general population.

§ 6201.2. Purpose.

This chapter establishes county responsibilities and content of services for county MH/MR programs.

§ 6201.3. Applicability.

This chapter applies to county MH/MR programs.

§ 6201.4. Legal base.

The legal authority for this chapter is section 201(2) of the Mental Health and Mental Retardation Act of 1966 (50 P. S. § 4201(2)).

SERVICE DELIVERY

§ 6201.11. County program.

The county is responsible for the following objectives:

(1) Primary prevention of organic and functional mental retardation.

(2) Earliest possible case finding and diagnosis.

(3) Medical and surgical correction or amelioration of systemic defects, when possible.

(4) Shaping and maintaining an environment most productive of basic human personality qualities involving parent-child and sibling relationships, environmental adaptation, self-awareness and learning motiviation and ability.

(5) Specific training and learning situations designed and implemented to develop all potential.

(6) Community development and restructuring to achieve the maximum normalization for mentally retarded persons.

§ 6201.12. Base service unit.

(a) The county administrator is responsible for establishing an organizational unit consisting of multidisciplinary professional and nonprofessional staff capable of planning, directing and coordinating appropriate services for persons who are mentally retarded and in need of service from the county program. This unit shall be called the base service unit, and the county administrator shall have the authority to direct, control and monitor the activities of the base service unit.

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(b) The base service unit is responsible for performing the following functions in such a way as to carry out the following objectives of the county program:

(1) Establish or develop a system utilizing preventive services in the community for the mentally retarded.

(2) Establish and operate a system for earliest possible casefinding.

(3) Maintain a continuing relationship with the mentally retarded person and with a facility or provider of service responsible for service to the mentally retarded person during any stage of his life-management process.

(4) Constitute a fixed point of referral and information for mentally retarded persons and their families.

(5) Initiate, develop and maintain a pattern of interaction between the diagnostic and evaluation team and others concerned with services to any mentally retarded person and his family. This pattern shall emphasize participation in the life-management planning process of such persons as the family, physician, local public health nurse, teacher, representative of human service resources, vocational rehabilitation counselor, other providers of service, advocates and the mentally retarded person, whenever possible.

(6) Provide opportunities for advancing the knowledge and understanding of persons inside and outside its immediate setting, particularly those who have a responsibility in carrying out the life-management process.

(7) Foster cooperation through the use of multidisciplinary approach.

(8) Ensure that if service to the mentally retarded is provided by other than the base service unit and the mentally retarded person is referred for intake into the county program, the referring agency or the provider of service are invited to cooperate with the base service unit in diagnosis, evaluation and planning for the person.

(9) Ensure that services will not be authorized for funding by the county program unless they are consistent with the life-management plan as developed by the base service unit and approved by the county administrator.

(10) Provide for comprehensive diagnosis and evaluation services to do all of the following:

(i) Diagnose, appraise and evaluate mental retardation and associated disabilities; define the strengths, skills, abilities and potentials for improvement of the individual.

(ii) Assess the needs of the individual and his family.

(iii) Develop a practical life-management plan for individuals and their families and provide the necessary counseling and follow-along services.

(iv) Reassess the progress of the individual at regular intervals to determine continuing needs for service and for changes in his management plan.

Notes of Decisions

Under subsection (b), a county is required to seek the advice of the current provider before reaching a decision as to whether a patient transfer is appropriate; therefore, where a county has completely disregarded the recommendations of those familiar with the case, the county is guilty of an abuse of discretion. *In re M.J.S.*, 480 A.2d 349 (Pa. Cmwlth. 1984).

§ 6201.13. Intake services.

(a) Intake into the county program shall be through the base service unit.

(b) The condition and circumstances of each individual presumed to require service shall be thoroughly assessed before a disposition is made of his referral.

(1) If it is determined after the assessment that the individual does not currently require further service from the base service unit, the presenting problem, the results of the assessment and the disposition of the case—alternative referral or recommendation—shall be recorded on Form MH/MR 10, Intake and Proposed Service Plan.

(2) If it is determined after assessment that the person requires service, he shall be provided with coordinated services necessary to identify the presence of mental retardation, its cause and complications, and the extent to which mental retardation limits or is likely limit the individual's daily living and work activities.

(c) Assessment services shall include a systematic appraisal of the findings in terms of pertinent physical, psychological, vocational, educational, cultural, social, economic, legal, environmental and other factors of the mentally retarded person and his family for all of the following:

(1) To determine how and to what extent the disabling condition may be expected to be removed, corrected or minimized by services.

(2) To determine the nature and scope of services to be provided.

(3) To select the service objectives which are commensurate to the individual's interests, capacities and limitations.

(4) To devise an individualized program of action to be followed, at the intervals needed, by periodic reappraisals.

(5) To reevaluate progress of the person at intervals as necessary for the periodic appraisal.

(d) Each program service authorized shall have a service objective in keeping with each mentally retarded person's personal development goal; this goal shall be the basis for individualized life management planning.

(1) This information shall be recorded on the Intake and Proposed Service Plan, Form MH/MR 10, along with a listing of the counseling, follow-along, and other services to be provided within a specified period of time in coordinated association with the program service immediately authorized.

(2) A specific date for evaluation of the person's progress and reevaluation of his life-management plan shall also be part of the Intake and Proposed Service Plan.

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(3) In all cases, the mentally retarded person's family; the social, economic, cultural, educational, vocational, legal and environmental circumstances affecting him; and his physical and psychological condition shall be considered essential aspects of the life management plan.

Notes of Decisions

Reduction or elimination of benefits for mentally retarded persons living at home did not violate equal protection or due process. *Philadelphia Police and Fire Association for Handicapped Children, Inc. v. City of Philadelphia*, 874 F.2d 156 (1989).

§ 6201.14. Aftercare services.

(a) Aftercare services shall be available to prevent unnecessary and prolonged institutionalization and to facilitate the return of persons to their homes or communities. These services shall be designed to enable persons who are mentally retarded to achieve their maximum potential for self-care, self-support, self-sufficiency and social competence.

(b) Aftercare services shall include the following:

(1) Evaluation of persons currently in residential placement.

(2) Preparation of individual life-management plans for persons in placement, to include a definition of the special purpose served by the placement as part of the life-management plan of each individual.

(3) Establishment of an individually appropriate and realistic social development goal to be accomplished by each placement.

(4) Regular liaison with the facility to ensure that time spent in residence is limited to the time required to accomplish the established goal, and that service provided by the facility is consistently more suitable than the person might receive in the community.

(5) Prerelease counseling services to resident and family, referral with follow-through to appropriate community resources for post-release services and follow-along responsibility for post-release life management.

(6) Provision of short-term inpatient, emergency, out-patient, partial hospitalization and rehabilitation and training services, as indicated by individual life-management plans.

(7) Nursing home care for older individuals primarily in need of medically supervised nursing services.

(8) Supervised sheltered personal care living arrangements—groups or singly—for those whose primary need is not medical.

(9) Foster home care, individual and group living.

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