A GUIDE TO SUPPORTING PEOPLE MOVING FROM STATE CENTERS INTO THE COMMUNITY

Commonwealth of Pennsylvania
Department of Public Welfare
Office of Mental Retardation
INTRODUCTION

New opportunities are being made available to people living in State Centers. Through the expansion of the County Mental Health and Mental Retardation (MH/MR) Program, the Office of Mental Retardation can provide residents in our centers the opportunity to live nearer to their families and in their home communities.

We realize that for those people residing in our centers for many years, there is a need for information about community services and what options are available. In addition to information, it is important for people to have the opportunity to explore the kinds of services that are available in the community through visits and talking with people.

Individuals and families must know what to expect. For this reason, we have developed a standard set of procedures to be followed in planning for individuals in State Centers. Many people from our centers have moved successfully to the community over the years. These procedures build on what we have learned from those individuals and their families as well as county and provider staff.

The procedures will tell you what you can expect. They are specific about the role of the person and their family and friends in the entire process from getting basic information to making the move to the community. The procedures are a basic set of standards and practices. County MH/MR Programs may enhance them to meet the need of individuals and families.

New opportunities and change can bring out fears and worries that may be based on earlier experiences, stories we have heard from others, or just our own assumptions.

Fears and worries, however, should not stand in the way of people moving on to something that can be good or even better for them. They should not interfere with listening to the options, going to see for yourself, and perhaps giving something a try.

These procedures lay out the process that will be followed. They are a commitment to listen and involve the people who care the most, and in doing so, creating the best life for each and every person living in our State Centers.
OPTIONS

Being Informed

Preparing for the future can be an overwhelming experience when you don’t have all the information you need to make decisions. It is essential that individuals residing in State Centers and their family members, as well as advocates and friends, have the information, experience and opportunities they need to make informed and responsible choices. State and county staff are responsible for assuring that residents in State Centers and their families are provided with full and ongoing information about all service options.

Individuals and their families will receive information about the mental retardation service delivery system in Pennsylvania.

- The types and array of services.
- The rights of persons with disabilities and those of their families.
- The process of developing a plan for community living.
- Service monitoring and safeguards to protect health and safety.
- The responsibilities of state and county government.

Opportunities for information exchange include:

- Resident council meetings and parent meetings.
- Special training/information sessions for residents and families at the center and in the community.
- Discussion and support groups for residents and families at the center and in the community.
- Annual planning and quarterly review meetings.

Individuals and their families will be provided with regular contact with county staff—called case managers—who maintain responsibility for the planning and management of their services and supports.

- Individuals and their families will be offered the opportunity to visit community living options in their county and, if they desire, in other counties.
- State Center residents and their families will be offered the opportunity to meet with other individuals and families who have experienced transition from State Centers to the community.

EXERCISING THE OPTION

Each person living in a State Center has an individual planning team that includes the person, family and friends, and state and county mental retardation professionals. The responsibility for evaluating information, determining the needs of the person, and making decisions is generally shared by the person’s ‘‘team.’’

All individuals living in State Centers and members of their team must be informed of and offered the option of living in the community and receiving community-based services.

Teams must be prepared to recognize that there are individuals living in State Centers:

- who assertively and independently request to move to the community;
- whose families request community services on their behalf;
- who cannot express the desire to move from the State Center, but who, through behavior and their response to different experiences, demonstrate a preference for an alternative;
- who mental retardation professionals determine would benefit from an alternative service;
- who choose to remain in the State Center;
- whose families prefer continued services in the State Center.

Individuals and their families will continue to be provided with information and opportunities to explore options. As people learn more, they may modify or change earlier decisions. We must, therefore, maintain a flexible approach to planning.
DEVELOPING AN INDIVIDUALIZED SUPPORT PLAN

Each individual planning to move into the community will have an individual support plan designed to meet their unique needs and preferences.

The County MH/MR Program will take the lead in developing the plan, which will then serve as the foundation for the services the county will arrange for and supervise, in the community.

What to expect in the development of the individual support plan:

☐ The plan will be developed by a planning team of all those the person chooses to participate, including family, friends, and all key people in the person’s life. It is essential that those close to the person be involved at the onset of the planning, particularly staff in the State Center who know the person well.

☐ The planning will be led by a county mental retardation professional called a case manager. Should another member of the team, including the person, choose to lead the planning process, the case manager continues to be responsible for writing up the plan and managing its implementation.

☐ The plan will be presented in written form and shared with all team members. The written plan will serve as the blueprint for services for the community provider.

☒ Community mental retardation providers will meet the individual and their families prior to submitting proposals to serve the person.

☒ Community mental retardation providers will submit a written proposal, which identifies all supports to be provided, and the estimated cost.

☒ The planning team, including the family, will review the proposals. Provider selection will include input from the person, the family, and the planning team, honoring their preferences to the fullest extent possible.

☒ The selected provider will meet with the planning team and review the plan.
The written plan will include:

"Where do I want to live?"
Communities, family and friends the person would like to be close to.

"What do I need to be safe, healthy, and successful?"
Essential things the person needs to live safely and successfully in the community.

"Whom will I share my home with?"
Close friends or people the person would like to share a home with.

"What are people who care about me concerned about?"
Issues and concerns expressed by family, friends, and advocates that will enrich the individual’s life and promote safety.

"What would I like to keep in my life? What new things would I like to try?"
Preferred things that will make life enjoyable; opportunities to try new things not available before.

"How do I want to spend my time?"
Daytime and evening activities that reflect the person’s interests and skills.

"What I might not like and how I might respond."
Potential problems or negative reactions to situations or events. Information must be identified as either current or historical.

The plan is the beginning. People’s wants and desires may change with experience and the plan should change accordingly.

In reviewing the proposals presented by providers, the team, including the person and their family, should evaluate whether the plan:

- Meets the person’s essential needs.
- Meets the need for medical care as defined in the proposal. Are medical personnel identified?
- Protects the health and safety of the person. Is staffing adequate? Is the environment safe? Will staff be adequately trained?
- Adequately addresses the person’s preferences.
- Responds to concerns expressed by family and friends.
- Supports the person’s relationships with family and friends.
- Questions, concerns and responses to the plan are discussed with the county case manager and other county personnel, as appropriate.
- The County MH/MR Program is the responsible authority for developing and overseeing services to each individual.
- The planning process creates the opportunity for the individual, family and friends to develop relationships with county staff.
TRANSITIONING TO THE COMMUNITY

Planning for transition is part of the process of moving to the community. It serves to describe the relationship building process between the individual, family, county, community provider agency, and others in the community. It also assures that the move will be comfortable and safe.

The planning team, now including the selected provider agency, and under the direction of the county case manager, will develop the plan for transition.

The plan for transition should:

1. Help the person become familiar with their new physical environment and develop a sense of “being home.” Day and overnight visits should be scheduled with the frequency and duration that is needed by each person.
2. Develop relationships with the case manager, new support service staff, and others in the community.
3. Include experiences with daytime activities and work, as appropriate.
4. Familiarize the person with designated providers of medical, dental, and other health services. Direct services should be initiated or in place before the person moves to the community.

The first 30 or 60 days are generally considered “trial visits” prior to discharge from the State Center. The plan should specify the trial visit time-frame.

During the transition process, the family will be provided with names and numbers of county and agency personnel who are responsible for services. Contact between the case manager and the individual/family must be ongoing.

The transition process is a very important time. Sharing of information and resources will be coordinated between State Center and county staff.

LIVING IN THE COMMUNITY

After moving to their new home, each person will receive all services specified in their plan. Family and friends will continue to be a part of the person’s life, visiting in their new home and going out together.

The following information is also important to note:

1. Community homes for people with mental retardation are licensed annually by the Department of Public Welfare’s Office of Mental Retardation.
2. County case management will maintain frequent contact with each person. Monitoring visits will be conducted regularly.
3. Families will have regular access to information regarding their family member’s life.
4. Each individual’s plan will be reviewed regularly and revised as needed.
5. The Department of Public Welfare’s Office of Mental Retardation’s Regional Office will complete follow-up monitoring visits to assure all aspects of the plan have been provided.
6. All concerns may be raised with the county case manager and County MH/MR Program Administrator. If unresolved, they may be reported to the Department of Public Welfare’s Office of Mental Retardation at this toll free number: 1-888-565-9435.