CHAPTER 26

Rights of Clients With Intellectual Disability

**SECTION 44‑26‑10.** Definitions.

As used in this chapter:

(1) “Aversive stimuli” means a clinical procedure which staff apply, contingent upon the exhibition of maladapted behavior, startling, unpleasant, or painful stimuli or stimuli that have a potentially noxious effect.

(2) “Client” means a person who is determined by the South Carolina Department of Disabilities and Special Needs to have intellectual disability or a related disability and is receiving services or is an infant at risk of having intellectual disability or a related disability and is receiving services.

(3) “Client’s representative” means the client’s parent, guardian, legal counsel, or other person who acts on behalf or in the best interest of a person with intellectual disability or a related disability.

(4) “Director” means the South Carolina Director of Disabilities and Special Needs.

(5) “Court” means a probate court of appropriate jurisdiction unless specified otherwise.

(6) “Department” means the South Carolina Department of Disabilities and Special Needs.

(7) “Facility” means a residential setting operated, assisted, or contracted out by the department that provides twenty‑four hour care and supervision.

(8) “Habilitation” means the attempt to remedy the delayed learning process to develop maximum growth potential by the acquisition of self‑help, language, personal, social, educational, vocational, and recreational skills.

(9) “Intellectual disability” means significantly subaverage general intellectual functioning existing concurrently with deficits in adaptive behavior and manifested during the developmental period.

(10) “Intellectual disability professional” means a person responsible for supervising a client’s plan of care, integrating various aspects of the program, recording progress, and initiating periodic review of each individual plan of habilitation.

(11) “Interdisciplinary team” means persons drawn from or representing the professional disciplines or service areas included in the individual habilitation plan.

(12) “Major medical treatment” means a medical, surgical, or diagnostic intervention or procedure proposed for a person with intellectual disability or a related disability, where a general anesthetic is used or which involves a significant invasion of bodily integrity requiring an incision, producing substantial pain, discomfort, debilitation, or having a significant recovery period. It does not include routine diagnosis or treatment such as the administration of medications or nutrition or the extractions of bodily fluids for analysis or dental care performed with a local anesthetic or a nonpermanent procedure designed for the prevention of pregnancy.

(13) “Plan of habilitation” means a written plan setting forth measurable goals or behaviorally stated objectives in prescribing an integrated program of individually designed activities or therapies necessary to achieve the goals and objectives.

(14) “Planned exclusionary time‑out” means the technique of behavior modification in which a client is removed from the immediate environment to a physically safe, lighted, and normal temperature room for a specific period of time not to exceed one hour under the direct continued observation of staff.

HISTORY: 1992 Act No. 366, Section 1; 1993 Act No. 181, Section 1088; 2011 Act No. 47, Section 6, eff June 7, 2011.

RESEARCH REFERENCES

Encyclopedias

S.C. Jur. Mental Health Section 3, Definitions‑ Statutory Terms.

NOTES OF DECISIONS

In general 1

1. In general

Private residential treatment center had statutory duty to exercise reasonable care in supervising mentally retarded resident, under statutes addressing licensing of facilities and programs for mentally disabled persons and statutes setting forth rights of mental retardation clients. Madison ex rel. Bryant v. Babcock Center, Inc. (S.C. 2006) 371 S.C. 123, 638 S.E.2d 650, rehearing denied. Asylums And Assisted Living Facilities 35(2)

**SECTION 44‑26‑20.** Right to writ of habeas corpus.

Clients have the right to a writ of habeas corpus.

HISTORY: 1992 Act No. 366, Section 1; 2011 Act No. 47, Section 6, eff June 7, 2011.

Library References

Mental Health 40.3.

Westlaw Topic No. 257A.

NOTES OF DECISIONS

In general 1

1. In general

A person restrained of her liberty by State process cannot maintain habeas corpus action in a federal district court to determine whether such restraint constitutes a violation of the provisions of the United States Constitution and amendments thereto without first having exhausted every remedy available to her in the State courts. Rikard v. South Carolina State Hospital, 1962, 202 F.Supp. 763. Habeas Corpus 319.1

**SECTION 44‑26‑30.** Right to representation by counsel.

A person with intellectual disability has the right to be represented by counsel when involuntarily committed to the department pursuant to Section 44‑20‑450.

HISTORY: 1992 Act No. 366, Section 1; 2011 Act No. 47, Section 6, eff June 7, 2011.

**SECTION 44‑26‑40.** Determination of competency to consent to or refuse major medical treatment.

If a client resides in a facility operated by or contracted to by the department, the determination of that client’s competency to consent to or refuse major medical treatment must be made pursuant to Section 44‑66‑20(6) of the Adult Health Care Consent Act. The department shall abide by the decision of a client found competent to consent.

HISTORY: 1992 Act No. 366, Section 1; 2011 Act No. 47, Section 6, eff June 7, 2011.

Library References

Health 912.

Westlaw Topic No. 198H.

C.J.S. Right to Die Sections 15, 27 to 30, 33, 44, 46, 55.

**SECTION 44‑26‑50.** Health care decisions of client found incompetent to consent to or refuse major medical treatment.

If the client is found incompetent to consent to or refuse major medical treatment, the decisions concerning his health care must be made pursuant to Section 44‑66‑30 of the Adult Health Care Consent Act. An authorized designee of the department may make a health care decision pursuant to Section 44‑66‑30(8) of the Adult Health Care Consent Act. The person making the decision must be informed of the need for major medical treatment, alternative treatments, and the nature and implications of the proposed health care and shall consult the attending physician before making decisions. When feasible, the person making the decision shall observe or consult with the client found to be incompetent.

HISTORY: 1992 Act No. 366, Section 1; 2011 Act No. 47, Section 6, eff June 7, 2011.

Library References

Health 912.

Westlaw Topic No. 198H.

C.J.S. Right to Die Sections 15, 27 to 30, 33, 44, 46, 55.

RESEARCH REFERENCES

Encyclopedias

S.C. Jur. Hospitals Section 29, Consent to Medical Treatment.

**SECTION 44‑26‑60.** Health care decisions of minor clients.

(A) If the client is a minor, the decisions concerning his health care must be made by the following persons in the following order of priority:

(1) legal guardian;

(2) parent;

(3) grandparent or adult sibling;

(4) other relative by blood or marriage who reasonably is believed by the health care professional to have a close personal relationship with the client;

(5) other person who reasonably is believed by the health care professional to have a close personal relationship with the client;

(6) authorized designee of the department.

(B) If persons of equal priority disagree on whether certain health care must be provided to a client who is a minor, a person authorized in subsection (A), a health care provider involved in the care of the client, or another person interested in the welfare of the client may petition the probate court for an order determining what care is to be provided or for appointment of a temporary or permanent guardian.

(C) Priority under this section must not be given to a person if a health care provider, responsible for the care of a client who is unable to consent, determines that the person is not reasonably available, is not willing to make health care decisions for the client, or is unable to consent as defined in Section 44‑66‑20(6) of the Adult Health Care Consent Act.

(D) In an emergency health care may be provided without consent pursuant to Section 44‑66‑40 of the Adult Health Care Consent Act to a person found incompetent to consent to or refuse major medical treatment or who is incapacitated solely by virtue of minority.

HISTORY: 1992 Act No. 366, Section 1; 2011 Act No. 47, Section 6, eff June 7, 2011.

Library References

Health 912.

Westlaw Topic No. 198H.

C.J.S. Right to Die Sections 15, 27 to 30, 33, 44, 46, 55.

**SECTION 44‑26‑70.** Human rights committees.

(A) Human rights committees must be established for each regional center and for each county/multicounty program to:

(1) review and advise the regional center or the county/multicounty board on the policies pertaining to clients’ rights policies;

(2) hear and make recommendations to the regional center or county/multicounty board on research proposals which involve individuals receiving services as research participants pursuant to Section 44‑20‑260;

(3) review and advise the regional center or county/multicounty board on program plans for behavior management which may restrict personal freedoms or rights of clients;

(4) advise the regional center or county/multicounty board on other matters as requested pertaining to the rights of clients.

(B) Human rights committees must be appointed by the director or his designee. Each committee consists of not less than the following five persons, except employees or former employees of the regional center or county/multicounty board must not be appointed:

(1) a family member of a person with intellectual disability or a related disability;

(2) a client of the department, if appropriate;

(3) a representative of the community at large with expertise or a demonstrated interest in the care and treatment of persons with intellectual disability or related disabilities.

(C) The department shall establish policy and procedures for the operations of the committees.

(D) Members of the committees serve in an advisory capacity only and are exempt from liability.

HISTORY: 1992 Act No. 366, Section 1; 1993 Act No. 31, Section 1; 1993 Act No. 181, Section 1089; 2011 Act No. 47, Section 6, eff June 7, 2011.

Library References

Mental Health 20.

Westlaw Topic No. 257A.

**SECTION 44‑26‑80.** Appeal of decisions concerning services or treatment provided.

A client or his representative has the right to appeal decisions concerning the services or treatment provided by the department, county/multicounty board, or contracted service provider. A human rights committee established in Section 44‑26‑70 shall review and advise on grievances concerning applicants or clients receiving services. The department shall establish policies and procedures for the review of grievances and the appeal of decisions. The director has final authority.

HISTORY: 1992 Act No. 366, Section 1; 1993 Act No. 181, Section 1090; 2011 Act No. 47, Section 6, eff June 7, 2011.

Library References

Mental Health 51.20.

Westlaw Topic No. 257A.

C.J.S. Mental Health Sections 113 to 118.

**SECTION 44‑26‑90.** Rights of client not to be denied.

Unless a client has been adjudicated incompetent, he must not be denied the right to:

(1) dispose of property, real and personal;

(2) execute instruments;

(3) make purchases;

(4) enter into contractual relationships;

(5) hold a driver’s license;

(6) marry or divorce;

(7) be a qualified elector if otherwise qualified. The county board of voter registration in counties with department facilities reasonably shall assist clients who express a desire to vote to:

(a) obtain voter registration forms, applications for absentee ballots, and absentee ballots;

(b) comply with other requirements which are prerequisite for voting;

(c) vote by absentee ballot if necessary;

(8) exercise rights of citizenship in the same manner as a person without intellectual disability or a related disability.

HISTORY: 1992 Act No. 366, Section 1; 2011 Act No. 47, Section 6, eff June 7, 2011.

Library References

Mental Health 51.

Westlaw Topic No. 257A.

C.J.S. Mental Health Sections 98, 102 to 118.

**SECTION 44‑26‑100.** General rights of clients; limitations on rights.

(A) Except to the extent an interdisciplinary team of a residential program determines that it is required by the medical needs, safety, or habilitative goals of the client to impose restrictions, a client may:

(1) communicate by sealed mail, telephone, or otherwise with persons, including official agencies, inside or outside the institution. Reasonable access to writing materials, stamps, envelopes, and telephones, including reasonable funds or means by which to use telephones, must be provided;

(2) receive visitors. A facility must have a designated area where clients and visitors may speak privately;

(3) wear his clothes, have access to personal hygiene articles, keep and spend a reasonable sum of his money, and keep and use his personal possessions, including articles for personal grooming not provided for by the facility unless the clothes or personal possessions are determined by an intellectual disability professional or physician to be dangerous or otherwise inappropriate to the habilitation regimen. If clothing is provided by the facility, clients must have the opportunity to select from neat, clean, seasonal clothing that allows the client to appear normal in the community. The clothing must be considered to be the client’s throughout his stay in the facility;

(4) have access to individual storage space for private use. Personal property of a client brought into the facility and placed in storage by the facility must be inventoried. Receipts must be given to the client and at least one other interested person. The personal property may be reclaimed only by the client or his guardian as long as he is living unless otherwise ordered by the court;

(5) follow or abstain from religious practices. Religious practices may be prohibited by the facility supervisor if they lead to physical harm to the client or to others, harassment of other clients, or damage to property.

(B) The department shall determine what constitutes reasonable access for the rights provided in this section. Limitations imposed on the exercise of the rights by the client and the reasons for the limitations must be made part of the client’s record. The limitations are valid for no more than thirty days. The time may be extended an additional thirty days if, upon review, it is determined the client’s safety or habilitation warrants limitations of the rights. If the department restricts rights, the reasons for the restriction and why the condition cannot be resolved in a less restrictive manner must be recorded in the client’s record.

HISTORY: 1992 Act No. 366, Section 1; 2011 Act No. 47, Section 6, eff June 7, 2011.

Library References

Mental Health 51.

Westlaw Topic No. 257A.

C.J.S. Mental Health Sections 98, 102 to 118.

**SECTION 44‑26‑110.** Right to daily physical exercise.

Clients have the right to daily physical exercise. Operators of a facility shall provide indoor and outdoor areas and equipment for this purpose. Clients determined able to be outdoors on a daily basis pursuant to Section 44‑26‑150 must be allowed this privilege in the absence of contrary medical considerations or during periods of inclement weather.

HISTORY: 1992 Act No. 366, Section 1; 2011 Act No. 47, Section 6, eff June 7, 2011.

Library References

Mental Health 51.

Westlaw Topic No. 257A.

C.J.S. Mental Health Sections 98, 102 to 118.

**SECTION 44‑26‑120.** Access to medical and habilitative records; grounds for denial of access; appeal of denial of access; disclosure form.

(A) A client or his representative with the appropriate permission may have reasonable access to the client’s medical and habilitative records. The requests must be made in writing.

(B) A client or his representative may be refused access to information in the medical and habilitative records if:

(1) provided by a third party under assurance that the information remains confidential;

(2) the attending physician has determined in writing that the information would be detrimental to the client’s habilitation regimen. The determination must be placed in the client’s records and is considered part of restricted information.

(C) A client or his representative refused access to medical or habilitative records may appeal the refusal to the department director. The director of the residential program shall notify the client or his representative of the right to appeal.

(D) Persons granted access to client records shall sign a disclosure form. Disclosure forms are considered part of a client’s confidential record.

HISTORY: 1992 Act No. 366, Section 1; 1993 Act No. 181, Section 1091; 2011 Act No. 47, Section 6, eff June 7, 2011.

Library References

Mental Health 21.

Westlaw Topic No. 257A.

RESEARCH REFERENCES

Encyclopedias

87 Am. Jur. Proof of Facts 3d 259, Confidentiality of Medical and Other Treatment Records.

Attorney General’s Opinions

Incident reports used by campus police to report activities occurring within Department of Mental Health which may have criminal implications and which contain patient identities are public information, but to extent that it contains confidential information, such information is exempt from disclosure under FOIA. 1984 Op.Atty.Gen. No. 84‑85, p. 205 (January 20, 1984) 1984 WL 159814.

**SECTION 44‑26‑130.** Confidentiality of communications with, and records of clients; disclosure.

(A) Communications between clients and intellectual disability professionals, including general physicians, psychiatrists, psychologists, nurses, social workers, members of interdisciplinary teams, or other staff members employed in a client‑therapist capacity or an employee under supervision of them are considered confidential. Certificates, applications, records, and reports made for the purpose of this chapter that directly or indirectly identify a client, as well as privileged communications, must be kept confidential and must not be disclosed by a person unless:

(1) the identified client or his representative consents;

(2) a court directs disclosure upon its determination that disclosure is necessary for the conduct of proceedings before it and that failure to make the disclosure is contrary to the public interest;

(3) disclosure is required for research conducted or authorized by the department;

(4) disclosure is necessary to cooperate with law enforcement, health, welfare, and other state agencies, schools, and county entities;

(5) disclosure is necessary to carry out this chapter.

(B) Nothing in this section precludes disclosure:

(1) upon proper inquiry, of information as to a client’s current medical condition, to appropriate next of kin;

(2) if the information is used in an educational or informational capacity if the identity of the client is concealed;

(3) of information to the Governor’s ombudsman office or the South Carolina Protection and Advocacy System for the Handicapped, Inc., as consistent with state law.

HISTORY: 1992 Act No. 366, Section 1; 2011 Act No. 47, Section 6, eff June 7, 2011.

Library References

Mental Health 21.

Westlaw Topic No. 257A.

RESEARCH REFERENCES

Encyclopedias

87 Am. Jur. Proof of Facts 3d 259, Confidentiality of Medical and Other Treatment Records.

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Incident reports used by campus police to report activities occurring within Department of Mental Health which may have criminal implications and which contain patient identities are public information, but to extent that it contains confidential information, such information is exempt from disclosure under FOIA. 1984 Op.Atty.Gen. No. 84‑85, p. 205 (January 20, 1984) 1984 WL 159814.

**SECTION 44‑26‑140.** Clients to receive least restrictive appropriate care and habilitation available; exceptions.

(A) Clients receiving services for intellectual disability shall receive care and habilitation suited to their needs and in the least restrictive appropriate care and habilitation available. The care and habilitation must be administered skillfully, safely, and humanely with full respect for the client’s dignity and personal integrity. The department shall make every effort, based on available resources, to develop services necessary to meet the needs of its clients.

(B) In emergency admissions when the least restrictive setting is not available a client must be admitted to the nearest proper facility until he may be moved to the least restrictive setting.

(C) In judicial or emergency admissions to the department every attempt must be made by the court to ensure a client’s placement in the least restrictive alternative of services available.

(D) No client may remain at a level of care that is more restrictive than is warranted to meet his needs if alternative care is available. A residential program must attempt to move clients from:

(1) more to less structured living;

(2) larger to smaller facilities;

(3) larger to smaller living units;

(4) group to individual residence;

(5) segregated from the community to integrated into the community;

(6) dependent to independent living.

HISTORY: 1992 Act No. 366, Section 1; 1993 Act No. 31, Section 2; 2011 Act No. 47, Section 6, eff June 7, 2011.

Library References

Mental Health 51.

Westlaw Topic No. 257A.

C.J.S. Mental Health Sections 98, 102 to 118.

NOTES OF DECISIONS

In general 1

1. In general

Private residential treatment center had statutory duty to exercise reasonable care in supervising mentally retarded resident, under statutes addressing licensing of facilities and programs for mentally disabled persons and statutes setting forth rights of mental retardation clients. Madison ex rel. Bryant v. Babcock Center, Inc. (S.C. 2006) 371 S.C. 123, 638 S.E.2d 650, rehearing denied. Asylums And Assisted Living Facilities 35(2)

**SECTION 44‑26‑150.** Clients to be informed of rights upon admission; written individualized plan of habilitation; review of plan; revision of, or changes in, plan.

(A) Before or at the time of admission to an intellectual disability residential program, a client or his representative must be provided with an explanation in terms and language appropriate to his ability to understand the client’s rights while under the care of the facility.

(B) Within thirty days of admission a client or his representative must be provided with a written individualized plan of habilitation formulated by an interdisciplinary team and the client’s attending physician. A client or his representative may participate in an appropriate manner in the planning of services. An interim habilitation program based on the preadmission evaluation of the client may be implemented promptly upon admission. The service plan must be developed with the active participation of the individual receiving the services to the extent he is able to participate meaningfully. Each individualized habilitation plan must contain:

(1) a statement of the nature and degree of the client’s intellectual disability and the needs of the client;

(2) if a physical examination has been conducted, the client’s physical condition;

(3) a description of intermediate and long‑range habilitative goals and, if possible, future available services;

(4) a statement as to whether or not the client may be permitted outdoors on a daily basis and, if not, the reasons why.

(C) An intellectual disability professional shall review each client’s individual records quarterly in relation to goals and objectives established in the habilitation plan. This review must be documented and entered into the client’s record. The interdisciplinary team shall conduct a full review of the client’s records and habilitation program annually.

(D) Included in a review must be a reassessment of the client’s plan of habilitation. If the reassessment indicates a need for revisions in the client’s plan of habilitation, the revisions must be implemented.

(E) A client or his representative shall receive an updated plan of habilitation, upon request, pursuant to Section 44‑26‑120.

(F) A client or his representative may request a change in the plan of habilitation. If a request for a change in the plan of habilitation is denied, a grievance may be filed by the client or his representative on his behalf. The request must be reviewed according to the grievance procedure pursuant to Section 44‑26‑80.

HISTORY: 1992 Act No. 366, Section 1; 2011 Act No. 47, Section 6, eff June 7, 2011.

Library References

Mental Health 51.

Westlaw Topic No. 257A.

C.J.S. Mental Health Sections 98, 102 to 118.

**SECTION 44‑26‑160.** Mechanical, physical, or chemical restraint of clients.

(A) No client residing in an intellectual disability facility may be subjected to chemical or mechanical restraint or a form of physical coercion or restraint unless the action is authorized in writing by an intellectual disability professional or attending physician as being required by the habilitation or medical needs of the client and it is the least restrictive alternative possible to meet the needs of the client. Emergency restraints require the written authorization of the attending physician or designated staff member and must be noted in the client’s record.

(B) Each use of a restraint and justification for it must be entered into the client’s record. The authorization is not valid for more than twelve hours during which the client’s condition must be charted at thirty‑minute intervals. If the orders are extended beyond the twelve hours, the extension must have written authorization by an intellectual disability professional or attending physician. Within twenty‑four hours a copy of the authorization must be forwarded to the facility supervisor for review. Clients under a form of restraint must be allowed no less than ten minutes every two hours for motion and exercise. Mechanical restraint must be employed in a manner that lessens the possibility of physical injury and ensures the least possible discomfort.

(C) No form of restraint may be used for the convenience of staff, as punishment, as a substitute for a habilitation program or in a manner that interferes with the client’s habilitation program.

(D) In an emergency such as a serious threat of extreme violence, injury to others, personal injury, or attempted suicide, if the attending physician or an intellectual disability professional is not available, staff may authorize mechanical restraint or physical restraint, in conjunction with state and federal regulations, when these means are necessary for as long as the behavior that warrants restraint persists. The use must be reported immediately to the attending physician or an intellectual disability professional who shall authorize its continuance or cessation and make a written record of the reasons for its use and his review. The records and review must be entered into the client’s record. The facility must have written policies and procedures governing the use of mechanical and physical restraints.

(E) The client’s family or his representative, or both, must be notified immediately of the use of restraints.

(F) The appropriate human rights committees must be notified of the use of emergency restraints.

(G) Documentation of less restrictive methods that have failed must be entered into the client’s record when applicable.

HISTORY: 1992 Act No. 366, Section 1; 2011 Act No. 47, Section 6, eff June 7, 2011.

Library References

Mental Health 51.

Westlaw Topic No. 257A.

C.J.S. Mental Health Sections 98, 102 to 118.

**SECTION 44‑26‑170.** Use of certain types of behavior modification.

(A) Behavior modification programs involving the use of aversive stimuli are discouraged and may be used only in extraordinary cases where all other efforts have proven ineffective. Clients must not be subjected to aversive stimuli in the absence of:

(1) prior written approval for the technique by the director;

(2) the informed consent of the client on whom the aversive stimuli is to be used or his representative. Each use of aversive stimuli and justification for it must be entered into the client’s record;

(3) documentation of less restrictive methods that have failed must be entered into the client’s record.

(B) Seclusion must not be used on clients with intellectual disability.

(C) Planned exclusionary time‑out procedures may be utilized under close and direct professional supervision as a technique in behavior shaping.

(D) Behavior modification plans must be reviewed by the interdisciplinary team periodically for continued appropriateness.

HISTORY: 1992 Act No. 366, Section 1; 1993 Act No. 181, Section 1092; 2011 Act No. 47, Section 6, eff June 7, 2011.

Library References

Mental Health 51.

Westlaw Topic No. 257A.

C.J.S. Mental Health Sections 98, 102 to 118.

**SECTION 44‑26‑180.** Informed consent required for participation in research; promulgation of regulations.

A client or his representative shall give informed consent in every case before participation in research conducted by, for, or in cooperation with the department. The department shall promulgate regulations to obtain informed consent and to protect the dignity of the individual.

HISTORY: 1992 Act No. 366, Section 1; 2011 Act No. 47, Section 6, eff June 7, 2011.

CROSS REFERENCES

Authority of department to conduct research on mental retardation, provided client’s prior consent is obtained pursuant to this section, see Section 44‑20‑260.

Library References

Mental Health 51.

Westlaw Topic No. 257A.

C.J.S. Mental Health Sections 98, 102 to 118.

**SECTION 44‑26‑190.** Department of Education to develop and utilize most current methods of education and training of clients; rights of school‑aged clients to appropriate education.

(A) The State Department of Education shall seek to develop and utilize the most current and promising methods for the education and training of people with intellectual disability. It shall utilize the assistance, service, and findings of other state and federal agencies.

(B) School‑aged clients with intellectual disability have the right to an appropriate education regardless of the degree of retardation or accompanying disabilities as provided in Public Law 94‑142, the Education of Handicapped Children Act. Placement of a school‑aged person with intellectual disability in a facility of the department does not preclude his attendance in community‑based public schools. It is the goal of each intellectual disability facility to effect a move of each resident client from facility‑based educational programs to community‑based public schools.

HISTORY: 1992 Act No. 366, Section 1; 2011 Act No. 47, Section 6, eff June 7, 2011.

Library References

Mental Health 51.

Westlaw Topic No. 257A.

C.J.S. Mental Health Sections 98, 102 to 118.

**SECTION 44‑26‑200.** State Employment Services Division and State Agency of Vocational Rehabilitation to find employment for citizens with intellectual disability.

The South Carolina State Employment Service Division of the South Carolina Department of Employment and Workforce and the State Agency of Vocational Rehabilitation shall work together to find employment for citizens with intellectual disability. Services must include, but are not limited to, counseling, referral, timely notification of job listings, and other services of the division and the agency.

HISTORY: 1992 Act No. 366, Section 1; 2011 Act No. 47, Section 6, eff June 7, 2011.

Library References

Mental Health 51.

Westlaw Topic No. 257A.

C.J.S. Mental Health Sections 98, 102 to 118.

**SECTION 44‑26‑210.** Penalties for denying client rights accorded under this chapter.

A person who wilfully causes, or conspires with or assists another to cause, the denial to a client of rights accorded to him under this chapter, upon conviction, must be fined not more than one thousand dollars or imprisoned not more than one year, or both. A person acting in good faith, upon actual knowledge or information thought by him to be reliable, is exempt from criminal liability.

HISTORY: 1992 Act No. 366, Section 1; 2011 Act No. 47, Section 6, eff June 7, 2011.

Library References

Mental Health 51.

Westlaw Topic No. 257A.

C.J.S. Mental Health Sections 98, 102 to 118.

**SECTION 44‑26‑220.** Person making health care decision not subject to civil or criminal liability, nor liable for cost of care; health care provider not subject to civil or criminal liability or disciplinary penalty for relying on decision.

(A) A person who in good faith makes a health care decision as provided in this chapter is not subjected to civil or criminal liability on account of the substance of the decision.

(B) A person who consents to major medical treatment as provided in this chapter does not by virtue of that consent become liable for the costs of care provided to the client found incompetent to consent to or refuse treatment.

(C) A health care provider who in good faith relies on a health care decision made by a client or as authorized by this chapter is not subject to civil or criminal liability or disciplinary penalty on account of his reliance on the decision.

(D) This section does not affect a health care provider’s liability arising from provision of care in a negligent manner.

HISTORY: 1992 Act No. 366, Section 1; 2011 Act No. 47, Section 6, eff June 7, 2011.