The Roles of School Districts and State Agencies in Providing Residential Placement for Students with Severe Mental and Behavioral Health Needs: How to Navigate the Current System

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ConnCASE/SERC/CSDE Leadership Forum

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What Is the Standard for Residential Placement?

- Mrs. B. v. Milford Board of Educ., 103 F.3d 1114 (2d Cir. 1997):
- Determine whether the child requires the residential program in order to receive educational benefit.
- The fact that residential placement may be required in order to alter behavior in the home as well as the classroom, or is required primarily due to emotional problems, does not relieve the obligation to pay for residential program if necessary to ensure the child can be properly educated.
- Adopts the "inextricably intertwined" standard: when medical, social or emotional problems create or are intertwined with the educational problem, such that the child cannot otherwise be educated, the district has responsibility for the cost of the residential placement.

Examine Facts of Mrs. B.

- M.M. was 17 years old identified under LD, but with significant emotional problems.
- Previous IEPs called for the provision of therapy by a social worker in a community mental health clinic paid for by the district as a related service on the IEP.
- The social worker from the clinic then recommended residential placement due to the failure to make sufficient progress in an outpatient setting.
- DCF funded the placement at Devereux Glenholme for other than educational reasons.
- Parent then sued for reimbursement of the costs paid by DCF from the school district so that she would not be liable to refund costs to DCF.

What Was M.M.'s Educational Record?

- Not progressing in the educational program despite low average intelligence.
- Serious writing problems due to task avoidance led team to remove all writing requirements.
- Teachers stated she was not learning in the program.
- Failed to meet basic academic and behavioral standards.
- IEP going into hearing did not provide for psychological therapy.
- Met only 4 of 32 objectives listed in the IEP.

What Did the Residential Placement Provide?

- Educational component 6 hour school day
- Life skills program
- Counseling from social worker
- Small group program to work on development of self-esteem, resisting negative peer pressure, appropriate social skills.
- After school activities including sports, arts intended to foster self confidence and creativity.
- Coordinated approach between school and residential staff to improve academic and social skills.

What Did the Hearing Officer and Lower Court Decide?

- Sided with the school district, finding that the placement was made for non-educational reasons and that was why it was funded by DCF.
- “where predominantly and significantly the child’s problems grow out of the home situation rather than the school environment, the school cannot be taken to task”.
- “Because much of the time M. willfully refused to drink at the fountain of learning does not mean that the fountain was not there or was not operable.”

- Federal magistrate judge reversed on appeal, in part because the hearing officer had ordered that the student not be transitioned back to the public school until the beginning of the following school year.

What Did the 2nd Circuit Decide?

- Walking through the Rowley standard, more than "mere trivial advancement" is required to satisfy FAPE.
- Child's academic progress must be viewed in light of the limitations imposed by the child's disability.
- Limited progress for many years in public school program, followed by regression in the year awaiting space in the residential program did not satisfy standard for this student.
- Failed to meet nearly all of the objectives in the IEP and nearly all grades were unsatisfactory.
- District offered no plan to deal with her worsening behavior.
- The concept of "education" is necessarily broad with respect to children with special education needs – implying it includes social emotional learning as well as academics.

CSDE MEMO 12/5/16

What Does It Say?

- DDS provides residential placement for school aged students on a discretionary basis.
- Its decision to do so in the past has led to confusion about whether it is required by law that DDS provide residential placement.
- AG issued an opinion letter confirming that DDS does not have a legal obligation to do so under State law, and that school districts may have a legal obligation to do so under IDEA and State law.
- **State budget restrictions have led DDS to stop funding residential placements for school aged students.**

DDS Declines in Appropriations

	FY 2016	FY 2018	FY 2019
Total	262,000,000	207,000,000	194,000,000
Behavioral Services Program	32,000,000	22,500,000	

What Does CSDE Require?

- If an LEA receives notice from DDS or parent that DDS is discontinuing funding of residential placement, LEA should conduct a PPT meeting in accordance with IDEA and State law.
- At the PPT, the team must determine what services the student requires in order to receive FAPE, including whether residential placement is needed as a related service.
- If the parent disagrees with the PPT determination, s/he may seek review through procedural safeguards processes of mediation, due process, or complaint resolution.
- DDS will continue to make staff available for purpose of educating school staff and parents about options provided for adults with disabilities.

CASE STUDY: STUDENT M

History of Diagnoses/Services: Preschool to Grade 1

- Pervasive Developmental Disorder (PDD) dx age 3, neurologist
  - Motor milestones achieved on schedule
  - Mostly nonverbal
  - Not toilet trained
- Preschool/K services provided in NY, 6:1:1 classroom
  - "Not testable"
  - Tantrums and SIB (head-banging) when frustrated
  - Eligible under Mental Retardation category
- 1st grade services in Connecticut
  - In-district self contained special education program
  - Eligibility category Multiple Disabilities
  - Moved mid-year to RESC PLC program

History of Diagnoses/Services: Elementary School

- Assessed at RESC Developmental Stage 1 (of 3) at arrival, progressed to Transitional Stage 1/2
- Unable to calm self following motor activities, tactile defensiveness
  - OT services 1.0 hour per week (reduced to 0.5 hour after 2 years, discontinued after 3 years), sensory diet implemented
- Mouthing objects/PICA
- **Physically aggressive**
- **Easily frustrated**
- No verbal expressive language
  - SLP services 1.5 hours per week
- Self injurious behaviors
- Function of behaviors: escape from demands, attention from adults
- Still not fully toilet trained but accidents in moments of tantrum/frustration only
- **164 lbs in 3rd grade**
- Emergence of OCD-like symptoms in 3rd grade

History of Diagnoses/Services: 4th and 5th Grade

- No Triennial Reevaluation done: file review sufficient to continue services
- Allowed to wear hat due to light sensitivity
- Dx lead poisoning, treated with Chemet
- Meds: Trazodone (antidepressant), Tenex (hypertension), Zoloft (antidepressant), Clonazepam (anxiety)
- Progressed to Developmental Stage 2 in 4th grade: still dysregulates easily, has difficulty recovering
- Goal to wait his turn during mealtime without aggression
- Dx Autism 5th grade, Primary Disability changed to Autism
- **Remains nonverbal, communication through gestures**, Mayer-Johnson picture board, MLU 3 words, signs help, water, bathroom; speech generating device

History of Diagnoses/Services: Middle School

- Activities mastered in school setting with assistance:
  - Assembly of “kits”
  - Assemble and file mail
  - Washing windows and tables
  - Delivering messages
  - Shredding paper
  - Emptying garbage
  - Use of exercise machines, i.e. treadmill
  - Hygiene routine with visual aids
  - Uses utensils during mealtimes

History of Diagnoses/Services: 7th and 8th grade

- Seclusion/restraint 1x 7th grade, DLC program (puberty onset?)
  - **Screaming, biting self, banging head, charged at staff, hitting and head-butting**
- AT evaluation → Proloquo2go on iPad
- 7th grade team begins discussion with family re DDS application
- Dx Intermittent **Explosive disorder**
- Light sensitivity due to lead poisoning continues
- 2013 Psychoeducational testing
  - CTONI FSIQ 45
  - Vineland composite 54 (teacher), 43 (parent)
- 2013 SLP evaluation – unable to test
- Continued to be eligible under Autism category

History of Diagnoses/Services: High School

- 9th grade reports decline in dysregulation, more independence
- 10th grade ER visit due to head injury at school
- 11th grade ER visit due to head injury, sprained ankle at school
- **Access to food minimized due to dysregulation**
- **Hitting, SIB (6x), biting, aggression toward staff and peers (3x), disrobing, biting arm/hand**
- Functional Independent Skills Handbook (FISH)
  - Adaptive behavior skills 60%
  - Affective skills 27%
  - Cognitive skills 48%
  - Sensorimotor skills 100%
  - Social skills 59%
  - Speech and language skills 29%
  - Vocational skills 28%

School Involvement

- Referred to Care Coordination (C&FG) in 2016 regarding self injurious and aggressive behaviors
- Parent Legal counsel obtained November 2016, request for residential placement for educational reasons denied at PPT
- At school, incident of head banging results in head wound and destruction of bathroom tile in stall
- In-hospital ABA services provided during lengthy hospitalization awaiting placement

M: CASE STUDY

PARENT ATTORNEY CONCERNS, ISSUES AND STRATEGY

OBTAINING RESIDENTIAL PLACEMENT ASAP WHEN SAFETY OF CHILD AND CAREGIVER IS AT STAKE

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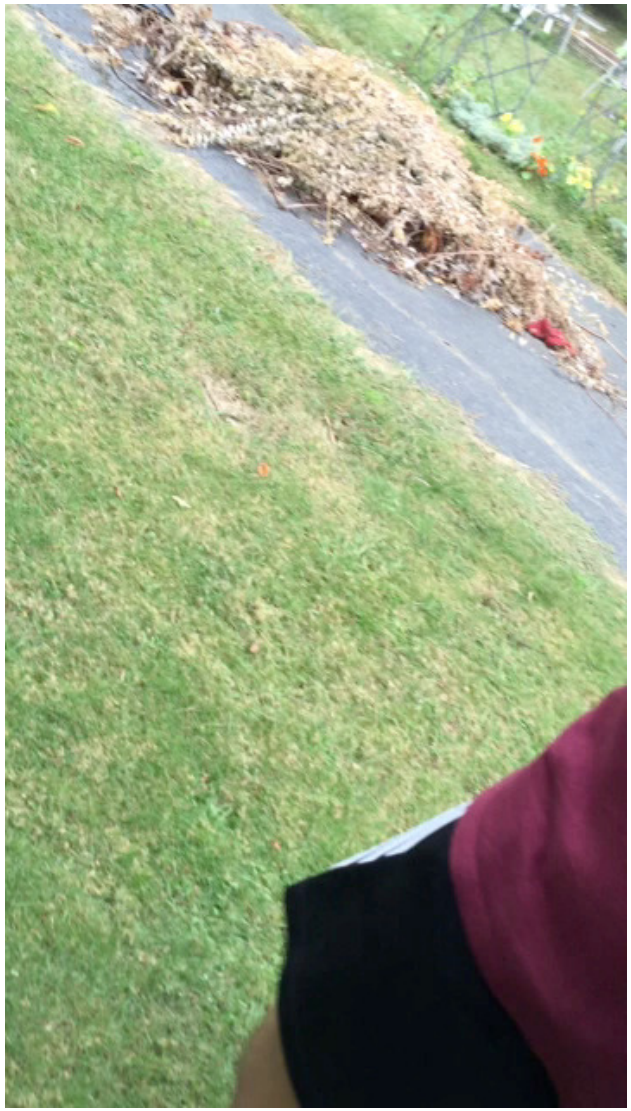
REVIEW

- Child & Family Guidance Referral: Why?
- Parent's contention for residential need
- STRATEGIC DECISION: File Due Process or request DDS Priority Hearing or both?
- DDS PRIORITY HEARING >formal objection to Commissioner
- LESSONS LEARNED
  - No Interagency Dispute Process

Parent Contention

- M was unable at home to use any transition skills taught in school
- M was becoming increasingly dangerous to others
  - Attacking parent while driving car;
  - Physically attacking parent at home
- M. was becoming increasingly dangerous to himself
  - 320 pounds, 6 feet height
  - Food obsession
  - Broken doors, bars on windows in order to reach food
- Dysregulation occurred 24/7
- DDS provided $1200 month parents for additional support
  - No behaviorist available/ daughter provided support until too dangerous

Meet MITCH
Antecedent: Butterfly flew away



HOME

HOME

HOME

HOME

DDS: To obtain a **Priority Rating** for Services, must establish Level of Need

PRIORITY RATING	
Emergency	need for **immediate** residential placement
P1: Urgent	**urgent** need for residential placement **within 1 year**
P2: Future	service need in two or more years
P3: Future	service need in two or more years

DDS Waitlist

Rating	6/30/17	12/31/17	Description
E	20	22	Immediate need for residential services
P1 (urgent)	480	526	Needs residential placement within 1 year
P2	746	1099	Will need residential placement in 2 plus years
P3	336		

June 2016 DDS Initial Intake: 1st Step to obtain Priority Rating

The family home has been physically destroyed by Mitchell's property-destructive behaviors; walls have been completely knocked down to the frames, including the bathroom tile walls, which he has head-butted to the point of putting holes in the tiles and necessitating visits to the hospital emergency room for sutures to his profusely bleeding scalp. In addition, closet doors have been torn off their hinges during the course of Mitchell's behaviors, and shelves have been torn from the closets, forcing Mitchell's family to leave their clothes in heaps on the floor. Mitchell and his family members sleep on mattresses on the floor, as Mitchell has broken all the bed frames. There is a lock on the kitchen door due to Mitchell's impulsive food or liquid ingestion. There is also an alarm on the front door, as Mitchell has left the family home, gone into a neighbor's home uninvited and began helping himself to their food. In addition to his property destructive behaviors, Mitchell has become aggressive toward both his family members and school staff, causing injury. His mother and father, when a behavior begins, attempt to speak softly to Mitchell and offer him food, but the behavior can accelerate quickly and they are forced to vacate to another room or area to avoid risking their own bodily injury.

JUNE 2016 DDS Level of Need Summary

Assessment Summary:

Section	0	1	2	3	4	5	6	7	8
Composite Score (Home/Res)						X			
Composite Score (Day/Voc/School)							X		

October: LON Reassessment due to Family request for “E” Rating to obtain Residential Placement

Assessment Summary:

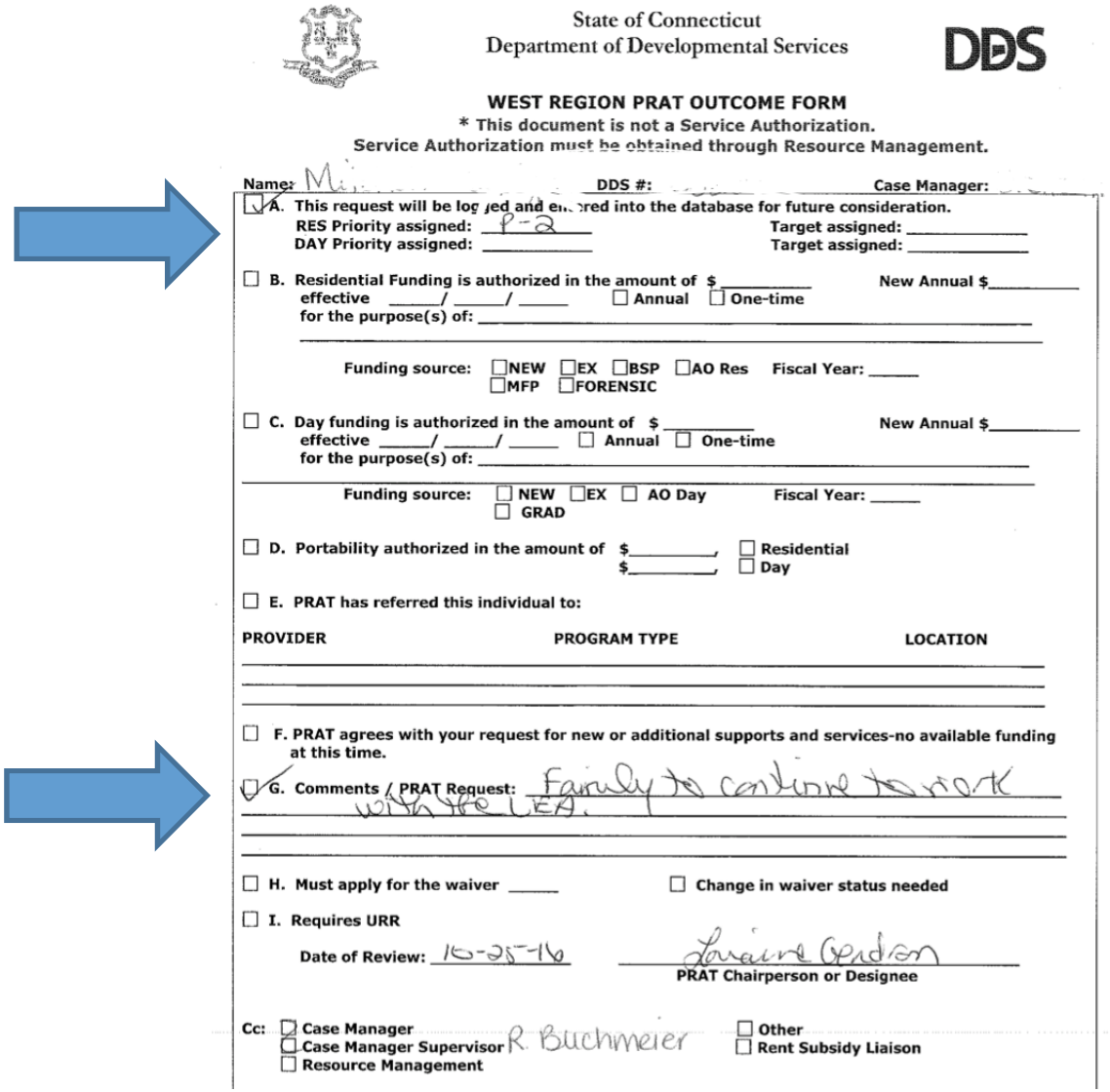
Section	0	1	2	3	4	5	6	7	8
Composite Score (Home/Res)								X	
Composite Score (Day/Voc/School)							X		

October 2016 DDS/LON
Family request to DDS for Emergency rating

Assessment Summary:

Section	0	1	2	3	4	5	6	7	8
Composite Score (Home/Res)								X	
Composite Score (Day/Voc/School)							X		

DDS PRAT review of October Level of Need: P2 Rating



State of Connecticut
Department of Developmental Services

DDS

WEST REGION PRAT OUTCOME FORM

* This document is not a Service Authorization.
Service Authorization must be obtained through Resource Management.

Name: Mi... DDS #: Case Manager:

☑ A. This request will be logged and entered into the database for future consideration.
RES Priority assigned: P-2 Target assigned: _____
DAY Priority assigned: _____ Target assigned: _____

☐ B. Residential Funding is authorized in the amount of $_____ New Annual $_____
effective _____/ _____/ _____ ☐ Annual ☐ One-time
for the purpose(s) of: _____

Funding source: ☐NEW ☐EX ☐BSP ☐AO Res Fiscal Year: _____
☐MFP ☐FORENSIC

☐ C. Day funding is authorized in the amount of $_____ New Annual $_____
effective _____/ _____/ _____ ☐ Annual ☐ One-time
for the purpose(s) of: _____

Funding source: ☐ NEW ☐EX ☐ AO Day Fiscal Year: _____
☐ GRAD

☐ D. Portability authorized in the amount of $_____, ☐ Residential
$_____, ☐ Day

☐ E. PRAT has referred this individual to:

PROVIDER PROGRAM TYPE LOCATION

☐ F. PRAT agrees with your request for new or additional supports and services-no available funding at this time.

☑ G. Comments / PRAT Request: Family to continue to work with the LEA.

☐ H. Must apply for the waiver _____ ☐ Change in waiver status needed

☐ I. Requires URR

Date of Review: 10-25-16 Lorraine Gordon
PRAT Chairperson or Designee

Cc: ☑ Case Manager R. Buchmeier ☐ Other
☐ Case Manager Supervisor ☐ Rent Subsidy Liaison
☐ Resource Management

Child and Family Guidance Referral to Attorney

- Child and Family Guidance Assessment
  - Visit to home by case worker indicated dire circumstances
    - Child not eligible for IICAPS due to worker safety concerns
    - Child not eligible for Respite due to safety concerns
  - DDS case manager informed C&FG that child needed residential but it was the school district's responsibility
  - School district had denied parent's request for residential services
    - Claimed child was making progress in school with appropriate support
      - 2-6 individuals depending on level of dysregulation
    - Claimed child was being properly transitioned for after 21 age placement in group home given same level of support

Due Process versus DDS Hearing

- All parties agreed residential placement was necessary BUT
  - School district at most would only pay for educational component;
- Due Process would take 4-5 months until HO decision.
  - Financial burden of DP huge for lower income parents;
  - If parent lost at due process, would have to appeal decision adding additional time;
- DDS outright refused to even consider residential placement because of LEA involvement and P2 rating;
  - Priority Hearing scheduled for April; if pending due process hearing, DDS would put off Priority hearing.
- AGE OUT

Time Bomb for Residential Services: Age-Out Eligibility

Applicant upon reaching age 21:

Received residential funding and services for **not less than one year prior** to requesting age-out funding

Has non-DDS funding from a state or municipal agency or LEA; or

DCF placement outside of the home

DDS Age-Out Disqualification

Residential funding by an **individual, an individual's family or any non-governmental entity** (ie private pay) shall not qualify an individual for funding.

NEGATIVE IMPACT: Unilateral agreement for residential placement that requires parental contribution voids qualification for age-out funding

January 2017: Police Report and Hospitalization

first (21st) birthday. Throughout the past years time, I, along with several other Stratford Police Officers along with fire and EMS personnel have been called to Robert and Mitchell's residence by Robert due to Mitchell acting out of control. On two (2) separate occasions, I have personally witnessed Mitchell bite into his own arms using his teeth causing flesh to be torn from his person, then spit it onto the ground. On my last response to this residence on 01/22/2017, I also witnessed Mitchell slam his own head into a wall causing a large wound to the back of his head.

Due to the dangerous nature of Mitchell's behavior when called to assist him and Robert, Stratford Dispatch has "flagged" this address in the computer aided dispatch (CAD) system advising them to send additional police officers to respond and to advised fire and EMS personnel to stage outside until cleared to enter by police. During my responses to this residence, Mitchell has been uncontrollable and has attempted to strike both officers and Robert. Mitchell is over six feet (6') tall and weighs in excess of three hundred pounds (300LBS).

February: DDS Priority Hearing date set for April 2017

- Mission was to obtain an “E” rating for Mitch;
- Had been in the hospital for 30 days during which he was being physically and chemically restrained several times a day;
- Regressing mentally
- Physically gaining weight: 40 lbs from meds

DDS "E" Rating Standard

An emergency situation *currently* exists where the health and safety of individual and his family are at great risk and that the situation cannot be resolved any other way.

DDS Procedure Manuel D(4)(n)

Priority Hearing Witnesses

- DDS: PRAT
  - Limited Review to Intake and LON
    - Did not request any additional information (procedural defect)
      - Police reports
      - Multiple hospital visits
  - LEA's denial of parent's request for residential placement
- Hospital physician
  - Mitch not safe in hospital
    - Daily Chemical and physical restraint
- School (CES) Psychologist Environmental assessment of home
  - Need for Mitch to be in highly structured setting
  - Need for multiple behaviorists to control dysregulation
- Parents

Hospitalist Testimony of Self-Injurious Behavior

Q. And can you describe what that behavior is like?

A. Nothing I've ever seen before. So one time he -- I mean, there's multiple events, but one that I can remember vividly, he was basically banging his head against the wall to the point where there was a hole. And then he banged his head backwards to the other wall, and there was also a hole. And there was some blood and he had a laceration in the back of his head. (Hear Tr. 99:18-25; 100:1.)

Hospitalist Testimony of Danger to Others

Q. And when staff would care for Mitch, would they go in the room by themselves as they would any other patient?

A. No.

Q. What was the difference? What did Mitch require?

A. Because his behavior was very unpredictable, we had to have people by his side all the time. So we always have a security as well as a tech in the room with him. And of course the nurse would come and give medication. We wouldn't have one person like just a nurse going in, just because of the unpredictability of his behavior.

Hospitalist Testimony of property damage

Q. Has he caused any physical damage when he was at -- on the regular floor, with mirrors and things like that, did he cause any physical damage to that room?

A. Yes. He broke tiles in the shower. He put two holes in the wall.

Hospitalist Testimony: Use of chemical restraints

"Between January 21, 2017 and March 15, 2017, the hospital has utilized both physical and chemical restraints to control Mitchell's behaviors on thirty-four different days including multiple incidents on several days."

Hospital Chemical Restraint (partial list)

Medications (Injections only) while at Bridgeport Hospital

Date Given	Time	Medication	Dose	Route
1/21	23:25	HALDOL	5 mg	Intramuscular (right deltoid)
1/21	23:25	ATIVAN	2 mg	Intramuscular (left deltoid)
1/22	01:08	HALDOL	5 mg	Intramuscular
2/01	21:00	ATIVAN	2 mg	Intramuscular
2/03	11:39	ATIVAN	2 mg	Intramuscular
	11:40	HALDOL	5 mg	Intramuscular
2/06	21:53	HALDOL	5 mg	Intramuscular
2/07	22:11	HALDOL	5 mg	Intramuscular
2/08	05:10	HALDOL	5 mg	Intramuscular
	11:11	HALDOL	5 mg	Intramuscular
	11:12	ATIVAN	2 mg	Intramuscular
2/09	21:40	ATIVAN	2 mg	Intramuscular
2/10	14:22	HALDOL	5 mg	Intramuscular
	14:17	BENADRYL	50 mg	Intramuscular
2/12	09:28	HALDOL	5 mg	Intramuscular
	09:28	ATIVAN	2 mg	Intramuscular
	09:28	BENADRYL	50 mg	Intramuscular
2/15	23:47	BENADRYL	50 mg	Intramuscular
	23:54	HALDOL	5 mg	Intramuscular
	23:48	ATIVAN	2 mg	Intramuscular

Hospitalist Testimony: Danger of Continued Hospitalization

BY MS. KELLER:

Q. Do you have any concerns over his physical well-being of staying in the hospital long term? I'm talking about are there any risks to him medically staying in the hospital for a long period of time?

A. Well, I mean, I said now I don't have any medical thing to treat, but my fear is that one of these days I will, because the hospital as we know is not the safest place when it comes to infection.

We have, you know, resistant bacterias like Staph aureus. We have E. coli infections, which patients who stay a long period of time do get that. Also one of the things that could be fatal, which is blood clots. Because he's not ambulating enough, he can develop blood clots in his legs that can potentially go to his lungs. And we see these things in patients that are in the hospital for a long period of time.

Priority Hearing Officer Decision: Change from P2 to P1

"There is no evidence that the hospital is unable to keep Mitchell and others safe."

Hearing Officer Lapidus

Opposition to DDS HO Decision and request for Commissioner Review

Parent Opposition claimed that within the Priority Hearing transcript, and particularly the testimony of witness Dr. Astou Seye, there was repeated evidence of a **current emergency situation** created through the escalated self injurious harm to Mitch and physical harm to others and through the use of physical and chemical restraints.

PPT Meeting at time of DDS Opposition Filing

- Parent requested Mitch be transported by CES daily for instruction versus tutoring in hospital;
- Parent attorney informed school district and CES staff of use of chemical restraints in the hospital;
- CES denied continued admission due to safety concerns of staff given increased dysregulation and 40 pound weight gain.

Granting of "E" Status

- Day after Opposition brief was filed, parent counsel informed by DDS counsel that Commissioner had granted **Emergency** status;
- DDS to contact school district to work out funding.

Mitch: EATING

NOVEMBER 2016

HOME

FEBRUARY 2018

RESTAURANT

Lessons Learned

School District needs to be more proactive in assisting parent to find community resources considering:

Early Intervention whenever there is disparity between home and school behavior. Also consider the culture of the family.

DDS funding is through appropriations therefore always based on priority of needs

Parents without counsel can not effectively object to priority rating.

INTERAGENCY DISPUTE PROCESS DOES NOT EXIST BETWEEN SDE, LEA AND AGENCIES: DDS & DCF

No process for parties to sit down and attempt work-outs

DDS Testimony Feb 26, 2018: Looking Forward

- $5,000,000 DDS grant to assist with emergency placements
- Purpose is to build resources within the community to reduce reliance on hospitalization for individuals with acute needs.
- Recognition by DDS:
  - Gaps in continuum
  - Rely on hospital ERs for extended periods of time due to nature of crisis and constraint
  - No present alternative to emergency rooms
  - No step down after hospitalization

Questions?