

**COMMONWEALTH OF MASSACHUSETTS
DIVISION OF ADMINISTRATIVE LAW APPEALS**

BUREAU OF SPECIAL EDUCATION APPEALS

**In Re: Boston Public Schools and
Mass. Dept. of Mental Health**

BSEA #1707097

DECISION

This decision is issued pursuant to the Individuals with Disabilities Education Act or IDEA (20 USC §1400 et seq.); Section 504 of the Rehabilitation Act of 1973 (29 USC §794); the Massachusetts special education statute or “Chapter 766,” (MGL c. 71B) the Massachusetts Administrative Procedures Act (MGL c. 30A) and the regulations promulgated under these statutes.

This case involves a fifteen-year-old young woman (Student) with multiple, complex disabilities who has been confined to a locked adolescent unit of a psychiatric hospital since August 2016. Student’s clinicians have determined that Student is ready for release to an appropriate setting as soon as one becomes available. The parties in this matter generally agree with the clinicians’ determination. Additionally, the parties agree that at this time, Student cannot return to her family home, and that she needs some type of residential services in order to be able to leave the hospital and attend school. The major points of contention among the parties are, first, whether Student requires a residential placement for educational or non-educational reasons, and, second, if she needs residential services for non-educational reasons, whether the Department of Mental Health (DMH) is responsible for providing and/or funding such services. Neither Boston Public Schools (Boston or BPS) nor DMH, which funds the current hospital program, has agreed to provide and/or fund Student’s residential placement and/or services. Rather, each agency points to the other as being responsible for such services. Until the dispute between BPS and DMH is resolved, Student will remain in the locked facility.

On April 12, 2107, Parents filed a request for an expedited hearing¹ with the Bureau of Special Education Appeals (BSEA) in which they sought an order directing BPS to immediately place Student in a therapeutically-oriented residential special education school. In the alternative, Parents sought an order directing BPS and DMH to share the costs of such a placement, if, after a hearing, the BSEA Hearing Officer were to determine that Student needs a residential placement for other than educational reasons. On April 13, 2017, the BSEA granted expedited status to this matter as requested by Parents, set an initial hearing date of April 27, 2017, and assigned this matter to Hearing Officer Rosa Figueroa.

Both BPS and DMH filed responses to Parents’ hearing request on April 18, 2017. In its response, Boston contested the grant of expedited status, stating that Student was, in fact

¹ Parents alleged that Student’s case meets the criteria for expedited status under Rule II(C)(1)(b)(i) of the BSEA *Hearing Rules* because Student “is without an available educational program and/or the special education services the student is currently receiving are sufficiently inadequate that harm to the student is likely.” *Id.*

receiving educational services within the hospital setting. Additionally, BPS asserted that Student's educational needs could be met in a therapeutic day school setting, and that Boston previously had proposed such a placement. According to BPS, any need that Student might have for residential placement is based on her complex medical and psychiatric profile, and is distinct from her educational needs. BPS contended that DMH is the appropriate agency to fund any residential placement that Student might require to meet her clinical needs.

Like Boston, DMH disputed the grant of expedited status on the grounds that Student was receiving educational services in the hospital. DMH also filed a *Motion to Dismiss the Department of Mental Health as a Party* on the grounds that DMH previously had found Student to be ineligible for DMH services; because Student was not a DMH client, the BSEA lacked authority to order DMH to provide any services to Student. Parents filed an *Opposition to DMH's Motion* on April 19, 2017. On April 24, 2017, Hearing Officer Rosa Figueroa issued a ruling that denied DMH's *Motion*, thereby maintaining this matter's expedited status and retaining DMH as a party. Subsequently, also on April 24, 2017, the BSEA Director administratively reassigned this matter to the undersigned Hearing Officer.

An evidentiary hearing took place on April 25 and 26, 2017² at the office of the BSEA. Each party was represented by counsel, presented documentary evidence, and examined and cross-examined witnesses. On April 26, 2017 all parties presented oral closing arguments; Parents submitted a written closing brief, and the record closed.

The record in this case consists of Parent's Exhibits P-1 through P-18, Boston's Exhibits S-1 through S-17, DMH Exhibit's D-1 through D-5, and approximately ten hours of electronically recorded testimony and argument. In addition to the electronic recording made by the Hearing Officer, the hearing was stenographically recorded by a court reporter, and the printed transcripts will become part of the record when completed.

The following persons were present for all or part of the proceeding:

Student's Mother	
Student's Father	
Jennifer Sweeney	Special Education Dept., Boston Public Schools
Jessica Geragosian, Psy. D.	Neuropsychologist
Cynthia Berkowitz, M.D.	Metro. Boston Child and Adolescent Psychiatrist, DMH
Sarah Jane Frankel, LICSW	Therapist, Worcester Recovery Center & Hospital (WRCH)
Brian Denietolis, Psy.D.	Clinical Director, Adolescent Continuing Care Unit, WRCH
Agnes Martin, Ph.D.	School Psychologist, BPS (testified by telephone)
Joshua Armentrout	Coordinator of Special Education, BPS
Jeffrey Sankey, Esq.	Attorney for Parents and Student
Kathleen Brekka, Esq.	Attorney for Parents and Student
Carolyn Weisman, Esq.	Attorney for BPS
Jane Williamson	Court Reporter
Sara Berman	BSEA Hearing Officer

² By agreement, the parties started the hearing before the "automatic" hearing date of April 27, 2017.

ISSUES PRESENTED

The issues for hearing are the following:

1. Whether Boston's proposed IEP and placement in a substantially separate therapeutic day program at the McKinley School is reasonably calculated to provide Student with FAPE, either on its own or in conjunction with a residential setting provided by another agency such as DMH;
2. If not, whether Student requires a residential placement upon discharge from WRCH;
3. If Student does require a residential placement, whether she requires it for educational or non-educational reasons.

POSITION OF PARENTS

Student has serious, longstanding mental health issues and significant academic, social/emotional, and communication needs. Taken together, Student's challenges are so severe and pervasive that they must be addressed in an integrated manner within a residential educational setting to ensure generalization of skills and enable her to make effective progress. Student's mental health and social/emotional deficits are so closely intertwined with her educational needs that they cannot be separated; as such, Student requires a residential school placement for educational reasons.

POSITION OF BOSTON PUBLIC SCHOOLS

Student's educational needs can be met within a substantially-separate therapeutic day school setting. Boston's proposed IEP calling for such programming is reasonably calculated to provide Student with FAPE. Boston's proposed placement in a therapeutic program at the McKinley Middle School can implement Student's IEP and meet her educational needs. Student's medical and psychiatric needs are separate and distinct from her educational requirements, and it is the responsibility of DMH to address those needs. If Student's medical and psychiatric care and treatment require a residential placement, then DMH should fund the residential portion of such placement. Although DMH contends that Student is not a client of that agency, Student has been receiving services from DMH since August 2016. DMH should continue to provide any residential services that might be needed to monitor treatment for Student's mental health conditions.

POSITION OF DMH

BSEA jurisdiction over state human services agencies such as DMH is limited to situations in which the student is eligible for services under the agency's own regulations. DMH has deemed Student ineligible for its services. Although Parents have contested this determination within the DMH fair hearing process, their appeal is still pending and likely will not be resolved until after a decision has issued in the instant BSEA case. The BSEA has no authority to order DMH to provide services to an ineligible individual such as Student.

SUMMARY OF THE EVIDENCE

1. Student is fifteen years old and is a resident of Boston. There is no dispute that Student is a child with disabilities as defined by federal and Massachusetts special education statutes, and that BPS is the Local Education Authority (LEA) responsible for ensuring that Student receives a FAPE in the least restrictive environment (LRE). Since approximately August 2016, Student has been hospitalized in the UMass Adolescent Continuing Care Unit, which is a locked psychiatric facility for teens with serious mental health needs within the Worcester Recovery Center and Hospital (WRCH).³ WRCH is a state psychiatric hospital located in Worcester, MA and operated by DMH. (Mother, Denietolis)
2. Student is described as a kind, friendly, and caring young woman with a good sense of humor and strong work ethic. (Mother, Frankel, Martin, S-6) Despite these and other strengths, Student's functioning since early childhood has been significantly compromised by emotional, behavioral, learning, and health-related challenges, as well as family stressors. Recent diagnoses have included severe anxiety, a restrictive eating disorder, expressive and receptive language disorder, borderline intellectual functioning, and a developmental trauma disorder. (Geragosian) Student also has been diagnosed with an Autism Spectrum Disorder (ASD), although this diagnosis is currently in dispute. Student's disabilities have manifested in behavioral dysregulation, self-injurious behaviors, severe and dangerous food refusal, and suicidal ideation and gestures. (Geragosian, Mother, Frankel, Berkowitz, Denietolis, Martin,
3. Student's challenges began emerging very early in her life. Student's early developmental milestones were delayed, and she was very shy and anxious. Student received Early Intervention (EI) services as a toddler and transitioned to an IEP from BPS at the age of 3. Student attended BPS elementary schools for Kindergarten and first grade. After an unsuccessful second grade experience in parochial school, where she was unable to keep up with the assigned work, Student returned to BPS where she repeated second grade. Student remained in BPS until the beginning of her eighth grade year, in September 2015, when she began the pattern of hospitalizations which ultimately led to her current inpatient placement. (Mother, D-3, P-4, S-6)
4. During most of her tenure in BPS, Student had IEPs indicating that she had specific learning disabilities affecting academics. Her IEPs generally called for full-inclusion placements with pull-out services in reading, writing, math, and speech/language. (Mother, D-3, P-4)
5. During Student's elementary years, Parents were very concerned that Student was extremely shy and anxious. Student wanted friends and did have a few close friendships, but was afraid to initiate new relationships with peers or advocate for herself with current friends. Student had multiple fears which made it extremely difficult to try new experiences or separate from Parents. (Mother, D-3) In addition to developmental issues, Student was affected by family stressors. Throughout Student's childhood, Parents obtained private services from medical and counseling providers in an effort to support Student. (Mother, Geragosian, Frankel, Denietolis)

³ Student's current hospital placement will be referred to as "WRCH"

6. In August 2013, when Student was eleven years old and about to enter fifth grade, Parents obtained a private neuropsychological evaluation from Sherral Devine, Ph.D. of Boston Neuropsychological Services. Parents took this action because both they and Student's pediatrician questioned whether Student might have an Autism Spectrum Disorder (ASD) (D-3)
7. Dr. Devine's evaluation took place in late August and early September 2013 and consisted of a battery of standardized cognitive assessments, Parent and teacher rating scales, Parent and Student interviews, and a review of records. The interviews and record reviews showed that Student had many strengths in that she was hard-working, well-behaved motivated to do well, imaginative, and artistic. Student was able to regulate her emotions and behavior in school. Student had close friends and wanted to spend as much time with them as possible. Dr. Devine found that Student's areas of weakness included all aspects of language (verbal reasoning, expressive and receptive language, written expression, and verbal comprehension), social pragmatics, attention and focus, and executive functioning. Parent and teacher responses to the BASC-2 showed concerns in a number of domains including depression, withdrawal, functional communication, social skills, emotional self-control, anxiety, attention, and "atypicality." (D-3)
8. More specifically, testing showed that Student had "borderline" verbal comprehension skills and processing speed, and generally "average" visual-spatial and working memory abilities. Academically, Student had "low average" skills in reading and writing, and "borderline" skills in math. (D-3)
9. Based on her evaluation, Dr. Devine concluded that Student met criteria for the following: ASD with accompanying language impairments, a separate language disorder, generalized anxiety disorder and specific learning disorders with impairment in reading, mathematics and written expression. (D-3)
10. The ASD diagnosis was based upon Student's meeting the relevant DSM-V criteria including deficits in social communication and pragmatic skills, a history of echolalia and hand-flapping with anxiety, and sensory sensitivity. Dr. Devine's evaluation did not include the Autism Diagnostic Observation Schedule-2 (ADOS-2), which currently is considered the "gold standard" for diagnosing ASD. (D-3; Berkowitz, Denietolis)
11. Dr. Devine made extensive recommendations, including a small-group classroom for all core academic subjects, direct speech and language therapy, multiple accommodations and strategies to support Student academically, home based services to help Student establish routines for study and self-care, and outside psychotherapy to address anxiety. (D-3) Dr. Devine did not mention or recommend ABA (Applied Behavior Analysis) services or a formal FBA (functional behavioral assessment).
12. In or about October 2013, after receipt of Dr. Devine's evaluation, Boston conducted its own psychological evaluation and convened a Team meeting. The record does not fully document the results of this evaluation, but at some point, Student's disability category was changed from "specific learning disability" to "ASD," and Student was found eligible for DDS services as a result of the ASD diagnosis. (Berkowitz, Mother)

13. In the middle of fifth grade, (2013-2014 school year) Student transferred to a full-inclusion placement at the Haley K-8 Pilot School and continued there for sixth grade (2014-2015). Much of Student's sixth grade year was productive. Student worked hard, was focused and well-behaved, and earned good grades. (S-12) She was quiet and shy, but was involved with a group of other quiet girls and had a few friendships. (Armentrout)
14. In the spring of 2015, during sixth grade, Parents noticed that Student's emotional and behavioral status declined noticeably. Student appeared to be depressed, had increased anxiety, often refused to attend school, and became emotionally dysregulated when she came home from school. Student engaged in increasing amounts of self-injurious behavior and expressed that she wanted to die. Additionally, Student began to restrict her food and fluid intake, and lost a large amount of weight. In June 2016, Parents took Student to an outpatient eating disorders clinic at Boston Children's Hospital (BCH), (Student already was receiving treatment from a therapist and a developmental pediatrician). In September 2015, Student was admitted to BCH for inpatient treatment of her eating disorder, where she remained until early November 2015, when she was "stepped down" to an eating disorders program at Cambridge Hospital. Student returned to BCH a few days later on an emergency basis due to food refusal. After medical treatment, Student was transferred to the BCH inpatient psychiatric unit in late November 2015. (Mother, P-16)
15. From that point until August 2016, Student was repeatedly hospitalized at BCH for food and/or fluid refusal and self-harming behavior. Student would be discharged from BCH only to be readmitted shortly after returning home. During her hospitalizations Student was physically and/or chemically restrained on multiple occasions for self-harming behavior and occasional aggression to staff. At various points she required tube feeding as well as 1:1 monitoring for safety. During this period, Student received some tutoring from BPS but was essentially unable to attend school for more than a day or two at a time during the 2015-2016 school year. (Mother, P-10, S-12)
16. In February and March 2016, while Student was hospitalized at BCH, BPS conducted an unscheduled re-evaluation of Student consisting of a "Sociological Assessment" by a school social worker and "Behavioral Health Services Assessment" by a school psychologist. (Armentrout, S-10, S-11) The school psychologist interviewed Student, Parents and various providers, but deferred standardized testing in light of Student's emotional fragility. (S-11, Martin) At the time of the Team meeting, hospital staff indicated that Student had been "stable" for approximately three weeks, in that she had been eating and had not required restraints. (P-3)
17. Boston convened a Team meeting in March 2016. The Team issued an IEP that changed Student's disability category from ASD to "emotional impairment," contained goals focusing on "self-regulation" as well as reading, written expression, and math, and proposed an extended evaluation and placement in a therapeutic, substantially-separate classroom. On or about April 6, 2016 Parent rejected the proposed IEP. (P-3, Armentrout)
18. In August 2016, Student was admitted to her current placement in the UMass Adolescent Continuing Care Unit (CCU) at WRCH (WRCH) on "conditional voluntary" status pursuant

to MGL c. 123, §§10 and 11. (Berkowitz, Frankel, Denietolis) This unit is a locked, long-term acute care facility that provides 24-hour, seven-day care that includes psychiatric treatment and monitoring (including nursing care), milieu, family and individual therapy, occupational therapy/life-skills instruction and a school program operated by SEIS.⁴ WRCH is the only locked, long-term psychiatric treatment facility for adolescents in Massachusetts. (Denietolis)

19. Teens admitted to WRCH typically have one of three different profiles. One such profile pertains to adolescents with a long history of complex mental health diagnoses who have been in and out of hospitals or other settings for a long period of time. Student fits into this category. The other profiles describe students who have been court-ordered into the facility to determine competency or for other reasons, and students who have experienced one significant incident (such as a serious crime) prior to hospitalization. (Frankel, Denietolis) Approximately 60% to 70% of youth admitted to WRCH have severe mood dysregulation, suicidality, a history of complex trauma, and/or aggression. A smaller percentage presents with psychosis. (Denietolis)
20. A typical day for Student includes approximately 3.5 hours of academic instruction by SEIS teachers, who are certified in special education, followed by clinical and community skills groups, weekly individual and family therapy. Student's food intake at meals is monitored because of her history of food restriction. When Student's behavior has been safe, she is able to go on community outings with staff and other students. Student also has earned passes to go home for day and overnight visits. The programming for Student and others at WRCH is highly structured and integrated. Milieu staff, teachers, and clinicians meet regularly with the Clinical Director, Brian Denietolis, to ensure that each student's goals are consistently addressed across all settings. Milieu counselors attend academic classes with students to provide in-the-moment therapeutic intervention if needed and help redirect an upset or dysregulated student back to academic tasks as quickly as possible. (Frankel, Denietolis)
21. In October 2016, after Student had spent approximately two months at WRCH, she was evaluated by a BPS psychologist, Agnes Martin, Ph.D. (Martin, S-10) Dr. Martin administered a battery of standardized tests of Student's cognitive, academic, adaptive, and emotional functioning. Student's overall cognitive functioning as measured by the WISC-5 fell in the "Very Low" range. Student also performed below same-aged peers in academics, executive functioning, adaptive and social skills. Dr. Martin cautioned that these scores might underestimate Student's true potential, in light of her history of language impairments, emotional instability, trauma, multiple hospitalizations, and interrupted schooling. Dr. Martin viewed Student as "sad, anxious and vulnerable." Dr. Martin recommended a highly structured educational program with access to 1:1 instruction, continued medication monitoring, and social skills development infused in all school-based activities. (Martin, S-10)
22. There is no dispute that Student has made substantial progress in WRCH. At the time of her admission in August 2016, Student was engaged in chronic self-harm in the form of food

⁴ SEIS stands for Special Education in Institutional Settings, and is the program operated by the Department of Elementary and Secondary Education to provide educational services to students placed in facilities run by state agencies such as, for example, DMH and the Departments of Public Health and Youth Services.

restriction, suicidality, and mood dysregulation. She presented as highly anxious, not communicative, easily dysregulated, and either aggressive or withdrawn. Currently, Student's anxiety level has been reduced enough to enable her to attend school daily and participate in groups and activities. She is able to leave WRCH on community outings on a regular basis. While still socially anxious, Student is able to connect with certain peers and communicate with staff. Student has had episodes of dysregulation as recently as March 2017, but these episodes last a day or two as opposed to several weeks when Student was at BCH. (Frankel, Denietolis)

23. Student actually began making progress in the WRCH within a few months after her admission. In December 2016, in order to begin planning for Student's next step, as well as to develop an updated IEP, BPS convened a Team meeting to consider Dr. Martin's evaluation, a speech-language and ABA evaluation as well as the assessments of Student's clinical providers, and SEIS staff. WRCH clinical staff reported that Student was making slow, steady process and that they would consider discharge to an appropriate placement. WRCH asserted that Student would still require 24-hour monitoring in her next placement, and that she could not return home safely because she became dysregulated too easily there. SEIS staff reported that Student attended class regularly and was engaged with the curriculum. She needed support with writing and multi-step problem solving. The ABA assessment indicated that Student did not require ABA-based instruction. Speech-language evaluation showed that Student had overall below-average language skills, but also had skills that were intact and adequate for accessing the curriculum. (S-4)
24. On December 16, 2016 BPS issued an IEP providing goals in self-regulation, reading, writing, and math; therapeutic supports and multiple accommodations. The IEP proposed placement in the McKinley School therapeutic day program. Parents rejected the IEP and placement in January 2017. The basis for rejection was the absence of a residential component. (S-6)
25. Throughout Student's school career, Parents had sought assistance for her from many sources. They first sought services for Student from DMH prior to Student's first round of hospitalizations. DMH rejected their initial application. (Berkowitz) Staff from BCH initiated a second application for DMH services on behalf of Student while she was hospitalized there. DMH also rejected that application. At least part of the rejection was based on Student's past diagnosis of ASD, which, according to DMH regulations, usually is not one of the psychiatric conditions that makes an individual eligible for services from that agency. Rather, persons whose major functional impairments are caused by ASD are generally served by DDS. Parents are now awaiting a fair hearing on the rejected application (Berkowitz) Student was eligible for placement at WRCH, which is a DMH-operated facility, by virtue of a "special exception," by which otherwise ineligible persons may be hospitalized in a DMH facility if required for safety and/or treatment that is not available elsewhere; however, such hospital admission does not translate into eligibility for ongoing services. (Berkowitz, Denietolis)
26. In January 2017, in an effort to clarify whether or not Student's diagnosis of ASD is currently accurate as well as to make recommendations for future services, DMH contracted with Neuropsychology and Education Services for Children and Adolescents (NESCA),

located in Newton, MA to conduct an independent neuropsychological evaluation of Student. (Berkowitz, Geragosian, P-4)

27. The NESCA evaluation was conducted on January 30 and February 6 2017 by Jessica Geragosian, Psy.D. Dr. Geragosian reviewed Student's records and past evaluations, interviewed Parents, Student, and providers at WRCH, and administered a battery of standardized tests and rating scales, including the ADOS-2. In her report, Dr. Geragosian concluded that Student had a complex profile that "can be best understood in the context of diagnoses of Language Disorder, Borderline Intellectual Functioning and Developmental Trauma Disorder." She concluded in addition that "[w]hile her behavior at times certainly reflects that which is common for a child with ASD, [Student] does not appear to have a primary social deficit. Rather, her social deficits appear to be subsequent to a chronic language disorder, very significant anxiety, and poor adaptive problem solving...she does not present with restricted interests or stereotypes typical of children on the spectrum." (P-4)
28. Dr. Geragosian stated that Student should be considered "at high and imminent risk of imminent physical harm to herself if her emotional needs are not sufficiently supported." In the absence of such support, Student will be at risk both of repeated hospitalizations and of having patterns of emotional dysregulation becoming increasingly ingrained. (P-4)
29. Dr. Geragosian further opined that "[d]ue to the severity of her trauma, anxiety, and psychological vulnerability, [Student] requires placement in residential therapeutic school...on account of the ongoing nature of [Student's] challenges and the need for 24/7 support in order to manage anxiety and help her self-monitor...[and] reduce...crisis states...[and]...reliance on maladaptive coping strategies...Returning back to the home setting at this time would be extremely dangerous given the ongoing conflict and potential for retraumatization." (P-4)
30. In her testimony, Dr. Geragosian elaborated that Student needs residential placement in a structured therapeutic program that can provide in-the-moment behavioral support, and social coaching throughout the day, and not just in the classroom setting during school hours, in order to teach Student how to generalize her coping and social skills. To the extent possible, peers should not have acting out behaviors. Dr. Geragosian opined that Student's therapeutic and learning needs are so closely intertwined that they must be addressed in a single, integrated setting. A therapeutic day school combined with a group home would not be sufficiently integrated to meet Student's needs at this juncture. (Geragosian)
31. Dr. Berkowitz disagreed with Dr. Geragosian's diagnostic conclusions that Student does not have ASD, and wrote a response to Dr. Geragosian's report on April 3, 2017 in which she stated, in essence, that Student's developmental trauma, anxiety, and other challenges co-existed with ASD, and that these multiple disabilities potentiated each other. For example, Dr. Berkowitz stated that "having the social impairments inherent in an ASD is extremely stressful and sets the individual at risk for traumatic experiences...When life stressors are metabolized through a lens of severely impaired social and language functioning, comprehending and coping is increasingly difficult, so the individual has great difficulty resolving the ensuing, intense anxiety. Even typical social interactions can be quite anxiety

provoking. As the concept of [Developmental Trauma Disorder] asserts, the subsequent anxiety further impairs social and cognitive development...(D-2)

32. Dr. Berkowitz based her disagreement with Dr. Geragosian on her interpretation of the latter's testing and in light of Student's history. (She had met Student on a few occasions, but did not conduct formal testing). Despite this disagreement, Dr. Berkowitz agreed with Dr. Geragosian's recommendation for Student's treatment consisting of placement in a therapeutic residential school where social and therapeutic interventions are available during all waking hours and skills are reinforced across all settings. (D-2, Berkowitz) She further agreed with Dr. Geragosian that Student's placement should be "trauma informed." Dr. Berkowitz emphasized, however, that such a setting should serve a population with a "high representation of youth with ASD's," and provide "intensive ASD-relevant social skills training" in addition to academic, language, and therapeutic supports. With respect to the peer group, Dr. Berkowitz stated that placement with peers who are more socially competent than Student yet prone to acting out would be counterproductive, as such a peer setting might set Student up for bullying and isolation as well as expose her to the detrimental influence of "dramatic scenes and behavioral modeling." (Berkowitz, D-2)
33. Brian Denietolis, Psy.D., is the clinical director of the Adolescent CCU at WRCH. His educational and professional background includes clinical training in neurodevelopmental evaluation of children with ASD as well as post-doctoral work in the area of developmental trauma.⁵ Dr. Denietolis testified regarding Student's "marked progress" in achieving behavioral stability while at WRCH. He stated that Student benefited from the close coordination among clinicians, milieu staff and SEIS teachers that takes place at WRCH. He went on to state that she was ready for discharge to an "open residential" school setting that would provide educational, therapeutic, and developmental services in a single, integrated setting. Despite Parents' support for and commitment to Student, discharge to the home would be unsafe. Student's ability to self-regulate has improved but is still too fragile for the home setting. Additionally, she will continue to need monitoring of various factors affecting her safety including food intake and medication. Further, Dr. Denietolis testified that for Student to generalize mood and behavioral regulation skills from one setting to another, educational and treatment staff needed to work closely together in the same setting, and that "bifurcated care" involving, for example, a DMH group home would be ineffective and possibly unsafe for Student. (Denietolis)
34. On the other hand, Student does not require a locked or hospital setting and does not qualify for a DMH-operated Intensive Residential Treatment Program (IRTP) because she no longer meets the "commitability" standard required for admission to such a facility. When asked for examples of unlocked, open residential schools that would additionally be able to provide the level of medical and safety oversight that Student requires, Dr. Denietolis mentioned Dr. Franklin Perkins, and Glen Haven Academy. (Denietolis)
35. Sarah Jane Frankel, LICSW, has been Student's individual therapist and family co-therapist since Student's admission to WRCH in August 2016. Ms. Frankel described in some detail

⁵ Dr. Denietolis agreed with Dr. Geragosian's view that Student does not carry a current ASD diagnosis, based on test results, his prior experience evaluating children on the autism spectrum, and his observations of Student at WRCH. (Denietolis)

how staff coordination takes place at WRCH. She testified that each resident (including Student) is assigned a primary counselor from the milieu staff for the morning and the afternoon. The primary counselors accompany students to the SEIS classrooms to work with teachers and students on generalizing goals from the residential portion of the program. Additionally, the clinical director, Dr. Deneitolis, meets with each SEIS teacher monthly to work on integrating student goals across settings. He also conducts weekly informal “curbside consults” with SEIS staff. (Frankel)

36. Ms. Frankel testified that she agreed with the WRCH team position that Student was ready for discharge to a less restrictive setting, but that she could not safely return home at this time because a home and family setting is not structured enough to prevent and/or contain Student’s emotional reactivity to small stressors, monitor her food intake, and otherwise keep her safe. She noted that Student’s only recent episodes of dysregulation (which took place in March 2017) occurred in conjunction with home visits. Ms. Frankel stated that she believed Student should attend a residential school where all services are on site in a single setting, and where Student would have access to individual and family therapy as needed, psychiatric oversight, nursing services to monitor food intake, and close coordination of educational and therapeutic services. (Frankel)
37. Parents support recommendations for a residential school. They are deeply committed to Student’s health, well-being, and education, have visited her at least every other day at WRCH, have participated in weekly family therapy, and have attended virtually all Team meetings and other meetings to which they have been invited. (Mother, Denietolis) Although they want her to come home when she is ready to do so, Parents agree with Student’s clinicians that Student cannot currently live at home without compromising her safety. (Mother)

38.

PROGRAM REQUESTED BY PARENTS

Parents seek placement in an approved private residential school that is capable of providing Student with integrated special education programming and clinical support so that Student can generalize her academic and social/emotional skills across all settings as recommended by Drs. Denietolis, Geragosian, and Berkowitz. Parents have not designated any particular facility, and seek to have the Team send referrals to several potentially appropriate placements.

PROGRAM PROPOSED BY BOSTON PUBLIC SCHOOLS

In December 2016, BPS issued an IEP calling for placement at the substantially separate McKinley Middle School in a therapeutic program. On April 7, 2017, after reviewing Dr. Geragosian’s report, BPS again issued an IEP proposing the McKinley placement. The McKinley School serves BPS students who have a variety of psychiatric, social/emotional, behavioral and learning needs. BPS would be able to implement the recommendations of Dr. Geragosian within the McKinley program by providing Student with small classes with like peers, special education services, and extensive therapeutic supports, social skills instruction, and the like. Student would not be grouped with “acting out” peers.

In BPS view, Student's relative stability, appropriate behavior, and ability to access instruction within BPS classrooms when she had attended as well as in the classes operated by SEIS all indicate that she can make effective educational progress in a day school setting. To the extent that Student has residential needs, including medication monitoring and nursing oversight of food intake, these needs are medical and/or clinical and not educational in nature. It may be that Student cannot currently live at home, but any needs that she may have for out-of-home supports are separate and distinct from her educational requirements. (Armentrout)

POSITION OF DMH

Because DMH has found Student ineligible for its services it has not formally proposed any educational programming for Student. To the extent that Dr. Berkowitz represents DMH, she endorses a residential educational program that serves a significant number of students who have ASD and function similarly to Student and that offers intensive social skills and language instruction geared towards students with ASD.

DISCUSSION

There is no dispute that Student is a school-aged child with a disability who is eligible for special education and related services pursuant to the IDEA, 20 USC Section 1400, *et seq.*, and the Massachusetts special education statute, M.G.L. c. 71B ("Chapter 766"). Student is entitled, therefore, to a free appropriate public education (FAPE), that is, to a program and services that are tailored to her unique needs and potential, and is designed to provide 'effective results' and 'demonstrable improvement' in the educational and personal skills identified as special needs." 34 C.F.R. 300.300(3)(ii); *North Reading School Committee v. BSEA*, 480 F. Supp. 2d 489 (D. Mass. 2007); citing *Lenn v. Portland School Committee*, 998 F.2d 1083 (1st Cir. 1993).

While Student is not entitled to an educational program that maximizes her potential, she is entitled to one which is capable of providing not merely trivial benefit, but "meaningful" educational benefit. See *Andrew F. v. Douglas County School District RE-1*, 69 IDELR 174 (March 22, 2017), *Bd. of Education of the Hendrick Hudson Central School District v. Rowley*, 458 US 176, 201 (1982), *Town of Burlington v. Dept. of Education*, 736 F.2d 773, 789 (1st Cir. 1984); 675 F.3d 26, 34 (1st Cir. 2012). Whether educational benefit is "meaningful" must be determined in the context of a student's potential to learn. *Rowley, supra*, at 202, *Lessard v. Wilton Lyndeborough Cooperative School District*, 518 F.3d 18, 29 (1st Cir. 2008); *D.B. v. Esposito, supra*. As the U.S. Supreme court recently held in *Andrew F.* at 69 IDELR 174, even if a child is not likely to progress at the same rate as non-disabled peers, his or her goals should be "appropriately ambitious in light of [his or her] circumstances, just as advancement from grade to grade is appropriately ambitious for most children in the regular classroom. The goals may be different, but every child should have the chance to meet challenging objectives." *Id.* In cases where a student's potential to learn is difficult to determine because, for example, the student's disability is complex and not fully understood, or the student has communication deficits or behaviors that interfere with his or her ability to express thoughts, it is still possible to "assess the likelihood that the IEP will confer a meaningful educational benefit by measurably

advancing the child toward the goal of increased learning and independence.” *D.B. v. Esposito, supra*. Finally, eligible children must be educated in the least restrictive environment (LRE) consistent with an appropriate program; that is, students should be placed in more restrictive environments, such as private day or residential schools, only when the nature or severity of the child’s disability is such that the child cannot receive FAPE in a less restrictive setting. On the other hand, the opportunity to be educated with non-disabled students does not cure a program that otherwise is inappropriate. *School Committee of Town of Burlington v. Dept. of Education of Mass.*, 471 U.S. 359 (1985).

When evaluating whether or not a residential placement is appropriate for a particular student, a court or hearing officer must determine whether around-the-clock services are necessary to enable the student to make meaningful educational progress in the areas identified as special needs, or whether the problems that a student might have outside of the school setting are “separable from [the student’s] educational problems.” *Gonzalez v. Puerto Rico Dept. of Education*, 254 F.3d 350, 352-353 (1st Cir. 2001)

A recent BSEA decision making such an analysis is the matter of *Agawam Public Schools*, BSEA No. 1403554, 20 MSER 1, 10-13 (Crane, 2014). In the *Agawam* case, the student carried multiple diagnoses, including ASD with severe, pervasive, dangerous behaviors and significant intellectual disability. The school district had proposed a specialized day placement coupled with a program to train the parents to implement behavioral strategies in the home. The hearing officer in *Agawam* found that given the severity of the child’s behaviors, there was no evidence to conclude that parents could manage and correct the problematic behaviors or even keep their child safe at home. He also found that:

Student’s behavioral deficits, as manifested at school, in the community and at home, are not separate and distinct from but rather are inextricably intertwined with his learning needs—in fact, his behavioral needs are presently his most critical educational needs. I find that it is only through services that can allow Student to be safe and that reduce his aberrant behaviors that he will have the opportunity to engage in meaningful learning. And, the only way that Student’s behavior needs can be appropriately and safely addressed is through an around-the-clock residential educational placement.” *Id.*, p. 13.

Although Student in this case has a very different profile from the student in *Agawam*, the cases have striking parallels. As was the case in *Agawam*, Student in this matter has multiple impairments that exacerbate one another and compromise her ability to make academic progress. She has longstanding struggles with emotional and behavioral lability, severe anxiety, receptive and expressive language disorders, learning disabilities, and borderline intellectual functioning. Additionally, Student has been affected by trauma. When Student is emotionally dysregulated, she restricts her food and fluid intake, putting herself at risk medically. She has a history of suicidal ideation and gestures so frequent and pervasive that she needed 1:1 supervision while she was an inpatient at BCH. Student missed an entire year of school because of her psychiatric and emotional condition, and was unable to access any academic services until she was stabilized in the locked, highly structured setting of WRCH. In the instant case, there is virtual unanimity

among the witnesses who know and who have worked with Student that her educational needs are inextricably intertwined with her clinical and psychiatric needs. Every witness who either evaluated Student or spent time with her on a daily basis, including Dr. Geragosian, Mother, Sarah Jane Frankel, Dr. Denietolis, Dr. Martin and Dr. Berkowitz testified that Student could not access academic education unless she was emotionally stable, and that to a great extent, such stability had to be taught and learned via individual and group therapy as well as in-the-moment coaching. (See testimony of Deneitolis). As was the case in *Agawam*, learning how to self-regulate was and perhaps is one of Student’s “most critical educational needs,” as evidenced by IEPs that identified “self-regulation” both inside and outside the classroom as Student’s primary educational goals. *Agawam, supra*.

Moreover, the evidence overwhelmingly establishes that Student’s intertwined needs can only be met in the context of an appropriate residential school placement. There is no dispute that Student cannot safely go home. Moreover, the virtually unanimous testimony of the witnesses referred to above was that such a placement is necessary both to keep Student safe and to enable her to generalize self-regulation, social and emotional skills from one setting to another,⁶ and that a “bifurcated” placement involving a therapeutic day school combined with a group home would be too fragmented to meet Student’s needs. Clearly, Parents and Student have more than met their burden of demonstrating that Student needs a residential placement for educational reasons, and that BPS is responsible for providing such a placement.

At this juncture, it is appropriate to address the issue of DMH involvement with Student’s case. DMH has determined that Student has not met its eligibility criteria. Parents have requested a fair hearing to contest the finding of ineligibility, but no evidence was provided in this matter as to when DMH will conduct the hearing or issue a decision. According to the testimony of Dr. Berkowitz, one reason for DMH’s finding that Student is ineligible for its services is Student’s 2013 ASD diagnosis by Dr. Devine. Dr. Berkowitz testified that an individual may not be eligible for DMH services if ASD is the primary cause of his or her functional impairment; rather, services for such individuals are the responsibility of DDS.

It is beyond the scope of this Decision or the authority of the BSEA to take issue with DMH eligibility criteria or to dispute the allocation of resources and responsibilities between DDS and DMH. It is noteworthy, however, that to date, DMH has stood by its initial adoption of a 2013 ASD determination by a neuropsychologist who did not testify at the hearing, despite persuasive conclusions to the contrary by professionals who were either employed by or under contract with DMH and who either conducted extensive evaluations (*i.e.*, Dr. Geragosian) or worked with Student on a daily basis at WRCH, (*i.e.*, Dr. Denietolis and Sarah Frankel). Despite the 2013 ASD label, the credible evidence on the record is that at present, Student’s intertwined mental health issues (*e.g.*, anxiety, emotional dysregulation, food restriction, and effects of trauma) and learning issues (*e.g.*, learning disabilities, language impairments, and borderline cognitive functioning) are the reasons for her need for residential placement. It is also clear from the record that even within a residential placement, Student will need the types of clinical

⁶ Boston’s assertion that Student could make effective progress in its proposed McKinley School placement because she behaved well in the SEIS classroom at WRCH is not supported by the record, which clearly shows that Student was only able to access instruction in the SEIS classroom because of the massive therapeutic supports that she received during all waking hours. (See testimony of Denietolis and Frankel).

supports and safety-related supervision that DMH can provide in programs such as Dr. Franklin Perkins, Walden Street, and Glen Haven, whether or not she was given an ASD diagnosis four years ago. (See testimony of Dr. Denietolis)

CONCLUSION AND ORDER

Based on the evidence in this matter I conclude that Parents have proved that Student needs a residential educational placement in order to receive FAPE in the LRE. Boston shall immediately issue referral packets to appropriate, approved therapeutic residential school programs that can provide the Student with services similar to those outlined by Drs. Geragosian and Denietolis as well as by Ms. Frankel.

By the Hearing Officer:

Sara Berman

Date: May 8, 2017

