

DISABILITY LAW

SECTION NEWSLETTER

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Shelby and the 3:1 Model: One-Size-Does-NOT-Fit-All

By Lana L. Traynor



Lana L. Traynor

In 2001, speech-language pathologists in Portland Public Schools (Oregon) piloted a new district-wide service delivery model, called the “3:1 Model.” See Annett, M., *Service Delivery Success: SLPs in Oregon Schools Tackle Workload, Enhance Recruitment*, The ASHA Leader, pp. 1, 12-13 (March 2, 2004). Under this 3:1 Model, public schools provide “direct” services to qualifying students on Individualized Education Programs (IEPs) in the areas of occupational therapy (OT), physical therapy (PT) and/or speech-language therapy (SLP) for three weeks. During the fourth week, the related service providers perform “indirect” or “consultative” services. The 3:1 Model, according to the American Speech and Hearing Association (ASHA) website, promotes “increased job satisfaction and staff retention” for public school districts. (February 15, 2009).

In November 2006, ASHA sought guidance from the Office of Special Education and Programs (OSEP) about the appropriateness of the 3:1 Model under the Individuals with Disabilities Education Act (IDEA). In March 2007, OSEP clarified that, “the type of related service, as well as the amount and location of services” must be “based on a child’s individual and unique needs, and cannot be made as a matter of general policy by administrators, teachers or others apart from the IEP Team process.” See Letter to Clarke, 107 LRP 13115 (March 8, 2007) (*quoting* Fed. Reg. 46575 (Aug. 14, 2006)).

Nearly seven months later, the Puyallup School District (Puyallup) in Washington State implemented the 3:1 Model as a general, district-wide policy. In October 2007, Puyallup sent a “form” letter to Shelby’s parents (and other similarly-situated families), stating that its new 3:1 Model would take effect on November 19, 2007. In Shelby’s case, the District included a Prior Written Notice and a new IEP service summary page (to reflect three weeks of direct services and one week of indirect service) with its form letter. Puyallup administration explained that it could implement the 3:1 Model outside the IEP process because it merely altered the *location* of Shelby’s related services (not the total number of service minutes).

In October 2008, Shelby’s parents filed a Special Education Citizen Complaint with the Office of Superintendent for Public Instruction (OSPI). OSPI subsequently struck down the District’s one-size-fits-all 3:1 Model and concluded that the “District violated procedures for amending or revising the Student’s IEP when it failed to include the Parent in a meeting to address the changes to OT and speech services.” See Citizen Complaint No. 08-47, at p.7. (December 8, 2008).

Continued on next page

OSPI also noted that the District's desire to secure special education funding "rather than ensuring that it involved the Parent in the annual [Spring 2008] IEP meeting" meant that Shelby did not have a current IEP in place at the beginning of the 2008-2009 school year. *Id.* at 8.

As part of its corrective action plan, OSPI ordered Shelby-specific remedies, including: compensatory education for

"direct" OT and SLP services; an IEP meeting, and; removal of Shelby from the District's "count" for special education state funding for the 2008-2009 academic year. *Id.* OSPI also ordered several District-specific corrective actions, including: policy and procedure review; staff training, and; IEP-reviews for all students subjected to the 3:1 Model. *Id.* at 10. In the end, the 3:1 Model cost the Puyallup School District time, money and parent-relationships.

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New Right to Hearing on Medications Fosters Dignity & Communication at State Psychiatric Facilities

By Rebecca Lease

Jane sat quietly with me and another attorney in a room at Oregon State Hospital, holding a towel that she used to wipe away saliva that dripped from her mouth. We were meeting to discuss her legal challenge to the hospital's decision to force treatment on her that she did not want. Unable to speak, she wrote slowly on a notepad in front of her, "What are my chances?" We did not know how to respond because Jane was the first patient to use a new administrative procedure to challenge the hospital's decision to subject her to involuntary medication. See: Oregon Administrative Rules 309-114-0000 through -0030.

It was December 2007, and the OARs had just been modified to ensure that residents of state psychiatric facilities have the right to procedural due process before being involuntarily administered a "significant procedure" like psychotropic medication or electroconvulsive therapy. Psychotropic medications are commonly used to treat symptoms of mental illnesses like schizophrenia and bipolar disorder. These medications are highly intrusive in that they alter the chemical balance in the brain and may cause significant and potentially fatal side effects.

The Supreme Court addressed the

rights of prisoners with mental illness "to be free from the arbitrary administration" of psychotropic medications in *Washington v. Harper*. 494 U.S. 210, 221 (1990). The Court held that there is a "significant liberty interest in avoiding the unwanted administration" of these medications, and the Fourteenth Amendment guarantees the right to procedural due process prior to being treated with them involuntarily. *Id.*, at 221-2. This liberty interest can only be infringed after an inmate is provided an opportunity for due process, which must include minimum procedural safeguards. *Id.*, at 228-36

Prior to the rule changes, a patient's treating psychiatrist conducted an evaluation of the patient's capacity to give or withhold informed consent to treatment. If the doctor found that the patient lacked capacity, an independent consultant would then evaluate the patient. If these doctors agreed that the patient could not give or withhold informed consent, the individual would receive notification from the chief medical officer or hospital superintendent that the hospital intended to treat the patient with psychotropic medications. After receiving this notice, the patient would not be allowed to refuse medica-

tions that the doctor prescribed. For some patients, this meant they were injected with psychotropic medications without their consent. Revisions to the OARs were necessary because a patient had no effective means to challenge the hospital's decision to administer these involuntary treatments.

The revised OARs provide that the state can involuntarily administer psychiatric medications if it can demonstrate that "good cause" exists. The state must show that the person lacks capacity, or the ability to understand and reasonably weigh the risks and benefits of the proposed treatment. It must also prove that the proposed treatment is likely to restore or prevent deterioration of the person's mental or physical health, that it is the most appropriate treatment according to current clinical practice, and that no other less restrictive treatment would be effective. OAR 309-114-0020.

Patients now have the right to a hearing in front of an independent decision-maker prior to being administered psychotropic medications without their consent. OAR 309-114-0025. Specially trained administrative law judges travel to state psychiatric institutions to conduct hearings and an attor-

ney is appointed to represent the patient. Hearings must be conducted within fourteen days of the date that the patient submits a request for hearing, and a written order is to be delivered within two business days following the hearing. The patient has the right to appeal any unfavorable decision to the Oregon State Court of Appeals. Even if a patient is required to accept medication, his or her capacity to consent to treatment must be reviewed at least once every 180 days thereafter.

For Jane, this hearing was a significant event. She was diagnosed with schizoaffective disorder many years ago, and the side effects of the medications that she was forced to take were severely impacting her quality of life. She sometimes heard frightening voices and acknowledged that psychotropic medication can help reduce the intensity and frequency of those voices. Jane was unable to speak due to a progressive neurological condition and relied on her ability to write or type to communicate. Her medications caused a significant hand tremor that made it extremely difficult for her to communicate with others. Jane, an accomplished artist, was also robbed by the tremor of her ability to paint and draw, an activity that gave her solace. In addition, she experienced

drooling caused by the medications, which she found very embarrassing.

At her hearing, Jane informed the judge that she believed medication had been helpful to her in the past and likely would be in the future. In the dosages and combinations that she was being forced to take, however, she was experiencing such significant side effects that the benefits of having fewer psychiatric symptoms no longer outweighed the risks of the treatment. The judge was convinced that Jane had the capacity to give or withhold her consent to treatment and ruled in her favor. As a result, Jane did not stop taking medicine. She was able to work with her treating psychiatrist to identify a dosage of medication that quieted the voices to the point that they were no longer disturbing to her with only minimal drooling and tremors.

For Jane and other patients who are able to demonstrate their ability to understand and weigh the risks and benefits of the proposed treatment, the new involuntary treatment procedures have been life altering. Jane reported that she now feels listened to and respected, and she values her new-found ability to work closely with her doctor to manage her psychiatric symptoms.

Even patients who were unable to demonstrate capacity at a hearing have indicated that they appreciated the right to be heard and file an appeal if they were dissatisfied with the judge's decision. And finally, even doctors have shared that they learn things about their patients during hearings that they might not have learned otherwise.

Today, doctors in state facilities continue to evaluate their patients' capacity to give or withhold consent to medication, and request that outside consultants evaluate those patients that lack capacity. Patients report a greater willingness on the part doctors to work collaboratively. As part of this process, some patients choose to take medication and others work with their physician to manage their mental health symptoms without psychotropic medications. But the greatest success related to these rule changes is that procedural safeguards are in place to protect the fundamental human rights of patients in state psychiatric institutions.

Rebecca Lease is a staff attorney at Disability Rights Oregon. She represents residents of state psychiatric facilities in administrative hearings.

Forest Grove School District v. T.A.: School District's Refusal to Provide Special Education Services to a Student with Disabilities Triggered Its Liability for the Student's Private School Tuition

By Lana L. Traynor

On June 22, 2009, the United States Supreme Court ruled that a school district was required to reimburse a parent for private services because the district failed to identify a student with disabilities and provide an Individual Education (IEP) as required under the Individuals

with Disabilities Education Act (IDEA). *Forest Grove Sch. Dist. v. T.A.*, 557 U.S. at ___ (slip op., at 16-17) (2009).

Forest Grove elementary and middle school teachers noted the Student's task-completion and attention-related issues. The Student continued to decline during

his freshman year in high school and the Parents requested a special education evaluation of their child. The District declared the Student ineligible for services under the IDEA at the end of his freshman year. The Student's condition worsened during his sophomore and

junior years in high school. As a result, the Parents placed their child in a private facility during his junior year and filed for a Due Process Hearing in April 2003. The District then evaluated the Student and the Parents cooperated throughout the process.

After its evaluation, the District declared the Student ineligible for special education services in July 2003. The District reasoned that the Student's attention deficit hyperactive disorder (ADHD) did not have an adverse impact on his education. The hearing officer reviewed the evidence and concluded that the Student did, in fact, qualify for special education services. The District's failure to identify the Student for special education services violated the IDEA. As a remedy, the hearing officer ordered the District to reimburse the Parents for tuition at the private school, an appropriate placement for the Student. The District appealed, arguing that the hearing officer's tuition reimbursement award was impermissible under the IDEA and its implementing regulations. In support of its argument, the District asserted that the IDEA requires a student to receive special education services from a public entity before a parent can seek reimbursement for a unilateral private placement.

The District Court agreed with the hearing officer's findings, but disallowed the reimbursement for private tuition based on the District's legal reasoning. The District Court reasoned that the 1997 Amendments to the IDEA "categorically bar reimbursement of private-school tuition for students who have not 'previously received special education and related services under the authority of a public agency.'" 557 U.S. at ___ (slip op., at 4) (citations omitted). On appeal, the Court of Appeals for the Ninth Circuit rejected the District Court's interpretation of the Amendments, and reversed and remanded to the District Court. The District appealed the Ninth Circuit's decision to the United States Supreme Court (Supreme Court), which granted certiorari.

The Supreme Court granted certiorari to address the issue of whether a parent might be entitled to reimbursement for private tuition even if a school district had not provided special education services to the child. The "express purpose" of the IDEA is to "ensure that all children with disabilities have available to them a free appropriate public education [FAPE] that emphasizes special education and related services designed to meet their unique needs...[.]" 557 U.S. at ___ (slip op., at 13-14) (citations omitted). The Supreme Court analyzed the IDEA, its legislative history, and subsequent decisional law and concluded that the District's legal arguments lacked merit. The Supreme Court explained:

"Indeed, by immunizing a school district's refusal to find a child eligible for special-education services no matter how compelling the child's need, the School District's interpretation of § 1412(a)(10)(C) would produce a rule bordering on the irrational. It would be particularly strange for the Act to provide a remedy, as all agree it does, when a school district offers a child inadequate special-education services but to leave parents without relief in the more egregious situation in which the school district unreasonably denies a child access to such services altogether." 557 U.S. at ___ (slip op., at 14).



Heidi von Ravensberg

New Fund to Help Defray Cost of Attending ABA National Association of Law Students with Disabilities Conference

By Heidi von Ravensberg, JD

The OSB Disability Law Section Executive Committee has established a fund to help Oregon law students with disabilities who attend the American Bar Association's National Association of Law Students with Disabilities Conference defray their expenses. To learn more about NALSWD or its conference, go to <http://www.nalswd.org/>. To learn more about the fund or submit a request for financial assistance, contact Heidi von Ravensberg, Chair Exec. Cmte. At (541) 346-2472 or email hvr@uoregon.edu.

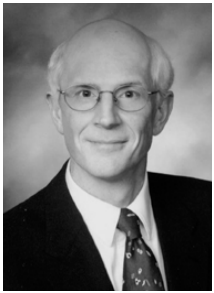
The Supreme Court held that the "IDEA authorizes reimbursement for the cost of private special-education services when a school district fails to provide a FAPE and the private-school placement is appropriate, regardless of whether the child previously received special education or related services through the public school." 557 U.S. at ___ (slip op., at 16).

The Supreme Court affirmed the opinion of the Ninth Circuit and remanded the case to the District Court for consideration of the "equities." 557 U.S. at ___ (slip op., at 17). In balancing the equities, the Supreme Court ordered the District Court to "consider all relevant factors, including the notice provided by the parents and the school district's opportunities for evaluating the child, in determining whether reimbursement for some or all of the cost of the child's private education is warranted." 557 U.S. at ___ (slip op., at 17).

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Oregon Legislative Wrap Up 2009

By Bob Joondeph



Bob Joondeph

(Bob Joondeph has served as Executive Director for Disability Rights Oregon for over 20 years. His thoughts and comments on disability related legal news appears on the web at: www.disabilityrightsoregon.org/the-dro-blog)

The 2009 legislative session was very ambitious despite the economic woes that threatened every public budget. From a disability rights perspective, the session produced three major accomplishments. The first was avoiding major cuts to human services, education and other programs. The second was health care: expansion coverage and advancement of reform efforts. Finally, a group of bills were passed that provide greater protection for vulnerable individuals with disabilities.

Although the legislature cut about \$2 billion from the amount necessary to continue all state services, it was able to maintain core services and expand Oregon Health Plan coverage by passing three major revenue packages. House Bill 2649 increased the income tax that higher-income individuals will pay for the next four years. For households with an adjusted income over \$250,000 or single-filers with adjusted income over \$125,000, the income tax rate rose from 9 to 10.8 percent. This will generate a net of \$472 million for state services.

HB 3405 increased the corporate minimum tax (now \$10) to a sliding scale between \$150 and \$100,000, based on Oregon sales. It also contains a permanent increase in tax rate for corporate net income greater than \$10 million. The current rate of 6.6 percent is raised to 7.6 percent. This bill will generate

about \$261 million for state services.

A third revenue bill allowed Oregon to expand health care coverage to children and low-income adults. House Bill 2116 created a 1% health insurance premium assessment on health insurers, Medicaid managed care plans, and the Public Employee Benefit Board, and set up an assessment on hospitals that receive Medicare funds. The insurance assessment is expected to provide health coverage for 80,000 children during the 2009-11 biennium. The Hospital assessment will allow Oregon Health Plan Standard to double its present enrollment and provide coverage for 50,000 low-income adults during the 2009-11 biennium. Both new assessments are slated to end on September 30, 2013.

The vehicle for major health care policy changes was House Bill 2009.

It creates the Oregon Health Policy Board that is mandated to develop a plan by which the legislature can provide and fund access to affordable health care for all Oregonians by 2015. The Board is also tasked with establishing and refining statewide health care quality standards, establishing evidence-based clinical standards, establishing cost-containment mechanisms to reduce health care costs and ensuring that Oregon's health care workforce has sufficient numbers and training to meet demand for health care.

The Board will work within a newly-created Oregon Health Authority. This new agency will be a reassembly of existing state offices, including the Division of Medical Assistance Programs, the Addictions and Mental Health Division and the Public Health Division that are now in the Department of Human Services; the Oregon Medical Insurance Pool that is now in the Department of Consumer and Business Services; the Office of

Private Health Partnerships; the Public Employees' Benefit Board; and the Oregon Educators Benefit Board. The new OHA is to be operational by June 30, 2011.

HB 2009 directs the Board to begin to implement certain reform initiatives to reduce health care costs and improve the quality of care. These include a statewide Physician Orders for Life Sustaining Treatment registry, a Health Information Technology Oversight Council to promote the use of electronic health records, a Statewide Health Improvement Program to prevent chronic diseases and reduce expensive and invasive acute treatments, a Healthcare Workforce database, and evidence-based health care guidelines for use by health care providers, consumers and purchasers.

The bill directs the collection of health market data to help determine the distribution of resources allocated to health care, identify demands for health care, evaluate the effectiveness of intervention programs, compare the costs and effectiveness of various treatment settings, improve the quality and affordability of health care, and evaluate health disparities—including those related to race and ethnicity.

HB 2009 also directs the Department of Consumer and Business Services to change certain notice and review procedures used in reviewing premium rate filings that are submitted by insurers who provide health coverage for individuals or small businesses

Perhaps the most significant bill creating greater protections for vulnerable Oregonians was House Bill 2442. It was crafted in response to a series of reports in *The Oregonian* finding unacceptable levels of resident abuse in community facilities serving individuals with developmental disabilities.

Disability Law Section Executive Committee

Summer 2009

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Notice:

A CD recording of the "Fibromyalgia, Misconceptions and the Law" CLE held by the Disability Law Section on September 18, 2009 is available for free to Section members, along with accompanying materials. Contact Ted Wenk at 503-243-2081 for information.

The bill creates a Quality Care Fund to support training, technical assistance, quality improvement and licensing enforcement to ensure high standards of care. Increased licensing fees and civil penalties are to be deposited in the fund.

HB 2442 will increase the safety and care of vulnerable residents by expanding the definition of what constitutes abuse for elderly persons and persons with developmental disabilities. It provides immunity from civil liability for

facility operators who disclose substantiated findings of abuse by their employee or former employee to a prospective employer. It prohibits the use of public funds to pay caregivers who have been convicted of serious crimes and sets standards for communications between the state, law enforcement and district attorneys concerning abuse reports. District attorneys are also directed to establish a multidisciplinary team to develop a protocol for investigating and notifying persons of abuse procedures.

The following is a list of bills of particular interest to the disability community that have been signed by the Governor. The date upon which they become law is noted for each.

DISABILITY RIGHTS OREGON BILLS

BILL #	SUMMARY	EFFECTIVE DATE
SB 874	Changes unlawful discrimination laws that determine if individual is person with disability to be more similar to federal Americans with Disabilities Act	January 1, 2010
SB 287	Imposes requirements for licensure of person to operate multiple residential facilities in state.	January 1, 2010
SB 288	Authorizes individual with mental illness who is committed to DHS to be represented by specified persons in contested case hearing with respect to potentially unusual or hazardous treatment.	January 1, 2010

OTHER BILLS

BILL #	SUMMARY	EFFECTIVE DATE
HB 2009	Establishes Oregon Health Authority Board and Oregon Health Authority	June 26, 2009
HB 2052	Requires Local Public Safety Coordinating Council to be consulted before siting a secure PSRB facility.	January 1, 2010
HB 2059	Requires licensee of health professional regulatory board to report prohibited conduct to board.	January 1, 2010
HB 2137	Provides immunity from civil liability for person who provides protected health, mental health, financial or legal information to DHS or office of public guardian in connection with protective proceeding.	June 24, 2009
HB 2139	Modifies grounds for court to order appointment of a trustee and allows for appointment of a temporary manager by DHS for long term care facility or residential facility. Increases penalties.	January 1, 2010
HB 2144	Requires certain state agencies to cooperate in wraparound initiative for youth services.	January 1, 2010

HB 2343	Modifies definition of “mentally incapacitated” for purposes of sex crimes. Protects persons who cannot give consent due to incapacity brought on by voluntary behavior such as intoxication.	January 1, 2010
HB 2345	Directs DHS to create Impaired Health Professional Program	July 14, 2009
HB 2441	Permits prosecution of sex crimes based solely upon a confession when victim is incapable of testifying due to status as a vulnerable person.	January 1, 2010
HB 2442	Establishes Quality Care Fund for Protective Services	July 28, 2009
HB 2535	Creates Charitable Prescription Drug Program	June 17, 2009
HB 2599	Requires school districts to include specified elements in anti-bullying policies.	July 1, 2009
HB 2666	Creates work group on perinatal mental health disorders within Department of Human Services.	June 26, 2009
HB 2853	Requires information regarding commitments and convictions to be sent to FBI to prevent illegal gun sales.	January 1, 2009
HB 2883	Creates Public Guardian and Conservator Task Force.	June 17, 2009
HB 3114	New protections for overmedication of children in foster care	June 30, 2010
HB 3353	Creates Alcohol and Drug Policy Commission	July 28, 2009
HB 3466	Requires Dept. of State Police to create health database to aid law enforcement agencies in assisting persons with disabilities who need assistance in obtaining services.	January 1, 2010
SB 16	Adds authorization for treatment of dementia to advance health care directive	July 18, 2009
SB 23	Establishes Oregon Patient Safety Commission	January 1, 2010
SB 24	Requires health plans to cover telemedical health services	January 1, 2010
SB 25	Establishes Oregon State Hospital Advisory Board	July 14, 2009
SB 58	Conforms state law to Federal Fair Housing Act regarding reasonable modifications of rentals; reasonable modification of rules, policies, practices or services; failure to design and construct multifamily dwellings as required by FHA.	May 21, 2009
SB 72	Reduces responsibilities of ESD for purposes of special education.	June 16, 2009
SB 77	Establishes process to declare public safety services emergency in fiscally distressed counties.	July 23, 2009
SB 87	Requires MH provider to cooperate with death investigations.	June 4, 2009
SB 123	Requires DHS to release records related to child abuse to Teacher Standards and Practices Commission for investigations	June 18, 2009
SB 160	Requires DHS to adopt rule to authorize HIV testing of residents of certain state institutions	March 24, 2009
SB 162	Prohibits DHS and AAA from disclosing confidential information when providing public access to abuse investigations or reports	January 1, 2010
SB 165	Requires DHS to provide or contract for DD services of community program declines to do so.	January 1, 2010
SB 238	Enacts Uniform Adult Guardianship and Protective Proceedings Jurisdiction Act.	January 1, 2010
SB 275	Permits inmates to apply for medical benefits before discharge.	June 18, 2009
SB 277	Requires places of public accommodation to allow customer to toilet facilities if customer has certain medical conditions.	January 1, 2010
SB 348	Requires training for coaches to recognize TBI.	July 1, 2009
SB 355	Establishes prescription monitoring program.	July 23, 2009
SB 381	Requires health benefit plan to provide coverage of medically necessary treatment for TBI.	June 18, 2009
SB 512	Requires notice to school when a youth is charged in juvenile court.	June 23, 2009
SB 731	Prohibits bank for honoring garnishment order for certain funds that are exempt from garnishment under federal law.	January 1, 2010
SB 734	Requires health insurers to cover tobacco cessation programs.	June 24, 2009
SB 911	Requires DHS to adopt rules for PSRB secure residential facilities	January 1, 2010

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