Administrative Policies and Procedures: 19.6

Subject:	**Placement of Mentally Retarded Youth**
Authority:	TCA 33-3-401, 33-3-402, 37-5-106
Standards:	ACA 4-JCF4D-06; DCS Practice Standard 7-122D; 7-125D, 8-306
Application:	To All Department of Children's Services Staff

Policy Statement:

Youth with a diagnosis of Mild Mental retardation shall not be placed in a youth development center without a waiver. The Central Office Population Management Committee shall have full authority to review and approve waiver requests for mentally retarded youths referred for admission to youth development centers. Youth with a diagnosis of Moderate, Severe, or Profound Mental retardation shall be referred to the Department of Mental Health and Mental Retardation (DMRS) for placement in a suitable facility. Youth with the diagnosis of Mild Mental Retardation shall be placed in the least restrictive environment that can meet their treatment and security needs. No mentally retarded youth shall be placed at Taft.

Purpose:

The overall goal for each case is to ensure that the least restrictive service placement and treatment milieu for each youth is accomplished or approval is requested for a waiver for placement in a more restrictive environment.

Procedures:

A. DCS Mental Retardation Coordinator

The DCS Mental Retardation Coordinator must:

1. Coordinate service delivery for all delinquent youth diagnosed as mildly mentally retarded;
2. Provide expertise to DCS staff in matters concerning delinquent youth diagnosed as mildly mentally retarded;
3. Collect statistics regarding the identification, placement, treatment, and release of delinquent youth diagnosed as mildly mentally retarded.

B. Review of Records

1. Moderate, severe or profound mental retardation

All youth diagnosed with moderate, severe or profound mental retardation must be referred to the Department of Mental Health and Mental Retardation(DMRS)

2. Mild mental retardation

a) When a delinquent youth assessed as mildly retarded is admitted to a

	youth development center, the YDC classification supervisor/ designee must immediately notify the DCS Mental Retardation Coordinator and FAX a copy of the youth's records as outlined in section *B, 3*, to DCS central office. b) When a delinquent youth assessed as mildly retarded is admitted to a DCS group home, the group home supervisor or designee must immediately notify the DCS Mental Retardation Coordinator in the central office and FAX a copy of the youth's records as outlined in section *B, 3* to DCS central office. c) The DCS Mental Retardation Coordinator must contact DMRS to arrange for immediate placement of youth assessed as moderately, severely, profoundly retarded as specified by interdepartmental agreement. **3. Records required** The record sent to the DCS MR Manager must minimally include: a) ***Facility Face Sheet***, DCS form ***CS-0606*** (for identifying information) b) A statement from a certifying specialist that the youth is mentally retarded; c) A psychological report (no more than 3 years old) that includes an assessment of intellectual, academic, visual/motor, vocational, and personality areas; d) An adaptive behavior assessment report; e) Medical records, ***CS-0543, Well Being Information and History***, including immunization record, if available; f) Classroom observation and disciplinary reports, if applicable; g) The commitment order; h) A Family Functional Assessment, DCS form ***CS-0777*** i) The youth's Social Security card and birth certificate (or proof of application for birth certificate), if available; j) Prior school records or a copy of the letter sent to the Local Education Agency requesting such records. **4. Timeliness/completeness of review** The DCS Mental Retardation Coordinator must review the record packet within two (2) days, and may request additional information, if deemed appropriate.
C. Interdepartmental Staffing	**1. Scheduling the meeting** When all necessary information is obtained, the DCS Mental Retardation Coordinator must contact the YDC or DCS Classification Supervisor or designee and the DMRS to schedule the interdepartmental staffing. (MR Referrals to Youth Development Centers). **2. Team members** The staffing team must, at a minimum, include the DCS classification team, a DMRS representative, the DCS Mental Retardation Coordinator or designee, Family Service Worker (FSW), parents/guardians and child/youth, and other

	appropriate DCS staff or contract persons deemed necessary by DCS DMRS Manager. The interdepartmental staffing may serve as a Child and Family Team Meeting (CFTM). **3. Team process** a) At the staffing, the interdepartmental team must review the youth's record, discuss the youth's needs, and attempt to reach a consensus of opinion regarding the youth's treatment and placement needs. (See DCS form ***CS-0747, Child and Family Team Meeting Summary***) The child and family will actively participate in the decision. b) In the event of disagreement among team participants, the majority decision must rule. c) All decisions made by the staffing team are final and binding until such time as reclassification or special treatment staffings are held and it is determined that changes in placement or treatment are necessary (refer to ***CS-0230, Staffing Summary and Placement Justification***).
D. Placements	**1. Setting** Mentally retarded youth must be placed in programs less restrictive than youth development centers, except when there is agreement by the interdepartmental staffing team, the DCS Mental Retardation Coordinator, and approval by the DCS commissioner/designee. **2. Review of placement** Mentally retarded youth returned to youth development centers from less restrictive placements must be staffed by the YDC treatment team on a monthly basis to determine progress and readiness for less restrictive program placement. A CFTM shall be convened prior to placement changes or release.
E. Individual Program Plan (IPP)	**1. Responsibility for implementation** DCS facility staff and the FSW must work closely with the DCS mental Retardation Coordinator to implement the youth's ***Individual Program Plan (IPP)***, DCS form ***CS-0228.*** **2. Documentation** Copies of the youth's IPP and program staffing summaries and CFTM summaries must be sent to the DCS Mental retardation Coordinator.
F. Reconsideration of Classification or Treatment/ Placement	**1. Convening staffings** Reclassification staffings or special treatment staffings to consider significant changes in treatment/placement for mentally retarded youth must be convened through the DCS Mental Retardation Coordinator in central office. Such staffings will include the FSW, child and family and will meet DCS requirements regarding facilitated CFTMs.

	2. DMHDD representation The DMRS representative must be invited to attend all reclassification/special treatment staffings.
G. Releases	**1. Youth in transfer status** The DCS Mental Retardation Coordinator must coordinate the release of moderately, severely or profoundly retarded youth under transfer status to DMRS, according to the provisions set forth in the interdepartmental agreement, and DCS release procedure guidelines. **2. Youth in DCS-operated or contract facilities** Releases, discharges, and transfers of mentally retarded youth placed in DCS-operated or contracted facilities must follow departmental policies and be coordinated by the DCS Mental Retardation Coordinator (see DCS forms ***CS-0309, Notification of Program Transfer, Discharge, CS-0046 or CS-0004, Determinate Commitment Release Notification***).
Data Systems Documentation	1. Placement information for children/youth in DCS custody must be entered into TFACTS according to best practice and in a timeframe that allows for the needs of the child/youth being placed. This includes: disruptions, move toward permanency, to a lower level placement or change in resource home. 2. Events not documented elsewhere in TFACTS needing fuller explanation are entered into Case Recordings which shall be recorded and completed within 30 days of date of occurrence

Forms:	***CS-0004, Determinate Commitment Release Notification*** ***CS-0046, Discharge*** ***CS-0060, Facility Face Sheet*** ***CS-0226, Classification Report Cover Sheet*** ***CS-0228, Individual Program Plan*** ***CS-0230, Staffing Summary and Placement Justification*** ***CS-0309, Notification of Program Transfer*** ***CS-0543, Well Being Information and History*** ***CS-0747, Child and Family Team Meeting Summary*** ***CS-0777, Family Functional Assessment***

Collateral documents:	***MR Referrals to Youth Development Centers***

Glossary:	
Mental Retardation:	Mental retardation refers to substantial limitations in present functioning. It is characterized by significantly sub-average intellectual functioning, existing concurrently with related limitations in two or more of the following applicable adaptive skill areas: communication, self-care, home living, social skills, community use, self-direction, health and safety, functional academics, leisure and work. Mental retardation manifests before age18 (AAMR). Mental Retardation is generally thought to be present if an individual has an IQ test score of approximately 70 or below. An obtained IQ score must always be considered in light of its standard error of measurement, appropriateness and consistency with administrative guidelines. Since the standard of error of measurement of most IQ tests is approximately5, the ceiling may go up to 75. IQ test results should be considered wit results of adaptive skills test results before a diagnosis of mental retardation is determined.
Mild Mental Retardation:	Persons identified as having IQ scores that area at least2, but less than 3 standard deviations below the mean, in conjunction with the other criteria of mental retardation. Mild mental retardation is a condition that is characterized by a significantly lower than average level of general intellectual functioning. IQ levels range from 50-55 up to about 70.
Moderate Mental Retardation:	Persons identified as having IQ scores in the range of 40-54 with a standard error of measurement of 5 before or below the noted IQ score