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Julia C. Dimoff

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THE INADEQUACY OF THE IDEA IN ASSESSING MENTAL HEALTH FOR ADOLESCENTS: A CALL FOR SCHOOL-BASED MENTAL HEALTH

Julia C. Dimoff

INTRODUCTION

Katherine had always been a good student. Her transcript demonstrated above-average ability and performance. Her parents described her as bright; she had never been diagnosed with learning disabilities. In the eighth grade, however, Katherine’s grades fell ranging from As to Fs. However, her test scores were very high, indicating that she was not performing to her potential. Katherine wrote a poem describing her depression and voicing that she did not see the point in living. She also wrote a note describing inappropriate sexual behavior that was found by a teacher and given to her parents, who then consulted the school counselor.

Despite these worrisome behaviors, her teachers described her as outgoing and vivacious. When Katherine was referred for special education services, teachers testified at the IDEA due-process hearing that Katherine did not show any signs of depression. They said that she lacked motivation and displayed “boy crazy” behavior, but they did not consider her to be a worrisome case compared to other teenagers. However, Katherine, testified that she often acted happy, while in reality she did not feel that way. She also tried to hide her fears, limiting interactions with teachers and classmates. Later,

* Julia C. Dimoff is the Case Brief Editor of the DePaul Journal of Health Care Law. She holds B.A and MSSW degrees from the University of Wisconsin-Madison and is a J.D. candidate graduating in May 2003 from DePaul University College of Law. The author wishes to thank her mother and father, whose personal sacrifices made her education possible.
Katherine admitted that she had been raped by a male classmate on the school premises.¹

Katherine’s teachers noticed changes in her behavior, but considered them within normal range because her grades were passing, and she masked her depression well.² Katherine’s behavior did not fit squarely within the construct of a mental health issue that could be addressed within special education, and therefore, she was not eligible for services within the school.³ Katherine’s story is sadly a common one.⁴ Current laws mandate that educators address mental health issues through special education.⁵ However, this avenue is only reaching a small number of students with mental health needs: those with disabilities defined under special education laws.⁶ Although these laws have been a giant step forward in the effort to provide some form of treatment and accommodation to students, it is evident that mental health issues in children and adolescents have a direct impact on educational achievement for all children, not just those in special education.⁷ Assessing mental health concerns exclusively within the construct of special education has resulted in decreased access to mental health treatment, misdiagnosis and inappropriate placements in special education.⁸

¹ See Katherine S. v. Umbach, 2002 U.S. Dist. LEXIS 2523 at *4-6. This case example is adapted from the facts of a real case in which the court decided that the child was not entitled to services under the Individuals with Disabilities Education Act (IDEA).
² Id. at *5-6.
³ See infra note 6 and accompanying text.
⁴ See Springer v. Fairfax County Sch. Bd. 134 F. 3d 659, 666 (4th Cir. 1998). The court held that the evidence did not support a finding that the child had a serious emotional disturbance within the meaning of the IDEA, thus the child was not eligible for special education services. See id.
⁵ Id.
⁶ Robert Caperton Hannon, Returning to the True Goal of the Individuals with Disabilities Education Act: Self-Sufficiency, 50 VAND. L. REV. 715 (1997) ("School districts have shown an inability to deal effectively with children with serious emotional disturbances. The most common shortcomings . . ., failing to identify the children as having a disability.").
⁷ See POLICY LEADERSHIP CADRE FOR MENTAL HEALTH IN SCHOOLS, Mental Health in Schools: Guidelines, Models, Resources and Policy Considerations Executive Summary, May 2001 available at http://smhp.psych.ucla.edu [hereinafter "Cadre"], (stating " . . . it has long been acknowledged that a variety of psychosocial and physical health problems affect learning in profound ways. Moreover, these problems are exacerbated as youngsters internalize the debilitating effects of performing poorly at school and are punished for the misbehavior that is a common correlate of school failure.").
⁸ Theresa Glennon, Disabling Ambiguities: Confronting Barriers to the Education of Students with Emotional Disabilities, 60 TENN. L. REV. 295, 303 (1993) ("Notwithstanding the IDEA and efforts by the United States Department of Education, fewer than one-half of this
In Katherine's case, her problem was largely downplayed; even when the underlying problem emerged, Katherine was not considered in need of special education services. While Katherine was able to receive outside assistance, the school environment contributed greatly to her mental health issues; it would seem appropriate for Katherine to address some of these issues there, yet no program was set in place to help her. Using special education as the only model for mental health assessment in schools fails to properly identify and serve the needs of all children and adolescents.

Changes in academic performance and acting out behaviors can be signs of more serious problems, but schools are not always cognizant of these signals. Behaviors like those exhibited by Katherine are looked at as part of adolescent development, or mere social maladjustment that can be remedied by itself over time. However, mental health issues in childhood and adolescence are growing, and they are not going away by themselves. In 1999, the Surgeon General's Report on Mental Health found that one in five children and adolescents experiences the symptoms associated with a serious mental disorder during the course of a year. Even more shocking is the fact that over 40% of adolescent mental health issues are never addressed.

One of the most innovative solutions to this problem has been to handle these issues within school-based mental health programs. While a great number of schools are moving in this direction, some would argue that schools are not the appropriate forum for mental health services. Epidemiological studies suggest that approximately three to five percent of American children have serious emotional disabilities.

See Katherine S. v. Umbach, 2002 U.S. Dist. LEXIS 2523, supra note 1 and accompanying text.

Id.

Glennon, supra note 8, at 304 ("A recent United States government report estimates that only nineteen percent of students with serious emotional disabilities are served; thus, the majority of children with serious emotional disabilities are not even in the special education system.").

Id.

See infra notes 36-72 and accompanying text.

See id

See id.

Nicole Kendell, Issue Brief: School Based Mental Health, HEALTH POLICY TRACKING SERVICE (June 2000), available at http://www.hpts.org (to access this information, a subscription is required).

Cadre, supra note 7, at 1.
health intervention. Some educators would say addressing mental health issues in schools takes time away from the educational mission. Others are simply fearful that the subject of mental health in general conjures up thoughts of stigma for students, and legal problems for schools. However, since children spend a large portion of their time at school, it would make sense that the school environment would be the best place to treat children and adolescents. According to the Diagnostic and Statistical Manual of Mental Disorders (DSM-IV), symptoms and indicators of mental illness consistently manifest themselves in behaviors exhibited within the school setting; these issues cannot be ignored if a school is to educate its students.

The first part of this paper will discuss the shortcomings of identifying and treating mental health problems in children and adolescents. I will explore the prevalence of mental health problems in this group, and demonstrate how current methods of identification fail to get children and adolescents the treatment that is needed. The second part will demonstrate that while school-based identification appears to be the best avenue to reach children in need of treatment, the IDEA’s approach of assessing and treating mental health problems falls short in addressing the mental health issues of all children. The third section will discuss the ways in which school-based mental health programs can be implemented to compliment what is being done within the sphere of special education, while assisting in proper assessment and treatment for all children.

THE PROBLEMS ASSOCIATED WITH IDENTIFYING AND TREATING MENTAL HEALTH PROBLEMS IN CHILDREN AND ADOLESCENTS

The mental health of children and adolescents is a serious matter. Each year, the number of children and adolescents in need of mental health

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18 Id.
19 Id. at 2.
20 Id. at 1.
21 Kendall, supra note 16, at 1. (noting “48 million children sit in classrooms for six to eight hours per day, 180 days a year.”).
22 AMERICAN PSYCHIATRIC ASSOCIATION: DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS (DSM-IV) 89-91 (4th ed. 1994) [hereinafter DSM-IV] (stating “the onset of conduct disorder and oppositional defiant disorder is usually found in late childhood to early adolescence, rarely occurring after the age of sixteen. Both disorders include as part of their diagnostic criteria a ‘significant impairment in social, academic, and social functioning’”).
treatment in the United States grows at an alarming rate. To complicate matters further, the identification of these disorders is made more difficult because there is such a wide spectrum of diagnostic choices. The diagnosis process can be erratic and inaccurate at times resulting in over-diagnosis as well as under-diagnosis. There is research to suggest that adolescents may receive a mental health diagnosis when, in fact, the adolescent is simply displaying behaviors that are typical, or behaviors that will cease after adolescence. The diagnosis of conduct disorder is a good illustration of the difficulty associated with making the distinction between normal behaviors and those attributed to mental illness.

Conduct disorder is characterized by behaviors that are not appropriate given the child’s age and frequently result in delinquent behaviors. In order to meet the criteria for a conduct disorder there must be “a repetitive and persistent pattern of behavior in which the basic rights of others or major age-appropriate societal norms or rules are violated.” Several of these factors are based largely upon opposition or status violations that could be a product of adolescent development and angst, rather than result of a conduct disorder. This means that in many cases, the diagnosis of conduct disorder can be both under and over inclusive. One example of this phenomenon comes from the study by Frances J. Lexcen & N. Dickon Reppucci, Effects of Psychopathology on Adolescent Medical Decision-Making, 5 U. CHI. ROUNDTABLE 63, 72 (1998) (citing Terrie Moffit, Adolescence-Limited and Life-Course Persistent Anti-social Behavior: A Developmental Taxonomy 100 PSYCHOLOGICAL REV. 674 (1993)).

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24 DSM-IV, supra note 22, at 875-886. The index gives a glimpse into the many diagnostic choices available.


26 Id. at 94-95.

27 See DSM-IV, supra note 22, at 85-90 (discussing the diagnostic criteria for conduct disorder).

28 Id. at 90. There are 15 criteria that can lead to a diagnosis of conduct disorder. Three or more of the behaviors must be present in the past 12 months with at least one behavior present in the past 6 months. Within these criteria, there are four major categories of behaviors that suggest a conduct disorder, these are, aggression to people and animals, destruction of property, deceitfulness or theft, and serious violations of rules. See id.

29 Id. Serious violation of rules includes staying out late despite parental disapproval, running away from home and truancy. See id.
from a case involving Edward, a student who met the symptoms for conduct disorder, but was denied special education services: 30

Edward demonstrated no need for special educational services during the majority of his years in school. He progressed successfully from grade to grade in regular education programs. Throughout elementary school his grades were consistently average or above average. Edward developed significant behavioral problems in his eleventh grade year; he would frequently sneak out of his parents’ house, stay out all night with friends, and steal from his parents and others. Edward regularly used marijuana and alcohol, and often broke school rules and had a high rate of absenteeism. He was disciplined for driving recklessly on school property, cutting classes, forgery, leaving school grounds without permission and fighting. He was evaluated by a school psychologist, and she administered a battery of tests to evaluate Edward’s psychological condition. She discovered symptoms of social maladjustment finding that Edward displayed a disregard for social demands or expectations. She concluded Edward’s behavior was most consistent with a diagnosis of conduct disorder. Although it was undisputed that the behaviors were generally congruent with the DSM-IV diagnosis of a conduct disorder, the court found that Edward was not entitled to special services.

Given the consequences for children and adolescents like Edward, it does not appear that professionals have found the proper way to identify mental problems like conduct disorder in children and adolescents. 31 In areas of high crime or poverty, the identification of a mental illness like conduct disorder is more prevalent; the thought is that labeling the behavior as a mental illness will protect the child. 32 However, often the method of identification is highly subjective, and focuses on the child’s reaction to his environment, not actual symptoms

30 See generally Springer v. Fairfax County Sch. Bd., 134 F.3d 659 (4th Cir. 1998). This case example is taken from the aforementioned case in which a student was denied special education services, when he failed to establish he had a conduct disorder.

31 See Robert J. McMahon & Karen C. Wells, Conduct Disorders, Treatment of Childhood Disorders 113 (Eric J. Mash & Russell A. Barkely eds., The Guilford Press 2d ed. 1998). There are listed several behaviors that are indicative of conduct disorder but could also be considered appropriate in another situation. It seems clear that this subjectivity is harming children and keeping them from getting treatment. See id.

32 Id. at 117.
suggesting a mental illness.\textsuperscript{33} In Edward’s case, school officials acted in the opposite manner; they were unwilling to label Edward with a mental illness, and rather viewed his behaviors in terms of social maladjustment. While it is questionable whether Edward did or did not deserve special education services, he was in need of some form of mental health treatment.

Unfortunately, adolescents like Edward and Katherine consistently fall through the cracks because they are under-identified under the special education model.\textsuperscript{34} Additionally, traditional methods of identification have failed to recognize mental illness in this group.\textsuperscript{35} Currently, there are three avenues by which identification can be made: parental identification, self-identification and physician-identification; each of these options suggest a need for a better method to identify mental illness in children.\textsuperscript{36}

\textbf{Parental Identification as a Method of Recognizing Mental Illness is Insufficient}

Parental identification most often occurs when a parent recognizes changes in her child and seeks outside assistance. In the case of Katherine described above, the parents could have recognized Katherine’s declining grades and uncharacteristic behavior as a sign of a more serious problem.\textsuperscript{37} However, like most parents, Katherine’s parents did not seek the attention of a school counselor until a teacher alerted them to a troubling note written by Katherine.\textsuperscript{38} Parental identification can be problematic because while many parents are in tune with the normal behaviors of their child, generally, parents do not have the expertise to distinguish between troublesome behaviors and those that could be a serious mental illness.\textsuperscript{39} Still, of those parents who have positively identified a problem in their child, there are a number of parents who believe that the problem will remedy itself.\textsuperscript{40} While

\begin{footnotesize}
\begin{itemize}
\item[^{33}] Id.
\item[^{34}] See supra notes 6-8 and accompanying text.
\item[^{35}] Kendell, supra note 16.
\item[^{36}] See infra notes 23-36 and accompanying text.
\item[^{37}] See Katherine S. v. Umbach, 2002 U.S. Dist. LEXIS 2523, supra note 1 and accompanying text.
\item[^{38}] See id.
\item[^{40}] E.H. Taylor, Advances in the Diagnosis and Treatment of Children with Serious Mental Illness, 77 CHILD WELFARE 771, 771-73 (1998).
\end{itemize}
\end{footnotesize}
Katherine’s parents took action, too many parents choose to ignore the signs of mental illness in their child for fear of stigma.\textsuperscript{41} In a study conducted for the National Alliance for the Mentally Ill (NAMI), researchers found that parents of children with mental illness demonstrated a higher risk for marital problems and financial strain.\textsuperscript{42} Almost half of the parents felt that friends and neighbors were not supportive, and even blamed them for their child’s illness.\textsuperscript{43}

A contributing problem is an increased parent-adolescent conflict that accompanies mental health problems in adolescence.\textsuperscript{44} Many disorders in childhood are aggravated by relationship problems between the parent and child.\textsuperscript{45} In Edward’s case, his family endured frequent episodes of drug use, fighting and stealing.\textsuperscript{46} Family communication problems and conflict has shown to be increased in families where the child is dealing with a mental health problem.\textsuperscript{47} Consequently, it may be difficult for parents to objectively identify a mental health issue in their child.\textsuperscript{48} It would not have been unreasonable for Edward’s parents to minimize the problem or dismiss him as a "bad seed."\textsuperscript{49} While this was not the case, there is a strong argument to suggest many parents would not have sought help under similar circumstances.\textsuperscript{50}

**Self-Identification Places Too Much Responsibility on the Child**

Self-identification raises issues relating to the capacity of a child or adolescent to identify and seek treatment on their own.\textsuperscript{51} Adolescence is a transition period between childhood and adulthood; consequently, adolescents must learn to adjust to a wide variety of social, emotional, and physical changes while maintaining self-esteem and confidence.\textsuperscript{52}
As a result, recognizing a mental problem and seeking help may not be a priority for the adolescent; the feeling of being different and the fear of social withdrawal could keep the problem hidden. Katherine described herself as feeling scared; she acted bubbly and happy, and often tried to hide much of her behavior from teachers and classmates. This behavior is not uncommon; several studies have proven that the fear of stigma can compel a person to change their behavior in order to fit in. However, this same attempt to appear normal and socialize with others can cause serious damage to a person's self-esteem.

A second problem with relying on adolescents to identify their own mental problem is the relationship between psychopathology and decision-making ability. Research into some areas of psychopathology suggests that some mental disorders can impair the decisional capacity of the individual. For example, disorders such as schizophrenia and depression exhibit decreased reasoning and perception skills. In children and adolescents, depression has been shown to cause an increase in isolating behavior and negatively affecting interpersonal and problem-solving skills. Katherine stated that she tried to hide much of her behavior and interactions with boys from her teachers and classmates; clearly, a child with limited problem-solving skills who feels isolated from peers and other social supports will not be in the best position to identify and seek help for herself.

53 Id.
54 See generally Katherine S. v. Umbach, 2002 U.S. Dist. LEXIS 2523, supra note 1 and accompanying text.
56 Id.
57 Lexcen, supra note 25, at 103.
58 See supra notes 46-49 and accompanying text.
59 See Lexcen, supra note 25.
61 See Katherine S. v. Umbach, 2002 U.S. Dist. LEXIS 2523, supra note 1 and accompanying text.
Physician Identification Has Not Worked to Find All Children in Need

Physician identification is made difficult because children and adolescents do not consistently run to the doctor when they are having problems. Furthermore, given the problems with parent-identification, there is little reason to believe that parents will consistently refer their child to a doctor.\textsuperscript{62} Even when a referral is made, the first step is often to a primary care physician.\textsuperscript{63} In the NAMI study, only 34\% of participants reported that their primary care physician screened for mental problems.\textsuperscript{64} So it seems if parents and children are not raising possible mental health concerns, chances are, they will not be addressed in the doctor’s office.\textsuperscript{65}

Traditional methods of identifying mental illness in children and adolescents are not solving the problem.\textsuperscript{66} One possible solution focuses its efforts in the schools where children spend a majority of their day.\textsuperscript{67} Schools have been found to have a significant role in child development; one study showed that schools, under optimal conditions have the ability to protect students from risky behaviors.\textsuperscript{68} In addition, school-based support has been found to provide a “buffer against potentially hazardous conditions in the home and other non-school environments.”\textsuperscript{69} Consequently, it is reasonable to say that schools may have a unique advantage in the effort to identify mental health problems in its students.

Unfortunately, many school-based programs are not addressing the needs of all children.\textsuperscript{70} The NAMI study showed that 68\% of parents felt that their child must fail before he can receive additional services, and only 7\% felt that school professionals were able to deal with serious mental illness in their children.\textsuperscript{71} While, schools have the potential to reach a large number of children and adolescents, parents are not confident that schools are meeting and supporting the needs of

\begin{footnotesize}
\begin{itemize}
  \item See supra notes 37-50 and accompanying text.
  \item NAMI, supra note 39, at 1.
  \item Id.
  \item Id.
  \item Id.
  \item Id.
  \item Id.
  \item Id.
  \item Id. at 11.
  \item Id.
  \item NAMI, supra note 39, at 2.
\end{itemize}
\end{footnotesize}
their children. The following discussion will explore the law that has become the standard for mental health identification and treatment in schools.

THE INDIVIDUALS WITH DISABILITIES ACT:
THE INTRODUCTION OF MENTAL HEALTH TREATMENT IN SCHOOLS

Historically, school-based mental health services have focused on students in special education. As a result, special education law has created a psycho-educational view by which educators have learned to identify and deal with mental illness. The predominant law governing special education and mental health services within education developed out of Public Law 94-142, the "Education for All Handicapped Children Act of 1975." In 1990, the law was amended to become the "Individuals with Disabilities Education Act" (IDEA).

IDEA requires that schools provide an appropriate education for students with disabilities, including those with emotional and behavioral disorders. Many terms are used to describe emotional, behavioral or mental disorders within the school setting. Under IDEA, these terms are grouped into the larger definition of "serious emotional disturbance" defined as the following:

A condition exhibiting one or more of the following characteristics over a long period of time and to a marked degree that adversely affects educational performance--

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72 Id.
73 Hannon, supra note 6, at 733 and accompanying text.
74 See McMahon, supra note 31, at 113.
75 Nancy D. Brener, Jim Martindale, & Mark Weist, Mental Health and Social Services: Results from the School Health Policies and Programs Study, 71 J. OF SCH. HEALTH 305-27 (2001).
76 Id. at 305-26.
77 NATIONAL INFORMATION CENTER FOR CHILDREN AND YOUTH WITH DISABILITIES (NICHCY), Questions and Answers About IDEA, available at http://www.nichcy.org/pubs/newsdig/nd21.htm. The regulations for IDEA defines, under P.L. 101-476 Section 300.7, a child with a disability to have one or more of the disabilities listed by IDEA, including: mental retardation, a hearing impairment including deafness, a speech or language impairment, a visual impairment including blindness, serious emotional disturbance, an orthopedic impairment, autism, traumatic brain injury, an other health impairment, a specific learning disability, deaf-blindness, or multiple disabilities, and who, by reason thereof, needs special education and related services. Id.
78 Id.
79 C.F.R 34 §300.7 (2002).
(A) An inability to learn that cannot be explained by intellectual, sensory, or health factors;
(B) An inability to build or maintain satisfactory interpersonal relationships with peers and teachers;
(C) Inappropriate types of behavior or feelings under normal circumstances;
(D) A general pervasive mood of unhappiness or depression; or
(E) A tendency to develop physical symptoms or fears associated with personal or school problems.

"Serious emotional disturbance" as defined under the IDEA has some major limitations.\(^8\) The definition groups together a series of situational factors when considered independently, may be indicative of a serious disorder or might simply a normal adjustment problem characteristic of an adolescent in school.\(^8\) Additionally, because the decision to refer a child for services is based upon situational or developmentally inappropriate behavior, it is not uncommon for one student to be referred for services, while another student's behavior is deemed normal.\(^8\) As a result, “decisions concerning evaluation and treatment are highly dependent on social and cultural issues, and judgments made by individuals in the child's environment, usually the teacher.”\(^8\)

The Definition of “Serious Emotional Disturbance” Under the IDEA is too Subjective, and Decreases Access to Services

One of the major challenges for teachers in identifying a serious emotional disturbance is understanding what the characteristics actually mean; there is no uniform explanation in the law, and teachers are left with the task of explaining these terms on their own.\(^8\) For example, Part B of the definition says that a serious emotional disturbance can be defined as “an inability to build or maintain satisfactory interpersonal relationships with peers and teachers.”\(^8\) One possible explanation of a serious emotional disturbance by a school in Virginia said a child who exhibits poor communication skills, interrupts class, has difficulty taking turns, makes poor eye contact, cannot stay on topic, has

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\(^8\) See infra text accompanying notes 84-155.

\(^8\) McMahon, supra note 31 and accompanying text.

\(^8\) See Mash, supra note 23, at 3-4 and accompanying text.

\(^8\) Id. at 3.

\(^8\) McMahon, supra note 31 and accompanying text.

\(^8\) C.F.R. 34 §300.7 (2002).
inappropriate conversations and does not tell the truth could qualify under this part. This is true if any of these behaviors occurred over a long period of time and to a marked degree, while adversely affecting the child’s educational performance. The definition pointedly excludes students, whose behavior is attributable to social maladjustment, unless they also suffer an independent serious emotional disturbance.

The indicators explained above are undoubtedly meant to serve as a guide to help teachers identify more serious problems and help students get treatment. However, depending on who is observing these behaviors, they may likely qualify as normal adolescent behavior. Additionally, the IDEA says that where the behavior is attributable to a social maladjustment alone, a child will not be labeled with a serious emotional disturbance. Courts have routinely declined to consider a conduct disorder or social maladjustment as a qualifier for a “serious emotional disturbance” under the IDEA. In Edward’s case, the court held that because reports of psychologists and other witnesses uniformly described a child’s condition in terms of social maladjustment, he would not have a serious emotional disturbance within the meaning of the IDEA. Yet, while the courts continue to rule this way, conduct disorder continues to be among the most frequently diagnosed disorders in childhood.

Research shows that conduct disorders make up one-half to one-third of referrals to outpatient and inpatient mental health settings. The reality is, if schools are not consistently identifying children who qualify for services under the IDEA even when the symptoms are strikingly similar, many children who should get services do not

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87 C.F.R. 34 §300.7 (2002).
88 Id.
89 Id.
90 Id.
92 Springer v. Fairfax County Sch. Bd., 134 F.3d 659, 664 (4th Cir. 1998) (noting “socially maladjusted [is] a persistent pattern of violating societal norms with lots of truancy, substance abuse, i.e., a perpetual struggle with authority, easily frustrated, impulsive, and manipulative” (quoting In re Sequoia Union High Sch. Dist., 1987-88 EHLR Dec. 559, at 135 (N.D. Cal. 1987))).
93 McMahon, supra note 31, at 111-16, discussing conduct disorder.
94 Id. at 111.
qualify. Edward’s school understood the term to refer to “continued
misbehavior outside acceptable norms.” Interestingly, the IDEA also
defines a “serious emotional disturbance” as “inappropriate types of
behavior or feelings under normal circumstances.” These two
definitions do not seem different, yet one describes a social
maladjustment, and the other describes a symptom of a serious
emotional disturbance. Unfortunately, this example shows that a
definitional interpretation can make the difference between a child who
receives services, and one who does not.

The Definition of “Serious Emotional Disturbance” Under the
IDEA is too Broad, and Increases the Chance for Misdiagnosis
Children and adolescents like adults experience a wide variety of
mental illness, and they often meet the criteria for more than one illness
at a time. The IDEA’s criteria for a serious emotional disturbance
allows for so much subjectivity, that a great number of children could
be misdiagnosed or not diagnosed at all.

Depression
Persons who exhibit symptoms of depression experience a variety of
symptoms such as depressed mood most of the day, diminished interest
or pleasure in almost all activities, significant weight loss, insomnia or
hypersomnia, fatigue, feelings of worthlessness and guilt, diminished
ability to concentrate and suicidal ideation. While the DSM-IV
identifies several symptoms and factors to consider in order to diagnose
depression, the IDEA applies a more generalized approach, requiring
only “a general pervasive mood of unhappiness or depression.” In
addition, under traditional standards for mental health diagnosis as followed by the DSM-IV, the time period for exhibition of symptoms is clearly defined, usually between six and twelve months.\textsuperscript{103}

Under the IDEA definition, a teacher can decide when a behavior becomes serious under the law. Again, teacher perception rather than child behaviors per se, may be influencing referral for special education and related mental health services.\textsuperscript{104} The wording chosen by the IDEA seems to give too much discretion to the teacher or other professional in diagnosing an illness in a child. Second, the definition fails to address the possibility that the depression, requiring one course of treatment, may be masking another disorder with a completely different treatment plan.\textsuperscript{105} In fact, there are many diagnoses that have been found to be comorbid with this disorder.\textsuperscript{106} While the options are limitless, some of the more common comorbid conditions include anxiety disorder, conduct disorder, oppositional defiant disorder, attention deficit and hyperactivity disorders and substance abuse.\textsuperscript{107}

### Anxiety Disorder

Anxiety disorder is characterized by at least six months of persistent and excessive anxiety and worry. Excessive and persistent worry occurs across a variety of situations, such as school-work, sports or social performance.\textsuperscript{108} Generally, the anxiety or worry is associated with three or more of either of the following: restlessness or feeling on edge, being easily fatigued, difficulty concentrating, irritability, muscle tension or sleep disturbances.\textsuperscript{109} When at least one of the symptoms is present for the majority of six months, a person may qualify for a

\textsuperscript{103} DSM-IV, supra note 22, at 325. Generally, the majority of disorders found in this manual require that symptoms be present for 6-12 months; depression and anxiety disorders are not the only examples. See id.

\textsuperscript{104} McMahon, supra note 31, at 127.

\textsuperscript{105} Kazdin, supra note 60, at 213 (discussing the effects of comorbidity between diagnoses).

\textsuperscript{106} DSM-IV, supra note 22, at 325 (stating that "in prepubertal children, major depressive episodes occur more frequently in conjunction with other mental disorders").

\textsuperscript{107} Kazdin, supra note 60 at 213.

\textsuperscript{108} DSM-IV, supra note 22 at 436-37. There are many different types of anxiety disorders including panics, phobias and obsessive-compulsive behaviors. However, for this paper, I will be referring to anxiety and its criteria as established under "generalized anxiety disorder," Diagnostic Code 300.02. See id.

\textsuperscript{109} Id. at 436.
generalized anxiety disorder. In children, however, only one of the aforementioned symptoms is required. “Symptoms in middle childhood and adolescence generally include the physiologic symptoms associated with anxiety (restlessness, sweating, tension) and avoidance behaviors such as refusal to attend school and lack of participation in school, decline in classroom performance or social functions.” It is clear that many of the same symptoms of depression are also common to anxiety disorder, and that it is likely that a child could have either one of these diagnoses, if not both.

The high association of depression with anxiety disorder suggests that diagnosis is often challenging, even for the most talented clinicians. So, given the overly broad definition outlined by the IDEA, how can a busy teacher be expected to make such fine distinctions in diagnosis to assure that a child is being served, and more importantly, served with the right treatment? There are numerous treatments available to aid depression. Cognitive behavior approaches aim to provide children with the skills and tools to control their depressed mood; psychosocial approaches focus their attention on individual psychotherapy to help children understand problems within themselves and interpersonal relationships. Therapists teach self-monitoring and role-playing as a way to minimize depressive thoughts. Finally, there are a wide variety of pharmaceutical options.

The treatment of an anxiety disorder, on the other hand, is largely different; treatment options for anxiety disorder are often dependent on the source of the anxiety, whether the diagnosis is a phobia or a generalized anxiety diagnosis. Additionally, unlike the treatment for depression, there is some research to suggest that some anxiety

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110 Id. In addition to the criteria stated, the anxiety must not be related to a general medical condition, or substance, and must cause “clinically significant distress or impairment in social, occupational, or other important areas of functioning.” Id.


112 Id.

113 See generally Kazdin, supra note 60, at 226-31. There is a lot of detailed information regarding the treatment options for depression. However, this short description is provided for the sole purpose of showing how a treatment plan can differ greatly based upon the diagnosis.

114 Id. at 226.

115 Id. at 231-32.

116 Id. at 232.

behaviors are adaptive, and therefore, do not require treatment.118 For example, children often perceive a threat differently simply based upon their age or experience.119 So, while one adolescent may not appear to be fearful, another child who has experienced violence may find that same threat as particularly dangerous.120 Therefore, treatment options may vary based on the child.121 Treatments for anxiety disorders like those for depressive disorders utilize behavioral methods.122 However, therapies focused on anxiety work to address a specific fear and incorporating desensitization and self-monitoring to rid the child of the specific fear.123

Because the treatments for anxiety and depression vary greatly, it is essential that the right diagnosis is made so that the child can be helped.124 Still, even more factors complicate a correct diagnosis aside from the issues relating to comorbidity; cultural differences also play into the ability to successfully identify a mental illness.125 In some cultures depression will manifest itself frequently as a somatic complaint, rather than by a “pervasive mood of unhappiness or depression” as it is defined in the IDEA.126 These somatic complaints can include complaints about feeling nervous, having headaches, tiredness or imbalance.127 Children and adolescents often experience mental illness symptoms in a similar fashion to persons from other cultures such as somatic complaints and social withdrawal.128 Consequently, it is very important that the method of identification also considers these differences; the IDEA definition leaves no room to consider these factors.129

The third criterion under the IDEA suggests inappropriate types of behavior or feelings under normal circumstances, is indicative of a

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118 Id. at 254.
119 Id. at 260.
120 Id.
121 Id.
122 Barrios, supra note 117, at 265-66.
123 Id. at 266.
124 Id.
125 See supra notes 110-14 and accompanying text.
126 DSM-IV, supra note 22, at 324.
127 Id. Latino cultures are more likely to identify a depressive symptom in terms of nerves or headaches, while Asian cultures are likely to identify a symptom in terms of “weakness, tiredness, or imbalance.” Id.
128 Id. at 325.
129 See supra notes 23-72 and accompanying text.
severe emotional disturbance. No other qualification is listed in the language of the rule. As noted above, many adolescent behaviors while normal in some situations can be maladaptive given different circumstances. This was certainly true in the case of Edward, and the chance for misdiagnosis increases when culture is a factor. For example, clinical presentations of anxiety disorders identify completely different results in Americans compared to those from an Asian culture. Whereas American children suffering from anxiety may have exhibit tantrums or a decline in school performance, Asian American children are more likely to maintain their grades, instead exhibiting physical reactions such as blushing or a failure to make eye contact.

The IDEA as the Exclusive Model for Mental Health in Schools Fails to Correctly Identify Racial Minorities

Cultural bias is always a challenging part of diagnosis, and it is certainly a problem within the IDEA; however, much more research suggests that the IDEA is seriously deficient with regard to the identification and treatment of minority children with mental illness. The IDEA as a model for mental health in schools has powerful and sometimes devastating results for racial minorities. Much has been written on the over-representation of racial minorities within special education. Studies have shown that African-American students are over-represented in several categories within education, including seriously emotionally disturbed. A 1992 study by the Department of Education demonstrated that African-American students are 1.46 times more likely than white students to be labeled as having a serious emotional disturbance. Studies looking at adult minorities do not

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130 C.F.R. 34 §300.7 (2002).
131 Lexcen, supra note 25, at 72 (discussing behaviors that suggest adolescent angst rather than a severe emotion disturbance).
132 DSM-IV, supra note 22, at 324.
133 Id. at 413 (the DSM does not specify if these are white Americans, or from what Asian culture these children are members).
134 Id. at 413-14.
135 See infra text accompanying notes 142-49.
137 Id. at 1251.
138 Race, Education, and the Construction of a Disabled Class, supra note 136, at 1251-52.
suggest that minority status is related to increased rates of severe mental illness, and while there is not a lot of research answering the same question in minority children, it is likely that there are similar results in the adult population. Given these facts, the question still remains, why are minority children more likely to be labeled with a severe mental illness?

The IDEA relies on the assumption that because "disabilities are objectively discernable, race does not influence their identification and subsequent referral to special education."\(^{140}\) Not surprisingly, research into hospitalization rates tells a different story.\(^{141}\) Hospitalization rates of school-aged children for treatment of mental illness suggest some interesting explanations as to this difference between white and black children.\(^{142}\) While overall rates of hospitalization for mental illness in black children did not differ from rates of hospitalization for white children, there is strong evidence by this same study to suggest the statistics hide an underlying social problem.\(^{143}\)

Many adolescent minorities are not hospitalized at all.\(^{144}\) Rather, they are diverted to the welfare and juvenile justice systems when they are in need of mental health services.\(^{145}\) Black children "constitute 26 percent of those arrested, 30 percent of the cases in juvenile court, 40 percent of youth in juvenile detention, 45 percent of cases involving some kind of detention, and 46 percent of the cases waived to criminal court."\(^{146}\) The adult data refuting the belief that minorities are more likely to suffer from mental illness suggests there is no proper basis for the more frequent labeling of minority children.\(^{147}\) Furthermore, the statistics demonstrating an overwhelming presence of black children in

\(^{139}\) Anand Chabra, Gilberto Chavez, & Emily Harris, Mental Illness in Elementary School-Aged Children, 170 WESTERN. J. OF MED. 21, 27-30 (Jan. 1999).

\(^{140}\) Race, Education, and the Construction of a Disabled Class, supra note 136, at 1242.

\(^{141}\) See infra notes 142-46 and accompanying text.

\(^{142}\) Chabra, supra note 139 and accompanying text.

\(^{143}\) Id. at 29-30.

\(^{144}\) See infra text accompanying notes 145-48.

\(^{145}\) Daniel J. Losen & Kevin G. Welner, Disabling Discrimination in Our Public Schools: Comprehensive Legal Challenges to Inappropriate and Inadequate Special Education Services for Minority Children, 36 HARV. C.R.-C.L. L. REV. 407, 419 (2001) ("For African American children and youth, the proportion of students identified as emotionally and behaviorally disturbed (EBD), the proportion expelled or removed from their local school settings, and the proportion ultimately arrested and adjudicated into the juvenile correctional system is far greater than comparable percentages for white youth.").

\(^{146}\) Id. at 419.

\(^{147}\) Id.
the juvenile system in comparison to their white counterparts seems to say that labeling arises largely out of individual bias.\footnote{McMahon, supra note 31 at 127.}

Opening the door to individual perceptions, prejudice, and other personal factors turns what is supposed to be an objective analysis into a subjective judgment of a child.\footnote{Id.} Within the school setting, this means decisions concerning the evaluation and treatment of any child, are highly dependent on social and cultural issues, and judgments made by individuals in the child's environment, usually the teacher.\footnote{Id. at 411.} While some might argue that teacher perception cannot be influential here, there is a strong argument to the contrary.\footnote{Losen, supra note 145.} The consequences of being wrongfully labeled by a teacher and placed into special education can be very damaging.\footnote{See supra text accompanying notes 136-52.} IDEA advocates recognize the stigma and isolation associated with labeling children. However, greater efforts are needed to prevent the intensification of problems connected with mislabeling and high dropout rates among minority children with disabilities.\footnote{NAMI, supra note 39. Recall that only 68% of parents felt that their child must fail before he can receive additional services, and only 7% felt that school professionals were able to deal with serious mental illness in their children. This evidence seems to suggest that the IDEA model is not addressing the mental health issues of all children and adolescents. Id.}

The IDEA is a good law with good intentions, yet it is clear throughout this examination of the law, that it cannot prevent the undesired harms on its own.\footnote{See infra text accompanying notes 84-98.} A different option needs to be available for those who do not fit perfectly within the rigid guidelines of the IDEA, and for those who may be mislabeled because of subjectivity inherent in the law's definition of a serious emotional disturbance. The following discussion will explore the development of a new framework for assisting in the identification and treatment of mental illness in schools.

\footnotesize
\begin{itemize}
  \item Id.
  \item Id. at 411.
  \item McMahon, supra note 31 at 127.
  \item Id.
  \item Losen, supra note 145.
  \item See supra text accompanying notes 136-52.
  \item NAMI, supra note 39. Recall that only 68% of parents felt that their child must fail before he can receive additional services, and only 7% felt that school professionals were able to deal with serious mental illness in their children. This evidence seems to suggest that the IDEA model is not addressing the mental health issues of all children and adolescents. Id.
  \item See infra text accompanying notes 84-98.
\end{itemize}
THE EMERGENCE OF SCHOOL BASED MENTAL HEALTH PROGRAMS: A POSITIVE STEP TOWARD ASSESSING AND TREATING ALL CHILDREN AND ADOLESCENTS

Schools are recognized as institutions that can have great influence on the health of children and adolescents. Health education and programming has lead to a decrease in smoking, drinking and other drug abuse among students. The increase in positive outcomes for school-based health has made these programs more than just a viable option. The majority of these programs focus on physical health, but there is growing support for school-based mental health programs as well. Children between the ages of 9 and 17 are experiencing growing mental health problems. An estimated 21% experienced the signs of a DSM-IV disorder; 16% of these children had significant to extreme impairment arising out of the disorder.

In an effort to address this concern, a number of states have passed laws relating to school-based mental health services. However, the laws vary greatly from state to state; in California the law is attempting to “establish throughout the state, a school-based primary intervention program designed for the early detection and prevention of emotional, behavioral, and learning problems.” The health education program would be offered in kindergarten through the 12th grade through the public school system. The program would include in-class and out of class activities that address mental health issues.

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156 See infra text accompanying notes 17-22.
157 Id.
158 Ellen Beth Levitt, Studies Show Effectiveness of School-Based Mental Health Programs, U. OF MARYLAND MED. NEWS (2000), available at http://www.umm.edu/news/releases/mental_health.htm (quoting a 1997 study conducted in public schools that showed that “[S]chool-based mental health programs reduced discipline problems by 95 percent. The course failure rate dropped by 13 percent and school absenteeism decreased by 32 percent.”).
160 Id.
161 Kendell, supra note 16, at 3.
163 Id.
164 Id.
Illinois law is much less progressive in terms of school-based mental health.\textsuperscript{165} The statute defines the role of a school counselor and states that school counseling services include crisis intervention programs, individual and group counseling, and addressing all the needs of students by designing a classroom curriculum for counseling and providing referrals to outside sources when necessary.\textsuperscript{166} The law promotes the values of school-based mental health, and allows "other certified school personnel" to provide services, leaving primary responsibility to the guidance counselor; it does not establish an integrated and comprehensive program for students.\textsuperscript{167}

Very few states are enacting uniform legislation that focuses on mental health in schools.\textsuperscript{168} The lack of uniformity in mandated service suggests an unnecessary hesitance on the part of the states to implement comparable school-based services across the states. One argument against school-based mental health is that there is too much stigma surrounding those who suffer from a mental illness for a school to take a chance on such a program.\textsuperscript{169} Studies describing the stigmatizing views of mental illness have found that "while stigma is very common in the general public, even well-trained professionals subscribe to the stereotypes of mental illness, and that mental illness has become even more stigmatized in the past thirty years."\textsuperscript{170} However, it is possible that school-based programs could actually decrease stigma because children in these mental health programs have access to services regardless of whether they qualify under the IDEA. No child would be labeled before receiving services because school-based programs view each student as healthy, not mentally ill.\textsuperscript{171} In addition, most school programs are located on the school grounds, which decreases stigma by not isolating those students who need assistance from the general population.\textsuperscript{172}

A second benefit is that each program tries to incorporate the assistance of several licensed professionals who work concurrently with the school nurse, counselor, teachers, parents and the

\textsuperscript{165}105 ILL COMP. STAT. 5/14-1.09 (2002).
\textsuperscript{166}Id.; see also, Kendell, supra note 16, at 4.
\textsuperscript{167}Id.
\textsuperscript{168}Id.
\textsuperscript{169}Id.
\textsuperscript{170}Corrigan, supra note 55 (manuscript at 7, on file with author).
\textsuperscript{171}Id.
\textsuperscript{172}Kendell, supra note 16, at 1.
community. This plan helps to reduce the subjectivity problem that has grown out of the IDEA by allowing more than just one person to evaluate a potential mental health problem, thereby decreasing the influence of individual bias. The IDEA model relies too heavily on the classroom teacher to make a decision about a child’s health. The school-based model would compliment the current system by monitoring all students, and providing a safeguard against mislabeling a student. Finally, growing interest in school-based mental health is starting to decrease fears that would affect funding efforts for schools.

School-based mental health is funded mainly through general state funds; however, they are not directly aimed at providing mental health services to adolescents, but rather are funded through general school-based health programs. This might suggest an unwillingness to highlight the mental health needs of students, but the tide is changing. The Robert Wood Johnson Foundation (RWJF) has recently awarded grants to 15 organizations to support and expand school mental health centers; currently, there are “more than 1,400 centers across the country.” In addition, “Congress has urged the Centers for Disease control (CDC) to expand support of health programs in schools.” In 1999, the CDC funded 16 state health programs in order to provide health information and programming to students.

CONCLUSION

The IDEA’s model for addressing mental health in schools should be a primary issue for public debate. Expanding school-based mental health clinics is a winning proposition. Although the IDEA will continue to be the primary avenue for assessing mental health within education, there

173 Id.
174 Losen, supra note 145, at 418-19.
175 McMahon, supra note 31, at 127 and accompanying text.
176 See supra text accompanying notes 156-72.
177 Cadre, supra note 7, at 1.
178 Id.
180 Id.
181 Id.
182 Id.
is little doubt that a supplementary and comprehensive program cannot co-exist along side the IDEA. School administrators should focus on the proven outcomes of current school-based programs and recognize that the mutual benefits for schools and children, and recognize the limitations imposed by the IDEA to effectively diagnose and treat all children and adolescents who suffer from mental illness.