



Psychiatric Disorders

from the

School's Perspective:

Seeing Your Patients

Through Their Eyes

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Schools have made significant progress over the past several years incorporating concepts of school supports and positive school climates.

They have continued to have difficulty with the “tip of the pyramid” students who have significant emotional and/or behavioral difficulties.

They tend to be the most psychiatrically disturbed students. Many are in special education receiving ED services.

The vast majority of students who have mental health difficulties are in regular education, not special education.

Given the time constraints of this presentation, it will focus more on the special education students who have psychiatric difficulties. The same issues apply to a lesser extent to regular education students as well.

For example, in a given community, only about 2% of students are in ED special education, but up to 70-80% of adolescents in juvenile probation may be ED students.

How do schools conceptualize the nature of these students' problems?

How can mental health professionals assist schools in a paradigm shift toward a more clinical perspective?

The first step is
understanding their point of
view.

Children and adolescents
who have mental health
disorders are served
in a variety of systems.

E.g.:

Corrections

Social Services

Education

Mental Health

Each system has its own

- Agendas

- Mandates

- Vocabulary

- Funding Streams

- Philosophy

- Etc., Etc.

The overlap of the mental health and educational systems contains some areas of concordance and other areas of significant disparity.

The mental health model is based on the concepts of diagnosis and treatment. It looks for underlying reasons for an individual's emotional and/or behavioral difficulties.

**Mental health professionals
may be surprised to discover
that a student's diagnosis
is not always relevant to
a school system's assessment
or intervention plan.**

School staff may be irked
by notes, sent by medical or
mental health professionals,
“prescribing” special education
services and outlining specific
interventions

Given the discrepancies in philosophy, mandates, funding streams, etc., it behooves each system to better understand the other.

School districts' approaches
to student mental health
issues varies widely
across the nation.

They vary from “head in the sand” approaches (“we don’t do mental health”) to directly providing mental health diagnostic and treatment services, and all points in between.

**This presentation addresses
“the big picture” issues.
Every district, even every
school, is different.**

Schools have the option of providing accommodations and modifications for students who are not receiving special education or 504 services.

Concept of “Disability”

The medical definition is that it is a physical or mental condition that limits a person's movements, senses or activities.

However, in regard to school law, disability is a legal, not a clinical term.

Section 504 is a part of the Rehabilitation Act of 1973 that prohibits discrimination based upon disability. Section 504 is an anti-discrimination, civil rights statute that requires the needs of students with disabilities to be met as adequately as the needs of the non-disabled are met.

A student is eligible for a 504 plan if he
or she:

- Has a physical or mental impairment that “substantially” limits one or more major life activities
- Has a record of the impairment
- Is regarded as having an impairment that is not temporary

A student is eligible for special education if he or she fits the criteria for one of the disability categories.

IDEA lists 13 different disability categories under which 3- through 21-year-olds may be eligible for services. The disability categories listed in IDEA are:

Autism

Deaf-Blindness

Deafness

Emotional Disturbance

Hearing Impairment

Intellectual Disability

Multiple Disabilities

Orthopedic Impairment
Other Health Impairment
Specific Learning Disability
Speech or Language
Impairment
Traumatic Brain Injury
Visual Impairment

Note that “Other Health Impairment” (OHI) requires a medical diagnosis, “Autism” is an educational and not a clinical category and “Emotional Disturbance” requires no diagnosis and is not necessarily an option even if there is a mental health diagnosis.

OHI means having **limited strength, vitality, or alertness**, including a heightened alertness to environmental stimuli, that results in limited alertness with respect to the educational environment, that—

(a) is **due to chronic or acute health problems** such as asthma, attention deficit disorder or attention deficit hyperactivity disorder, diabetes, epilepsy, a heart condition, hemophilia, lead poisoning, leukemia, nephritis, rheumatic fever, sickle cell anemia, and Tourette syndrome; and

(b) **adversely affects a child's educational performance.**

Although the majority of students who receive OHI for a mental health disorder have ADHD, in fact this category can include other mental health disorders including Depression, Bipolar Disorder, Obsessive Compulsive Disorder, etc. Many parents (and even some school district personnel are unaware of this fact).

In responding to requests to specifically list mental health disabilities into the federal regulations, the USDOE commented:

“The list of acute or chronic health conditions in the definition of other health impairment is not exhaustive, but rather provides examples of problems that children have that could make them eligible for special education and related services under the category of other health impairment. We decline to include dysphagia, FAS, bipolar disorders, and other organic neurological disorders in the definition of other health impairment because these conditions are commonly understood to be health impairments.

Autism means a developmental disability significantly affecting verbal and nonverbal communication and social interaction, generally evident before age three, that adversely affects a child's educational performance. Other characteristics often associated with autism are engaging in repetitive activities and stereotyped movements, resistance to environmental change or change in daily routines, and unusual responses to sensory experiences. The term autism does not apply if the child's educational performance is adversely affected primarily because the child has an emotional disturbance.

Although Autism special education criteria tend to parallel clinical criteria, a student who has a diagnosis of Autism Spectrum Disorder would only qualify for special education if the condition had a significant impact on the student's learning.

Emotional Disturbance

means a condition exhibiting **one or more** of the following characteristics **over a long period of time** and to a **marked degree** that **adversely affects a child's educational performance:**

(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.

(e) A tendency to develop physical symptoms or fears associated with personal or school problems.

The term includes schizophrenia. **The term does not apply to children who are socially maladjusted, unless it is determined that they have an emotional disturbance.**

Although the ED category does is not based on psychiatric diagnosis, research indicates that the vast majority of these students either have been diagnosed with, or display significant evidence of mental health disorders such as ADHD, mood disorders, anxiety disorders and even psychotic disorders.

Problems with the ED Category

It has remained unchanged for
40 years, despite the
advancing knowledge in
childhood emotional and
behavioral disorders.

For example, problems need to have been present for a long period of time. This requirement is not the case for symptoms resulting from sudden hearing loss, traumatic brain injury, etc.

Symptoms of disorders such as Post Traumatic Stress Disorder, Panic Disorder, Bipolar Disorder, etc. may have a sudden, severe onset. Delaying interventions could cause significant difficulties.

ED is the only disability category that does not have a requirement to specify the nature of the underlying disability.

The category *is* the disability.

The ED category tends to encourage school personnel to view problems from a behavioral rather than a clinical perspective.

This can lead to functional behavioral assessments (FBAs) to mistakenly assign behavioral functions to behaviors that are in fact direct manifestation of clinical symptoms.

Even if a student's mental health disorder is known, the IEP team may view the student from an behavioral perspective rather than from a clinical perspective if the student has behavioral difficulties. In fact, these difficulties may also be part of the criteria of the student's mental health disorder (e.g., irritability in Bipolar disorder).

How badly does
educational performance
need to be affected?

According to IDEA, states must make a free appropriate public education available to “any individual child with a disability who needs special education and related services, even if the child has not failed or been retained in a course or grade, and is advancing from grade to grade.”

What does “social
maladjustment” mean?

E.g. A child who has a persistent pattern of violating societal norms with truancy, substance abuse, a perpetual struggle with authority, is easily frustrated, impulsive, and manipulative

Does this make sense?

What is the obligation to identify an underlying mental health disorder for qualifying a student for ED services?

Minnesota Rule 3525.1329

states that the student's
emotional or behavioral

“responses must not be primarily
the result of intellectual, sensory,
**or acute or chronic physical
health conditions.”**

Since **ADHD is identified as a physical health condition** in the IDEA description of OHI, and since **it is a chronic condition**, then Minnesota's ED criteria should exclude students who have ADHD when their symptoms at school are primarily caused by ADHD. Yet, distractibility, impulsivity, and hyperactivity are the most frequently identified mental health symptoms found in ED students.

Child Find requires all school districts to identify, locate and evaluate all children with disabilities, regardless of the severity of their disabilities.

Schools are required to locate, identify and evaluate all children with disabilities from birth through age 21.

This includes all children who are suspected of having a disability, including children who receive passing grades and are advancing from grade to grade.

So, does it follow that, if a student is displaying significant evidence of ADHD (e.g., distractibility, impulsivity, hyperactivity) that, if diagnosed, would result in qualifying for OHI services, the district is therefore responsible to conduct or pay for a diagnostic evaluation to determine eligibility?

Payer of Last Resort

IDEA clearly states that schools may be obligated to conduct or pay for medical diagnostic evaluations and ancillary services (e.g., nursing interventions at school), but are not obligated to fund medical treatment.

However, because “counseling” was identified as a related service in the 1975 Education for All Handicapped Children Act, subsequent court rulings put schools in the position of paying for students’ mental health treatment.

The rationale was that the students' educational needs and mental health needs were “inextricably intertwined”

This has resulted in some situations where districts have had to pay hundreds of thousands of dollars for residential treatment placements.

School social workers,
psychologists and counselors
may feel that they are under a
“gag order” to never recommend
or refer a student to mental
health treatment due to potential
legal and financial
consequences.

In my opinion, as a result of:

-Payer of last result

-Endorsement of behavioral models rather than
medical models

-Lack of understanding of student mental health
issues

Students who have mental health disorders often do not receive educational services that are focused on the underlying mental health reasons for their emotional and/or behavioral difficulties in the school environment.

However, there is justification for schools to not embrace a model that is based on diagnosis.

- Most (up to 80%) of students who have a mental health disorder are never diagnosed.

-The majority of those who are diagnosed are seen by primary care physicians who may not have adequate training in diagnosis and treatment of mental health disorders.

**-There is poor reliability
between different
diagnosticians. School staff
often encounter situations
where a student has received
multiple, differing diagnoses
from various mental health
professionals.**

Schools are in a quandary
regarding student mental
health issues.

Compounding the problem
is the high cost and poor
outcome of special
education ED students.

Over half of ED students drop
out of school.

Outcomes in employment, post
secondary education, arrest
rates and unwed pregnancy are
similarly poor.

The main reason is that
the “E” in “ED” is rarely
treated effectively.

**Educational
assessments of
students who have
mental health disorders**

According to IDEA, the IEP Team may also include additional individuals with knowledge or special expertise about the child. These individuals participate as members of the team at the discretion of the parents or the school system, meaning that either the parent or the school system invites their participation.

If the student's disability is an actual disorder (e.g. Bipolar disorder) served via OHI, then the invited expert can translate mental health issues into educational language.

If the student is in the ED category, there is no obligation to view the student's mental health disorder as his or her educational disability. It may or may not be viewed as a relevant factor.

In short, the deck is stacked against schools regarding effective addressing of student's mental health issues.

It is helpful to understand that the issue isn't, "Is the problem clinical or is it behavioral?" ("On purpose" or "Can't help it"), but rather, "Where does the student's problem lie on the Clinical-Behavioral Spectrum?"

X

X

Learned Behavior

Predominantly Learned

Mixed

Predominantly Internal

Internal Causation

Hurdles to overcome:

Payer of last resort

Lack of mental health training

Outdated special education criteria

Difficulty accessing quality mental health services

Lack of district mental health plans

What Mental Health Professionals Can Do

Understand the nature of schools' legal mandates in regular education, 504 and Special Education.

You can be a team member, but cannot “write prescriptions” for educational services.

Help schools build bridges to mental health while maintaining legal and financial firewalls.

E.g., Become involved in co-located, on-site mental health diagnostic and treatment services provided by community clinics.

Remember: Boundaries, boundaries, boundaries!

Help educate school staff regarding the nature of mental health disorders that affect students, how these disorders manifest in the classroom, and interventions that can be effective in addressing these disorders.

Encourage schools to
adopt evidence-based
teaching practices for
students who have
emotional and/or behavioral
difficulties:

Encourage the use of
the Clinical-Behavioral
Spectrum concept

Encourage your professional organizations to lobby for policy changes:

- Massive overhaul or elimination of the ED category**
- Elimination of the payer of last resort requirement in IDEA**

**Assist schools in
adopting mental health
plans**

Consider advocating for your patients to receive OHI, not ED services, and to have accommodations and modifications based on the underlying psychiatric disorder's symptoms.

Learn to be a “Mental Health Rosetta Stone”, translating the concepts between each system.

Good Luck!

