

Assessing, Teaching, and Treating
the Delinquent, Mentally Ill Student

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What is the meaning of a
“behavioral disorder”?

What underlies behavior?

3 Major Causes of Emotional and/or Behavioral Problems

1. Problems with adjustment to stress
2. Medical disorders, medication side effects, effects of toxins
3. Problems due to core psychiatric disorders that have biological bases

Two are Intrinsic Factors, with Internal Causation

#2 - Medical disorders, medication side effects, and effects of toxins

#3- Problems due to core psychiatric disorders that have biological basis

The other end of the spectrum is “behavioral” reflecting learned behavior.

Visualize a scale, with “learned behavior” on one end and “internal causation” (due to clinical factors) on the other end

X



X

Learned
Behavior

Internal Causation

“Internal Causation”

- ~ e.g. severe psychosis with hallucinations, delusions, etc.
- ~ Behavioral interventions are not likely to be effective

Treatment (e.g., medication) is needed.
If treatment is effective, the behavioral problems
will resolve.

“Learned Behavior”

- ~This individual needs behavioral interventions.
 - ~No medication will be of help.
- ~What is indicated is a behavioral plan with “a narrow path with high walls”.

Very few children and adolescents
are at either extreme.

X

Learned
Behavior

Predominantly Learned

Mixed

Predominantly Internal

Internal Causation

X

What is “Predominately Learned”?

This is a child or adolescent who happens to have a mental health disorder, but whose behavior problems are due to volitional planning, and not significantly related to the mental health disorder.

“Predominately Learned”

Example:

an antisocial child/adolescent who happens to also have ADHD.

Medication will help him plan his crimes better

This individual needs behavioral interventions.
Medication treatment can be helpful, but
won't significantly impact the behavioral problem
without behavioral interventions.

What is “Predominately Internal”?

This is a child or adolescent whose problems are predominately due to a psychiatric disorder. There may be some tendencies towards power struggles or other behavioral problems, but these are minor compared to the psychiatric disorder.

Behavioral interventions are unlikely to be successful without treatment of the underlying disorder

What is “Mixed”?

This is an individual who has a combination of clinical (internal) and behavioral (learned) contributors to their problems.

This part of the Clinical-Behavioral Spectrum typifies the mentally ill, delinquent student.

Identifying where a child or adolescent is on the continuum can be of help in identifying the most effective interventions.

Behavior problems can be present anywhere
on the spectrum.

Mental health (clinical) problems may be
present at the:

- ~Internal,
- ~Predominately Internal,
- ~Mixed, or
- ~Predominately Learned

Thus, a “mentally ill delinquent” student may be anywhere on the spectrum except the “Learned Behavior” location.

Interventions with a student whose behaviors directly result from clinical disorders (e.g., an agitated manic student or a delusional psychotic student) should be considerably different than those with a student whose behaviors are predominately learned.

X

Learned
Behavior

Predominantly Learned

Mixed

Predominantly Internal

Internal Causation

X

Although we don't always know about the nature of a student's mental health difficulties, many times we do.

Also, if a district adopts a mental health plan that frames mental health in a public health context similar to medical disorders, there is a greater likelihood that mental health issues will be discussed and addressed.

The Value of the Spectrum Concept

The Clinical-Behavioral Spectrum
bridges the conceptual gap
between behavioral and clinical
models.

It addresses the bias of educators who tend to overly rely on behavioral concepts to explain students' difficulties. This over reliance results in failed behavioral interventions, frustrated teachers and parents, and demoralized students.

It also addresses the bias of clinicians who may overly rely on a medical model of diagnosis and clinical treatment, without recognizing that many students require a major focus on behavioral interventions.

It “fine tunes” black and white into various gradations.
For some students, instead of “either/or”,
the discussion is “both/and”

It “diagnoses” your system- if there is a wide disagreement among team members regarding a student’s place on the spectrum, it will be difficult to succeed with interventions until the issue is resolved.

It encourages resolution of conflict between parents and educators, when both groups are encouraged to find common ground. (e.g., most parents realize that it is rare for a student to have no control over behavior).

It raises awareness regarding the clinical end of the spectrum and encourages school staff to recognize internal contributors to a student's difficulties.

This should occur from the assessment through the interventions- from the FBA to accommodations and modifications.

It also raises awareness regarding situations in which the behavioral approach is preferable and more likely to succeed than the clinical approach.

It encourages mental health training of teachers, administrators, school social workers, psychologists, counselors and nurses.

It provides individualized interventions that address the underlying causes and contributors to behavioral difficulties rather than only focusing on the external manifestations of the problem.

Assessing a Student's Position on the Spectrum

Has a mental health diagnosis been made?

Are the behaviors observed the diagnostic criteria of the diagnosis?

Do behavior problems improve or even disappear with treatment? Do they recur if treatment stops?

Is there evidence of an undiagnosed mental health disorder?

Is there evidence of volitional, planned misbehavior?

Do behaviors fit social responsiveness patterns or functions of avoidance, attention seeking or gaining tangibles?

How to Assign a Spectrum Location

High Likelihood of
Accurate Placement

for Internal Causation

- Diagnosis has been made
- Behaviors seen are the criteria of the diagnosis
- Problems disappear with treatment
- Problems re-occur when treatment stops
- No evidence of volitional planning
- Does not fit social responsiveness patterns or functions of avoidance, attention-seeking or gaining tangibles

High Likelihood of Accurate
Placement

for Learned Behavior

- No diagnosis has been made
- Mental health screening yields no evidence of diagnosis other than Conduct Disorder or Oppositional Defiant Disorder
- Clear evidence of function to behaviors
- Behavior is planned and volitional
- No remorse

High Likelihood of Accurate Placement

for Mixed

Clear evidence of both clinical disorder symptoms contributing to behavioral difficulties and of functional behavioral contributors as well

Medium Likelihood of
Accurate Placement

When all of the “High Likelihood” factors are not present, but there is compelling evidence for the placement.

Example - No diagnosis has been made, but screening provides strong evidence of depression, ADHD, etc., with symptoms that match the behaviors in question

Low Likelihood of Accurate Placement

When there is no clear information to clarify whether the individual has evidence of mental health disorders or of functional behavioral difficulties.

The Clinical-Behavioral Spectrum isn't a diagnostic tool.

It is a “hypothesis generator” that raises awareness that clinical and behavioral issues are often not “either-or” but “both-and”

Educational Assessments that
Incorporate the
Clinical/Behavioral Spectrum Concept

Having a sense of where a student is on the Spectrum allows for a more holistic approach to educational assessment.

Major changes need to be made in two arenas:

Behavioral analysis and interventions

Recognition of mental health contributors to a student's problems

Behavioral analysis needs to address the internal contributors to behavior. The “function” of inattention in a student who has significant ADHD is not “avoiding schoolwork”, any more than the “function” of a diabetic student’s irritability associated with low blood sugar is.

FBAAs need to recognize the contributors of mental health disorders to behavior. Functions need to be expanded to include:

- Seeking attention

- Avoiding schoolwork

- Gaining tangibles

- Internal (mental or physical health) contributors

The traditional educational approach of focusing mostly on behavior may be effective for students who are on the “behavioral” end of the spectrum, but tends to fail for students on the clinical end.

When mentally ill delinquent students are viewed uniformly with assessments and responses mainly in the behavioral realm, outcomes are generally poor for those students on the clinical end of the spectrum.

On the other hand, a student who is diagnosed with a mental health disorder may in fact predominately display learned misbehavior.

This information is helpful for mental health clinicians, as they will be less likely to focus solely on mental health contributors to their patient's misbehaviors.

If a student's problems is predominately due to clinical contributors, then it is helpful to acknowledge that fact.

Ideally, disorders should be effectively treated. This is unfortunately often not the case.

If a student has undiagnosed mental health problems, school staff can discuss their concerns about a possible disorder with parents. This is not the same thing as diagnosing or referring for treatment.

If there is no clear function to behaviors, that fact needs to be acknowledged in educational assessment.

School districts that have mental health plans that include access to on-site mental health services increase the likelihood of success for students who have combinations of clinical and learned behavior problems.

Educational Approaches Using the Clinical/Behavioral Spectrum Concept

Schools tend to do a good job with providing educational interventions for uncomplicated ADHD students.

These students are often served in the OHI category of special education or with 504 plans.

The situation becomes more problematic when a student has a mixture of learned and clinical factors contributing to behavior problems.

These students often are served in ED programs. Services tend to focus on behavioral interventions more than clinical interventions.

In fact, most of these students are in the “mixed” or even the “predominately clinical” regions of the spectrum.

ED students have a high degree of mental health disorders including ADHD, mood disorders, anxiety disorders and even psychotic disorders.

However, their behavioral difficulties make treatment difficult, and they are often discharged from day treatment programs.

The outcome of ED students is the worst of all disability categories, in areas of dropout rates, arrest rates, employment, post-secondary education and unwed pregnancy.

They are very expensive to serve and tend to have very poor outcomes. A primary reason for this is that the “E” (emotional) in ED is rarely served.

Successfully educating students who have combined delinquent behaviors and mental health disorders the “mixed” students requires an integrated approach that addresses both types of contributors.

Clinical interventions require awareness of the limitations of clinical treatment and the integration of behavioral interventions with clinical interventions.

This can often best be done with cooperative arrangements between school districts and community mental health clinics that provide on-site, co-located mental health treatment in the school.

FBA's that are done correctly and that identify both learned behavior and intrinsic clinical contributors can provide guidelines for appropriate interventions.

In order for the spectrum concept to succeed, there needs to be a significant change in school personnel's roles, responsibilities and activities. This process requires effective leadership.

In order for the Spectrum concept to be effective, schools need to have a system in place wherein students' mental health issues are effectively addressed by the school.

In our opinion, schools should “stay out of the mental health business” of diagnosis and treatment. However, just as school staff understand the nature of health conditions and provide appropriate accommodations and modifications for them, they can do the same for mental health conditions.

This is a public health model for student mental health.

Schools tend to have health plans for students who have health disorders (e.g., asthma, diabetes, etc.).

Similarly, schools are most successful when they also have mental health plans.

The ideal approach is one of “Bridges and Firewalls”:

Building bridges to mental health services while maintaining protective firewalls to reduce risk of legal and financial liability.

A School Mental Health Plan

Examples of mental health plan items that
are essential for the success of
the Clinical/Behavioral Spectrum:

Clarification of roles and responsibilities of school staff in their work with a student who has a mental health disorder.

Who is going to seek releases of information and gather information?

Who is going to translate mental health information into educational terms?

Who is going to have expertise in mental health accommodations and modifications?

Who is going to lead the team in the Clinical-Behavioral Spectrum process?

Clarification of “Need to Know” (Legitimate Educational Interest)

Who knows that a student has a mental health disorder (e.g., nurses)?

How is it determined whether this information is shared with others (e.g., teachers)?

Is there consistency in the district on this issue? If not, this could create potential liability.

Mental Health Data Practices

Does the district update student health records annually, including questions about medications?

How are student mental health issues documented?

When is it “desk drawer” information?

How is information obtained from and shared with treating professionals?

Mental Health Training

In order for school staff to utilize the Clinical-Behavioral Spectrum concept, they need to know:

- The nature of the various mental health disorders affecting children and adolescents
- How these disorders manifest in the classroom
- Effective interventions that address the manifestations of these disorders

Conducting Educational Assessments of Students who have Mental Health Disorders

- ~ Those who have been diagnosed
- ~ Those who have evidence of disorders

Co-Located, On-Site Mental Health Diagnostic and Treatment Services

What are best-practices relationships between school districts and mental health providers that provide access to services directed toward students on the Clinical portion of the Spectrum?

How can services be made accessible without the school taking on potential legal and financial liability?

Supervision

Who supervises the mental health staff (social workers, psychologists, counselors, nurses)?

If it is the special education director, does this person have adequate mental health training to supervise mental health activities?

What additional training would be helpful?

Summary

Mentally ill, delinquent students may appear on the surface to be very similar. However, they may have various degrees of clinical and learned behavioral contributors to their difficulties.

Using the Clinical-Behavioral Spectrum concept allows for “fine tuning” of assessments and interventions that will result in less restrictive placements, cost savings and improved behavioral and academic outcomes.

