Diagnostic, Treatment and Educational Considerations that Ensure Success for Emotionally Disabled Students

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“If you want to build a ship, don't herd people together to collect wood and don't assign them tasks and work, but rather teach them to long for the endless immensity of the sea.”

Antoine de Saint-Exupery

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:

Three of them particularly apply to students who have mental health disorders.

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

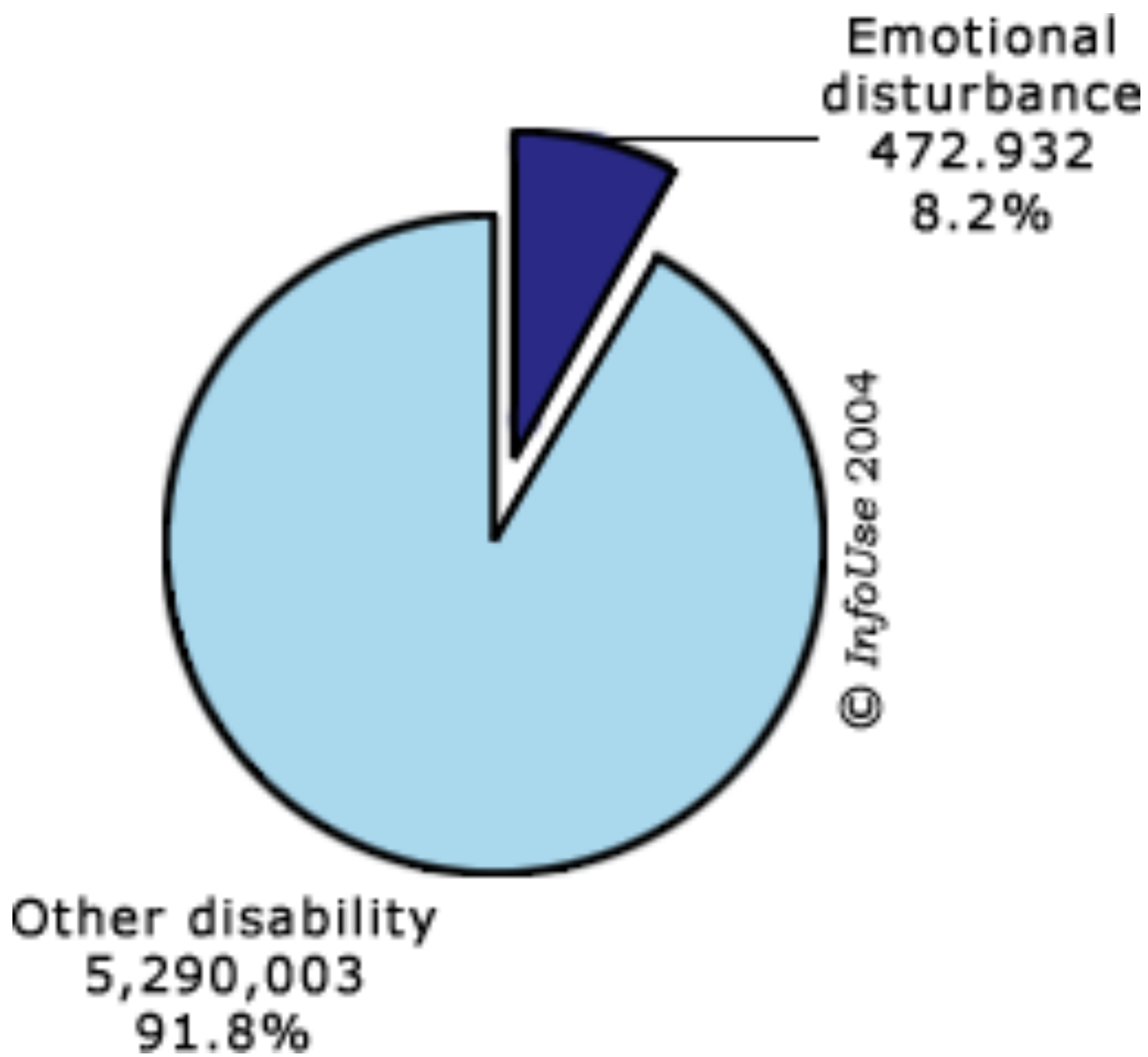
Note that “Other Health Impairment” (OHI) requires a medical diagnosis, “Autism” is an educational and not a clinical category and “Emotional Disturbance” requires no diagnosis and is not necessarily an option even if there is a mental health diagnosis.

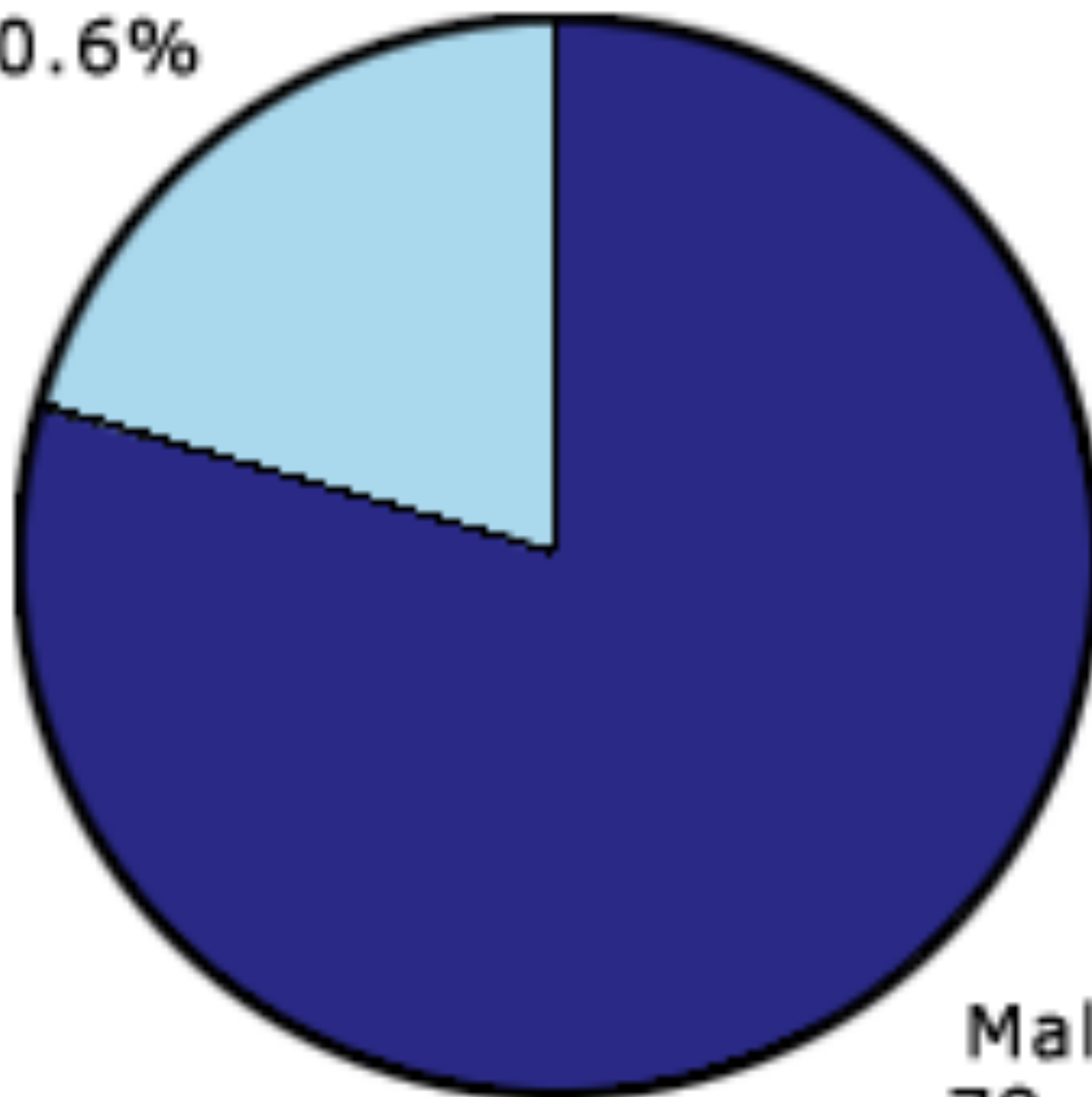
Many significantly emotionally and/or behaviorly disturbed students are served in the ED category.

A typical school district may have approximately 2% of the students in the ED special education category.

Remarkably, it is not unusual for the same community's juvenile probation population to be comprised of over 70% ED students.

(Hint: If you want to prevent juvenile crime, identify students who are at risk of requiring ED special education services, and provide coordinated services to meet their unmet needs)


Emotional disturbance
472.932
8.2%
Other disability
5,290,003
91.8%
© InfoUse 2004


Females
20.6%
Males
79.4%
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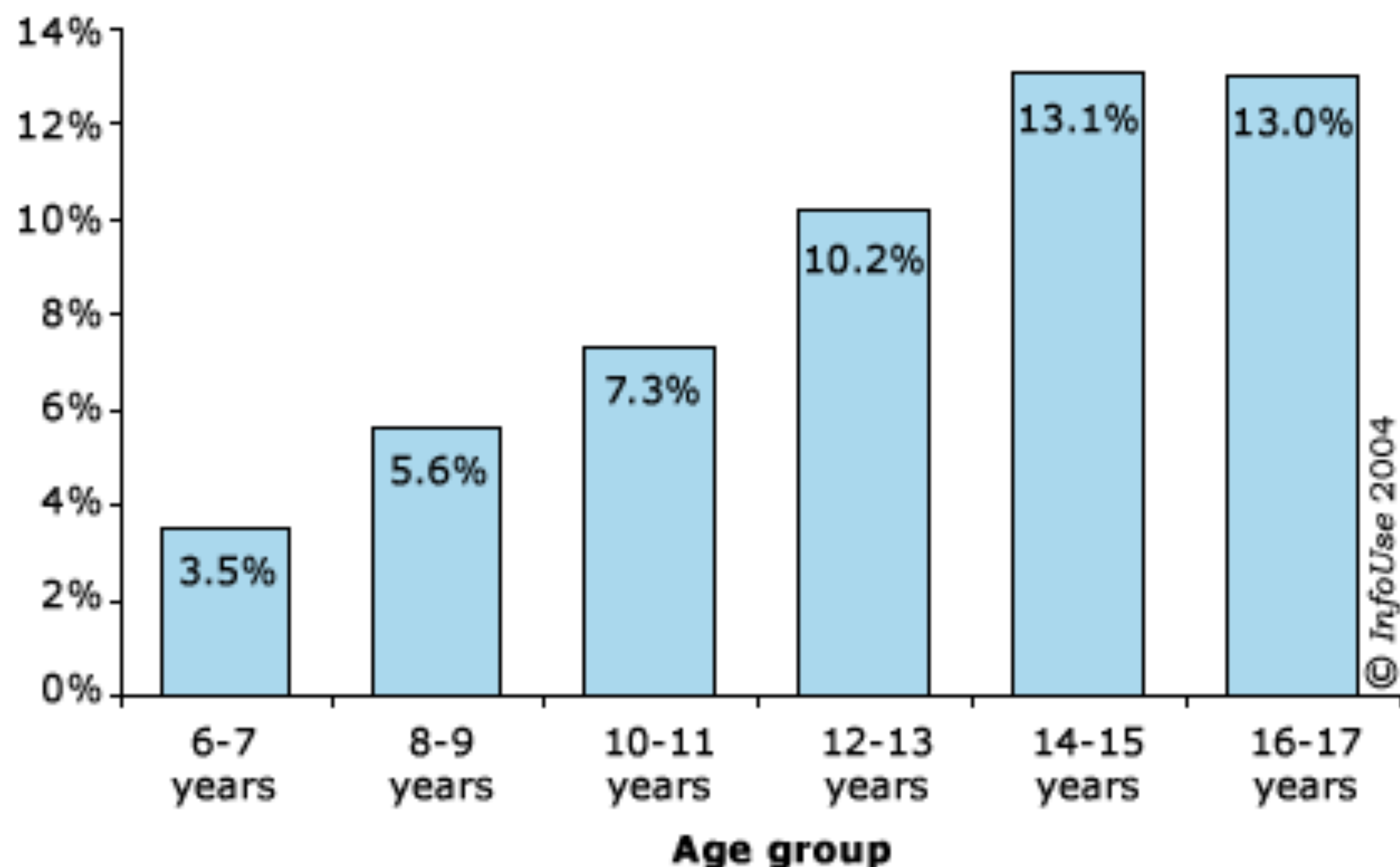
Percent of students served by IDEA who have emotional disturbance
14%
12%
10%
8%
6%
4%
2%
0%
3.5%
5.6%
7.3%
10.2%
13.1%
13.0%
6-7 years
8-9 years
10-11 years
12-13 years
14-15 years
16-17 years
Age group
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What is the definition of Emotional Disturbance (ED)?

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."

(But not depression? Anxiety disorders such as
panic disorder or PTSD? OCD?)

Schizophrenia?

Really?

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

Socially maladjusted?

Although research in children's mental health disorders has advanced significantly since the 1950s (e.g., childhood depression was not recognized as a disorder at that time),

the criteria have remained essentially unchanged.

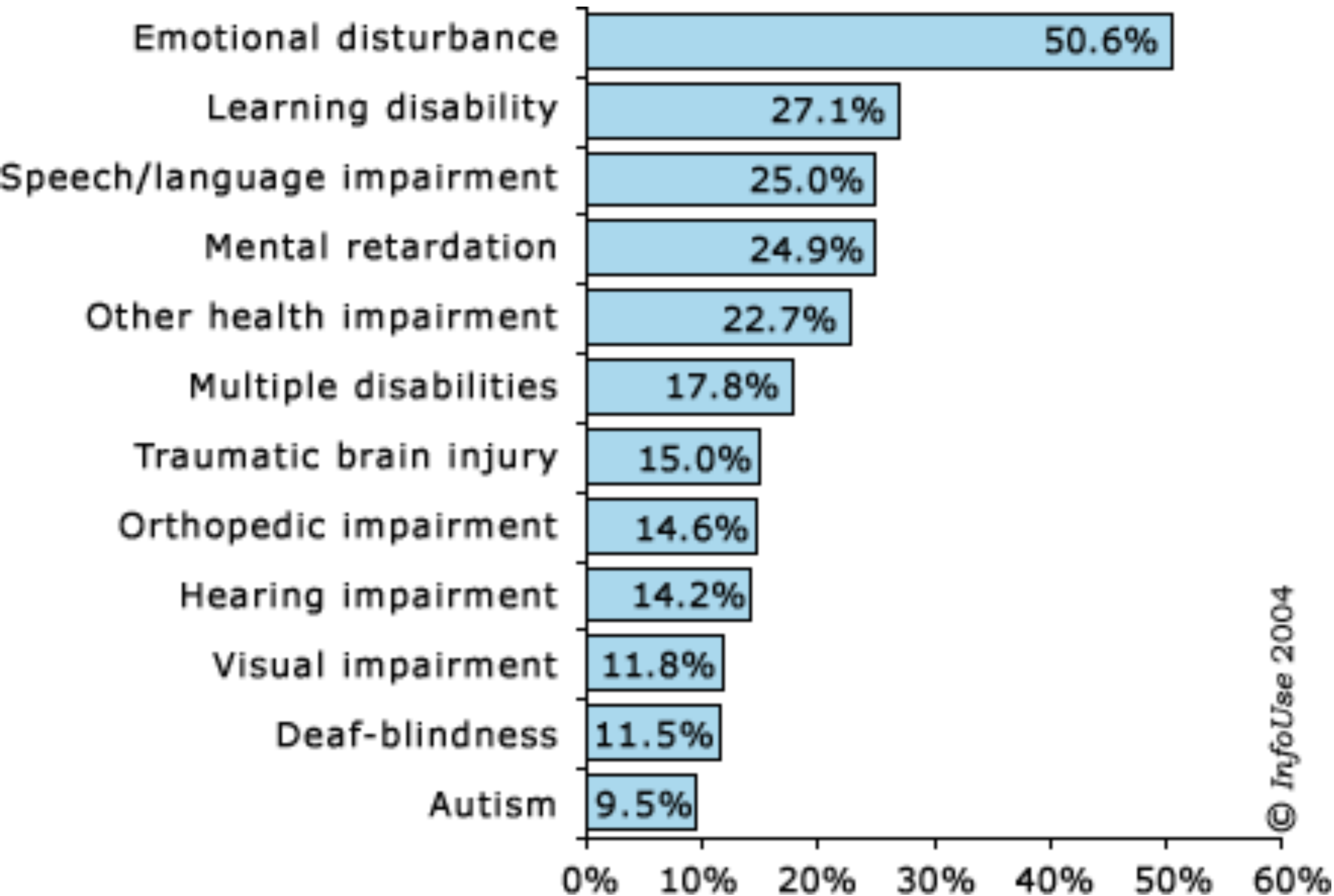
ED students have the worst outcome of any category of special education.

Mary M. Wagner,
Outcomes for Youths with Serious Emotional Disturbance in Secondary School and Early Adulthood,

Percentages of Youths With:	SED	Any Disability	Genl Population
Ever enrolled in any postsecondary school when out of high school three to five years	25.6	26.7	68.3
Currently competitively employed when out of high school three to five years	47.4	56.8	69.4
Married or living with someone of the opposite sex three to five years after high school	17.2	19.4	29.6
Women who were mothers three to five years after high school	48.4	40.6	27.8
Had ever been arrested One year after high school	25.0	12.2	7.8
Three to five years after high school	57.6	29.5	—

2006 data from Maryland indicate that ED students' dropout rate was sixteen times (49% versus 3%) the dropout rate of students in regular education.

Dropout Rates In Special Education


Emotional disturbance
50.6%
Learning disability
27.1%
Speech/language impairment
25.0%
Mental retardation
24.9%
Other health impairment
22.7%
Multiple disabilities
17.8%
Traumatic brain injury
15.0%
Orthopedic impairment
14.6%
Hearing impairment
14.2%
Visual impairment
11.8%
Deaf-blindness
11.5%
Autism
9.5%
0%
10%
20%
30%
40%
50%
60%
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Although ED students comprised only 8% of Maryland’s students in the various special education disabilities categories, they represented 52% of suspensions.

ED is the only special education category that does not require identifying a disability. The category IS the disability.

According to special education law, a diagnosis is not necessary for ED services to be provided.

If a student has a mental health diagnosis, this information will be considered but this may not result in ED placement.

It is not unusual for school district staff to view mental health diagnoses as not being relevant to a special education assessment, nor to special education services that will be provided.

Who are these ED students? Do they have mental health disorders? Is knowledge of their unmet mental health needs pertinent to their educational success?

Minnesota’s children’s mental health advocates were successful in adding a rule that required a mental health screening for all students being considered for placement in the ED category of special education.

After the rule had been in effect for several years, the state director of special education was asked about the results of screening. (E.g., what percentage of students had a positive screens, what types of disorders were suggested, etc.)

The answer? Since the rule did not require the department or the districts to analyze the results of screening, this information was not available.

Moral: If you are going to advocate for mental health screening of students at risk for ED services, require the rule to mandate screening tools that are sensitive, specific, reliable and valid,

and require data collection and analysis to clarify the nature and extent of evidence of mental health disorders in this population.

The data are in school district files, however, and can be analyzed by file review, should the district be interested in knowing this information.

As a psychiatric consultant to school districts across the U.S., I am generally asked to make recommendations that will result in improved academic and behavioral outcomes.
I always recommend starting with an analysis of the district's own data.

The mental health data identified in students' educational files should be considered to be a low estimate, as many parents do not choose to share their children's mental health diagnostic or treatment information with school districts.

This fact makes this presentation of student mental health data all the more compelling.

The key questions are:

-What is the nature and extent of evidence of mental health disorders in the ED population?

-How does this differ between students who are in high intensity, self contained setting 4 programs and students seen for their first assessment that leads to ED special education?

-Have the students been identified, diagnosed and treated in the past?

-Are they receiving treatment at this time?

-Are their identified emotional and/or behavioral difficulties consistent with the presentation of mental health disorders?

-For students who are being treated, is there communication between school district staff and treatment providers?

Example:

In 1998, a special education director asked me to review the files of students from his district who were in a Setting 4 program for behaviorally disturbed students.

Their educational files revealed that 85% had already received mental health diagnoses, but that only 5% were receiving any mental health treatment.

I helped the district partner with a community mental health clinic to provide on-site, co-located mental health services.

Most of the students were brought back to the district's less restrictive programs, and benefited from treatment.

The district of 5000 students subsequently saved $800,000.00/year as a result.

I then assisted the Intermediate District that had been providing Setting 4 services to these students, in analyzing their own data regarding the mental health characteristics of their program for behaviorally disordered students and their day treatment program.

(The district's intention was to provide mental health day treatment to the "mental health students" and behavioral programming to the "behavioral students".)

They were shocked to discover that the “behaviorally disordered” students had more severe mental health problems than the “mental health” students.

E.g., more use of psychiatric medications, more suicide attempts. more psychiatric hospitalizations, etc.

Characteristics of Setting 4 EBD students compared to Setting 4 Day Treatment Students

*= Higher percentage

	EBD	Day Rx
# Hospitalizations/Student	*	
# Suicide Attempts/Student	*	
Use of Antidepressant medication	*	
Severity of Mental Health history	*	

The mental health data resulted in a re-framing of the way that the students were viewed, the ability of the district to receive additional funds from the county mental health collaborative and an alteration in the model of mental health services that were provided.

For these types of students who had a mixture of mental health and behavioral problems. traditional day treatment services were ineffective.

In fact, they tended to be expelled from the programs for the same reasons that they were initially admitted. (E.g., truancy, oppositionality, defiance, etc.)

Analysis of Mental Health Data of these Setting 4 Students

Psychiatric Characteristics of EBD Students Placed in Out of District Setting 4 Schools
Suburban West Metro District

(n=20)

Diagnosis	Has been made	Evidence	Total
ADHD	40%	60%	100%
Depression	40%	40%	80%
Chemical Abuse or Dependency	40%	20%	60%
Psychotic Disorders	15%	15%	30%

PTSD	5%	15%	20%
Other Anxiety Disorders	0%	25%	25%
PDD	15%	0%	15%
Tic Disorder	0%	15%	15%
Dysthymia	10%	0%	10%

Obsessive-Compulsive Disorder	5%	5%	10%
Schizo-Affective Disorder	5%	0%	5%
Bulemia	5%	5%	5%
Adjustment Disorder	5%	0%	5%

Misc. Disorders:

Learning Disabilities	30%	15%	45%
Low Avg. IQ	30%	0%	30%
Speech and Language Disorders	25%	0%	25%

Developmental Delays	10%	0%	10%
Neurological Disorders	10%	0%	10%
FAE/FAS/ FDE/FDS	0%	5%	5%

Psychiatric Medication Usage of EBD Students Placed in Out-of-District Setting 4 Schools:
Suburban West Metro District
n=20

Type of Medication	# of Students
Any Medication	11 (55%)
Stimulant	7
Antipsychotic	3
Antidepressant	6
Antianxiety	2
Antimanic	0

Percentage of students who had been diagnosed in the past: 85%

Percentage of students receiving mental health therapy while in the Setting 4 placement: 5%

These data paralleled data from a Minnesota study of adolescents who were in the Juvenile Corrections system.

Although the assumption in the study was that mental health screening in juvenile detention would identify kids in need of mental health services….

It was found that 85% had already been diagnosed, but only 5% were receiving treatment.

Traditional treatment models were not successful for this population.

Mattison (1999):

3 year study of elementary school students in Special Education SED.
89 students ages 7-18
39% were taking psychiatric medication at the beginning of the study
26% on stimulants, with the rest on antipsychotics, antidepressants and clonidine.
17% were on multiple medications
24% were on medication consistently over the 3 year period

Psychiatric Characteristics of EBD Students Placed in Out of District Setting 4 Schools Suburban East Metro District

Students in Program #1 (Elementary/Middle School) (N=12)

	Dx	Evidence	Total
ADHD	75%	17%	92%
Depression	50%	8%	58%
O.D.D.	42%	0%	42%
P.D.D.	17%	25%	42%
PTSD	8%	33%	42%
Bipolar D/O	25%	8%	33%

Anxiety D/O	25%	8%	33%
Drug/Alcohol	8%	8%	17%
Borderline Features	17%	0%	17%
Depression NOS	17%	0%	17%
Mood D/O NOS	17%	0%	17%
Asperger’s Syndrome	17%	0%	17%
R.A.D.	8%	8%	17%
OCD	8%	8%	17%

Mental Retardation	8%	0%	8%
Borderline IQ	8%	0%	8%
Impulse Control D/O	8%	0%	8%
Sexual Acting Out	8%	0%	8%
Tourette's Syndrome	8%	0%	8%
Dysthymic D/O	8%	0%	8%
Episodic Dyscontrol	8%	0%	8%

Adjustment D/O	8%	0%	8%
Disruptive Behav. D/O	8%	0%	8%
Conduct D/O	8%	0%	8%
Autism	8%	0%	8%
Panic D/O	8%	0%	8%
Enuresis	8%	0%	8%
Psychotic D/O	8%	0%	8%
Fetal Alcohol Spectrum	0%	8%	8%

Number of diagnoses/student

	Dx	Evidence	Total
#1	12	1	13
#2	8	2	10
#3	6	1	7
#4	6	1	7
#5	3	3	6
#6	2	4	6
#7	5	0	5
#8	4	1	5
#9	3	2	5
#10	2	0	2
#11	2	0	2
#12	0	2	2

% Who have received diagnoses: 92%
% With either diagnosis or evidence of diagnosis: 100%
Average number of diagnoses/student: 4.4
Average number of diagnosis or evidence of diagnosis/student: 5.8

Students in Program #2- (Middle/High School) N=7

	Dx	Evidence	Total
ADHD	71%	29%	100%
Conduct D/O	29%	43%	71%
O.D.D.	29%	29%	57%
PTSD	0%	29%	29%
Depression	0%	29%	29%
Phobia	0%	29%	29%
Anxiety D/O	0%	29%	29%

Adjustment D/O	14%	0%	14%
Bipolar D/O	14%	0%	14%
Drug/Alcohol	14%	0%	14%
Depression NOS	14%	0%	14%
Mood D/O NOS	14%	0%	14%
Intermittent Explosive D/O	14%	0%	14%
Sexual Predator	14%	0%	14%
Dysthymic D/O	14%	0%	14%
Psychotic D/O	0%	14%	14%

Number of diagnoses/student

	Dx	Evidence	Total
#1	4	4	8
#2	6	1	7
#3	1	4	5
#4	4	0	4
#5	2	2	4
#6	0	4	4
#7	2	1	3

% of students who have received a diagnosis: 86%

% With diagnosis or evidence of diagnosis: 100%

Average number of diagnoses/student: 2.7

Average number of diagnosis or evidence of diagnosis/student: 5

How Do Setting 4 Students Compare With Students at the Time of Their First EBD Assessment?

Suburban West Metro Minnesota District

Psychiatric Characteristics of Students at Time of First EBD Assessment

(n=33)

Diagnosis	Dx	Evidence	Total
ADHD	48%	52%	100%
Depression	21%	55%	76%
Dysthymia	3%	0%	3%
Bipolar	6%	12%	18%

Chemical Abuse or Dependency	0%	0%	0%
Psychotic Disorders	0%	6%	6%
Schizo-Affective Disorder	0%	0%	0%
Obsessive-Compulsive Disorder	3%	0%	3%

PTSD	3%	0%	3%
Other Anxiety Disorders	3%	58%	61%
PDD	3%	9%	12%
Tic Disorder	3%	0%	3%
Bulemia	0%	0%	0%

Bulemia	0%	0%	0%
Adjustment Disorder	0%	48%	48%
Speech and Language Disorders	6%	0%	6%
Learning Disabilities	21%	0%	21%
Developmental Delays	0%	0%	0%
FAE/FAS/FDE/FDS	0%	0%	0%

Two Rural Minnesota Districts:

# Psychiatric Characteristics of Students- First Special Education Assessment for EBD- Rural District #1
N=15 students

Diagnosis	Dx	Evidence	Total
O.D.D.	15 (100%)	0	15 (100%)
ADHD	10 (66%)	5 (33%)	15 (100%)
Conduct D/O	0	12 (80%)	12 (80%)
Depression	1 (7%)	8 (53%)	9 (60%)
PTSD	1 (7%)	4 (27%)	5 (33%)
Other Anxiety D/O	0	8 (53%)	8 (53%)
Psychotic D/O	1 (7%)	0	1 (7%)
Dev. Delays	4 (27%)	0	4 (27%)
Tourette's	1 (7%)	0	1 (7%)

Medication Use:

	Use now	History	Total
ADHD Medication	6 (40%)	3 (20%)	9 (60%)
Antidepressants	1 (7%)	0	1 (7%)

Social History:

Parental Divorce/Separation	8	(53%)
Foster Care/ Adopted	5	(33%)
History of Physical Abuse	4	(27%)
History of Sexual Abuse	3	(20%)
Parental Chemical Dependencåy	4	(27%)

Special Education Services:

EBD	15
LD	6
Speech/Language	5
OHD	2
MMMI	1

Psychiatric Characteristics of Students-
First Special Education Assessment for EBD-
Rural District #2
N=6 students

Diagnosis	Number of Students	%
ATTENTION/IMPULSIVITY:		
ADHD	6	100
BEHAVIOR:		
Oppositional/Defiant	4	67
Disruptive Behavior Disorder	1	17
Conduct Disorder	1(evidence)	17

MOOD		
Mood Disorder NOS	2	33
Depression NOS	1	17
ANXIETY		
Anxiety Disorder NOS	2	33
PTSD	1	17
AUTISM SPECTRUM		
Asperger's Syndrome	1	17
ASD (rule out)	1	17

ATTACHMENT		
Reactive Attachment Disorder	1	17
MISCELLANEOUS		
Sexual Abuse of Child	1	17
Adjustment Disorder	1	17

MEDICAL

Shaken Baby Syndrome	1	17
Traumatic Brain Injury	1	17
Developmental Delays	1	17
Developmental Articulation Disorder	2	33
FAS/FASD (rule out)	1	17
Encopresis	1	17
Enuresis	1	17

Average number of diagnoses/
child= 4.7
Including evidence of diagnoses,
number/child= 5.7

Minnesota Rules mandate that students placed in the EBD category have a mental health screening as part of the evaluation. Why screen for a problem when the percentage likely to be found is approximately 100%?

Conclusion: Mental Health Disorders are pervasive, not only in Setting 4, but also at the pre-referral stage of ED Special Education

Ironically, it is not uncommon for nearly half of the students seen for a special education assessment to already be on medication at the time of referral.

The medication is usually for ADHD, and the referral for special education assessment is generally for impulsivity, hyperactivity and distractibility symptoms that are interfering with the student's educational progress.

Common sense would dictate that the next logical step would be to request that the parents sign a release of information to the prescribing physician, and then communicate about the ongoing ADHD symptoms that are not responding to the present dosage of medication.

Unfortunately, this step is often overlooked. This leads to an expensive evaluation, ongoing lack of efficacy of treatment, and lack of educational success.

A district mental health plan should operationalize this step
in communication with the prescriber as being a necessary pre-referral intervention.

What's the problem with the ED category?

1.) The category is based on outdated concepts

2.) Unlike all of the other Special Education categories, it lacks a connection to any specific disability

3.) It is tautological (the category is the “disability”)

4.) Despite the fact that the vast majority of students in this disability have been diagnosed with, or have evidence of a mental health disorder...

There is no mandate to identify the disorder, or to accommodate the mental health disabilities when they have been diagnosed

5.) The category is based on behavioral conceptualizations that are inappropriate for many psychiatrically disabled students

6.) It has abysmal outcomes

The conceptual framework of ED is similar to having a category of "Breathing Disorder", in which asthma, cystic fibrosis, chronic bronchitis and environmental allergies were generally the causal factors…

but in which there was no expectation that these disorders would be identified and no requirement that interventions would take the diagnoses into account.

Dakota tribal wisdom says that when you discover you are riding a dead horse, the best strategy is to dismount.

However, in our work, we often try other strategies with dead horses, including the following:

1. **Buying a stronger whip.**
2. **Changing riders.**
3. **Saying things like "This is the way we always have ridden this horse."**
4. **Appointing a committee to study the horse.**
5. **Arranging to visit other sites to see how they ride dead horses.**
6. **Increasing the standards to qualify as a dead horse rider.**
7. **Appointing a team to revive the dead horse.**

8. Pass legislation declaring that "This horse is not dead."
9. Unilaterally declaring, "no horse is too dead to beat."
10. Blaming the horse's parents.
11. Providing additional funding to increase the horse's performance.
12. Do a Cost Analysis Study to see if contractors can ride the horse cheaper.
13. Declare the horse is "better, faster and cheaper" dead.
14. Revisit the performance requirements for horses.
15. Promote the dead horse to a supervisory position.

These students often are not successful with traditional mental health interventions, due to the presence of behavioral difficulties that are not due to their mental health disorders.

Behavioral —Predominately—Mixed—Predominately—Clinical
Behavioral   Clinical

Although ED students are often viewed as being mostly behavioral, they are in fact generally “mixed” or “predominately clinical”.

They require an integrated approach utilizing a combination of behavioral and clinical interventions.

Educational efforts are most successful when the clinical aspects are understood, and accommodations and modifications are based on the nature of the student's underlying disorder.

Labeling the failing student as being "oppositional and defiant" only adds insult to injury if the underlying issue is a clinical disorder (e.g., anxiety, mood, ADHD, etc.)

Alternatives to ED

Other Health Impaired:

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**.

In many districts, OHI placement for mental health disorders applies to non-delinquent, non-disruptive, compliant students, generally with ADHD as their disability

This ignores the fact that behavioral disruptions may be key features of some disorders (e.g., mania in bipolar disorder),

or common accompaniments (e.g. due to impulsivity in ADHD).

I recommend that, whenever possible, OHD rather than ED placement be sought.

Special education law requires a member of the team to have adequate knowledge of the student's disability.

ED is not a disability.
The mental health disorders accompanying ED may not be viewed as being the student's disability.
Go for OHI.

However, a student who is making good educational progress may not qualify for OHI, but might qualify for ED due to impaired social-emotional functioning.

I would not recommend a 504 plan for a student who qualifies for special education, as parents have more safeguards and involvement with special education.

Although many districts' special education is considered non-categorical, students need to qualify for special education based on categories. This impacts the way school staff view the students.

What can be done about ED?

For Educators:

If you are an educator (teacher, administrator, school psychologist, social worker, counselor, etc.), recognized that these are students with unique mental health needs regarding their education.

Develop mental health plans for them, just as you would have medical plans for students who have asthma or diabetes.

Educate yourself about the nature of mental health disorders in children and adolescents, how they impact educational progress, and the types of interventions that are most likely to be successful.

Utilize evidence-based teaching methods for these students including:

Proactive Classroom Management techniques (PCM)
Clear Rules/Expectations (CRE)
Crisis Intervention Planning (CIP)
Academic supports and curricular/instructional modifications (CIM)
Systemic approach to cooperative learning (CL)
Specialized instruction to promote learning and study skills

Peer-Assisted Learning Strategies (PALS)
Peer-mediated intervention to promote positive behavioral skills (PMI)
A conflict resolution program (CRP)
Social skills instruction taught as part of regular classroom instruction (SSI)
Anger management program (AMP)
A behavior support/management plan (BSM)
Pre-correction instructional strategies (PCIS)

Group-oriented contingency management (GOCM)
Choice-making opportunities for students
Instruction in self-monitoring of student performance (SMSP)
A system of positive behavioral intervention and support
Peer reinforcement to promote appropriate student behavior (PR)
Instruction in self-monitoring of non-academic behaviors (SMAB)
Behavior contracts (BC)
A formal procedure for developing function-based interventions (FBA)

For Clinicians:

Recognize that the school may have a behavioral bias, and help staff understand the students' clinical issues.

Recognize the non-clinical aspects that may undermine traditional mental health interventions.

Have the treatment fit the student, not vice-versa.

For Policy Advocates:

Advocate for either the elimination of the ED category, or for changes that reflect contemporary understanding of the nature of childhood mental health disorders.

For Parents:

Ask the school district representative for outcome data on its ED students.

Request OHI rather than ED placement whenever possible

Make sure that the team has a member who is knowledgeable in the student’s mental health disability.

Good Luck!