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**THE IDEA'S PROMISE UNFULFILLED: A SECOND LOOK AT  
SPECIAL EDUCATION & RELATED SERVICES FOR  
CHILDREN WITH MENTAL HEALTH NEEDS  
AFTER *GARRET F.***

ELLEN A. CALLEGARY\*

“BRIAN,”<sup>1</sup> age 15

His parents had an extremely difficult time persuading him to attend school, and he began to have panic attacks and feel that he was unable to breathe on the way to school and in the school parking lot. When “Brian” did attend school, he spent a majority of the day either in the health suite or in the guidance office. [T]he school guidance counselor was unable to persuade “Brian” to attend class. While in the health room, “Brian” would spend periods of 60 minutes at a time in the restroom. On one occasion, the school nurse enlisted the help of the school psychologist, who spoke with “Brian” through the bathroom door.

“Brian’s” condition worsened to the point where he was screaming and crying, and his parents could not force him to attend school. He spent ten days at a Day Hospital for treatment of his anxiety and depression, and then an attempt was made to return him to [the pub-

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1. All names of children have been changed in this article to protect their confidentiality unless their names are being quoted from published opinions.

lic high] school with an abbreviated schedule. His parents brought him to school, where he remained in the guidance office, the health suite, or the nurse's restroom. [T]he guidance counselor, persuaded "Brian" to attend class, where he huddled in the back of the room almost hidden behind a computer. "Brian" was psychiatrically hospitalized.

For most of the school year, "Brian" received home and hospital teaching through teleclasses, without any special education services. He had a great deal of difficulty processing information over the telephone and completing work independently, and received Ds in all subjects.

The [neuropsychologist] provided a follow-up evaluation of "Brian". . . . "Brian" continued to demonstrate weaknesses in organization, attention, and written language skills, and [the neuropsychologist] noted a dramatic increase in his social/emotional difficulties, particularly anxiety.<sup>2</sup>

"Lisa" age 15

By 9th grade, the IEP developed called for special education services with a resource period. At the start of school at [the public high school], the child was in fact placed in a resource room. The only problem was that the resource room teacher had no idea who the child was or why she was there. After several weeks of school, the child was sent to the guidance office because the resource teacher believed the child was not coded for special education. She clearly did not receive any meaningful special education services during this time, although she was in a resource room. This is hardly the way for a child with a learning disability, who has been denied services for two years, to begin high school.

By the start of 9th grade, the emotional problems, which had surfaced in earlier years, began to increase in frequency and severity. There were panic attacks with hyperventilation and visits to the health room. In Spring, 1997, the child started self-mutilation in small ways, such as destroying her fingernails. She had suicidal ideation, although she was never actively suicidal. It was in 1997 that the parents obtained the services of . . . a psychologist, not because they thought the academic program was inadequate, but because, like the school system, they thought something else was at work.<sup>3</sup>

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2. Letter from "Brian's" attorney to Public School Officials (June 13, 2000) (on file with the author).

3. Montgomery County (MD) Pub. Sch., 31 IDELR 70 (1999).

## I. INTRODUCTION &amp; STATEMENT OF THE PROBLEM

Children with complex mental health needs like “Lisa” and “Brian” often end up being isolated, hospitalized multiple times and excluded from school or placed in more restrictive settings. Such results can be due to several of the legal and policy barriers to providing a free and appropriate public education (FAPE) in the least restrictive environment to children with mental health needs. These barriers not only result in the under identification of children who need mental health services, but also in problems with the delivery of those services once their needs have been identified.<sup>4</sup> Based on experience, these problems persist even where there are dedicated educators, psychologists, nurses, social workers, and speech pathologists all working together in a school setting in the best interests of children. School personnel, families, and advocates are often in the extremely difficult position of attempting to serve children with disabilities with too few resources and too little training.<sup>5</sup>

Even after twenty-five years of implementation, “federal efforts to enforce the law [the IDEA and its predecessors] . . . have been inconsistent, ineffective, and lacking any real teeth.”<sup>6</sup> These deficiencies have been documented in numerous Office of Special Education Programs (OSEP) reports reviewing states’ compliance with the IDEA’s legal mandates.<sup>7</sup> The National Council on Disability<sup>8</sup> found that “[p]ervasive and persistent noncompliance with IDEA is a complex problem with often dramatic implications on a daily basis for the lives

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4. See *infra*, notes 96-143 and accompanying text.

5. See 2000 U.S. DEP’T OF EDUC., OSEP ANN. REP. 22, at III-8 [hereinafter OSEP ANN. REP.].

Every year, schools are being asked to do more with fewer resources. New initiatives to improve literacy, enhance character, accommodate rapidly advancing technologies, make schools violence free, and facilitate school-to-work transitions are added to the educator’s workday. Schools are being asked to achieve new and more results, yet seldom are allowed to cease work on the growing list of initiatives. Educators also are being asked to educate an increasingly heterogeneous population of students. An increasing number of students in our schools have English as a second language, limited family supports, significant learning and/or behavioral problems, families who face major financial barriers, and a great need for mental health, social welfare, medical, and vocational assistance.

*Id.*

6. NATIONAL COUNCIL ON DISABILITY, Back to School on Civil Rights 5 (Jan. 25, 2000), available at [http://www.ncd.gov/newsroom/publications/backtoschool\\_1.html](http://www.ncd.gov/newsroom/publications/backtoschool_1.html). [hereinafter BACK TO SCHOOL ON CIVIL RIGHTS]

7. See *e.g.*, *id.* at 79-152.

8. The National Council on Disability is “an independent federal agency with 15 members appointed by the President of the United States and confirmed by the U.S. Senate.” *Id.* at 380. Its purpose is to “promote policies, programs, practices, and procedures that guarantee equal opportunity for all individuals with disabilities. . . .” *Id.*

of children and their families.”<sup>9</sup> In short, the IDEA’s promise remains unfulfilled for too many children.

This article focuses on those implementation problems associated with providing services for children with mental health needs. Additionally, it reviews the legal requirements for special education and related services in light of the United States Supreme Court’s ruling in *Cedar Rapids Community School District v. Garret F.*<sup>10</sup> and the 1997 amendments to the Individuals with Disabilities Education Act (IDEA).<sup>11</sup> It concludes that all special education and related services that a child needs to remain in school and benefit from education must be provided even if those services include such expensive and rare services as an “on site” mental health professional who is available to the child during all school hours or psychiatric care for diagnostic and evaluation purposes.<sup>12</sup>

This article consists of four sections. Section I provides an overview of the IDEA and the legal framework for special education and related services after the *Garret F.* decision and the 1997 amendments to the IDEA. Section II describes the barriers to receipt of services. Section III reviews problems with the delivery of needed services to children. Finally, Section IV posits recommendations for removal of those barriers.<sup>13</sup>

## II. THE INDIVIDUALS WITH DISABILITIES EDUCATION ACT

### A. History

In 1975, Congress enacted the Education for All Handicapped Children Act,<sup>14</sup> renamed the Individuals with Disabilities Education Act in 1990 (IDEA).<sup>15</sup> The IDEA requires that children with disabilities receive a free and appropriate public education (FAPE).<sup>16</sup> The legislation was prompted, in part, by Congressional findings that of

9. *Id.* at 11.

10. *Cedar Rapids Cmty. Sch. Dist. v. Garret F.*, 526 U.S. 66 (1999).

11. Individuals with Disabilities Education Act Amendments of 1997, Pub. L. No. 105-117, 111 Stat. 37 (1997).

12. See discussion *infra*, Part II.

13. Some of the concepts in this article were presented at the symposium on “Children with Special Needs: The Intersection of Health Care, Education & the Law” which was sponsored by the Law and Health Care Program of the University of Maryland School of Law on May 17, 2001. I have incorporated some of the recommendations that were produced by the interdisciplinary Workshops at the conference.

14. Education for All Handicapped Children Act of 1975, Pub. L. No. 94-142, 89 Stat. 773 (1975).

15. Individuals with Disabilities Education Act Amendments of 1991, Pub. L. No. 102-119, 105 Stat. 587 (1991)

16. 20 U.S.C. § 1412(a)(1)(A), (a)(5)(A) (Supp. V 1999).

the 8 million disabled children below the age of 21, 2.5 million of those children were receiving an inappropriate education, and 1.75 million children with disabilities were totally excluded from public schools.<sup>17</sup> According to the National Council on Disability, prior to the enactment of the IDEA, only 1 in 5 students with disabilities were educated in schools.<sup>18</sup> Those with emotional disabilities were among the most poorly served of disabled students. Studies revealed that in the academic year immediately preceding passage of the Act, the educational needs of 82% of all children with emotional disabilities went unmet.<sup>19</sup>

The IDEA was designed to remedy these problems by helping to finance state programs and requiring states to provide educational opportunities to all disabled children.<sup>20</sup> At the time of the IDEA's reauthorization in 1997, Congress declared it to be "a very successful law."<sup>21</sup>

### B. IDEA's "Purposes"

The IDEA was designed to ensure's that "all children with disabilities have available to them a free appropriate public education emphasizing special education and related services designed to meet their unique needs and prepare them for employment and independent living,"<sup>22</sup> and to ensure that "the rights of children with disabilities and . . . [their] parents are protected."<sup>23</sup> To meet these goals, states are required to implement a "statewide, comprehensive, coordinated, multidisciplinary, interagency system of early intervention services for infants and toddlers with disabilities and their families."<sup>24</sup>

Although the IDEA is a powerful federal civil rights statute that requires each State to ensure that children with disabilities receive a FAPE meeting their special education and related services needs in

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17. S. REP. NO. 94-168, at 8 (1975), *reprinted in* 1975 U.S.C.C.A.N. 1425, 1432.

18. BACK TO SCHOOL ON CIVIL RIGHTS, *supra* note 6, at 6.

19. Lucy Shum, Comment, *Educationally Related Mental Health Services for Children with Serious Emotional Disturbance: Addressing Barriers to Access through the IDEA*, 5 J. HEALTH CARE L. & POL'Y forthcoming (Spring 2002) (quoting S. REP. NO. 94-168, at 8 (1975), *reprinted in* 1975 U.S.C.C.A.N. 1425, 1432).

20. See BACK TO SCHOOL ON CIVIL RIGHTS, *supra* note 6, at 6.

21. *The number of children with developmental disabilities in State institutions has declined by close to 90 percent.* The number of young adults with disabilities enrolled in post secondary education has tripled, and the unemployment rate for individuals with disabilities in their twenties is almost half that of their older counterparts. H.R. REP. NO. 105-95, at 84 (1997), *reprinted in* 1997 U.S.C.C.A.N. 78, 81 (emphasis added).

22. 20 U.S.C. § 1400 (d)(1)(A) (Supp. V 1999).

23. *Id.* at § 1400(d)(1)(B).

24. *Id.* at § 1400(d)(2).

the least restrictive environment, there is widespread noncompliance with this mandate. The National Council on Disability found that between 1994 and 1998 every State was out of compliance with the IDEA and had been for many years, that the parents of children with disabilities bore the burden of enforcing the law through formal complaint procedures and due process hearings, and that the Department of Education had not made full use of its authority to enforce the IDEA through sanctions such as withholding funds or referrals to the Department of Justice.<sup>25</sup>

### C. Garret F. & *The Mandate to Provide Related Service*

In 1999, the U.S. Supreme Court decided *Cedar Rapids Community School District v. Garret F.*, in which the Court addressed the school system's obligation to meet the needs of a student who was paralyzed from the neck down.<sup>26</sup>

Because Garret required a trained person to attend him at all times in order to receive the numerous services he needed, a regular school nurse who was also responsible for other children in the school could not perform all of Garret's procedures. The Court rejected the school system's argument that the continuous character of the care and its cost should be taken into consideration in determining its legal obligations under the IDEA.<sup>27</sup> In reaching this conclusion, the Court noted that the law "does not employ cost" in its "related services" definition and thus "accepting the District's cost-based standard . . . would require us to engage in judicial lawmaking without any guidance from Congress. It would also create some tension with the purposes of the IDEA."<sup>28</sup> Quoting its decision in *Board of Education v. Rowley*,<sup>29</sup> the Court stated that "Congress intended 'to open the door of public education' to all qualified children and 'require[d] partici-

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25. BACK TO SCHOOL ON CIVIL RIGHTS, *supra* note 6, at 7. The National Council on Disability's review was based on the Department of Education's monitoring reports of the States.

26. *Cedar Rapids Cmty. Sch. Dist. v. Garret F.*, 526 U.S. 66 (1999). The Court found that Garret needed:

assistance with urinary bladder catheterization once a day, the suctioning of his tracheotomy tube as needed, but at least once every six hours, with food and drink at lunchtime, in getting into a reclining position for five minutes of each hour, and ambu bagging occasionally as needed when the ventilator is checked for proper functioning. He also needs assistance from someone familiar with his ventilator in the event there is a malfunction or electrical problem, and someone who can perform emergency procedures. *Id.* at 69 n.3.

27. *See id.* at 76-79.

28. *Id.* at 77.

29. 458 U.S. 176 (1982).

pating States to educate handicapped children with non-handicapped children whenever possible.’”<sup>30</sup> The Court went on to state that:

This case is about whether meaningful access to the public schools will be assured. . . . It is undisputed that the services at issue must be provided if Garret is to remain in school. . . . [T]he District must fund such ‘related services’ in order to help guarantee that students like Garret are integrated into the public schools.<sup>31</sup>

Thus, *Garret F.* requires public schools to hire and train additional staff and to make any other needed accommodations to enable students with disabilities, including those with mental health needs and emotional disturbances, to attend school and benefit from instruction regardless of the cost. The provision of appropriate related services in the school setting can be the critical element that helps these children stay in school and make progress towards independent living.<sup>32</sup>

1. *The United States Supreme Court Speaks: What Is Included in “Related Services?”*

In *Garret F.*, the Court clarified that the term “related services” should be interpreted broadly. It found that:

[T]he related services definition . . . broadly encompasses those supportive services that may be required to assist a child with a disability to benefit from special education. . . . As a general matter, services that enable a disabled child to remain in school during the day provide the student with the meaningful access to education that Congress envisioned.<sup>33</sup>

2. *What Do the Federal Regulations Say About Related Services?*

The related services definition in the federal regulations implementing the IDEA includes a number of services that are essential to helping certain children with mental health needs remain in school and benefit from their education. These services include: speech-language pathology, psychological services, psychiatric services for diagnostic and evaluation purposes, therapeutic recreation, counseling

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30. *Garret F.*, 526 U.S., at 78 (quoting *Bd. of Educ. v. Rowley*, 458 U.S. 176, 192 (1982)).

31. *Id.* at 79.

32. See Leslie Seid Margolis, *The Provision of School Health Services to Students with Disabilities: The Intersection of Health Care Policy, Education and the Law in the Post-Garret F. Era*, 5 J. HEALTH CARE L. & POL’Y (forthcoming Spring 2002).

33. *Garret F.* 526, at 73. (citations omitted).



services, school health services, social work services in schools, and parent counseling and training.<sup>34</sup>

3. *Are Related Services Limited to Those Services Specifically Listed in the Related Services Definition?*

Because the federal regulation's related services definition contains a laundry list of included services, there is a misperception that school systems may not provide related services unless they are on the list. This is not the case. In fact, the Office of Special Education Programs (OSEP) clarified this point stating that: "The list of related services is not exhaustive and may include other developmental, corrective, or supportive services if they are required to assist a child with a disability to benefit from special education."<sup>35</sup> OSEP then indicated that these services could include services such as nutritional services or service coordination.<sup>36</sup>

For children with complex mental health needs, this ability to be flexible, creative and to think "outside the box," can mean the difference between being able to stay in school or being hospitalized. It is striking that OSEP specifically mentioned service coordination because it is a service that is rarely offered and may be one of the most important related services that a school system can provide when a child is involved with multiple agencies and multiple service providers. Based on personal experience and that of other advocates, children with complex mental health needs may have both private and public agency professionals working with them including developmental pediatricians, psychiatrists, psychologists, social workers, school nurses, occupational therapists, speech-language pathologists, respite care providers and family counselors.<sup>37</sup> At the interdiscipli-

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34. 34 C.F.R. § 300.24 (2001). The complete definition of related services is: As used in this part, the term related services means transportation and such developmental, corrective, and other supportive services as are required to assist a child with a disability to benefit from special education, and includes speech-language pathology and audiology services, psychological services, physical and occupational therapy, recreation, including therapeutic recreation, early identification and assessment of disabilities in children, counseling services, including rehabilitation counseling, orientation and mobility services, and medical services for diagnostic or evaluation purposes. The term also includes school health services, social work services in schools, and parent counseling and training.

34 C.F.R. § 300.24(a).

35. 34 C.F.R. Part 300, Appendix A (2001).

36. *Id.*

37. Based on interviews with Leslie Seid Margolis, Esq., attorney with the Maryland Disability Law Center, Member of the Maryland Developmental Disabilities Council, and Member of the Professional Advisory Board of CHADD of Greater Baltimore (Aug. 3, 2001

nary conference on Children with Special Needs: The Intersection of Health Care, Education & The Law, many of the workshop participants identified service coordination as a need.

4. *Related Services Must Be Provided: "Good Faith Efforts" Are Not Enough*

A recent Maryland federal district court decision makes it clear that if a related service is written into the child's IEP, the service must be provided. A "good faith effort" at service provision is not enough.<sup>38</sup> The Court rejected the school district's argument that "it attempted to implement Brandon's IEP 'to the best of its ability,'"<sup>39</sup> stating that:

Provision of those services is within the control of and is the obligation of the school and BCPS as they have agreed that the services listed in the IEP are the ones required by the child to receive a FAPE. A 'good faith effort' will not meet the statutory and regulatory commands.

Providing [a service] in accordance with the IEP is mandatory, not discretionary.<sup>40</sup>

5. *Least Restrictive Environment: Without Mental Health Related Services, IDEA's Requirements for LRE Cannot Be Met*

The IDEA requires that children with disabilities receive an education in the least restrictive environment (LRE) that meets their needs.<sup>41</sup> Although we typically think of the least restrictive environment as a general education classroom in a child's neighborhood school, there are times when the least restrictive environment for a child may be a specialized public or private day program or even a residential treatment program. Two cases decided in United States Courts of Appeals illustrate when a residential placement may be appropriate for a child with complex mental health needs.

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& Sept. 10, 2001); Wayne D. Steedman, Esq., Partner with Callegary and Steedman, and a clinical social worker (Aug. 10, 2001 & Aug. 14, 2001).

38. See *Manalansan v. Board of Education of Baltimore City*, No. AMD 01-312, 2001 WL 939699, at \*24-25 (D. Md. Aug. 14, 2001).

39. *Id.* at \*24.

40. *Id.* at \*25.

41. The Act states that:

To the maximum extent appropriate, children with disabilities . . . are educated with children who are not disabled, and . . . removal of children with disabilities from the regular educational environment occurs only when the nature or severity of the disability of a child is such that education in regular classes with the use of supplementary aids and services cannot be achieved satisfactorily.

20 U.S.C. § 1412(a)(5) (2000); see MD REGS CODE tit. 13A, § 05.01.10 (2001).

“Brian” and “Lisa” did not receive the mental health services that they needed in the public schools that they attended. Their emotional needs were not recognized and addressed by their public schools until it was too late for them to remain in their neighborhood schools. Their panic attacks at school had increased so much in intensity and frequency, that they could no longer benefit from their educational programs. As a consequence, they both ended up going to private day schools (at public expense) that could meet their unique needs.

In a recent case the Court of Appeals for the Eighth Circuit found that a residential placement was needed “to provide treatment for a psychological problem that has prevented A.C. from making acceptable educational progress.”<sup>42</sup> In reaching this conclusion, the court cited the neuropsychologist’s testimony “that neither medication, individual psychotherapy, nor family therapy was likely to do much good, but that the residential aspect of a secure facility would probably have therapeutic benefit: ‘the fact is that at a residential treatment program, . . . the environment is the therapy.’”<sup>43</sup> Although the school system argued that “the IDEA’s preference for mainstream placements counsels against placing A.C. in a residential facility,” the court noted that “[t]he statute requires mainstreaming only ‘to the maximum extent appropriate,’ not to the maximum extent possible.”<sup>44</sup> The court went on to note that a school system is responsible for paying for a student’s residential placement if the student will not benefit from an education otherwise.<sup>45</sup>

In *County of San Diego v. California Special Education Hearing Office*,<sup>46</sup> the Ninth Circuit applied three tests to determine whether the school system was responsible for the child’s residential placement:

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42. *Indep. Sch. Dist. No. 284, Wayzata Area Schools, Wayzata, Minnesota v. A.C.*, 258 F.3d 769, 778 (8th Cir. 2001).

43. *Id.*

44. *Id.* at 779.

45. *Id.* at 774.

46. *County of San Diego v. California Special Educ. Hearing Office*, 93 F.3d 1458 (9th Cir. 1996). This case involved a middle school student who had violent outbursts and a hospitalization related to preparing a school science report. The student’s frustration with the assignment led her physically to abuse her mother and to break windows in the family’s home. She was found eligible for special education services following that hospitalization. Upon transfer into high school, the student’s behavior deteriorated - she would avoid therapy sessions and took her mother’s company car on a joyride. When the day program in which the school system placed the student failed to adequately address her needs, her mother unilaterally placed her in a residential program and requested reimbursement from the school. When the school refused, her mother took them to hearing and won. The school board appealed to the United States District Court and the District Court upheld the hearing officer’s finding that the student required residential placement. The

(1) where the placement is 'supportive' of the pupil's education; (2) where medical, social or emotional problems that require residential placement are intertwined with educational problems; and (3) when the placement is primarily to aid the student to benefit from special education.<sup>47</sup>

The court concluded that Rosalind's "primary therapeutic need is educational and the primary purpose of her residential placement is educational."<sup>48</sup>

In order for children with complex mental health needs to remain in, or return to, their home schools from residential placements or private day schools, intensive mental health services must be available when needed. For a child with complex mental health needs, those services are like the wheelchair ramp that allows a child who uses a wheelchair to enter and participate freely throughout his home school. Based on experience, an interdisciplinary service model is needed in order for those mental health services to be effective.<sup>49</sup>

6. *After Garret F. & the 1997 Amendments to the IDEA: Raising the "Floor of Opportunity"*

The *Garret F.* decision when read in combination with the 1997 amendments to the IDEA raises the floor of educational opportunity that must be provided to children with disabilities. They move us beyond the minimum standards enunciated by the United States Supreme Court in *Board of Education v. Rowley*.<sup>50</sup> In *Rowley*, the Court looked at the IDEA's legislative history and the statutory definition of FAPE and concluded that the law only guaranteed a "basic floor of opportunity" consisting of "access to specialized instruction and related services which are individually designed to provide educational benefit to the handicapped child."<sup>51</sup> Despite Justice Rehnquist's caution that the *Rowley* decision did not create "any one test" for deter-

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Circuit Court of Appeals agreed and found that the student did not receive an educational benefit from the day treatment because she had not made progress on her mental health goals. *Id.* at 1462-64.

47. *Id.* at 1468.

48. *Id.* The court found that the residential "placement [was] supportive of her education in that it provides the structure, discipline, and support she needs to achieve her IEP and mental health goals." *Id.* The court also found that "Rosalind's difficulties clearly include substantial educational problems that are related to non-educational problems" and that her "primary problems were educationally related." *Id.*

49. See discussion *infra* Part IV.

50. Bd. of Educ. v. Rowley, 458 U.S. 176 (1982).

51. *Id.* at 201. The Court rejected the district court's finding that the IDEA provided children with disabilities "an opportunity to achieve [their] full potential commensurate with the opportunity provided to other children." *Id.* at 176.

mining educational benefit,<sup>52</sup> “‘some educational benefit’ . . . has become a term of art used to describe the standard espoused by the *Rowley* Court.”<sup>53</sup> The unfortunate consequence of the belief that *Rowley* set the “some educational benefit” standard for “the adequacy of educational benefits conferred upon all children covered by the Act,”<sup>54</sup> is that school systems argue that they have met the Act’s requirements if a child makes any educational progress at all. However, the school districts are not insulated from legal liability if a child makes only minimally acceptable educational progress.<sup>55</sup> “[W]hen it is clear that the statute has been violated, a school should not be released from liability because a child has made some minimal educational progress.”<sup>56</sup>

As discussed above, *Garret F.* requires that school systems provide related services without regard to cost if the services are needed to maintain a child in school. The 1997 amendments to the IDEA and their legislative history have moved the law’s guarantees beyond mere “access” to the classroom in which the child is only entitled to education that is “sufficient to confer some educational benefit.”<sup>57</sup> “The level of ‘educational benefit’ required by *Rowley* has been hotly disputed in Maryland and throughout the nation.”<sup>58</sup> “With the 1997 amendments’ greater emphasis on measurable progress, the legal debate is expected to continue.”<sup>59</sup> At least one other commentator has

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52. *Rowley*, 458 U.S. at 202.

53. Jane K. Babin, *Adequate Education: Do California Schools Meet the Test?*, 37 SAN DIEGO LAW REVIEW 211, 219 n. 87.

54. *Rowley*, 458 U.S. at 202.

55. See *Manalansan v. Board of Education of Baltimore City*, No. AMD 01-312, 2001 WL 939699 (D. Md. Aug. 14, 2001).

[T]hat Brandon may have made some educational progress despite the significant lapses in TJ’s implementation of his IEP cannot be used as a shield to deny him the baseline opportunity to benefit from his educational program in the ways deemed appropriate by the IEP.

*Id.* at \*25.

56. *Id.* at \*24.

[T]he Fourth Circuit has held that “failures to meet the Act’s procedural requirements are adequate grounds by themselves” for finding a denial of FAPE, apparently without an inquiry into whether educational benefit was conferred on the student despite the procedural violation. *Hall v. Vance County Board of Education*, 774 F.2d 629, 635 (4th Cir. 1985). Such a holding would seem to reflect a belief that the IDEA serves a deterrent function and creates substantive rights that can be enforced even if a child has been lucky enough to make progress despite a school’s failure to comply with the federal law.

*Id.* at \*25.

57. *Rowley*, 458 U.S. 200.

58. See *Fritschle v. Andes*, 45 F. Supp. 2d 500 (D. Md. 1999).

59. Ellen A. Callegary & Abigail F. Cohen, *Laws Protecting Children with Special Needs*, MD. BAR J., at 38, 40 (Mar./Apr. 2000).

argued that the 1997 amendments alone have raised the level of educational opportunity guaranteed by the IDEA.<sup>60</sup> That commentator also posited that the new provisions requiring measurable goals and focusing on the student's progress, may indicate Congress' intent to raise the standards for educational benefit.<sup>61</sup>

However, it is not only the IDEA's new emphasis on measurable progress<sup>62</sup> that moves us beyond *Rowley's* minimum standards, it is also the new language in the statute that speaks to "equality of opportunity" and the fact that "low expectations" have impeded the law's implementation.<sup>63</sup> Specifically, the IDEA states that "[i]mproving educational results for children with disabilities is an essential element of our national policy of ensuring equality of opportunity, full participation, independent living, and economic self-sufficiency for individuals with disabilities."<sup>64</sup> This policy of ensuring "equality of opportunity" which appears for the first time in the 1997 amendments,<sup>65</sup> hearkens back to the language contained in the legislative history of the Act's original 1975 enactment. This language was quoted in Justice White's dissenting opinion in *Rowley*: "According to the Senate Report, . . . the Act does 'guarantee that handicapped children are provided *equal* educational opportunity.'"<sup>66</sup> It is striking that Congress has now chosen to put that exact language in the statute as if affirming Justice White's dissent, and indicating their intention for a higher standard than the one the majority of Justices enunciated in *Rowley*. Although the legislative history of the 1997 amendments is silent on this point, there have certainly been enough substantive changes in the law since *Rowley* was decided to merit a reexamination of exactly where the "floor of opportunity" is today.

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60. Tara L. Eyer, Comment, *Greater Expectations: How the 1997 IDEA Amendments Raise the Basic Floor of Opportunity for Children with Disabilities*, 126 ED. LAW REP. 1 (1998).

61. *Id.* at 7.

62. See 20 U.S.C. §1414(d)(1)(A) (2000).

63. See 20 U.S.C. §1400(c) (2000). Based on Congress' intent, as demonstrated by the emphasis of these requirements on each child's progress toward measurable goals in terms of the regular education curriculum, and the sufficiency of the child's progress toward those goals, the Supreme Court's reasoning in *Rowley* has lost much of its foundation. *Id.* (citation omitted).

64. 20 U.S.C. §1400(c) (2000).

65. Individuals with Disabilities Education Act Amendments of 1997, Pub. L. No. 105-17, 111 Stat. 37 (1997).

66. Bd. of Educ. v. *Rowley*, 458 U.S. 176, 213 (1982) (quoting S. REP. NO. 94-168, at 9 (1975) *reprinted in* 1975 U.S.C.C.A.N. 1425, 1433).

*D. Procedures & Procedural Safeguards*

The procedural and substantive purposes of IDEA are well-settled. I [the Honorable Andre M. Davis, United States District Judge] have stated:

The IDEA was drafted to “assure that all handicapped children have available to them . . . a free appropriate public education which emphasizes special education and related services designed to meet their unique needs.” The “centerpiece” of this “free appropriate public education” is the individualized education program (“IEP”) which is a collaboratively developed plan for a disabled child’s education. . . . Moreover, although a school system is not required to maximize a child’s potential . . . it is imperative that the educational placement “be likely to produce progress, not regression or trivial educational advance.”<sup>67</sup>

The IDEA requires state and local education agencies to provide students suspected of having a disability with a comprehensive evaluation through the use of multiple assessment tools and strategies.<sup>68</sup> State and local educational agencies have the responsibility of evaluating children who are suspected of having disabilities in order to determine their needs for these services.<sup>69</sup> Education agencies have the responsibility of identifying and screening children suspected of having an emotional disturbance.<sup>70</sup> Because the IDEA provides disciplinary protection for children with ED who are not yet eligible for services,<sup>71</sup> school districts are also responsible for the identification and assessment of children when families challenge suspensions or expulsions because of behavior relating to an unidentified disability.<sup>72</sup>

Once school districts identify children with disabilities, they are responsible for annual assessments and the delivery of educationally related services.<sup>73</sup> Although evaluations should occur with parental informed consent, the agency may pursue them without consent

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67. *Manalansan v. Bd. of Educ. of Baltimore City*, No. AMD 01-312, 2001 WL 939699, \*13-14 (D. Md. Aug. 14, 2001) (quoting *Cavanaugh v. Grasmick*, 75 F. Supp. 2d 446, 456-57 (D. Md. 1999) (citations omitted)).

68. Shum, *supra* note 19 (citing 20 U.S.C. §§ 1412(a)(7), 1414(a),(b) (2000)).

69. 20 U.S.C. § 1414(a)(1)(A).

70. *Id.* § 1414(a)(1)(B).

71. *Id.* § 1415(k)(8)(A).

72. *See id.* § 1415(k)(6).

73. *Id.* §§ 1414(a)(2), 1411(a)(1).

through mediation and due process proceedings.<sup>74</sup> School personnel or the child's parents may initiate the evaluations.<sup>75</sup>

The next required step is the development of an Individualized Education Program (IEP) for the child by an interdisciplinary team that includes the child's parents, possible related services providers and at least one of the child's special education teachers and regular classroom teachers.<sup>76</sup> Parents must also be included in any decisions regarding their child's educational placement.<sup>77</sup> As discussed above, the IDEA requires schools to provide all services written into the child's IEP.<sup>78</sup>

The IEP documents the child's current educational performance, includes goals and objectives to be achieved in the upcoming school year, describes the instruction and related services that will enable the child to meet those objectives, and describes how the goals will be evaluated.<sup>79</sup> The IEP Team Meeting is the process through which individualized special education and related services are planned, provided, and reviewed.<sup>80</sup> The scope of any reevaluation will be determined by the IEP Team and may range from no evaluation to a full evaluation.<sup>81</sup> The evaluation should provide a determination as to whether or not the child has a disability.<sup>82</sup> If the child has a disability, the evaluation should contain recommendations to the IEP Team concerning the child's educational needs.<sup>83</sup>

The IDEA provides procedural safeguards for children with disabilities and their parents.<sup>84</sup> School systems must make all records concerning the child available to the child's parents.<sup>85</sup> Parents must be given an opportunity to participate in meetings with respect to the "identification, evaluation, and educational placement of the[ir] child."<sup>86</sup> Parents are also guaranteed "an opportunity to present complaints with respect to any matter relating to the identification, evaluation, or educational placement of the[ir] child, or the provision of a

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74. Shum, *supra* note 19 (citing 20 U.S.C. § 1414(a)(1)(C) (2000)).

75. *Id.*

76. *Id.* (citing 20 U.S.C. § 1414 (d)(1)(B) (2000)).

77. *Id.* (citing 20 U.S.C. § 1415 (b)(1) (2000)).

78. *See infra* Part II.C.4.

79. 20 U.S.C. § 1414(d)(1)(A) (2000).

80. *See id.* at § 1414(d)(3)(A).

81. *Id.* § 1414(d)(4).

82. Shum, *supra* note 19 (citing 20 U.S.C. § 1414(a)(1)(B) (2000)).

83. *Id.*

84. Shum, *supra* note 19.

85. 20 U.S.C. § 1415(b)(1) (2000).

86. Shum, *supra* note 19 (citing 20 U.S.C. § 1415(b)(1) (2000)).



[FAPE] to [their] child.”<sup>87</sup> The IDEA provides for voluntary mediation, as well as for an impartial due process hearing when the parents of a child with a disability file a complaint.<sup>88</sup> The IDEA provides for an appeals process in state or federal court if the parents are dissatisfied with the results of the hearing.<sup>89</sup>

### III. SOME OF THE BARRIERS TO SERVICE DELIVERY FOR CHILDREN WITH COMPLEX MENTAL HEALTH NEEDS

#### A. *Introduction: Why these Barriers Are Particularly Difficult to Overcome in Providing Services to Children with Complex Mental Health Needs*

Although several of the barriers discussed below also prevent children with other disabilities from receiving a FAPE, the impact is often greater upon children with mental illnesses because their disability is invisible; there is a longstanding stigma attached to mental illnesses;<sup>90</sup> there is a need for teacher training in the identification and education of children with complex mental health needs; there is confusion over whether there is a volitional element to the disability (“you could control yourself if you really tried!”); and because of the often disruptive nature of the disability upon classroom routines.

Indeed, the barriers for children with emotional disturbances are so great that in 1990, Congress found that “children with serious emotional disturbance remain the most underserved population of students with disabilities.”<sup>91</sup> Although children with emotional disturbances may act out aggressively, they may also be quietly depressed and sit silently in class. The legal definition of “emotional disturbance” results in the children who act out being more easily identified and impedes the identification, education and treatment of the “quiet” children.

#### B. *Barrier: Resource-Based v. Needs-Based Service Provision*

Mental health related services such as psychological counseling and social work services are often provided based on their availability in the particular school setting rather than on the student’s needs. In

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87. 20 U.S.C. § 1415 (b)(6) (2000).

88. Shum, *supra* note 19 (citing 20 U.S.C. § 1415(b)(5) (2000)).

89. *Id.* (citing 20 U.S.C. § 1415(i)(2) (2000)).

90. In fact, one of the U.S. Surgeon General’s recommendations in his report on Children’s Mental Health is to “[c]onduct a public education campaign to address the stigma associated with mental health disorders.” REPORT OF THE SURGEON GENERAL’S CONFERENCE ON CHILDREN’S MENTAL HEALTH: A NATIONAL ACTION AGENDA 5 (2001) [hereinafter NATIONAL ACTION AGENDA].

91. H.R. Rep. No. 101-544, at 39 (1990), *reprinted in* 1990 U.S.C.C.A.N. 1723, 1765.

some settings, these needs are not even being identified on the student's IEP unless the services are readily available and in good supply.

Although it is clear from the IDEA, its implementing regulations and *Garret F.* that related services must be provided if needed, OSEP found widespread noncompliance with these requirements:

OSEP found that "34 states (68%) had failed to ensure compliance with the related services requirements, as shown in the following examples:

OSEP was informed in interviews with . . . administrators, teachers and related services personnel . . . that psychological counseling, as a related service, is *not* available to students with disabilities, regardless of need. . . . OSEP was informed by two related service providers . . . that they were instructed not to list individual therapy on their caseload(s). . . . A special education teacher . . . told OSEP that students may have to go to a center-based or day program if they need more intense counseling services. An administrator . . . confirmed "that related services . . . are not based on the individual student's needs but are based upon the availability of the service provider."<sup>92</sup>

OSEP's latest report concerning Maryland's implementation of the IDEA, revealed noncompliance in four areas including a "[f]ailure to [p]rovide [a]ll [r]elated [s]ervices as a [p]art of a [f]ree [a]ppropriate [p]ublic [e]ducation. . . ."<sup>93</sup>

In fact, OSEP found that in some school districts, psychological counseling was not provided even if the student needed it, and that it was not even written into their IEPs.<sup>94</sup>

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92. BACK TO SCHOOL ON CIVIL RIGHTS, *supra* note 6, at 93.

93. OFFICE OF SPECIAL EDUCATION PROGRAMS, MARYLAND MONITORING REPORT, EXECUTIVE SUMMARY 1 (1999) [hereinafter MARYLAND MONITORING REPORT]. Specifically, participants at OSEP's public forums identified the following issues:

(a) special education and related services are not implemented as specified in IEPs; (b) related services, such as speech/language, occupational and physical therapy, are often interrupted as a result of staff changes and the school-wide scheduling of annual IEP reviews; (d) there is a lack of related services personnel; (f) many districts lack a full continuum of placement options for students with disabilities; (g) a number of special education programs are understaffed; (h) many special educators, general educators, and related services personnel are not certified and lack the skills to provide adequate special education services; (i) behavior plans are generic in nature, or lacking; and (j) extended school year services are not available in all cases when a student needs the services to benefit from special education.

*Id.* at 30.

94. *See id.* at 34. The report notes that:

[A] related services provider informed OSEP that the related services personnel had the responsibility of working with children in five schools and staffing was a

Interviews with advocates for children with disabilities revealed that this barrier continues to prevent children with mental health needs from getting the services they need. Advocates still hear comments from school personnel at IEP Team Meetings about not being able to provide specific related services because: "The psychologist is only here on Wednesdays" or, "She is spending all of her time doing assessments and can't provide counseling" or, "Our social worker isn't doing social skills groups this quarter, maybe we can fit him into a group in the Spring."<sup>95</sup> Recently, one child psychologist in private practice was requesting that direct therapy be given to one of her patients by the school psychologist, and was given this equivocal, yet candid response: "I do not know what my role in this building [the public middle school] will be this year. If it's my traditional role, I'll only be doing assessments and attending team meetings. You know, I'm only in this building once or twice a week."<sup>96</sup>

*C. Barrier: Confusion Over Who Is Entitled to Mental Health Related Services*

There is widespread misunderstanding that only children who are labeled as "emotionally disturbed" are entitled to mental health services in the school setting. This is simply wrong. Children do not have to be labeled "ED" to be entitled to mental health services. If it is on the child's IEP, it must be provided.<sup>97</sup> According to some advocates, this reflects a deeper systemwide myth that services flow from the child's label, that is, an educationally handicapping condition,

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problem in this district. Due to staffing problems, students do not receive any psychological counseling regardless of need. Those students in need of the counseling will receive the service outside of school . . . and the service is not written into the IEP. In the second of these two districts, two related service providers indicated delays in the provision of services to children. One therapist stated services were suspended when the therapist participated in annual review meetings and conducted reevaluations. Regarding reevaluations and annual reviews "direct instruction is impacted and is sometimes suspended." Another therapist in this same district reported that delays and interruptions in the provision of services happen "fairly often;" the therapist reschedules suspended sessions for another day during planning periods but is not always able to keep the rescheduled sessions. This related service provider reported the district is understaffed.

*Id.* at 34.

95. Based on interviews with Leslie Seid Margolis, Esq., & Wayne D. Steedman, Esq., *supra* note 37.

96. Interview with Karen Cruise, Ph.D., Child Psychologist, Private Practice and a Member of the Clinical Faculty, Children's National Medical Center (Sept. 10, 2001).

97. See discussion *supra*, Part I.C.

rather than from the child's IEP.<sup>98</sup> Instead of looking at the needs that the child is displaying in the educational setting, educators often look at the label or the diagnosis to determine services.<sup>99</sup>

*D. Barrier: Blaming the Child or Her Parents for the Behaviors Associated with the Mental Illness*

Educators who would never dream of blaming a child who uses a wheelchair for not walking up the stairs will blame a child or his family when a child with a mental illness cannot control himself in class or exhibits other antisocial behaviors. For example, in "Lisa's" case, the school system attempted to argue that her serious emotional problems were unrelated to her problems in school.<sup>100</sup> However, the Administrative Law Judge ("ALJ") strongly rejected this argument and found that:

[t]he school system's approach to the emotional issues in this case can only be termed a defense in search of facts. Contrary to the school system's suggestion, the emotional problems in this case do not arise from asthma, Ritalin, weight problems, an overbearing mother, high humidity, or any of the various and sundry notions that the school system concocted from thin air. . . ."<sup>101</sup>

Indeed, the ALJ found that "Lisa's" "emotional problems become more understandable . . . [i]n light of the failure [of the school system] to provide services."<sup>102</sup> The unfortunate consequence of this "blaming the victim" is that the needs of children like "Lisa" go unmet in the school system, and the parents must rely upon outside mental health professionals for help.<sup>103</sup> Although private mental health services outside the school setting may be a useful adjunct to those services provided at school, it remains the school system's responsibility to see that those needs of the child are met.<sup>104</sup>

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98. Interview with Dr. Cruise *supra* note 96; Interviews with Margolis & Steedman, *supra* note 37.

99. Interview with Dr. Cruise *supra* note 96; Interviews with Margolis & Steedman, *supra* note 37.

100. Montgomery County Pub. Sch., 31 IDELR 251, 262-63 (1999).

101. *Id.* at 262.

102. *Id.*

103. *See id.* at 261. In "Lisa's" case, her family turned to private psychologists for help. *Id.*

104. *See id.* at 260.

While the school system wasted an inordinate amount of time questioning witnesses about why the parent did not request any due processes [sic] hearings, or what the parent knew or should have known about her rights, the real issue in this

*E. Barrier: Disagreements over Which Children Fit within the  
Educationally Handicapping Condition of  
"Emotional Disturbance"*

There is confusion among special educators, mental health professionals, parents and judges about what constitutes an "emotional disturbance" under the IDEA. There is wide variation in judicial interpretation and, based on experience, IEP Team interpretation of when a child may be labeled as having an "emotional disturbance" under the IDEA. It is not only a definitional problem but also a cross discipline problem - mental health professionals use a different vocabulary than special educators and misunderstandings abound.<sup>105</sup> According to the National Association of School Psychologists, the special education classification system results in multiple, pervasive problems for children with disabilities, including unreliability of classification and stigmatization of classified children.<sup>106</sup>

*1. Problems Inherent in the Legal Definition of  
"Emotional Disturbance"*

The definition of "emotional disturbance" and inconsistencies in judicial interpretation of this term create obstacles for children who need educationally related mental health services. The Code of Federal Regulations defines "Emotional Disturbance" as follows:

- (i) The term 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.

case is why the school system did not act. If the school system really wanted to implement the IEP, or change it, it could have done so. . . .

While there have been recent changes in the law, they do not include shifting responsibility from the school system to the parent for providing a free appropriate public education. "[A] child's entitlement to special education should not depend upon the vigilance of the parents . . . nor be abridged because the district's behavior did not rise to the level of slothfulness or bad faith."

*Id.* at 260. (quoting *J.C. v. Central Regional Sch. Dist.*, 81 F.3d 389, 397 (3rd Cir. 1996)).

105. See interview with Dr. Cruise, *supra* note 96.

106. BEST PRACTICES IN SCHOOL PSYCHOLOGY-II, 1231 (Alex Thomas & Jeff Grimes, eds., 1995).

- (D) A general pervasive mood of unhappiness or depression.
- (E) A tendency to develop physical symptoms or fears associated with personal or school problems.
- (ii) 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.<sup>107</sup>

To fall within the definition of "emotional disturbance," section (i) requires that the child have a "condition" exhibiting at least one of the "characteristics" within subsections (A) through (E) "over a long period of time" and "to a marked degree." This "condition" must "adversely affect" the child's educational performance.<sup>108</sup> The term "condition" is not defined. Similarly, the regulations provide us with no clues as to how long "a long period of time" is or how intense "to a marked degree" must be. Thus, the determination of the duration and intensity with which a child must exhibit these characteristics is completely subjective.<sup>109</sup> Section (ii) specifies that the term "emotional disturbance" includes "schizophrenia" and sets forth the exclusion of children who are "socially maladjusted," unless a determination has been made that the child is emotionally disturbed.<sup>110</sup> Thus, the regulation excludes children who are "socially maladjusted" only if they do not otherwise meet criteria for "emotional disturbance."<sup>111</sup> However, the term "socially maladjusted" is not defined.

Because there are no operational definitions in the statute or the regulations for the terms that form the basis of the "emotional disturbance" definition, it is more likely that there will be inconsistencies in interpretation of the definition. Special educators may look at the same child and view his or her mental illness as completely separate from and having no impact in the educational setting. If the disagreement can not be worked out through the IEP Team process, then courts are the final arbiters of whether the child receives special education and related services in the school setting.<sup>112</sup> The clashes often arise when these two different sets of professionals, who use completely different sets of vocabularies, attempt to mesh their frameworks together to understand the child and his or her needs.

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107. 34 C.F.R. § 300.7(c)(4) (2001).

108. Shum, *supra* note 19.

109. *Id.*

110. *Id.*

111. *Id.*

112. See 20 U.S.C. § 1415(i)(2) (2000).

The IDEA represents a true intersection of health care, education and the law and nowhere is this more evident than in the IDEA's treatment of issues related to children with emotional disturbances. Mental health professionals, such as psychiatrists, psychologists, social workers, counselors, psychiatric nurses may be absolutely convinced that a child has a mental illness that needs treatment throughout that child's day including in the educational setting. These medical versus educational versus legal frameworks do not work well together in the context of "emotional disturbance." Some mental health professionals have a hard time understanding why special educators or regular educators can make what amounts to mental health decisions about their students. Can anyone other than a mental health clinician determine whether depression is the source of a student's quietness, reclusiveness and isolation from peers at school?<sup>113</sup>

Case law that examines whether a child has an emotional disturbance often turns on the courts' interpretation of the adverse affect clause and the socially maladjusted exclusion. The requirement for an adverse effect on educational performance may exclude children with emotional disturbances who are not disruptive because they are less likely to be identified for evaluation by educators. The socially maladjusted characterization may exclude children who are disruptive because school districts and the judiciary perceive their behavior as bad conduct or a discipline problem rather than the manifestation of an emotional disturbance. Noting that neither the IDEA nor its regulations contain operational definitions for the terms contained in the definition of emotional disturbance, OSEP has attempted to clarify the definition. In a 1989 letter, they answered several questions about the definition of ED (formerly known as "SED"). They advised:

[T]he terms 'long period of time,' 'to a marked degree,' and 'adversely affects educational performance' of the federal SED definition have not been specifically defined within . . . . Operational definitions for the purpose of assisting public agencies . . . with the identification of SED children and youth are generally outlined within individual state administrative regulations and/or accompanying guidelines . . . . Few State Education Agencies . . . define 'marked degree.'<sup>114</sup>

OSEP also addressed the question of whether the behavior must be exhibited both at home and in school. They stated:

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113. See interview with Dr. Cruise, *supra* note 96.

114. Letter to Anonymous, 213 EHLR 247 (Aug. 11, 1989).

While for eligibility purposes, the student must meet the parameters of the SED definition within the educational environment, knowledge of the student's continuation/discontinuation of such behaviors in other settings (e.g., home, community) may be helpful in program planning.<sup>115</sup>

One caveat in looking at a child's behavior at home was expressed by a child psychologist who has had extensive experience with families who are working their way through the special education process.<sup>116</sup> She noted that:

In some cases, when school personnel ask about behavior problems at home, parents are reluctant to fully share their child's difficulties for fear that they will be further blamed for the child's problems. Although some schools acknowledge that a child may legitimately discharge school related stress at home, others use parent reports of such behavior to blame parents for failure to properly manage their child.<sup>117</sup>

## 2. *What Constitutes an "Adverse Affect on a Child's Educational Performance?"*

Neither the IDEA nor the federal regulations define the meaning of "adverse affect on educational performance," leaving it to each IEP Team to interpret the clause. Some questions that are raised in IEP Team Meetings with some frequency are: Does the adverse impact have to be manifested in "bad" grades, poor standardized tests results or lack of progress on IEP Goals? Is it sufficient that the child is having delusions, bizarre thoughts or hallucinations during class time or does there have to be a clear diminution of the child's academic skills? What if the child sits quietly during classes and the child's mental illness only manifests itself through extreme acting out behavior at home?

At Team Meetings, psychologists, special educators, speech-language pathologists and parents sometimes argue about the answers to these questions with little agreement even among the professionals who have evaluated the same child. Because the Act provides little guidance on these points, OSEP has received many inquiries concerning the "emotional disturbance" definition.<sup>118</sup> In response, OSEP has stated that the application of "additional procedures and guidance . . .

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115. *Id.*

116. Interview with Dr. Cruise, *supra* note 96.

117. *See id.*

118. *See e.g.*, Letter to Gray, 211 EHLR 447 (1987); Letter to Woodson, 213 EHLR 224 (Apr. 5, 1989); Letter to Lane, 16 EHLR 959 (Apr. 27, 1990); Letter to Anonymous, 213



to a particular child continues to be based largely on the unique facts, and circumstances of the particular case . . . ."<sup>119</sup>

Different states have different interpretations of the phrase "adversely affects educational performance."<sup>120</sup> In the same letter, OSEP points to *In re: Burton Valley School District*.<sup>121</sup> According to OSEP, in this case a student was "performing at or close to grade level in all academic areas," but the hearing officer found that he was eligible for "special services in order [for the child] to learn to control his behavior to a sufficient degree to enable him to remain in a classroom [and found it to be] . . . self-evident that the inability to be present in a classroom adversely affects one's education performance." In so deciding, the Hearing Officer "ruled that 'the term 'educational performance' in 34 C.F.R. § 300.5 (B)(8) includes more than the acquisition of basic academic skills.' *Id.* at 258."<sup>122</sup>

The Maryland School Psychologists' *Members' Advisory: Best Practice for SED Definition* provides a thoughtful perspective on particular criteria to consider when determining whether there is an adverse impact on the child's educational performance.<sup>123</sup> With respect to the adverse affect clause, their publication specifically recommends that the impact on the child's "interpersonal skills" should be taken into account.<sup>124</sup>

### 3. *Judicial Interpretation of the Phrase "Adversely Affects Educational Performance"*

Several courts have stated that when examining whether there is an adverse affect on educational performance, an IEP Team should not limit their review to academic progress but should also examine the student's progress socially and emotionally. In *County of San Diego*

EHLR 247 (Aug. 11, 1989); Letter to McNulty, 213 EHLR 108 (1987); Joint Policy Memorandum (ADD), 18 IDELR 116 (Sept. 16, 1991).

119. Letter to Anonymous, 213 EHLR 247 (Aug. 11, 1989).

120. *Id.*

121. *See id.*

122. *Id.*

123. MARYLAND SCHOOL PSYCHOLOGISTS' ASS'N, INC., MEMBERS' ADVISORY: BEST PRACTICE FOR SED DEFINITION (Oct. 1994).

124. *Id.* at 4-5.

The phrase "which adversely affects educational performance" should be defined in two ways. Educational performance should be defined as not just traditional academic achievement, but also as relevant interpersonal skills . . . . Educational performance also includes enabling skills which go beyond pure academics. These skills include the degree to which the student participates in class activities, relationships with peers and adults in the educational setting, and other interpersonal and social skills which impact academic performance.

*Id.*

*v. California Special Education Hearing Office*,<sup>125</sup> the Court of Appeals for the Ninth Circuit clarified that “educational benefit under the IDEA . . . is not limited to academic needs but includes social and emotional needs that affect academic progress, school behavior, and socialization.”<sup>126</sup> The Ninth Circuit also addressed this issue in *Seattle School District No. 1 v. B.S. and Office of the Superintendent of Public Instruction; Department of Social & Health Services Economic & Medical Service*.<sup>127</sup> It found that the ability to test appropriately on standardized tests is not the sine qua non of “educational benefit.”<sup>128</sup> The court went on to say that the term unique educational needs shall be broadly construed to include the handicapped child’s academic, social, health, emotional, communicative, physical and vocational needs.<sup>129</sup> In *Johnson v. Metro Davison County School District*,<sup>130</sup> the court found that although the child’s grades were satisfactory, her condition had an adverse effect on her educational performance because she was unable to remain in school.<sup>131</sup> Thus, Tiffney was eligible for special education services under the IDEA due to her emotional disturbance.

However, some courts have focused only on academic progress when analyzing whether the child’s emotional problems were having an adverse affect on his or her educational performance. In *Doe v. Board of Education of Connecticut*, a federal district court narrowly applied the adverse affect clause to exclude a child from special education.<sup>132</sup> Although the child had been psychiatrically hospitalized for depression and violent behavior, the court found that the child’s “academic performance (both his grades and his achievement test results) before, during, and after his hospitalization were satisfactory or above.”<sup>133</sup> Thus, when the court focused on pure academic performance, it found that the child’s “behavior problems” did not “adversely affect” his educational performance. He was therefore not emotionally disturbed and not entitled to special education.<sup>134</sup>

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125. 93 F.3d 1458 (9th Cir. 1996).

126. *Id.* at 1467.

127. 82 F.3d 1493 (9th Cir. 1996).

128. *Id.* at 1500.

129. *Id.* (quoting H.R. REP. NO. 98-410, at 19 (1983), *reprinted in* 1983 USCCAN 2088, 2106).

130. 108 F.Supp. 2d 906 (E.D. Tenn. 2000).

131. Shum, *supra* note 19 (quoting *Johnson*, 108 F. Supp. 2d at 918).

132. *Doe v. Board of Education*, 753 F. Supp. 65 (D. Conn. 1990).

133. *Id.* at 70.

134. *Id.* at 70-71; *see also*, *J.D. v. Pawlet Sch. Dist.*, 224 F.3d 60 (2d Cir. 2000).

#### 4. *Court Decisions: What Constitutes "Socially Maladjusted" Behavior*

When the court makes a determination that a child is socially maladjusted and does not have ED, that child does not qualify for related services under the IDEA. Because "socially maladjusted" is not defined, the judgment as to when a child is merely exhibiting characteristics of social maladjustment rather than a "condition" amounting to an "emotional disturbance," can be inconsistent. In *Springer v. Fairfax County School Board*,<sup>135</sup> Edward had developed significant behavioral problems. Although he scored in the average to superior range on standardized tests, his grades fell due to a high rate of absenteeism.<sup>136</sup> He was disciplined for driving recklessly on school property, cutting classes, forgery, leaving school grounds without permission, and fighting.<sup>137</sup> One mental health clinician diagnosed him with dysthymia.<sup>138</sup> The Fourth Circuit affirmed the school system's argument that he was "socially maladjusted" rather than emotionally disturbed, focusing on the delinquent behavior that was an outward manifestation of his illness rather than the root causes and processes.<sup>139</sup>

Conversely, in *Muller v. Committee on Special Education of the East Islip Union Free School District*,<sup>140</sup> the Second Circuit rejected the school district's argument that "students with conduct disorders are not entitled to special education services under the IDEA . . ."<sup>141</sup> The Court of Appeals found that the student met an additional criteria of emotional disturbance because she exhibited a "generally pervasive mood of unhappiness or depression for a long time and to a marked degree" despite the fact that she was not formally diagnosed with clinical depression.<sup>142</sup>

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135. 134 F.3d 659 (4th Cir. 1998).

136. Shum, *supra* note 19 (quoting *Springer*, 134 F.3d at 666).

137. *Id.* (quoting *Springer*, 134 F.3d at 662).

138. *Id.*

139. *Id.* at 664-66; *see also*, In *A.E. v. Independent School District No. 25*, 936 F.2d 472 (10th Cir. 1991). The Tenth Circuit also affirmed the school systems' finding that a child who was hospitalized for attempting suicide and diagnosed with conduct disorder related to emotional problems and a borderline personality disorder did not meet the criteria for ED. *Id.* at 473-74. A.E. was suspended for theft, fighting, and the use of improper language. *Id.* at 473. She experienced difficulties with peer interaction, impulse control, and excessive anxiety. *Id.* The Tenth Circuit, like the Fourth Circuit, focused on the behavior that was an outward manifestation of an illness and reasoned that A.E. was socially maladjusted. *Id.* at 476.

140. 145 F.3d 95 (2d Cir. 1998).

141. *Id.* at 103.

142. Shum, *supra* note 19 (quoting *Muller*, 145 F.3d at 104).

#### IV. PROPOSED SOLUTIONS FOR IMPROVING THE IDENTIFICATION AND DELIVERY OF SERVICES TO CHILDREN WITH MENTAL HEALTH NEEDS

##### A. *Expand Training & Support for Families, Regular & Special Educators and Related Services Providers*

At the Children with Special Needs Conference, there was universal agreement in all of the workshops that training and support must be immediately expanded for families, regular and special educators, and related services providers. This recommendation is included in several recent reports addressing noncompliance problems and in the U.S. Surgeon General's recent report on children's mental health. The recent OSEP Report concerning Maryland's failure to provide all related services recommends that "training opportunities" be expanded "for parents, administrators and school-based staff."<sup>143</sup> In the Surgeon General's *National Action Agenda on Children's Mental Health*, he recommends that "all primary health care providers and educational personnel" be trained "in ways to enhance child mental health and recognize early indicators of mental health problems in children. . . ."<sup>144</sup>

With respect to "Personnel Training Needs," the National Council On Disability found that:

Regular and special education teachers in many states are frustrated by the mixed messages regarding compliance from school administrators, local special education directors, state oversight agents, school district attorneys, and federal oversight agents. Teachers ultimately bear the responsibility to implement interventions and accommodations for students with disabilities, often without adequate training, planning time or assistance.<sup>145</sup>

These concerns about the stresses that special educators face with too little support were echoed by one local education agency official who commented that:

Special education teachers are exhausted - they have stress from not only the demands of their job but also too much paper work, developing IEPs after hours, attending contentious IEP Team Meetings. These issues are all part of why there is a national shortage of special education teachers - retention and recruitment of them is extremely difficult.<sup>146</sup>

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143. MARYLAND MONITORING REPORT, *supra* note 93, at EXECUTIVE SUMMARY 2.

144. NATIONAL ACTION AGENDA, *supra* note 90, at 7.

145. BACK TO SCHOOL ON CIVIL RIGHTS, *supra* note 6, at 11.

146. Interview with Ellen Meyer, AACPS Legal Issues Officer (Sept. 7, 2001).

The head of special education for one state shared her insights about how to help children with complex mental health needs be more fully included in public schools. She recommends:

- Understanding and individualizing inclusion. This is staff intensive and, for children with more complex needs, it may take a year of planning.
- Providing *meaningful* instructional supports.
- Consistently using accommodations in instruction and for testing situations.
- Providing training for general education personnel in special education and provide content based training for special educators.<sup>147</sup>

In order for her recommendations to be fully implemented, both regular and special educators will need ongoing training and support. Under the IDEA, educators are being asked to take on an enormous burden without being given the required supports to educate children with extremely complicated needs. If we are to truly make inclusion work and provide the intensive services that children need in their home schools, we must listen to teachers and give them ongoing support.<sup>148</sup>

*B. Increase the Use of Functional Behavioral Assessments (FBAs) and Behavioral Intervention Plans (BIPs)*

The IDEA and its implementing regulations include several provisions intended to aid children with mental health needs to remain in school and learn. Two tools that are available but underutilized are: Functional Behavioral Assessments (FBA), which should be conducted not only for children who are disciplinary problems but also for children who may be depressed, isolated and unable to fully participate in the learning process; and Behavioral Intervention Plans (BIP), which should be developed for children based on those assess-

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147. See interview with Carol Ann Baglin, Ed.D., Assistant State Superintendent, Division of Special Education/Early Intervention Services, State of Maryland (May 9, 2001).

148. Another experienced special educator agrees that effective inclusion involves preparing school staff a year in advance. It also "requires community involvement at the outset to secure local support, seeking technical support and training to develop local 'inclusion experts,' establishing school inclusion teams to develop a school-wide vision and specific plans for implementing inclusion, training all staff (including general and special educators, students, cafeteria workers, custodians and bus drivers) in the philosophy of inclusion and the needs of students with disabilities, dealing with fears and myths about inclusion and training teams of general and special educators in the collaborative-cooperative teaching model." See interview with Dr. Fadely, Practicum Coordinator for Special Education, Loyola College (Sept. 27, 2001).

ments.<sup>149</sup> Currently, the federal regulations require FBAs and/or implementation or modification of BIPs when a child has been removed from his or her educational placement.<sup>150</sup> FBAs & BIPs should not be limited to children who are behavior problems. They should be individualized rather than relying on “behavior plans that are generic . . .”<sup>151</sup> Additionally, FBAs & BIPs should include input from all team members including the family and should examine school, home and community factors.

*1. Functional Behavioral Assessments (FBA) and Behavioral Intervention Plans (BIP): What OSEP Says:*

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149. Courts have found that “therapy” is a related service under the Act. For example, in *Papacoda v. Connecticut*, 528 F.Supp. 68 (D. Conn. 1981), the court rejected the school system’s argument that therapy is not a related service within the meaning of the IDEA, reversing the decision of the impartial hearing officer. *Id.* at 72. The court indicated that the argument was inconsistent with the plain meaning of the statute, and that therapy was not a medical or diagnostic service. *Id.*

Similarly, in *T.G. v. Board of Education of Piscataway*, 576 F.Supp. 420 (D. N.J. 1983) the question of whether “psychotherapy” was a related service was at issue. *Id.* at 422. According to a policy statement issued by the SEA, “psychotherapy” other than necessary for diagnostic and evaluative purposes, was not a “related service” for which a local school district would be responsible under IDEA. The court found that, “while no explicit reference to ‘psychotherapy’ is made in either the Act or the regulations, the definitions of ‘related services’ which are provided are indicative of a Congressional intent to include it where appropriate among those services to be provided at no cost to the parents under the Act.” *Id.* at 423.

150. 34 C.F.R. § 300.520 (2001).

Either before or not later than 10 business days after either first removing the child for more than 10 school days in a school year or commencing a removal that constitutes a change of placement . . . [i]f the LEA did not conduct a functional behavioral assessment and implement a behavioral intervention plan for the child before the behavior that resulted in the removal . . . , the agency shall convene an IEP meeting to develop an assessment plan . . . . If the child already has a behavioral intervention plan, the IEP team shall meet to review the plan and its implementation, and, modify the plan and its implementation as necessary, to address the behavior . . . . *Id.* at § 300.520(a)(b)(1).

As soon as practicable after developing the plan described in . . . this section, and completing the assessments required by the plan, the LEA shall convene an IEP meeting to develop appropriate behavioral interventions to address that behavior and shall implement those interventions. *Id.* at § 300.520(b)(2).

If subsequently, a child with a disability who has a behavioral intervention plan and who has been removed from the child’s current educational placement for more than 10 school days in a school year is subjected to a removal that does not constitute a change of placement . . . , the IEP team members shall review the behavioral intervention plan and its implementation to determine if modifications are necessary . . . . If one or more of the team members believe that modifications are needed, the team shall meet to modify the plan and its implementation, to the extent the team determines necessary. *Id.* at § 300.520(c)(1).

151. MARYLAND MONITORING REPORT, *supra* note 93, at 30.

- Positive behavior support is the application of positive behavioral interventions and systems to achieve positive change.
- Positive behavior support is an approach to discipline and intervention that is proving both effective and practical in schools.
- Positive behavior support is the application of the science of behavior to achieve socially important change. The emphasis is on behavior change that is durable, comprehensive, and linked to academic and social gains.
- As a general matter, positive behavior support should be applied before any child is excluded from school due to problem behavior.
- The development of positive behavioral interventions and plans that are guided by functional behavioral assessment (FBA) is a foundation on which positive behavioral support is delivered.
- Functional behavioral assessment (FBA) is a systematic way of identifying problem behaviors and the events that predict occurrence, non-occurrence, and maintenance of those behaviors.
- Strong, active administrative leadership, support and participation is needed for effective efforts.
- Positive behavior support considers multiple contexts: community, family, district, school, classroom, non-classroom, and individual.<sup>152</sup>
- A proactive perspective is maintained along a continuum, using primary (what we do for all), secondary (what we do for some), and tertiary (what we do for a few) prevention and interventions.<sup>153</sup>

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152. The court in *Chris D. v. Montgomery County Board of Education*, 753 F. Supp. 922 (M.D. Ala. 1990) found that the school failed to establish an adequate system of behavioral control. *Id.* at 932. Instead of teaching the child skills to control his own behavior, the school used an outdated approach of rules and reinforcement, isolating him from the other students. *See id.* In addition, the court found that the school system ignored another component of a proper behavioral control program by failing to counsel and instruct his parents in how to complement at home the training he should have received at school. *Id.* at 933. The court emphasized that related services included counseling and training to assist parents in understanding the special needs of their child and providing information about child development. *Id.*

153. Letter from Judith Heumann, Assistant Secretary, Office of Special Education and Rehabilitative Services, and Kenneth Warlick, Director, Office of Special Education Programs, to School Administrators, *Prevention Research & the IDEA Discipline Provisions: A Guide for School Administrators*, <http://www.ed.gov/offices/OSERS/OSEP/Products/adminbeh.web.pdf> (on file with the Journal of Health Care Law & Policy).

Although every team member is an integral part of the development of FBAs and BIPs, psychologists can take a leadership role for children with complex mental health needs. The definition of “psychological services” is quite expansive and includes “psychological counseling for children and their parents” and “assisting in developing positive behavioral intervention strategies.”<sup>154</sup> Social workers should be included in this process not only to help the child but also to provide the family support that is contemplated by the statute. Social work services in schools include “[p]reparing a social or developmental history” of the disabled child and “[g]roup and individual counseling with the child and family.”<sup>155</sup> The services must consider the child’s living situation, such as their “home, school and community [which] affect the child’s adjustment in school,” and school and community resources must be mobilized “to enable the child to learn as effectively as possible in his or her educational program.”<sup>156</sup> Social work services in schools also include assisting with the development of positive behavioral intervention strategies.<sup>157</sup>

When a child with complex mental health needs exhibits behaviors that interfere with her ability to learn in the school setting, the

154. 34 C.F.R. § 300.24(b)(9) (2001).

Psychological services includes—

- (i) Administering psychological and educational tests, and other assessment procedures;
- (ii) Interpreting assessment results;
- (iii) Obtaining, integrating, and interpreting information about child behavior and conditions relating to learning;
- (iv) Consulting with other staff members in planning school programs to meet the special needs of children as indicated by psychological tests, interviews, and behavioral evaluations;
- (v) Planning and managing a program of psychological services, including psychological counseling for children and parents; and
- (vi) Assisting in developing positive behavioral intervention strategies.

*Id.*

155. 34 C.F.R. § 300.24(b)(13)(i) (2001).

156. 34 C.F.R. § 300.24(b)(13)(iii), (iv).

157. 34 C.F.R. § 300.24(b)(13)(v). The complete definition of “social work services” follows:

Social work services in schools includes—

- (i) Preparing a social or developmental history on a child with a disability;
- (ii) Group and individual counseling with the child and family;
- (iii) Working in partnership with parents and others on those problems in a child’s living situation (home, school, and community) that affect the child’s adjustment in school;
- (iv) Mobilizing school and community resources to enable the child to learn as effectively as possible in his or her educational program; and
- (v) Assisting in developing positive behavioral intervention strategies.

34 C.F.R. § 300.24(b)(13).



IDEA requires that an FBA be completed. It is the school psychologist's or behavioral specialist's responsibility to work with the IEP Team to develop an assessment plan that should include input from "multiple contexts: community, family, district, school, classroom, non-classroom, and individual."<sup>158</sup> However, many schools lack the resources and trained personnel to properly identify children who need intervention and when identified to provide the intensive support they need.<sup>159</sup> The U.S. Department of Education noted the importance of these new provisions in its 22<sup>nd</sup> Annual Report to Congress.

Many schools lack the capacity to identify, adopt, and sustain policies, practices, and systems that effectively and efficiently meet the needs of all students. . . . Schools often rely on outside behavioral expertise because local personnel lack specialized skills to educate students with significant problem behaviors. School morale is often low because ongoing staff support is limited. Although many students have significant social skill needs, social skill instruction is not a conspicuous and systemic component of the school-wide curriculum. Behavioral interventions are not based on information obtained from assessments. In general, systems for the identification, adoption, and sustained use of research-validated practices are lacking. . . .

In sum, the challenges facing educators are significant and persistent. If not addressed, their impact on students, school personnel, families, and community members can be dramatic. However, the problem is not that schools lack procedures and practices to address these challenges. Procedures and practices have been defined and growing over the past 30 years. . . . The greater problem has been that researchers have been unable to create and sustain the "contextual fit" between what the procedures and practices are and the features of the environments (e.g., classroom, workplace, home, neighborhood, playground) in which the student displays problem behavior. . . . The systemic solution is to create effective "host environments" that support the use of preferred and effective practices. . . . Effective host environments have policies (e.g., proactive discipline handbooks, procedural handbooks), structures (e.g., behavioral support teams), and routines (e.g., opportunities for students to learn expected behavior, staff development, data-based decision making)

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158. Heumann, *supra* note 153.

159. OSEP ANNUAL REPORT, *supra* note 5, at III-7.

that promote the identification, adoption, implementation, and monitoring of research-validated practices.<sup>160</sup>

Although an FBA is only explicitly mandated after a child has been suspended for 10 days or more, or is recommended for an alternative placement, it is also required if the IEP Team recommends an assessment of the child or development of a plan for the child. Specifically, the federal regulations require that positive behavioral strategies be looked at for inclusion in the IEP if the child's behavior impedes learning.<sup>161</sup>

Unfortunately, functional behavioral assessments and behavioral intervention plans are not explicitly mentioned in the federal regulations except in the sections governing discipline issues. This placement in the regulations leads some educators to only think of using these important tools when a child is acting out in a disruptive or aggressive manner. FBAs and BIPs are equally important for children whose isolation, anxiety or depression interfere with their ability to learn. DOE's Annual Report to Congress emphasized that these children's needs should not be forgotten.<sup>162</sup> One child psychologist noted how important it is to identify these children early on and be proactive:

A child in difficult circumstances has a limited number of ways to react. One is to become anxious, another is to become depressed, and finally to "act out." Some children do all three.

It is an unhappy fact that by the time some children come to the attention of professionals their experience of multiple

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160. *Id.* at III-8 to III-9 (citations omitted).

161. 34 C.F.R. § 300.346 (2001). The regulations state that:

- (1) In developing each child's IEP, the IEP team, shall consider—
    - (i) The strengths of the child and the concerns of the parents for enhancing the education of their child;
    - (ii) The results of the initial or most recent evaluation of the child; and
    - (iii) As appropriate, the results of the child's performance on any general State or district-wide assessment programs.
  - (2) Consideration of special factors. The IEP team also shall—
    - (i) In the case of a child whose behavior impedes his or her learning or that of others, consider, if appropriate, strategies, including positive behavioral interventions, strategies, and supports to address that behavior;
- ....

*Id.*

162. OSEP ANNUAL REPORT, *supra* note 5, at III-8. The Report states that: "Most attention has focused on students with externalizing problem behavior (e.g., aggressive, antisocial, destructive), students with internalizing problem behavior (e.g. social withdrawal, depression) also represent an important concern of families, schools, and communities." *Id.* (citations omitted).

failures and their reaction to this experience qualifies them for an ED classification when this was not initially a part of their presenting picture.<sup>163</sup>

One school psychologist confirmed this need to be proactive and intervene early. "Children whose behavior impedes their own or other students' learning are trying to tell us something with their behavior and we need to listen to them. We need to look at the function of their behavior and develop an intervention plan as soon as possible."<sup>164</sup> Recognizing this need, this school psychologist was part of an interdisciplinary group formed by a Local Education Agency (LEA) to develop a "Best Practices" Model for conducting FBAs.<sup>165</sup> The group defined an FBA to be "a process of gathering information to determine the function or intent of a student's behavior. Administrators, teachers, parents, school psychologists, counselors, pupil personnel workers and other appropriate team members are instrumental in gathering this data for students who display problem behaviors . . . ."<sup>166</sup> In addition to the discipline context, their Model clarifies that it is appropriate to discuss an FBA "when social, emotional and behavior issues are raised during the initial consideration of an educational disability or upon review of current educational services."<sup>167</sup> If children are assessed early on and provided with a BIP if needed, perhaps some of their behaviors can be eliminated even before there is the need to classify them as emotionally disturbed.

*C. Another Tool for Supporting Children with Mental Health Needs:  
Extended School Year (ESY) Services*

For children with emotional disturbances, the long summer break can be disastrous without the proper supports. Anxiety, depression, school phobias can be exacerbated away from the routines of school. Regression in social skills and in the ability to tolerate classroom routines can also be a problem. However, the typical ESY programs offered by school systems often only address academic skills. We need to rethink our approach to ESY for children with mental health needs. For example, ESY services should be individualized;

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163. See interview with Dr. Cruise, *supra* note 96.

164. Interview with Nickolas P. Silvestri, NCSP, School Psychologist, Anne Arundel County Public School System, Maryland (Sept. 13, 2001).

165. *Id.*; see ANNE ARUNDEL COUNTY PUBLIC SCHOOLS, FUNCTIONAL BEHAVIORAL ASSESSMENT: GUIDELINES AND PROCEDURES FOR IMPLEMENTATION (Jun. 1999) [hereinafter FUNCTIONAL BEHAVIORAL ASSESSMENT].

166. FUNCTIONAL BEHAVIORAL ASSESSMENT, *supra* note 165, at 3.

167. *Id.* at 4.

mental health services should be included; and innovative programs should be considered.

Children with emotional disturbances' ESY programs need to be individualized to creatively keep them engaged or reengage them in their schools. Individual counseling with children and their families may need to continue or be intensified throughout summer months. Social skills groups may need to be formed or continued. The Maryland regulations<sup>168</sup> require that, at least annually, the IEP team shall determine whether the student requires the provision of extended school year services in accordance with Education Article, §8-405, Annotated Code of Maryland.<sup>169</sup>

168. The exact language in the federal regulations governing "extended school year services" follows:

- (1) Each public agency shall ensure that extended school year services are available as necessary to provide FAPE, consistent with paragraph (a)(2) of this section.
- (2) Extended school year services must be provided only if a child's IEP team determines, on an individual basis, in accordance with Secs. 300.340-300.350, that the services are necessary for the provision of FAPE to the child.
- (3) In implementing the requirements of this section, a public agency may not –
  - (i) Limit extended school year services to particular categories of disability; or
  - (ii) Unilaterally limit the type, amount, or duration of those services.
    - (b) Definition. As used in this section, the term extended school year services means special education and related services that –
      - (1) Are provided to a child with a disability –
        - (i) Beyond the normal school year of the public agency;
        - (ii) In accordance with the child's IEP; and
        - (iii) At no cost to the parents of the child; and
      - (2) Meet the standards of the SEA.

34 C.F.R. § 300.309 (2001).

169. MD. REGS. CODE tit. 13A, § 05.01.08(2) (2001) The IEP team shall consider:

- (i) Whether the student's IEP includes annual goals related to critical life skills;
- (ii) Whether there is a likelihood of substantial regression of critical life skills caused by the normal school break and a failure to recover those lost skills in a reasonable time;
- (iii) The student's degree of progress toward mastery of IEP goals related to critical life skills;
- (iv) The presence of emerging skills or breakthrough opportunities;
- (v) Interfering behaviors;
- (vi) The nature and severity of the disability; and
- (vii) Special circumstances.

*Id.*

*D. Create a Truly Interdisciplinary Team Approach: Fully Incorporate Mental Health Professionals and Speech-Language Pathologists into the Interdisciplinary Team*

Without true integration and coordination of the related services providers into the classroom as equal partners, their effectiveness is greatly diminished.<sup>170</sup> Because of scarce resources, many psychologists and speech-language pathologists are itinerant workers. Since they often move from school to school they are not as readily available for spur of the moment quick consultations with other members of the child's team or to stop in to observe the child in class. It is extremely difficult to get a complete picture of a child if you only see her during "pull out" therapy sessions. Thus, it is important to explicitly build in to the IEP "indirect" service hours for consultation, collaboration and observation.<sup>171</sup> For some children with complex mental health needs, daily contact with other team members may be necessary.<sup>172</sup> In order for this level of collaboration to be possible, caseloads must be decreased for related services providers.

Including speech-language pathologists as part of the team providing services to children with mental health needs is critically important.<sup>173</sup> One speech-language pathologist described children with emotional disturbances' unique needs:

The language based skills must be taught explicitly to many children with mental illnesses. These skills are potent tools that are used by children and adults to analyze their own feelings and those of others. Teaching empathy is so critical. They need to be taught to use verbal reasoning to make their way in life. They are often poor observers of others and thus,

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170. Interview with Ellie Giles, M.Ed., special education teacher in a public school in Maryland, lecturer, graduate level special education courses, Trinity College and Johns Hopkins University (Aug. 2001).

171. *Id.*

172. See interview with Dr. Cruise, *supra* note 96.

173. Speech-language pathology services includes:

- (i) Identification of children with speech or language impairments;
- (ii) Diagnosis and appraisal of specific speech or language impairments;
- (iii) Referral for medical or other professional attention necessary for the habilitation of speech or language impairments;
- (iv) Provision of speech and language services for the habilitation or prevention of communicative impairments; and
- (v) Counseling and guidance of parents, children, and teachers regarding speech and language impairments.

34 C.F.R. § 300.24(b)(14) (2001).

do not learn how to negotiate effectively to make sure that their needs are met.<sup>174</sup>

One strategy that can be especially effective for children with complex mental health needs is including them in a small group run by both a psychologist and a speech-language pathologist. It is helpful if at least some children in the group can provide role models for others.<sup>175</sup> Their combined expertise can greatly increase the effectiveness of the treatment intervention.<sup>176</sup>

### *E. The Federal Government Should Finally Fully Fund the IDEA*

This article has addressed numerous problems with the IDEA's implementation. In order for those problems to be fully addressed and the barriers removed, the IDEA must be fully funded by the federal government. Although its drafters envisioned federal funding at the 40% level of the extra costs of educating children with disabilities,<sup>177</sup> the federal government has never contributed more than 14.9% under the statutory funding formula in which Federal, State, and local governments share the costs of educating children with disabilities.<sup>178</sup> The IDEA authorizes the Federal Government to fund grants to States through a funding formula which looks at the number of children ages 3 through 21 in the state with disabilities and multiplies that number by 40 % of the average per-pupil expenditure in public elementary and secondary schools in the United States.<sup>179</sup> However, the current federal funding is only 13% of the average per-pupil expenditure.<sup>180</sup> Thus, under the IDEA, the federal government is authorized to spend \$15,568,000,000 (40% FY '00 level) but is only contributing \$ 4,989,686,000.<sup>181</sup>

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174. Interview with Dr. Spencer, speech language pathologist in private practice in Maryland (Aug. 29, 2001).

175. *Id.* See generally COMMUNICATION DISORDERS AND CHILDREN WITH PSYCHIATRIC AND BEHAVIORAL DISORDERS, (Diana Rogers-Adkinson & Penny L. Griffith eds., 1999) (providing more information regarding the language characteristics of children with emotional disturbances).

176. Interview with Dr. Spencer, *supra* note 174.

177. 20 U.S.C. § 1411(a)(2)(B) (2000).

178. Family Voices Policy Issues, *Full Funding the Individuals with Disabilities Act (IDEA)*, <http://www.familyvoices.org/policy/ffidea.html> (on file with the Journal of Health Care Law and Policy).

179. *Id.* at § 1411(a)(2).

180. National Campaign to Fully Fund IDEA, *Full Funding of IDEA*, <http://www.ncffi.org/fullfunding/htm> (last visited Apr. 3, 2002) (on file with the Journal of Health Care Law and Policy).

181. *Id.* According to the National Campaign to Fully Fund IDEA (NCFI), the "New Formula" will be "[w]ith the 13% current level of federal funding, the appropriation for Part B of IDEA has reached (and slightly exceeded) the \$4,924,672,200 trigger identified

Some members of Congress have attempted to mandate full funding. Senate Bill 466 was introduced in the United States Senate in the 1<sup>st</sup> Session of the 107<sup>th</sup> Congress,<sup>182</sup> requiring mandatory funding at the 40% level.<sup>183</sup> The Bill notes that “[w]hile the Federal Government has more than doubled funding for Part B of the IDEA since 1995, the Federal Government has never provided more than 15% of the maximum State grant allocation for educating children with disabilities.”<sup>184</sup> The purpose of the Bill would be to “strengthen the ability of States and localities to implement the requirements of IDEA.”<sup>185</sup>

This shortfall is hurting school districts because “special education costs for local school districts are rising substantially faster than new federal funding . . . . The federal government is shortchanging local school districts more than \$11.01 billion in FY2001 alone.”<sup>186</sup> If the IDEA had been properly funded over the past twenty-five years, there would have been \$300 billion “available to increase teacher salaries, to reduce class size, or to purchase new computers and up-to-date textbooks.”<sup>187</sup>

The human impact of this “underfunded mandate” is illustrated by these comments shared by “Alex’s” parents. They felt that because “FAPE is, at this time, essentially an underfunded mandate, the lack of funds pits school administrators at many levels against the parents, and the lack of manpower and resources pits teachers against the advocates of handicapped children as well.”<sup>188</sup> They felt that if the IDEA were properly funded, much of this tension between school personnel and families would be eliminated.<sup>189</sup>

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in the Act. Funding, above the 13% level, will be distributed to States according to a new formula based 85% on all children 3-21 years living in the State and 15% based on all children living in poverty in the State. This new formula eliminates any incentive to identify students for special education. Federal Funds distributed under the new formula will enable States to address the diverse learning needs of all children. 20% of federal funds over and above the \$4,924,672,200 can be used by school districts to fund regular education programs and initiatives. Federal funding below the trigger level will continue to be distributed according to the number of children with disabilities in the State. *Id.*

182. Helping Children Succeed by Fully Funding the Individuals with Disability Education Act (IDEA), S. 466, 107th Cong. (2001).

183. *Id.*

184. *Id.*

185. *Id.*

186. IDEA Funding Coalition, *IDEA Funding: Time for a New Approach, Mandatory Funding Proposal*, [http://www.nsba.org/advocacy/issue\\_briefs/funding\\_proposal.htm](http://www.nsba.org/advocacy/issue_briefs/funding_proposal.htm) (last visited Nov. 3, 2001).

187. *Id.*

188. Interview with “Alex’s” parents. (Sept. 14, 2001).

189. *Id.*

*F. Increase Interagency Cooperation/Create a Single Point of Entry to Agencies that Provide Services to Children with Disabilities*

Every workgroup at the Special Needs Conference addressed the need for greater interagency cooperation, and several groups recommended that a “single point of entry” be created to access services for their children.<sup>190</sup> For children with complex mental health needs, this cooperation is especially critical. I have represented many children who have multiple agency involvement including social services, juvenile justice, mental health and developmental disabilities agencies. There is enormous stress on families trying to navigate these multiple systems. When the U.S. Surgeon General released his National Action Agenda on Children’s Mental Health, he noted that, “the multiple systems for mental health care can be very difficult to navigate for many families” and that “the burden of suffering by children with mental health needs and their families has created a crisis in this country.”<sup>191</sup> The magnitude of the problem for families who are trying to cope on a daily basis with their children’s complex needs can not be underestimated. For example, “Alex’s” parents were exhausted after years of trying to get appropriate services for their young son who is diagnosed with both an autism spectrum disorder (PDD NOS) and with depression. At age seven, his depression was so severe that he was psychiatrically hospitalized after a suicide attempt.

“Alex” began the 2000-2001 school year in 2<sup>nd</sup> grade at [the public elementary school]. From the start, he had frequent behavior problems. On September 8, 2000, “Alex” was suspended for a day and a half after an incident in which he hit and punched a teacher, tried to stab her with a pencil, and kicked over the classroom trash can. The suspension was devastating to “Alex’s” self-esteem and he made comments at home such as “I’m stupid,” “I’m a dumb-head,” and “I’m terrible – just let me die.”<sup>192</sup>

Because Alex kept running away from school and was in an emotional crisis, he was placed on Home and Hospital for his educational services. It was several months after this incident that Alex tried to kill

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190. See, Leslie Seid Margolis, *The Provision of School Health Services to Students with Disabilities: the Intersection of Health Care Policy, Education and the Law in the Post-Garret F. Era*, 5 J. HEALTH CARE L. & POL’Y (forthcoming Spring 2002) (providing a discussion of the need for interagency cooperation for children with complex medical needs).

191. Press Release, United States Surgeon General, Surgeon General Releases a National Action Agenda for Children’s Mental Health (Jan. 3, 2001).

192. Letter from “Alex’s” attorney to school officials (Jan. 24, 2001) (on file with the author).



himself. Before and after this suicide attempt, Alex's parents contacted numerous state and local mental health, education, developmental disabilities and social services agencies in an attempt to get in-home services so that they could safely maintain their son at home. Although they were able to get help from the LEA to place him in a highly specialized private school, the school had no openings for months and they felt that he could not be safe in any available public school. Finally, they met with a local interagency group to find out what services might be available to help "Alex" and support the family so that he would not have to go to a residential treatment center. At the meeting, one of the participants from the local mental health agency would not acknowledge that her agency had any responsibility for "Alex" because, in her view, his "primary" diagnosis was not the depression but rather was the autism spectrum disorder. When the parents were completely worn down from no agency accepting responsibility and simply offering the family more telephone numbers to call, the father, who was almost in tears, spoke poignantly: "We just don't have the emotional energy to make all of these phone calls any more."<sup>193</sup> Ultimately, as a result of that meeting, the family was able to get a service coordinator assigned to them from a social services agency. Even with her help, coordinating services for "Alex" continues to require enormous time and energy from both parents.<sup>194</sup>

Recognizing this need for interagency coordination, Maryland created the Governor's Office for Children, Youth and Families (OCYF) which works with all of the state agencies that provide services to children.<sup>195</sup> Within this office is housed several "Units" including the State Coordinating Council for Residential Placement of Handicapped Children and the Advisory Committee for Children, Youth and Families.<sup>196</sup> OCYF's Special Secretary "is responsible for overseeing the general policy for children, youth, and family services in the State."<sup>197</sup> This "policy shall be to promote a stable, safe, and healthy environment for children and families, thereby increasing self-sufficiency and family preservation."<sup>198</sup> In order to accomplish this goal, "a comprehensive, coordinated interagency approach to provide a continuum of care that is family and child oriented and emphasizes

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193. Interview with "Alex's" parents, *supra* note 188.

194. *Id.*

195. MD. ANN. CODE of 1957 art. 49D § 1 (1998).

196. *Id.* at § 1(d).

197. *Id.* at § 2(a).

198. *Id.* at § 2(b)(1).

prevention, early intervention, and community-based services" is required.<sup>199</sup>

Despite this mandate, the service system continues to be fragmented in Maryland<sup>200</sup> as well as nationally. One parent advocate expressed concern that this fragmentation may actually be worsening: "I am very troubled with the lowering priority on providing services intended to divert children from out of home placements, coupled with the movement to create more institutional beds. This concern reflects changing governmental priorities and a tightening economy."<sup>201</sup> Indeed, the U.S. Surgeon General reports that "[c]hildren and families are suffering because of missed opportunities for prevention and early identification, fragmented treatment services, and low priorities for resources."<sup>202</sup>

Additionally, because there is no single point of entry into the service system, there are potentially helpful services or sources of funding available of which many families and clinicians are unaware. For example, Maryland Disability Law Center (MDLC) has been trying to get the word out to pediatricians and other clinicians about Early & Periodic Screening, Diagnosis & Treatment (EPSDT). EPSDT is a federally mandated program that requires states

to provide . . . all 'medically necessary' treatment services, including mental health services, to all Medicaid recipients under 21. EPSDT is a way to obtain the individualized wrap-around treatment and support services necessary to allow children to remain at home and in their community, or to return there after a hospitalization or other out-of-home placement.<sup>203</sup>

If there were a single point of entry system, all children with disabilities would be screened to determine their eligibility for this important program.

The federal regulations contemplate that Local Education Agencies (LEAs) will "develop and implement a coordinated services system designed to improve results for children and families . . . ."<sup>204</sup> Specifically, the regulations require that:

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199. *Id.* § 2(b)(2).

200. See interviews with Margolis & Steedman, *supra* note 37; interview with Dr. Cruise, *supra* note 96; interview with "Alex's" father, *supra* note 188.

201. See interview with Bob Astrove, M.B.A., parent advocate (Feb. 2002).

202. NATIONAL ACTION AGENDA, *supra* note 90, at 12.

203. See MARYLAND DISABILITY LAW CENTER, ACCESSING MENTAL HEALTH SERVICES FOR CHILDREN IN MARYLAND THROUGH THE MEDICAL ASSISTANCE/MEDICAID EPSDT BENEFIT (2001).

204. 34 C.F.R. § 300.244(a) (2001).

In implementing a coordinated services system under this section, an LEA may carry out activities that include—

- (1) Improving the effectiveness and efficiency of service delivery, including developing strategies that promote accountability for results;
- (2) Service coordination and case management that facilitate the linkage of IEPs under Part B of the Act and IFSPs under Part C of the Act with individualized service plans under multiple Federal and State programs . . .
- (3) Developing and implementing interagency financing strategies for the provision of education, health, mental health, and social services, including transition services and related services under the Act; and
- (4) Interagency personnel development for individuals working on coordinated services.<sup>205</sup>

In fact, the U.S. Surgeon General has suggested that schools should play an essential role in an interdisciplinary service model. He suggests that “to improve access” to “mental health services,” they should be co-located “with other key systems” including education.<sup>206</sup> Further, he recommends that “the resource capacity of schools” should be strengthened “to serve as a key link to a comprehensive, seamless system of school- and community-based identification, assessment and treatment services to meet the needs of youth and their families where they are.”<sup>207</sup>

*G. Create Interdisciplinary Workgroups at the National, State & Local Levels to Create a Coordinated Service Delivery Model & to Revise the Definition of “Emotional Disturbance” to Increase Access to Appropriate Services*

In January, 2001, the U.S. Surgeon General issued a *National Action Agenda* which contains a “blueprint for addressing children’s mental health needs in the United States.”<sup>208</sup> At the National level, the United States Department of Education in conjunction with the National Council on Disability and the Office of the Surgeon General should convene an interdisciplinary workgroup to implement those aspects of the “blueprint” which address the removal of barriers to providing services to children with mental health needs in our schools.<sup>209</sup> This group must include representatives from families,

205. *Id.* § 300.244(b).

206. *See* NATIONAL ACTION AGENDA, *supra* note 90, at 6.

207. *Id.*

208. *Id.* at 1.

209. *Id.* at 5.

mental health professionals, regular and special educators, pediatricians, nurses, related services providers from every discipline and children's advocates.<sup>210</sup> Similar groups should be convened at the state and local levels.<sup>211</sup> These groups should devise specific action plans to follow up on and implement the Surgeon General's *National Action Agenda* recommendations that impact schools. These action plans would include a "coordinated service delivery model" for service provision to children with complex mental health needs that would focus on early intervention, interdisciplinary and interagency team approaches and "Best Practices" for inclusion that will really work for children.

There are at least two initiatives in Maryland that may help to achieve the Surgeon General's goal of moving "toward a community health system that balances health promotion, disease prevention, early detection and universal access to care."<sup>212</sup> One of these initiatives will infuse \$2 million into local systems "to develop or enhance broad local partnerships composed of local agencies; school systems; teachers and pupil services staff; parents and family members."<sup>213</sup> The purpose of those local partnerships will be to plan and to implement evidence-based mental health promotion . . . activities in schools.<sup>214</sup> Successful local partnerships will be expected to develop a comprehensive set of prevention and intervention strategies . . . [and] to integrate these proposed activities with existing school-based mental health treatment services and school based health centers currently supported by the State."<sup>215</sup>

The second initiative that relates to the Surgeon General's call for universal access to care, is the Proposed Plan for Universal Health Insurance Coverage in the State of Maryland, which was released in draft form on September 7, 2001. If implemented, all children would have access to health care including mental health care by expanding the Maryland Children's Health Program to cover all uninsured children.<sup>216</sup>

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210. *Id.* at 8.

211. *Id.* at 2.

212. *Id.* at 4.

213. Mental Health Association in Talbot County, *Integrated and Coordinated School Based Mental Health Services*, [http://www.mhamdes.org/legislative\\_alerts.htm](http://www.mhamdes.org/legislative_alerts.htm) (updated July 7, 2001) (on file with the Journal of Health Care Law & Policy).

214. *Id.*

215. *Id.*

216. Maryland Citizen's Health Initiative, Proposed Plan for Universal Health Insurance Coverage in the State of Maryland, at vii, prepared by the Maryland Citizen's Health Initiative Education Fund, Inc. (Draft Released Sept. 7, 2001).

The Surgeon General's *National Action Agenda* also calls for the modification of "definitions and evaluation procedures used by education systems to identify and serve children and youth who have mental health needs. These definitions should facilitate access to, not exclusion from, essential services."<sup>217</sup> The national group should also revise the "emotional disturbance" definition and draft operational definitions of its component terms so that there is less confusion and greater uniformity around the country concerning this educationally handicapping condition.

#### V. CONCLUSION

In order for children with mental health needs to receive a free and appropriate public education in the least restrictive environment, the numerous legal and policy barriers identified in this article must be removed. Accomplishing this goal will require a coordinated interdisciplinary effort within each school as well as at the national level among federal agencies. As Congress is looking at the Reauthorization of the IDEA in the 2002 Session, it needs to reaffirm its commitment to children with disabilities by not only increasing funding, but also stepping up its enforcement of its legal mandates. The future of our children depends on it.

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217. NATIONAL ACTION AGENDA, *supra* note 90, at 9.