Legally Speaking: What You Need to Know About Addressing Students’ Mental Health at School

California Student Mental Wellness Conference
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Topics We’ll Cover

• Child Find Obligations
• Appropriate Mental Health Assessments
• Legally-Defensible Mental Health Goals
• Services
• Residential Placement
Sources of Law

• Constitution (Federal and State)
• Statutes
  – Individuals with Disabilities Education Improvement Act (‘‘IDEIA’’)
  – Section 504 of the Rehabilitation Act
  – California Education Code
• Regulations
  – 34 C.F.R. 300.100 et seq.
  – 34 C.F.R. 104.1 et seq.
  – Title 5, California Code of Regulations
• Administrative Agencies (Quasi-Judicial Function)
  – Office of Special Education and Rehabilitative Services (OSERS)
  – Office of Special Education Programs (OSEP)
  – California Office of Administrative Hearings (OAH)
  – Office of Civil Rights (OCR)
Case law

Published opinions of judges that interpret statutes, regulations and constitutional provisions

School/SELPA policies
Mental Health as a Related Service

• Under IDEA –
  – Related services accompany special education to allow a child with a disability to benefit from special education.
    • E.g., psychological services, counseling, social work services, parent counseling/training.

• Under Section 504 –
  – Related aids and services must be provided to the extent they enable a school to meet the needs of students with disabilities as adequately as it meets the needs of nondisabled students.
## Mental Health Facts

**National Alliance on Mental Illness**

**Fact:** 1 in 5 children ages 13-18 have, or will have a serious mental illness.

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<thead>
<tr>
<th>Percentage</th>
<th>Description</th>
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<tr>
<td>20%</td>
<td>20% of youth ages 13-18 live with a mental health condition&lt;sup&gt;1&lt;/sup&gt;</td>
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<td>11%</td>
<td>11% of youth have a mood disorder&lt;sup&gt;1&lt;/sup&gt;</td>
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<td>10%</td>
<td>10% of youth have a behavior or conduct disorder&lt;sup&gt;1&lt;/sup&gt;</td>
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<td>8%</td>
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Mental Health Facts
National Alliance on Mental Illness

Impact

50%  50% of all lifetime cases of mental illness begin by age 14 and 75% by age 24.¹

10 yrs  The average delay between onset of symptoms and intervention is 8-10 years.¹

37%  37% of students with a mental health condition age 14 and older drop out of school—the highest dropout rate of any disability group.¹

70%  70% of youth in state and local juvenile justice systems have a mental illness.¹
“Child Find”
“Child Find” Under IDEA

• Affirmative, ongoing obligation to identify, locate, and evaluate all children with disabilities that either:
  – Have disabilities and need special education as a result of those disabilities; or
  – Are suspected of having, disabilities and need special education as a result of those disabilities.

• Parent is not required to request that a school assess the child.

• LEAs must seek out IDEA-eligible students.
“Child Find” Under IDEA

• Failure to identify may entitle a student to compensatory education or tuition reimbursement accruing from the time the LEA first should have suspected the disability.
Role of General Education Teachers in Child Find

• Some teachers may:
  – Tell parents that they should take the child to the doctor; or
  – After parents share a student's diagnosis, provide informal accommodations without referring the student for an evaluation.
Role of General Education Teachers in Child Find

• If depression, anxiety, or other mental health conditions are suspected:
  – Discuss with school psychologist, counselors who are skilled in evaluating these conditions.
  – Describe observations of student.

• Discipline referrals are not the best screener for finding students with internalizing behaviors (e.g., depression/anxiety).
FACTS: Student born in Africa, adopted from orphanage around 8 years old.

Letter in record from therapist who treated Student for reactive attachment disorder, depression, and PTSD.

Student eligible for special education under the category of SLD.

In HS, often late to class, refused to participate, and appeared to be under the influence.

District attributed behavior to drug use.

District funded an IEE which concluded that Student’s eligibility should be ED and required counseling.
Child Find

Oakland Unified School Distr. v. N.S., 115 LRP 53402 (N.D. Cal. 11/10/15)

• Student hospitalized, District did not offer mental health services until it could complete its own assessment.
• Parents unilaterally placed Student out of state, filed due process and requested reimbursement.
• District offered a mental health assessment, but argued that Student must be available locally.
• District did not take any steps to determine if it would be safe for Student to return for an assessment.
Child Find

Oakland Unified School Distr. V. N.S., 115 LRP 53402 (N.D. Cal. 11/10/15)

• HELD: Failure to timely assess mental health needs and offer mental health services was a denial of FAPE.
• Threshold trigger for mental health assessment is relatively low.
• Student’s marijuana use did not relieve District of duty to conduct an assessment of his mental health functioning.
• District was on notice that Student’s mental health needs adversely affected his education.
Child Find Triggers

• Reasons parents enroll in new school or a particular program (including independent study)

• Anxiety

• School phobia

• School refusal
Child Find Triggers

- Excessive absenteeism by itself is not a *per se* basis for suspecting the child has a disability.
- Child find obligations may be triggered where:
  - Significant absences
  - Reason to believe absences are linked to a disability, and
  - Need for services.
- Where truancy is the result of social maladjustment, family or social circumstances, unlikely that LEA has a duty to refer student for an evaluation.
Evaluating Students
Evaluation Components

1. Review Records
2. Developmental History
3. Observations, such as:
   a) In academic activities
   b) During PE
   c) During lunch/break time, etc.
4. Interviews, such as:
   a) Student
   b) School staff
   c) Parents
   d) Health care providers, etc. (exchange information)
5. Administer Tests & Rating Forms
Rating Forms – Cautions and Limitations

• Do not rely solely upon rating forms.

• They measure someone’s opinion of student behavior, NOT a student’s functioning.

• Some are too specific, some are too broad.

• Teachers may be unwilling or too busy to be sufficiently careful.
Rating Forms – Cautions and Limitations

• Teachers and parents may exaggerate concerns in effort to obtain help.

• Student may be unwilling to acknowledge problems.

• Student may have distorted perceptions.
Evaluation – Other Considerations

• Common symptoms: irritability, fatigue, loss of pleasure; and problems with concentrating, sleep, tolerating frustration, completing tasks.

• People with mood or thought disorders tend to perform worse on tests of memory, attention, executive functions, cognitive efficiency.

• Executive dysfunction impairs memory test performance.

• Children with Conduct Disorders tend to perform OK on executive function tests.

• Psychosis produces many cognitive impairments, and the most prominent are related to memory, processing speed, attention, & executive functions.
Writing Defensible Mental Health Goals
Mental Health Goals

Student v. Marin County Mental Health Youth and Family Services (OAH CASE NO. 2011081106).

- HELD: goal did not meet Student’s mental health needs and denied Student FAPE.

- Student will utilize “specific coping skills and awareness of emotional issues to maintain attentional focus” so he could complete classroom assignments as required for 80 percent of the time.
Mental Health Goals

Student v. Marin County Mental Health Youth and Family Services (OAH CASE NO. 2011081106).

No evidence as to:

• How progress would be measured,
• How a teacher would know if Student silently used a coping skill,
• Whether Student had to announce that he was aware of an emotional episode,
• Whether someone was going to keep track of vocal outbursts or moments of defiance,
• Whether/how someone would conclude that he had not tried to use a coping skill or “awareness” of an emotion, or
• Whether an incident had to be tied to not completing an assignment.
Guidelines for Defensible Mental Health Goals

#1. Do not write goals for feelings.

- Not an IEP team’s responsibility to “cure” children of their disabilities.
- Avoid writing goals that require the person responsible for implementation to “mind-read.”
  - Example: “When Sara is feeling depressed, she will ...”
  - How will the teacher know when Sara is feeling depressed?
Guidelines for Defensible Mental Health Goals

#2. Write goals to improve measurable behaviors.

Focus on the relevant behavioral manifestation of the identified social-emotional problems (i.e., measurable behaviors that result from social-emotional problems & prevent student from getting FAPE)
Guidelines for Defensible Mental Health Goals

#2. Write goals to improve measurable behaviors.

When tempted to use unmeasurable terms such as "difficulty," “trouble”, "weak," "unmotivated," "limited," "defiant," "irresponsible," "uncooperative,” stop and ask:

What do I see the student doing that makes me make this judgment call?

What you actually see the student doing is the measurable content you need to identify in your present level.
#3. Observations, classroom based data collection, and/or other staff reports can provide useful quantified baseline data.

Without adequate baselines, it is difficult to determine if goal adequately addresses Student’s needs or whether progress can be accurately evaluated.
Guidelines for Defensible Mental Health Goals

#3. Observations, classroom based data collection, and/or other staff reports can provide useful quantified baseline data.

Baseline information that merely restates a child’s need to develop skills in a certain area does not provide IEP team members with sufficient information on a child’s present levels.
#3. Observations, classroom based data collection, and/or other staff reports can provide useful quantified baseline data.

Example: Student has difficulty completing assignments and turning them in on time.

• What percent of the time? Once a day/week?
• Homework assignments or class work?
• In which classes?
Guidelines for Defensible Mental Health Goals

#4. Wording in Baseline and Goal should be very similar.

- Baseline information that merely restates a child’s assessment scores, with no mention of scores in goal
- Example:
  - **Baseline**: Student’s scores for anxiety were clinically significant on the Behavioral Assessment System for Children, 2nd edition of yielded standard score of 65.
  - **Goal**: By [date], when in a counseling setting, Student will list five ways to decrease personal anxiety with school activities and peer interactions with 100% accuracy in two out of three trials as measured by interview, data collection, and/or observations.

- No link between baseline and goal!
Guidelines for Defensible Mental Health Goals

#5. Make the goals easy for a layperson to understand.

• The Stranger Test: someone unfamiliar with the student could read the goal and understand it.
• Keep it simple, have only one variable in a goal.
#1. By _____, Student will improve self esteem, as measured by participation in weekly group counseling.

• Participation is not proof of improved self esteem, student could participate in group counseling but still perform poorly in school;

• Goal is not quantified; and

• “Participation” is vague.
#2. By _____, when in need of clarification on an assignment or task, Student will seek assistance from staff and only ask questions related to the assignment or task 70% of the time as measured by teacher observations.

- Requires mind reading (to know when the student needs or doesn’t need clarification);
- Two distinct variables; and
- Impossible to measure accurately.
Poorly Written Mental Health Goals

#3. By _____, Student will appropriately interact with peers and adults by maintaining healthy boundaries and engaging in appropriate communication in 2 out of 4 situations as measured by staff observations and charting.

• Too vague (what is a healthy boundary?);
• Two variables (healthy boundaries & appropriate communication) that need to be measured separately.
Well-Written Mental Health Goals

Improving Conduct

• BASELINE: Student currently demonstrates inappropriate behaviors in class including swearing at students and staff, mumbling under his breath, glaring at others, and slamming objects down on his desk 9 times per month.

• GOAL: By ______, Student will reduce the frequency of his inappropriate behaviors in class (e.g., swearing at students and staff, mumbling under his breath, glaring at others, and slamming objects down on his desk) to 2 or fewer times per month as measured by daily behavior logs.
Well-Written Mental Health Goals

Compliance with Directions

• BASELINE: In core academic classes, Student complies with staff directives 40% of the time.

• GOAL: By ______, in core academic classes Student will comply with staff directions 80% of the time as measured by daily behavior logs.
Well-Written Mental Health Goals

Task Completion

• BASELINE: Student completes 20% of his assignments each month, as measured by teacher assignment completion/grade book.

• GOAL: By ____, Student will complete 70% of his assignments per month, as measured by teacher assignment completion/grade book.
Well-Written Mental Health Goals

Coping Skills

• BASELINE: Following one verbal prompt from school staff, Student moves to a time out area, study carrel, or other identified area to calm self, in 2 out of 10 situations.

• GOAL: By ________, following one verbal prompt from school staff, Student will move to a time out area, study carrel, or other identified area to calm self in 8 out of 10 situations.
Mental Health Services for Students
Mental Health Services

• Not just available for children qualifying as emotionally disturbed!

• Mental health needs may, however, be a significant consideration when developing an IEP for a child who qualifies as emotionally disturbed.
Counseling and Guidance Services

5 C.C.R. 3051.9

• Designed to **supplement** the regular guidance and counseling program

• May include:
  – Educational counseling to assist in planning and implement immediate and long-range program
  – Career counseling to assist in assessing aptitudes, abilities, and interests in order to make realistic career decisions
  – Personal counseling to help develop ability to function with social and personal responsibility
  – Counseling and consultation with parents and staff members on learning problems and guidance programs.
Counseling and Guidance Services
5 C.C.R. 3051.9

Who may provide it?

• License as a Marriage and Family Therapist, or Marriage and Family Therapist Registered Intern who is under the supervision of a Licensed Marriage and Family Therapist, a Licensed Clinical Social Worker, a Licensed Professional Clinical Counselor, a Licensed Psychologist, or a Physician who is certified in psychiatry by the Medical Board of California, the Board of Behavioral Sciences, or the Board of Psychology, within the Department of Consumer Affairs.

• License as a Clinical Social Worker, or Associate Clinical Social Worker who is under the supervision of either a Licensed Clinical Social Worker or a licensed Mental Health Professional by the Board of Behavioral Sciences, within the Department of Consumer Affairs; or
Counseling and Guidance Services
5 C.C.R. 3051.9

• License as an Educational Psychologist issued by a licensing agency within the Department of Consumer Affairs; or

• License in psychology, or who are working under supervision of a licensed psychologist, both regulated by the Board of Psychology, within the Department of Consumer Affairs; or

• Pupil Personnel Services Credential, which authorizes school counseling or school psychology.
Counseling and Guidance Services
5 C.C.R. 3051.9

• License as a Licensed Professional Clinical Counselor, or a Professional Clinical Counselor Registered Intern who is under the supervision of a Licensed Professional Clinical Counselor, a Licensed Marriage and Family Therapist, a Licensed Clinical Social Worker, a Licensed Clinical Psychologist, or a Physician who is certified in psychiatry by the American Board of Psychiatry and Neurology.
Parent Counseling/Training

5 C.C.R. 3051.11

• Must assist the child in developing skills needed to benefit from special education or correct conditions that interfere with progress toward IEP goals and objectives.

Letter to Dagley, 17 IDELR 1107 (OSEP 1991), Stanislaus COE, 507 IDELR 364 (SEA CA 1985)

• May include:
  – Assisting parents in understanding the special needs of their child
  – Providing parents with information about child development
  – Helping parents acquire the necessary skills that will allow them to support the implementation of their child IEP or IFSP.

34 C.F.R. 300.34(c)(8).
Parent Counseling/Training

5 C.C.R. 3051.11

Who may provide it?

• Credential that authorizes special education instruction; or
• Credential that authorizes health and nursing services; or
• License as a Marriage and Family Therapist, or Marriage and Family Therapist Registered Intern who is under the supervision of a Licensed Marriage and Family Therapist, a Licensed Clinical Social Worker, a Licensed Professional Clinical Counselor, a Licensed Psychologist, or a Physician who is certified in psychiatry by the Medical Board of California, the Board of Behavioral Sciences, or the Board of Psychology, within the Department of Consumer Affairs; or
• License as a Clinical Social Worker, or Associate Clinical Social Worker who is under the supervision of either a Licensed Clinical Social Worker or a licensed Mental Health Professional by the Board of Behavioral Sciences, within the Department of Consumer Affairs; or
Parent Counseling/Training

5 C.C.R. 3051.11

- License as an Educational Psychologist, issued by a licensing agency within the Department of Consumer Affairs; or
- License as a Psychologist, or who are working under the supervision of a licensed Psychologist, both regulated by the Board of Psychology, within the Department of Consumer Affairs; or
- Pupil Personnel Services Credential that authorizes school counseling or school psychology or school social work.
- License as a Licensed Professional Clinical Counselor, or a Professional Clinical Counselor Registered Intern who is under the supervision of a Licensed Professional Clinical Counselor, a Licensed Marriage and Family Therapist, a Licensed Clinical Social Worker, a Licensed Clinical Psychologist, or a Physician who is certified in psychiatry by the American Board of Psychiatry and Neurology.
Social Work Services in Schools
34 C.F.R. 300.34(c)(14); 5 C.C.R. 3051.13

Includes—

• Preparing a social or developmental history on a child with a disability;

• Group and individual counseling with the child and family;

• 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;

• Mobilizing school and community resources to enable the child to learn as effectively as possible in his or her educational program;
  – Making appropriate referrals and maintaining liaison relationships among the school, student, family, and various agencies providing social, income maintenance, employment development, mental health, or other developmental services

• Assisting in developing positive behavioral intervention strategies.
Who may provide it?

- License as a Clinical Social Worker, or Associate Clinical Social Worker who is under the supervision of either a Licensed Clinical Social Worker or a licensed Mental Health Professional by the Board of Behavioral Sciences, within the Department of Consumer Affairs; or

- License as a Marriage and Family Therapist, or Marriage and Family Therapist Registered Intern who is under the supervision of a Licensed Marriage and Family Therapist, a Licensed Clinical Social Worker, a Licensed Professional Clinical Counselor, a Licensed Psychologist, or a Physician who is certified in psychiatry by the Medical Board of California, the Board of Behavioral Sciences, or the Board of Psychology, within the Department of Consumer Affairs; or
Social Work Services in Schools

34 C.F.R. 300.34(c)(14); 5 C.C.R. 3051.13

• Credential authorizing school social work.
• License as a Licensed Professional Clinical Counselor, or a Professional Clinical Counselor Registered Intern who is under the supervision of a Licensed Professional Clinical Counselor, a Licensed Marriage and Family Therapist, a Licensed Clinical Social Worker, a Licensed Clinical Psychologist, or a Physician who is certified in psychiatry by the American Board of Psychiatry and Neurology.
Psychological Services
34 C.F.R. 300.34(c)(10).

Includes—

• Administering psychological and educational tests, and other assessment procedures;
• Interpreting assessment results;
• Obtaining, integrating, and interpreting information about child behavior and conditions relating to learning;
• Consulting with other staff members in planning school programs to meet the special educational needs of children as indicated by psychological tests, interviews, direct observation, and behavioral evaluations;
• Planning and managing a program of psychological services, including psychological counseling for children and parents; and
• Assisting in developing positive behavioral intervention strategies.
Psychological Services
5 C.C.R. 3051.10

Psychological Services may include:

• Counseling provided to a special education student by a credentialed or licensed psychologist or other qualified personnel.

• Consultative services to parents, pupils, teachers, and other school personnel.

• Planning and implement a program of psychological counseling for special education students and parents.
Who may provide it?

• Licensed Educational Psychologist pursuant to Business and Professions Code section 4989.14;
• Licensed Marriage and Family Therapist pursuant to Business and Professions Code section 4980.02;
• Licensed Clinical Social Worker pursuant to Business and Professions Code section 4996.9; or
• Licensed Psychologist pursuant to Business and Professions Code section 2903; or
• Pupil Personnel Services Credential that authorizes school psychology.
Residential Placement
Residential Placement

• IDEA provides that:
  – If placement in a public or private residential program is necessary to provide special education and related services to a child with a disability, the program, including non-medical care and room and board, must be at no cost to the parents of the child.

  34 C.F.R. 300.104.

• Key Question: What evidence exists that Student would be unable to attain educational benefit outside of a residential treatment facility?
Placement Must be for Educational Purposes

Must focus on whether placement is necessary for **educational purposes**, or whether the placement is a response to medical, social, or emotional problems that is necessary quite apart from the learning process.

LEAs are not responsible for the provision of substance abuse treatment to a disabled student even when the substance abuse interferes with the student’s education and is intertwined with emotional disturbance or other disabling condition.

Example: Residential Placement Not Necessary to Meet Educational Needs

- R.J. was a female student, eligible for special education due to ADHD.

- Needs included:
  - Difficulty with distractibility in the classroom
    - Completing tasks
    - Working independently
    - Organizing assignments
  - Receives A’s and B’s when she completed assignments and turned them in on time, but consistently struggles to do so and earns C’s and D’s

- IEP called for specially designed instruction and counseling support.
Example: Residential Placement Not Necessary (cont’d.)

- *Freshman* – with counselor at school and discussed parents’ divorce, and began dating a student who allegedly committed sexual assault. R.J. started showing signs of depression.
- R.J. was reevaluated.
- Psychologist determined that ADHD was not having a significant impact on classroom performance.
- IEP team continued her existing IEP.
- Finished fall semester with one A, three B’s and two D’s.
Example: Residential Placement Not Necessary (cont’d.)

• January of Freshman year, R.J. stayed late one night at home of high school custodian.
• District reassigned the custodian to night shift and demanded no further contact with R.J.
• R.J. began some self-harming behavior. A psychiatric nurse diagnosed R.J. with adjustment disorder.
• February, parents kept R.J. at home. District provided a home tutor.
Example: Residential Placement Not Necessary (cont’d.)

- Came back to school in March and finished year with two B’s and three F’s.
- During the summer, R.J. snuck out of the house several times to see male friends.
- In September, mother informed District that she was considering placing R.J. in a more restrictive program due to her “risky behaviors”.

Example: Residential Placement Not Necessary (cont’d.)

• District convened an IEP team meeting.
• Teachers reported that R.J. participates in class, receives A’s and B’s on assignments that she completes. Director of Student Services reported that she was, by and large, successful at school.
• District recommended that mother look into community resources on setting limits at home.
• R.J. continued to sneak out of the house and be dishonest with her mother.
Example: Residential Placement Not Necessary (cont’d.)

• Parents withdrew daughter from District and enroll her at a private residential facility in Oregon.
• R.J. was expelled from Oregon facility for having sex with another student.
• Parents then enrolled R.J. at a more restrictive, clinical, all-girls residential facility in Arizona.
• Parents sought reimbursement from District due to District’s failure to provide FAPE.
Example: Residential Placement Not Necessary (cont’d.)

• HELD: R.J. did not require a residential placement “for any educational reason” and denied reimbursement.
• R.J. earned good grades when she managed to complete her work, not disruptive in class, capable of benefiting from education provided by school.
• It was R.J.’s “risky behaviors” outside of school that prompted parents to place her elsewhere.
• Despite testimony for residential facility representatives that R.J. was “incapable of succeeding outside of the residential facility”.

_Ashland School District v. Parents of Student R.J. (9th Cir. 2009) (588 F.3d 1004)._
Example: Residential Placement Necessary to Meet Educational Needs

- Student had been hospitalized for violent outbursts related to preparing a school science report.
- Student was assigned little or no homework because it was too stressful for her.
- Student’s primary problems were educationally related.
- Court concluded that residential placement was necessary.
Residential Placement

- The common thread of all cases is that to warrant a residential placement, a student must demonstrate that he is unable to benefit from his educational placement and unable to progress toward meeting his IEP goals, even if his behaviors at home result in psychiatric hospitalizations.

- Only where the student’s home behavior has impacted his or her ability to function in the school environment has a court found that an IEP-based residential placement was warranted.

*Student v. Riverside County Department of Mental Health* (2009) OAH case number 2008100383
Questions?

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