The Education and Mental Health Systems: Establishing Shared Outcomes for Youth with Emotional Disorders

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The education system is the only child-serving institution mandated to serve children and youth with emotional disorders. The Individuals with Disabilities Education Improvement Act (IDEIA) of 2004 guarantees access to a free, appropriate public education for all children with disabilities; that group now includes approximately 450,000 children with emotional disorders. However, for the majority of these children and youth, the outcomes are poor. For over half of these youth, their educational experience ends in decision to drop out of school (U.S. Department of Education, 2002), the highest dropout rate of any disability category. These dropout rates reflect the fact that these students earn lower grades and fail more courses than any other disability group served in special education environments (Landrum et al., 2003). Adding to these bleak outcomes is the fact that 47% of all elementary/middle school children classified as ED have been suspended or expelled at some time during their school career while 73% of youth with ED at the secondary level have been subject to this kind of disciplinary action at school. Additionally 61% of youth score in the bottom quartile on standardized reading measures. Yet, about 40% of these youth are receiving mental health services along with their special education classroom services. Clearly, there is a lack of shared agreement on prioritizing the outcomes and implementing effective, integrated interventions for these youth between the mental health and education systems.

Policy Response

Within the federal policy arena, there is evidence of a shared agenda of integrating mental health services with the school system. On the mental health side, both the Surgeon General’s report (US DHSS, 1999) and the report from the President’s New Freedom Commission on Mental Health (2003) propose the expansion of mental health services for children in the nation’s schools. Likewise, the education system has called for the increased accountability and integration between the mental health and educational system. The No Child Left Behind Act signed into law in 2002, emphasized accountability, particularly for academic achievement and increased use of scientifically based programs and teaching methods, and stressed the need to ensure “student access to quality mental health care by developing innovative programs to link the local school system with the local mental health system” (U.S. Department of Education Office of Elementary and Secondary Education, 2002, p 427). It is clear at the federal level that there is support for the integration of school and mental health systems.

Empirical Rationale

Two things are clear. First, students identified with ED and served in special education programs in public schools have severe levels of emotional impairment. National longitudinal studies of these students found that their levels of impairment were at the clinical range as measured by standardized diagnostic instruments and similar to that of youths placed in residential treatment programs (e.g., Greenbaum et al., 1998; Silver et al., 1997). Second, as stated above, the outcomes for these students continue to be poor (Kessler, Chiu, Demler, & Walters, 2005; Wagner, 1995) and less than half of these students actually receive mental health services (Wagner et al., 2006). In fact, these efforts of schools to ensure successful emotional functioning in their students has resulted in the finding that most of the children in this
country who get any mental health service at all, receive it from their school (Burns et al., 1995; Leaf, et al., 1996). This has led to the suggestion that the school system has become the de facto children’s mental health system (Burns et al., 1995).

In a national study on the implementation of IDEA, Minow (2001) also found that psychological services were not implemented very often for these students. Professionals were diverted to testing and crisis intervention rather than sustained support. She further found that “many school systems resist the provision of related services on the theory that they are not educational but medical or psychological, even though these services are required under the act where necessary to enable the student’s free appropriate public education. Provision of related services often fails when school districts and other local agencies disagree over who should provide and pay for them” (Minow, 2001, p.4).

**State of the science**  A lack of rigorous studies contributes to our uncertainty of the effectiveness of mental health services for these students. Rones and Hoagwood (2000) examined the empirical literature published during a 15 year period on school based mental health services. They uncovered 5,128 entries on the topic but only 47 met criteria for rigorously evaluated research. Further, only a few of these studies had students with ED who were served in special education programs as participants. Even the recently completed report on school based mental health by the Government Accountability Office (GAO) excluded children in special education from its study (GAO, 2007, p. 2). Summarily, Zins, Weissberg, Wang, & Walberg (2004) report that a typical school delivers, on average, 14 separate programs to address the mental health needs of their students. Of these programs, however, most were not empirically based or systematically deployed. Rather, they seemed to emerge in response to immediate pressure or trends. Even when rigorous studies are conducted on mental health intervention studies, the most rudimentary school related outcomes are rarely included (Hoagwood & Johnson, 2003; Hoagwood et al., 2007).

As more children continue to need mental health services and supports and with school serving a central roll in facilitating access to services, it is increasingly important to understand the services delivered in schools and their effectiveness. In the field, school administrators are faced with mandates, models of service delivery and a need for focus and clarity to improve practice and student outcomes. Researchers should help fill the gap between educational and emotional outcomes for these youth as well as the effective service delivery mechanisms that can adequately address both outcome domains. As suggested by Farmer and Farmer (1999), "An examination of treatment context without more fully recognizing the central role of educational context provides an incomplete, and potentially misleading approach to implementation and evaluation of mental health services and outcomes" (pp 380-381).

**Building the research base** There are several research areas that could be addressed in order to increase our understanding of youth with ED served in special education settings and thus lead to a better linkage between policy and practice between the educational and mental health service systems. Three such strategies are briefly described below.

**(1) Existing data sets** The US Department of Education recently funded the Special Education Elementary Longitudinal Study (SEELS) and the National Longitudinal Transition
Study-2 (NLTS-2), to evaluate the effectiveness of all special education programs. The SEELS focuses on elementary and middle school children and NLTS2 focuses on secondary school youth as they transition to early adulthood. The two data sets describe a nationally representative sample of children and youth with repeated waves of measurement over the 6-year and 10-year lives of the two studies. Kutash and Duchnowski have joined Wagner, the PI for SEELS and NLTS-2, in examining the characteristics and educational settings of youth with ED population in these studies (Wagner et al., 2006; Wagner, Kutash, Duchnowski, & Epstein, 2005; Wagner, Kutash, Duchnowski, Epstein, & Sumi, 2005). However, researchers need to specifically examine these data sets for predictors of school success for students with ED. The factors that are associated with those who succeed in school (graduation, grades, attendance) and if these outcomes are associated with the receipt of mental health services and the types of services associated with positive outcomes.

(2) What are their emotional disorders? While SEELS and NLTS2 studies offer a wealth of information, no standardized measure of emotional impairment was included, limiting the utility of the study findings. There needs to be a systematic study of the emotional and behavioral needs of the children and youth served in special education within the category of ED. In the purposed study, the sampling strategy already developed by the SEELS and NLTS2 research team that results in a nationally representative sample of youth with ED in special education could be used to obtain a sample of youth that could be administered a battery of standardized instruments to understand their emotional functioning as well as their barriers to learning.

(3) Conceptual model. One of the most pressing needs in this area is a conceptual model that clearly articulates for providers in both mental health and education the effective services and programs that can be used to address both the educational and mental health needs of youth, especially those in special education settings, and that can be successfully implemented in schools. Currently there are competing models of support (e.g., school wide positive behavior support, functional behavioral assessments, social emotional learning programs as well as mental health services) that have created a patch work of ineffective services and programs that have helped sustain the poor outcomes of these youth. The development of an integrated program model that is based on the best empirical evidence available and addresses the educational and emotional domains for youth with ED who are served in special education is needed. The resulting document from this activity should be directed to leadership in mental health and education to inform practice and policy. The document should ideally result from a consensus conference of leading experts who would review the current evidence-base and provide insights for local practice and policy.

References


