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The Legislative History of Mental Disorders in Federal Education Programs

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THE HISTORY OF THE DIAGNOSIS AND TREATMENT OF MENTAL DISORDERS IN FEDERAL EDUCATION PROGRAMS

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Abstract

This paper traces the increased federal role in the diagnosis and treatment of mental and behavioral health disorders in public schools. In recent years, the diagnosis of mental disorders in school age children such as Attention Deficit Disorder (ADD), Attention-Deficit/Hyperactivity Disorder (ADHD), Early Onset Bipolar Disorder (EOBD), and Oppositional Defiant Disorder (ODD) have increased as a percentage of the total school population. This paper looks at the development of federal education policies based on legislation that includes the Elementary and Secondary Education Act, No Child Left Behind, and the recent Every Student Succeeds Act. It also includes the development of federal education policy through legislation regarding students with disabilities.

Terms related to the diagnosis of childhood mental disorders will be defined as recorded in the Diagnostic and Statistical Manual (DSM), published by the American Psychiatric Association. The paper considers how the changes to the DSM over time have affected the meanings of the mental disorders that can be found in subsequent iterations of federal and state law. This paper analyzes the implementation of school sanctioned and/or recommended or prescribed treatments for the identified disorders. It looks at the results of the implementation of these prescriptions and/or treatments over time and the perceived results related to the next steps in federal and state legislation regarding mental and behavioral health polices for students.

The Elementary and Secondary Education Act of 1965

The involvement of the federal government in childhood mental health diagnosis and treatment can be traced back to the Elementary and Secondary Education Act of 1965[1]. The 31-page law provided funding to strengthen and support state departments of education in meeting the "special educational needs of educationally deprived children." State departments of education would provide financial assistance to local educational agencies serving areas with concentrations of children from low-income families. Supplementary educational services would be provided for comprehensive guidance and counseling, remedial instruction, and school health, physical education, recreation, psychological, and social work services. Vocational guidance and counseling would also be provided. Although reports would be submitted to the Commissioner, there was no federally prescribed test required for the psychological and social work services that would be provided to high concentrations of low-income students in public schools. Section 604 contained a disclaimer about federal control over education, "Nothing contained in this Act shall be construed to authorize any department, agency, officer, or employee of the United States to exercise any direction, supervision, or control over the curriculum, program of instruction, administration, or personnel of any educational institution or school system, or over the selection of library resources, textbooks, or other printed or published instructional materials by any educational institution or school system."

No Child Left Behind

The federal role in childhood mental health expanded with the 2001 passage of No Child Left Behind.[2] Section 5541 provided grants for the integration of schools and mental health systems. The goal was to "to increase student access to quality mental health care by developing

innovative programs to link local school systems with the local mental health system." Funds were available to "enhance, improve, or develop collaborative efforts between school-based service systems and mental health service systems to provide, enhance, or improve prevention, diagnosis, and treatment services to students."[3] Crisis intervention services were enhanced and referrals for students potentially in need of mental health services were made available under these cooperative agreements. Training was also provided to school personnel to carry out the program. Although the federal role in mental health expanded under NCLB, parents of the students participating in the services were to be involved in the design and implementation of the services.

NCLB also expanded mental health in early childhood emotional and social development.[4] Services would be delivered to eligible children and their families to foster emotional, behavioral, and social development. Students under the age of 7 who exhibited two or more risk factors were eligible for services. One of the risk factors was being at 200 percent of the poverty line. Other risk factors included low birth weight, parental substance abuse, homelessness, having a parent with depression or mental illness, or being abused, mistreated, neglected or exposed to violence. However, the parents of the students participating in these services were to be involved in the design and implementation of the services.[5]

Every Student Succeeds Act

Passed in 2015, the Every Student Succeeds Act[6] again expanded the federal role in mental health programs in pubic schools, including "counseling, school-based mental health programs."[7] The state plans would carry out in-service training for school personnel in the techniques and supports needed to help educators understand when and how to refer students affected by trauma, and children with, or at risk of mental illness. The plan would include forming partnerships between school-based mental health programs and public or private mental health organizations. However, unlike NCLB, ESSA does not strictly require parents to be involved in the design and implementation of the mental health services. Instead, although informed written parental consent would normally be required, there are circumstances where mental health testing and services can be given to a child without parental consent. In an emergency, where it is necessary to protect the immediate health and safety of the child, or other children, or entity personnel, or other instances in which an entity seeks parental consent but consent cannot be reasonably obtained as determined by the State or local educational agency or in the case of a child whose parent has not responded to the required notice. In addition, no consent is necessary if the child is at least 14 years old and is an unaccompanied youth.[8]

How Reliable is a Mental Health Diagnosis?

One of the most often diagnosed childhood mental health illnesses has been ADHD. Many children diagnosed with ADHD have been prescribed stimulants. Some have wondered why children with Attention Deficit Hyperactivity Disorder would be given a stimulant, since they are already hyperactive to begin with. The stimulant enhances attention span and helps the students concentrate on the task at hand. However, there can be side effects to stimulants such as

stomach aches, decreased appetite, headaches, difficulty falling asleep, jitteriness and a rebound effect when the drug wears off.[9]

With the ever-increasing numbers of young children being diagnosed with mental illnesses, and with the increased federal funding and authority for programs to identify students with mental illness, even without parental consent, it becomes important to accurately and scientifically define exactly what defines mental illness in children with a high degree of certainty. What will be the effect of a misdiagnosis? What will be the lifelong consequences of telling a parent and a student that they have a mental illness such as ADD, ADHD, ODD, or EOBD if in fact they do not?

According to Rosemond and Ravenel, the American Psychological Society's own DSM-IV that lists and describes mental disorders cannot accurately distinguish the characteristics of someone with a mental disorder and someone without a mental disorder. As quoted from the DSM-IV by Rosemond and Ravenel, "It must be admitted that no definition adequately specifies precise boundaries of the concept of 'mental disorder.' The concept of mental disorder, like many other concepts in medicine and science, lacks a consistent operational definition that covers all situations.... In DSM-IV there is no assumption that each category of mental disorder is a completely discrete entity with absolute boundaries dividing it from other mental disorders or from no mental disorder."[10]

Many question the validity of a diagnosis made with purely observational data. After all, someone may observe another person with a checklist, but it is much harder to know for certain what someone is thinking by their behavior alone. Some mental professionals have used the phrase "chemical imbalance" to describe mental health challenges and the need to regulate this balance with some type of pharmaceutical. However, according to Rosemond and Ravenel, "To speak of imbalance requires knowing what constitutes a state of balance, as such a state is impossible to determine, if there even is such a thing…whereas brain-imaging techniques can measure electrical activity, blood flow to various brain areas, or brain anatomy, there is no way of measuring brain chemistry."[11]

Additionally, although the makers of pharmaceuticals for the treatment of ADHD claim that a lack of serotonin can cause mental disorders, "…no peer-reviewed article has ever been published that would 'directly support the claims of serotonin deficiency in any mental disorder, while there are many articles that support counterevidence.'" Thus, the Chair of the FDA psychopharmacology Advisory Committee admitted that the notion of chemical imbalances is nothing more than a 'useful metaphor.'"[12]

The role of the pharmaceutical companies has been described as follows: "First, the APA invents a new diagnosis, thus creating a new client base; second, it uses non-science and other nonsense to 'medicalize' the supposed disorder; third, it expands the boundaries of the diagnosis so as to capture more and more clients in the new diagnostic 'net.'"[13]

Let us examine an ADHD rating scale published by the APA. The items on the scale include the following:

1. Attention to details/careless mistakes
2. Difficulty sustaining attention
3. Does not listen
4. Does not follow instructions
5. Difficulty organizing
6. Dislikes mental effort tasks
7. Loses things
8. Easily distracted
9. Forgetful
10. Fidgets or squirms
11. Leaves seat
12. Runs or climbs
13. Difficulty engaging in activities quietly
14. On the go or driven by a motor
15. Talks excessively
16. Blurts out answers
17. Difficulty awaiting turn
18. Interrupts others[14]

As seen above, the diagnostic for ADHD could apply to many students who do not actually have ADHD. The current DSM also shows the ambiguity and the subjective nature of mental health diagnosis, "A growing body of scientific evidence favors dimensional concepts in the diagnosis of mental disorders. The limitations of a categorical approach to diagnosis include the failure to find zones of rarity between diagnoses (i.e., delineation of mental disorders from one another by natural boundaries)… relative lack of utility in furthering the identification of unique antecedent validators for most mental disorders, and lack of treatment specificity for the various diagnostic categories."[15]

The DSM authors use excessive verbiage above just to say what many people with common sense can already see; that although teachers, parents, and doctors can observe the behavior of people in general and students in particular, they have no reliable scientific way of diagnosing a student based on a scale with many common characteristics that may apply to students who do not have a mental illness. Beyond that, the treatments are not specific either.

What would it be like to be the child or the parents of a child who has all the necessary ingredients for success in school and in life, and to be told by someone who thinks they know, that the child is not the master of his or her own destiny? What would it be like to assume that discipline, hard work, and effort are not enough for the child to succeed, no, instead they are in need of a pharmaceutical to be able to overcome a problem that they were born with, inherited from their parents due to "brain chemistry" or a "chemical imbalance?" What if you were told this by people who knew that brain chemistry and chemical imbalances are only metaphors? These have been the experiences for far too many children and parents. What should the role of

the federal government be in childhood mental health diagnosis and treatment? Should the federal government, working in tandem with the local schools be able to make decisions about childhood mental health diagnosis and treatment without the consent of the student or the student's parents?

Endnotes

[1] 89 P.L. 10, 79 Stat. 27

[2] NO CHILD LEFT BEHIND ACT OF 2001, 107 P.L. 110, 115 Stat. 1425

[3] NCLB Section 5541 (c) (1)

[4] NCLB Section 5542 (c) (1) (f) (1)

[5] NCLB Section 5542 (b) (3) (E)

[6] 114 P.L. 95, 129 Stat. 1802

[7] 114 P.L. 95, 1008 (b) (7) (A) (iii) (I)

[8] 20 U.S.C.A. § 7101

[9] Rosemond, J. & Ravenel, B. *The Diseasing of America's Children: Exposing the ADHD Fiasco and Empowering Parents to Take Back Control*. 2008 pg. 92-93.

[10] Ibid. pg. 15.

[11] Ibid. pg. 64.

[12] Ibid. pg. 65.

[13] Ibid. pg. 30.

[14] PsycTESTS™ is a database of the American Psychological Association Thaler, Nicholas S., Bello, Danielle T., & Etcoff, Lewis M. (2013). WISC-IV profiles are associated with differences in symptomatology and outcome in children with ADHD. Journal of Attention Disorders, Vol 17(4), 291-301. doi: https://dx.doi.org/10.1177/1087054711428806, © 2013 by SAGE Publications.

[15] https://dsm.psychiatryonline.org/doi/full/10.1176/appi.books.9780890425596.AssessmentMeasures