SPECIAL EDUCATION & MENTAL HEALTH - What do the numbers really say?

Continuing my focus on special education and child and adolescent mental health, this article will discuss actual Franklin County school statistics regarding total school populations and, within that number, special education students (SpEd), while providing an analysis of what the numbers do not reveal at first glance.

On the Massachusetts Department of Education website, one can find downloadable spreadsheets with special education statistics. Here's the DOE link for all kinds of enrollment data in downloadable spreadsheets (e.g. Excel or Quattro Pro):
http://www.doe.mass.edu/InfoServices/reports/enroll
The spreadsheet I used lists total students in the district and the total SpEd students within that population. In turn, the SpEd number is further broken down into 13 different categories ranging from autism to emotional to physical to neurological, just to name a few. Please keep in mind, though, that the focus here is on mental health concerns within SpEd populations.

I used the 2006-07 spreadsheet data to cull out Franklin County data for these districts: Frontier, Gill-Montague, Greenfield, Mahar, Mohawk and Pioneer. I placed calls to the SpEd Directors in each district to discuss the statistics with them. The response was less than hoped for and in some cases non-existent. In no way was it intended to put anyone on the spot. Actually, the intent was, and remains, to acquire more knowledge and insight into issues specifically related to mental health concerns. Let's discuss the findings so that we can see the extent of the difficulties faced by SpEd personnel in dealing with mental health conditions in their district. It should be noted as well that situations are quite similar throughout the United States and are not solely endemic to Massachusetts or Franklin County.

Let's take Frontier Regional as one example. The 2006-07 DOE statistics list that district as having 743 total students, of which 153 are special ed, meaning those are the students who have an Individual Education Plan (IEP) or a 504 Plan. Of those 153 students, 22 are in the emotional category, obviously related to some mental health condition such as depression. Eighty-five students are in the category of specific learning disability and 9 are in the multiple disability category. Percentage wise, almost 21% of Frontier's total student population is classified as SpEd. The 22 in the emotional category constitute a little over 14% of the entire SpEd population at Frontier. Combining the emotional and learning disability figures, conditions that are highly co-morbid, we find that 70% of Frontier's special education students are in those two categories,

Mohawk Trail Regional is another appropriate example. The DOE figures give Mohawk 1,284 total students of which 265 are special education, almost 21% of their student population. (Current figures direct from Mohawk give 1,204 and 279 respectively which skew the statistics slightly). Of those 265 students, 34, or about 13% of Mohawk's SpEd students are in the emotional category. Seventy-one students are categorized with a specific learning disability while 18 are in the multiple disability category. As before with Frontier, when combining the highly co-morbid categories of emotional and specific learning disability, the total is 105, almost 40% of the entire SpEd population at Mohawk. Clearly, these districts are, as are all districts, faced with educating children and

adolescents with multiple challenges, mental health and learning alike. There are, however, a few caveats not revealed in the numbers.

Not every student who receives classroom assistance/accommodations to support their learning or emotional needs have, or necessarily require, an IEP. There are, no doubt in every district, students who are accommodated/assisted in some way, thanks to a positive, supportive administrative environment and to the efforts of various educational personnel. There are also, no doubt, students who need and who could benefit from an IEP or a 504 Plan that do not have one. Then there is the decision about in which category to place/record the student. In which category does a child with depression and a learning disability, or with Bi-Polar Disorder and pervasive developmental delay (PDD), get recorded? Or, a child with Tourette Syndrome, usually thought of as just a neurological condition, who has, as highly co-morbid conditions, Attention Deficit Hyperactivity Disorder (ADHD) and Obsessive-Compulsive Disorder (OCD) as well? How is that determination made?

As students with co-morbid conditions cannot be placed in more than one category, each school district must decide in which category to place such students. How they do that no doubt accounts for some of the percentage discrepancies between districts in the previous examples. In choosing, the assigned category often represents the one most impeding the educational process, which is not necessarily the mental health condition.

The implications are clear. The statistics in no way clarify the complexities of these kids' lives especially relative to the high co-morbid rates among the various categories. The extent of the challenges is dramatically understated. The overlap between the traditional SpEd camp and the clinical camp is not addressed. We continue to attempt to educate those students with mental health challenges in an environment that has as its legitimate priority educating, not treating, its students.

Schools were never intended to be mental health clinics. Today, the bulk of child and adolescent mental health services are delivered through school systems nationwide. They have become the de facto mental health clinic annexes. These students spend 6-7 hours a day in school. Professionally, I believe that is good and here's why. These young people benefit from an organized, structured environment that is facilitated by people who are there consistently over extended periods of time. It is also where their peers are who assist greatly with the socialization aspects. I for one think we do not utilize the other students enough to help their fellow classmates challenged by mental health concerns. That, however, is a topic for another day.

Despite the mandates to educate these kids, educational personnel are not clinicians. Nor do they tend to receive appropriate training to increase their effectiveness. The situation presented by the statistics gives only a cursory overview of the extent of the disabilities these kids face. If we are to effectively treat and educate kids with mental health and educational challenges (remember the co-mingling/blending of traditional educational challenges like learning disabilities and those of the mental health variety such as depression), we need to find ways to provide the necessary services to accomplish those goals. Obviously, the core issue is resources and that means money for personnel, for

various programs and their needs and for appropriate and effective training to assist educational personnel to better treat/educate these kids.

Additionally, it is my professional experience that there is a decided lack of qualified, competent and effective clinicians to treat children and adolescents. (I am not referring to child and adolescent psychiatrists who prescribe the medications used. For an alarming report regarding the number and availability of child & adolescent psychiatrists go to: http://pn.psychiatryonline.org/cgi/content/full/36/8/26). While perhaps many clinicians claim such expertise, it appears otherwise. Further, the usual treatment continues to focus almost exclusively on behavioral issues (mostly mandated by managed care because that approach supposedly delivers measurable outcomes), an approach that falls short for these types of kids. The traditional "50 Minute Hour" per week of outpatient therapy is barely better than nothing. And, due to a lack of compensation, there is rarely collaboration among educational and clinical personnel.

If, as I suspect, schools are supplying mental health services under the guise of equal access to education, then perhaps it's time to turn to the usual payers of such services, namely managed care insurance companies for reimbursement. Make no mistake, mental health services are labor intensive and therefore costly. The earlier the interventions, the better the outcomes. Children and adolescents with mental health challenges are quite capable of becoming productive contributors to our communities. What is needed are competent, capable and effective people in both the educational and mental health arenas to work together to help these kids deal with their clinical conditions and to become academic achievers. They need our help. All of it is possible.

Special thanks is extended to Michael Ponti and Patricia Bell, Special Education Directors at Frontier Regional and Mohawk Regional respectively for taking time out from their over-scheduled day to speak with me. Keep up the good work.

Next in the series will be information/discussion on the various child and adolescent mental health conditions previously mentioned in this series of articles. They will, as does this article, appear on The Greenfield Optimist. Please check back regularly for this continuing series.

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