

2015

## Mandatory School-Based Mental Health Services and the Prevention of School Violence

Tessa Heller

Follow this and additional works at: <https://scholarlycommons.law.case.edu/healthmatrix>



Part of the [Health Law and Policy Commons](#)

---

### Recommended Citation

Tessa Heller, *Mandatory School-Based Mental Health Services and the Prevention of School Violence*, 24 *Health Matrix* 279 (2014)

Available at: <https://scholarlycommons.law.case.edu/healthmatrix/vol24/iss1/11>

This Note is brought to you for free and open access by the Student Journals at Case Western Reserve University School of Law Scholarly Commons. It has been accepted for inclusion in *Health Matrix: The Journal of Law-Medicine* by an authorized administrator of Case Western Reserve University School of Law Scholarly Commons.

# MANDATORY SCHOOL-BASED MENTAL HEALTH SERVICES AND THE PREVENTION OF SCHOOL VIOLENCE

*Tessa Heller*<sup>†</sup>

## CONTENTS

INTRODUCTION .....	279
I. MENTAL ILLNESS IN SCHOOL-AGED CHILDREN .....	283
<i>A. Symptoms and Signs of Mental Illness in Children</i> .....	284
<i>B. Care and Treatment</i> .....	286
<i>C. Violence Caused by Mental Illness</i> .....	288
II. THE DUTY TO MONITOR AND DISCOVER A CHILD'S MENTAL ILLNESS.....	289
<i>A. The Problem: Accessibility</i> .....	291
<i>B. Mental Health Assessment in Schools</i> .....	292
III. PROPOSED STATUTE .....	297
<i>A. Model Mental Health Statute</i> .....	298
<i>B. Periodical Mental Health Screenings</i> .....	300
<i>C. Improved Accessibility to Mental Health Services</i> .....	301
<i>D. Education of Teachers, School Officials, and Students</i> .....	302
IV. PASSING THE LAW .....	305
<i>A. Barriers and Solutions</i> .....	305
1. Funding.....	305
2. Parental Rights .....	308
3. Teachers .....	311
4. Civil Rights and Medical Privacy Rights .....	312
<i>B. Other Benefits of the Law</i> .....	314
CONCLUSION .....	315

## INTRODUCTION

On the morning of February 27, 2012, T.J. Lane, a 17-year-old high school student, entered a school in Chardon, Ohio and initiated a shooting rampage.<sup>1</sup> Lane is said to have fired ten rounds from a .22-

---

† J.D., 2014, Case Western Reserve University School of Law. I would like to thank Professor Sharona Hoffman and Deborah Pergament for their guidance and helpful input during the note-writing process. I would also like to thank the Health Matrix Volume 24 editorial board and staff as well as the Case Western Reserve University School of Law library staff.

1. Sabrina Tavernise & Jennifer Preston, *Ohio Shooting Suspect Confesses, Prosecutor Says*, N.Y. TIMES (Feb 28, 2012),

caliber semiautomatic pistol towards four students at a table in the cafeteria.<sup>2</sup> He left four unconscious teenage boys on the floor of Chardon High School in pools of their own blood.<sup>3</sup> The next day, Lane confessed to the shooting, admitting that his victims were randomly chosen.<sup>4</sup> This tragedy left more questions than answers. What caused this young boy, known to many as a loner and a “fairly quiet . . . good kid,”<sup>5</sup> to leave his house armed with a gun and the intention to shoot fellow students? What was going through his mind?

While bullying is often an initial theory in school shootings, the prosecutor in this case never seemed to believe that bullying was the cause of Lane’s violence.<sup>6</sup> In fact, the more popular theory that emerged after the shootings is that Lane is mentally ill.<sup>7</sup> Lane had reported “altered mental states”<sup>8</sup> to doctors, saying he felt “preoccupied, and mentally not there.”<sup>9</sup> He also reported having had “delusions, hallucinations, and involuntary fantasies.”<sup>10</sup> This begs the

---

<http://www.nytimes.com/2012/02/29/us/ohio-school-shooting-suspect-confesses-prosecutor-says.html?pagewanted=all>.

2. *Id.*
3. *Id.*
4. *Id.*
5. *Id.*
6. See Molly Bloom, *Mental Illness, Not Bullying, behind Chardon High School Shooting, Prosecutor Says*, NPR STATEIMPACT (May 29, 2012), <http://stateimpact.npr.org/ohio/2012/05/29/mental-illness-not-bullying-behind-chardon-high-school-shooting-prosecutor-says>.
7. See John M. Grohol, *The Psychology of a School Shooting: T.J. Lane in Chardon, Ohio*, PSYCHCENTRAL (2012), <http://psychcentral.com/blog/archives/2012/02/29/the-psychology-of-a-school-shooting-tj-lane-in-chardon-ohio/> (last visited Apr. 19, 2014); see also Rachel Dissell, *Accused Chardon High School Shooter T.J. Lane’s Legal Case is Far From Normal, Experts Say*, THE PLAIN DEALER (March 2, 2012), available at [http://www.cleveland.com/chardon-shooting/index.ssf/2012/03/legal\\_case\\_of\\_accused\\_chardon.html](http://www.cleveland.com/chardon-shooting/index.ssf/2012/03/legal_case_of_accused_chardon.html) (reporting that Geauga County Prosecutor David Jounce hinted that Lane might be mentally ill). Lane’s possible mental illness was further evidenced during his sentencing hearing. On March 19, 2013, a Geauga County Common Pleas judge sentenced Lane to life in prison without parole. At the hearing, Lane wore a t-shirt with the word “killer” written on it. Lane proceeded to make an explicit and sexual statement to the families of his victims, shocking the courtroom. John Caniglia, *T.J. Lane Sentenced to Life in Prison in Chardon High School Shootings*, THE PLAIN DEALER (Mar. 19, 2013), available at [http://www.cleveland.com/chardon-shooting/index.ssf/2013/03/tj\\_lane\\_sentenced\\_in\\_chardon\\_h.html](http://www.cleveland.com/chardon-shooting/index.ssf/2013/03/tj_lane_sentenced_in_chardon_h.html).
8. Bloom, *supra* note 6.
9. *Id.*
10. *Id.*

question: could this attack have been prevented? If Lane's mental illness had been detected earlier, could someone have intervened? Should someone in Lane's life have known he could have been a danger?<sup>11</sup>

School violence,<sup>12</sup> like many other types of violence, is all too common.<sup>13</sup> Perhaps school violence is of greater concern to the public because young people are often viewed as more innocent and less deserving victims. Beyond the everyday fights and threats that occur at schools, the public has become aware of violent shooting rampages such as the one at Chardon High School and, more recently, the tragedy at Sandy Hook Elementary School in Newtown, Connecticut.<sup>14</sup> Although the frequency of these massacres has not increased

- 
11. On February 26, 2013, T.J. Lane pled guilty to three counts of aggravated murder. Lane previously withdrew his plea of not guilty by reason of insanity. *Ohio Teen Pleads Guilty in School Shooting*, INST. OF AM. STUD. (Mar. 3, 2013), <http://www.asipress.us/vdcbzwb8.rhb9spe4ur.html> (“A juvenile court judge ruled that Mr. Lane was mentally competent despite evidence he suffers from hallucinations, psychosis and fantasies.”).
  12. There is an important distinction between the terms “youth violence” and “school violence.” Youth violence is defined as: “The intentional use of physical force or power, threatened or actual, . . . that either results in or has a high likelihood of resulting in injury, death, psychological harm, maldevelopment, or deprivation . . . involving people between the ages 10-29.” WORLD HEALTH ORG., WORLD REPORT ON VIOLENCE AND HEALTH: SUMMARY 4 (2002), *available at* [http://www.who.int/violence\\_injury\\_prevention/violence/world\\_report/en/summary\\_en.pdf](http://www.who.int/violence_injury_prevention/violence/world_report/en/summary_en.pdf). School violence is a more specific term that refers to “school-associated” violence, which “occurs on school grounds, in route to or from school, or during school-sponsored events.” Laura E. Agnich, *A Cross-National Study of School Violence* 6 (May 11, 2011) (unpublished Ph.D. dissertation, Virginia Tech), *available at* [http://scholar.lib.vt.edu/theses/available/etd-06292011-114002/unrestricted/Agnich\\_LE\\_D\\_2011.pdf](http://scholar.lib.vt.edu/theses/available/etd-06292011-114002/unrestricted/Agnich_LE_D_2011.pdf). Throughout this article when I refer to any sort of violence, I am referring to “school-associated” violence.
  13. *See* CTRS. FOR DISEASE CONTROL, *YOUTH VIOLENCE: FACTS AT A GLANCE* 2010, at 1 (2010), *available at* [http://ophp.sph.rutgers.edu/njphct/AP\\_-\\_Public\\_Health\\_Policy\\_files/YV-DataSheet-a.pdf](http://ophp.sph.rutgers.edu/njphct/AP_-_Public_Health_Policy_files/YV-DataSheet-a.pdf) (stating that in 2009, 11.1% of children in the ninth through the twelfth grades “reported being involved in a physical fight on school property” within the last year, and 7.7% of these children “reported being injured or threatened with a weapon on school property” at least once).
  14. *See The Shootings at Sandy Hook Elementary School*, N.Y. TIMES (Dec.14, 2012), *available at* <http://www.nytimes.com/interactive/2012/12/14/nyregion/The-shooting-at-the-Sandy-Hook-Elementary.html> (summarizing that on December 14, 2012, Adam Lanza killed twenty-six people, twenty of them children ages 5 to 10, and then killed himself at Sandy Hook Elementary School in Newtown, Connecticut).

dramatically since the early 1990s,<sup>15</sup> the number of school shootings per year is higher now than it was in the 1990s.<sup>16</sup> Moreover, the fact that school shootings are still occurring demonstrates a lack of a proper response by policymakers to help prevent these shootings. The initial shock<sup>17</sup> that the public felt after hearing of the Columbine shooting in 1999<sup>18</sup> has weakened, partially because violence portrayed in the media has caused Americans to become more desensitized to violence.<sup>19</sup> Less publicized school violence, especially in inner-city schools, is even more frequent<sup>20</sup> and often ignored.

A 2002 study conducted by the Secret Service determined that most school shooters “engaged in some behavior prior to the incident that caused others concern or indicated a need for help.”<sup>21</sup> In addition, most of these shooters had attempted or considered suicide and had expressed difficulty coping with loss in their lives.<sup>22</sup> Experts have

- 
15. See *School-Associated Student Homicides --- United States, 1992 -- 2006*, CTRS. FOR DISEASE CONTROL (Jan. 18, 2008), <http://www.cdc.gov/mmwr/preview/mmwrhtml/mm5702a1.htm> (reporting that the number of school-associated student homicides remained stable between July 1999 and June 2006, when “116 students were killed in 109 school-associated homicide events”).
  16. See *Time Line of Worldwide School and Mass Shootings*, INFOPLEASE, <http://www.infoplease.com/ipa/A0777958.html> (last visited Apr. 19, 2014).
  17. See Sandra J. Austin, *Lessons Learned from the Shootings at Columbine High School*, in *THE HUMAN SIDE OF SCHOOL CRISES – A PUBLIC ENTITY RISK INSTITUTE SYMPOSIUM 1* (2003), available at <http://www.schoolcounselor.org/files/columbine.pdf>.
  18. See *The Shootings at Sandy Hook Elementary School*, *supra* note 14 (reporting that on April 20, 1999, Eric Harris and Dylan Klebold shot and killed thirteen people at Columbine High School in Littleton, Colorado).
  19. See Eric C. Chaffee, *Sailing Toward Safe Harbor Hours: The Constitutionality of Regulating Television Violence*, 39 U. MICH. J.L. REFORM 1, 27 (2005) (“The best evidence for the desensitizing effects of violence in the media may be the intensifying acts of violence committed by children and adolescents.”).
  20. Mark D. Lerner, *Preventing School Violence and Reducing the Frequency of Disturbing Threats*, AM. ACAD. OF EXPERTS IN TRAUMATIC STRESS, available at <http://www.aets.org/article107.htm> (last visited Jan. 21, 2014) (“Even more disturbing is that less-publicized tragedies are impacting upon members of our school families, every day, at a significantly faster rate than ever before.”).
  21. BRYAN VOSSEKUIL ET AL., U.S. SECRET SERV. & U.S. DEP’T OF EDUC., *THE FINAL REPORT AND FINDINGS OF THE SAFE SCHOOL INITIATIVE: IMPLICATIONS FOR THE PREVENTION OF SCHOOL ATTACKS IN THE UNITED STATES* 11 (2002), available at [http://www.secretservice.gov/ntac/ssi\\_final\\_report.pdf](http://www.secretservice.gov/ntac/ssi_final_report.pdf).
  22. *Id.*

determined that mental illness and social isolation are the two main factors that cause youth violence.<sup>23</sup> Consequently, it is crucial to discover and treat these mental illnesses. This will both benefit the child with mental illness and help increase the safety of the public. Although most mentally ill children are not violent,<sup>24</sup> the potential for violence causes a need to identify, assess, and treat students with mental health issues.

I will argue that it is necessary to implement legislation that will require public schools to enact programs with strict policies to monitor children's mental health and improve access to mental health in schools. The purpose of these policies is to provide schools with guidelines and requirements for when it is necessary to intervene in order to prevent violence that occurs because of a child's mental illness.

First, I will analyze mental illness in school-aged children, including its symptoms and available treatments. Then, I will assess the issue of violence and mental illness in children and how the two concepts are interrelated. From there, I will examine who should be responsible for overseeing children's mental health and why schools are one of the best avenues for this duty. I will propose a statute that mandates that all public schools implement programs to: monitor children's mental health, increase accessibility to mental health care, and increase mental health education. Finally, I will address the various obstacles that may inhibit the passing of this law and offer solutions.

## I. MENTAL ILLNESS IN SCHOOL-AGED CHILDREN

Statistics demonstrate that one in ten children suffer from mental illness; however, less than one in five of these children receive the treatment they need.<sup>25</sup> Mental illness in children often remains undiscovered for far too long. In fact, fewer than half of children and adolescents receive psychiatric surveillance<sup>26</sup> and various estimates

- 
23. *Resources: Wake-Up Call*, PBS (Apr. 20, 2009), <http://www.pbs.org/wnet/cryforhelp/episodes/resources/wake-up-call/22/>.
24. Heather Stuart, *Violence and Mental Illness: An Overview*, 2 WORLD PSYCHIATRY 121, 122 (2003).
25. Kristy A. Mount, Note, *Children's Mental Health Disabilities and Discipline: Protecting Children's Rights while Maintaining Safe Schools*, 3 BARRY L. REV. 103, 103 (2002) (citing H.R. 2283, 107th Cong. § 1 (2001)).
26. Am. Acad. of Pediatrics, *The Case for Routine Mental Health Screening*, 125 PEDIATRICS S133, S133 (2010).

suggest that between one-third<sup>27</sup> and one-fifth<sup>28</sup> of mental illnesses in children remain undetected. This occurs not only because of lack of surveillance but also because many families lack the resources or ability to discover these illnesses.<sup>29</sup> Even if a child's symptoms of mental illness are noticeable, it is possible that there will be no one in this child's life with the capacity or desire to recognize the issue.

*A. Symptoms and Signs of Mental Illness in Children*

Mental health problems in children can range from very mild to extremely severe. There are certain signs that indicate that a child may need professional help to resolve mental health problems.<sup>30</sup> In children, these signs are sometimes difficult to recognize, as they may be typical of a child's behavior.<sup>31</sup> While some of the symptoms may be mild, other symptoms, such as persistent disobedience or temper tantrums, may be signs of a disorder that requires professional help.<sup>32</sup> In addition, the combination of certain symptoms can create a serious concern. For instance, while stress and anxiety alone may be a common symptom in children, these symptoms combined with loneliness, rejection, depression, and thoughts of hurting others could create a serious potential for dangerous behavior and violence.<sup>33</sup>

- 
27. *Id.* (“[F]ewer than 1 of 3 children with a mental health problem is identified in primary care settings.”).
  28. Claudia Kalb & Joan Raymond, *Troubled Souls*, NEWSWEEK, Sept. 22, 2003, at 52-53 (“[L]ess than 20 percent of children with mental illnesses get the care they need.”).
  29. *See, e.g., id.*; *see also* Irina v. Sokolova, *Depression in Children: What Causes It and How We Can Help* (Dec. 2003) (unpublished manuscript), <http://www.personalityresearch.org/papers/sokolova.html> (“Symptoms for mental disorders can be so nonspecific that even parents cannot tell if the child is being rambunctious or seriously ill.”); Sarah Horwitz et al., *Parents’ Perceptions of Benefit of Children’s Mental Health Treatment and Continued Use of Services*, 63 PSYCHIATRIC SERVS. 793, 793 (2012) (stating that some of the barriers to discovering and treating children’s mental health include family beliefs and expectations, social norms, attitudes, and structural barriers such as availability of services, transportation, and insurance).
  30. *Recognizing Mental Health Problems in Children*, MENTAL HEALTH AMERICA, <http://www.mentalhealthamerica.net/recognizing-mental-health-problems-children> (last visited Apr. 19, 2014).
  31. *See* Kalb & Raymond, *supra* note 28 (“In kids, symptoms of mental disorders can be nonspecific –stomachaches and irritability –and can blur from one disorder to the next.”).
  32. *See Recognizing Mental Health Problems in Children, supra* note 30.
  33. *School Psychologists: Providing Mental Health Services to Improve the Lives and Learning of Children and Youth*, NASP ADVOCACY [hereinafter *School Psychologists*], <http://www.nasponline.org/advocacy/mhbrochure.aspx> (last visited Apr. 19, 2014).

Certain symptoms are rare but extremely worrisome, such as social withdrawal, signs of self-destructive behavior (such as head-banging), and repeated thoughts of death.<sup>34</sup>

General symptoms indicating that a child may be suffering from mental illness include: changes in school performance, drug abuse, inability to cope, changes in sleeping, defying authority, frequent outbursts of anger, and hyperactivity.<sup>35</sup> Serious symptoms demonstrated by adults with severe mental diseases or defects can also appear in children, including: hearing voices, hallucinating, and aggressive behavior.<sup>36</sup> Some symptoms may be severe enough to require immediate hospitalization.<sup>37</sup>

Other indicators may demonstrate an increased risk for mental illness in children. Research shows that children raised by parents with mental illness are more likely to develop mental health issues.<sup>38</sup> Additionally, the Adverse Childhood Experiences (ACE) Study found that certain ACEs such as childhood abuse, neglect, and growing up in a seriously dysfunctional household<sup>39</sup> may increase the potential for a child to exhibit “social, emotional, and cognitive impairments” that

- 
34. NAT'L INST. OF MENTAL HEALTH, TREATMENT OF CHILDREN WITH MENTAL ILLNESS 1 (2009), *available at* <http://www.nimh.nih.gov/health/publications/treatment-of-children-with-mental-illness-fact-sheet/index.shtml>.
35. *Mental Illness in Children: What Are the Symptoms of Mental Illness in Children?*, MEDICINET (Feb. 20, 2012), [http://www.medicinenet.com/mental\\_illness\\_in\\_children/page2.htm#what\\_are\\_the\\_symptoms\\_of\\_mental\\_illness\\_in\\_children](http://www.medicinenet.com/mental_illness_in_children/page2.htm#what_are_the_symptoms_of_mental_illness_in_children).
36. *Id.*
37. Elyce H. Zenoff & Alan B. Zients, *If Civil Commitment Is the Answer for Children, What Are the Questions?*, 51 GEO. WASH. L. REV. 171, 197 (1983) (“Children who manifest bizarre or inappropriate behavior or a sudden change in behavior might need to be hospitalized—for example, a youngster with no history of aggressive behavior who suddenly attacks siblings or has uncontrollable temper tantrums. Children who are acutely psychotic need to be hospitalized in order to receive treatment for their symptoms. Uncontrollable aggression, extreme hyperactivity, or other symptoms which prohibit management at home and in the community may require hospitalization.”).
38. Stephanie N. Gwillim, *The Death Penalty of Civil Cases: The Need for Individualized Assessment & Judicial Education When Terminating Parental Rights of Mentally Ill Individuals*, 29 ST. LOUIS U. PUB. L. REV. 341, 359 (2009).
39. ROBERT ANDA, CTRS. FOR DISEASE CONTROL & KAISER HEALTH PLAN, THE HEALTH AND SOCIAL IMPACT OF GROWING UP WITH ADVERSE CHILDHOOD EXPERIENCES: THE HUMAN AND ECONOMIC COSTS OF THE STATUS QUO 6 (2009), *available at* [http://acestudy.org/files/Review\\_of\\_ACE\\_Study\\_with\\_references\\_summary\\_table\\_2\\_.pdf](http://acestudy.org/files/Review_of_ACE_Study_with_references_summary_table_2_.pdf).

may result in unhealthy behaviors such as violence.<sup>40</sup> This occurs because:

the pain and negative long-term effects [of the ACE] reverberate as an echo of the lives of the people they grew up with – and then they grow up, at risk for taking on the same characteristics and behaviors – thereby sustaining the cycle of abuse, neglect, violence and substance abuse, and mental illness.<sup>41</sup>

Most mental illnesses can be diagnosed or recognized during childhood: “half of all lifetime cases of mental illness are recognizable by age 14 and three-quarters by age 24.”<sup>42</sup> Children can suffer from many different mental illnesses including: anxiety, disruptive behavior, pervasive development, eating, elimination, affective, schizophrenic, and tic disorders.<sup>43</sup> Although advancements have been made over the past few decades to further our understanding of children’s mental health,<sup>44</sup> statistics indicating the extremely low rate of detection of these illnesses<sup>45</sup> illustrate that the public’s mental health education is far from sufficient.

#### *B. Care and Treatment*

In order to respond appropriately to a child’s mental illness, there must be “timely recognition of psychiatric disorders, psychosocial

---

40. *Id.* at 2.

41. *Id.* at 14.

42. AM. ACAD. OF CHILD & ADOLESCENT PSYCHIATRY, 2013 APPROPRIATIONS 1 (2012), available at [http://www.aacap.org/App\\_Themes/AACAP/docs/Advocacy/federal\\_and\\_state\\_initiatives/psychiatric\\_medications\\_and\\_research/aacap\\_policy\\_summary\\_on\\_fy\\_2013\\_appropriations.pdf](http://www.aacap.org/App_Themes/AACAP/docs/Advocacy/federal_and_state_initiatives/psychiatric_medications_and_research/aacap_policy_summary_on_fy_2013_appropriations.pdf). See also Ronald C. Kessler et al., *Lifetime Prevalence and Age-of-Onset Distributions of DSM-IV Disorders in the National Comorbidity Survey Replication*, 62 ARCHIVES GEN. PSYCHIATRY 593, 593 (2005) (“Median age of onset is much earlier for anxiety (11 years) and impulse control (11 years) disorders than for substance use (20 years) and mood (30 years) disorders.”).

43. *Mental Illness in Children*, MEDICINENET (Feb. 20, 2012), [http://www.medicinenet.com/mental\\_illness\\_in\\_children/article.htm](http://www.medicinenet.com/mental_illness_in_children/article.htm).

44. Kalb & Raymond, *supra* note 28 (“[K]ids’ mental health is finally getting some attention . . . . Scientists are learning more about genetic and environmental triggers –and about what the disorders look like in children, and how to treat them. ‘We’ve made major progress in the last 30 years,’ says Dr. Daniel Pine of the National Institute of Mental Health, but ‘we cannot ignore the fact that we have serious work to do.’”).

45. See *supra* notes 25-28 and accompanying text.

problems, and serious family dysfunction by primary care providers.”<sup>46</sup> Despite the potential for effective treatments, there are usually extended delays between the first signs and symptoms of a mental disorder and the point at which patients seek treatment.<sup>47</sup> Furthermore, children who do receive some attention often receive inadequate treatment.<sup>48</sup> One reason early detection is important is that “a person needing, but not receiving, appropriate medical care may well face even greater social ostracism resulting from the observable symptoms of an untreated disorder.”<sup>49</sup>

Early and Periodic Screening, Diagnosis and Treatment (EPSDT) is a successful way of detecting possible mental illness.<sup>50</sup> EPSDT is a program that entitles all Medicaid-eligible children under 21 to receive mental health services.<sup>51</sup> More importantly, EPSDT can serve as a model for the most beneficial way to care for children with mental illness. Initially, a screening process serves to detect mental illness.<sup>52</sup> From there, EPSDT mandates that “a child receive any medically necessary diagnostic or treatment services required to correct or ameliorate the condition.”<sup>53</sup>

Treatment comes after the detection of symptoms and signs of mental illness and can include medication, psychotherapy, or another option specified by a child’s doctor.<sup>54</sup> Often, treatment depends on the preferences of a child’s family.<sup>55</sup> The treatment of children’s mental illness is a complex medical issue that is beyond the scope of this Note; however, it is important to consider that only half of children

- 
46. Cynthia Dailard & Michele Melden, *Screening for Mental Health Problems in Children*, 26 CLEARINGHOUSE REV.: J. OF POVERTY L. AND POL’Y 898, 898 (1992).
47. See Philip S. Wang et al., *Failure and Delay in Initial Treatment Contact after First Onset of Mental Disorders in the National Comorbidity Survey Replication*, 62 ARCHIVES GEN. PSYCHIATRY 603, 603 (2005) (concluding that “delay among those who eventually make treatment contact ranges from 6 to 8 years for mood disorders and 9 to 23 years for anxiety disorders”). Early age of onset is one of the factors that determines a longer delay before treatment.
48. Horwitz et al., *supra* note 29.
49. Parham v. J.R., 442 U.S. 584, 601 (1979).
50. See Dailard & Melden, *supra* note 46.
51. *Id.*
52. See *id.* at 900.
53. *Id.*
54. NAT’L INST. OF MENTAL HEALTH, *supra* note 34, at 2.
55. Horwitz et al., *supra* note 29, at 794 (stating that, for instance, African-American parents prefer psychotherapy over medication).

with mental health problems receive treatment services, and many of these services are inadequate.<sup>56</sup>

*C. Violence Caused by Mental Illness*

Mental illness in children raises concerns about future violent behavior. Not all mentally ill children or adults are violent. Although the majority of mentally ill patients are not violent,<sup>57</sup> there is still an increased likelihood that persons will commit violent acts if they are mentally ill.<sup>58</sup> It is estimated that 18% of people with a psychiatric disorder commit at least one act of violence in a year.<sup>59</sup> Furthermore, a mentally ill person is more likely to be convicted of a crime than a person without a mental illness,<sup>60</sup> and in 2006, over half of the prison and jail population in the United States was reported to be suffering from mental illness.<sup>61</sup> Schizophrenia in particular poses a significant concern for violence: between 1973 and 2006, 5.1% of the general population and 8.5% of the schizophrenic population were convicted of a violent crime.<sup>62</sup>

Young people are more likely than adults to act violently,<sup>63</sup> and most violent behavior starts during adolescence.<sup>64</sup> These facts demonstrate the crucial need for preventing youth violence, an epidemic that has become increasingly prevalent in recent years. The number of

---

56. *Id.* at 793.

57. Heather Stuart, *Violence and Mental Illness: An Overview*, 2 *WORLD PSYCHIATRY* 121, 121 (2003) (stating that “clinical experiences with violence are not representative of the behaviours of the majority of mentally ill”).

58. *See Mental Illness and Violence*, HARV. HEALTH PUBL’NS (Jan. 2011), [http://www.health.harvard.edu/newsletters/Harvard\\_Mental\\_Health\\_Letter/2011/January/mental-illness-and-violence](http://www.health.harvard.edu/newsletters/Harvard_Mental_Health_Letter/2011/January/mental-illness-and-violence).

59. *Id.*

60. *Id.*

61. DORIS L. JAMES & LAUREN E. GLAZE, U.S. DEP’T OF JUSTICE, BUREAU OF JUSTICE STATISTICS, *MENTAL HEALTH PROBLEMS OF PRISON AND JAIL INMATES* 1 (Dec. 2006), *available at* <http://www.bjs.gov/content/pub/pdf/mhppji.pdf> (reporting, based on personal interviews with prisoners, that “at midyear 2005 more than half of all prison and jail inmates had a mental health problem”). *See also* Stephanie V. Phan, *Mental Illness and the Criminal Justice System: Where Are We Now?*, *MENTAL HEALTH CLINICIAN* (Feb. 2012), <http://cpnp.org/resource/mhc/2012/02/mental-illness-and-criminal-justice-system-where-are-we-now> (last visited Jan. 14, 2014).

62. *Mental Illness and Violence*, *supra* note 58.

63. *Id.*

64. *See* OFFICE OF THE SURGEON GEN., *YOUTH VIOLENCE: A REPORT OF THE SURGEON GENERAL* 5 (2001).

children who exhibit violent behavior has remained high since it peaked in the 1990s.<sup>65</sup>

Certain mental illnesses and symptoms increase the potential for violence in a child or adult. Violence or aggression is often manifested in people with “borderline personality disorder, antisocial personality disorder, conduct disorder, and other personality disorders.”<sup>66</sup> The combination of a personality disorder and another psychiatric disorder can increase the risk of violent behavior.<sup>67</sup> Furthermore, early onset bipolar disorder may be more severe than forms that appear later in life, generating a greater likelihood of violence.<sup>68</sup> Symptoms such as social withdrawal and isolation also carry the possibility of violent behavior.<sup>69</sup> Professionals have hypothesized that this behavior may have contributed to the December 14, 2012 tragedy in Newtown, Connecticut,<sup>70</sup> stating, “[T]here appears to be reasonable consensus that [Adam] Lanza was withdrawn and isolated early in his life and that condition persisted through adolescence.”<sup>71</sup>

## II. THE DUTY TO MONITOR AND DISCOVER A CHILD’S MENTAL ILLNESS

It is widely accepted that parents are responsible for caring for their children. The public generally assumes that parents will act in the best interests of their children,<sup>72</sup> and the Supreme Court has

---

65. *Id.* (stating that confidential reports by youths have shown that “the proportion of young people who acknowledge having committed serious, potentially lethal acts of physical violence has remained level since the peak of the [1990s]”).

66. *Mental Illness and Violence*, *supra* note 58.

67. *Id.*

68. NAT’L INST. OF MENTAL HEALTH, BIPOLAR DISORDER IN CHILDREN AND ADOLESCENTS FACT SHEET 1, *available at* <http://www.nimh.nih.gov/health/publications/bipolar-disorder-in-children-and-adolescents-fact-sheet/bipolar-disorder-in-children-and-adolescents.pdf> (stating that early onset bipolar disorder is described as starting during childhood or the teen years, as opposed to forms that first appear in older teens and adults).

69. John T. Walkup & David H. Rubin, *Social Withdrawal and Violence – Newtown, Connecticut*, 368 NEW ENG. J. 399, 399 (2013).

70. *See id.*

71. *Id.*

72. *See* Dennis E. Cichon, *Developing a Mental Health Code for Minors*, 13 T.M. COOLEY L. REV. 529, 553 (1996) (quoting *Parham v. J.R.*, 442 U.S. 584, 602 (1979)) (“[H]istorically [the law] has recognized that natural bonds of affection lead parents to act in the best interests of their children.”).

recognized this presumption.<sup>73</sup> In addition, parents have certain responsibilities under the law. A child who “lacks adequate parental care” or whose parents or guardians do not provide “proper or necessary . . . care or treatment” is considered “neglected.”<sup>74</sup> The courts have determined that this includes medical care, finding that parents have the right and duty to recognize symptoms of illness and to seek proper medical care.<sup>75</sup> However, “most states lack an organized and adequate system of care and treatment for youth with mental and emotional impairments.”<sup>76</sup>

Many families are unaware of the signs that a child may have mental health issues or they may refuse to recognize the fact that their child is mentally ill. They may not be aware of the potential for mental illness in their child and may be unaware of the symptoms. Moreover, researchers have concluded that some of the barriers to discovering and treating children’s mental health also include family beliefs and expectations, social norms, attitudes, and structural barriers such as availability of services, transportation, and insurance.<sup>77</sup> Many parents may not be capable, mentally or physically, of scrutinizing their children for signs of mental illness.

Another reason that the responsibility to monitor children’s mental health should not be left solely in the hands of parents is that many parents may not care about or take the time to learn of any illness. Alleged school shooter T.J. Lane is said to have had a troubled upbringing. Lane’s family was preoccupied with divorce and violence, and his father spent time in jail on multiple charges.<sup>78</sup> It is possible that Lane’s parents were too busy and too self-involved to notice or investigate their son’s possible mental illness. Ultimately, many families need to depend on the government and schools to help address the needs of their children.

---

73. *Parham v. J.R.*, 442 U.S. 584, 604 (stating that there is a “traditional presumption that the parents act in best interests of their child . . .”).

74. OHIO REV. CODE ANN. § 2151.03(A)(3), (4) (West 2012) (“[A] neglected child includes any child: . . . (3) Whose parents, guardian, or custodian neglects the child or refuses to provide proper or necessary subsistence, education, medical or surgical care or treatment, or other care necessary for the child’s health, morals, or well being; (4) Whose parents, guardian, or custodian neglects the child or refuses to provide the special care made necessary by the child’s mental condition.”).

75. *Parham*, 442 U.S. at 602.

76. Cichon, *supra* note 72, at 529.

77. Horwitz et al., *supra* note 29.

78. Christina Ng & Barbara Lowe, *Chardon High School Shooting: Second Student Dies as Alleged Gunman Is Identified*, ABC NEWS (Feb. 28, 2012), <http://abcnews.go.com/US/chardon-high-school-shooting-gunman-identified-tj-lane/story?id=15799815#.UJFZsWl25o9>.

*A. The Problem: Accessibility*

The parents and guardians of many children do not have the resources to detect mental illnesses. Furthermore, by the time parents realize that their child is showing signs of a mental disease the child may already be on the path to unhealthy or violent behavior.

Low accessibility is a key reason why the current mental health system is inadequate for children. For instance, private health insurance plans often have very limited benefits for mental health, and “those plans that do offer mental health services are often woefully inadequate in meeting the needs of children with severe or complex conditions.”<sup>79</sup> In addition, Medicaid only covers low income and medically needy children, leaving many uninsured children without care.<sup>80</sup> Although the Mental Health Parity and Addiction Equity Act of 2008 ensures that “financial requirements and treatment limitations” for mental health disorders are no more restrictive than all other medical problems,<sup>81</sup> mental health care is still not fully covered by most insurance programs. State-funded insurance certainly does not pay for all the resources necessary, and many private insurance companies do not cover those services or will not pay for multiple services at once.<sup>82</sup>

Moreover, the millions of children without insurance have limited access to mental health care.<sup>83</sup> Although the Patient Protection and Affordable Care Act will expand access to mental health services, these effects may not be seen for years to come.<sup>84</sup> To heighten the

- 
79. John A. English, *Preventing Custody Relinquishment for Youth with Mental Health Needs: Implications for the State of Utah*, 12 J.L. & FAM. STUD. 237, 238 (2010).
80. *E.g., id.* Within the next five to ten years, mental health care should become more accessible to a larger population of Americans under the Patient Protection and Affordable Care Act. Private insurance will become more affordable and easier to obtain, and the expansion of the Medicaid program should cover more low-income families. John M. Grohol, *Mental Health Care Benefits Under Affordable Care Act (Obamacare)*, PSYCHCENTRAL (July 2, 2012), <http://psychcentral.com/news/2012/06/30/mental-health-care-benefits-under-affordable-care-act-obamacare/41052.html>.
81. *FAQs about the Mental Health Parity Act*, U.S. DEP’T OF LABOR, [http://www.dol.gov/ebsa/faqs/faq\\_consumer\\_mentalhealthparity.html](http://www.dol.gov/ebsa/faqs/faq_consumer_mentalhealthparity.html) (last visited Apr. 19, 2014).
82. *See* English, *supra* note 79.
83. JANET B. ZIMMERMAN ET AL., THE SCHOOL-BASED HEALTH CARE POLICY PROGRAM: CAPSTONE EVALUATION, at i (2011), *available at* <http://www.schoolbasedhealthcare.org/wp-content/uploads/2011/12/SBHCPP-Capstone-Evaluation-Report-2004-2010-Rev-Dec-2011-2.pdf>.
84. *See* Grohol, *supra* note 80.

concern for low-income children, studies have shown that children with public or no health insurance have the highest rates of serious emotional disorders.<sup>85</sup> While serious emotional disorders are the least prevalent among children whose families have private health insurance coverage,<sup>86</sup> “almost one-third (31.3 percent) of children in the . . . sample who had Medicaid coverage met criteria for serious emotional disorder.”<sup>87</sup> Researchers drawing conclusions from a 1992 community survey of families stated that there is an “insignificant role of insurance in the child mental health system.”<sup>88</sup>

*B. Mental Health Assessment in Schools*

It is crucial that schools share the duty to supervise children’s mental health. Schools have a heightened responsibility since they have the opportunity not only to prevent violence but also to help safeguard the social and emotional development of children.<sup>89</sup> Most children spend an average of six hours per day at school surrounded by trained professionals<sup>90</sup> who care about their success, happiness, and health. Moreover, research has shown that “students were 21 times more likely to make mental health-related visits to school-based [mental-health facilities] than to community health clinics.”<sup>91</sup> Students at schools with school-based mental health centers have experienced other benefits such as fewer “urgent or emergency visits” to medical care facilities and “less difficulty obtaining primary care” than students in schools without these centers.<sup>92</sup> A 2008 study determined

- 
85. Sherry Glied et al., *Children’s Access to Mental Health Care: Does Insurance Matter?*, 16 HEALTH AFFS. 167, 167 (1997).
86. *Id.* at 170.
87. *Id.*
88. *Id.* at 173.
89. ANASTASIA K. SKALSKI & MARTA J. SMITH, NAT’L ASS’N OF SCH. PSYCHOLOGISTS, RESPONDING TO THE MENTAL HEALTH NEEDS OF STUDENTS 12-13 (2006), available at <http://www.nasponline.org/resources/principals/School-Based%20Mental%20Health%20Services%20NASSP%20Sept%202006.pdf>.
90. *School Psychologists*, *supra* note 33.
91. Jamie Chamberlin, *Schools Expand Mental Health Care*, MONITOR ON PSYCHOL. (2009), <http://www.apa.org/monitor/2009/01/school-clinics.aspx> (citing Linda Juszczak et al., *Use of Health and Mental Health Services by Adolescents Across Multiple Delivery Sites*, 32 J. OF ADOLESCENT HEALTH 108 (2003)).
92. Jeff J. Guo et al., *Impact of School-Based Health Centers on Students with Mental Health Problems*, 123 PUB. HEALTH REPS. 768, 769 (2008) (“[S]urvey studies in Colorado schools found that students with SBHCs were more likely to make mental health visits to the centers, had fewer urgent or emergency visits in the community, and had less difficulty obtaining primary care than students in a comparison school.”).

that “the accessibility of mental health services increased significantly for students after the implementation of a (school-based health care) program.”<sup>93</sup>

There are many reasons that schools are the ideal setting for monitoring children’s mental health and providing them with the services they need. The school environment is a “natural context for prevention and intervention.”<sup>94</sup> A troublesome family life, socialization concerns, physical health problems, mental disabilities, and many other difficulties a child may face are often discovered at school. Additionally, school is the best place to observe children when they feel comfortable in their own environment.<sup>95</sup>

Federal special education law already requires that school districts employ school psychologists “to evaluate students for special education purposes.”<sup>96</sup> These psychologists also manage students’ mental health needs.<sup>97</sup> The National Association for School Psychologists recommends that each district employ one school psychologist for every 500 to 700 students;<sup>98</sup> however, most schools employ one psychologist for every 2,000 to 3,500 students.<sup>99</sup> A school psychologist’s general responsibility is to “provide mental health services that address needs at home and school to help students succeed academically, emotionally, and socially.”<sup>100</sup>

While teachers and other school staff have the ability to recognize when a child is severely mentally ill, school psychologists are trained to recognize behavioral problems that may be signs of an illness.<sup>101</sup> Those schools that already have school psychologists recognize the benefits not only for children’s mental health but also in the areas of academic achievement, social skills, and respect for others.<sup>102</sup> Early

---

93. *Id.* at 778.

94. *School Psychologists*, *supra* note 33.

95. *See, e.g.*, Chamberlin, *supra* note 91 (“Psychologists on the front lines in these centers agree that setting up shop on school grounds is the best way to reach children. ‘Not only can you observe them in their social context, you are setting up an environment where they feel they are on their own terms and on their own turf,’ says Laura Hurwitz, who directs school mental health programs at the National Assembly on School-Based Health Care.”).

96. Kristen Weir, *School Psychologists Feel the Squeeze*, MONITOR ON PSYCHOL. (2012), <http://www.apa.org/monitor/2012/09/squeeze.aspx>.

97. *E.g., id.*

98. *Id.*

99. *School Psychologists*, *supra* note 33.

100. *Id.*

101. *See id.*

102. *Id.*

intervention by school psychologists, with the help of teachers and other professionals, will not only help children overcome existing mental health problems but may “prevent or minimize the occurrence of mental health problems,”<sup>103</sup> which, in turn, will minimize the likelihood of these problems causing violence. Even if the mental illness is not detected early, the school psychologists can diagnose the child’s mental illness and determine how to best approach the problem.<sup>104</sup> An Australian study of school-aged children participating in a program to address anxiety concluded that all children who received intervention “showed improvements from pre- to post-assessment on self-report measures of anxiety.”<sup>105</sup> Both psychologists and teachers were beneficial in helping to minimize these anxiety symptoms.<sup>106</sup>

Experts have determined that the fantasies of school shooters are often “aired publicly before the killings are carried out.”<sup>107</sup> These students have “almost always put the word out about their grievances and their plans well in advance of carrying them out.”<sup>108</sup> These words are the mentally disturbed child’s way of reaching out. The only way to help these children is to have services in place that will identify these signs and do something about them.

Currently, there are no sufficient plans in place to monitor children with mental illness in order to facilitate early intervention and treatment. The resources that are available mostly serve to help children after their mental illness has been discovered. Many schools will work with children with mental illnesses and incorporate them into the special education services at the school;<sup>109</sup> however, not all mentally ill children qualify for these services.<sup>110</sup> Students who qualify are eligible under the Individuals with Disabilities Education Act (IDEA),<sup>111</sup> and the school is required to develop an “individualized

---

103. *Id.*

104. *Id.*

105. Paula Barrett & Cynthia Turner, *Prevention of Anxiety Symptoms in Primary School Children: Preliminary Results from a Universal School-Based Trial*, 40 BRIT. J. OF CLINICAL PSYCHOL. 399, 406 (2001).

106. *Id.* at 407.

107. *See Resources: Wake-Up Call*, *supra* note 23.

108. *Id.*

109. *See, e.g.*, NAT’L INST. OF MENTAL HEALTH, *supra* note 34, at 3-4.

110. *Id.* at 3.

111. IDEA defines a child with a disability as a “child . . . with intellectual disabilities, hearing impairments (including deafness), speech or language impairments, visual impairments (including blindness), serious emotional disturbance . . . orthopedic impairments, autism, traumatic brain injury, other health impairments, or specific learning disabilities;

education program” (IEP) specifically for this child.<sup>112</sup> However, IEPs cannot benefit students whose mental illness remains undetected. In addition, IEP services will become limited when recent federal funding cuts, referred to as the sequester, go into effect, causing “cuts to special education funding” that will eliminate certain staff who provide “essential instruction and support” to students with disabilities.<sup>113</sup>

Although not all children with mental illness have access to special education services, some children with disabilities who are not eligible for IEPs have other special treatment methods available.

If your child is not eligible for special education services, he or she is still entitled to “free appropriate public education,” available to all public school children with disabilities under Section 504 of the Rehabilitation Act of 1973. Your child is entitled to this regardless of the nature or severity of his or her disability.<sup>114</sup>

The services that are available to children with mental health problems are not being fully utilized. For instance, mental health services are available under EPSDT to all Medicaid-eligible children under age 21.<sup>115</sup> However, EPSDT is not being used to the extent necessary for it to be effective,<sup>116</sup> possibly because many families are unaware of the benefits available.<sup>117</sup> Additionally, most states “have been reluctant to implement the screening programs required by federal law.”<sup>118</sup> For those children who do receive screening visits, problems were identified in 43% of them; however, only 22% received treatment.<sup>119</sup>

---

and, who . . . [because of the condition] needs special education and related services.” 20 U.S.C. § 1401(3)(A) (2012).

112. 20 U.S.C. § 1401(14) (2012). *See* NAT’L INST. OF MENTAL HEALTH, *supra* note 34.

113. THE WHITE HOUSE, IMPACT OF MARCH 1<sup>ST</sup> CUTS ON MIDDLE CLASS FAMILIES, JOBS AND ECONOMIC SECURITY: THE DISTRICT OF COLUMBIA 6, *available at* <http://www.whitehouse.gov/sites/default/files/docs/sequester-factsheets/district-of-columbia.pdf> (last visited Apr. 19, 2014).

114. *Id.*

115. 42 U.S.C § 1396d(r) (2012).

116. Dailard & Melden, *supra* note 46, at 898; U.S. GOV’T ACCOUNTING OFFICE, GAO-01-749, MEDICAID: STRONGER EFFORTS NEEDED TO ENSURE CHILDREN’S ACCESS TO HEALTH SCREENING SERVICES 3 (2001).

117. U.S. GOV’T ACCOUNTING OFFICE, *supra* note 116, at 1.

118. Dailard & Melden, *supra* note 46, at 898; *see also* U.S. GOV’T ACCOUNTING OFFICE *supra* note 116, at 1.

119. KAY JOHNSON, NAT’L ACAD. FOR ST. HEALTH POL’Y, MANAGING THE “T” IN EPSDT SERVICES 6 (2010).

In addition, the government has shown a lack of response to initiatives seeking to prevent violence through mental health care in schools.<sup>120</sup> Within a year of the tragedy at Columbine High School, the United States Surgeon General held a conference on juvenile health and published a report recommending community-wide psychological health services.<sup>121</sup> President George W. Bush introduced a bill to Congress in 2001 that would authorize emotional health assessment programs at educational facilities; however, it never passed.<sup>122</sup> Other similar bills were introduced but never passed, including the Mental Health in Schools Act of 2007<sup>123</sup> and the School-Based Health Clinic Establishment Act of 2007.<sup>124</sup> Various mental health organizations have suggested similar solutions to the issue of children's mental health, but nothing has been mandated. The Ohio Mental Health Network for School Success is a program comprised of a set of beneficial recommendations to help schools improve children's development, especially for children with mental health problems;<sup>125</sup> however, this program is not mandatory.

Schools are an unparalleled resource for monitoring children's mental illness and intervening to prevent violence.<sup>126</sup> Many families are unaware of and unequipped to deal with the complexities of mental illness.<sup>127</sup> Mental health services in schools can help school

- 
120. See, e.g., Patrick Gardner, *Crossing Guards Wanted: Navigating Among the Intersections of Public Mental Health Programs for Youth*, CLEARINGHOUSE REV.: J. OF POVERTY L. AND POL'Y, July-Aug. 2001, at 178.
  121. Jennifer H. Gelman, *Brave New School: A Constitutional Argument Against State-Mandated Mental Health Assessments in Public Schools*, 26 N. ILL. U. L. REV. 213, 214 (2005).
  122. E.g., *id.* See also Children's Mental Health Screening and Prevention Act of 2003, H.R. 3036, 108th Cong. (1st Sess. 2003).
  123. Mental Health in Schools Act of 2007, S. 1332, 110th Cong. (1st Sess. 2007) (proposing "to amend the Public Health Service Act to revise and extend projects relating to children and violence to provide access to school-based comprehensive mental health programs").
  124. School-Based Health Clinic Establishment Act of 2007, S. 600, 110th Cong. (1st Sess. 2007) (proposing "to amend the Public Health Service Act to establish the School-Based Health Clinic program, and for other purposes").
  125. *Ohio Mental Health Network for School Success*, MIAMI UNIVERSITY OF OHIO, <http://www.units.muohio.edu/csbnhp/network/index.html> (last visited Jan. 20, 2013) ("OMHNSS is striving to help Ohio's schools, community-based agencies, and families work together to achieve improved educational and developmental outcomes for all children, especially those at emotional or behavioral risk and those with mental health problems.").
  126. See, e.g., *infra* Part III.B.
  127. See, e.g., *supra* Part II.

officials detect problems children may be having and help provide a safe environment for other students, teachers, and staff.<sup>128</sup>

### III. PROPOSED STATUTE

The best solution to the problem of inadequate mental health care for children in public schools is a statute mandating periodical mental health assessments, increased accessibility to mental health care, and a comprehensive plan for the mental health education of teachers and students.

Various laws with a similar goal may serve as a starting point for how this statute could be designed. The Illinois legislature enacted the Children's Mental Health Act of 2003,<sup>129</sup> mandating emotional health assessment for children throughout Illinois:

The State of Illinois shall develop a Children's Mental Health Plan containing short-term and long-term recommendations to provide comprehensive, coordinated mental health prevention, early intervention, and treatment services for children from birth through age 18.<sup>130</sup>

Although the Children's Mental Health Act is not oriented towards schools, the concept is similar. Regarding schools, the Act includes various recommendations for a plan, including "guidelines for incorporating social and emotional development into school learning standards and educational programs."<sup>131</sup> However, the Act does not include specific methods for implementing these standards and instead leaves this responsibility up to the Illinois State Board of Education.<sup>132</sup> While the Children's Mental Health Act of 2003<sup>133</sup> serves as a powerful starting point for laws in other states, a specific and detailed law would more appropriately serve the purpose of preventing school violence.

---

128. *E.g.*, Kristy A. Mount, *Children's Mental Health Disabilities and Discipline: Protecting Children's Rights while Maintaining Safe Schools*, 3 BARRY L. REV. 103 (2002).

129. 405 ILL. COMP. STAT. 49/1 (2003).

130. 405 ILL. COMP. STAT. 49/5 (2003).

131. *Id.*

132. 405 ILL. COMP. STAT. 49/15 (2003) ("The Illinois State Board of Education shall develop and implement a plan to incorporate social and emotional development standards as part of the Illinois Learning Standards for the purpose of enhancing and measuring children's school readiness and ability to achieve academic success.").

133. 405 ILL. COMP. STAT. 49/5 (2003).

The Ohio Revised Code Section 3313.666, enacted in 2007, requires that schools enact policies to prohibit bullying.<sup>134</sup> This statute includes detailed requirements about what the policy must include.<sup>135</sup> This law has proved to be successful, and research has found that in states with anti-bullying statutes there is a decrease in certain bullying-related behaviors.<sup>136</sup> The Ohio statute requires that school districts publish a semi-annual report of the number of bullying incidents,<sup>137</sup> and cities such as Lexington, Ohio<sup>138</sup> and other districts<sup>139</sup> have seen a dramatic drop in the number of reported bullying incidents since 2009. A statute in every state requiring that schools monitor mental illness can follow this precedent.

A. *Model Mental Health Statute*

A model statute would be titled “Policy requiring mental health screenings, teacher and children education, and improved accessibility to mental health services.” In most states, it would belong in the education section of the state code.

The mental health statute would mandate that public schools enact and follow a program similar to the one mandated by Ohio’s bullying statute.<sup>140</sup> The statute would list certain requirements that

---

134. OHIO REV. CODE ANN. § 3313.666 (West 2012).

135. The Ohio School Board had already developed a model policy regarding bullying. OHIO DEP’T OF EDUC., ANTI-HARASSMENT, ANTI-INTIMIDATION OR ANTI-BULLYING MODEL POLICY (2007), *available at* <http://www.ohioschoolboards.org/files/ModelBullyODE.pdf>.

136. Samantha Neiman et al., *Bullying: A State of Affairs*, 41 J.L. & EDUC. 603, 648 (2012).

137. OHIO REV. CODE ANN. § 3313.666 (B)(11). *See also, e.g.*, LAKEWOOD CITY SCHS., SEMI-ANNUAL BULLYING AND HARASSMENT REPORT SUMMARY (2012), *available at* <http://www.lakewoodcityschools.org/userfiles/2312/Bullying%20Report%20Feb%20June%202012.pdf>.

138. *See Lexington Bullying Report*, LEXINGTON LOCAL SCHS., <http://www.lexington.k12.oh.us/index.php/district/lexington-bullying-report> (last visited Jan. 14, 2014) (listing that in the 2009-2010 school year, forty-two verified incidents of bullying occurred, while in the 2011-2012 year, only twenty-four incidents occurred).

139. *See, e.g., Bullying Report*, BRISTOL LOCAL SCHOOL DISTRICT, <http://www.bristol.k12.oh.us/BullyingReports.aspx> (last visited Apr. 19, 2014) (stating that elementary school bullying incidents decreased from fourteen in the 2010-2011 school year to six in the 2011-2012 school year); *see also Bullying Report for Ross Local Schools*, ROSS LOCAL SCHS., <http://www.rossrams.com/bullying-reports> (last visited Jan. 25, 2014).

140. OHIO REV. CODE ANN. § 3313.666 (B) (“The board of education of each city, local, exempted village, and joint vocational school district shall establish a policy prohibiting harassment, intimidation, or bullying. The

the policy must include while the state board of education would develop the specifics of the statute.

A sample statute may begin with a section (A) demanding that the state board of education develop and implement a policy to improve the mental health care in schools. From there, it would list certain elements that the policy must include. The first element, (1), is a plan requiring that each student shall receive periodical mental health screenings upon the recommendation of parents, teachers, other school staff, upon other necessity, or upon request by the student. The screenings shall be conducted by a mental health professional employed at the school, unless the parents express a desire to see and pay for a private doctor and provide proof of this visit. The second element, (2), is a plan for improved accessibility to mental health services for students. This plan would include a proposal for the school to hire more school psychologists. Additionally, the plan should provide for an opportunity for all students to obtain mental health care. This should include “open hours” where students can visit a mental health professional on school premises of their own accord.

The final two elements, (3) and (4), would include a plan for the education of teachers, other school staff, and students. Element (3) would describe the education of teachers and other school staff on the early identification of mental illness, including how to recognize the symptoms and signs of mental illness as well as the proper steps to take after a mental illness is suspected. Additionally, the plan shall dictate steps that school staff should take if they suspect a mental illness is present. Element (4), regarding the mental health education of students, would mandate curriculum that would include: descriptions of the stages of mental and emotional development in children; how to identify symptoms of mental illness; methods of treatment; and ways to manage mental illness. This education would begin in the fifth grade.

From here, each district would develop and implement a plan tailored to the needs of its students.<sup>141</sup> The statute would include a date by which each district must submit its policy to the state board of education.

---

policy shall be developed in consultation with parents, school employees, school volunteers, students, and community members.”).

141. Illinois developed a comprehensive plan for social and emotional learning standards in response to the Children’s Mental Health Act of 2003. 405 ILL. COMP. STAT. 49/ (2003). This plan, which can serve as a sample plan for many other states, can be found on the Illinois State Board of Education Website. *Illinois Learning Standards: Social/Emotional Learning*, ILL. ST. BD. OF EDUC., [http://www.isbe.state.il.us/ils/social\\_emotional/standards.htm](http://www.isbe.state.il.us/ils/social_emotional/standards.htm) (last visited Apr. 19, 2014).

*B. Periodical Mental Health Screenings*

A model statute would require anyone who witnesses a child exhibiting behavior that may indicate the presence of a mental illness to report it immediately to a school psychologist. Section (C): “Education of Teachers, School Officials, and Students” will help these people learn what the symptoms of mental illness are and when they should be reported.<sup>142</sup> School psychologists will review these reports and decide if the child needs a mental health screening. Each school or school district will work with its school psychologists and, if desired, other mental health professionals, to develop a plan that helps teachers and staff understand the symptoms and signs<sup>143</sup> of mental illness in children and when they should be reported.

Interviews with past school shooters have demonstrated that most of them would have discussed their emotions and possibly their desire to act violently before it happened:

“All of the school shooters actually said– if someone would have approached me with how I’m feeling, what goes on in my mind, I would have told them,” [Dr. Frank Robertz, co-founder of the Institute for Violence Prevention and Applied Criminology in Berlin] says. “So if teachers actually approach kids, they have a very high chance that they will talk about what’s going on in their minds, and will talk about their violent fantasies.”<sup>144</sup>

If children have the opportunity to speak with a professional, this person may be able to intervene and stop the violence before it happens. Many children may wish they had the chance to speak with a mental health professional but are afraid to because of the potential response by their parents, teachers, and peers. Moreover, severely mentally ill people often do not voluntarily seek treatment,<sup>145</sup> and thus there is a need for mandatory evaluations. Although not all children will speak openly with a professional, it is crucial to give them this opportunity.

Concerning the process of identifying and treating a mental illness, this mental health screening will serve only as an initial evaluation by the school psychologist of the student. This screening will not be considered an examination for the purposes of diagnosis. This will only occur after the student has been thoroughly monitored and a mental illness has been detected through comprehensive psychiatric evaluations.

---

142. *See infra* Part IV.C.

143. *See supra* Part I.A.

144. *See Resources: Wake-Up Call, supra* note 23.

145. Walkup & Rubin, *supra* note 69, at 400.

Within the policy developed by each city and school board, there should be a requirement for reporting suspicious behavior and a procedure for responding to it. All reports should be kept with the school's other student health records. These records should be checked periodically in case suspicious behavior becomes apparent over time rather than being immediately recognized by the school psychologist.

A necessary parent notification provision similar to Ohio's Section 3313.666 (B)(5) would also be included:

A requirement that the custodial parent or guardian of any student involved in a prohibited incident be notified and, to the extent permitted by section 3319.321 of the Revised Code and the "Family Educational Rights and Privacy Act of 1974," 88 Stat. 571, 20 U.S.C. 1232g, as amended, have access to any written reports pertaining to the prohibited incident.<sup>146</sup>

The details of the procedure for requiring periodical mental health screenings would be left up to the discretion of the city and school board. While certain requirements<sup>147</sup> must be met in order to ensure that proper mental health services are being provided, giving the school some options ensures that each community will feel as if the statute is tailored to the needs and demographics of their city.

Ultimately, periodic mental health screenings will increase the likelihood that mental illness will be caught as early as possible.<sup>148</sup> Knowing that the screenings are available will create more awareness of the possibility of mental illness in children. Moreover, if a mental illness is detected during the screenings, mental health professionals can work with that child to begin the process of treatment. Treatment may be provided through the school mental health care services or through private mental health care initiated by the child's family.

### *C. Improved Accessibility to Mental Health Services*

Low accessibility is a key factor that hinders the early detection of mental illness in children.<sup>149</sup> Schools that do not currently have a sufficient staff of school psychologists<sup>150</sup> employed at the school would be required to hire them. Accessibility can also be increased by giving teachers the ability to recommend students for mental health services and requiring that school psychologists pay special attention to children that are recommended by parents, teachers, or other staff.

---

146. OHIO REV. CODE ANN. § 3313.666(B)(5) (West 2012).

147. See *supra* Part III. (describing the requirements in the proposed statute).

148. See *supra* Part I.B. (discussing how early detection is beneficial for children with mental illness).

149. *E.g.*, *supra* Part III.A.

150. This will depend on the number of students at the school.

Accessibility to mental health services will improve after more school psychologists are hired. Most school districts are not meeting the recommendations suggested by the National Association for School Psychologists.<sup>151</sup> Instead of one school psychologist for every 500 to 700 students,<sup>152</sup> “the ratio is more in the neighborhood of one to 2,000, though in some states it goes as high as one to 3,500.”<sup>153</sup> Without these additional professionals, many schools cannot provide the full range of mental health services.<sup>154</sup> Part of the reason that children cannot access mental health services is because many families cannot afford it.<sup>155</sup> Hiring more staff and making mental health care available to students in school would increase this accessibility dramatically.

*D. Education of Teachers, School Officials, and Students*

Children and adolescents would benefit from further education about mental illness. Currently, the public does not have a proper understanding of mental illness, and this lack of knowledge increases the shame associated with mental diseases.

Mental Health America, the leading U.S. nonprofit organization devoted to improving the lives of individuals with mental illness, estimates that 71 percent of Americans continue to believe that mental illness is caused by mental weakness, 65 percent believe that mental illness is the product of poor parenting, and 35 percent believe that mental illness is a form of retribution for sinful or immoral behavior.<sup>156</sup>

This education would begin in fifth grade when students are mature enough to comprehend the concept of mental illness. Each state has laws regarding the curriculum for all schools under the state’s control.<sup>157</sup> For instance, Ohio requires health education, including instruction in nutrition, drugs, sex education, personal safety, and

---

151. See Weir, *supra* note 96.

152. *Id.*

153. *Id.*

154. See *id.*

155. See generally *supra* Part III.A.

156. Stacey A. Tovino, *Further Support for Mental Health Parity Law and Mandatory Mental Health and Substance Use Disorder Benefits*, 21 ANNALS HEALTH L. 147, 161 (2012).

157. For a list of all states and their policies, see *State School Health Policy Database*, NAT’L ASS’N OF ST. BDS. OF EDUC., [http://www.nasbe.org/healthy\\_schools/hs/map.php](http://www.nasbe.org/healthy_schools/hs/map.php) (last visited Apr. 19, 2014).

dating violence.<sup>158</sup> Mental health education would become part of this health curriculum. Students would learn about the symptoms and signs of the various types of mental illness. Additionally, these children would be taught that mental illness, like any other disease, is no one's "fault" and mentally ill people should not be judged or ridiculed based on their illness.

Currently, thirty-four states require elementary schools to teach emotional and mental health;<sup>159</sup> however, only three of these states – Alabama, Kentucky, and Vermont – include recognizing symptoms of mental illness as part of this curriculum.<sup>160</sup> While some states list important aspects of mental health education that should be included in this curriculum,<sup>161</sup> some of these states do not have strict requirements about what must be taught, or they leave this up to the district's board of education.<sup>162</sup> Additionally, some states require that

---

158. OHIO REV. CODE ANN. § 3313.60 (West 2012).

159. *See State-Level School Health Policies and Practices*, CTRS. FOR DISEASE CONTROL AND PREVENTION (2006), available at [http://www.cdc.gov/healthyouth/shpps/2006/summaries/pdf/HE\\_State\\_Level\\_Summaries\\_SHPPS2006.pdf](http://www.cdc.gov/healthyouth/shpps/2006/summaries/pdf/HE_State_Level_Summaries_SHPPS2006.pdf).

160. *State School Health Policy Database: Emotional, Social and Mental Health Education*, NAT'L ASS'N OF ST. BDS. OF EDUC. [hereinafter *State School Health Policy Database*], [http://www.nasbe.org/healthy\\_schools/hs/bytopics.php?topicid=1130&catExpand=acdnbtm\\_catA](http://www.nasbe.org/healthy_schools/hs/bytopics.php?topicid=1130&catExpand=acdnbtm_catA) (last visited Jan. 14, 2014).

161. *See, e.g., State School Health Policy Database: New York*, NAT'L ASS'N OF ST. BDS. OF EDUC. (July 15, 2010), [http://www.nasbe.org/healthy\\_schools/hs/state.php?state=New%20York](http://www.nasbe.org/healthy_schools/hs/state.php?state=New%20York) (“[Regulations] require students in grades K-12 be taught various aspects of social, mental, and emotional health. Standard 1 Intermediate requires students be taught how to recognize the mental, social, and emotional aspects of good health and stress management and stress management. Standard 2 Intermediate requires students learn the emotional conditions necessary for safety. Standard 2 Commencement requires students be taught stress management, the mental and emotional benefits of exercise, and to understand the stages of child development and apply this knowledge to activities designed to enrich the physical, social, mental, and emotional development of a young child. Standard 3 Intermediate requires students be taught to understand how the family can provide for the economic, physical, and emotional needs of its members.”). *See also State School Health Policy Database: Wisconsin*, NAT'L ASS'N OF ST. BDS. OF EDUC. (Aug. 22, 2013), [http://www.nasbe.org/healthy\\_schools/hs/state.php?state=Wisconsin](http://www.nasbe.org/healthy_schools/hs/state.php?state=Wisconsin) (stating that Wisconsin's Model Academic Standards for Health Education includes recommendations for teaching students the ability to recognize symptoms of mental illness).

162. *See, e.g., State School Health Policy Database: Georgia*, NAT'L ASS'N OF ST. BDS. OF EDUC. (Aug. 25, 2009), [http://www.nasbe.org/healthy\\_schools/hs/state.php?state=Georgia](http://www.nasbe.org/healthy_schools/hs/state.php?state=Georgia)

students learn only certain aspects of social and psychological health<sup>163</sup> as opposed to the important details of mental illness. Ultimately, mandating uniform standards for mental health education including the symptoms and signs of mental illness will greatly benefit students.

The education of teachers and school officials would include how to identify children with mental health issues, how to identify signs that a child may act violently, and what to do if they do suspect there may be a mental illness. Moreover, having mental health care in a school “enables mental health professionals to guide teachers on ways to follow up on a child’s therapy in the classroom.”<sup>164</sup> In addition to learning how to recognize symptoms of mental illness, teachers would be educated on how to monitor a child to the best of their abilities after a mental illness has been detected.

Many resources are already available for teachers to learn about mental health education. The National Alliance for the Mentally Ill (NAMI) created a tool kit in 2004 that serves as a training manual to promote mental illness education in schools.<sup>165</sup> NAMI also offers a two-hour program entitled “Parents and Teachers as Allies,” focusing on “helping school professionals and families within the school community better understand the early warning signs of mental illness in children and adolescents and how best to intervene.”<sup>166</sup>

---

(stating that Georgia requires local boards to implement a mental health education plan).

163. See *State School Health Policy Database*, *supra* note 160 (stating that Arizona “does not recommend or require any specific curricula”); *State School Health Policy Database: Pennsylvania*, NAT’L ASS’N OF ST. BDS. OF EDUC. (Sept. 28, 2010), [http://www.nasbe.org/healthy\\_schools/hs/state.php?state=Pennsylvania](http://www.nasbe.org/healthy_schools/hs/state.php?state=Pennsylvania) (stating that students in Pennsylvania should be taught “physical activity’s social and psychological benefits” as well as “growth and development changes” that occur in childhood and adolescence).
164. Chamberlin, *supra* note 91 (“Psychology practitioner Christine Cheng, PhD, for example, recently worked with a first-grade teacher whose student was so attached to him, he worried the boy wouldn’t come to school the week he’d be on vacation. Cheng, who works at the Montefiore Medical Center School Health Clinic at P.S. 105 in the Bronx, told the teacher to give the boy something of his to keep all week. The boy not only made it through the week with few tears, he gained confidence in the classroom. ‘He’s doing better academically, he’s speaking up more . . . he even went on stage for a school performance,’ says Cheng.”).
165. See Janet Susin, N.Y. St. Psychiatric Ass’n, *Promoting Mental Illness Education in the Schools*, THE BULLETIN (2004), [http://www.btslessonplans.org/art\\_bulletin.htm](http://www.btslessonplans.org/art_bulletin.htm).
166. NAT’L ALLIANCE ON MENTAL ILLNESS, PARENTS & TEACHERS AS ALLIES: IN-SERVICES MENTAL HEALTH EDUCATION FOR SCHOOL PROFESSIONALS (2011), *available at*

Ultimately, further mental health education of teachers and school staff will help improve their ability to recognize mental illness in students and react properly.

#### IV. PASSING THE LAW

##### A. *Barriers and Solutions*

Certain obstacles may obstruct the enactment of this statute. While not all of these can be anticipated or resolved at this time, a few of the main barriers include: funding, parental rights, teachers, and the civil and privacy rights of children.

##### 1. Funding

Funding will be a large barrier to the passage of this law. Funding for public schools is already limited and because of sizeable cuts to education funding since the recession, many schools are stretching resources to provide for students' needs.<sup>167</sup> However, it is important that schools make this law a priority and pursue all avenues for potential funding. Currently, school revenue comes from local sources (42.8%), the states (49.4%), the federal government (7.8%), and private sources (2.5%).<sup>168</sup> Funding for a law mandating mental health services in schools could come from all four of these sources.

Currently, schools with school-based mental health centers receive limited federal funding.<sup>169</sup> Instead, the funding comes from "state grants, partnerships with local hospitals or public health departments, or grants from nonprofits."<sup>170</sup> With a system for this funding already in place, each of these various sources could increase the amount of funds already given.

---

[http://www.nami.org/Content/ContentGroups/CAAC/Parents\\_and\\_Teachers\\_as\\_Allies.pdf](http://www.nami.org/Content/ContentGroups/CAAC/Parents_and_Teachers_as_Allies.pdf).

167. See PHIL OLIFF ET AL., CTR. ON BUDGET AND POL'Y PRIORITIES, NEW SCHOOL YEAR BRINGS MORE CUTS IN STATE FUNDING FOR SCHOOLS 1, available at <http://www.cbpp.org/files/9-4-12sfp.pdf> (stating that "because states relied heavily on spending reductions in response to the recession . . . funding for schools and other public services fell sharply."); see also Bruce J. Biddle & David C. Berliner, *A Research Synthesis / Unequal School Funding in the United States*, EDUCATIONAL LEADERSHIP, May 2002, at 48 (stating that about half of all funding for public schools comes from local property taxes, creating large differences in the funding of wealthy and low-income communities and causing even more concern for the impoverished communities).

168. E. GORDON GEE & PHILIP T.K. DANIEL, LAW AND PUBLIC EDUCATION: CASES AND MATERIALS 10 (4th ed. 2008) (citing national averages).

169. *E.g.*, Chamberlin, *supra* note 91.

170. *Id.*

The American Academy of Child and Adolescent Psychiatry advocates for “increased funding for federal agencies and laws that support state and community mental health treatment and services” through “the annual federal appropriations process.”<sup>171</sup> Through the help of the AACAP, the funding for the services mandated by this law could partially come from federal agencies. In addition, schools could allocate part of their public funding for this purpose. These funds may be part of the general school district funds that are not already allocated to another program. Districts around the country have been successful in distributing these funds for mental health services purposes.<sup>172</sup> Additionally, “several states have initiated grant programs as vehicles to drive the expansion of school mental health programs.”<sup>173</sup> For example, the Department of Human Services in Minnesota distributed \$12.5 million to cultivate school-based mental health programs.<sup>174</sup> In Michigan, the Department of Education funds various mental health care programs throughout the state’s schools.<sup>175</sup> These successful programs show that states will be able to fund the mental health care statute with the help of various federal sources.

In 2004 the State of California passed the Mental Health Services Act.<sup>176</sup> This act provides for increased mental health services to facilitate early diagnosis and adequate treatment. California funded the act by increasing taxes on “very high-income individuals.”<sup>177</sup> These individuals pay an “additional one percent of that portion of their annual income that exceeds one million dollars.”<sup>178</sup> Since the MHSA provides for mental health services for adults and children, a school-oriented law would require less funding and this high of an income tax increase would not be necessary.

For the states who do not wish to incorporate an increased income tax, or who wish to find additional funding in other ways, certain non-profits such as the W.K. Kellogg Foundation and the

---

171. *Community-Based Systems of Care*, AM. ACAD. OF CHILD & ADOLESCENT PSYCHIATRY, [http://www.aacap.org/cs/root/legislative\\_action/communitybased\\_systems\\_of\\_care](http://www.aacap.org/cs/root/legislative_action/communitybased_systems_of_care) (last visited Apr. 19, 2014).

172. OLGA ACOSTA PRICE & JULIA GRAHAM LEAR, CTR. FOR HEALTH & HEALTH CARE IN SCHS., *SCHOOL MENTAL HEALTH SERVICES FOR THE 21<sup>ST</sup> CENTURY: LESSONS FROM THE DISTRICT OF COLUMBIA SCHOOL MENTAL HEALTH PROGRAM 41* (2008).

173. *Id.* at 39.

174. *Id.*

175. *Id.*

176. CAL. WELF. & INST. CODE § 5840 (West 2012).

177. *Id.*

178. *Id.*

Robert Wood Johnson Foundation have historically given money to help build school-based health care systems.<sup>179</sup>

Additionally, the Substance Abuse and Mental Health Services Administration<sup>180</sup> (SAMHSA) has programs that may provide federal funding for school-based mental health care. These include: the Safe Schools/Healthy Students Initiative,<sup>181</sup> the Systems of Care Program,<sup>182</sup> the Cooperative Agreements for State-Sponsored Youth Suicide Prevention and Early Intervention,<sup>183</sup> and the Mental Health Transformation State Incentive Grant Program.<sup>184</sup> The U.S. Department of Education also may provide additional resources to support this law through two grants, the Mental Health and Education Integration Grant and the Safe and Drug-Free Schools and Communities Act State Grants Program.<sup>185</sup>

Furthermore, states might save money in the long run through these programs:

Untreated mental illness is the leading cause of disability and suicide and imposes high costs on state and local government.... Adults lose their ability to work and be independent; many become homeless and are subject to frequent hospitalizations or jail. State and county governments are forced to pay billions of dollars each year in emergency medical care, long-term nursing

- 
179. ZIMMERMAN ET AL., *supra* note 83, at 5 (stating that in 2004, the W.K. Kellogg Foundation launched the School-Based Health Care Policy Program, awarding \$26 million to national, state, and local entities to participate in their initiative); Chamberlin, *supra* note 91 (referencing certain school-based health care centers that receive grants from nonprofits “such as the W.K. Kellogg Foundation and the Robert Wood Johnson Foundation, which has funded more than 80 centers”).
180. *Prevention of Substance Abuse and Mental Illness*, SUBSTANCE ABUSE AND MENTAL HEALTH SERVS. ADMIN., <http://www.samhsa.gov/> (last visited Apr. 19, 2014).
181. PRICE & LEAR, *supra* note 172, at 90 (describing the SS/HS Initiative as promoting “the mental health of students...through...early intervention programs, policies and procedures”).
182. *Id.* (stating that the Systems of Care Program provides for mental health care for children within their home, school, and community).
183. *Id.* (describing a program made available by the Garrett Lee Smith Suicide Prevention Act which aims to prevent youth suicide).
184. *Id.* (defining this program as one which “will support an array of infrastructure and service delivery improvement activities to help grantees build a solid foundation for delivering and sustaining effective mental health and related services”).
185. *Id.*

home care, unemployment, housing, and law enforcement, including juvenile justice, jail and prison costs.<sup>186</sup>

States may also save money on health reimbursement costs for low-income children. A 2008 study concluded that “the total health care reimbursement cost for students remained lower [for students in schools with school-based mental health care]” than students at schools without these services.<sup>187</sup> And some schools and states will not require as much of an increase in funding as others to implement this law. The number of school-based health centers with health professionals on staff has already more than doubled in the last ten years.<sup>188</sup> Thus, some schools already have necessary staff and resources.

Ultimately, although funding this law will be a challenge, the beneficial results of the statute and the potential negative repercussions schools and students may face if the law is not enacted justify making this law a priority for current funds and pursuing additional resources that may help fill gaps in funding.

## 2. Parental Rights

Many parents will not approve of schools’ having authority to get involved in the mental health of their children. In two notable cases, *Meyer v. Nebraska*<sup>189</sup> and *Pierce v. Society of Sisters*,<sup>190</sup> the Supreme Court recognized the right of parents and guardians “to direct the upbringing and education of children under their control.”<sup>191</sup> The Supreme Court has never specified whether the parental right is considered fundamental.<sup>192</sup> If parental rights are fundamental, any intrusion on them would be reviewed with strict scrutiny,<sup>193</sup> yet case law indicates that rational basis would be a more appropriate level of

---

186. CAL. WELF. & INST. CODE § 5840 (West 2012).

187. Guo et al., *supra* note 92, at 778.

188. Chamberlin, *supra* note 91.

189. 262 U.S. 390, 396-403 (1922).

190. 268 U.S. 510, 514 (1925).

191. *Id.* at 534-35.

192. *Immediato v. Rye Neck School Dist.*, 73 F.3d 454, 461 (2d Cir.1996).

193. *Id.*

review.<sup>194</sup> Furthermore, courts have clearly stated “the parental liberty interest is not absolute.”<sup>195</sup>

Schools already have the ability to monitor the health of children,<sup>196</sup> and they have the responsibility to make sure that violence is avoided and a safe environment is provided for students.<sup>197</sup> In *Parents United for Better Schools, Inc. v. School District of Philadelphia Board of Education*, the Third Circuit found that the implementation of a condom distribution program “did not violate parents’ fundamental right to remain free from unnecessary governmental interference with bringing up their children.”<sup>198</sup> In addition, it is widely recognized that the state has the power to regulate all schools and within this regulation it may exercise some control over the students.<sup>199</sup> While the

- 
194. *Id.* (quoting *Black v. Beame*, 550 F.2d 815, 816 (2d Cir.1977)) (“There is a long line of precedents indicating that the government may not *unreasonably* interfere with . . . [the right to] raise one’s children as one wishes.”).
195. *Anspach ex rel. Anspach v. City of Philadelphia, Dep’t of Pub. Health*, 503 F.3d 256, 261 (3d Cir. 2007); *see also* *Planned Parenthood of Cent. Mo. v. Danforth*, 428 U.S. 52 (1976).
196. *See, e.g.,* CONNIE BOARD ET AL., NAT’L ASS’N OF SCHOOL NURSES, ROLE OF THE SCHOOL NURSE 1 (2011), *available at* <http://www.nasn.org/PolicyAdvocacy/PositionPapersandReports/NASNPositionStatementsFullView/tabid/462/ArticleId/87/Role-of-the-School-Nurse-Revised-2011> (“It is the position of the National Association of School Nurses that the registered professional school nurse is the leader in the school community to oversee school health policies and programs. The school nurse serves in a pivotal role to provide expertise and oversight for the provision of school health services and promotion of health education.”).
197. THOMAS HUTTON & KIRK BAILEY, SCHOOL POLICIES AND LEGAL ISSUES SUPPORTING SAFE SCHOOLS 14-15 (2007), *available at* <http://gwired.gwu.edu/hamfish/merlin-cgi/p/downloadfile/d/20708/n/off/other/1/name/legalpdf/> (outlining federal legislation and regulation regarding safety requirements in schools, including the No Child Left Behind Act, which allows students to transfer to “safe” schools, and the Safe and Drug-Free Schools and Communities Act, supporting school violence prevention programs). Schools may also face civil tort liability for failing to supervise students adequately or warn students of danger. Other liability may arise from a school’s failure to respond to harassment or failure to protect a disabled student from harassment. *Id.*
198. *Parents United For Better Schs., Inc. v. Sch. Dist. of Philadelphia Bd. of Educ.*, 148 F.3d 260, 261 (3d Cir. 1998).
199. *Pierce v. Soc’y of the Sisters*, 268 U.S. 510, 534 (1925) (“No question is raised concerning the power of the state reasonably to regulate all schools, to inspect, supervise and examine them, their teachers and pupils; to require that all children of proper age attend some school, that teachers shall be of good moral character and patriotic disposition, that certain studies plainly essential to good citizenship must be taught,

responsibility for a child's care resides mostly with parents, parents are not the only people with the ability to make decisions regarding the welfare of children,<sup>200</sup> and sometimes parents are not able to make the best judgments regarding a child's health.<sup>201</sup> This is especially apparent in families where certain factors such as religious beliefs or household income may inhibit parents from seeking out proper medical care for their children.<sup>202</sup>

Furthermore, parents must recognize that they are not always in the best position to discover psychiatric problems with their child. Many children and teenagers are private about their personal lives and emotional struggles. It has been reported that parents are unaware of approximately "90% of suicide attempts made by teenagers, and the vast majority of teens who attempt suicide give no warning to parents, siblings or friends."<sup>203</sup>

Moreover, parents should acknowledge that the benefits of this model law outweigh any concern they may have regarding the school's involvement with their child's health. Many parents are concerned with school violence, and this number has increased since the shooting at Sandy Hook Elementary School.<sup>204</sup> More than half of Americans believe that a similar tragedy could happen in their community.<sup>205</sup> Improved mental health care services in schools would help alleviate parents' concerns for the safety of their children.

This law will benefit parents who are unable to provide care for their child with mental health problems. A 2002 study determined that "approximately one third of parents who identified that their child had mental health needs report[ed] barriers to care."<sup>206</sup> The

---

and that nothing be taught which is manifestly inimical to the public welfare.").

200. *Parham v. J. R.*, 442 U.S. 584, 600 (1979).

201. *See supra* Part III.

202. *See* Jennifer H. Gelman, *Brave New School: A Constitutional Argument against State-Mandated Mental Health Assessments in Public Schools*, 26 N. ILL. U. L. REV. 213, 239 (2005) ("In general, Hispanics and Asian Americans attach a comparatively stronger stigma to mental illness.").

203. Richard A. Friedman, *Uncovering an Epidemic – Screening for Mental Illness in Teens*, 355 NEW. ENG. J. MED. 2717, 2718 (2008).

204. Lydia Saad, *Parents' Fear for Children's Safety at School Rises Slightly*, GALLUP (Dec. 28, 2012), <http://www.gallup.com/poll/159584/parents-fear-children-safety-school-rises-slightly.aspx> (stating that 33% of parents fear for their child's safety at school).

205. *Id.*

206. Pamela L. Owens et al., *Barriers to Children's Mental Health Services*, 41 J. AM. ACAD. CHILD ADOLESC. PSYCHIATRY 731, 735 (2002) (noting that these barriers are related to structural constraints, perceptions of mental health problems, and perceptions of services).

results of this study suggest that many parents will appreciate the expanded access to mental health care services.

Under the model law, parents will have the option of visiting a private doctor instead of the school psychologist for a periodical mental health screening.<sup>207</sup> Courts have recognized that giving parents the option of not participating in school health services ensures that parental rights are not violated.<sup>208</sup> They must provide proof of this visit to the school and the family will be responsible for the payment. If the parents prefer, a consultation with a private doctor could replace a visit to the school psychologist.

Additionally, the thorough process of discovering, reporting, and treating a child with a potential mental illness will diminish parents concerns. Teachers only have the power to recommend that a school psychologist screen a child. This screening will not constitute an official examination, and the psychologist will not have the ability to diagnose a child after this screening. The recommendation and initial visit with the school psychologist will only be the starting point to determine whether a child may have mental health problems.

### 3. Teachers

Many teachers may be upset about the prospect of having even more day-to-day duties. However, the duties that this law would impose on teachers are not extensive. Teachers would have to observe students, as they are already required to do,<sup>209</sup> and report any behavior that may indicate a possible mental illness to the school psychologist.<sup>210</sup>

This law will also benefit both teachers and their students. Although teachers will have the burden of monitoring their students for suspicious behavior, this will provide extensive benefits for both the children and the public. Often, mentally ill children have problems that can disrupt their learning and behavior.<sup>211</sup> Getting help for these

---

207. *See supra* Part IV.A.

208. *Parents United for Better Schs., Inc. v. Sch. Dist. of Philadelphia Bd. of Educ.*, 148 F.3d 260, 275 (3d Cir. 1998) (“We recognize the strong parental interest in deciding what is proper for the preservation of their children’s health. But we do not believe the Board’s policy intrudes on this right. Participation in the program is voluntary. The program specifically reserves to parents the option of refusing their child’s participation.”).

209. 78 C.J.S. *Schools and School Districts* § 502 (2008).

210. This behavior will be defined by the school district in its mental health statute. *See supra* Part III.A.

211. *See, e.g., School Psychologists: Providing Mental Health Services to Improve the Lives and Learning of Children and Youth*, NASP ADVOCACY, <http://www.nasponline.org/advocacy/mhbrochure.aspx> (last visited Apr. 19, 2014).

will make teaching easier and help the learning environment for the other students.

#### 4. Civil Rights and Medical Privacy Rights

The Supreme Court has recognized that children have certain fundamental rights under the Constitution.<sup>212</sup> However, children's rights in public schools are a problematic and controversial matter.<sup>213</sup> While this paper cannot adequately address the complexities of children's civil rights, it is clear that schools have the power to monitor children's mental health.

The fundamental rights possessed by all Americans<sup>214</sup> make it difficult to enact legislation that would require monitoring of children outside of a school environment. However, although children retain the constitutional rights entitled to all citizens as held in *Powell v. Alabama*,<sup>215</sup> public schools are already established as institutions where children's rights are limited.<sup>216</sup> The Supreme Court has recog-

---

212. See, e.g., *In re Gault*, 387 U.S. 1, 1-2 (1967) (holding a juvenile has the right to "notice of charges, to counsel, to confrontation and cross-examination of witnesses, and to privilege against self-incrimination").

213. Norberto Valdez et al., *Police in Schools: The Struggle for Student and Parental Rights*, 78 DENV. U. L. REV. 1063, 1073-74 (2001) ("This has complicated the matter of children's rights by venturing into mostly uncharted territory, traditionally held to be the domain of school administrators and parents. Questions defining constitutional rights in schools have been pressed all the way to the Supreme Court."). See generally Barbara Bennett Woodhouse & Sarah Rebecca Katz, *Martyrs, the Media and the Web: Examining A Grassroots Children's Rights Movement Through the Lens of Social Movement Theory*, 5 WHITTIER J. CHILD & FAM. ADVOC. 121 (2005).

214. The concept of fundamental rights is a complicated and long studied part of American History. In 1934, Justice Cardozo "opined that a purported right is fundamental when infringement upon the alleged right would 'offend some principle of justice so rooted in the traditions and conscience of our people.'" Adam B. Wolf, *Fundamentally Flawed: Tradition and Fundamental Rights*, 57 U. MIAMI L. REV. 101, 110 (2003) (quoting *Snyder v. Massachusetts*, 291 U.S. 97, 105 (1934)). Since then, the Supreme Court has expanded and elaborated on our fundamental rights as Americans. *Id.* To many, tradition has become "the primary - if not the exclusive - fundamental rights methodology." *Id.* at 111. In this case, the fundamental right at issue would be a privacy issue, allowing one to protect his or her ability to keep themselves and their children's health private and not allowing others to interfere without a legitimate purpose.

215. 287 U.S. 45 (1932) (holding that child defendants had been denied due process under the Fourteenth Amendment).

216. Anne C. Dailey, *Children's Constitutional Rights*, 95 MINN. L. REV. 2099, 2118-19 (2011) (citations omitted) ("In a series of cases, the Court has taken the position that public schools, while they cannot be 'enclaves of totalitarianism,' nevertheless do have the authority and

nized that children “lack innate decision making skills,”<sup>217</sup> recognizing that there are authorities, such as schools and parents, that need to regulate children’s choices. Parental rights already supersede children’s rights.<sup>218</sup> Moreover, the state can intercede in parental authority through “a *parens patriae* interest in preserving and promoting the child’s welfare.”<sup>219</sup> The long recognized theories of parental rights and *parens patriae* demonstrate the Supreme Court’s recognition that children are somehow “less than full constitutional rights-holders.”<sup>220</sup> While children retain certain rights, outside organizations such as the government and schools can help serve the best interests of a child.

The potential for mental illness to cause suicide or violence against others creates a public health concern that outweighs the possible invasion of privacy. In addition, it is already common medical practice for students to be physically examined either by a private doctor or by the school nurse, although the chances that a physical ailment will be discovered through this process are small.<sup>221</sup> However, “the chance that a teen has a treatable psychiatric illness (such as anxiety, mood, or addictive disorder) is nearly 21%.”<sup>222</sup>

Regarding medical privacy, the students’ mental health records will be kept confidential pursuant to the Family Educational Rights and Privacy Act,<sup>223</sup> though parents have a right to access all educa-

---

duty to instill certain civic values such as tolerance for opposing viewpoints and civility. The Court has ‘acknowledged the importance of the public schools’ in the preparation of individuals for participation as citizens, and in the preservation of the values on which our society rests.”).

217. *Id.* at 2110-11 (“[T]he point that children have impaired rational choice – that is, that they lack innate decisionmaking skills – is present either explicitly or implicitly in almost all cases involving children’s rights.”).
218. *Id.* at 2111-12 (quoting *Prince v. Mass.*, 321 U.S. 158, 166 (1944)) (“As the Supreme Court observed in *Prince v. Massachusetts*, “It is cardinal with us that the custody, care and nurture of the child reside first in the parents, whose primary function and freedom include preparation for obligations the state can neither supply nor hinder.” In *Parham*, the Court further emphasized that parental authority derives from a presumption that parents possess what children lack in decision making skills.”).
219. *Santosky v. Kramer*, 455 U.S. 743, 746 (1982).
220. Dailey, *supra* note 216, at 2113; *see also In re Gault*, 387 U.S. 1, 16 (1967) (“The Latin phrase proved to be a great help to those who sought to rationalize the exclusion of juveniles from the constitutional scheme.”).
221. Friedman, *supra* note 203, at 2719.
222. *Id.*
223. The Family Educational Rights and Privacy Act, 20 U.S.C. § 1232g(b) (2012).

tional records about their children.<sup>224</sup> Additionally, parents have the right to contest the accuracy of these records.<sup>225</sup> Aside from certain explicit exceptions,<sup>226</sup> students' records are only available upon written request by the student or parent.<sup>227</sup> If further medical attention is necessary for mental health purposes, the family may request copies of the records and provide them to a doctor.<sup>228</sup> Additionally, information about students' health will not be disclosed unless necessary, as provided by the Code of Ethics of the National Education Association.<sup>229</sup>

*B. Other Benefits of the Law*

Opponents of this statute should also recognize that there are benefits of this law that extend beyond preventing school violence and will benefit society as a whole. Mental illness is still overly stigmatized,<sup>230</sup> and the public is not always aware of the truths about mental illness. Mental illness professionals feel that people are afraid of mental illness and do not understand what causes it.<sup>231</sup> If this law

- 
224. See, e.g., *Overarching Guidelines*, HEALTH, MENTAL HEALTH AND SAFETY GUIDELINES FOR SCHOOLS, <http://www.nationalguidelines.org/guideline.cfm?guideNum=0-03> (last visited Apr. 19, 2014) (stating that the Family Education Rights and Privacy Act gives parents “the right to access all the records a school has on their children”).
225. *Family Educational Rights and Privacy Act (FERPA)*, U.S. DEP’T OF EDUC., <http://www2.ed.gov/policy/gen/guid/fpco/ferpa/index.html> (last visited Apr. 19, 2014) (stating that “parents . . . have the right to inspect and review the student’s education records maintained by the school”).
226. *Id.* (listing certain scenarios where a student’s records may be disclosed, including to: “school officials with legitimate educational interest; other schools to which a student is transferring; specified officials for audit or evaluation purposes; appropriate parties in connection with financial aid to a student; organizations conducting certain studies for or on behalf of the school; accrediting organizations; to comply with a judicial order or lawfully issued subpoena; appropriate officials in cases of health and safety emergencies; and state and local authorities, within a juvenile justice system, pursuant to specific State law”).
227. *Id.*
228. *Id.*
229. *Overarching Guidelines*, *supra* note 224.
230. Tovino, *supra* note 156, at 161 (“The stigma associated with mental illness has served as a formidable obstacle to mental health parity even when all other obstacles have been removed.”).
231. See generally *id.*; Email from Kate Trasher, Child and Adolescent Social Worker (Oct. 31, 2012) (on file with author) (“In general, society needs more education about mental illness. People are still afraid of it. People still do not see it as an illness but rather that someone did something to bring it on.”).

were passed, it would help the public recognize the seriousness of mental illness. Further legal acknowledgment of mental illness would help de-stigmatize the issue. Moreover, children will better cope with mental health problems for the rest of their lives if the problems are acknowledged and accepted in their youth.

The passage of this law may help children with mental illness avoid future legal trouble as young people with a psychiatric condition often end up in juvenile court.<sup>232</sup> Ultimately, early diagnosis and treatment will be extremely beneficial to a child with mental health problems.

## CONCLUSION

As stated by the National Association of School Psychologists, “children are remarkably resilient when they get the help they need.”<sup>233</sup> In order to give children this help regarding mental illness, we need legal mandates. The benefits that this model law could provide for the mental health of children and eventually adults in America are substantial. The most notable benefit would be the decrease in school violence. The lives taken in the massive school shooting tragedies perpetrated by allegedly mentally ill gunmen are reason enough to implement improved mental health care services in schools.

---

232. English, *supra* note 79, at 246.

233. *School Psychologists: Providing Mental Health Services to Improve the Lives and Learning of Children and Youth*, NASP ADVOCACY, <http://www.nasponline.org/advocacy/mhbrochure.aspx> (last visited Apr. 19, 2014).