Educating Children with Dual Cognitive and Emotional Disabilities

By Nikki Mitchell and Hope Tipton



Adam, age 15, was statistically destined to fail. His grandmother was raising him because his parents had substance abuse issues. Adam often went without enough food to eat or clean clothing to wear. Additionally, Adam had an intellectual disability. He had an IQ of 55 and functioned at the same capacity of an 8-year-old. At his public school, Adam received special education services through an Individualized Education Program (IEP) with a primary disability coding of Intellectually Limited. This means that Adam has low cognitive ability and adaptive behavior deficits that impact his learning.

Adam's life was a daily struggle and while walking the halls of his high school, he experienced an event that would alter his personality, school experience, and his entire life. Adam witnessed the murder of a fellow classmate inside his school building. Adam was traumatized from the event. While most adolescents would have difficulty coping with this experience, Adam's low adaptive skills made him especially incapable of processing his feelings. Because of this event, Adam developed Post Traumatic Stress Disorder (PTSD). PTSD is often diagnosed in children because the child exhibits aggressive behaviors or re-experiences the traumatic event when specific triggers are present.[1]

Adam became aggressive in class when his PTSD was triggered. He had extraordinary difficulty focusing on schoolwork and interacting appropriately with his peers. Eventually, the emotional toll of Adam's PTSD caused him to stop attending school. As a result of these behaviors, the IEP team changed Adam's primary disability on his IEP to that of Emotional Disability. Adam was already in a self-contained classroom, the most-restrictive environment possible at his public school, but when his teachers became concerned that they could no longer educate Adam due to his PTSD behaviors, they recommended he be placed in a new, alternative school for Emotionally Disabled students. These placements are known as "ED" programs.

ED programs are for a student diagnosed with disorders that make it difficult for the individual to control his or her emotions and behavior without significant intervention and thereby impacting his or her learning. Oftentimes, a student with an emotional disability exhibits aggressive, oppositional behavior. On Adam's first day of school in the ED program, his PTSD was triggered when he witnessed a fellow classmate choke another classmate in the hallway. Unfortunately, these kinds of incidents were a regular occurrence at his new school and reminded him all too vividly of the frightening event that caused his PTSD. Sadly, Adam stopped coming to school again to avoid re-experiencing these events and triggering his PTSD.

Worried, Adam's grandmother inquired about other possible placements and was told by the IEP team that there were none available. The IEP team was half-correct. There were no other **public** school placement options for Adam. However, there were non-public placement options that provided education services to children exactly like Adam, those with both cognitive and behavioral/emotional disabilities, or dual-diagnosed children. A student with a dual diagnosis has two separate disorders that interfere with some area of life.[2] Adam's grandmother was not aware that the law requires a public school to acknowledge when it is incapable of educating a student in a public school setting.[3] If a school cannot meet the educational needs of a student in a public school setting, then the school must pay for the student to attend a non-public school.[4] Non-public school placements are often more expensive for the public school system and thus are not common.[5]

One wishes Adam's story were the exception, but, unfortunately, there are many children like Adam in public school systems across the United States. However, few public school districts have programs designed to effectively educate these children while taking into account

their cognitive and emotional limitations and are hesitant to agree to a non-public placement for various reasons. Instead, these children often miss significant amounts of school because parents are unable to navigate the special education process and feel helpless, often resulting in truancy, suspension, and expulsion of the student.

The federal Individuals with Disabilities Education Act of 2004 (IDEA) governs the education of children with disabilities.[6] IDEA defines special education as "specially designed instruction, at no cost to parents, to meet the unique needs of a child with a disability [...]."[7] In order to receive special education services, a child must be diagnosed with a disability that adversely impacts his or her ability to learn. In general, children whose skills are commensurate with their cognitive abilities do not qualify for special education services. If the child is diagnosed with more than one disability, the IEP team must decide which is the primary disability affecting the child's ability to learn.

Children with intellectual disabilities must have significantly sub-average educational performance, combined with deficits in adaptive behavior that manifests during the developmental period.[8] Children with emotional disabilities display inappropriate types of behaviors or feelings, a general pervasive mood of unhappiness or depression, or have a tendency to develop physical symptoms or fears associated with their academic or social problems.[9] Examples of these disorders are Opposition Defiant Disorder (ODD), Major Depression, and PTSD. The determination of the primary disability code can have serious consequences for the child when the IEP team determines the best educational placement option. Children with an intellectual disability are 7.3 times more likely to be diagnosed with a psychiatric disorder than their non-disabled peers.[10] Specifically, children with an intellectual disability are 4.8 times more likely to develop PTSD than their non-disabled peers.[11] Placement in an ED classroom, where many children have conduct disorders, aggressive behaviors, and emotional melt-downs, is likely to trigger a child's PTSD symptoms.

The statute requires that educational services are rendered at no cost to the parents of the child and authorizes the funding of grants to the states conditioned upon the requirements of the legislation.[12] The formula for determining how much a state will receive is enumerated in the statute based on the population.[13] For example, in the 2013-2014 school year, Maryland received approximately $805,478,144, or 6.60 percent of its general education budget from federal dollars.[14] In the same school year, Maryland expended approximately $1,481,789,761, or 12.22 percent of its total budget on special education services.[15] In Maryland, of the 102,578 children receiving special education services in the 2013-2014 school year, 5,289 of them did so as a result of an intellectual disability.[16] In the same school year, 6,632 of them were doing so for an emotional disability.[17] (This number also does not include students with Attention Deficit Hyperactivity Disorder, which would be classified as "Other Health Impaired"). Because the severity of intellectual and emotional disabilities fall along a spectrum, not every child with one or both of these disabilities will appear the same or have the same educational requirements.

For several possible reasons, public school systems have not created separate programs for dual-diagnosed children. And, non-public placements, which may have programs specially designed for dual-diagnosed children, are terribly hard to attain by the parents. Though it is hard to measure why this is the case, one can speculate that it has much to do with funding. In addition to school systems having limited funds, parents are often in the same position. If parents cannot successfully petition their child's school for a non-public placement whereby the school becomes responsible for payment, then most parents cannot afford the cost of a non-public education for their child.

While much research has been done and education techniques implemented for other disabilities, such as Autism, little has been done to understand the effect new learning environments have on dual-diagnosed children.[18] It is perhaps this lack of understanding that results in a lack of motivation to explore new educational techniques for dual-diagnosed children. Critics of the current educational techniques for children with both a severe intellectual and emotional disability cite the lack of teacher training in new educational techniques as a primary issue.[19] Indeed, the PCESE found in 2002 that "our nation is less likely to serve children with disabilities well because of our failure to appropriately train [...] special education teachers" and that this failure would "undermine efforts to increase the achievement of students with disabilities."[20]

It is imperative that new training options include the **entire** IEP team. The IEP team, consisting of teachers, parents, school psychologists and counselors, principals, and school personnel, must be trained regarding the signs and symptoms of a student's disabilities before the IEP team can determine what educational services are necessary for the student. In other words, you cannot put the cart before the horse. Once educational professionals and parents understand the disability and how it impacts their particular student then the IEP team can draft an IEP and arrange for an educational placement that fully meets the student's needs. When IEP teams do not understand the student's disability and how it impacts the student and his or her learning, then what gets developed is a very generic IEP that barely meets the basic educational needs of the student. Instead, it is an educational plan that would be appropriate for any student that has learning deficits. In addition, furnishing training options that are inclusive of parents and/or caregivers assists parents in navigating the special education system by providing a knowledge foundation about their child. It allows parents to more fully participate as a member of the IEP team. Ensuring that **all** members of the IEP team are on the same page is critical to the student's educational success. After all, the school and parents have the same goal—to educate the student. Therefore, aligning training for parents and members of the IEP team ensures that the entire team is equipped with sufficient knowledge to create a meaningful IEP tailored to the needs of each individual child.

When considering educational placements, it is important for IEP teams to be trained to recognize and understand the difference between PTSD and other emotional disabilities. For example, in Adam's scenario, putting a student diagnosed with PTSD in a classroom with students who are ODD, aggressive, impulsive and otherwise hard to manage

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is not a beneficial learning environment for Adam. This is especially important to consider when students with disabilities are two to three times more likely to be bullied than their non-disabled peers.[21] It is imperative for public school systems to recognize the need for more appropriate placement options and work toward removing this obstacle if dual-diagnosed children are to have academic success, and, in turn, long-term success. In other words, when it comes to educational placements for dual-diagnosed students, one size does not fit all. Instead, it is a holistic approach that is necessary when educating dual-diagnosed children.

The IDEA furthers this obstacle by forcing the IEP team to choose just one disability as the primary disability. Dual-Diagnosed children can be particularly challenging, because the strategies (accommodations and modifications to the child's classroom instruction and work) that usually work with one diagnosis might not work when another is thrown into the mix.[22] The natural ramifications of having either an Intellectual Disability or Emotional Disability as the child's primary disability coding are illuminated in placement settings where general educational techniques are most often employed. For example, for students with processing and reading deficits, it may be challenging for them to receive oral instruction as how to complete a worksheet and simply complete the task. Rather, students would benefit from the IEP reflecting the true nature of the combination of disabilities so that individually tailored instruction can be implemented. Again, the IEP needs to be tailored to the student's specific education needs, which must take into consideration each of the child's disabilities and how those disabilities impact the student's learning. It is naïve to require an IEP team to compartmentalize the disabilities and only address the one causing the most impact. This is futile at best when the student, who is living with the disabilities, cannot do so in order to learn in a classroom setting.

Changes to the IDEA could help alleviate many of the issues discussed. As the understanding of the effects of having an intellectual and emotional disability evolve, so too, should the legislation. The first way in which legislators can assist children with a dual-diagnosis is by making it a separate disability code for children with a dual-diagnosed combination of severe intellectual and emotional disabilities. In the very least, the legislators could expand the Multiple Disabilities code to include the combination of an intellectual and emotional disability. Currently, this disability code only includes 1) sensory and cognitive disabilities; 2) sensory and physical disabilities; or 3) cognitive and physical disabilities. Adding a new disability or expanding the Multiple Disability code will provide guidance to IEP teams for more appropriate IEP development. Moreover, this allows the IEP team to choose the most accurate primary disability code since it is the combination of the disabilities that is most adversely affecting the child's education. Creating a separate disability coding or expanding the current coding is not enough if appropriate public educational placements do not exist within a school district. For example, a public school system should be required to have at least one program within the system dedicated to educating children with a dual-diagnosis of intellectual and emotional disabilities.

Whether the solution is found in better teacher training, changes to federal law, more public educational placements or some combination thereof, the IDEA requires states to educate dual-diagnosed children appropriately.

If the school system is not able to submit plans for such a program, it should automatically be required by law that a child with a qualified dual-diagnosis, per the definition, is given a non-public placement at an appropriate non-public school. A program suited to the particular needs of dual-diagnosed children, in general, should be equipped to implement personalized instruction and psychosocial techniques according to the needs of the child. A more expedient transition to a non-public placement for these children is crucial to their success because, when the current public placement options are inadequate to address a child's needs, the child must remain in that placement until the conclusion of their due process hearings or a the public school system concedes that it cannot meet the child's educational needs. For each day this occurs, a dual-diagnosed child misses instructional opportunity, fails to master skills and materials, and falls further behind in his or her education. The student is also at a greater risk for truancy, suspension, and expulsion.

The advancement of resources and services available to dual-diagnosed students is crucial. More importantly, there is a need for a change in the atmosphere in the special education system and the approach for dual-diagnosed children. Whether the solution is found in better teacher training, changes to federal law, more public educational placements or some combination thereof, the IDEA requires states to educate dual-diagnosed children appropriately. Policies that are structured to address the needs of dual-diagnosed children will serve to provide the atmosphere and services that would truly benefit these students. Children who are living with such severe disabilities deserve no less.

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NOTES:

1. *National Center for PTSD, U.S. Dept. of Veterans Affairs, available at http://www.ptsd.va.gov/.*
2. V. Thompson, *What is Dual Diagnosis in Special Education?* Available at http://www.ehow.com/info_12266034_dual-diagnosis-special-education.html.
3. 20 U.S.C. §1412(a)(10)(B)(i) (2011).
4. *Id.*
5. Terry L. Jackson, et al., *Non-Public Placements: State Policies and Procedures,* National Association of State Directors of Special Education, Inc. (June 2004) http://nasde.org/Portals/0/Documents/Download%20Publications/DFR-0405.pdf.
6. 20 U.S.C. §§1401 et. seq. (2011).
7. 20 U.S.C. §1401(29) (2011).
8. 34 CFR 300.8(c)(9).
9. 34 CFR 300.8(c)(4).
10. E. Emerson, *Prevalence of Psychiatric Disorders in Children and Adolescents With and Without Intellectual Disability,* 47 Journal of Intellectual Disability Research 51 (2003).
11. *Id.*
12. 20 U.S.C. §1411(a)(1) (2011).
13. *Id.* at §1411(2)(A)-(B).
14. Maryland State Department of Education, The Fact Book 2013-2014.
15. *Id.*
16. *Id.*
17. *Id.*
18. Jane McCarthy, *Post Traumatic Stress Disorder in People With Learning Disability,* 7 Adv. Psychiatr. Treat. 163, 167 (2001).
19. President's Commission on Excellence in Special Education (PCESE), *Final Report to the President: Section 6 – Teacher and Administrator Preparation, Training and Retention,* available at http://www2.ed.gov/inits/commissionsboards/whspecialeducation/reports/six.html#teach.
20. *Id.*
21. *National Bullying Prevention Center, http.www.pacer.org/bullying/resources/students-with-disabilities.*
22. V. Thompson, *What is Dual Diagnosis in Special Education?* at http://www.ehow.com/info_12266034_dual-diagnosis-special-education.html.

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