Identifying the Unidentifiable: How Washington's Public Education System Can Aid in the Prevention and Detection of Childhood Mental Illness

Alexis L. $Toma^{\dagger}$

I. INTRODUCTION

In the wake of the tragedies at Columbine, Virginia Tech, and Northern Illinois University, FDA black box warnings on antidepressants for young adults, and the Church of Scientology's public stance against psychotropic medications, children's mental health is of great and growing concern to parents, schools, and society at large. Although

[†] J.D. Candidate, Seattle University School of Law, 2010; M.A., Clinical Psychology with an emphasis on Marriage and Family Therapy, Pepperdine University, 2006; B.S., Psychology, University of Arizona, 2004. I would like to thank Megan Farooqui, Micol Sirkin, Lindsay Taft, and the members of the *Seattle University Law Review* for all of their hard work and contributions. I also owe many thanks to my family and friends, especially Mary Beth Leeper, for their love and support. Finally, I would like to dedicate this Comment to my husband, who never ceases to amaze and inspire me.

^{1.} On the morning of April 20, 1999, two students at Columbine High School, Eric Harris and Dylan Klebold, walked onto campus, shot to death twelve fellow students and a teacher, and then killed themselves. Tina Kelley, *In an Era of School Shootings, A New Drill,* N.Y. TIMES, March 25, 2008, http://www.nytimes.com/2008/03/25/nyregion/25drills.html. On April 16, 2007, a student at the Virginia Polytechnic Institute and State University, Seung-Hui Cho, opened fire in a dormitory and classroom building on campus, killing thirty-two people before committing suicide. Kelley, *supra*; Elizabeth Stone, *The Expanding Safety Net,* N.Y. TIMES, April 20, 2008, http://www.nytimes.com/2008/04/20/education/edlife/mental.html. On February 14, 2008, Stephen Kazmierczak, a former student at Northern Illinois University, opened fire on students in a lecture hall, fatally shooting five students and injuring eighteen more, before turning the gun on himself. Kelley, *supra*; Stone, *supra*. All four individuals suffered from mental health problems, including depression and anger management issues, antisocial personality disorder, extreme social anxiety and isolative tendencies, and obsessive compulsive disorder, respectively.

^{2.} The Food and Drug Administration ordered drug manufacturers to add warnings (in a black box displayed on the prescribing information) to antidepressant medications, which inform users that the drug may increase the risk of suicidal thinking or behavior in some young adults. Benedict Carey, *F.D.A. Expands Suicide Warning on Drugs*, N.Y. TIMES, May 3, 2007, http://www.nytimes.com/2007/05/03/health/03depress.html.

^{3.} Joel Sappell & Robert W. Welkos, *Suits, Protests Fuel a Campaign Against Psychiatry*, L.A. TIMES, June 29, 1990, http://www.latimes.com/la-scientology062990a,0,3292532.story (explaining Scientologists' eager campaign against the "problem of psychiatric drugging").

^{4.} Stone, supra note 1.

research is improving, relatively little is known about the most effective strategies for the prevention, detection, diagnosis, and treatment of child-hood mental disorders.⁵

Because factors such as lack of medical knowledge, cultural beliefs, privacy concerns, and stigmatization shape attitudes toward children's mental health, this social issue lacks consensus on not only basic definitions but also effective strategies.⁶ As a result, states have begun to take radically different approaches to children's mental health legislation.⁷ In addition to the factors that influence peoples' attitudes toward children's mental health, several core issues complicate the debate on children's mental health, including the role of parenting and family values,⁸ the decision to treat children with pharmaceuticals,⁹ and the ethics of pediatric clinical research.¹⁰ While these factors and issues guide parents, schools, and legislators in acknowledging childhood mental illness,¹¹ they should not take precedence over the best interests of the mentally ill child. If the intention of all those involved is to protect the best interests of the mentally ill child, the issues that most need to be addressed in this dialogue are how to prevent and detect children's mental illness.¹²

To improve the prevention and detection of childhood mental illness, it is first necessary to consider the systems at work. That is, who is in the best position to prevent the onset of a child's mental disorder?¹³ Who is in the best position to detect if a child suffers from mental illness?¹⁴ Few would argue that the two social groups most intimately involved in a child's life, and therefore in the best positions to prevent and recognize a child's mental health issue, are parents and family members

^{5.} SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION, OFFICE OF THE SURGEON GENERAL, MENTAL HEALTH: A REPORT OF THE SURGEON GENERAL 193 (1999), available at http://www.surgeongeneral.gov/library/mentalhealth/home.html [hereinafter REPORT OF SURGEON GENERAL]. The Surgeon General's office created this report on mental health to provide a review of scientific advances in the study of mental health and of mental illnesses for the public. *Id.* at 3.

^{6.} Jeffrey Kluger et al., *Medicating Young Minds*, TIME, Nov. 3, 2003, at 48, *available at* http://www.time.com/time/magazine/article/0,9171,1006034,00.html.

^{7.} See infra Part V.

^{8.} See infra Part IV.

^{9.} NATIONAL INSTITUTE OF MENTAL HEALTH, QUESTIONS AND ANSWERS: TREATMENT OF CHILDREN WITH MENTAL DISORDERS 2 (2000), available at http://www.nimh.nih.gov/health/publications/treatment-of-children-with-mentaldisorders/complete.pdf [hereinafter QUESTIONS AND ANSWERS].

^{10.} Kathleen C. Glass & Ariella Binik, *Rethinking Risk in Pediatric Research*, 36 J.L. MED. & ETHICS 567, 573 (2008).

^{11.} See infra Part V.

^{12.} Howard S. Adelman & Linda Taylor, *Mental Health in Schools and Public Health*, 121 PUBLIC HEALTH REPORTS 294, 296 (May-June 2006).

^{13.} Id.

^{14.} *Id*.

and teachers and schools.¹⁵ But if both the family unit and the education system are gatekeepers of a child's mental health, which system should be responsible for standing guard? And what is the best way for that system to implement comprehensive prevention and detection measures? These are the central issues of this Comment. Consensus is polarized on the issue of the proper respective roles of parents and the public education system in not only offering preventative measures but also detecting childhood mental illness.¹⁶

This Comment explores three states' approaches to mental health screenings for earlier identification of impaired mental health functioning in educational settings. The State of Washington has yet to pass any legislation aimed at instituting a mental health schema within its public schools. This Comment argues that the Washington legislature should enact children's mental health legislation that reflects an integration of the three state positions.¹⁷ Specifically, Washington should adopt a cooperative and transparent mental health scheme for public schools that includes in-school screening, informed and active parental consent, educator training, and emotional health curriculum because it preserves parental rights while also protecting the well-being of mentally ill children.

Part II of this Comment discusses both the current state of children's mental health and the concepts of prevention and detection. It emphasizes the significance of educating teachers, implementing emotional health curricula in public schools, and utilizing mental health screenings as early detection devices. It also provides a summary of the current state of children's mental health law as it relates to Washington's public education system. Part III describes the federal government's attitude toward children's mental health and reviews federal statutes pertaining to the distribution of school surveys in public schools. Part IV explains the development of the constitutional right to parent and its application to children's mental health. It also discusses the tension between parents and schools on privacy issues such as distributing screenings to students. Part V presents children's mental health legislation from three states: Illinois, Utah, and Connecticut. This Part introduces not only the substance of the various legislative measures but also the radically different positions taken. Part VI recommends that Washington adopt a cooperative and transparent system that includes in-school screening, informed and active parental consent, educator training, and emotional health curricula.

^{15.} REPORT OF SURGEON GENERAL, supra note 5, at 136.

^{16.} See infra Part V.

¹⁷. The three states that will be discussed are Illinois, Utah, and Connecticut. The scope of the legislation is described further in Part V.

II. BACKGROUND

Before describing the mental health legislation Washington ought to adopt, it is first necessary to define mental health and mental disorder and discuss how children are affected when they are labeled by such terms. This Part also introduces the concepts of prevention and detection to emphasize the need for holistic legislation and mental health screenings. Finally, this Part concludes with a summary of Washington's current children's mental health legislation.

A. The Mentally Ill Child

According to the Surgeon General's Report on Mental Health, mental health is "a state of successful performance of mental functioning, resulting in productive activities, fulfilling relationships with other people, and the ability to adapt to change and cope with adversity." Mental illness, on the other hand, "refers collectively to all of the diagnosable mental disorders" included in the Diagnostic and Statistics Manual of Mental Disorders IV. Mental disorders are "health conditions that are characterized by alterations in thinking, mood, or behavior (or some combination thereof) associated with distress or impaired functioning."

Mental health is perceived along a spectrum stretching from "successful mental functioning" to "impaired functioning." The mental health spectrum exists for both children and adults. In the relatively recent past, professionals believed that mental disorders such as anxiety disorders, depression, and bipolar disorder began in adulthood. Now, however, it is well-known that these disorders can begin in childhood. It is estimated that ten percent of children and adolescents in the United States suffer from mental illness severe enough to cause some level of impairment. The National Institute of Mental Health estimates that fewer than one in five of those children receive treatment.

^{18.} REPORT OF SURGEON GENERAL, supra note 5, at 4.

^{19.} *Id.* at 5.

^{20.} See American Psychiatric Administration, Diagnostic and Statistical Manual of Mental Disorders (4th ed. 1994).

^{21.} REPORT OF SURGEON GENERAL, supra note 5, at 5.

^{22.} Id.

^{23.} Id.

^{24.} QUESTIONS AND ANSWERS, *supra* note 10, at 2. The National Institute of Mental Health collaborated with the Department of Health and Human Services, the Public Health Service, and the National Institutes of Health to create this document for the public especially for parents concerned about doctors prescribing psychotropic medications to their children. *Id.*

^{25.} Id.

^{26.} Id.

^{27.} Id.

This startling statistic can be explained by problems with detection. Because children develop and grow at a rapid pace, it is often difficult for professionals such as pediatricians, child and adolescent psychiatrists, therapists, and school personnel to diagnose childhood mental illness.²⁸ For example, some mental health problems are short-lived—such as situational anxiety or depression—and therefore require no treatment.²⁹ Others are persistent and serious—such as autism, bipolar disorder, and schizophrenia—and necessitate substantial professional treatment.³⁰

Because mental illness affects ten percent of children and adolescents, it is important for states to take positive steps toward enacting legislation addressing this issue. Children's mental health legislation should target holistic prevention by means of educator training and introducing emotional health curricula and early detection by implementing mental health screenings.

B. Prevention

To effectively address the concerns about children's mental health, the Washington legislature must integrate a preventative-education component into the legislation. This prevention component should include training educators on children's mental health issues and introducing emotional health curriculum to students. Public schools stand in a particularly good position to educate children on managing their emotions and employ preventative measures to help thwart the development of mental disorders. This section focuses on the development of prevention interventions and the factors associated with creating and implementing prevention programs.

Progress in the development of prevention interventions in the field of mental health has faced several challenges.³² Prevention advancement has been slow for two reasons: insufficient knowledge of the cause of mental disorders and inability to alter the known causes of a particular disorder.³³ To improve prevention interventions, researchers have developed prevention programs aimed at reducing risk factors and enhancing protective factors.³⁴

29. See generally JAMES MORRISON, DSM-IV MADE EASY (The Guilford Press 2001) (1995) (containing diagnostic criteria and explanatory material regarding all mental health disorders, including disorders usually first diagnosed in infancy, childhood, or adolescence).

^{28.} *Id*

^{30.} *Id*

^{31.} Howard S. Adelman & Linda Taylor, *Mental Health in Schools: A Shared Agenda*, Emotional and Behavioral Disorders in Youth, Summer 2004, at 62.

^{32.} REPORT OF SURGEON GENERAL, supra note 5, at 62.

^{33.} Id.

^{34.} Id. at 63.

There are various risk factors associated with prevention programs. Risk factors are characteristics or hazards that, if present, make it more likely that a particular child, rather than another child will develop a disorder. Examples of risk factors include lack of social support, inability to read, difficult temperament, and exposure to bullying. To reduce a child's chances of developing mental illness, researchers focus on decreasing the accumulation of risk factors. This strategy changes the risks that are most easily and quickly amenable to intervention. For example, altering a child's classroom environment and reinforcing positive academic accomplishments—rather than altering a child's unstable and dysfunctional home environment—may minimize disruptive and isolative behaviors.

Prevention programs focus not only on risk factors but also on protective factors. Protective factors improve an individual's coping mechanism or adaptive response to an environmental hazard; for example, direct teacher instruction designed to enhance specific areas of knowledge, skills, and attitudes on mental health matters or after-school youth development programs. By enhancing protective factors, researchers believe that individuals can learn to buffer the negative effects of risk factors.

Prevention programs that reduce risk factors and enhance protective factors are amenable to the school environment. These interventions can be extremely helpful, are relatively uncontroversial, and are easy to implement. Accordingly, children's mental health legislation should include a preventative component that educates teachers and school personnel about children's mental health issues and implements emotional health curricula. Student curricula should focus on themes such as anger management, conflict resolution skills, and relaxation techniques. Partnering this preventative component with a detection component will enable educators to institute programs that focus on the source of childhood mental illness.

36. Id.

^{35.} Id.

^{37.} Id. at 64.

^{38.} Id.

^{39.} *Id*.

^{40.} Id. at 63.

^{41.} Id.

^{42.} Adelman & Taylor, supra note 12, at 296.

^{43.} REPORT OF SURGEON GENERAL, supra note 5, at 64.

C. Detection

Detecting a child's mental illness is just as important as preventing it.⁴⁴ This section discusses the process of detecting mental illness and includes a specific introduction to mental health screening instruments.

Generally speaking, successful treatment of children with mental disorders is a result of the following process: detection of a potential mental health problem, comprehensive assessment and evaluation, diagnosis, recommendation for target intervention, and treatment. Researchers have introduced the concept of screening—also called prescreening or first-level screening—as a tool for detecting potential mental health problems. While screenings do not produce a diagnosis, they are used as an instrument by a variety of individuals, including pediatricians, nurses, school personnel, and therapists, to identify the types of mental health disorders that may cause a child's emotional or behavioral difficulties.

A mental health screening is usually a brief, culturally sensitive instrument designed to identify children and adolescents who may be at risk of impaired mental health functioning and who may therefore require immediate attention, a diagnostic assessment referral, or intervention. The primary purpose of a screening is to recognize, using a valid, reliable mental health instrument, a need for further assessment of a child. The screening instrument is typically one to two pages long, rapidly administered, and easy to understand (i.e., no complex terminology). The screening instrument usually includes questions regarding childhood and family background and any family history of mental health problems. The goal of mental health screenings is to enhance detection and, ultimately, to prevent the ultimate exacerbation of a mental health problem.

Although mental health screenings are important for early detection of mental illness, these screening instruments have four major limitations. First, social constructions of mental disorders vary from culture to

^{44.} Adelman & Taylor, supra note 12, at 296.

^{45.} REPORT OF SURGEON GENERAL, supra note 5, at 136-39.

^{46.} Adelman & Taylor, supra note 12, at 296.

^{47.} REPORT OF SURGEON GENERAL, supra note 5, at 138.

^{48.} OFFICE OF JUVENILE JUSTICE AND DELINQUENCY PREVENTION, U.S. DEPARTMENT OF JUSTICE, SCREENING AND ASSESSING MENTAL HEALTH AND SUBSTANCE USE DISORDERS AMONG YOUTH IN THE JUVENILE JUSTICE SYSTEM 2 (2004), http://www.ncjrs.gov/pdffiles1/ojjdp/204956.pdf [hereinafter Screening and Assessing Mental Health].

^{49.} Howard S. Adelman & Linda Taylor, *Mental Health in Schools and System Restructuring*, 19 CLINICAL PSYCHOL. REV. 137, 142 (1999).

^{50.} See generally SCREENING AND ASSESSING MENTAL HEALTH, supra note 48, at 2.

^{51.} *Id.* at 2–12.

^{52.} *Id*.

culture, and mental health screening instruments might not successfully address inherent language or cultural bias.⁵³ Second, because the administrator of the test reviews and interprets some of the screening instruments' results, the outcome of those results may be impacted or skewed by potential subjectivity.⁵⁴ Third, it is imperative that screening instruments are age appropriate and that administrators consider the cognitive level of the student being tested.⁵⁵ Fourth, some mental health screening instruments lack evidence of psychometric reliability.⁵⁶

While there are drawbacks to mental health screenings, most diagnostic instruments contain inherent biases.⁵⁷ Relatively minor problems with reliability and validity, while notable, are not critical, considering the purpose of these instruments is to promote early detection of possible mental health issues, not to diagnose a child with a mental health disorder. Currently, the two laws Washington has enacted regarding children's mental health do not require schools to use mental health screenings.

D. The Current State of Children's Mental Health Law in Washington

Although Washington has yet to take any explicit steps to improve children's mental health in the public school system, there have been some initial steps in the right direction. This section discusses the Mental Health Transformation Project and introduces two state statutes regarding the children's mental health system in Washington.

In October 2005, Washington was awarded a Mental Health Transformation State Incentive Grant.⁵⁸ The grant created the Washington Mental Health Transformation Project and called for a focus on systemwide reform.⁵⁹ The conditions of the grant require specific focus on the areas of planning and implementation, community organization activities, research and evaluation, and recommendations for change in service delivery.⁶⁰

The Mental Health Transformation Project submitted Plan Phase I in 2006, which included an entire chapter devoted to prevention and ear-

^{53.} Id. at 9.

^{54.} Id. at 10.

^{55.} Id. at 9.

^{56.} *Id.* at 12. 57. *Id.* at 11.

^{58.} Washington's Mental Health Transformation Project: Partnerships for Recovery and Resiliency, The Project, http://mhtransformation.wa.gov/MHTG/project.shtml (last visited July 2009).

^{59.} Id.

^{60.} Id.

ly intervention.⁶¹ The plan stated that "while excellent work occurs in . . . education programs, issues around screening and early intervention for children in public schools remains a challenge."⁶² It called for a system of "coordinated school health" in Washington.⁶³

David Brenna, former Senior Policy Analyst for the Transformation Project, believes that mental health screening instruments could affect teachers' responses to social and emotional development in the classroom. Brenna recognizes that the challenge for teachers is that they are unfamiliar with mental health services. Therefore, Brenna advocates that Washington should engage teachers with "sets of tools to better understand children who present challenges in the learning environment." He believes that educating children and teachers about social and emotional barriers to learning not only helps teachers do their job but also helps identify children with emotional issues. Thus, Brenna argues prevention through teacher education and social and developmental standards is a great approach to transforming Washington children's mental health. This is the direction that the Transformation Project is now headed.

While Washington has begun to take introductory steps to address children's mental health through grant incentives such as the Mental Health Transformation Project, it has yet to implement any legislation aimed to improve children's mental health in coordination with the public education system. However, there are two statutes in particular worth mentioning.

First, the Community Mental Health Services Act was enacted with the intent to establish a community mental health program that provides access to mental health services for both adults and children who are acutely mentally ill or severely emotionally disturbed.⁷⁰ The statute's purpose is to promote earlier identification of mentally ill children and to ensure that children receive treatment appropriate for their developmen-

^{61.} WASHINGTON STATE'S MENTAL HEALTH TRANSFORMATION PROJECT, 2006 WASHINGTON MENTAL HEALTH TRANSFORMATION PLAN: PHASE I 122-30 (Sep. 30, 2006), available at http://mhtransformation.wa.gov/pdf/mhtg/CMHP Ch4.pdf.

^{62.} Id. at 125.

^{63.} Id. at 126.

^{64.} Telephone Interview with David Brenna, Senior Policy Analyst, Mental Health Transformation Project, in Seattle, Wash. (Oct. 21, 2008).

^{65.} Id.

^{66.} Id.

^{67.} *Id*.

^{68.} Id.

^{69.} Id.

^{70.} Wash. Rev. Code § 71.24.015(1) (2009).

tal level.⁷¹ The statute also provides for coordination of services between the Department of Health and Human Services, the office of the superintendent of public instruction, mental hospitals, county authorities, and other support services, including the families of mentally ill individuals,⁷² as well as creates regional support network programs to facilitate the delivery of those services.⁷³ Although the Community Mental Health Services Act recognizes the importance of and need for children's mental health services, it does not incorporate the public education system in its efforts to prevent and detect childhood mental illness.

The second statute, Coordination of Children's Mental Health Services, was created to implement an improved system of children's mental health services in Washington. The statute's goal is to promote early identification, intervention, and prevention; coordinate existing mental health programs; and integrate educational support services to address students' diverse learning styles. Additionally, the statute recognizes that such a system should provide a continuum of services, equity in access to services, and qualified mental health providers. However, the statute's purpose—to improve the efficacy of the current system—does not integrate the public education system.

In sum, to successfully curb the prevalence of mental health disorders in children, legislators should afford special attention to the concepts of prevention and detection. The Washington legislature should incorporate not only a curriculum and educator training component into children's mental health laws but also a mental health screening component to help effectuate the detection of possible mental health problems. While Washington statutes do recognize the need for children's mental health services and are striving to improve those existing services, there is no current legislation addressing the issue at hand. As discussed in the next Part, the federal government recognizes the importance of public school involvement in children's mental health, including early detection through mental health screenings.

III. FEDERAL CHILDREN'S MENTAL HEALTH LAW

While schools may not be in the business of mental health, the public education system must address children's mental health concerns if schools are to serve their function of teaching students and promoting

^{71.} *Id*.

^{72.} Id. § 71.24.015(6).

^{73.} Id. § 71.24.016 (2009).

^{74.} Id. § 71.36.005 (2009).

^{75.} *Id*.

^{76.} Id. § 71.36.025 (2009).

their success.⁷⁷ Even though schools may not be responsible for meeting every need of each student, they must address those needs that directly affect learning.⁷⁸

This Part discusses federal initiatives and statutes that aim to improve mental health systems in schools and regulate the distribution of school surveys—which could potentially include mental health screenings. These initiatives and statutes include: (1) the President's New Freedom Commission on Mental Health, (2) the Protection of Pupil Rights Act and the No Child Left Behind Act, and (3) the Individuals with Disabilities Education Act. It is especially important for Washington to consider federal laws that regulate the administration of surveys because these statutes dictate the requisite structure of state mental health schemes. Of particular importance are the federal statutes that regulate parental consent because consent plays a large role in the constitutionality of mental health screenings, discussed in Part IV.

A. The President's New Freedom Commission on Mental Health

The federal government supports improving the children's mental health system. In 2002, by Executive Order, President George W. Bush created the President's New Freedom Commission on Mental Health ("the Commission"). The Commission was to, among other things, "recommend improvements that allow . . . children with serious emotional disturbance to live, work, learn, and participate fully in their communities." The Communities of the children with serious emotional disturbance to live, work, learn, and participate fully in their communities.

In 2003, the Commission released a critical report addressing the problem of fragmented health care in the United States. Because access to mental health care is scattered in this country, families are often responsible for coordinating their own support and services. Naturally, the search for care usually occurs at a time of crisis; when the family's ability to realize this responsibility is most compromised. While multiple programs, regulated by various federal agencies are involved in the field of mental health, most care is managed by states and localities.

^{77.} Adelman & Taylor, supra note 31, at 59.

^{78.} Id.

^{79.} Exec. Order No. 13,263, 67 Fed. Reg. 22,337 (Apr. 29, 2002).

^{30.} *Id*.

^{81.} THE PRESIDENT'S NEW FREEDOM COMMISSION ON MENTAL HEALTH, ACHIEVING THE PROMISE: TRANSFORMING MENTAL HEALTH CARE IN AMERICA (2003), available at http://www.mentalhealthcommission.gov/reports/FinalReport/downloads/FinalReport.pdf [hereinafter President's New Freedom Commission].

^{82.} Michael F. Hogan, *Introduction* to THE PRESIDENT'S NEW FREEDOM COMMISSION, *supra* note 81, at 1.

^{83.} PRESIDENT'S NEW FREEDOM COMMISSION, supra note 82, at 8.

^{84.} *Id*.

Furthermore, these various programs are governed by different statutes, shaped by diverse congressional committees, and defended by multiple constituencies. So Consequently, the political dynamics between these layers of government tend to frustrate comprehensive reform of the system. So

To implement comprehensive reform, the report recommends "fundamentally transforming how mental health care is delivered in the United States." The report proposes six goals for achieving transformation, including (1) "Americans Understand that Mental Health is Essential to Overall Health;" (2) "Mental Health Care is Consumer and Family Driven;" and (3) "Early Mental Health Screening, Assessment and Referral to Services Are Common Practice."

Most important for the purposes of this Comment is the third goal—"Early mental health screening[s] . . . are common practice."89 The third goal specifically recommends that the government improve and expand school mental health programs. 90 The report recognizes that many problems associated with the current mental health system result from late diagnosis and lack of participation in care. 91 To address this problem, the report recommends a stronger focus on early childhood mental health and endorses the aforementioned concept of preventative interventions. 92 The report suggests that the government should re-think how school systems can more efficiently partner with and use state and federal funds to support school-based mental health services. 93 Of particular importance, the report states that "[s]chools are in a key position to identify mental health problems early and to provide a link to appropriate services."94 Thus, the Commission's report robustly supports the notion that states should enact mental health legislation to include mental health screenings in public schools.

B. The Protection of Pupil Rights Act and the No Child Left Behind Act

In addition to the New Freedom Commission, the federal government has also enacted statutes that affect state mental health schemes.

^{85.} Id.

^{86.} *Id*.

^{87.} Id. at 4.

^{88.} *Id.* at 5 (emphasis added). The other three goals include (4) "Disparities in Mental Health Services are Eliminated;" (5) "Excellent Mental Health Care is Delivered and Research is Accelerated," and (6) "Technology is Used to Access Mental Health Care and Information." *Id.*

^{89.} Id. at 11.

^{90.} Id.

^{91.} Id.

^{92.} *Id*.

^{93.} Id. at 53.

^{94.} Id. at 58 (emphasis added).

The Protection of Pupil Rights Act (PPRA) was enacted in 1974.⁹⁵ The PPRA protects student privacy and regulates parental consent to public school administration of surveys and evaluations.⁹⁶ In 2002, the No Child Left Behind Act (NCLB) expanded the PPRA.⁹⁷

The PPRA now requires schools to allow parents to inspect surveys and evaluations. The statute dictates that no student shall be required to submit to a survey that reveals personal information, including "mental or psychological problems of the student or the student's family." The school must also notify parents of upcoming surveys and offer an opportunity for the parent to opt the student out of participation in a survey that collects personal information. 100

In sum, the PPRA requires schools to inform parents of sensitive surveys and allow parents to rebut assumed consent. ¹⁰¹ Thus the statute models passive parental consent. Understanding the relationship between mental health screenings and surveys in the context of the PPRA is important because parental consent, as discussed *infra* in Part IV.B, is a sensitive topic in diagnosing childhood mental illness. Thus, the issue of importance is whether mental health screenings constitute surveys under the PPRA.

The PPRA statute does not define "survey," but it states that surveys include evaluations, and it refers to "survey, analysis, or evaluation" several times. Technically speaking, screening instruments are only indicator tools, not evaluative tools. Thus, the purpose of a mental health screening is not to assess, analyze, or evaluate but to refer children with potential mental health issues for evaluation. Nevertheless, most individuals would agree that mental health screenings could easily be classified as sensitive surveys. To be safe, schools planning on administering mental health screenings should comply with the PPRA passive consent model.

Although passive parental consent is the floor, the Washington legislature should heighten that standard to require informed and active parental consent to mental health screenings. Washington's legislation should therefore include provisions that require public schools to provide

^{95.} Protection of Pupil Rights Act, 20 U.S.C. § 1232h (2002).

⁹⁶ *Id*

^{97.} No Child Left Behind Act, Pub. L. No. 107-110 § 1061, 115 Stat. 1425, 2083 (2002).

^{98.} Protection of Pupil Rights Act, 20 U.S.C. §§ 1232h(c)(1)(A)–(B) (2002).

^{99.} *Id*.

^{100.} Id. § 1232h(c)(2).

^{101.} See generally Lynn M. Daggett, Student Privacy and the Protection of Pupil Rights Act as Amended by No Child Left Behind, 12 U.C. DAVIS J. JUV. L. & POL'Y 51 (2008).

^{102.} Protection of Pupil Rights Act, 20 U.S.C. § 1232h (2002).

 $^{103. \} Screening \ and \ Assessing \ Mental Health, \ supra$ note 48, at 2.

parents with advanced notice of screenings and active consent forms. Active parental consent not only explicitly notifies parents that students, with their permission, are going to be asked to divulge sensitive information but also offers comfort to those concerned with student privacy. Thus, to avoid ambiguity under the PPRA, Washington should explicitly require informed and active parental consent as part of its children's mental health legislation.

C. The Individuals with Disabilities Education Act

In addition to the PPRA and the NCLB, the Individuals with Disabilities Education Act (IDEA), reauthorized in 2004 under the Individuals with Disabilities Improvement Act, includes an important implication for teachers, parents, and children with regard to childhood mental illness. An amendment to IDEA, entitled "Prohibition on Mandatory Medication," bans "state and local educational personnel from requiring a child to obtain a prescription . . . as a condition of attending school [or] . . . receiving an evaluation." Because teachers were concerned with potential communication barriers, the legislature included a provision explicitly allowing teachers to share classroom-based observations with parents. This language is particularly important because it encourages collaboration and transparency between parents and public schools vis-à-vis children's mental health. Mental screening legislation should reinforce open communication between families and education systems when it concerns a child's mental well-being.

While the President's New Freedom Commission, the PPRA, and the IDEA do not explicitly address regulations regarding the distribution of mental health screenings in public schools, each plays an important role. The federal government clearly recognizes the need for early mental health screenings as evidenced by the goals of the Commission's report. The PPRA and the NCLB regulate parental consent to sensitive school surveys and model passive parental consent, and the IDEA plainly encourages full and frank communication between teachers and parents regarding children's behavioral health. While the federal statutes address formalistic concerns with enacting a mental health scheme in Washington, case law, particularly Supreme Court precedent, tackles the normative concerns with mental health screening legislation, specifically in relation to family privacy and the fundamental right to parent.

^{104.} Individuals with Disabilities Education Improvement Act, Pub. L. No. 108-779 \S 25, 118 Stat. 2647 (2004).

^{105.} Id. § 25, 118 Stat. at 2691.

^{106.} Id.

IV. THE FUNDAMENTAL RIGHT TO PARENT

Because Washington should adopt a transparent mental health scheme for public schools that implements routine in-school screenings, it is essential that the legislature address issues surrounding privacy and parental rights. Mental health screenings concern very private and personal matters, and traditionally, children's mental health issues have been kept inside the family circle. Thus, mental health screening legislation naturally raises questions relating to privacy, constitutionality, and infringement of the fundamental right to parent.¹⁰⁷

Despite their personal and sensitive content, mental health screenings are not typically conducted in private and are generally administered by individuals who are not family members. As a result, public schools have access to personal data that is usually privy to a child's parents and family members. Do mental health screenings blur the line between privacy, the fundamental right to parent, and the best interests of the child? Constitutional debates regarding mental health screenings primarily arise out of Supreme Court holdings and other courts' subsequent interpretations.

A. The Supreme Court's Interpretation of the Fundamental Right to Parent

Because mental health screenings concern information of an intimately private nature, mental health legislation must acknowledge the nebulous line between constitutional and unconstitutional infringements on the fundamental right to parent. The broader question of constitutional concern in the area of mental health is whether individuals are entitled to have mental health problems without the government stepping in and doing something about it. However, the question addressed in this Comment is narrower: is the fundamental right to parent infringed upon by the implementation of widespread mental health screenings in public schools? To answer this question, it is first necessary to understand the constitutional foundation for the fundamental right to parent.

The Fourteenth Amendment of the U.S. Constitution dictates that no state shall "deprive any person of life, liberty, or property, without due process of law." The Supreme Court has found that, under this guarantee, certain individual rights are so fundamental that the government must justify its interference by proving that its action is necessary

^{107.} Katherine McKeon Curran, Mental Health Screening in Schools: An Analysis of Recent Legislative Developments and the Legal Implications for Parents, Children, and the State, 11 QUINNIPIAC HEALTH L.J. 87, 115–19 (2008).

^{108.} U.S. CONST. amend. XIV, § 1.

to achieve a compelling government purpose. Recognized fundamental rights include: the right to marry, the right to procreate, and the right to abortion, and the right to control the upbringing of one's children. While none of these rights are specifically enumerated in the Constitution, the Court has held that liberty should be construed to include these fundamental rights under the Fourteenth Amendment substantive due process analysis. It

The first Supreme Court cases recognizing constitutional protection for family autonomy involved the rights of parents to control the upbringing of their children. In 1923, the Supreme Court, in *Meyer v. Nebraska*, declared a state law prohibiting public schools from teaching in any language other than English unconstitutional. The Court invalidated the law under a substantive due process analysis and held that the statute violated the rights of parents to make decisions regarding their children. Justice McReynolds noted, "Corresponding to the right of control, it is the natural duty of the parent to give his children education suitable to their station in life."

Just two years later, in *Pierce v. Society of Sisters*, the Court held a state law requiring children to attend public schools unconstitutional.¹¹⁹ The Court stated, "The child is not the mere creature of the state; those who nurture him and direct his destiny have the right, coupled with the high duty, to recognize and prepare him for his additional obligations."¹²⁰ With these two cases, the Supreme Court established the fundamental liberty of parents and guardians to control the upbringing and education of their children.¹²¹

However, the Court has also recognized parents' right to make decisions and to control the upbringing of their child is not absolute and

^{109.} ERWIN CHEMERINSKY, CONSTITUTIONAL LAW: PRINCIPLES AND POLICIES 809 (3rd ed. 2006).

^{110.} Loving v. Virginia, 388 U.S. 1, 12 (1967).

^{111.} Skinner v. Oklahoma ex rel. Williamson, 316 U.S. 535, 541(1990)

^{112.} Roe v. Wade, 410 U.S. 113, 153 (1973).

^{113.} Meyer v. Nebraska, 262 U.S. 390, 400 (1923).

^{114.} See Griswold v. Connecticut, 381 U.S. 479 (1965).

^{115.} Meyer, 262 U.S. at 390; see also CHEMERINSKY, supra note 109, at 809.

^{116.} Meyer, 262 U.S. at 402-03; see also CHEMERINSKY, supra note 109, at 809.

^{117.} Meyer, 262 U.S. at 403; see also CHEMERINSKY, supra note 109, at 809.

^{118.} Mever, 262 U.S. at 400.

^{119.} Pierce v Soc'y of Sisters, 268 U.S. 510, 534 (1925); see also CHEMERINSKY, supra note 109. at 809.

^{120.} Pierce, 268 U.S. at 535; see also CHEMERINSKY, supra note 109, at 809.

^{121.} Meyer, 262 U.S. at 390; Pierce, 268 U.S. at 510; see also CHEMERINSKY, supra note 109, at 809

can be interfered with by the state if it is necessary to protect a child. ¹²² In *Prince v. Massachusetts*, the Court upheld the application of child labor laws to a nine-year-old girl who had distributed religious literature at the direction of her parents. ¹²³ While the Court acknowledged that there is a "private realm of family life which the state cannot enter," it also stated that the "family itself is not beyond regulation in the public interest" and that "[a]cting to guard the general interest in youth's well being, the state as *parens patriae* may restrict the parent's control by requiring school attendance, regulating or prohibiting the child's labor and in many other ways." ¹²⁴

Since the initial recognition of the fundamental right to parent, the Supreme Court has given great deference to parents when weighing parents' and states' competing claims on behalf of children. ¹²⁵ In *Wisconsin v. Yoder*, the Supreme Court held that Amish parents had a constitutional right, based on their fundamental rights to parent and to freely exercise their religion, to excuse their children from a compulsory school attendance law. ¹²⁶ The Court noted that under the *Meyer v Nebraska* doctrine, the compulsory school attendance law interfered with "the liberty of parents and guardians to direct the upbringing and education of children under their control." ¹²⁷

The Court has also granted substantial deference to parents in the context of children's mental health. In Parham v. J.R., the Court was presented with the issue of what type of due process must be provided to children when their parents commit them to a mental institution. The Court stated that before a child can be institutionalized by a parent, the child must be screened by either a doctor or other neutral fact-finder. Writing for the Court, Chief Justice Burger noted that while the fact "[t]hat some parents 'may at times be acting against the interest of their children'... creates a basis for caution," "[t]he statist notion that governmental power should supersede parental authority in all cases because some parents abuse and neglect children is repugnant to American tradi-

^{122.} Prince v. Massachusetts, 321 U.S. 158 (1944); see also CHEMERINSKY, supra note 109, at 809.

^{123.} Prince, 321 U.S.at 166–171; see also CHEMERINSKY, supra note 109, at 809.

^{124.} Prince, 321 U.S. at 166 (emphasis added)

^{125.} Wisconsin v. Yoder, 406 U.S. 205 (1972); see also CHEMERINSKY, supra note 109, at 810.

^{126.} Yoder, 406 U.S. at 234; see also Chemerinsky, supra note 109, at 810.

^{127.} Yoder, 406 U.S. at 232-33; see also CHEMERINSKY, supra note 109, at 810.

^{128.} Parham v J.R., 442 U.S. 584 (1979).

^{129.} Parham, 442 U.S. at 584; see also CHEMERINSKY, supra note 109, at 811.

^{130.} Parham, 442 U.S. at 618; see also CHEMERINSKY, supra note 109, at 811.

tion." Both *Parham* and *Yoder* reflect the extent of the Court's eagerness to defer to parental decision-making. 132

While the Supreme Court has consistently affirmed and recognized that parents have a fundamental liberty interest in raising and controlling the upbringing of their children, ¹³³ it has also acknowledged that in certain situations, such as protecting children from economic exploitation, a parent's interest yields to the state's interest in protecting the child. ¹³⁴ Because the Court has not established a bright-line rule for determining when a state has impermissibly intruded on the fundamental right to parent, the Court's involvement in parental rights cases has increased in the wake of recent controversies including mandatory contraception distribution programs, ¹³⁵ sex education classes in public schools, ¹³⁶ and comprehensive mental health screening programs. ¹³⁷

B. Other Courts' Interpretations of the Fundamental Right to Parent

Because the Supreme Court has not articulated a bright-line rule for ascertaining when a state has impermissibly intruded on the fundamental right to parent, this section explores the approaches that other courts have taken with respect to state public school action, such as distribution of school surveys. These cases help determine whether mental health screenings in public schools violate the constitutional right to parent.

Circuit courts strictly construe actionable violations of the familial privacy right to include only those instances where a state official's action is aimed directly at the parent-child relationship. For example, in *Gruenke v. Seip*, the Third Circuit held that a school precluding parents

^{131.} Parham, 442 U.S. at 602–03 (quoting Bartley v. Kremens, 402 F. Supp. 1039, 1047–1048 (E.D. Pa. 1975), vacated, 431 U.S. 119 (1977)); see also CHEMERINSKY, supra note 109, at 811.

^{132.} Parham, 442 U.S. at 584; Yoder, 406 U.S. at 205; see also CHEMERINSKY, supra note 109, at 810–11.

^{133.} Parham, 442 U.S. at 584; Yoder, 406 U.S. at 205; Pierce v Soc'y of Sisters, 268 U.S. 510, 510 (1925); Meyer v. Nebraska, 262 U.S. 390, 390 (1923).

^{134.} Prince v. Massachusetts, 321 U.S. 158, 158 (1944).

^{135.} See Alfonso v. Fernandez, 606 N.Y.S.2d 259, 261–62 (N.Y. App. Div. 1993) (holding that such programs infringe on the fundamental right to parent and educate their children as they see fit); but see Curtis v. School Committee, 652 N.E.2d 580, 586 (Mass. 1995) (holding that a condom distribution program did not violate the fundamental right to parent).

^{136.} See Brown v. Hot, Sexy & Safer Prods., Inc., 68 F.3d 525, 529 (1st Cir. 1995).

^{137.} See infra Part V.

^{138.} Robert Kubica, Let's Talk About Sex: School Surveys and Parents' Fundamental Right to Make Decisions Concerning the Upbringing of Their Children, 51 VILL. L. REV. 1085, 1089 (2006) (citing Pittsley v. Warish, 927 F.2d 3, 8–9 (1st Cir. 1991) (holding that police did not violate a family's right to privacy when telling children that they would never see their arrested family member and not letting the children kiss the family member goodbye); Duchesne v. Sugarman, 566 F.2d 817, 825 (2d Cir. 1977) (holding that the liberty interest in family privacy was deprived when children were not returned to their mother)).

from making vital decisions concerning their children violated the parents' constitutional right to parent. 139

When a school coach forced a student to take a pregnancy test, the girl's parents filed suit against the coach for violating their constitutional right to make decisions regarding the upbringing of their child. ¹⁴⁰ Because the situation was forced and entirely concentrated on an intensely personal issue, the Third Circuit found that this case "present[ed]... another example of the arrogation of the parental role by a school."¹⁴¹ Notably, the court stated that "[s]chool-sponsored counseling and psychological testing that pry into private family activities can overstep the boundaries of school authority and impermissibly usurp the fundamental right of parents to bring up their children, as they are guaranteed by the Constitution." Thus, the court articulated a distinction between those school actions that are directly aimed at parental decisionmaking authority and those that simply affect the making of parental decisions. 143 This distinction will be important to take into consideration when weighing whether public schools, specifically Washington public schools, should implement mental health screening programs.

Other courts have been willing to uphold school action as constitutional if information was gathered from students on a voluntary basis and for a community purpose. In C.N. v. Ridgewood Board of Education, the district court considered the constitutionality of a questionnaire administered to middle and high school students that posed highly personal questions, the results of which were to be collectively used to develop community programs. Before the questionnaire was administered, parents were notified about the nature of the survey and were given an opportunity to assess the questionnaire. Nevertheless, parents brought suit against the school, claiming that the survey was not anonymous and was involuntarily administered. The court rejected these arguments

^{139.} Gruenke v. Seip, 225 F.3d 290, 306 (3d Cir. 2000) (recognizing the distinction between actions that strike at the heart of parental decision-making authority and those that merely complicate making and implementing parental decisions).

^{140.} *Id.* at 295–297.

^{141.} Id. at 306.

^{142.} Id. at 307.

^{143.} Id. at 306.

^{144.} C.N. v. Ridgewood Bd. of Educ., 319 F. Supp. 2d 483 (D.N.J. 2004); *see also* Fields v. Palmdale Sch. Dist., 427 F.3d 1197 (9th Cir. 2005) (establishing parents' decision-making right lessens once a parent has chosen to enroll their child in public school rather than choosing private or home schooling).

^{145.} 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, 233 (2006) (citing *Ridgewood*, 319 F. Supp. at 483).

^{146.} Ridgewood, 319 F. Supp. 2d at 497.

^{147.} Id. at 496.

and suggested that the parents should have inferred from the school mailings that the nature of the questionnaire was personal and that failure to respond constituted implicit consent. And while the court agreed that it was reasonable to infer that the survey was involuntary, it held that a "voluntary, anonymous survey with notice of opt-out possibilities to parents" does not constitute an intrusion into the constitutionally-protected fundamental right to parent without governmental interference. 149

Thus, in *C.N.*, the notice and opt-out provisions were instrumental in finding the school action constitutional.¹⁵⁰ This case provides a particularly usefully analysis regarding school surveys that collect sensitive personal information, which will be utilized in Part VI to determine the type of mental health screening Washington should enact.

In *Fields v. Palmdale School District*, the Ninth Circuit also addressed the issue of controversial school surveys. ¹⁵¹ In that case, parents had given permission for their elementary school students to take part in a district survey regarding psychological barriers to learning. ¹⁵² After the survey was distributed, parents learned that several of the survey questions were related to sexual topics. ¹⁵³ Parental-rights proponents claimed that the explicit nature of the questions violated their fundamental right to introduce their children to sexual matters as they see fit—without interference from the state. ¹⁵⁴ The Ninth Circuit affirmed the district court's dismissal of the case, holding that a parent's right to control a child's education does not encompass the right to control the flow of information in public schools. ¹⁵⁵ The court stated that the survey questions were allowed because they were rationally related to the school board's legitimate interest in the effective education and mental welfare of its students. ¹⁵⁶

While parents legally remain the sole decision-makers for their children, the fundamental right to parent is neither absolute nor unqualified. Although the Third Circuit held, in *Gruenke*, that school action aimed directly at the parent-child relationship was unconstitutional, cases like *Ridgewood* and *Fields* exemplify the judicial trend of shifting parental authority over to schools. This trend is most applicable when the

^{148.} Id. at 498.

^{149.} *Id*.

^{150.} Id.

^{151.} Fields v. Palmdale Sch. Dist., 427 F.3d 1197, 1197 (9th Cir. 2005).

^{152.} Id. at 1200.

^{153.} *Id*.

^{154.} Id.

^{155.} Id. at 1206.

^{156.} *Id.* at 1210 (holding that the state's broad interest was justified under the doctrine of *parens patriae*).

school provides notice, makes participation voluntary, and has a legitimate interest, such as protecting students' mental welfare. Because the Supreme Court has not provided a bright-line rule as to when school actions infringe upon the fundamental right to parent, these factors are important to consider in light of states' diverse approaches to children's mental health legislation.

V. STATE APPROACHES TO CHILDREN'S MENTAL HEALTH LEGISLATION

As the Washington legislature considers legislation requiring mental health screenings in public schools, it is important to review similar legislation adopted by other states. Illinois has adopted a broad approach that emphasizes comprehensive children's mental health reform and widespread mental screenings. Utah has adopted a narrow approach which emphasizes privacy and limitations on parent–teacher communication. Connecticut has adopted a more moderate approach that emphasizes cooperative and transparent school mental health programs. This Part describes these three approaches in consideration of what children's mental health legislation Washington should enact.

A. Illinois: The Broad Approach

Of the three state approaches described, Illinois has the most comprehensive children's mental health legislation. Illinois implemented the Children's Mental Health Act in 2003. This statute provides comprehensive and wide-ranging goals for Illinois's Children's Mental Health Plan, including

(2) Guidelines for incorporating social and emotional development into school learning standards and educational programs . . .; (4) Recommendations regarding a State budget for children's mental health prevention, early intervention, and treatment across all State agencies . . .; (8) Recommendations for a comprehensive, multifaceted public awareness campaign to reduce the stigma of mental illness and educate families . . . about the benefits of children's . . . development . . .; [and] (9) Recommendations for creating a quality-driven children's mental health system . . . that conducts ongoing needs assessments ¹⁶⁰

In regards to the relationship between mental health and the public school system, the Illinois statute states that

^{157. 405} ILL. COMP. STAT. 49/5 (2007).

^{158.} UTAH CODE ANN. § 53A-11-605 (2007).

^{159.} CONN. GEN. STAT. § 10-76w (1993).

^{160, 405} ILL, COMP. STAT. 49/5(a) (2007).

(a) 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 . . . [and] (b) Every Illinois school district shall develop a policy for incorporating social and emotional development into the district's educational program . . . [that] shall address teaching and assessing social and emotional skills and protocols for responding to children with social, emotional, or mental health problems . . . that impact learning ability. ¹⁶¹

There are three key parts to this statute. First, it requires the state of Illinois to develop a multi-faceted, strategic system to address prevention and early intervention of children's mental illness. Second, it directs the Illinois Board of Education to incorporate social and emotional development standards into state learning standards. Finally, it addresses the assessment of children's social, emotional, and mental health problems. Read altogether, the Illinois statute suggests that Illinois school districts must develop an all-encompassing mental health program for its students; one that not only implements curriculum standards but also encourages proactive identification of students with social and emotional problems. Thus, the statute calls for the implementation of mental health screenings in all public schools.

In addition to recognizing the need for mental health screening programs, there are three other positive aspects of the statute: (1) it focuses on the best interests of the child; (2) it emphasizes destignatization; and (3) it recognizes a school's unique position in identifying children's mental health issues.

First, while the statute affords schools, and therefore the state, considerable authority, it also offers comprehensive, unreserved attention to the best interests of the child. For example, the statute "recommend[s]...[that] key State agencies and programs conduct ongoing needs assessments," and it directs the Illinois Board of Education to "develop a policy...[that] address[es]... social and emotional skills and protocols for responding to children with social, emotional, or mental health problems." These clauses ordain the state with considerable power, which may infringe upon the fundamental right to parent. The

^{161. 405} ILL. COMP. STAT. 49/15 (2003).

^{162. 405} ILL. COMP. STAT. 49/5(a)(3) (2007).

^{163. 405} ILL. COMP. STAT. 49/15(a) (2003).

^{164.} Id. 49/15(b).

^{165. 405} ILL. COMP. STAT. 49/5; 405 ILL. COMP. STAT. 49/15.

^{166. 405} ILL. COMP. STAT. 49/5; 405 ILL. COMP. STAT. 49/15.

^{167. 405} Ill. Comp. Stat. 49/5(a)(9).

^{168. 405} ILL. COMP. STAT. 49/15(b) (2003).

thrust of the statute, however, spotlights the overall healthy social and emotional development of children and underscores the public benefit of doing so. Accordingly, the statute strives to "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." It also recommends a "comprehensive, multi-faceted public awareness campaign." This enthusiastic attitude toward active prevention and detection of mental illness gets to the heart of the issue and provides a more progressive approach than other states. ¹⁷¹

Second, the Illinois statute explicitly requires a "campaign to reduce the stigma of mental illness." As mentioned *supra* in Part III.A, one of the main goals of the President's New Freedom Commission is to implement marketing campaigns that focus on destigmatization. Illinois's statutory mandate for a campaign to reduce the stigma of mental illness encourages active dialogue regarding children's mental health and is consistent with the goals of federal legislation. ¹⁷³

Third, the Illinois statute recognizes that schools are in a key position to identify mental health problems early and to provide appropriate services or links to services. The statute incorporates guidelines into school learning standards, implores school districts to "develop a policy for incorporating social and emotional development into the district's educational program," and addresses protocols for responding to children with mental health problems.¹⁷⁴ By realizing that educators stand in a unique position—both as experts in children's behavior and as individuals who spend large amounts of time with students, the statute compels teachers to play a key role in detecting mental illness.¹⁷⁵

The Illinois statute's three strong emphases—the best interests of the child, destigmatization of mental illness, and involvement of the education community in the detection of mental illness—could potentially serve as the building blocks for Washington's children's mental health legislation. There are, however, two worrisome aspects of the Illinois statute. First, the statute favors school authority and, consequently, sub-

^{169. 405} ILL. COMP. STAT. 49/5(a) (2007).

^{170.} Id. 49/5(a)(8).

^{171.} See infra Part V.B.

^{172. 405} ILL. COMP. STAT. 49/5(a)(8).

^{173.} See infra Part III.A.

^{174. 405} ILL. COMP. STAT. 49/15(b) (2003).

^{175.} See generally Jessica Fu, The Researcher's Second Laboratory: Protecting Our Children from Social Surveys in Public Schools in Light of Fields v. Palmdale School District, 80 S. CAL. L. REV. 589 (2007).

stantial state power.¹⁷⁶ And second, the statute does not address whether this legislation mandates mental health screenings for all children in the public school system, regardless of parental consent;¹⁷⁷ there are no notice, consent, or opt-out provisions in the statute.¹⁷⁸ Because the statute favors state involvement in children's mental illness and is unclear on the parental consent process, this statute might face serious constitutional challenges.

In considering whether the Illinois statute infringes on the fundamental right to parent, courts will likely examine the validity of the state's interest in guarding the general well-being of children. While protecting children's mental health is of great importance, there is no case law on point. As a result, it is unclear how the court would rule on this issue. However, in comparison to the *C.N.* case, where the court held that a school survey was constitutional because there was parental notice and an opt-out provision, the Illinois statute's ambiguousness might weigh against constitutionality. Thus, in drafting Washington's mental health legislation, care should be taken to avoid ambiguity regarding parental notice and consent provisions.

B. Utah: The Narrow Approach

Utah takes a much narrower approach than Illinois. Utah does not have a specific statute like Illinois, but in 2007, Utah enacted the Medication Recommendations for Children Act, which pertains specifically to children's mental health.¹⁸¹ The Utah statute places specific restrictions on school personnel, which is defined to include all school district employees.¹⁸² Section two of the statute states that school personnel *may*

provide information and observations to a student's parent or guardian about that student, including observations and concerns in the following areas: . . . (ii) health and wellness; (iii) social interactions; [and] (iv) behavior . . . [and] refer students to other appropriate school personnel . . . including referrals and communication with a school counselor or other mental health professionals working within the school system. ¹⁸³

^{176. 405} ILL. COMP. STAT. 49/5(a)(9).

^{177.} Id. 49/5.

^{178.} Id.

^{179.} See supra Part IV.A.

^{180.} See supra Part IV.

^{181.} Curran, supra note 107, at 111; UTAH CODE ANN. § 53A-11-605 (2007).

^{182.} UTAH CODE ANN. § 53A-11-605(1)(b).

^{183.} Id. § 53A-11-605(2) (emphasis added).

Section four, however, explicitly addresses the actions that school personnel may not take. Specifically, school personnel *may not*

(a) recommend . . . that a child take . . . a psychotropic medication; (b) require that a student take . . . a psychotropic medication as a condition for attending school; (c) recommend that a parent . . . seek or use a type of psychiatric or psychological treatment for a child; [or] (d) conduct a psychiatric or behavioral health evaluation or mental health screening, test, evaluation, or assessment of a child.¹⁸⁴

The statute then states that a *school counselor* or other mental health professional may "(a) *recommend, but not require, a psychiatric or behavioral health evaluation of a child*; (b) recommend, but not require, psychiatric, psychological, or behavioral treatment for a child; [and] (c) *conduct a psychiatric or behavioral health evaluation or mental health screening, test, evaluation, or assessment of a child*."¹⁸⁵

The Utah statutory language opposes mental health screenings. The law places severe communication restrictions on teachers and school administrators. For example, although teachers may discuss observations regarding health, social wellness, and behavior with parents, they may not recommend psychotropic medication that a parent seek psychological treatment for a child. Each teacher, however, retains the right to communicate with a school counselor or mental health professional, who may then recommend, but not require, a behavioral health evaluation or conduct a mental health screening. Thus, the most restrictive aspect of the statute is its attempt to place clear boundaries on parent—teacher communication regarding a student's mental health.

Specifically, the Utah statute places a strong emphasis on (1) family privacy, (2) the social construction of emotional health, and (3) destignatization. First, Utah's Medication Recommendations for Children Act favors generous parental rights and family autonomy. While the statute does not ban mental health screenings, it significantly curtails liberal implementation of the tool. Thus, by logical inference, the Utah statute recognizes parents' countervailing interest against the state's interest in

^{184.} Id. § 53A-11-605(4) (emphasis added).

^{185.} Id. § 53A-11-605(6) (emphasis added).

^{186.} Id. § 53A-11-605(2).

^{187.} Id. § 53A-11-605(4)(a).

^{188.} Id. § 53A-11-605(4)(c).

^{189.} Id. § 53A-11-605(6)(a).

^{190.} Id. § 53A-11-605(6)(c).

making private and personal determinations on how much information the family would like to share with a school. ¹⁹¹

Second, because the Utah statute skirts away from parent-teacher communication regarding mental health and psychotropic medications, there may be some hesitation regarding the social construction of emotional health. Unlike the stable and universally accepted standards for routine in-school vision, hearing, or physical health examinations, standards for what constitute emotional health are ever-changing and of considerable debate. 192 For example, the most dramatic example of what constitutes "good emotional health" concerns the construction of homosexuality. 193 While 30 years ago, the American Psychiatric Association included homosexuality as a category of mental illness, the Association no longer views homosexuality as a pathology. 194 Moreover, it is likely that there are contemporary notions of emotional disturbance held by the majority that, in the eyes of some parents, are well within the continuum of emotional health. 195 Because Utah's statute deemphasizes active dialogue regarding children's mental health, perhaps it has chosen to support parents' rights to subscribe to a definition of mental health that best suits their cultural and religious conceptions of emotional well-being. 196

Third, the Utah statute reflects concern with stigmatization. Because the statute places such strict limitations on parent–teacher communication and on psychological assessments of students, the state is likely concerned with the unnecessary stigmatization of children. Children are an inherently vulnerable population, and mental health is undoubtedly a highly personal topic.¹⁹⁷ The stigma attached to the possibility, or even the mere intimation, of mental illness may be reason enough for parents to prefer to deal with their child's emotional health without school involvement.¹⁹⁸ The statutory language could reflect the state legislature's belief that children's mental health is a subject better left to the family or, perhaps, to an intimate and private conversation between parents and their child's pediatrician.

Although the Utah statute emphasizes three important aspects of children's mental health, there is one grave concern with this legislative

194. *Id.* at 238 (citing AMERICAN PSYCHIATRIC ASSOCIATION, GAY, LESBIAN, AND BISEXUAL ISSUES, *available at* http://healthyminds.org/More-Info-For/GayLesbianBisexuals.aspx (last visited July 19, 2009) (acknowledging the Association's new position on homosexuality)).

^{191.} Gelman, supra note 145, at 244.

^{192.} Id. at 237.

^{193.} Id.

^{195.} Gelman, supra note 145, at 237.

^{196.} Id.

^{197.} Id.

^{198.} Id.

approach: such a narrow approach restricts the school's ability to communicate with parents about mental health concerns and therefore may not be in the best interests of the child. Because open discussions between parents and teachers regarding a child's behavior might help persuade a parent that psychological testing is needed, restriction on such dialogue may further exacerbate the condition. The restrictive Utah law has the potential to create "silent witnesses," which does not help the child, the parent, or the state. Moreover, restricted communication may serve to propagate further denial of a child's mental health problems, and concerns with stigmatization should not remain a barrier to seeking care.

It is unclear whether the restrictions that Utah places on open and frank discussions between parents and teachers conflicts with the IDEA provision, which explicitly allows teachers to raise concerns about mental health issues with parents. While the Utah Code prohibits teachers from discussing psychological treatment or psychotropic medication with parents, the federal statute expressly encourages teachers to share with parents classroom observations or the need for special education and related services. Although further discussion of this topic is beyond the scope of this Comment, the statute's mixed messages and uncertainties likely create confusion for Utah educators.

Because Washington should adopt a mental health scheme for public schools consistent with the notion of parental rights while also protecting the well-being of mentally ill children, state legislation should incorporate only certain features of the Utah statute; specifically, a definition of mental health that reflects cultural sensitivity and preservation of parental rights through notice and active consent.

C. Connecticut: The Moderate Approach

Unlike Illinois's broad approach or Utah's narrow approach, Connecticut takes a more moderate position. The Connecticut statute pertaining to children's mental health focuses on the duties of the Education Department. The duties of the Department are as follows: "(1) [to] [c] coordinate *school-based early detection and prevention programs*..., and (2) in conjunction with the Department of Children and Families and local mental health agencies, [to] provide training [and] consultation . . . to . . . boards of education in early detection, intervention techniques,

^{199.} Curran, supra note 107, at 142.

^{200.} Id.

^{201.} Id. at 143.

^{202.} Id. at 140.

^{203.} CONN. GEN. STAT. § 10-76w (1993).

screening . . . and evaluation."²⁰⁴ The statute also states that the Department "shall identify specific goals and objectives for the program prior to the solicitation of applications for participation in such program and shall define in advance what specific measures it shall employ to measure the attainment of the goals and objectives."²⁰⁵

The Connecticut statute creates a school-based early detection and prevention program under the specific pretext of cooperation with the Department of Children and Families. The statute emphasizes educator training on early detection techniques, including mental health screenings. Because the statute requires each school to identify specific goals and objectives for these programs and to define what measures it shall employ, each public school is held accountable not only for a thorough review of the purposes for the children's mental health program but also for an assessment of the best screening instruments for implementing the primary mental health program.

The Connecticut statute has four key characteristics: (1) cooperation, (2) training and utilization of educators, (3) a more transparent assessment process focused on accountability, and (4) early detection.

First, because the Connecticut statute explicitly requires that the Department of Education implement school mental health "detection and prevention programs . . . in conjunction with the Department of Children and Families [sic] and local mental health agencies," the Connecticut legislature has chosen to emphasize cooperation and utilize existing children's mental health expertise. Naturally, the Department of Children and Families and local mental health agencies are in a better position than the Department of Education to recognize the newest, most effective, and culturally appropriate assessment instruments. This cooperation between agencies lends itself to more thorough, efficient, and proper mental health assessment programs.

Second, like the Illinois statute, the Connecticut statute recognizes the concept of educators as experts, but it takes this idea one step further by providing unequivocal language requiring training, consultation, and assistance²¹² to educators to help develop and implement successful programs. Because educators stand in a key position for identifying child-

^{204.} Id. § 10-76w(a).

^{205.} Id. § 10-76w(c).

^{206.} Id. § 10-76w(a)(2).

^{207.} Id.

^{208.} Id. § 10-76w(c).

^{209.} Id. § 10-76w(a)(1)-(2).

^{210.} Adelman & Taylor, supra note 12, at 297.

^{211.} Id.

^{212.} CONN. GEN. STAT. § 10-76w(a)(2).

hood mental illness, this statutorily mandated support will likely lead to an increase in the detection of students' mental health issues.²¹³

Third, the Connecticut statute incorporates a natural accountability mechanism. The Connecticut law requires the Department of Education to identify specific goals and objectives as part of a school's application for participation in the primary mental health program. Thus, each school is held accountable not only for thoroughly contemplating the curriculum of its program but also for assessing the measures it will employ to ensure a successful program. Essentially, each school will likely strive to identify the most appropriate screening instruments to guarantee an effective program, which, in turn, will ensure its continued participation in the primary mental health program. This accountability serves to enhance the transparency of the assessment process for educators and parents alike. Lastly, the benefits of focusing on early detection, as discussed above, further support the inherent value of Connecticut's moderate approach. ²¹⁶

Fourth, the Connecticut approach favors a cooperative and transparent mental health scheme for public schools. Although the statute lacks language touching upon parental rights and a specific structure for schools' primary mental health programs, the Connecticut approach still offers a number of admirable qualities such as educator training, school accountability, and a focus on early detection. Thus, the Connecticut statute provides a strong basic framework for Washington.

Illinois, Utah, and Connecticut have enacted children's mental health statutes across the spectrum, ranging from supportive of school authority to emphasis on family privacy. The Illinois statute illustrates the importance of in-school screenings, educator training, and emotional health curriculum. Utah's approach demonstrates how legislation can be respectful of family privacy and sensitive to the meaning of mental health across cultures. Finally, the Connecticut statute illustrates the importance of a cooperative and transparent approach and emphasizes accountability and early detection. Washington should enact children's mental health legislation that reflects an integration of these three positions.

VI. RECOMMENDATION FOR WASHINGTON

In light of the positive and negative characteristics of the Illinois, Utah, and Connecticut statutes, Washington should adopt a modified ver-

^{213.} Adelman & Taylor, supra note 12, at 297.

^{214.} CONN. GEN. STAT. § 10-76w(c).

^{215.} Id.

^{216.} Id. § 10-76w(a)(2).

sion of the moderate approach. Washington should enact a cooperative and transparent mental health scheme for public schools that includes inschool screenings, informed and active parental consent, educator training, and emotional health curriculum. This Part recommends specific actions that the Washington legislature should take to enact this cooperative and transparent mental health scheme.

To capture the most benefits of the state approaches mentioned above and to adequately address the concerns, Washington should implement legislation that revolves around four themes: (1) a commitment to preserving open parent–teacher communication and dispelling stigma; (2) an informed and active parental consent process combined with annual mental health screenings; (3) a cooperative framework with emphasis on utilizing mental health experts, training educators, and integrating social and development curriculum into the school system; and (4) a dedication to the overarching goal of furthering the best interests of each and every child.

First, as opposed to the restrictions placed on teacher–parent communication in the Utah statute, Washington should embrace an open door policy that encourages communication between all involved parties. Simply put, perpetuating the secrecy and stigma associated with mental illness does not aid in the diagnosis or treatment of children with mental health issues. Both the IDEA²¹⁷ and the New Freedom Commission²¹⁸ support destigmatizing mental illness in the United States. While teachers should respect family privacy, especially considering the sensitive nature of mental health, they should also feel free to work together with parents to help address the issues at hand and to improve students' emotional health. Open communication between students, parents, teachers, administrators, and mental health professionals is essential to ameliorating the U.S.'s children's mental health crisis.

Second, the Washington legislature should incorporate an informed and active parental consent process and implement annual mental health screenings. Perhaps the greatest concern with the public school system administering mental health screenings is the infringement on the fundamental right to parent. As discussed earlier, the Supreme Court has not provided a bright-line rule as to when constitutional school action ends and infringement on the fundamental right to parent begins.²¹⁹

^{217.} See supra Part III.C. Because teachers were concerned about potential barriers to communication with parents regarding a child's behavior or mental health, lawmakers included a provision explicitly allowing teachers to share classroom-based observations with parents regarding a student's behavior in the classroom.

^{218.} See supra Part III.A.

^{219.} See supra Part IV.A.

However, as evidenced by district and circuit court decisions, the most important factors to consider in deciding whether the screening is constitutional are the nature of the administration of the survey, the notice, consent, or opt-out procedures, and the effect of the survey on the parent—child relationship. Because mental health screenings are important, resourceful, and evidence-based early detection tools, Washington must find a way to balance these interests. Washington should encourage public schools to provide voluntary annual mental health screenings to children, predicated on obtaining explicit, informed, and active consent. Although informed and active consent is more cumbersome than an opt-out procedure, this safety measure ensures that mental health screenings distributed by schools will not infringe on the fundamental right to parent.

Third, Washington should implement legislation that adopts a cooperative framework that utilizes mental health expertise, trains educators, and integrates social and development standards into school curricula. Crafted after the Connecticut statute, which stressed educator training, school accountability, and cooperation, ²²¹ such an approach would boost the comprehensiveness of detection, teacher knowledge, and school accountability. Moreover, by employing local mental health experts to develop and implement the screenings and mental health programs, those concerned with the validity of the instruments or lack of cultural sensitivity may be put more at ease.

Finally, the intent of the Washington statute should stress the state's dedication to furthering the best interests of the child. The Illinois statute, in particular, did an excellent job conveying this concept by underscoring the benefits of ensuring the healthy social and emotional development of children.²²² In deciding the most beneficial children's mental health scheme for Washington, the balance between protecting parental rights and granting schools the authority to help detect mental illness must always be viewed in light of the best interests of the child.

In sum, Washington should adopt a cooperative and transparent mental health scheme for public schools that includes in-school screening, informed and active parental consent, educator training, and emotional health curriculum. Such legislation should focus on preserving parent—teacher communication, fostering an explicit parental consent process, involving the mental health community, and spotlighting the best interests of the child. This approach is consonant with the notion of

^{220.} See supra Part IV.B.

^{221.} See supra Part V.C.

^{222.} See supra Part V.A.

parental rights, while protecting the well-being of Washington's mentally ill children.

VII. CONCLUSION

Because it is estimated that ten percent of children in the United States suffer from some form of mental illness²²³ and because this nation has experienced tragedies such as Columbine, Virginia Tech, and Northern Illinois University (which were later attributed to undetected mental illness), ²²⁴ children's mental health is an issue of great importance.

Although federal legislation does not specifically require public schools to administer mental health screening instruments, it advocates for early detection, parental consent, and open communication. Moreover, while Supreme Court jurisprudence does not consider the fundamental right to parent an absolute or qualified right, subsequent lower court decisions provide some clarity by reciting factors that might affect the constitutionality of mental health screenings.²²⁵

States have taken drastically different approaches to children's mental health legislation. Whereas Illinois embraces a broad focus on comprehensive children's mental health law reform, Utah applies a narrower approach that limits parent—teacher communication regarding students' mental health. Connecticut, on the other hand, adopts more moderate legislation tailored toward cooperative and transparent mental health programs in public schools.

Taking into consideration the various elements of these state statutes, the Washington legislature should enact children's mental health legislation that encourages open parent—teacher communication, requires explicit notice and active parental consent for in-school mental health screenings, fosters cooperation with the mental health community, and focuses on the best interests of the child. Hopefully, Washington will choose to participate in the national dialogue on children's mental health and will aspire to enact thoughtful and comprehensive mental health legislation specifically aimed at utilizing its public education system.

224. See supra Part I.

^{223.} See supra Part II.

^{225.} See supra Part IV.