

ACCOMMODATING ONE ANOTHER: LAW AND THE SOCIAL MODEL OF MENTAL HEALTH

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“Has it ever occurred to you that maybe you’re not too big? That maybe this place is just too small?”

– Big Fish, Daniel Wallace (novel), John August (screenplay).

I. INTRODUCTION

With the recent health care reforms and the increasing political salience of mental health needs, we will likely see increased efforts to address mental health needs in the coming years. Despite these efforts, many mental health needs will go unmet. This is true in part because some amount of mental health needs may be endemic to the human experience and cannot be entirely met given current research, but it is true also in part because the current approach is not well tailored to the nature of mental health needs as we now understand them. The current approach to policy reflects one particular understanding of mental health and its relationship to law and society – the medical model. Such an approach is not inevitable, and current law does not confine us to it. Here, I will elaborate on another potential model for understanding mental health – the social model – and illustrate how efforts to address mental health needs would differ if we pursued this other approach.

In Part II, I provide a brief overview of what mental health needs are and their prevalence in the United States. In Part III, I examine the two major Congressional initiatives that promote the treatment of mental health needs in children and how both represent a medical model approach to mental health, which may not be as desirable as a social model approach. Note that I focus on children in particular throughout the article for two reasons. First, there is the greatest possibility for ensuring healthy mental development and preventing and mitigating potential future needs when we act early. Second, children are placed into the most structured environments, so interventions during this time period may enjoy the most effective implementation. In Part IV, I explain how we could pursue a social model approach by applying existing law differently. Part

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V gives an example of how to pursue a social model approach to mental health. In Part VI, I conclude briefly with an overview of the social model approach to mental health.

II. THE NATURE AND EXTENT OF MENTAL HEALTH NEEDS

Mental health needs can be understood broadly in one of two ways: first, as a prolonged pattern of thinking or acting that we would rather not experience, and second, as a prolonged pattern of thinking or acting that we would presumably rather not experience due to the nature of the symptoms and the degree of social exclusion that follows from thinking or acting in these ways.¹ Mental health needs should be distinguished from thinking and acting in an undesirable manner solely because we have a job we dislike or are in an unpleasant relationship – although such experiences may add to the development of a mental health need, the needs themselves are best conceived as more sustained than a temporary response to stimuli.² A subset of these mental health needs may be considered “mental disorders” under the American Psychiatric Association’s *Diagnostic and Statistical Manual (DSM)*, which creates a taxonomy of what the Association has deemed to be clinically significant psychiatric patient presentations.³

Among the needs we can address, mental health needs should trouble us in particular because they affect everyone and they undermine what is most important to us in life. Everyone will be affected by mental health needs in their lifetime, whether they experience such needs personally or through their interactions with others. Although most mental health needs will not be so severe as to be clinically-significant, “[a]bout half of Americans will meet the criteria for a *DSM-IV* disorder sometime in their life, with first onset usually in childhood or adolescence.”⁴ At any given time, approximately one-fifth⁵ to one-

1. Some may take exception with this rather expansive definition as it seems to swallow up quite a lot of what we think of as part of just being alive and make it into a social problem. Where there is room to make people better off though, a social problem exists.

2. AM. PSYCHIATRIC ASS’N, *DIAGNOSTIC AND STATISTICAL MANUAL* 222 (5th ed. 2013) [hereinafter *DSM-V*] (noting that with generalized anxiety disorder, “[t]he essential feature . . . is excessive anxiety and worry (apprehensive expectation) about a number of events or activities. The intensity, duration, or frequency of the anxiety and worry is out of proportion to the actual likelihood or impact of the anticipated event”); see also Allen J. Frances & Thomas Widiger, *Psychiatric Diagnosis: Lessons from the DSM-IV Past and Cautions for the DSM-5 Future*, 8 ANN. REV. CLINICAL PSYCHOL. 109, 112 (2012) (describing the future work to explain the neurobiological causes of mental illness and stating, “[t]here will likely be not one but rather hundreds of different pathways producing each illness”).

3. See *DSM-V*, *supra* note 2, at 20 (defining mental disorder as “a syndrome characterized by clinically significant disturbance in an individual’s cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning”).

4. Ronald C. Kessler et al., *Lifetime Prevalence and Age-of-Onset Distributions of DSM-IV Disorders in the National Comorbidity Survey Replication*, 62 ARCHIVES GEN. PSYCHIATRY 593, 593 (2005).

5. SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., RESULTS FROM THE 2011

fourth⁶ of adults has a diagnosable mental disorder. Of these adults, over 60% will not receive any services,⁷ and a much greater proportion will not receive adequate or effective services.

Mental health needs heavily impact children and adolescents as well. For children 8 to 15 years old, an estimated one in eight met the criteria for a *DSM-IV* mental disorder in the past year,⁸ which coheres with estimates that the median age of onset for a first mental disorder is age 14.⁹ For children 13 to 18 years old with a diagnosable mental disorder, again over 60% will go completely untreated,¹⁰ and a larger proportion will not receive adequate or effective care.

When mental health needs go untreated, it makes the individual, those around her, and society as a whole worse off. For the individual, mental health needs may lead to lower lifetime earnings,¹¹ lower educational attainment,¹² increased likelihood of arrest,¹³ decreased physical health,¹⁴ decreased life satisfaction,¹⁵ and decreased life expectancy.¹⁶ For those around her, mental health needs may affect the formation and maintenance of interpersonal connections, potentially causing existing relationships to deteriorate and opportunities to form new relationships to be missed.¹⁷ For society as a whole, mental health needs create staggering economic costs in lost productivity, healthcare expenses, and social service spending.¹⁸

NATIONAL SURVEY ON DRUG USE AND HEALTH: MENTAL HEALTH FINDINGS 1 (2012).

6. Ronald C. Kessler et al., *Prevalence, Severity, and Comorbidity of 12-Month DSM-IV Disorders in the National Comorbidity Survey Replication*, 62 ARCHIVE GEN. PSYCHIATRY 617, 619 (2005).

7. SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., *supra* note 5.

8. Kathleen Ries Merikangas, et al., *Prevalence and Treatment of Mental Disorders Among US Children in the 2001–2004 NHANES*, 125 PEDIATRICS 75, 77 (2010).

9. Kessler et al., *Lifetime Prevalence and Age-of-Onset Distributions*, *supra* note 4, at 593.

10. Kathleen Ries Merikangas et al., *Service Utilization for Lifetime Mental Disorders in U.S. Adolescents: Results of the National Comorbidity Survey–Adolescent Supplement (NCS-A)*, 50 J. AM. ACAD. CHILD & ADOLESCENT PSYCHIATRY 32, 35 (2011).

11. See e.g., Ronald C. Kessler et al., *The Individual-Level and Societal-Level Effects of Mental Disorders on Earnings in the United States: Results from the National Comorbidity Survey Replication*, 165 AM. J. PSYCHIATRY 701, 707 (2008) (finding a 42% reduction in earnings for adults with serious mental illness).

12. See e.g., Joshua Breslau et al., *Mental Disorders and Subsequent Educational Attainment in a US National Sample*, 42 J. PSYCHIATRIC RES. 708, 712 (2008).

13. See e.g., Paul Hirschfield et al., *Mental Health and Juvenile Arrests: Criminality, Criminalization, or Compassion?*, 44 CRIMINOLOGY 593, 616 (2006).

14. See generally Martin Prince et al., *No Health Without Mental Health*, 370 THE LANCET 859 (2007).

15. See e.g., Corey L. M. Keyes, *Mental Illness and/or Mental Health? Investigating Axioms of the Complete State Model of Health*, 73 J. CONSULTING & CLINICAL PSYCHOL. 539, 540 (2005) (“Third, select measures of subjective well-being and common mental illnesses form distinct, correlated factors.”).

16. Prince, *supra* note 14, at 860.

17. See e.g., Keyes, *supra* note 15, at 546; see also Anne-Marie Baronet, *Factors Associated with Caregiver Burden in Mental Illness: A Critical Review of the Research Literature*, 19 CLINICAL PSYCHOL. REV. 819, 819–20 (1999).

18. See e.g., Thomas R. Insel, *Assessing the Economic Costs of Serious Mental Illness*, 165

When the effects of unaddressed mental health needs are given in a laundry list, it is easy to miss their significance. However, when each individual struggles on their own with mental health needs over their lifetime, everyone will be worse off. What this means will vary from person to person, but the impact will be profound over the course of a lifetime. Meaningful friendships will be lost or never be, lifelong partnerships will be challenged or fall apart, and great work that could have benefited everyone will not get done.

On the other hand, if we foster positive mental health, we can build stronger communities. Individuals will be ready to form relationships and engage in new projects, and everyone will have more opportunities to pursue the lives they want. Although mental health competes with other pressing needs facing our society, with so much at stake we should ask what more we can do.

III. COMPETING MODELS FOR MENTAL HEALTH CARE REFORM

A. *Our Current Approach and an Alternative*

Currently, many school-age children receive services for mental health needs through the operation of two federal laws: Medicaid and the Individuals with Disabilities Education Act (IDEA). Medicaid provides access to mental health services for children in low-income families,¹⁹ and the IDEA provides for educational supports for children with mental health needs.

The Medicaid statute provides federal assistance for states to administer a public health plan for eligible low-income individuals, including children.²⁰ State plans must be approved and must meet a number of requirements, including granting eligibility for certain populations and providing certain medical services.²¹ Among the services required, the “early and periodic screening, diagnostic, and treatment services” (EPSDT) provide notable protections for children with mental health needs, and will be the focus here.²² The EPSDT provision requires states to provide comprehensive mental health assessments to children during check-ups, and if a need is identified, then provide all necessary follow-up care to ameliorate the need, whether or not the follow-up services are otherwise provided by the state plan.²³ If fully implemented, the EPSDT requirement would ensure that all eligible children would, barring parental dissent, receive the mental health care they need.²⁴ Note

AM. J. PSYCHIATRY 663, 664 (2008) (estimating an annual cost of \$317 billion dollars annually in the United States).

19. Note that the Mental Health and Addiction Parity Act of 2008 was designed to make similar services available to privately-insured individuals. *See* 26 U.S.C. § 9812 (2012); 29 U.S.C. § 1185a (2012); 42 U.S.C. § 300gg-26 (2012).

20. 42 U.S.C. § 1396a (2012).

21. *Id.*

22. 42 U.S.C. § 1396d(r) (2012).

23. *Id.*

24. *Rosie D. v. Romney*, 410 F. Supp.2d 18, 22 (D. Mass. 2006) (“On December 19, 1989, Congress restated and deepened its commitment to eligible children by amending the Medicaid statute to promise that persons under twenty-one years of age would receive *all* reasonably

that more recently the Essential Health Benefits²⁵ and the behavioral health parity requirements²⁶ have expanded some of these protections to private insurance as well.

Meanwhile, the IDEA grants states federal funding on the condition that the state adopt a plan to provide free appropriate public education to all students with disabilities.²⁷ Like Medicaid, the IDEA requires school systems to assess children for mental health needs and then provide follow-up services to support their education.²⁸ In particular, the IDEA requires schools to assess children for “serious emotional disturbance,”²⁹ which is further defined in federal regulations as:

“[A] condition exhibiting one or more of the following characteristics over a long period of time and to a marked degree that adversely affects a child’s educational performance:

- (A) An inability to learn that cannot be explained by intellectual, sensory, or health factors.
- (B) An inability to build or maintain satisfactory interpersonal relationships with peers and teachers.
- (C) Inappropriate types of behavior or feelings under normal circumstances.
- (D) A general pervasive mood of unhappiness or depression.
- (E) A tendency to develop physical symptoms or fears associated with personal or school problems.”³⁰

When a child is identified as having a serious emotional disturbance or other disability, the school must create an Individualized Education Programs (IEP).³¹ IEPs are established in cooperation with parents, children, specialists, agency representatives, and school personnel³² to create a plan to support academic achievement. This plan is funded by the school, and includes “a statement of the special education and related services and supplementary aids and services, based on peer-reviewed research to the extent practicable, to be provided to the child, or on behalf of the child, and a statement of the program modifications or supports for school personnel that will be provided for the child.”³³

In practice, this means that teachers, parents, and administrators look for signs of mental health needs in students’ behavior and academic performance.³⁴ Once a potential need is identified, the educational agency has the child

necessary medical care regardless of ability to pay.”).

25. See 45 C.F.R. § 156.110 (2014).

26. See, e.g., 45 C.F.R. § 146.136 (2014).

27. 20 U.S.C. § 1412(a)(1)(A) (2012).

28. 20 U.S.C. § 1414 *et seq.* (2012).

29. 20 U.S.C. § 1401(3)(A)(i) (2012) (defining “child with disability” for the purposes of 20 U.S.C. § 1414 (2012)).

30. 34 C.F.R. § 300.8(c)(4)(i) (2014).

31. 20 U.S.C. § 1414(d) (2012).

32. 34 C.F.R. § 300.321(a) (2014).

33. 34 C.F.R. § 300.320(a)(4) (2014).

34. See *Schaffer v. Weast*, 546 U.S. 49, 53 (2005).

evaluated to determine whether she has a disability.³⁵ If the child is deemed to have a disability, then the parents, teachers, administrators, and specialists form an IEP team to determine the content of the child's IEP – i.e. what specific special educational services the child will receive.³⁶ The IEP team then periodically evaluates the success of the IEP with respect to academic performance and behavior, altering the program as necessary.³⁷

Together, Medicaid and the IDEA represent incredible progress in identifying and treating children with mental health needs. Medicaid and the IDEA also employ similar strategies for addressing mental health needs and represent a particular approach to this issue. Implicit in the approach is both that the difference of disability is inherently limiting and that it is endogenous to the individual – there is something wrong with *them* and they alone need treatment. This is sometimes referred to in literature as the medical model of disability.³⁸

This can be compared with a model of disability where the limitation of difference is seen as an artifact of our particular societal arrangements. With this model, we understand that the larger society was designed without consideration of all of the needs of the individuals that could arise within it, and this can cause a difference to become a limitation.³⁹ Although attention may be paid to the individual to alleviate suffering associated with the disability, the programs themselves are thought to be defective, not the individual, to the extent that they unnecessarily exclude the individual. For example, if our society did not rely on audible signals to communicate, then being deaf would not lead to exclusion absent accommodation. This understanding is sometimes referred to in literature as the social model of disability.⁴⁰

The social model of disability arose out of the British disability movement in the 1970s. The Union of the Physically Impaired Against Segregation (UPIAS) published *The Fundamental Principles of Disability*, which stated, “[i]n our view it is society which disables physically impaired people. Disability is something imposed on top of our impairments by the way we are unnecessarily isolated and excluded from full participation in society.”⁴¹

35. *Id.*

36. *Id.*

37. *Id.*

38. See Mary Crossley, *The Disability Kaleidoscope*, 74 NOTRE DAME L. REV. 621, 649 (1999) (“The defining characteristic of the medical model is its view of disability as a personal trait of the person in whom it inheres. The individual is the locus of the disability and, thus, the individual is properly understood as needing aid and assistance in remediating that disability.”).

39. Note that I do not present the idea that disability is caused purely by social factors, only that the structuring of institutions unnecessarily creates impairment out of disability with respect to participation. “A compelling criticism of the social model is that persons with disabilities do experience real limitations, and often suffering, in the daily experience of living in their bodies and that these limitations and sufferings exist independently of any disabling social environment.” *Id.* at 658.

40. *Id.*

41. Mike Oliver, *The Social Model in Action: If I Had a Hammer*, in IMPLEMENTING THE SOCIAL MODEL OF DISABILITY: THEORY AND RESEARCH 18, 19 (Colin Barnes & Geof Mercer eds., 2004).

Throughout the 1980s and 1990s, this idea became known as the social model of disability as it received academic attention, eventually becoming a dominant frame of disability studies.⁴² Since that time it has been debated and criticized within the disability movement as to whether it accurately represents individual experience, but the social model continues to be a powerful perspective that can inform projects of social change.⁴³ Advances in science and medicine also increasingly support a social model approach – increasingly, we find that our social ecology affects all aspects of our health, and that poor health at a population level can be most effectively remedied through social changes.⁴⁴ In the United States, our increase in chronic disease rates may be attributable to recent changes in social life, and social changes may improve health outcomes.⁴⁵

Note that the social model need not be specific to the disability and health context. The pronounced exclusions of individuals with physical disabilities, and the existence of remedies for this through medical intervention and physical alteration of the environment, made the path for achieving equality clearer in the disability context, but the path is open in other contexts as well.

B. Weighing the Competing Models

Given the existence of these two competing models, is there a reason to favor one over the other in treating mental health needs? The current Congressional approach will stand in synecdoche for the entire medical model in this section's discussion.⁴⁶ The examination will span six sets of considerations divided into two categories: issues of efficacy, i.e. how effectively does the model treat mental health needs, and issues of self-perception, i.e. what are the collateral effects of the model on individual experience.

1. Issues of Efficacy

This section will look at three points of comparison between the two models that bear on their efficacy in treating mental health issues.

First, we should worry about the extent to which each model will be able to treat all affected individuals with clinically significant mental health needs. Regardless of the skill of the specialist and the vigilance of the parents, teachers, and primary care physicians, some children who meet the criteria for a mental

42. Tom Shakespeare, *The Social Model of Disability*, in *THE DISABILITY STUDIES READER* 197, 199 (Lennard Davis ed., 2d ed. 2013).

43. See Crossley, *supra* note 38, at 658.

44. Michael Marmot, *Social Determinants of Health Inequalities*, 365 *THE LANCET* 1099, 1099 (2005) ("If health of a population suffers it is an indicator that the set of social arrangements needs to change.").

45. Neal Halfon & Paul W. Newacheck, *Evolving Notions of Childhood Chronic Illness*, 303 *JAMA* 665, 666 (2010) ("The epidemiologic shift, signified by the increasing number of children with obesity, ADHD, asthma, and other less severe chronic conditions, seems to be associated with a shift in the social ecology of childhood.").

46. We might be able to imagine a medical model approach that suffers from none of the problems discussed here, but, due to the limits of medical technology, our imagination, or the political process, this is not presently available to us, so we will work with what we have.

disorder will go undiagnosed under the medical model. There exist many excellent, clinically-validated screening tools that children could fill out in a couple minutes that would certainly identify needs effectively, but even these tools tend to be disorder-specific and will not be able to find every single child with clinically significant symptoms, especially if a child or her family does not wish to be found.⁴⁷

Because the social model alters the structure of institutions instead of directly applying treatment to an individual, individuals do not need to be diagnosed in order to be treated. The concern with the social model is whether the needs of the individuals can be met by altering existing arrangements. If the need is something that can be met entirely through modification, then all individuals with the need will benefit and no individual with the need will be missed. One obvious issue is that not all needs can be met this manner. If an individual experiences real distress that cannot be mitigated through modification, they will need individualized care. Also, it may be the case that the only effective modification may deprive others of substantial benefits, which might not be fair if there is an equally appropriate medical model treatment available.

Second, the two models also respond differently to sub-clinical presentations. As explained *supra*, mental health symptom presentations are on a spectrum.⁴⁸ For example, an individual may be diagnosed with major depressive disorder if they present five of nine enumerated symptoms over a two-week period. But, a similar individual may experience too few symptoms or experience symptoms over too short of a period to be clinically significant, yet the individual will still not be well and may benefit from treatment.⁴⁹

The medical model would not provide for treatment in sub-clinical instances, unless perhaps there was an increase in resources devoted to mental health care such that it became reasonable to expand the definition of clinically significant. With the clinical/subclinical dichotomy, clinically significant presentations gain the status of medical problems, while subclinical presentations become part of daily life and are left to private support systems for their management. The social model, in rearranging institutions instead of treating individuals, makes no such distinction and, to the extent that the modifications made are appropriate, addresses all needs equally.

47. See e.g., Marc Navon et al., *Use of the Pediatric Symptom Checklist in Strategies to Improve Preventive Mental health Care*, 52 PEDIATRIC SERVICES 800, 803 (2001); and Anna Goodman & Robert Goodman, *Population Mean Scores Predict Child Mental Disorder Rates: Validating SDQ Prevalence Estimators in Britain*, 52 J. CHILD PSYCHOL. & PSYCHIATRY. 100, 105 (2010).

48. It is worth noting that quite a lot of physical ailments are on a spectrum and physician consensus creates a threshold, at which point they become medical issues. See, e.g., Ichiro Kawachi & Peter Conrad, *Medicalization and the Pharmacological Treatment of Blood Pressure*, in *CONTESTED GROUND: PUBLIC PURPOSE AND PRIVATE INTEREST IN THE REGULATION OF PRESCRIPTION DRUGS* 26, 26–27 (Peter Davis ed., 1996) (discussing the medicalization of blood pressure).

49. *DSM-V*, *supra* note 2, at 160–61.

Third, assuming the two approaches were equally effective, which I do not assert here, then the cost of each would differ substantially. Although individualized mental health treatment has the potential to offset the costs of the treatment in lower healthcare spending overall and in increased productivity,⁵⁰ there is still enormous cost in treating all individuals with mental disorders individually. A social model approach may require additional staff or the retraining of existing staff, but there would not be a need for hours of specialist time devoted to each individual, which could prove immensely cost saving.

2. Issues of Self-Perception

This section will address three issues of self-perception that accompany the diagnosis of mental disorders. A defining feature of the medical model as it stands now is that there must be a diagnosis for treatment to follow.⁵¹ Diagnosis makes the individual aware that they have some clinically significant condition, a difference, and the impact of such awareness will be explored here.

First, the diagnosis of a mental disorder may cause the individual to feel devalued by others.⁵² Some individuals diagnosed with a mental disorder believe that others are less likely to want to befriend them or choose them for a job because they have a mental disorder.⁵³ Although the success of treatment may alleviate this psychic harm, especially if the individual's symptoms resolve and she is no longer diagnosed as having a mental disorder, it may otherwise lead to lower life satisfaction.⁵⁴ Individuals would be better off if they could enjoy the benefits of treatment without the negative effects of labeling, making the social model a better alternative if there is a possibility of delivering this level of benefit.

Second, whether or not there is associated stigma, the diagnosis of a mental disorder creates a basis of difference – the individual has been distinguished from the rest of the population.⁵⁵ Diagnosis may deeply alter an individual's identity and sense of self in relation to her larger society. The difference may not be negative – the individual may derive strength from the sense of uniqueness or potential new group membership⁵⁶ – but we should always pause

50. See e.g., Julie M. Donohue & Harold Alan Pincus, *Reducing the Societal Burden of Depression*, 25 PHARMACOECONOMICS 7, 17–19 (2007).

51. Derick T. Wade & Peter W. Halligan, *Do Biomedical Models of Illness Make for Good Healthcare Systems?*, 329 BRITISH MED. J. 1398, 1398–99 (2004).

52. Whether or not the stigma is “real” – i.e. do others actually treat her differently because of the diagnosis – is a different question. At issue here is whether individual either believes that this is the case, or would be the case if others found out.

53. Sarah Rosenfield, *Labeling Mental Illness: The Effects of Received Services and Perceived Stigma on Life Satisfaction*, 62 AM. SOC. REV. 660, 665 (1997).

54. *Id.* at 665–66.

55. See Patrick Corrigan, *How Stigma Interferes With Mental Health Care*, 59 AM. PSYCHOLOGIST 614, 614 (2004).

56. See e.g., Marjorie F. Olney & Karin F. Brockelman, *Out of the Disability Closet: Strategic Use of Perception Management by Select University Students with Disabilities*, 18 DISABILITY & SOC'Y 35, 47 (2003) (“Although most participants in our study did not identify with the disability rights movement, they adamantly declared a desire to remain as they were rather than be rid of the disability.”).

and reflect before creating difference. Even if the experience of difference as a result of diagnosis were always positive, this does not necessarily militate for diagnosis under the *DSM* framework. It may well militate for an infinitely expanded notion of difference capable of inspiring diverse differences in each person, so that all may enjoy the psychic benefit of uniqueness, but this is a separate consideration from mental health concerns. Without a principled reason for creating difference, we should be cautious in creating one, especially if the effect on the individual may not always be positive.

Third, after diagnosis, the individual may shape her identity around the expectations of an individual with that disorder. Ian Hacking explains this best in his theory on interactive kinds:

'Interactive' is a new concept that applies not to people but classifications . . . that can influence what is classified . . . We are especially concerned with classifications that, when known by people or those around them, and put to work in institutions, change the ways in which individuals experience themselves—and may even lead people to evolve their feelings and behavior in part because they are so classified.⁵⁷

When an individual is made aware of her *DSM-V* classification and what is expected of an individual with that diagnosis, she may alter her expectations of herself to match the expectations of an individual with the disorder. By avoiding diagnosis through the social model, no individual has an externally validated reason to link her expectations of herself to any particular mental disorder, avoiding unnecessary alterations of her self-perception and ensuring her greater freedom in defining herself.

As presented above, social model approaches could potentially confer great advantages over medical model approaches in effectively treating mental health needs in a community and in promoting autonomy over personal identity. So if we wanted to pursue the social model, what would we need to do?

3. Pursuing the Social Model

Real change will occur when individuals change their programs, practices, and policies to incorporate aspects of the social model and educate others about it. These personal and programmatic changes are essential in making the social model a reality, but require many different individuals to change their understandings and behaviors. Systemic change is of course incredibly challenging to motivate, and ambitious legal and institutional reforms are beyond the scope of this paper. Mass media campaigns and related interventions can be effective, but are also expensive and difficult to organize.

Sometimes existing law can be applied differently, both in the way that lawsuits are brought and in the way that the requirements of the law are discussed. This may be the best approach for lawyers in promoting social model

57. IAN HACKING, *THE SOCIAL CONSTRUCTION OF WHAT?*, 103-04 (1999); see also Jonathan Y. Tsou, *Hacking on the Looping Effects of Psychiatric Classifications: What Is an Interactive and Indifferent Kind?*, 21 INT'L STUD. PHIL. SCI. 329 (2007) (analyzing Hacking's claims in light of recent research on etiology of mental disorders).

innovation. Applying law differently does not require coordinated funding or political will, but still has the potential to have a broader impact. To better understand what applying existing law differently might look like, we will look at the laws that current govern the relationship between disability and our society.

IV. LAW AND THE SOCIAL MODEL

The current law governing disability can be applied differently to pursue the social model. Although our current legal regime is not ideally or specifically suited to social model approaches, it does allow for them and may even be able to support some larger transformation. We will look first to Medicaid and the IDEA, and then to the Americans with Disabilities Act (the ADA), and finally to what our understandings of the law could mean for promoting social model projects.

A. *Medicaid and the IDEA*

As explained *supra*, the Medicaid statute allows federal matching funds for medical assistance for eligible individuals under approved state plans.⁵⁸ It may be possible for some amount of social model-oriented interventions to be funded by traditional Medicaid without a waiver by using traditional Medicaid billing codes differently.

For example, the “early and periodic screening, diagnostic, and treatment services” (EPSDT) discussed *supra* includes regular “assessment of both physical and mental health development” for children and “necessary health care, diagnostic services, treatment, and other measures described in subsection (a) of this section to correct or ameliorate defects and physical and mental illnesses and conditions discovered by the screening services, whether or not such services are covered under the state plan.”⁵⁹ The subsection (a) referenced is sweeping and includes, for example, “services furnished by a certified pediatric nurse practitioner or certified family nurse practitioner,”⁶⁰ and “health education (including anticipatory guidance).”⁶¹ Depending on the state plan and the interpretation of the Medicaid statute, the nurse practitioner or health educator could ostensibly train the child’s teacher on how to integrate a classroom-wide intervention into their daily lessons, and this could be covered under Medicaid. The training would treat the child and benefit the other students as well, and potentially provide a similar amount of therapeutic value as a similar duration of therapy. As a public benefit, it would make sense for Medicaid to cover services that are equally as effective and cost a similar amount but benefit more individuals.⁶² All of this, of course, assumes that the Medicaid state plan

58. 42 U.S.C. § 1396a (2012).

59. 42 U.S.C. § 1396d(r)(5) (2012).

60. 42 U.S.C. § 1396d(a)(29) (2012).

61. 42 U.S.C. § 1396d(r)(1)(B)(v) (2012).

62. This is especially true in light of the change in the Free Care rule, where Medicaid will

does not have exclusions for services rendered outside of a clinical setting, to a group, or to an individual other than the beneficiary.⁶³

The IDEA and its related regulations require state and local school systems to provide individualized education programs (IEP) to eligible children, as explained *supra*. An IEP must provide for:

[S]pecial education and related services and supplementary aids and services, based on peer-reviewed research to the extent practicable, to be provided to the child, or on behalf of the child, and a statement of the program modifications or supports for school personnel that will be provided to enable the child . . . [t]o be educated and participate with other children with disabilities and nondisabled children in the activities described in this section.⁶⁴

As with Medicaid, some social model interventions could likely be provided as part of an IEP. The IDEA does not require that the IEP be a service from a provider to an individual student. Rather, the IDEA provides for “program modifications or supports,” which could allow for social model interventions that benefit the entire class.

Neither Medicaid nor the IDEA are ideal because they must be tied to an eligible individual. For either to operate, a child must qualify under law before a classroom can be modified. They are not well suited for system-wide reform, but do allow for some innovation, which could catalyze larger transformation.

B. The ADA

The Americans with Disabilities Act (ADA), passed in 1990⁶⁵ and amended most recently in 2008,⁶⁶ provides a legal framework for disability rights in the United States.⁶⁷ As such, the ADA governs not only what is possible through the legal system, but also represents and reinforces the public’s understanding of the relationship between disability and society. As relevant to our discussion, the ADA states that:

“Subject to the provisions of this subchapter, no qualified individual with a disability shall, by reason of such disability, be excluded from participation in or be denied the benefits of the services, programs, or

now reimburse for services provided to an eligible individual for free, even when it is being provided to non-Medicaid eligible individuals as well for free. *See* Letter from Cindy Mann, Director, Ctrs. for Medicare & Medicaid Servs., Medicaid Payment for Services Provided without Charge (Free Care), to State Medicaid Director (Dec. 15, 2014), *available at* <http://www.medicaid.gov/federal-policy-guidance/downloads/smd-medicaid-payment-for-services-provided-without-charge-free-care.pdf>.

63. Note though that this landscape is changing as the Mental Health Parity and Addiction Equity Act is applied to managed care plans under Medicaid. *See* 42 U.S.C. § 300gg–26 (2012).

64. 34 C.F.R. § 300.320(a)(4) (2014).

65. Americans with Disabilities Act of 1990, Pub. L. No. 101–336 (1990).

66. ADA Amendments Act of 2008, Pub. L. No. 110–325 (2008).

67. 42 U.S.C.A. § 12101(b)(1) (2009) (explaining that the ADA “provide[s] a clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities”).

activities of a public entity, or be subjected to discrimination by any such entity.”⁶⁸

Until recently, the ADA may not have been well suited to a social model approach. In 2008, amendments to the ADA greatly expanded the scope of what could be considered a disability under the law.⁶⁹ Previously, many mental disorders did not qualify as a disability within the meaning of the ADA.⁷⁰ Now, the ADA defines disability as “a physical or mental impairment that substantially limits one or more major life activities,” where major life activities include “learning, reading, concentrating, thinking, [and] communicating,” and may also include conditions that are “episodic or in remission . . . if it would substantially limit a major life activity when active.”⁷¹ Congress gives further guidance in the statute that the “definition of disability in this chapter shall be construed in favor of broad coverage of individuals under this chapter.”⁷² This appears to overlap with the definition of a mental disorder in the *DSM-V*. In the *DSM-V*, a mental disorder is defined as:

“[A] syndrome characterized by clinically significant disturbance in an individual’s cognition, emotion regulation, or behavior that reflects a dysfunction in the psychological, biological, or developmental processes underlying mental functioning.”⁷³

It may be that under the new standards, a diagnosis of “clinically significant disturbance” will often represent an “impairment that substantially limits one or more major life activities.”⁷⁴ Note that, as discussed *supra*, there is some amount of arbitrariness to these distinctions and everyone has some amount of need.

As a result of this change, the ADA is now better-suited to a social model approach in two ways. First, the mental health needs will be seen as increasingly ubiquitous as more mental health needs gain legal significance. Social model solutions that focus on modifying programs instead of individuals will seem more appropriate when it is clear that more people in the programs would benefit from the modifications. Second, the mental health needs presented will be less severe. Severe mental health needs demand intensive, often individualized

68. 42 U.S.C. § 12132 (1990).

69. ADA Amendments Act of 2008, Pub. L. No. 110–325 (2008).

70. See e.g., *Knapp v. City of Columbus*, 192 F. App’x 323, 330 (6th Cir. 2006) (finding that ADHD was not a disability in this instance because it did not substantially limit learning); *Boutin v. Home Depot U.S.A., Inc.*, 490 F. Supp. 2d 98, 104 (D. Mass. 2007) (finding that depression and anxiety disorder did not substantially limit a major life activity in this instance).

71. 42 U.S.C.A. § 12102 (2009).

72. *Id.*

73. *DSM-V*, *supra* note 2, at 20.

74. See e.g., *RHJ Med. Ctr., Inc. v. City of DuBois*, 754 F. Supp. 2d 723, 760 (W.D. Pa. 2010) (finding that opioid addiction is almost a disability *per se* and citing to the DSM for support that, as a mental disorder, it causes impairment of a major life activity). Note also that the 2008 Amendments were in part a response to *Toyota Motor Mfg., Ky., Inc. v. Williams*, 534 U.S. 184 (2002), where the Supreme Court asked for more intensive scrutiny as to whether a major life activity that most people engage in was truly impaired, asking instead that courts construe impairment more broadly.

treatment. Less severe mental health needs do not always demand this intensity and allow one to consider modifying the program instead.

What these amendments mean exactly for mental health needs has yet to be elaborated. Since the 2008 amendments were enacted, there have been few federal appellate decisions on the scope of the protections offered by the amended ADA with respect to mental health needs.⁷⁵ What constitutes a “reasonable modification” under the ADA remains fluid, so a medical model interpretation of the ADA is not yet inevitable.⁷⁶

1. Applying the Social Model to the ADA

A social model approach is a reasonable interpretation of the ADA. To demonstrate this, we will use a hypothetical case:

Our plaintiffs are a class of primary and secondary school children with mental disorders, diagnosed or as of yet undiagnosed, who are suing the state and local educational agency for some modification to the educational program in line with a social model understanding of disability. Before the suit may proceed, the plaintiffs must qualify as “individual[s] with a disability.”⁷⁷ For our purposes here, we will assume that the plaintiffs are disabled under the post-2008 definition of disability in the ADA, which is likely given the stipulation of their *DSM* diagnosis.

The plaintiffs are qualified individuals if they “mee[t] the essential eligibility requirements for the receipt of services or the participation in programs or activities provided by a public entity.”⁷⁸ Because we are dealing with children in school, they will always be considered qualified individuals.⁷⁹ The question then becomes whether the plaintiffs were “denied the benefits of” the education program “by reason of” their disabilities or otherwise “subjected to discrimination by any such entity.” The regulations accompanying the ADA further explain:

“A public entity shall make reasonable modifications in policies, practices, or procedures when the modifications are necessary to avoid discrimination on the basis of disability, unless the public entity can

75. See *E.E.O.C. v. Agro Distribution, LLC*, 555 F.3d 462, 469 (5th Cir. 2009) (“Congress recently enacted the ADA Amendments Act of 2008, Pub. L. No. 110–325 (2008), but these changes do not apply retroactively. See *Rivers v. Roadway Express, Inc.*, 511 U.S. 298, 313 (1994)”). See also *Sutton v. United Air Lines, Inc.*, 527 U.S. 471 (1999); *Toyota Motor Mfg., Ky., Inc. v. Williams*, 534 U.S. 184 (2002).

76. See Jeannette Cox, *Crossroads and Signposts: The ADA Amendments Act of 2008*, 85 Ind. L.J. 187, 188 (2010) (“Despite the ADAAA’s lack of attention to the ADA’s theoretical foundation, the amendments will nonetheless bring renewed attention and significance to this debate. By enabling more plaintiffs to overcome the initial hurdle of establishing membership in the ADA’s protected class, the amendments will require courts to address many important interpretive questions raised by the original statutory text, such as the scope of the amorphous term ‘reasonable accommodation.’”).

77. 42 U.S.C. § 12132 (1990).

78. 42 U.S.C. § 12131 (1990).

79. See e.g., *B.M. ex rel. Miller v. S. Callaway R-II Sch. Dist.*, 732 F.3d 882, 887 (8th Cir. 2013), reh’g denied (Dec. 3, 2013) (noting that child’s status as a qualified individual for school was not contested).

demonstrate that making the modifications would fundamentally alter the nature of the service, program, or activity.”⁸⁰

Based on these provisions and case law interpreting it, we will analyze our ADA claim in three parts: (1) whether the modification proposed is “necessary to avoid discrimination on the basis of disability,”⁸¹ (2) whether the modification is “reasonable,”⁸² and (3) whether the modification would “fundamentally alter the nature of” the educational program.⁸³

Note that it is possible that, in order for the ADA claim to be litigated, there may need to be an exhaustion of remedies beforehand under the IDEA.⁸⁴ Although it may pose an inconvenience, this hardly poses an insurmountable barrier, and in the end the IDEA does not limit the remedies available under the ADA.⁸⁵

a. Necessary to Avoid Discrimination on the Basis of Disability

As relevant to our hypothetical, there are two types of discrimination that can be alleged. First, there could be discrimination in that the children do not receive the full benefits of public education without the modification. Second, there could be discrimination in that the children are not as integrated as possible even if they are otherwise receiving the full benefits of a public education.

First, the ADA conceives of discrimination in part as a denial of a benefit⁸⁶ – in our case the benefit of public schooling. The claim would be that the school, as it exists now, denies these children with mental health needs the benefits of public education and it would be discrimination to not change policies and practices.⁸⁷ This then raises the question: what are the benefits of public

80. 28 C.F.R. § 35.130 (b)(7) (2011).

81. *See Olmstead v. L.C. ex rel. Zimring*, 527 U.S. 581, 597 (1999) (“We examine first whether, as the Eleventh Circuit held, undue institutionalization qualifies as discrimination ‘by reason of ... disability.’”).

82. *See id.* at 603–04 (analyzing issue of cost of the modifications proposed).

83. *See id.* (analyzing the impact on the fairness/essential nature of the program as it currently exists).

84. *Compare Payne v. Peninsula Sch. Dist.*, 653 F.3d 863, 871 (9th Cir. 2011) (“Non–IDEA claims that do not seek relief available under the IDEA are not subject to the exhaustion requirement, even if they allege injuries that could conceivably have been redressed by the IDEA”), *with Charlie F. v. Bd. of Educ.*, 98 F.3d 989, 992 (7th Cir. 1996) (“The nature of the claim and the governing law determine the relief no matter what the plaintiff demands. If this principle is equally applicable for purposes of § 1415(f), then the theory behind the grievance may activate the IDEA’s process, even if the plaintiff wants a form of relief that the IDEA does not supply.”).

85. *See* 20 U.S.C.A. § 1415(l) (2005) (“Nothing in this chapter shall be construed to restrict or limit the rights, procedures, and remedies available under the Constitution, the Americans with Disabilities Act of 1990, title V of the Rehabilitation Act of 1973, or other Federal laws protecting the rights of children with disabilities, except that before the filing of a civil action under such laws seeking relief that is also available under this subchapter, the procedures under subsections (f) and (g) shall be exhausted to the same extent as would be required had the action been brought under this subchapter.”).

86. 42 U.S.C. § 12132 (1990).

87. Note that some courts have held that the ADA allows one to allege discrimination in three different ways, only one of which is explored here. *See e.g., Wash. v. Ind. High Sch. Athletic Ass’n, Inc.*, 181 F.3d 840, 847 (7th Cir. 1999) (“[D]iscrimination under both [the ADA and Section

education and what do the children have a right to not be denied?⁸⁸ For Supplemental Security Income, the benefit might be obvious, but for other public services, like schools, the answer is less clear.

On one hand, we could conceive of the benefit as the single, core benefit that the program was designed to provide. For schools, this would be a “free appropriate public education,” which “meet[s] individual educational needs of handicapped persons as adequately as the needs of non-handicapped persons are met.”⁸⁹ In the context of equality of adequate service delivery, children have a right to meaningfully receive the course content, but not to excel or do as well as they would in school without the disability.⁹⁰ Some may think of this as fair in the sense that it may not make sense for children with disabilities to have a sudden right to excel, to be helped to get the most out of their educational experience, while children without a disability do not.⁹¹

On the other hand, we could conceive of the benefit as substantial benefits of the program that other recipients are receiving that the plaintiff cannot receive because of her disability. In the education context this could include free appropriate public education, social skill building, and meaningful opportunities for social network development. This conception of benefits raises the potential line drawing problems of what benefits public school programs should reasonably have to extend, but it is a problem that courts are capable of addressing.

It is not clear why a service need have a core benefit determined by the intent of the program, or why individuals should be denied access to other benefits that the service provides. The text of the ADA does not militate against the latter reading either, with its use of the plural “benefits”⁹² and its

504] may be established by evidence that (1) the defendant intentionally acted on the basis of the disability, (2) the defendant refused to provide a reasonable modification, or (3) the defendant's rule disproportionately impacts disabled people.”).

88. 42 U.S.C.A. § 12132 (1990); *see also* Wis. Cmty. Servs., Inc. v. City of Milwaukee, 465 F.3d 737, 754 (7th Cir. 2006) (“As we already have discussed, with respect to the Rehabilitation Act, *Choate* held that a modification is ‘necessary’ only when it allows the disabled to obtain benefits that they ordinarily could not have by reason of their disabilities, and not because of some quality that they share with the public generally” (citing *Alexander v. Choate*, 469 U.S. 287, 302 (1985)).

89. 34 C.F.R. § 104.33 (2000); *see also* N.M. Ass'n for Retarded Citizens v. New Mexico, 678 F.2d 847, 855 (10th Cir. 1982) (finding potential for discrimination where “the State's existing education programs preclude the handicapped from enjoying program benefits realized by the nonhandicapped” and “program modification would result in the handicapped obtaining those benefit”). *See also* 20 U.S.C.A. § 1412 (2005).

90. *See Weixel v. Bd. of Educ.*, 287 F.3d 138, 148 (2d Cir. 2002) (finding that it was not discrimination if failure to make modifications caused her to not be able to be placed in advanced courses, but it was discrimination if it caused her to miss periods of school).

91. *See* Michael Ashley Stein, *Same Struggle, Different Difference: ADA Accommodations As Antidiscrimination*, 153 U. PA. L. REV. 579 (2004) (“[B]oth legal commentators and Supreme Court Justices assert that the ADA's employment mandates distinguish the ADA from earlier antidiscrimination measures, most notably Title VII, because providing accommodations results in something more than equality for the disabled.”).

92. 42 U.S.C.A. § 12132 (1990).

accompanying regulation only mentioning avoiding discrimination by the entity. In short, the regulation does not indicate that this discrimination must only address the core benefit that the entity specifically intended to provide.⁹³ This broader understanding would allow for a more equal distribution of benefits across individuals. In addition, the concern about fairness in helping individuals excel may be a red herring because the claims must be tied to actual mental health needs. The ADA would not allow plaintiffs with mental health needs to get better results than all other students, only to ask that they are not discriminated against based on their mental health needs alone.

Second, the regulations provide that “[a] public entity shall administer services, programs, and activities in the most integrated setting appropriate to the needs of qualified individuals with disabilities,”⁹⁴ acknowledging that programs often have social benefits that should not be denied. Guidance further clarifies that “the most integrated setting” is one that “enables individuals with disabilities to interact with nondisabled persons to the fullest extent possible.”⁹⁵ Some courts have found this requirement to be coextensive with the IDEA, which requires that “special classes, separate schooling or other removal of children with disabilities from the regular educational environment occurs only when the nature or severity of the disability is such that education in regular classes with the use of supplementary aids and services cannot be achieved satisfactorily.”⁹⁶ All this could require is that the children with disabilities sit in the same room as the other children for classes, even if the children with disabilities are not meaningfully included.

The most integrated setting could also be one that avoids, to the extent practicable, distinguishing a student with mental health needs from her peers in any way and maximizes her possibilities for social inclusion. This interpretation is favored to some extent by the text because it makes sense with the word “enables,” and protects children from being “subject to discrimination.”⁹⁷ Individualized services are discrimination in its most fundamental sense – it marks a distinction between two individuals, which can be a good thing if it leads to better outcomes.⁹⁸ Individualized services are never in the most integrated setting though if those same services could be integrated into the program for the same outcomes without differentiating the child in need. Avoiding discrimination in this form is significant because of its impact on self-

93. 28 C.F.R. § 35.130 (b)(7) (2011).

94. 28 C.F.R. § 35.130 (d) (2011); *see also* *Olmstead v. L.C. ex rel. Zimring*, 527 U.S. 581, 597 (1999) (applying this regulation to require state to provide community-based services to individuals with mental health needs, rather than unnecessarily institutionalizing them).

95. 28 C.F.R. § 35 app. B (2011).

96. 34 C.F.R. § 300.550 (b)(2) (2002); *see also* *Corey H. v. Bd. of Educ.*, 995 F. Supp. 900, n.24 (N.D. Ill. 1998); *D.F. v. W. Sch. Corp.*, 921 F. Supp. 559, 574 (S.D. Ind. 1996) (“Because plaintiffs have failed to meet their burden of proving that D.F.’s IEP violated the IDEA, their claims based on the ADA and the Rehabilitation Act must also fail.”).

97. 42 U.S.C.A. § 12132 (1990).

98. *See e.g.*, *Mattei v. Mattei*, 126 F.3d 794, 804 (6th Cir. 1997) (reviewing a definition of discriminate in Webster’s New World Dictionary as “to distinguish; to make distinctions in treatment; show partiality or prejudice”).

perception, discussed *supra*. IEPs, for example, may “enable[e] individuals with disabilities to interact with nondisabled persons,” but it is not to “the fullest extent possible” unless all unnecessary discrimination has been eliminated to allow the disabled child to interact with her non-disabled peers without potentially feeling like an outsider.

b. Reasonableness of the Modification

For an ADA claim to be successful, the modification requested must also be “reasonable.” A modification is reasonable if it does not impose “undue financial and administrative burdens” on the program.⁹⁹ The reasonableness of the modification may also be contingent on the number of children who would benefit from it. As one court observed, “it seems apparent under *Lau* and *Southeastern Community College* that the greater the number of children needing the particular special education service, the more likely that failure to provide the service constitutes discrimination. This is so because the more children in need of the service, the more the benefits of that service outweigh its cost.”¹⁰⁰

For social model-based modifications, the reasonableness of the modification seems to hinge on the time it takes to be completed. Complete modification of a program by the end of the month could impose a high financial and administrative burden. Teachers and administrators would need to be intensively retrained and new policies would need to be quickly promulgated at all levels. On the other hand, if the modification were progressively realized over a term of years, the cost would be incredibly low. New policies could be promulgated in the normal course of administrative consideration and new teachers could be trained in the new procedures as they enter the field, while current teachers could learn the new procedures as part of their standard continuing education. This prong may control the timeline by which a violation must be remedied, but it will likely not be dispositive for social model interventions generally, unless the only possible social model modification would require major additions to the program.

c. Fundamentally Alters the Program

Finally, a modification must not fundamentally alter the nature of the program. The Supreme Court has visited the issue of fundamental alterations in the context of Title III of the ADA, relating to public accommodations.¹⁰¹ In deciding whether allowing a disabled golf player to use a cart during a PGA tournament would fundamentally alter the event, the Court differentiated

99. *Sch. Bd. of Nassau Cnty. v. Arline*, 480 U.S. 273, 288 & n. 17 (1987) (quoting *Se. Cmty. Coll. v. Davis*, 442 U.S. 397, 412 (1979)).

100. *N.M. Ass'n for Retarded Citizens v. New Mexico*, 678 F.2d 847, 854 (10th Cir. 1982) (citing *Se. Cmty. Coll. v. Davis*, 442 U.S. 397, 412 (1979); *Lau v. Nichols*, 414 U.S. 563, 567 (1974)).

101. *PGA Tour, Inc. v. Martin*, 532 U.S. 661, 682 (2001).

between essential and peripheral aspects of the game and looked at both the history of the game and its goals to determine what was “fundamental” to the sport.¹⁰²

“Fundamental alteration” and what might be classified as “essential” and “peripheral” could be approached in one of two ways. The first would be to focus on the history of the program and the stated program objectives and look for the main threads that make the program what it has been and what it continues to be today. Education is an interesting example because it is especially variable and has changed quite a lot with time.¹⁰³ We could imagine that some parts could be deemed essential, such as the use of teachers who create their own lesson plans, but other parts could easily be deemed peripheral, such as the ways in which class notes are available or the amount of the spoken lecture that is also conveyed on the chalkboard.

The other way to understand “fundamental alterations” would be to look at the benefits conferred by the program. Any program component is essential if it is currently conferring a benefit, while a program component is peripheral if it could be modified without the loss of a benefit for the program recipients. We could understand the Supreme Court’s opinion in *PGA Tour, Inc. v. Martin*, regarding whether the golfer could use a golf cart, in this way. The benefit of the golf tournament was its opportunity for a specific type of competition that the participants enjoyed, and because the use of the golf cart for the disabled participant did not diminish the competitive aspect, it was peripheral and allowed to be modified. Applying the same analysis to education, we might decide that a type of group project confers a benefit on students by allowing them a chance to develop teamwork skills and is therefore essential, but a disciplinary regime that could be modified to be more effective in promoting students’ academic and social growth is peripheral.

The latter understanding of “fundamental” better supports social model interventions and benefits more children while avoiding leveling down by causing some children to lose out on benefits to create equality. The former approach with its focus on history and intent creates a *status quo* bias, a sort of homage to history, where the very existence of the thing is seen as important and worth protecting, outside of any concrete benefit it may confer. Presumably with public programs we only care about the benefits we gain from them, not the integrity of the product being presented to us as such, and so the latter approach would more reliably protect what is “fundamental” about the “nature” of the program under the ADA.¹⁰⁴

The focus on not losing benefits is key to address a concern raised *supra*. It would be a poor answer in integrating a visually impaired student to remove all of the visual components from the educational program, as some children

102. *Id.* at 683–91.

103. Claudia Goldin, *A Brief History of Education in the United States* (Nat’l Bureau of Econ. Research, Working Paper No. 119, 1999), available at <http://www.cnefr.com/yjdh/wxlb/qt/images/2009/1/17/357.pdf>.

104. 28 C.F.R. § 35.130 (b)(7) (2011).

may derive benefit from these components. If equality were achieved consistently by removing components from programs, there may be very little left of the programs after all claims were made. To avoid the leveling down problem, the "fundamentally alter" inquiry should only look to see if the proposed modifications would cause other children to receive less benefit from the program.

C. Working Toward the Social Model in the Context of Current Law

If we believe that the interpretation of the ADA advanced here is a reasonable construction, what does this mean for our effort to pursue the social model? Although this raises a complex question of the role of law in social change, we will circumscribe our inquiry to how litigation and legal communication can promote broader change.

We will first look at using law in its traditional sense: as a platform for litigation. To advance a social model interpretation of Medicaid, IDEA, and ADA, one could either focus on bringing suits that advance a social model theory of discrimination, or focus on bringing suits that request social model remedies.

The interpretations advanced *supra* expand what one would consider a violation of each law. For example, under the ADA, a suit could claim discrimination in one of three situations: (1) when individuals are denied the social benefits of a program because of their mental health needs, (2) when individuals are singled out to receive services rather than having them incorporated into the program so the individuals can be most integrated, or (3) when a program fails to reasonably accommodate an individual along social model lines. Suits based on these conceptions of discrimination would be most effective in changing the way that the law operates and would greatly expand opportunities for social model programs. However, this approach may not be desirable because failure in the courts would create unfavorable precedent and be fatal to social model change.

To avoid risking unfavorable precedent, suits could advance a claim of discrimination that fits within existing precedent, and then suggest a social model-oriented approach as a remedy. For Medicaid, claims for systemic denials of services, especially denial of EPSDT services, could suggest social model reforms to ensure legally compliant service delivery arrangements. Under the IDEA, claims for systemic failures to provide effective IEPs for mental health needs could suggest that IEPs be designed with the social model in mind to avoid future denials since all students in the class would now be benefiting. It may be difficult to claim that a traditional medical model remedy would be legally insufficient in these cases, but pushing a social model approach could influence the remedy ultimately proposed.

Second, rather than litigating, we can use law as a way of guiding the way we understand relationships in society, thereby affecting social change. As lawyers communicate about the law, they can convey attitudes, associations, and metaphors that reflect social model thinking and alter the way in which the reader engages with mental health. These communications can challenge the

way that individuals feel about a subject, create new associations when they think about a topic, and help them structure their analysis when they consider an issue. Not only will this change the way individuals understand mental health, but it will also affect the kinds of solutions they will accept, support, and generate.¹⁰⁵

When a law is understood differently, it can change what may be accomplished through the law. For example, *Plessy v. Ferguson*¹⁰⁶ and *Brown v. Board of Education*,¹⁰⁷ both interpreted the same text – the Fourteenth Amendment – but came to different conclusions when given relatively similar facts. Although we could say that the realization that “separate but equal” was inherently unequal was the result of years of testing this proposition,¹⁰⁸ it was also likely the result of changing attitudes. In another example, *United States v. Windsor* may not have come out the same way if litigated immediately after the passage of DOMA in 1996,¹⁰⁹ although *Romer v. Evans*¹¹⁰ and *Lawrence v. Texas*,¹¹¹ each of which established foundational precedent for the opinion, had already been decided. The changed understandings of equal protection were key in each. Social model litigation, and other attempts at reform, will not be successful if judges and society conceive of disability solely under the medical model and instinctively assume that the narrower interpretation of the ADA is the only one possible.¹¹² If the law is understood differently, individuals may begin to generate different kinds of solutions when dealing with problems in mental health.¹¹³

105. See, e.g., LYNN DAVEY, HOW TO TALK ABOUT CHILDREN’S MENTAL HEALTH (2010), available at http://frameworksinstitute.org/assets/files/CMH_MM.pdf (exploring how people interact with different words and metaphors and how this influences the policy solutions they support).

106. 163 U.S. 537 (1896).

107. 347 U.S. 483 (1954).

108. *Id.* at 495.

109. 133 S. Ct. 2675 (2013).

110. *Id.* at 2692 (“[D]iscriminations of an unusual character especially suggest careful consideration to determine whether they are obnoxious to the constitutional provision.” *Romer v. Evans*, 517 U.S. 620, 633 (1996) (quoting *Louisville Gas & Elec. Co. v. Coleman*, 277 U.S. 32, 37–38 (1928))).

111. *Id.* (“The States’ interest in defining and regulating the marital relation, subject to constitutional guarantees, stems from the understanding that marriage is more than a routine classification for purposes of certain statutory benefits. Private, consensual sexual intimacy between two adult persons of the same sex may not be punished by the State, and it can form “but one element in a personal bond that is more enduring.” *Lawrence v. Texas*, 539 U.S. 558, 567 (2003)).

112. See, e.g., Michael J. Gerhardt, *How A Judge Thinks*, 93 MINN. L. REV. 2185, 2188 (2009) (comparing different models for understanding judging behavior, all of which are deeply contingent on the judge’s understanding of the law and of the workings of broader society).

113. We could imagine this is especially true if the law is taken to signal community norms and shapes behavior, even when an individual is not specifically trying to comply with the law.

V. AN EXAMPLE: SCHOOLS UNDER THE SOCIAL MODEL

Having discussed social model interventions in the abstract, what would it look like to actually pursue the social model? It means restructuring institutions, such as school, work, and public programming, based on evidence of what supports healthy development. In the extreme, this would even mean changing urban design based on research in mental health and development – restructuring of our physical world to facilitate positive and reinforcing social interactions.¹¹⁴ To illustrate this process, I will take schools as an example of how one might incorporate research on healthy development and psychosocial interventions into a program.¹¹⁵ A number of evidence-based programs exist that effectively accomplish this goal, but here I hope to focus on the process of pursuing the social model without endorsing a particular program.¹¹⁶

The vast majority of evidence-based psychosocial interventions are cognitive behavioral in nature.¹¹⁷ Cognitive behavioral therapy is a specific form of psychotherapy that uses a problem-solving framework to change an individual's thoughts and behaviors.¹¹⁸ Because of its structured nature, cognitive behavioral therapy procedures can also be made into a manual, which allows a therapy protocol to be administered by individuals other than the original practitioner and those she trained.¹¹⁹ Some of these treatment manuals

114. See generally Gary W. Evans, *The Built Environment and Mental Health*, 80 J. URB. HEALTH 536 (2003) ("Characteristics of the built environment can directly influence mental health. Environmental characteristics with direct effects on mental health include housing, crowding, noise, indoor air quality, and light. In addition to direct effects, the built environment can indirectly impact mental health by altering psychosocial processes with known mental health consequences."). See also Scott Weich et al., *Mental health and the built environment: cross-sectional survey of individual and contextual risk factors for depression*, 180 BRIT. J. PSYCHIATRY 428, 430 (2002) ("In two inner-city electoral wards, individuals living in housing areas characterised by properties of recent (post-1969) construction and with predominantly deck access experienced significantly higher rates of depression.").

115. Psychosocial interventions refer broadly to activities that seek to produce psychological change through social contact. This would be contrasted with pharmaceutical interventions.

116. See generally, MARY ELLEN O'CONNELL ET AL., PREVENTING MENTAL, EMOTIONAL, AND BEHAVIORAL DISORDERS AMONG YOUNG PEOPLE: PROGRESS AND POSSIBILITIES 168–90 (2009). See also Dennis D. Embry, *Community-Based Prevention Using Simple, Low-Cost, Evidence-Based Kernels and Behavior Vaccines*, 32 J. COMMUNITY PSYCHOL. 575, 583–84 (2004).

117. See generally H. Verdeli et al., *Review of Evidence-based Psychotherapies for Pediatric Mood and Anxiety Disorders*, 2 CURRENT PSYCHIATRY REVS. 395 (2006) (reviewing studies demonstrating the effectiveness of the therapy). See also JACQUELINE CORCORAN, *MENTAL HEALTH TREATMENT FOR CHILDREN AND ADOLESCENTS* 189 (2011) (expressing that further research needs to be done on other therapies, such as psychodynamic, narrative, and solution-focused therapies).

118. Phillip C. Kendall, *Guiding Theory for Therapy with Children and Adolescents*, in CHILD AND ADOLESCENT THERAPY: COGNITIVE-BEHAVIORAL PROCEDURES, 3–5 (Phillip C. Kendall ed., 2012).

119. Note that there are some issues with the use of evidence-based treatments as they currently stand. See generally, JOHN C. NORCROSS ET AL., EVIDENCE-BASED PRACTICES IN MENTAL HEALTH: DEBATE AND DIALOGUE ON THE FUNDAMENTAL QUESTIONS (2005); see also John R. Weisz et al., *Evidence-Based Youth Psychotherapies Versus Usual Clinical Care*, 61 AM. PSYCHOLOGIST 671 (2006). Studies can only support modes of therapy that are easily reproducible

have been independently evaluated for efficacy. Our example borrows from these manuals to ensure that alterations to the program are evidence-based.

Based on the content of evidence-based cognitive behavioral therapy manuals, I walk through four domains of reform to the educational program: classroom discipline, incentive systems, course content, and content delivery.

A. Classroom Discipline

Therapy manuals for group treatment of mental disorders for which inappropriate behavior is an issue, such as oppositional defiant disorder or conduct disorder, generally adopt specific disciplinary regimes that may be different from the ones that children are normally exposed to in school.¹²⁰ The fundamentals of the disciplinary regime used in the therapeutic context could be and should be applied to the classroom setting to help all children better manage their behavior. The elements of therapeutic regimes as relevant to the classroom are outlined below.

First, the classroom rules and consequences for breaking them should be clearly presented at the outset.¹²¹ Ideally, the rule set and the consequences could be decided upon with participation from the students so that they can, to the extent practicable, agree upon and accept the rules, or at least voice their opinions and have the teacher respond to them.¹²² Expected behaviors, i.e. what a child must do to avoid breaking a rule, should be explained, modeled, and

across clients, favoring some modes of psychotherapy to the exclusion of others – that is why here I only focus on cognitive behavioral therapy. *Id.* In conducting the studies, subjects are usually selected who do not have comorbid disorders, but in clinical practice comorbidity is common, and these studies may reveal little about what should be done in these instances. *Id.* Manualized treatments also prevent cultural and client-specific tailoring of therapy, so much may be lost in the use of these standardized protocols. *Id.* There is even some evidence to show that evidence-based treatments only slightly outperform treatment as usual, if at all. See Scott Miller et al., *Direct comparisons of treatment modalities for youth disorders: a meta-analysis*, 18 PSYCHOTHERAPY RES. 5 (2008) (finding that some evidence-based treatments may perform better than others, but the variation may be explained by therapist allegiance to the treatment protocol); see also John R. Weisz et al., *Evidence-Based Youth Psychotherapies Versus Usual Clinical Care*, 61 AM. PSYCHOLOGIST 671 (2006) (finding only small to medium effect size when evidence-based treatment is compared to usual care). This is something to keep in mind, although we will focus on evidence-based treatment here because manuals are easily gleaned for portable therapeutic strategies and do have demonstrated effectiveness.

120. See Carolyn Webster-Stratton and M. Jamila Reid, *Treating Conduct Problems and Strengthening Social and Emotional Competence in Young Children The Dina Dinosaur Treatment Program*, 11 J. EMOTIONAL & BEHAV. DISORDERS 130, 133 (2003); see also John Lochman et al., *Anger Control Training for Aggressive Youths*, in EVIDENCE-BASED PSYCHOTHERAPIES FOR CHILDREN & ADOLESCENTS 227, 228 (Alan E. Kazdin and John R. Weisz eds., 2010).

121. Webster-Stratton and Reid, *supra* note 120, at 133–35; see also M. C. Bradley and D. Mandell, *Oppositional defiant disorder: A systematic review of evidence of intervention effectiveness*, 1 J. EXPERIMENTAL CRIMINOLOGY 343 (2005) (reviewing studies demonstrating the effectiveness of the therapy).

122. Lochman et al., *supra* note 120, at 228; see also S. M. Eyberg et al., *Evidence-based psychosocial treatments for children and adolescents with disruptive behavior*, 37 J. CLINICAL CHILD & ADOLESCENT PSYCHOL. 215 (2008) (reviewing studies demonstrating the effectiveness of the therapy).

practiced by the children, preferably through role playing.¹²³ In addition, children should be encouraged to take account of the perspectives of others before they act¹²⁴ and to use the problem-solving framework explained *infra* to avoid pursuing courses of action that hurt others.

Second, the disciplinary measures must be constructively and positively framed. Upon infraction, the teacher should make it clear to the child what was done wrong and what is expected of her in the future.¹²⁵ Then, the child should be placed in timeout, which is framed as an opportunity to cool down before trying again, not as punishment for having done something wrong.¹²⁶ The child is coached to make positive self-statements during the timeout to encourage self-esteem and to help the child be successful in the future.¹²⁷ The other children are asked to ignore the child for the duration of the timeout and to reintegrate the child without comment when the timeout is over.¹²⁸

In this way, the disciplinary program is part of the overall learning process. The information and skills, both cognitive and behavioral, are presented and practiced at the outset, and then infractions serve as additional teachable moments to apply the skills learned and learn from mistakes.¹²⁹ Throughout, teachers should avoid assuming that children will understand what they did wrong or how to respond better next time, and the appropriate thoughts and behaviors should be modeled and practiced at each instance.

B. Incentive Systems

Goal setting systems with incentives should also be integrated into the classroom setting. Children should collaborate with the teacher in filling out a goal setting worksheet that sets timelines for meeting personal goals in academics, classroom behavior, and social growth.¹³⁰ The social goals should be geared toward addressing mental health needs in the child and promoting positive behaviors, i.e. children with behavioral problems should aspire toward pro-social behaviors such as not disrupting class or sharing with others,¹³¹ while children with a depressive affect should aspire toward pleasurable activities and social engagement with others.¹³²

Progress toward these goals should be regularly evaluated. When progress is made children should be rewarded with positive verbal reinforcement, and

123. Webster-Stratton and Reid, *supra* note 120, at 133–35.

124. See Lochman et al., *supra* note 120, at 231–33.

125. *Id.*

126. *Id.*

127. *Id.*

128. *Id.*

129. Webster-Stratton and Reid, *supra* note 120, at 133.

130. See Lochman et al., *supra* note 120, at 231.

131. *Id.*

132. Gregory Clarke & Lynn DeBar, *Group Cognitive-Behavioral Treatment for Adolescent Depression*, in EVIDENCE-BASED PSYCHOTHERAPIES FOR CHILDREN & ADOLESCENTS 110, 110–11 (Alan E. Kazdin and John R. Weisz eds., 2010); see also Verdelli et al., *supra* note 117 (reviewing studies demonstrating the effectiveness of the therapy).

potentially other reinforcement as well.¹³³ (Note that the other reinforcement need not be prizes, it could be opportunities for pro-social group activities, bringing the focus away from material gain). Failure to achieve goals should be met with encouragement, positive self-statements, de-emphasis of perfection, and assistance through modeling and practicing skills necessary to achieve the goal.¹³⁴ Among the skills modeled and practiced should be calming or coping techniques that will help the child avoid responding based on initial instincts and give them time to constructively problem-solve.¹³⁵ Eventually, these goal setting worksheets can be framed as the student self-contracting and self-rewarding for success.¹³⁶

C. Course Content

The cognitive behavioral therapy manuals tend to have similar lessons taught through the sessions,¹³⁷ and this content could be integrated into the standard educational program without burdening the curriculum. Therapies generally begin with exercises to explore thoughts and emotions.¹³⁸ Children are asked to identify what characters in a cartoon are thinking or feeling, first in straightforward situations and then in more ambiguous situations.¹³⁹ This exploration also includes why certain emotions or thoughts might occur, how they change over time, and how different people might react differently to the same event.¹⁴⁰ Children are then asked to take the perspective of others and try to figure out how multiple characters in a situation might be thinking and feeling and why they might do so, ultimately finding that it is often difficult to understand the intentions of others.¹⁴¹

Eventually the focus shifts to the children themselves and the way that they react to events both cognitively and emotionally.¹⁴² Children learn to identify their own thoughts and emotions, understand the transience of these emotions, and employ self-talk to develop more constructive and positive cognitive patterns.¹⁴³ On a deeper level, children begin to use this information

133. See Lochman et al., *supra* note 120, at 231.

134. See Phillip C. Kendall et al., *Child-Focused Treatment of Anxiety*, in EVIDENCE-BASED PSYCHOTHERAPIES FOR CHILDREN & ADOLESCENTS 45, 45 (Alan E. Kazdin and John R. Weisz eds., 2010); see also Verdeli et al., *supra* note 117.

135. See e.g., Lochman et al., *supra* note 120, at 232.

136. Clarke and DeBar, *supra* note 132, at 114–15.

137. See generally Philip Kendall, *supra* note 118, at 3–26. See Lochman et al., *supra* note 120, at 231–33; see also Kendall et al., *supra* note 134, at 49.

138. See Lochman et al., *supra* note 120, at 231–33; see also Kendall et al., *supra* note 134, at 49.

139. *Id.*

140. Webster-Stratton and Reid, *supra* note 120, at 133–35.

141. See Lochman et al., *supra* note 120, at 231–33.

142. See Kendall et al., *supra* note 134, at 49.

143. See GREGORY CLARKE ET AL., INSTRUCTOR'S MANUAL FOR THE ADOLESCENT COPING WITH DEPRESSION COURSE 91–95, 169–73 (1990), available at <http://www.kpchr.org/research/public/acwd/acwd.html>.

to interrogate irrational beliefs, correct misattributions, learn to use positive counter-thoughts, and avoid activating events.¹⁴⁴

A problem-solving framework is also introduced to help children reason through their behaviors as they face activating events. A good example would be the following seven-step process: (1) "How am I feeling, and what is my problem?" (2) "What is a solution?" (3) "What are more solutions?" (4) "What are the consequences?" (5) "What is the best solution? (Is the solution safe? Fair? Does it lead to good feelings?)" (6) "Can I use my plan?" (7) "How did I do? (evaluate outcome and reinforce efforts)."¹⁴⁵ The children learn the framework with relatively simple issues involving characters and generate the answers to each question together, before moving on to role-playing where students assume the identity of a character and receive positive reinforcement for their efforts.¹⁴⁶

This content should be integrated into the existing humanities and social studies curriculum, so that covering this material does not displace other core content. As an example curriculum, we can look at the Common Core Learning Standards as implemented by the New York City Public School System.¹⁴⁷ There are two ways that this material can be taught within the existing curriculum.

First and most simply, teachers could expose the children to the content described above through the informational reading curriculum.¹⁴⁸ Children in fifth grade are expected to learn to "[d]etermine two or more main ideas of a text and explain how they are supported by key details."¹⁴⁹ There is no requirement of what the texts must be about, aside from a general goal that students "[b]y the end of the year, [should] read and comprehend informational texts, including history/social studies, science, and technical texts."¹⁵⁰ Thus, children could read technical texts that explain perspective-taking and problem-solving, along with scientific texts that further elaborate and give context to these ideas, and historical texts that provide examples. Class time could be used to develop the

144. *Id.* See also e.g., Raymond Digiuseppe and Jill Kelter, *Treating Aggressive Children: A Rational-Emotive Behavior Systems Approach*, in RATIONAL EMOTIVE BEHAVIORAL APPROACHES TO CHILDHOOD DISORDERS THEORY: PRACTICE AND RESEARCH 258–59 (Albert Ellis and Michael Bernard eds., 2006) (delving further into the idea of irrational beliefs, stating that "Rational cognitions express preferential, flexible desires, whereas irrational cognitions express absolutistic, rigid needs. Rational thinking leads to happiness and enables individuals to attain goals and strive toward their potential; irrational thinking causes people to be extremely disturbed, and thwarts individuals' ability to attain their goals, leading to unhappiness," and describing some irrational beliefs that can lead to maladaptive behavior).

145. See Webster-Stratton and Reid, *supra* note 120, at 133–34.

146. See Lochman et al., *supra* note 120, at 232–33.

147. See N.Y.C. DEPT. OF ED., NEW YORK STATE P-12 COMMON CORE LEARNING STANDARDS FOR ENGLISH LANGUAGE ARTS & LITERACY (2011), available at http://schools.nyc.gov/NR/ronlyres/337BF93A-95FF-4A48-9434-CE9EA0B70E06/0/p12common_core_learning_standards_ela_final.pdf.

148. *Id.* at 21–25.

149. *Id.* at 22.

150. *Id.*

reading skills necessary to understand the information and help the children internalize the skills explained in the text.

Second, the skills that children will use in the analysis of literature reinforce the skills developed in cognitive-behavioral therapy. By fifth grade, children are expected to be able to “[d]etermine a theme of a story, drama, or poem from details in the text, including how characters in a story or drama respond to challenges,” “[c]ompare and contrast two or more characters, settings, or events in a story or drama,” “[e]xplain how a series of chapters, scenes, or stanzas fits together to provide the overall structure of a particular story,” and “[d]escribe how a narrator’s or speaker’s point of view influences how events are described.”¹⁵¹

In reaching these goals, one could imagine an approach to literary analysis in which students are asked to take the perspective of a character in a story and discuss her thoughts, emotions, and motivations. After taking the perspectives of the characters, the perspectives may be contrasted to see how different individuals react differently to the same events. In examining why characters acted the way they did in the story, students could interrogate the beliefs that caused the characters to act in the way that they did, use the problem-solving framework to evaluate what else the characters could have done, and look at the consequences of other alternatives as opposed to the course of action the characters selected. Students could even role-play the characters in the story to help it come to life. This approach to literary analysis, which advances the curricular goals, corresponds almost perfectly with the vignette-based exercises in cognitive-behavioral therapy manuals.¹⁵²

Children will be able to make further progress in therapy in their writing curriculum. By fifth grade, children will be expected to “[w]rite narratives to develop real or imagined experiences or events” and to “[u]se narrative techniques, such as dialogue, description, and pacing, to develop experiences and events or show the responses of characters to situations.”¹⁵³ In writing these pieces, children could have an opportunity to apply the perspective-taking and problem-solving skills to characters that they imagine and in situations they wish to explore. This would help the children not only continue to gain ownership over the skills used in cognitive behavioral therapy, but also to create more realistic, better developed narratives in which the characters are treated like living and volitional beings.¹⁵⁴

151. *Id.*

152. See, e.g., Bertram Bruce, *A New Point of View on Children’s Stories*, in *LEARNING TO READ IN AMERICAN SCHOOLS: BASAL READERS AND CONTENT TEXTS* 153, 157 (1984) (“Conflicts are a major source of complexity for stories . . . understanding of conflict implies understanding of characters’ goals, how their goals interrelated, and how plans to achieve these goals mesh or clash.”).

153. *Id.* at 30.

154. See, e.g., E.M. FORSTER, *ASPECTS OF THE NOVEL* (1927) (defining “flat” and “round” characters, with an emphasis on the importance of the reader’s acceptance of a persistent world in writing a successful story).

D. Content Delivery

Classroom activities can also be structured to allow for chances to develop social skills and promote social inclusion. The ultimate focus of cognitive behavioral therapy is social relationships – addressing issues of isolation, encoding of information from interactions, expectations before an interaction and attribution after, and behaviors and problem-solving strategies for improving connections.¹⁵⁵ Although therapy can be performed in groups and involve other individuals that play a major role in a child's life, the classroom setting is unique because the teacher has the opportunity to help children learn cognitive behavioral techniques with their actual peers and directly foster social growth.¹⁵⁶

To maximize this opportunity, teachers could give children opportunities for cooperative group work. Teachers could assign groups to ensure inclusion and select these groups in part based on the children's social objectives as set on their goal setting worksheets. Children may be hoping to improve their relationships with specific peers, or the children may have complimentary social skills that allow them to work well together.

The group work should of course reach a substantive academic end, but it should also have an explicitly social purpose. Cognitive-behavioral therapy sometimes includes lessons on basic friendship skills.¹⁵⁷ Teachers could, at the beginning of the year, teach students how to be friendly: begin a conversation with an appropriate comment, make eye contact, smile, say positive things, and talk about yourself.¹⁵⁸ These skills should be modeled, explained, and practiced by students, and then practiced again at the beginning of each group project until it becomes instinctual behavior for all students. Having all students practice these behaviors together may appear silly to those for whom the skills come naturally, but they will prove invaluable for children with mental health needs who need help to fit in and catch up.

Group projects should be concluded with sharing inside the group. The discussion should include some small amount of constructive feedback on how to be a good group member,¹⁵⁹ but dialogue should mostly act as a chance to give substantive compliments, focusing on concrete traits and behaviors rather than vague or physical traits.¹⁶⁰

155. Kendall, *surpa* note 118, at 3–4.

156. *Preventing Mental, Emotional, and Behavioral Disorders Among Young People: Progress and Possibilities*, NATIONAL RESEARCH COUNCIL AND INSTITUTE OF MEDICINE 178 (2009).

157. See Clarke *et al.*, *Instructor's manual*, *surpa* note 141, at 57–58, 71–72.

158. *Id.*

159. *Id.* at 59.

160. See John Lochman *et al.*, *Anger Control Training for Aggressive Youths*, *surpa* note 118, at 231.

E. Four Reforms Taken Together

These four reforms together would incorporate a great deal of cognitive behavioral therapy into the everyday workings of the classroom. Instead of introducing the therapy as another curricular topic to vie for limited class time, this weaves the intervention directly into the fabric of the educational program. Note that the four reforms are mutually reinforcing. The time-outs in discipline give children an opportunity to take the perspective of the other child and reconsider past decisions using the problem-solving framework explained and practiced during the course content. The group work helps with reintegration of children after behavioral disruptions and allows them to meet social goals set previously. By the end of the educational experience, the concepts that underlie cognitive behavioral therapy would be second nature to the children.

One thing to note is that these reforms are type of social regulation. Cognitive-behavioral therapy alters the patient's thought processes and behavioral responses, making it a kind of social regulation, even if the effects of the regulation are consistently positive.¹⁶¹ Cognitive-behavioral therapy teaches all children to process information and problem-solve using the same framework, potentially a deeper level of training than the basic values and social skills that schools generally impart in passing.¹⁶² There is always a potential danger that something important could be lost in encouraging all children to think and behave in similar ways, even when everyone is better off as a result.

For example, cognitive behavioral therapy does not produce sameness in a value-neutral way. In some instances, it uses an incentive systems that focuses on seeking positive social reinforcement, rather than emphasizing the development of a strong internal motivation. This may not be problematic, but the issue is one worth considering.

One could imagine another system where there is focus is on understanding how each child sees the world differently and thus working to include them in society, in all of their difference. However, mental health needs cause real distress and cognitive behavioral therapy is the most evidence-based technique in alleviating this distress.¹⁶³ Although other methods may work, there has been little opportunity to test the efficacy of approaches that comport with the latter, more idyllic goal.

161. Kendall, *supra* note 118, at 3–5. See also JULIAN HENRIQUES ET AL., CHANGING THE SUBJECT: PSYCHOLOGY, SOCIAL REGULATION, AND SUBJECTIVITY 1 (1984).

162. *Id.*

163. Richard Layard, *The Case for Psychological Treatment Centres*, 332 BRIT. MED. J. 1030, 1031 (2006) (“The best developed, and most studied, is cognitive behaviour therapy.”). See also David F. Tolin, *Is Cognitive-behavioral Therapy More Effective than Other Therapies?: A Meta-analytic Review*, 30 CLINICAL PSYCHOL. REV. 710 (2010) (concluding that cognitive-behavioral therapy is as effective or more effective than other therapies).

VI. CONCLUSION

Current mental health policy in the United States tends to reinforce a certain understanding of mental health needs: the medical model. In the medical model, limitations associated with mental health needs are viewed as inherent in the individual and treated through individualized care.¹⁶⁴ This can be compared with the social model, in which limitations associated with mental health needs are viewed as artifacts of societal arrangements and treated through reforms to society.¹⁶⁵ This article asserts that a social model approach to policy may be desirable because, to the extent that social model solutions are available, they can offer better outcomes across a broader population. A social model approach can be pursued and supported within our current legal framework by applying existing law differently. As lawyers challenge traditional understandings and introduce the social model, we have the opportunity to make a more gradually inclusive society that better meets our needs.

164. See Crossley, *supra* note 38, at 649.

165. *Id.* at 658.