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Tracking the Use of Antipsychotics by DYS Involved Youth in Massachusetts

Growing Number of Children with Emotional Needs

A recent study found a disproportionately high incidence of mental illness among U.S. youth. This finding should serve as a catalyst to advocates seeking to improve mental health care and make such care appealing to young people. One focus of such efforts should be the monitoring of young people's use of behavioral health medication. The survey, by the National Institute of Mental Health, sampled over 10,000 U.S. teenagers ages 13-18. Of those, nearly 50% of these youth reported meeting diagnostic criteria for at least one psychiatric disorder over a lifetime, and about 20 percent reported that they suffered from a mental disorder severe enough to impair their daily lives.[1] Moreover, a teen's risk for a disorder was heightened when certain parental characteristics existed, such as a parent's lack of a college degree or a parent's divorce.[2] This finding should put those working with delinquent teens, who may have less than stable family lives, on notice for an even higher incidence of disorders than that found in the general adolescent population.

Increased Use of Antipsychotic Medication by Youth Raising Concerns

In light of the large numbers of American youth meeting a diagnosis of a psychiatric disorder, the growing use of antipsychotic medication by this population is not surprising and warrants review. Antipsychotic use by youth with severe emotional and behavioral disturbances has increased substantially in recent years. The increase is reflected both in the population of youth in community settings and youth in state care.[3]

Antipsychotics, a class of medication including first and second generation antipsychotics, have a number of serious side effects.[4] Second generation antipsychotics, known as "atypicals," have different side effects than first generation antipsychotics, but these effects also can be serious. These side effects include type II diabetes (more of a risk if the individual is African-American) and weight gain (a serious concern for children).[5]

Atypicals deserve particular attention as they are widely prescribed to youth.[6] While originally dispensed upon a diagnosis of schizophrenia, atypicals now also are used as a mood stabilizer, such as for bipolar disorder.[7] Atypicals also are provided for non-specific aggression, anxiety and agitation in post traumatic stress disorder and autism-spectrum youth and as adjunctive medication for obsessive-compulsive disorder and Tourette's.[8]

Some observers are questioning using atypicals when youth have not been diagnosed with schizophrenia or bipolar.[9] Some observers see a red flag in treating something other

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Massachusetts' Anti-Bullying Law – What Will Be the Impact on Youth with Mental Health Disabilities?

Propelled by two highly publicized student suicides, *Chapter 92 of the Acts of 2010: An Act Relative to Bullying in Schools* was signed into law last spring. As schools take steps to comply with the new requirements, we highlight the potential benefits and risks for youth with disabilities, particularly mental health disabilities.

This legislation prohibits bullying at school and at school-related activities, as well as cyber-bullying, even if executed away from a school location or activity.[1] The law also obligates schools to initiate:

- anti-bullying and prevention procedures;
- retaliation prevention measures;
- professional development and training for school staff;
- mandatory reporting by school staff;
- mandatory notifications in cases of suspected bullying to parents of the targeted individual(s) and the aggressor(s), law enforcement, and district administration; and
- mandatory investigation and discipline procedures by the principal.[2]

All school districts, charter schools, non-public schools, approved private day or residential schools, and collaborative schools were required in 2010 to develop evidence-based bullying prevention and intervention plans that encompass these requirements.[3] To assist in this process, the Department of Elementary and Secondary Education (DESE) created a model plan and provided resources.[4]

Further, the law establishes a multi-agency commission, chaired by the Office of the Attorney General, to review its effectiveness. **Cont'd on p. 5**

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than a reasonably firm diagnosis, such as aggression, with these drugs.[10]

Others advocate caution when using atypicals even with a diagnosis of one of the disorders for which atypicals were originally entertained. Dr. Gary Sachs, director of the bipolar clinic and research program at Massachusetts General Hospital, notes that while the medications work well if the diagnosis is correct, accurate diagnosis is a challenge:

> "It's at least three times as much evaluation time requirement I think to see the situation clearly as it is with adults," … That's because you need to talk with parents, teachers and pediatricians to get a full picture. And that's something insurance companies don't pay doctors for, Sachs says, so diagnoses are often rushed.[11]

While in the past, mental health advocates argued that indiscriminate medicating produced zombie-like patients, advocates now suggest an added downside. While many in the field traditionally justified such a medication regime as a necessary precursor to the ability to pursue other tools of recovery, such as therapy, some now question the assumption that medicating a patient must precede the initiation of therapy.[12] Instead, they contend that the highly medicated patient is *less* able to pursue such treatments.[13]

Others contend that medication is simply a means of social control, and an ineffective one at that. And some suggest youth are being medicated as a substitute for the control that might have previously been secured through restraint. As restraint has become more regulated and less easily available, these observers argue, medication use has become a replacement means of management.[14] Others point out that medicating incarcerated youth is not effective in the long run anyway because it does nothing to change the violent settings to which many such youth will return. Such settings may increase risk of aggressive behavior.[15]

Antipsychotic Use by Certain Youth Subpopulations is Particularly Higher

For certain subpopulations of youth with mental illness, antipsychotic use is particularly high. One example is use of antipsychotics by youth with public insurance. Adjusting for patient diagnosis and background characteristics, mental health visits by publicly-insured children and adolescents were significantly more likely to include the prescription of an antipsychotic medication than were visits by privately-insured patients.[16] This finding is consistent with other studies which have documented higher antipsychotic use by youth covered by Medicaid compared with youth covered by private insurance.[17]

There is similarly a need to monitor the administration of antipsychotic medication to youth in state custody. The American Academy of Child and Adolescent Psychiatry explains the current climate: "as a result of several highly publicized cases of questionable inappropriate prescribing, treating youth in state custody with psychopharmacological agents has come under increasingly intense scrutiny."[18]

As members of these two subpopulations, youth served by the Massachusetts Department of Youth Services (DYS) could be at risk for inappropriate prescribing of antipsychotics. However, we do not actually know whether youth served by DYS, particularly those confined to DYS run or contracted facilities, are overmedicated, undermedicated, or otherwise poorly medicated. While there is certainly basis for such a concern based on the clinical literature[19] and on the experience of other states,[20] there is limited information published about the experience of youth in Massachusetts DYS. Thus, it is worthwhile to examine antipsychotic usage by DYS-involved youth.

Analysis of the use of psychiatric medications is underway for a similarly situated group in Massachusetts — youth in the custody of the Department of Children and Families (DCF).[21] The Office of the Child Advocate, in conjunction with Northeastern Law School's Legal Skills in Social Context Social Justice Program, is examining the *Rogers* substituted judgment process that is used to obtain informed consent for administering psychoactive medications for children in DCF custody.[22]

How mental health care is delivered to DYS-involved youth

Before contemplating review of medication rates of youth involved with DYS, it is helpful to outline the ways in which mental health services are delivered to this population. The mental health care delivery system for DYS-involved youth has two key features. First, the system retains parental/guardian involvement. Second, the system may be different in different types of settings. These dual features mean that multiple factors may be at play in mental health treatment decisions.

With respect to the first feature, Massachusetts DYS does not assume legal custody of youth confined to its facilities. Legal custody and, therefore, the ability to make decisions regarding the acceptance or refusal of anti-psychotic medication, is retained by the parents or legal guardians (through the court) (if the youth is younger than 18) and by the youth (if the youth is 18 or older). DYS will contact a parent, legal guardian, or youth, as appropriate, to obtain consent for invasive forms of treatment, including treatment with psychotropic medications.[23] Legal guardians, including the Department of Children and Families, may not individually consent to treatment with antipsychotics, but must pursue judicial authorization of a treatment plan.[24]

Thus, drug usage rates for DYS-involved youth are influenced not only by mental health providers, but also by decision-making of the parent or youth, or by the judicial substituted judgment process when there is a legal guardian. Nonetheless, the normal

tendencies of a lay decisionmaker to accept the treatment recommendations of a professional prescriber may be more pronounced when the decision-maker is not intimately involved in the clinical interactions. Such limited involvement may be a common experience for youth in DYS's physical custody.[25]

Second, the population of DYS-involved youth contains a number of distinct sub-groups who receive mental health services in various ways. One group is youth detained prior to adjudication. DYS has physical custody of these youth, but typically only for 15 to 30 days.[26] These youth have access to DYS-contracted medical professionals, but because of their short lengths of stay and the need to protect their Fifth Amendment rights in light of pending charges, DYS does not conduct any formal clinical assessment for the purpose of providing behavioral health treatment or medications.[27] However, DYS does continue any medications, including behavioral health medications, prescribed by the youth's current prescriber.[28]

Another group is composed of court-committed youth. Committed youth usually have an initial period of physical custody in a DYS locked (hardware) secure facility and typically progress to release to the community under DYS supervision, often with a stay in a DYS community-based residential program in between. In locked secure settings, DYS contracts with health services professionals to provide mental health services, including assessments and medication management.[29] With respect to DYS's community-based residential programs, some programs offer mental health treatment through clinicians contracted by the program and other programs refer youth to community behavioral health providers.[30] Youth residing in the community under DYS supervision also are seen by community providers.[31]

Thus, in certain ways, the DYS-involved population is similar to the general population of youth in the community. Decision-making authority regarding anti-psychotics does not change with detention or commitment to DYS. And, for certain categories, youth served by DYS, mental health treatment, including medication management, is performed by the same sorts of community providers that other non-DYS involved youth would see. Only youth confined to DYS locked secure facilities and the segment of the youth population confined to community-based residential programs have a pre-determined and common set of mental health providers.

DYS explains that the agency

> has gone to great lengths to ensure that its contracted medical providers are appropriately credentialed and employ the best standards of practice in working with youth and/or their parents/guardians who are seeking referrals, assessments and management of their behavioral health medications. . . . In the youth's monthly treatment meeting, the Department reviews each youth's treatment interventions and collaborates with the prescriber for youth on behavioral health medications.[32]

These measures by DYS offer a level of protection to committed, confined youth. Data collection of medication usage rates of the segments of the DYS-involved population served by the discrete cohort of contracted providers would serve a similar purpose and is equally important.

2006 study by the Massachusetts Behavioral Health Partnership

A 2006 study by the Massachusetts Behavioral Health Partnership (MBHP) examined the use of behavioral health medications by youth committed to DYS as compared with similarly situated children not involved with DYS, but also receiving MassHealth and MBHP services.[33] MBHP is a managed care organization that manages the mental health benefits covered by MassHealth for DYS committed youth. At the time of the study, all youth committed to DYS and in DYS's physical custody received their mental health services through MassHealth so it was possible for MBHP to track usage rates for that population. The MBHP study split the category of DYS committed youth into two subgroups: youth in secure settings and youth in community settings.[34]

The study found less overall use of behavioral health medications among the DYS-involved youth than among the non-DYS comparison group.[35] The researchers posited that the differences in overall use of behavioral health medications might be explained by a combination of factors: more intensive behavior management programming, physical containment, and/or a different clinical profile between DYS-involved and comparison group youth.[36] (*DYS* notes that the study's grouping of youth living in DYS residential programs with youth living in the community under DYS supervision makes it difficult to draw conclusions regarding the category of committed youth in community settings.[37])

Looking at the use of particular medications, the study found that DYS-involved youth, both those in locked settings and in the community, used notably less antipsychotics than the comparison group.[38] The investigators did not find this troubling.[39] The only finding regarding DYS-involved youth that raised their concerns was that committed youth in DYS locked settings diagnosed with bipolar disorder used significantly less mood stabilizers than a comparison group of non-DYS counterparts.[40]

One of the recommended next steps of the 2006 study was for MBHP to collaborate, upon request from DCF and/or DYS, "on further analysis of this data set and/or other ways to make the findings of this Performance Incentive Project useful."[41] MBHP subsequently did look at youth in DYS who were using multiple medications simultaneously, a concerning situation, and addressed cases in which problematic medication use was identified.[42] However, MBHP hasn't pursued this recommendation in other ways.[43]

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Today, MBHP cannot conduct the same sort of analysis that it did in 2006 as DYS-involved youth in locked secure settings and some youth in DYS residential programs receive mental health services through contracted providers paid by DYS or the program instead of through MassHealth-funded providers. Thus, MBHP no longer receives psychiatric medication usage data for some of the youth that were included in the 2006 study.

Now, in order to fully monitor psychiatric medication usage rates for DYS-involved youth, both MBHP and DYS must collect and analyze data. MBHP has the capacity to collect and analyze such data for DYS-involved youth receiving MassHealth mental health services. DYS could collect data for youth served by providers contracting with DYS or its vendors. However, DYS does not presently track the number of youth taking behavioral medication, or the type of medications, for the purpose of determining medication usage of its population.[44]

Conclusion

Were DYS and MBHP to again examine behavioral health medication use rates for DYS-involved youth, we might find that there continues to be an underuse, not overuse, of behavioral health medication, including antipsychotics. Such a finding would pose questions for follow-up, as the last study recommended. Or, we may find that usage rates have changed. As a first step, the relevant Massachusetts agencies must convene to plan the gathering, reporting, and evaluating of relevant data.

That data should be broken down to address differences among the situations of DYS-involved youth – at a minimum disaggregating the data for detained versus committed youth and for committed youth in DYS locked secure programs, DYS residential programs, and those released to the community but under DYS supervision. Additionally, subsequent studies should control for, or at least identify, the effects of the other factors that the 2006 study identified.

Endnotes

[1] Lifetime Prevalence of Mental Disorders in U.S. Adolescents: Results from the National Comorbidity Survey Replication–Adolescent Supplement (NCS-A) *Journal of the American Academy of Child and Adolescent Psychiatry* 49:10 (Oct. 2010), 980-89.
[2] *Id.*
[3] Mark Olfson, *et al*., National Trends in the Outpatient Treatment of Children and Adolescents With Antipsychotic Drugs, National Trends in the Outpatient Treatment of Children and Adolescents with Antipsychotic Drugs, 63 Arch. Gen. Psychiatry (June 2006), 679-685, http://www.njdc.info/2006resourceguide/PDFs/11%20Mental%20Health/B%20Treatment/Olfson-OutpatientTreatment.pdf; Michael W. Naylor *et al*., Psychotropic Medication Management for Youth in State Care: Consent, Oversight, and Policy Considerations, 86 Child Welfare 5 (Sept./Oct. 2007), 175-192, at 176. For a comprehensive examination of the recent increases in the use of medications to treat mental disorders, see Erik Parens and Josephine Johnston, Hastings Center, Troubled Children: Diagnosing, Treating, and Attending to Context (2011), http://www.thehastingscenter.org/Publications/SpecialReports/Detail.aspx?id=5181.
[4] Virginia Merritt, M.D., Red Flags in Juvenile Rogers Cases: Assessing the Affidavit, MCLE (Feb. 4, 2011) at 2-4. First generation antipsychotics are the typical antipsychotics that work by blocking dopamine receptors. Atypicals work on both dopamine and serotonin receptors. *Id.* at 1.
[5] *Id.*
[6] Mark Olfson *et al.*, *supra* note 3, at 684.
[7] Virginia Merritt, M.D., Red Flags in Juvenile Rogers Cases: Deciphering the Affidavit, MCLE (Feb. 4, 2011) at 1-2.
[8] *Id*. at 2.
[9] John Kelly, "Psych Meds in Jails", Youth Today (Oct. 1, 2010), www.youthtoday.org/view_article.cfm?article_id=4344.
[10] Virginia Merritt, M.D., Red Flags in Juvenile Rogers Cases: Deciphering the Affidavit, *supra* note 7, at 1-2.
[11] Monica Brady-Myerov, Parents Divided By The Medication Debate (Feb. 1, 2011), http://www.wbur.org/2011/02/01/childrens-mental-health-ii.
[12] John Kelly, *supra* note 9.
[13] *Id.*
[14] *Id.*
[15] Nancy Rappaport and Christopher Thomas, Recent Research Findings on Aggressive and Violent Behavior in Youth: Implications for Clinical Assessment and Intervention, 35 Journal of Adolescent Health (2004), 260-277 at 266, http://www.nancyrappaport.com/files/Rappaport%20and%20%20Behavior.pdf.
[16] Mark Olfson *et al*., *supra* note 3, at 683.
[17] *Id*.
[18] AACAP Position Statement on Oversight of Psychotropic Medication Use for Children in State Custody: A Best Principles Guideline, http://www.jdcap.org/SiteCollectionDocuments/Foster%20Parents%20Best%20Principle.pdf, at 1; *see also* Tennessee Department of Children's Services Pharmacy and Therapeutics Committee, Psychotropic Medication Utilization Parameters For Children in State Custody, http://www.tn.gov/youth/dcsguide/policies/chap20/PsychoMedUtilGuide.pdf.
[19] For example, a 2009 study, based on a review of Medicaid and private insurance claim records in seven states between 2001 and 2004, concluded that children covered by Medicaid are given powerful antipsychotic medicines at a rate four times higher than children whose parents have private insurance. Stephen Crystal *et al*., "Broadened Use Of Atypical Antipsychotics: Safety, Effectiveness, And Policy Challenges," HEALTH AFFAIRS (July 2009), http://content.healthaffairs.org/content/28/5/w770.abstract. Additionally, children on Medicaid are more likely to receive antipsychotics for less severe conditions than their middle-class counterparts with private insurance. While research suggests that low-income children have approximately twice the rate of mental health problems as their better-off counterparts, that does not explain the disparity the team found.
[20] *See* John Kelly, *supra* note 9.
[21] Outside the Commonwealth, the U.S. Government Accounting Office (GAO) is investigating various state policies for placing foster children on atypicals. The GAO is particularly looking at very young foster children prescribed certain kinds of psychotropic drugs, children prescribed psy-

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chotropic drugs in dosages that exceed accepted standards, children prescribed psychotropic drugs for purposes other than a medically accepted indication, or children taking numerous psychotropic drugs concurrently.
[22] Office of the Child Advocate of Massachusetts, Request for Stakeholder Input (Dec. 20, 2010).
[23] DYS, Authorization for Medical Care, Policy # 02.05.04 (Mar. 14, 2000), Procedures B.6.d.
[24] For information on DCF practice, see 110 CMR 11.14 and DCF, Routine and Extraordinary Health Care Services, Frequently Asked Questions, http://www.mass.gov/Eeohhs2/docs/dss/health_med_services/faqs_routine_and_extraordinary_hc.rtf.
[25] *See, e.g.,* AACAP Position Statement, *supra* note 18.
[26] Memorandum from Robert Turillo, DYS to Jennifer Honig (Mar. 3, 2011) (on file with MHLAC) at 1.
[27] *Id.*
[28] *Id.*
[29] *Id.* at 2; telephone communication from Robert Turillo, DYS to MHLAC (Feb. 22, 2010).
[30] Memorandum from Robert Turillo, *supra* note 26, at 2.
[31] *Id.* The youth's DYS caseworker assists the youth in accessing appropriate mental health services. *Id.*
[32] *Id.*
[33] Mass. Behavioral Health Partnership (MBHP), "Patterns of Medication Prescribing for Children in the Massachusetts Child Welfare and Juvenile Justice Systems" (June 30, 2006), http://www.masspartnership.com/tempdoc/PI5%20Report%202006%20Final%20Version.2-12-07.pdf.
[34] *Id.* at 2.
[35] *Id.* at 7, 20. DYS-involved youth were also found to be on fewer such medications than the comparison group. *Id*. at 7.
[36] *Id.* at 20.
[37] Memorandum from Robert Turillo, *supra* note 26, at 2.
[38] MBHP, *supra* note 33, at 9-10.
[39] *Id.* at 14, 20.
[40] *Id.*
[41] *Id.* at 21.
[42] Email from John Straus, MBHP to Jennifer Honig (Feb. 2, 2011). After the 2006 report, MBHP did not specifically study further DYS youth in terms of medication prescribing, but did look at the outlier prescribing as defined in the original study, such as 3 or more medications, for both state agency youth and non state agency youth covered by MassHealth through MBHP. MBHP concluded that when you just considered why medications were started, the reasons met "community standards." However, MBHP noticed that many youth had been on complex regimens for over six months, often much longer, without anyone trying to simplify the regimen even though the initial behavior justifying the medication was no longer problematic. MBHP identified some of those youth and successfully simplified their medication regimens. *Id.*
[43] *Id.*
[44] Memorandum from Robert Turillo, *supra* note 26, at 2.

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The commission has held public hearings[5] and must issue a report by June 30, 2011 containing the results of its investigation and study, recommendations, and drafts of legislation necessary to carry out any recommendations.[6]

How will schools respond to complaints of bullying?

Advocates are interested in how schools, with all these new procedures, will respond to individual complaints of bullying. In particular, advocates are interested in when principals will address cases of alleged bullying within the school and when they will refer cases to law enforcement. While the statute does not establish new criminal penalties for acts of bullying, it requires immediate notification by principals of local law enforcement when criminal charges may be pursued against the perpetrator.[7] The DESE regulation broadly interprets this requirement stating:

> At any point after receipt of a report of bullying or retaliation, including after an investigation, the principal shall notify the local law enforcement agency if the principal has a reasonable basis to believe that criminal charges may be pursued against the aggressor.[8]

Advocates had hoped that these regulations would provide clearer direction as to what cases should be referred to law enforcement. For example, the American Civil Liberties Union proposed that the principal should be instructed to refer a student only when the behavior actually constitutes a crime or crimes under Massachusetts law and only after a full investigation by the principal.[9] Further, the regulations explicitly single out the school resource officer (SRO), typically a local law enforcement officer assigned to schools pursuant to a cooperative agreement with school officials, as one person the principal may consult with in making the determination whether to notify law enforcement.[10] Advocates did not favor singling out the SRO.[11]

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Advocates were successful in adding language to ensure discipline is not simply used in a punitive way, but is used to encourage positive behavioral change. The regulations allow principals to take appropriate disciplinary or other action "provided that disciplinary actions balance the need for accountability with the need to teach appropriate behavior."[12]

And, acknowledging that the regulation did not provide much in the way of guidance to principals, DESE did indicate that:

> school districts and schools require guidance on ways to meet their obligation to notify law enforcement in certain circumstances. However, it is appropriate to do that in a guidance memorandum, not through regulation. ESE will work with its partners to issue guidance on implementation of the requirement.[13]

Moreover, the Act continues to allow suspension and/or exclusion as possible disciplinary responses to bullying. In fact, many of the school plans submitted to DESE in response to the Act's mandate allow for suspension and/or expulsion as possible responses.[14] The anti-bullying law could provide schools with alternatives to these types of responses. Below are some of these alternatives, specifically in the context of students with disabilities.

What does the statute mean for students with disabilities generally?

The anti-bullying statute provides students with disabilities protection from bullying and direction when the student is suspected of bullying.[15] For youth receiving special education services pursuant to IDEA, the Act requires the youth's IEP team to routinely consider whether the student has been involved in any bullying incident and use that information when developing the IEP.[16] Additionally, the team should convene if the parent or any staff believes that the student is at risk of being bullied and the risk is directly tied to the student's disability.[17] These processes will help ensure that youth with Individualized Education Programs (IEPs) are not targeted by other students because of their physical and/or mental disability. Also, the Act requires the team to convene if a student with an IEP is exhibiting bullying behavior and the behavior is directly tied to the student's disability.[18]

In addressing bullying risk or behavior, the team may, for example, provide additional counseling for skill-building supports to prevent or respond to bullying. The team may also conduct a Functional Behavioral Analysis and develop a Behavioral Intervention Plan that identifies target or aggressor behaviors, identifies antecedents to these behaviors, and proposes interventions for teaching the student to reduce and/or avoid these behaviors.[19]

Students with disabilities receiving accommodations or services under Section 504 of the Rehabilitation Act of 1973 also have a right to access bullying prevention and intervention programs, activities, and protections as would a non-disabled child.[20] Under Section 504, schools must ensure that any 504-eligible student receives a free appropriate public education.[21] To the extent that bullying is infringing on that right, 504-eligible youth have a right to services and/or accommodations to remedy that situation.[22]

Thus, youth with disabilities – both those with IEPs and those with 504 plans – can use the anti-bullying act to seek redress when bullying risk or behavior is preventing their access to education. And, for youth with behavioral health needs, the Act can provide additional supports, as the next section outlines.

What does the statute mean for youth specifically with behavioral health needs ?

Potentially, the anti-bullying law can benefit youth with behavioral health needs. One important indication of this possibility is DESE's encouragement of school districts to incorporate the draft Behavioral Health and Public School Framework into their anti-bullying plans.[23] This framework, codified in a 2008 state law, promotes positive and supportive school environments through collaboration between schools and behavioral health services.[24] Schools must address student behavioral needs through early behavioral intervention and intensive treatment for individuals. The framework is an important tool for schools as they address bullying as it will allow them to respond to the mental health needs of both the victims and the perpetrators. For the latter group, research has shown that undiagnosed and unmet mental health needs often play a role in the youth's physical aggression.[25]

Schools should draw from the work of the taskforce convened under the 2008 law. That taskforce will release its report June 30, 2011 detailing the findings of a statewide assessment and recommending a plan for statewide utilization of the framework.[26]

Conclusion

A recent study found that one fourth of Massachusetts middle school students have endured bullying.[27] Our anti-bullying statute contains positive requirements to address the specific needs of youth with disabilities, such as youth with behavioral health needs. At the same time, it leaves open the paths by which such youth have historically become entwined in the juvenile justice system. An ongoing tension remains between school responses that seek to keep the involved parties in school and those responses that seek to remove the parties through referrals to law enforcement, school exclusion and other means. (And, it is often not only the perpetrator that schools seek to remove, but also the victim who they see as at-risk and vulnerable.) Particularly as schools face constrained budgets, the lure of removing more needy students as a means of compliance with the new law becomes more attractive and deserves our attention.

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Endnotes

[1] G.L. c. 71, § 37O(b).
[2] G.L. c. 71, § 37O(d), (g).
[3] Chapter 92 of the Acts of 2010, § 15.
[4] *See* DESE, Model Bullying Prevention and Intervention Plan under M.G.L. c. 71, § 37O (Aug. 24, 2010), http://www.doe.mass.edu/news/news.aspx?id=5680.
[5] *See* Attorney General Coakley to Hold Commission Hearings on Legislative Order to Make Recommendations on Bullying and Cyber-Bullying Laws (Feb. 8, 2011), http://www.mass.gov/?pageID=cagopressrelease&L=1&L0=Home&sid=Cago&b=pressrelease&f=2011_02_08_bullying_advisory&csid=Cago.
[6] Chapter 92 of the Acts of 2010, § 18.
[7] G.L. c. 71, § 37O(d).
[8] 603 CMR 49.06(2).
[9] DESE, Analysis of Public Comments on Proposed New 603 CMR 49.00: Notification of Bullying or Retaliation (Sept. 2010), http://www.doe.mass.edu/boe/docs/0910/item5regs.doc.
[10] 603 CMR 49.06(2)(a).
[11] DESE, Analysis of Public Comments, *supra* note 9.
[12] 603 CMR 49.06(2)(b); DESE, Analysis of Public Comments, *supra* note 9.
[13] DESE, Analysis of Public Comments, *supra* note 9.
[14] For example, see plans submitted by Needham P.S (Dec. 22, 2010), at 36 (middle school) and 39 (high school), http://www.needham.k12.ma.us/documents/Bullying-Plan-Final.pdf; Mansfield P.S. (Dec. 2010), at 27 (high school); Brookline P.S. (Jan. 1, 2011), at 15, http://docs.google.com/viewer?a=v&q=cache:zU6iZLs1tW4J:www.brookline.k12.ma.us/index.php%3Foption%3Dcom_docman%26task%3Ddoc_download%26gid%3D640+school+bullying+plan+massachusetts&hl=en&gl=us&pid=bl&srcid=ADGEESiui5jJdowc-XC485pPZJQffrYDfGqMJXskUBTC85Phfbz; Wakefield P.S., Policy SA-100-04, Harassment, Bullying & Hazing Policy, at 6, http://www.wakefield.k12.ma.us/Pages/WakefieldPS_Committee/Final%20Harassment%20&%20bullying%209-9-10.pdf.
[15] Children with disabilities are two to three times more likely to be targets of bullying than nondisabled peers, Mass. Advocates for Children (MAC), Legal Protections to Prevent Bullying of Students with Disabilities (Mar. 1, 2011), at 3 (on file with MAC), and children who experience social rejection themselves are more likely to "pass it on" to others. Bullying Statistics website, Why do People Bully?, http://www.bullyingstatistics.org/content/why-do-people-bully.html.
[16] DESE, Technical Assistance *Advisory SPED 2011-2: Bullying Prevention and Intervention* (Feb. 11, 2011), http://www.doe.mass.edu/sped/advisories/11_2ta.html.
[17] *Id.*
[18] *Id.*
[19] *Id.*
[20] *Id.*
[21] *Id.*
[22] *Id.*
[23] DESE, Model Bullying Prevention and Intervention Plan, *supra* note 4.
[24] Section 19 of Chapter 321 of the Acts of 2008, An Act Relative to Children's Mental Health.
[25] *See, e.g.*, Naomi E. Sevin Goldstein *et al.*, Mental Health Disorders: The Neglected Risk Factors in Juvenile Delinquency, http://www.sjsu.edu/people/edward.cohen/courses/youth/s0/class%204_mental%20health%20disorders%20and%20juvenile%20delinquency.pdf, at 85.
[26] Chapter 321 of the Acts of 2008, An Act Relative to Children's Mental Health, § 19(g).
[27] CDC and Mass. DPH, Bullying Among Middle School and High School Students --- Massachusetts, 2009 (Apr. 22, 2011), http://www.cdc.gov/mmwr/preview/mmwrhtml/mm6015a1.htm?s_cid=mm6015a1_w.

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