

# Special Education's Service to Students with EBD



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# Percentage of the School Population Served

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Slightly less than 1% according to the annual reports to Congress on implementation of IDEA

# Percentage of the Target Population Served

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- ✦ About 20% by conservative estimates (including Surgeon General Hatcher's report in 2001 and annual reports to Congress)
- ✦ Based on the assumption that the prevalence rate of the majority of studies is correct (i.e., that children and youth with serious mental health problems constitute about 5% of the child population)

# Characteristics of Those Served

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- ✦ Most have been known by school and parents to have been problems for *several years*
- ✦ Most are in *middle* grades or early *adolescence* when identified as EBD
- ✦ Most have been *academic failures* and *social deviants* who have *not learned from appropriate peer models* and have *gravitated toward affiliation with deviant peers*

# We Know that These Things Elevate Risk

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- ✦ Academic failure
- ✦ Aggression
- ✦ Rejection by nondeviant peers
- ✦ Affiliation with deviant peers
- ✦ Early onset
- ✦ Poverty

# PREVENTION

## An Idea Everybody Loves

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### ◆ *THREE LEVELS:*

✦ *Primary*—problem never occurs

✦ *Secondary*—problem begins, but it is stopped or reversed; worsening is prevented

✦ *Tertiary*—problem is severe; we just keep it under control and prevent total breakdown

# Prevention: Things That We Know Are Preventative

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- ✳ Reward for appropriate behavior
- ✳ *Nonviolent* punishment of misbehavior
- ✳ Direct teaching of critical skills
- ✳ Consistent, predictable (structured) environment
- ✳ Immediate help in problem-solving
- ✳ Anticipation and *positive* pre-emption of misbehavior (not punishment)

# Preventing EBD: More of What We Know

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- √ Risk is a continuous distribution--there is no clear or obvious line dividing high from low risk
- √ We can identify conditions that elevate risk
- √ Early intervention can prevent later problems
- √ Early applies to symptoms and episodes
- √ Prevention must focus on what's effective
- √ Prevention at all levels is important
- √ The case for prevention is very hard to make

# LONG HISTORY OF *SAYING* WE'LL PRACTICE PREVENTION

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- ✦ Third White House Conference on Child Health and Protection (1930)
- ✦ Bower, E. M. (1960). *Early identification of emotionally handicapped children in school*. Springfield, IL: Thomas.
- ✦ Caplan, G. (Ed.). (1961). *Prevention of mental disorders in children*. New York: Basic Books
- ✦ Report of the President's Commission on Excellence in Special Education (July, 2002)
- ✦ Recent Reauthorization of IDEA

# Some of the Reasons We Do Not Prevent EBD

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- ⊙ We never see what we prevent (obviously, if it happens, then we didn't prevent it).
- ⊙ Some say that to anticipate or expect or predict is to make it happen.
- ⊙ Some argue that it wouldn't have happened anyway.
- ⊙ Effectiveness is hard to demonstrate, especially when we can't do random assignment.

# More About Why We Don't Practice Prevention

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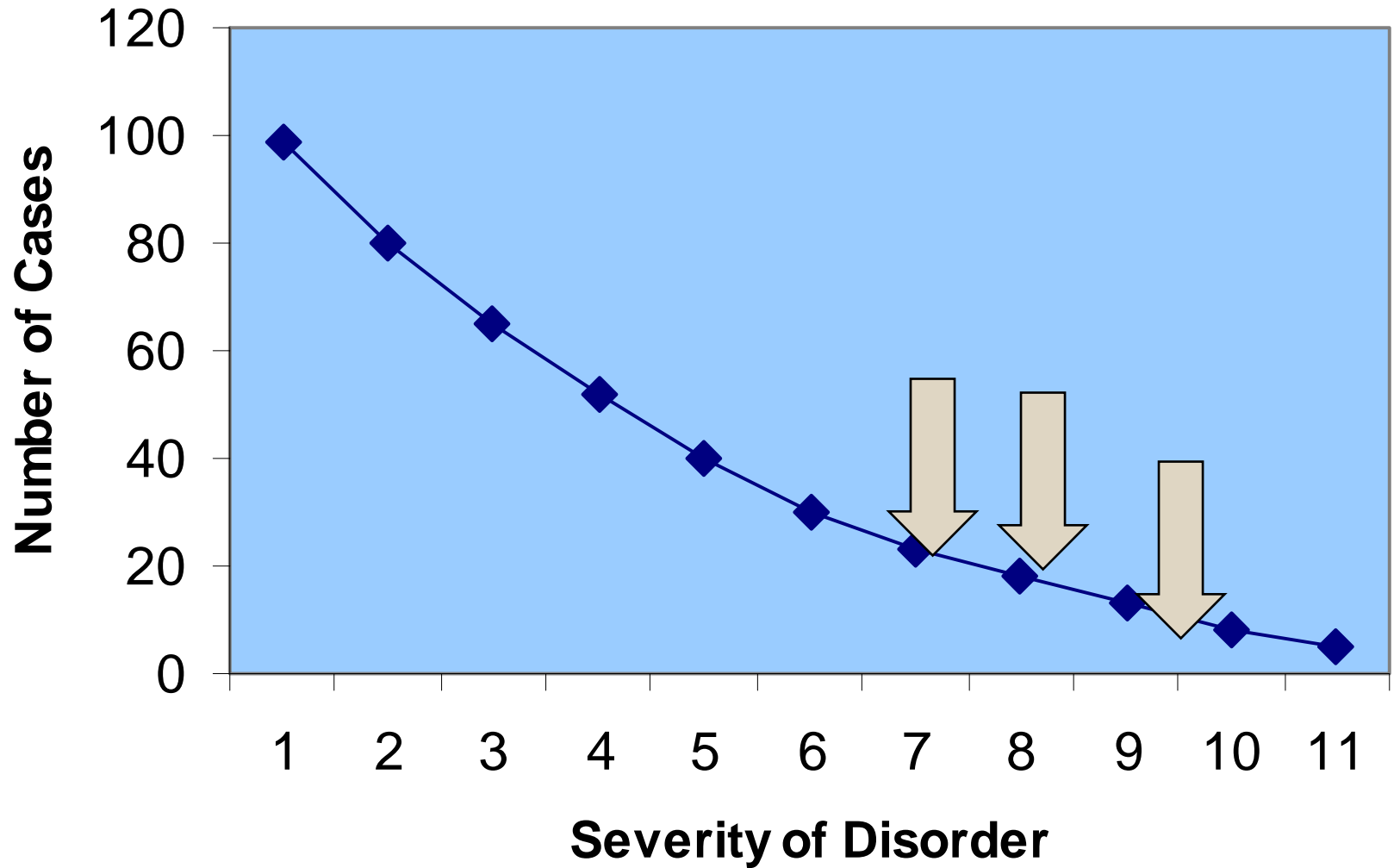
We worry **excessively** about things **other than** prevention. These may be legitimate concerns, but **if** we let them become more important to us than prevention, then we make prevention impossible.

# Some of the Excuses We Use Not to Prevent EBD

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1. Concern about *labels & stigma*
2. Wish to avoid all *false positives*
3. Assumption that *special education is bad or ineffective*
4. Wish to be *minimally intrusive and restrictive*
5. Concern about (a) **number**, (b) **cost**, (c) **disproportional identification**, and (d) **diversity of behavior**

## Number by Severity (probably close)



# Most Students with EBD Have Multiple, Severe Problems

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- ✦ Little wonder insurers don't want to deal with the reality
- ✦ Most students need multiple, protracted services
- ✦ Immediate cost savings trump long-term cost savings
- ✦ Rationales for denying services are powerful