Special Education’s Service to Students with EBD

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Percentage of the School Population Served

Slightly less than 1% according to the annual reports to Congress on implementation of IDEA
Percentage of the Target Population Served

- 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

- 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

- Academic failure
- Aggression
- Rejection by nondeviant peers
- Affiliation with deviant peers
- Early onset
- Poverty
PREVENTION
An Idea Everybody Loves

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

- 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

- 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

- Third White House Conference on Child Health and Protection (1930)
- 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

- 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

We worry excessively about things other than prevention. These may be legitimate concerns, but if we let them become more important to us then prevention, then we make prevention impossible.
Some of the Excuses We Use Not to Prevent EBD

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)

Number of Cases

Severity of Disorder

0 20 40 60 80 100 120

123 4 5 6 7 8 9 10 11
Most Students with EBD Have Multiple, Severe Problems

- 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